South Carolina Children's Advocacy Centers Landscape Study

Executive Report

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Between 2016 and 2017, the Institute for Child Success conducted a landscape study and analysis of member centers of the South Carolina Network of Children's Advocacy Centers (SCNCAC) on their organizational capacity, needs and outcomes. This study was designed to assess the current status, services and outcomes of South Carolina Child Advocacy Centers and yield valuable information that could inform any future quality improvement, strategic planning, and advocacy efforts from the state network and the individual CACs.

(by)

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These centers help investigate reports of child abuse in a way that helps collect accurate information while minimizing any further trauma for children. The CAC also connects children and their families with services that promote the healing process and help strengthen child and family resilience.

Children's Advocacy Centers across the country offer core services for the investigatory and healing process, including forensic interviews, multi-disciplinary team review of cases and information, medical examinations for child victims, and family advocacy. Other services provided by South Carolina's CACs – directly or through contracts – include group and individual mental health counseling, child support groups, parenting classes, school-based health education, community education and advocacy about child maltreatment prevention, and family and community outreach. Additionally, one South Carolina CAC is only the second in the nation to employ a chaplain, and several also use trained service animals in the clinical process.

There are 17 Children's Advocacy Centers in South Carolina, 16 of which are accredited by the National Children's Alliance (see Appendix C for detail and accreditation status). CACs vary in size, personnel, capacity, services, and geographic coverage. The state's CACs are supported by the South Carolina Network of Children's Advocacy Centers, an accredited chapter of the National Children's Alliance. Thirteen of the 17 CACs participated in the survey process as did the former Executive Director of the Network and the Executive Director of the South Carolina Children's Advocacy Medical Response System (SCCAMRS).

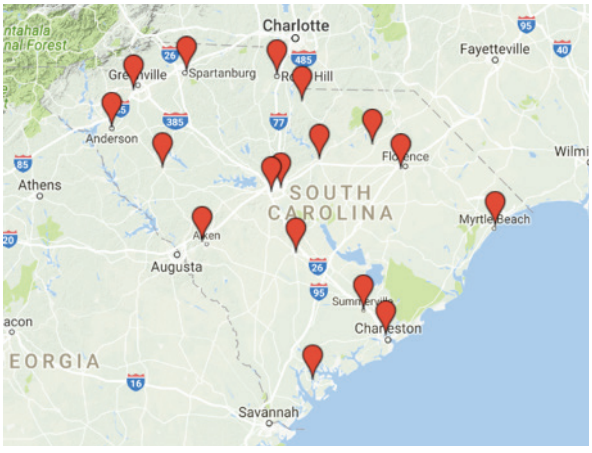

Figure 1: Map of South Carolina CACs

This study was conducted over the fall of 2016 and the early winter of 2017 through a survey and data collection process that included individual interviews with CAC staff as well as with the National Children's Alliance, the South Carolina Network of Children's Advocacy Centers, and South Carolina governmental

officials from the Department of Social Services and Department of Health and Environmental Control. Data and information not gleaned from these interviews are cited.

This project was generously supported by a grant from the BlueCross BlueShield of South Carolina Foundation. This report highlights key findings and opportunities to maximize the impact of CACs in South Carolina and beyond. Appendices follow:

- Appendix A: South Carolina Child Maltreatment Data by County
- Appendix B: Annual Unmet Need: Medical Exams
- Appendix C: South Carolina's Children's Advocacy Centers

(defining organizations)

Children's Advocacy Center – a child-friendly facility that investigates claims of child abuse, assists in the healing process with evidence-based treatment, and convenes relevant, multi-disciplinary stakeholders in the investigatory, healing, and legal processes.

South Carolina Network of Children's Advocacy Centers – The state chapter of the National Children's Alliance, which provides and facilitates professional development opportunities, grants management and technical assistance services, and acts as a convener for the state's 17 CACs. The Network represents and advocates on behalf of the individual CACs to state organizations and governmental entities.

National Children's Alliance – The national association for CACs and state chapters. This entity accredits local CACs, provides technical assistance and grants, and advocates on behalf of CACs and child victims of abuse and maltreatment at the federal level.

South Carolina Children's Advocacy Medical Response System (SCCAMRS) – Founded in 2003, SCCAMRS provides, coordinates and administers medical resources that support CACs, children's hospitals and state agencies in the investigation, assessment, treatment, and prosecution of child abuse or neglect. The program supports a consistent quality standard of care and practice for forensic medical examinations/consultations, participation in multi-disciplinary team (MDT) case conferences and review, and medical expert witness services. Additionally, the program has developed and maintains the only state medical database of children evaluated by medical specialists trained in child abuse pediatrics.

Project BEST – A joint project between the Medical University of South Carolina and the Dee Norton Lowcountry Children's Center, South Carolina's Project BEST is a statewide learning collaborative that trains mental health professionals in evidence-supported, trauma-informed therapeutic treatment programs. Project BEST maintains a public database of all professionals trained.

(key findings)

Child Welfare

Child maltreatment in South Carolina is on the rise and most often involves children ages 12 or younger. Children under age five represent nearly one in two cases of substantiated child maltreatment. In comparison with national data, physical abuse in South Carolina accounts for three times more substantiated cases than other types of abuse.

Founded Investigations. Over the past decade, the number of "founded investigations" for child abuse has risen dramatically, from around 4,800 in 2008 to just over 7,700 in 2015.[1] In that same year, the total number of children involved in abuse and/or neglect cases is slightly greater than 14,550,[I] of whom 75 percent were ages 10 or younger. Children under the age of five represent at least 40 percent of substantiations in South Carolina in each year from 2008 through 2015.[2] In South Carolina, the prevalence of physical abuse (in relation to other forms of child maltreatment) is well above that of the nation. *In 2015, 46 percent of substantiated cases within South Carolina involved physical abuse as compared with 17 percent of cases nationally.*[3] Data from 2016 show that roughly three quarters of the alleged offenders were parents, other relatives and other known persons.[4]

Acts of physical abuse can result in immediate damage to a child's body and brain, including head trauma and impaired brain development. In addition, long term negative impacts can occur that show up much later in life including hypertension, diabetes, asthma, and obesity as well as cardiovascular, lung, and liver disease.[5]

While the impact of child abuse and neglect is described in terms of psychological, behavioral, and societal consequences, it is virtually impossible to separate them. Physical consequences, such as damage to a child's growing brain, can have psychological implications, such as cognitive delays or emotional difficulties. Psychological problems often manifest as high-risk behaviors. Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or drugs, or overeat. High-risk behaviors, in turn, can lead to long-term physical health problems, such as sexually transmitted diseases, cancer, and obesity.[6]

Exposure to adverse experiences as a young child (including abuse, neglect, and family dysfunction) increases the likelihood of chronic illness in adulthood.[7] Witnessing violence also places children's physical and social-emotional health at risk. Nearly one in ten children in America has witnessed one family member assault another, and more than one in four has witnessed family violence during his/her lifetime. Exposure to just one kind of violence increases the probability that a child will be exposed to other types of violence, and exposed multiple times.[8]

I Data Note: KIDS COUNT data center reports several different total number of children confirmed as victims of maltreatment by indicator. This exemplifies a common limitation to confirming and understanding the true prevalence of child abuse across South Carolina. Different agencies and jurisdictions report different numbers and data sharing, especially in real time, is limited. Further, child abuse and neglect is underreported

Trends and Service Capacity

The number of child victims served by South Carolina's Children's Advocacy Centers is on the rise as well, but these diverse agencies are not able to meet the growing need. Funding challenges over the next two years will make meeting the need harder.

Children Served. From 2010 through 2016, the total number of children served by South Carolina's CACs rose from just over 6,000 to 8,117. Nearly eight in ten of these children were ages 12 and younger; of these, 35 percent were ages six or younger. More than half of the children served were referred for sexual abuse (4,416); 2,241 were referred for physical abuse, and 1,130 children were referred because they were witnesses to violence.[9]

Services Provided. Children's Advocacy Centers across the nation are a cost-effective means of responding to child abuse victims, specifically those for whom sexual abuse allegations have been made. According to 2016 data collected by the Network, of the 8,117 children served by the CACs, fewer than half (3,185) received a medical evaluation. Data from the South Carolina Children's Advocacy Medical Response System (SCCAMRS) shows that 3,957 unduplicated children received medical evaluations (4,101 exams) for allegations of abuse and/or neglect. Of those children, 3,543 were seen at CACs, either on site or through a linkage agreement with another CAC.

CACs provide forensic interviews, operate through multi-disciplinary teams, and provide or arrange for trauma-informed medical and mental health care. Their involvement increases rates of prosecution and shortens the length of the legal process. In addition, CACs provide community education about child abuse awareness, prevention, identification, and treatment.

Services provided by the CACs are always free of charge for the families they serve, many of whom are Medicaid eligible. Generally, South Carolina's CACs rely on federally-sourced, philanthropic and private dollars as well as fee-for-service reimbursements from the government. Very few CACs submit claims for private insurance payments, and only five are enrolled as Medicaid providers. Roughly one-third of CAC budgets are supported through private fundraising efforts.

Each CAC has historically received an annual award from the National Children's Alliance, passed through the South Carolina Network of Children's Advocacy Centers. These annual federal funds, once set at $10,000 for each CAC, are no longer available for local CACs. Shortly before publishing this paper, the state legislature enacted a full replacement of those dollars from state funds for the 2018-19 fiscal year. In doing so, South Carolina became the 38th state to directly support these services.

Funding Challenges for Local CACs. Reductions in other federal funding sources are also possible for upcoming years. Presently, CACs receive federal grants from the Violence Against Women Act and the Victims of Crime Act. Funding from the federal Victims of Crime Act have historically been the single largest source of funds for CACs nationwide.

Core Practices

South Carolina's Children's Advocacy Centers are highly valued as 'healing agencies' for victims of child abuse. Despite this good work, they face systemic challenges and barriers that can compromise the delivery of best practices, including the delivery of medical examinations. CACs are not reimbursed at full cost for forensic interviews, and systemic challenges exist in fully staffing multi-disciplinary teams and reducing member turnover.

Forensic Interviewing. Forensic interviewing is, "a developmentally sensitive and legally sound method of gathering factual information regarding allegations of abuse or exposure to violence. This interview is conducted by a competently trained, neutral professional utilizing research and practice-informed techniques as part of a larger investigative process."[10] The interview is a fact-finding mission to understand the depth of claims of maltreatment. The session is video recorded while members of the multi-disciplinary team watch from another room. An interview may be as short as 45 minutes with the child or may take several hours over repeat visits, depending on the child's level of distress and comfort disclosing information about the alleged abuse.

The South Carolina Department of Social Services (DSS) established a statewide reimbursement rate of $250 for each forensic interview as of August 2016, however, not all county DSS offices currently reimburse their local CAC. CACs estimate the actual cost of Forensic Interviews to be nearly 50 percent greater ($350). This estimate does not include later costs associated with testimony, data reporting, and legal proceedings.

Medical Services. In South Carolina, medical maltreatment examinations are most often recommended based on the outcome of forensic interviews with child victims, especially for those that are not admitted to an Emergency Room for acute medical emergencies. In South Carolina, there is no statutory mandate for victims to be afforded a medical examination and no state protocol for responding to abuse allegations. SCCAMRS data shows that in 2016, only 19 percent of children in need of exams were seen.[II] Children are eligible for a medical examination even if their legal or child welfare case has been closed between the time of the referral and the appointment.

Beyond the absence of statutory mandate for a medical examination in cases of alleged child sexual or physical abuse, other barriers contribute to the state's low rate of physical examinations, as reported by the National Alliance for Children. Families may cancel this important appointment due to transportation issues, or due to risk of losing work time or their employment. Beyond this, some parents have deep mistrust of the child welfare system.

A major contributor, however, could be a lack of sufficient access to medical practitioners who hold Child Abuse Pediatric board certification or requisite program qualifications and who are willing to conduct these examinations. Importantly, data shows South Carolina is above average on the allocation of child abuse pediatricians compared with other southern states and nationally,[11] yet the state's rural geography complicates the reach of providers.

II This data point "percent of need met," can be best described as a moving target, as this number is dependent on the number of reports DSS intake accepts for investigations and the number of children present per investigation. SC DSS recently shifted their intake strategy from county based intake lines to regional intake hubs with specifically trained workers to assess these reports. With this shift, the number of reports accepted for investigations increased and so the children associated with each report. The original rollout of these hubs in 2015, showed a 35 percent increase in cases accepted. DSS aims to have a single, statewide intake hotline operational at the end of 2017. Since the medical services as well as other CAC services such as forensic interviews, MDTs, etc. are tools needed at the outset of an investigation, readily available and properly funded resources are the limiting factor to support the state investigatory agencies: DSS and law enforcement. See Appendix B for a trend table.

The South Carolina Children's Advocacy Medical Response System has currently 23 child abuse medical specialists, with two additional physicians completing supervised training. Ten of these specialists are Board Certified in Child Abuse Pediatrics, completing a three-year fellowship after residency before taking board certification. SCCAMRS regularly convenes the statewide network of trained medical providers and works with CACs to identify and recruit new practitioners for a rigorous training program to serve children in need of medical services.

CAC-affiliated medical providers may be volunteers or may work under contract to a CAC in conjunction with their affiliation with a hospital or other community health care setting. They are often available to a CAC just one or two times a week or for a certain number of hours per month. In South Carolina, CACs that provide medical examinations report a two-week average wait time from referral to the medical visit, though in emergency situations, most CACs report that they can schedule an examination within one to two days. The 2016 SCCAMRS Healthcare Provider Survey completed on October 2016 revealed that 64 percent(14/22) of providers are available 3 days or more to provide medical evaluations. The remainder are available outside of regularly scheduled clinic days. The survey also revealed more than half of the counties in the Upstate are underserved. Richland, Lexington, York counties in the Midlands, Horry county in the Pee Dee and Beaufort in the Lowcountry, also have concerning trends for limited medical exam access.

The Pee Dee region, which includes the medically-underserved I-95 corridor, has 3 physicians available to families in its catchment area. Several counties in South Carolina, especially along the I-95 corridor, do not have a hospital-based, full-time pediatrician in the entire county.

Multi-Disciplinary Teams. Multi-disciplinary teams (MDTs) are responsible for coordinating the response of the different professionals required to appropriately coordinate, manage, and inform treatment for cases of child abuse. The team must include representatives from seven entities to attain national accreditation: the CAC, child protective services, medical provider, mental health provider, law enforcement officers, the Solicitor's Office, and victim's advocate. Some teams may include other representatives such as guardian ad litem for the child and staff from the local school district.

CACs act as the hub for the MDT and assist the investigatory agencies by providing critical services. For a child to be referred to a CAC for MDT treatment coordination, an investigatory body, either DSS (through their intake lines) or law enforcement makes a determination to open a case based on the legal definition of abuse and neglect. DSS has 45 days to complete the investigation into maltreatment claims and develop a family plan. During this investigation, if the maltreatment meets the definition of a crime, law enforcement is contacted. Once the DSS investigation is completed and the child is referred to the CAC, then the MDT may begin to coordinate and implement a treatment plan.

Once coordinated around a case, team members observe the forensic interview over video and collectively determine the need for a medical evaluation, the best course of treatment for the victim, and any next steps required in a legal context. Multi-disciplinary teams are most effective when there are strong interagency relationships among members and when there is minimal turnover among team members from the point of initial intake to trial, a period of up to two years. Each MDT across the state is different in their level of participation, case coordination, and participant retention.

Over the past three years, the South Carolina Network of Children's Advocacy Centers, in partnership with the University of South Carolina Children's Law Center has provided ongoing professional development opportunities on the roles, responsibilities, and protocols for multi-disciplinary team

members. Past trainings have been centrally delivered in Columbia. As MDT members are professionals that engage in other work beyond the MDT participation, many MDTs were unable to attend with all members, presenting an important barrier to team cohesion and collective knowledge building.

Social Service and Law Enforcement Jurisdictional Complexity. Geographic boundaries of the CACs often cross catchment areas for the South Carolina DSS DSS, local law enforcement offices and the courts. While there are DSS offices in each county, there are 16 court districts,[12] 46 sheriff's offices, 184 local police departments and 272 law enforcement agencies.[13] Thus, referrals to individual CACs may come from many counties that are not necessarily geographically-proximate to the communities and counties where CACs are located.

This jurisdictional complexity can impact on the composition and stability of individual multi-disciplinary team membership. Also, while DSS supports staff development, case management, and other management functions for its workers in each county, there is no analogous oversight and coordination structure across law enforcement agencies and offices. A statewide protocol tied to a consistent state policy could address MDT oversight.

Usage of Evidence-based Practices

Through Project BEST, South Carolina has become a national leader in the provision of trauma-informed, evidence-based mental health assessment and treatment for children involved in sexual abuse and other traumatic events.

South Carolina's Project BEST trains mental health professionals across the state in two evidence-supported treatment programs: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); and Alternatives for Families Cognitive Behavioral Therapy (AF-CFT). TF-CBT and AF-CBT support children and parents to process through trauma by reducing stress and depression, and to develop coping and self-regulation skills. It also supports the capacity of parents to provide a safe home environment for their children. Project BEST maintains a roster of all clinicians in South Carolina trained in TF-CBT and AF-CBT, enabling ease of access for all the state's CACs.

Project BEST was launched by the Dee Norton Child Advocacy Center and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Additional Project BEST partners include: The Office of the Governor; the South Carolina Guardian ad Litem Program; the South Carolina Departments of Social Services, Mental Health, and Juvenile Justice; the State Office of Victim Assistance; the Coastal Empire Community Mental Health Center; and the National Center on Child Traumatic Stress.[14]

Staffing Retention

Beyond challenges that impact direct service provision, staffing retention presents a common structural problem within and across Children's Advocacy Centers.

Employee Turnover. Survey results and interviews reveal that staff turnover "is not uncommon" among direct service CAC agencies. There are several reasons for this. Acquiring skills and competencies in forensic interviewing may function as a "stepping stone" to other employment for younger staff. Changes in family dynamics among staff members also contributes to turnover. CAC

leaders report that secondary and "vicarious" trauma among staff serving child abuse and child sexual abuse victims is "quite common" and can lead to staff burnout and job changes. Most CACs are not financially able to offer mental health benefits for their employees, although directors report making intentional and consistent efforts to support the emotional wellness of their staff by creating a positive working climate and offering benefits such as extra holidays.

Staff turnover is a particularly problematic when it involves forensic interviewing professionals. Directors report that forensic interviewing represents both a technical skill and the art of supportive and trusted engagement. Not all clinical staff who come to work at the CACS bring the necessary background and experiences, and they require formal professional training. Because this extensive training is only offered several times a year in South Carolina, there can be a lag time between hiring staff and their capacity to function in the role of forensic interviewer. Beyond this, few professions have the same emotional and mental fortitude as required in forensic interviewing. CACs take somewhat of a risk in the hiring and training of a new forensic interviewer, as there may be a professional mismatch in skill or fit that is only realized after an individual has been fully trained. This makes retention of these employees a high priority for all CACs in South Carolina.

Characteristics of Leadership. In contrast to turnover among younger direct service and clinical staff, many of the directors of local CACs have ten or more years of broad child welfare experience. Directors bring a wide range of training and credentialing to their roles, including from the social work, mental health and legal sectors. Based on this rich base of knowledge and experience, directors bring a deep level of insight about the issues facing child victims and their families as well as skills in program development, service coordination, and administrative management.

Recruitment and Retention Incentives. Incentives identified by directors that could improve both recruitment and retention of CAC staff include health insurance, retirement contributions, and flexible schedules as well as mental health supports for staff to address secondary trauma.

Network Capacity

The statewide South Carolina Network of Children's Advocacy Centers provides valued professional development opportunities across the CACs, coordinates knowledge-sharing and information from the National Children's Alliance, and serves as a pass-through for some funding sources to individual CACs. Its capacity is limited, however, due to staffing size and changes.

A Changing Role for the Network Office. In the view of executive leadership at the National Alliance for Children, the competency and capacity of state chapters "drives center competencies." Across the nation, state chapters have changed significantly in structure and function over the past decade. While state chapters were once viewed largely as professional development networking hubs for their local CACs, there is now an expectation that they will increase their capacity for policy advocacy and other forms of technical assistance to local CACs, including within the domains of data-development, management, and reporting. This evolving view at the National Alliance for Children served as the basis for its decision to eliminate financial support for individual CACs (passed through to CACs by state chapter offices) and reallocate that funding to make investments in capacity-building at the state chapter level.

South Carolina's local CAC directors speak highly of the skill and commitment of the state Network office, especially in regard to professional development opportunities and coordination. These directors also see the need for the state Network office to strengthen its policy advocacy work, believing that an increased Network presence will result in ongoing benefits for local CACs.

Network Staffing and Siting. The Network is staffed by a full-time Executive Director and a half-time Project Coordinator, and is housed at the Children's Law Center at the University of South Carolina School of Law. Office space and overhead costs are provided by the university as in-kind donations. In addition to professional development opportunities, Network staff write and manage grants, manage the pass-through of some grant funds to local CACs, conduct in-person and online professional development, and engage in statewide advocacy on behalf of abused children and the Children's Advocacy Centers.

With the recent departure of the Network Director and funding changes described below, network members will need consider the role and functions expected of a new network director.

Network Office Funding Changes. The Network is supported largely through grants, including grants from the National Children's Alliance, the Southern Regional Children's Advocacy Center, and the Duke Endowment. Individual CACs pay dues of $200 each per year plus an additional $100 annually for participation in the forensic interview peer review process. Private fund-raising efforts also support the Network's mission and staffing. As the National Children's Alliance withdrew its pass-through grants to local CACs (see earlier), leaders of the Alliance indicate that these same funds will be directed toward state chapter capacity building and state-level projects. Thus, additional capacity for the network to provide leadership and technical assistance will undergird the good work of the individual CACs.

While this may create an opportunity for a substantial increase for Network capacity-building, the reallocation of dollars away from local chapters poses both a political and actual financing problem for the local CACs.

Governance. The South Carolina Network of Children's Advocacy Centers is governed by a ten-person Board of Directors. This board is made up of six CAC directors and four community member representatives. The recent addition of community representatives has allowed for wider diversity in the expertise and input of Network governance.

Impact Measurement

Several management functions require investments that could strengthen both the Network and local CACs. These include improvements in data collection, data linking across agencies and sectors, analysis of information collected, and public reporting on client outcomes as well as client participation measured by numbers served.

The collection, analysis, and use of data is a critical capacity for assuring high quality, client-specific services and supports. These functions also make it possible for strategic planning to address needs and strategic accountability for outcomes. Additionally, both governmental and philanthropic funders are increasingly requiring child and family outcomes data in addition to number counts of the client population. This requires revision in the collection, analysis, and types of data collected.

National Data Challenges. The National Alliance requires data on clients served and types of services provided to be entered by accredited CACs into the NCATrak data system. NCATrak is a decade-old data platform that has not been updated to take advantage of current data technology. The NCATrak system collects data on outputs, not outcomes. By this, we mean that data collected revolves around client participation rather than data on the types of treatment received and its impact on child and family outcomes. NCATrak cannot collect or integrate data from electronic medical records, therapy notes, or case management records, meaning a CAC cannot ascertain whether or not a child has been seen before by a CAC, much less the results of any visits. It does not include county-level data such as the outcomes of prosecution activity. Most South Carolina CACs enter data into the NCATrak system only to provide information on clients served and for accreditation reporting purposes. Many state networks are beginning to shift their data collection strategy towards a state network-supported data center.

Additionally, South Carolina CACs use the National Children's Alliance-created Outcome Measurement System (OMS). The OMS includes a caregiver survey and a multi-disciplinary team survey, and allows CACs to report on two outcomes as defined by NCA: (1) "The CAC facilitates healing for children and caregivers; (2) The MDT approach results in more collaborative and efficient case investigations." These reporting measures, while important, do not offer the clearest, data-driven picture of impact in the short and long term on child and family outcomes.

Network Challenges. Network office staffing and technology limitations mean that the Network office generally acquires data that has been entered in the NCATrak system and then re-reports it. The Network office maintains additional data on the services it provides, including tracking professional development, grant writing and fiscal awards that it receives for statewide work or as a pass-through to local CACs.

CAC Challenges. Local CACs maintain data on whatever platform is active at their agencies. They cannot share data with one another, nor can they link databases to better serve clients who are aided across multiple agencies (including the South Carolina DSS and local law enforcement). Data are not generally available on child and family outcomes other than clients referred and served. Local CACs recognize these limitations but also report that while they have been able to raise funds to support direct services to their clients, funds necessary to upgrade and strengthen their data capacity are very difficult to secure.

Inter-Agency Challenges. There is limited cross-agency data sharing between the various agencies that interact with CACs and the CACs themselves, including South Carolina DSS, local law enforcement agencies, the Network of Children's Advocacy Centers, and the South Carolina Children's Advocacy Medical Response System. These entities all collect data on their own, but there is limited capacity and infrastructure to link these data to better understand and track interventions and outcomes in a meaningful way, resulting in data inconsistencies in the number of children seen for services between SCAMMRS, the Network, and the DSS. Additionally, directors report "DSS findings are often put in a typology that would be inconsistent" with CAC reports. These inconsistencies can complicate case management, care coordination, and legal proceedings.

Better data coordination could help the state and those involved in the child welfare system understand the prevalence of child maltreatment, treatments received, and long-term child and family outcomes.

(opportunities for South Carolina)

South Carolina's Children's Advocacy Centers perform reduce trauma for children, employ invested and caring professionals, and provide national leadership for evidence-based best practices. Their position as a hub offers an opportunity to efficiently invest in South Carolina's child welfare system. Smart investments could set the state's CACs up for better service delivery, financial stability, and sustainability. This section presents opportunities for public and private investment within the context of the state's landscape.

Operational Support

CACs perform a critical function and convene a number of state supported entities. Line-item budget funding that considers the administrative and human resource challenges identified in this report could support general operating needs common to all centers. This support could help mitigate a pending deficit and support sustainability.

At present, funding for South Carolina's Children's Advocacy Centers appears to be somewhat fragile. The recent $10,000-per-center federal funding shortfall from the National Alliance was filled by the state General Assembly, though that was done through a 1-year proviso and is not guaranteed for future years. Across the country, thirty-seven states include this vital work as part of their annual budgets. Thirty of these states make an award through their General Revenue Fund. In addition, 25 states have created dedicated funding streams for state chapter offices.[15] This is particularly appropriate because that operational support serves critical state functions: ensuring evidence is collected that allows the state to prosecute predators, while ensuring that children and families receive intervention that can help them thrive and maintain their long-term independence from the state.

While CACs have been able to raise direct donations to support this work, it is much easier to do so for the direct services portion of their budgets because these resources are understood by donors as related to individual children and their families. Securing funding essential administrative or human resources capacity – which is often deployed to support law enforcement or family court functioning – is much more difficult. This administrative funding barrier is common to the nonprofit sector, yet alleviating some burden of securing administrative funding would increase organizational stability and allow CACs to focus on their missions.

The state can support the Network office to expand capacity for grants management, technical assistance, and advocacy, adding further management supports CACs need.

As described, the past state Network Director has been lauded nationally and in South Carolina for her coalition building efforts, promotion of best practices, and state-level advocacy. Building on this momentum and as the National Children's Alliance moves towards state-level projects, additional capacity for the network to provide leadership and technical assistance will undergird the good work of the individual CACs.

Medical Provision

South Carolina can capitalize on the strong network and higher prevalence of physicians who are Board Certified in Child Abuse Pediatrics and can explore strategies that have been successful in other contexts within the state to address gaps in service, especially in regard to rural access to medical services.

As a rural state, South Carolina faces challenges in terms of serving populations in widespread geographic areas. This is especially true given the specialized medical professionals needed for CACs. Support is needed to explore and fund strategies to bridging this gap. Strategies may include regionalizing teams of Board-certified physicians or creating mobile teams of advance practice registered nurses (APRNs) to assure that physical examinations of child abuse victims are timely and are provided within a trauma-informed context.

Further, requiring a medical exam for every child seen by a CAC for allegations of abuse would increase connectivity to a medical home, and possibly leading to better investigations and addressing the maltreatment. It will be important to address the system's capacity to coordinate more children's medical exams, as such requirement would put more constraints on already-burdened systems.

HR Capacity

Shared resources for similar organizations can create efficiencies for business management. One or more investments can assist CACs in capacity-building within a human resource and management context, promoting better coordination and sustainability.

Such investments may include:

- Investing in the data systems and data analytic process so that CACs and the Network office can develop measures of child and family outcomes and modify their data platforms accordingly. More accurate data on family outcomes can improve service provision in the future.
- Supporting the Network office to explore a shared package of benefits, including access to mental health support for secondary trauma, that can be expected to reduce staffing turnover.
- Developing easily accessible learning modules that instruct on sound financial management practice and continuous quality improvement.

Several examples are relevant. The data opportunity could build upon an investment by the Duke Endowment in 2006 to support the identification of 11 data indicators that could better track outcomes. The Endowment reports that this was a positive experience as a funder and CACs have expressed enthusiasm for technical support to improve their practice through data tracking and analysis.

In Oregon, the state chapter secured a three-year, capacity-building grant from the national Nonprofit Finance Fund to secure coaching on basic financial principles and continuous quality improvement practice.

Advocacy

Given their expertise and training, CACs can be a strong, clear voice in informing South Carolina's policy makers, children's welfare stakeholders, and the public about the risks of violence, abuse, and trauma on children's development, well-being, and school and later life experiences – especially in the early years of childhood.

The South Carolina Network of Children's Advocacy Centers, along with the CACs themselves, are uniquely situated to increase their public education and advocacy role to build a stronger knowledge base about the impact of trauma and violence on the development of young children. Both CACs and the Network are highly regarded and bring long years of experience in serving children who have been abused, traumatized, or who have been witness to violence.

One area where Children's Advocacy Centers and their Network could further advance work to prevent child abuse and severe neglect is in response to the prevalence of domestic violence in South Carolina. While substantiated cases of child abuse are rising in South Carolina (as in the entire nation), the state holds the unenviable position of being within the top ten domestic violence states for the past 15 years. Children exposed to violence in their homes are 1500 percent more likely to be physically abused or seriously neglected than the national average. Experiencing domestic violence in childhood is one of the ten types of "adverse early childhood experiences" (ACEs) and is highly correlated with children's learning difficulties, attention and memory problems due to chronic stress, school performance challenges, and long term chronic health conditions.[16]

Another area where Children's Advocacy Centers and their Network are demonstrably expert is in response to ACEs in the lives of the state's children. Based on a 2014 survey of South Carolina adults, nearly 17 percent of the state's children lived with a caregiver who was depressed or who experienced significant mental health problems. One in four South Carolinian children lived with a parent who was either a problem drinker or an alcoholic. Slightly more than one in ten children lived with a caregiver who used illegal drugs or abused prescription medication, although with the explosion of opioid addiction nationwide, this probably represents an important underestimate.[17]

Children who live in a family with substance abuse are more likely to be abused or neglected than children in non-substance abusing households.[18] Data from the recent South Carolina ACEs survey found that three in ten of South Carolina's adults lived with a caregiver who emotionally abused them as a child, and more than one in ten have experienced sexual abuse and/or physical abuse. Exposure to these types of adverse childhood experiences predict significant health, well-being, developmental and school challenges for children.[19]

By combining their expertise from years of service with the public's growing awareness of ACEs, the CACs and their Network can help shape the conversation statewide.

Build Local Capacity

Community awareness and engagement have the power to reduce instances of abuse and prevent harmful situations. CACs can cultivate strong county and community partnerships, increasing local capacity to prevent, identify and intervene in child maltreatment and promote children's safety and healthy growth and development.

By statute and in practice, Children's Advocacy Center build and maintain close working relationships with other community providers, in effect serving as a hub for advancing local prevention efforts, strong interagency early identification efforts, and the use of evidence-informed program interventions and case practice. Local provider participation in training and professional development opportunities is strong and, with additional investment, could be scaled to improve outcomes for children reported for and at risk of maltreatment, thus improving prevention, reducing the likelihood of future abuse, and intervening in a trajectory where abused children grow up to be abusers.

> One CAC director reflected on her role, "Everyone clutches their pearls when they hear what I do. I work to lessen the stigma and reframe the work to be more about building and supporting healthy families. Even though they come to us as the result of a crime, even after the crime has been committed, they are still a family and the family has been broken. How can we put them back together so they are not in the shadow of this for the rest of their lives? When we have healthy families, we have healthy communities."

In South Carolina, the most frequently mentioned approach to community advocacy is through the Children of Stewards program. This nationally-rated promising program[20] was created by Darkness to Light, a Charleston, South Carolina located national organization dedicated to "empowering adults to prevent child sexual abuse." Children of Stewards' two-hour group sessions train adults in the signs and symptoms of sexual abuse, how to talk with children, and how to make reports of abuse. In 2016, 300 adults were trained in the Children of Stewards program in Aiken, South Carolina.[21]

Local Innovations

Care provision is evolving and several CACs are investigating new and different methods to promote healing. South Carolina can celebrate innovative investments that allow Children's Advocacy Centers to develop and test new practices that hold promise for better serving child victims, and their families.

As described earlier in this report, two innovative practices are in use in South Carolina's Children's Advocacy Centers. The first involves animal-assisted therapy in which a trained service animal, often a dog, is present when individuals who have experienced significant trauma engage with professionals for evaluation, support and intervention. Research has shown that this practice can improve emotional well-being and reduce anxiety and fear, especially among those experiencing from Post-Traumatic Stress Disorder.[22] Another example is the hiring of a Chaplin to work with children and families as an intentional staff member. This intervention can make a meaningful impact on child development, as abuse often raises big, eschatological questions for children that their caregivers or faith-based institutions may be ill-equipped to handle from a trauma-informed perspective. Intentionally supporting the development of innovations to address locally recognized problems may give rise to other promising practices in the field.

(opportunities beyond the CACs)

Data and Measurement

Due to data collection and linkage constraints, there is little understanding of the prevalence and extent of child abuse in South Carolina. Better data measures and coordination are needed. Data revealing that a very substantial proportion of child welfare substantiations in South Carolina are for physical abuse should be further investigated.

Data are a compelling way to understand impact and show outcomes. Research shows that data on victims of child abuse is limited, underscoring the importance of setting up infrastructure that can guide decision making for such a vulnerable population.

In most states, the majority of both referrals and substantiations are actually for neglect rather than abuse. A small but significant study of what contributes to the reverse pattern within South Carolina is needed. Understanding more about this trend can help organizations statewide better tailor their approaches to families in the child welfare system.

In Tennessee, Children's Advocacy Centers have a legislative mandate to automatically receive abuse and neglect cases within the child welfare system. Using a linked data system, all cases that pass through the Tennessee Department of Human Services' child abuse hotline, once relevant criteria are applied, are automatically entered in Tennessee's NCATrak database daily. Directors report that this process has reduced the numbers of children who would otherwise "fall through system cracks." The South Carolina Network has established communications with Tennessee's Department of Human Services to explore applicability and adoption within South Carolina. Tennessee has offered technical assistance to the South Carolina DSS to advance this data-sharing solution.

Data linkages between the various agencies would give a clearer picture of the prevalence of child abuse across the state. These linkages would allow for the study of outcomes as they relate to the treatment and legal response.

However, a more appropriate and robust data infrastructure is needed in order for these linkages to be effective.

Coordinated Response

Jurisdictional complexity and non-uniform protocol can lead to children slipping through the cracks. State statues explicitly outlining response can improve the identification of and referral for substantiated child abuse and the response of the Multi-Disciplinary Teams (MDTs).

We recommend considering two policy changes in this area. One would denote that the local CAC is the hub for the coordinated investigation and treatment of child abuse/maltreatment cases. Currently, while CACs act as the hub for investigation and treatment, their coordination is not required by law or statute. A second policy could outline the requirements for MDT coordination for all child abuse cases. Again, most cases have MDT coordination, but consistent implementation would ensure all children have the same opportunity for case management and coordination in an

instance of substantiated abuse. Legal requirements for case coordination would afford children appropriate and timely treatment and care. Geographic boundaries of the CACs often cross catchment areas for the South Carolina DSS, local law enforcement offices and the courts, creating complexities in referrals and in the work of the MDTs. These two protocols would streamline and promote a well-represented and informed response effort.

Prevention Through Protective Factors)

Evidence-based home visiting programs offer parenting support that improve family dynamics and reduce the risk for harmful situations. South Carolina has a strong network of these programs, which, if maximized, would reduce the risk of maltreatment and make service delivery more efficient. Several programs, like the Positive Parenting Program and Nurse-Family Partnership have been rigorously studied and are shown to reduce rates of child maltreatment and build more positive parental capacity.

The Positive Parenting Program (Triple P). Triple P is rigorously tested, population-level program shown to concurrently reduce child maltreatment and instances of child social and behavior problems while improving parenting practices and parent-child interactions. This multi-tiered approach builds parental skill at a population-level and through targeted interventions based on population need.Triple P's model de-stigmatizes parent education and builds parental self-efficacy and problem solving. It is associated with long-term reductions of child maltreatment, the effects of which can reduce the health and social costs of child maltreatment. The intervention has been shown to decrease child abuse-related hospitalizations, reduce out-of-home placements, and contribute to a reduction in the rate of substantiated cases of abuse. In Canada, the program reduced long term education, social service, and justice system costs. The program's cost-effectiveness and evidence base make it a prime intervention for a Pay for Success deal. The research suggests the start-up costs would be recouped in one year based on the subsequent reduction of child maltreatment and its associated costs. Outcomes are measurable, and the intervention can be implemented in a variety of settings. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups, and in all kinds of family structures.

The first major randomized control trial of Triple P in the US was conducted in 18 counties across South Carolina. All five levels were implemented. Researchers found the costs of Level 1 implementation was less than $1.00 per child, and provider training for Levels 2-4 totaled $11.74 per child.[23] An analysis of Triple P programming in Washington State, prepared by the Washington State Institute for Public Policy, determined the intervention yielded $9.58 in benefits per $1 cost investment. They also found a net present value of benefits as $1,278 worth of benefits per participant.

Because of the diversity of programs offering Triple P, there are no current state estimates for how pervasive program implementation is throughout the state. The Children's Trust of South Carolina supports provider training and program operations for Triple P, primarily at levels 2-4. Additionally, Triple P America is headquartered in Columbia, South Carolina.

Nurse Family Partnership. The South Carolina Nurse Family Partnership (NFP) is a nationally recognized, evidence-based nurse home visitation program for first-time, low-income mothers. Through ongoing consultations in the mother's home, registered nurses work to improve pregnancy outcomes, improve child health and development, and increase the economic self-sufficiency of the family. The program lasts from pregnancy until the child turns two. NFP serves over 4,000 families annually across 31 counties in South Carolina.[24]

The Last Word

Children's Advocacy Centers play a vital role in the prevention and treatment of child abuse. In South Carolina, their impact could be strengthened with increased resources and support for direct services, the continued provision of professional development, and administrative improvements in data systems.

Investing in this state's Children's Advocacy Centers will enable them to continue their services to children and families and promote strategic improvements to the state's child welfare system and its response to maltreatment. Further exploration into questions raised by this report, including trends and opportunities, could benefit some of the state's most vulnerable families and children.

(director notes)

"When we add a treatment, we try to increase capacity in the community around that treatment. [This approach] helped tip the balance to provide more onsite services. We needed more providers to refer to, and this increased capacity naturally."

"For families who say, 'everything is fine.' I always reply that no one is going to get better without therapy. We provide a specific kind that gives you the tools to prevent further abuse and grow up to be a healthy survivor."

"Our sexual abuse survivor support group for girls is very influential. They can be supportive of one another in a way that others can't be. There is a lot of power and strength in that."

"Our parent support group for parents who did not initially believe children's allegation gives parents the opportunity to become a protective caregiver. We meet them where they are, help them navigate more positive communications with DSS, and build better relationships."

"Often the abuser is the financial caregiver, leaving the mom to make an impossible choice: do I sacrifice my basic needs by reporting this abuse?"

"The majority of parents in our parenting program are at or below the poverty line. Historically, I have been opposed to incentivizing attendance for services, but we noticed low attendance was due to jobs, training, or higher 'immediate' priorities. We think about Maslow's Hierarchy of Needs and help with basic needs—the things they can't get with EBT. Community donations of toilet paper, gas cards, pine-sol, that sort of thing. It shows we get it, we care, and we don't want to put undue burden on them to come."

"Trauma is often overlooked in how it impacts children's lives. If you aren't trauma-informed or focused, you may miss a huge opportunity to improve the health and well-being of children and families. It Impacts the whole state and its ability to have a productive and healthy society."

"We provide free services to the community but at the end of the day, we're a business. If you don't have the admin support for your core functions, you cannot provide services effectively."

APPENDIX A
South Carolina Child Maltreatment Data by County

County	Children under 18*	Children in Poverty (#- 2015) **	Children in Poverty (%) **	Total Founded Maltreatment ***	Total Founded Abuse (Medical, Physical, Sexual) ***	High Risk for Abuse (physical, sexual) ***
Abbeville	5,332	1,373	26%	55	8	9
Aiken	36,383	9707	27%	535	57	93
Allendale	1,795	893	51%	46	1	9
Anderson	45,054	11,101	25%	1,318	369	322
Bamberg	2,967	1,278	44%	77	10	8
Barnwell	5,441	2,036	38%	127	10	15
Beaufort	35,395	7,378	21%	270	26	35
Berkeley	49,143	8,978	19%	1,035	84	388
Calhoun	2,980	862	29%	29	4	2
Charleston	78,207	17,569	23%	1,762	151	679
Cherokee	13,378	3,879	30%	659	128	212
Chester	7,397	2,761	38%	117	15	49
Chesterfield	10,586	3,483	34%	85	14	5
Clarendon	6,891	2,559	38%	110	24	10
Colleton	8,550	3,085	37%	406	31	104
Darlington	15,405	5,059	33%	465	48	92
Dillon	8,060	3,377	43%	233	21	29
Dorchester	38,764	7,143	19%	454	55	161
Edgefield	5,036	1,341	27%	67	3	0
Fairfield	4,634	1,522	33%	66	7	14
Florence	33,464	9,448	29%	644	75	235
Georgetown	12,107	3,796	32%	269	19	79
Greenville	115,082	19,976	18%	2,178	469	865
Greenwood	16,127	4,143	26%	187	28	75
Hampton	4,447	1,529	35%	63	11	3
Horry	58,904	17,039	30%	805	217	210
Jasper	5,922	2,335	40%	132	10	20
Kershaw	14,919	3,395	23%	264	48	46
Lancaster	18,749	3,862	21%	571	90	162
Laurens	14,781	4,409	31%	384	59	133
Lee	3,718	1,416	39%	85	7	46
Lexington	66,209	12,418	19%	1,425	233	439
Marion	7,473	3,015	41%	195	12	47
Marlboro	5,594	2,082	38%	209	22	42
McCormick	1,213	401	35%	13	6	0
Newberry	8,378	2,336	29%	179	44	46
Oconee	15,209	3,696	25%	463	48	305

County	Children under 18*	Children in Poverty (#- 2015) **	Children in Poverty (%) **	Total Founded Maltreatment ***	Total Founded Abuse (Medical, Physical, Sexual) ***	High Risk for Abuse (physical, sexual) ***
Orangeburg	20,050	7,228	37%	160	37	29
Pickens	23,855	4,506	19%	614	79	130
Richland	88,453	19,272	22%	1,533	322	555
Saluda	4,441	1,287	30%	77	11	40
Spartanburg	69,835	14,674	22%	2,410	424	673
Sumter	26,388	7,723	30%	424	48	113
Union	5,990	1,932	34%	134	30	35
Williamsburg	7,046	2,998	43%	83	8	14
York	61,836	10,347	17%	706	100	262
SOUTH CAROLINA	1,091,588	260,646	24%	22,203	3,549	6,856
State Office				80	16	26

* Source: Kids Count Data Center. Children Under 18 Years of Age by Race/Ethnicity. 2015

** Source: Kids Count Data Center, Children in Poverty, 2015

*** Source: SCDSS – Division of Accountability, Data, and Research (effective September 1, 2016). NOTE: The number of founded maltreatments is greater than the number of founded investigations since often more than one maltreatment is indicated during an investigation.

APPENDIX B
Annual Unmet Need: Medical Exams

Year	# of Medical Evaluations	# of Children in Need of Exams for Target Typologies*	% of Need Met
2008	3,412	10,654	32%
2009	3,550	10,248	35%
2010	3,672	10,894	34%
2011	3,503	12,260	29%
2012	3,124	9,209	34%
2013	3,126	10,053	31%
2014	3,002	14,293	21%
2015	3,467	15,927	22%
2016	4,032	21,604	19%

Data are from South Carolina Children's Advocacy Medical Response System and are current as of June 2017.

*Medical Abuse, Medical Neglect, Physical Abuse, Sexual Abuse, Witness to Domestic Violence, Substantial Risk- Medical Neglect, Substantial Risk- Physical Abuse, Substantial Risk-Sexual Abuse

APPENDIX C
South Carolina's Children's Advocacy Centers

AIKEN
(Aiken, Barnwell, Edgefield, Saluda)
Child Advocacy Center of Aiken County
4231 Trolley Line Road / PO Box 1763
Aiken, SC 29802

Susan Meehan, Executive Director
NCA Accredited Center

ANDERSON
(Anderson, Oconee)
Foothills Child Advocacy Center
216 East Calhoun Street
Anderson, SC 29621

Kristie Nimmons, CAC Director
NCA Accredited Center

BEAUFORT
(Beaufort, Colleton, Hampton, Allendale, Jasper)
Hopeful Horizons
(Formerly Hope Haven of the Lowcountry)
1212 Charles Street
Beaufort, SC 29902

Marian Lindsey, CAC Director
NCA Accredited Center

CAMDEN
(Kershaw, Lee)
The Family Resource Center
1111 Broad St
Camden, SC 29020

Rosalyn S. Moses, Executive Director
NCA Affiliate Center

CHARLESTON
(Charleston, Berkeley)
Dee Norton Lowcountry Children's Center
1061 King Street
Charleston, SC 29403

Carole Campbell Swiecicki, Executive Director
NCA Accredited Center

COLUMBIA
(Richland)
Metropolitan Children's Advocacy Center
3710 Landmark Drive, Suite 300
Columbia, SC 29204

Alicia Benedetto, Program Manager
NCA Accredited Center

FLORENCE
(Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Marlboro, Marion, Williamsburg)
The CARE House of The Pee Dee
1500 Patton Drive
Florence, SC 29501

Meg Temple, Executive Director
NCA Associate/Developing Center

HARTSVILLE
(Chesterfield, Clarendon, Darlington, Dillon, Florence, Marlboro, Marion, Williamsburg)
Durant Children's Center 4th Circuit Satellite
510 West Carolina Avenue
Hartsville, SC 29550
(843) 332-9299 l Fax: (843) 332-9269
Florence location

Gloria Davis, CAC Director
NCA Accredited Center

GREENVILLE
(Greenville, Pickens)
Julie Valentine Center
2905 White Horse Road
Greenville, SC 29611

Shauna Galloway-Williams, Executive Director
NCA Accredited Center

GREENWOOD
(Abbeville, Greenwood, Laurens, Newberry)
Beyond Abuse
115 E Alexander Ave
Greenwood, SC 29646

Jessica Bell, CAC Director
NCA Accredited Center

LANCASTER
(Chester, Fairfield, Lancaster)
Palmetto CASA – Children's Advocacy Center
106 North York Street
Lancaster, SC 29720

Charlene McGriff, Executive Director
NCA Accredited Center

LEXINGTON
(Lexington, Newberry, Saluda, Sumter)
Dickerson Children's Advocacy Center
140 Gibson Road
Lexington, SC 29072

Carol Yarborough, Executive Director
NCA Accredited Center

MYRTLE BEACH
(Horry, Georgetown)
Children's Recovery Center
1801 Legion Street, Myrtle Beach, SC 29577

Louise Carson, Executive Director
NCA Accredited Center

ORANGEBURG
(Bamberg, Calhoun, Orangeburg)
Edisto Children's Center
658 John C. Calhoun Dr.
Orangeburg, SC 29115

Labrena Aiken Furtick, Deputy Director
NCA Affiliate Center

ROCK HILL
(York)
Safe Passage Children's Advocacy Center
104 Oakland Ave
Rock Hill, SC 29730

Jada Charley, Executive Director
NCA Accredited Center

SPARTANBURG
(Spartanburg, Cherokee, Union)
Children's Advocacy Center of Spartanburg, Cherokee, and Union Counties
100 Washington Place
Spartanburg, SC 29302

Suzy Cole, Executive Director
NCA Accredited Center

SUMMERVILLE
(Berkeley, Dorchester)
Dorchester Children's Center
303 East Richardson Ave.
Summerville, SC 29483

Kay Phillips, Executive Director
NCA Accredited Center

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