CHILD PROTECTION ACCOUNTABILITY COMMISSION: COMMITTEE ON THE INVESTIGATION, PROSECUTION AND TREATMENT OF CHILD SEXUAL ABUSE CASES

FINAL REPORT – APPROVED NOVEMBER 15, 2023

I. PURPOSE

In FY21, the Child Protection Accountability Commission (CPAC) formed the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse ("Committee") to provide recommendations to improve the multidisciplinary team (MDT) response to child sexual abuse cases. CPAC appointed Jennifer Donahue, Esq., State Investigation Coordinator, and Haley King, Esq., Deputy Attorney General, as co-chairs of the Committee.

II. MEMBERSHIP

The Committee was comprised of members of the following multidisciplinary team agencies and entities:

A Better Chance for Our Children
Bayhealth Hospital
Beau Biden Foundation
Beebe Healthcare
Child Inc.
Children's Advocacy Center
Children and Families First
Delaware Health and Social Services
Delaware State Police
Department of Corrections
Department of Education
Department of Justice
Domestic Violence Coordinating Council
Dover Police Department
DSCYF – Division of Family Services
DSYCF – Division of Management Support Services/Institutional Abuse Unit
DSCYF – Division of Prevention and Behavioral Health Services
Family Court
Georgetown Police Department
Investigation Coordinator
Laurel Police Department
Middletown Police Department
Milford Police Department
Nemours Children's Health
New Castle City Police Department

New Castle County Police Department
Office of the Child Advocate
Prevent Child Abuse Delaware
Survivors of Abuse in Recovery
Tidal Health
Wilmington Police Department

III. EXECUTIVE SUMMARY

The implementation of multidisciplinary teams, statewide compliance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU"), and the availability of forensic interviews at the Children's Advocacy Centers have greatly improved how child sexual abuse cases are investigated and prosecuted in Delaware. However, child sexual abuse cases remain inherently challenging. Sexual abuse of a child is a crime that is most often committed without witnesses. Perpetrators will often groom their young victims to develop trust and maintain secrecy. Child victims do not fully understand the acts that are being perpetrated against them resulting in confusion, guilt, and shame. It is not uncommon for children to struggle with the disclosure process by not fully disclosing all the details of the abuse, or by delaying their disclosure, or by not disclosing the abuse at all. Since most child sexual abuse is perpetrated by a family member or an acquaintance of the victim, there may be challenges with appropriate family support of the victim throughout the investigation and prosecution. Mental health treatment for child victims is critical for recovery, yet availability of specialized providers is scarce.

The Committee initiated its work by distributing a cross-systems survey to gather current information on the investigative, administrative, and judicial processes related to child sexual abuse in Delaware. After an analysis of the results, the Committee developed an Action Plan with identified goals, action steps and anticipated competition dates with responsibilities assigned to the three (3) Workgroups: Multidisciplinary Team (MDT) Response and MOU Compliance ("MDT/MOU Compliance"); Extrafamilial, School, Institutional Abuse (IA) Response ("Extrafamilial/School Response"); and, Medical, Mental Health, and Prevention Response ("Med/MH/Prevention").

The Committee members contributed their time and expertise over a three (3) year period. This report provides a summary of the charges and final recommendations of the Committee and highlights the achievements accomplished by the Workgroups. The Committee is hopeful that the final recommendations summarized in this report will help remedy some of the inherent challenges in the investigation, prosecution, and treatment of child sexual abuse cases and further strengthen the Delaware MDT response.

IV. COMMITTEE CHARGE

On December 9, 2020, the Committee approved the following Charge:

To improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU") by addressing the following:

1. Identify system weaknesses and strengths in the investigation, prosecution and treatment of child sexual abuse cases and create an Action Plan of priorities.

2. Review, update and modify the MOU as needed to address the investigation, prosecution, and treatment of child sexual abuse cases, including differentiating between the various types of sexual abuse and building a response system unique to each.

3. Develop time-sensitive protocols to ensure cases of child sexual abuse progress promptly and effectively through both the civil and criminal systems while seeking safety, justice, and timely resolution for these victims.

4. Ensure that child victims of sexual abuse have access to and referrals for appropriate mental health services, medical care, and forensic interviews.

5. Identify and review existing prevention initiatives related to child sexual abuse.

6. Advocate for increased resources to those agencies that need further support in the investigation, prosecution, or treatment of child sexual abuse cases.

V. CROSS-SYSTEMS SURVEY

The Committee Co-Chairs drafted a survey for completion by the Committee members to gather current information on the investigative, administrative, and judicial processes related to child sexual abuse in Delaware. The survey was adapted from a model survey developed by the Virginia Department of Criminal Justice Services[1] and focused on three types of system areas for improvement: laws, policies and procedures, and training. The goal of the survey was to identify system strengths and challenges, as well as the medical and mental health needs

[1] Virginia Department of Criminal Justice Services. (2013, October). *Child Abuse: Improving Investigation & Prosecution Survey Report.*

of child victims. The survey results revealed several areas that required attention and intervention from the Committee, including, but not limited to, the following:

- Laws
    - Law enforcement/DOJ charging decisions
    - Prosecution outcomes
- Policies and Procedures
    - DFS safety assessment and planning
    - Availability of mental health services for child sexual abuse victims
- Training
    - Communication and collaboration between DFS and law enforcement
    - Family cooperation in mental health services
    - Response to child sexual abuse by schools
    - Child sexual abuse prevention initiatives

The survey results also revealed several system strengths and positive aspects of the current Delaware MDT:

- All groups work efficiently together once an investigation is initiated.
- The MOU guidelines have improved how child abuse cases are handled by the MDT.
- The use of forensic interviews of all child victims is beneficial.
- MDT members being present for the CAC interviews is beneficial.
- There is good collaboration between law enforcement, DFS and DOJ.
- The MDT has a passion for these cases and victims.

Based upon the survey results, the Committee approved the formation of three Workgroups at the December 9, 2020 meeting, each given specific charges to address the identified areas needing intervention.

VI. WORKGROUPS

At the January 21, 2021 meeting, the Committee formally approved the Workgroup co-chairs, identified the core members and assigned tasks as summarized below:

1. Multidisciplinary Team (MDT) Response and MOU Compliance ("MDT/MOU Compliance"): Co-Chairs appointed were Sgt. Jon King, Delaware State Police and Sarah Azevedo, Division of Family Services – Intake and Investigation Program Manager. The following tasks were assigned to the workgroup:

- Identify MDT/MOU system areas that need improvement and create a prioritized action plan.

- Examine criminal and civil responses focusing primarily on intrafamilial sexual abuse cases.
- Address complexity and variability of cases and need for response protocols unique to each: ages of victim/suspect; familial status of victim/suspect, type and severity of act (i.e. penetration, non-penetration); acute or late disclosure by victim; and other evidentiary issues.
- Examine whether a differential response track is feasible for certain cases instead of a full MDT investigation (i.e. child on child cases of non-penetration).
- Address development of time-sensitive priority response protocols for investigation, monitoring and review of cases to avoid delays.
- Consider creation of specialized Taskforce for MDT sexual abuse cases.
- MOU: review sexual abuse protocols and update/edit as needed.
- Address any other issues as the workgroup deems necessary.

2. Extrafamilial, School, Institutional Abuse (IA) Response ("Extrafamilial/School Response"): Co-Chairs appointed were Kitty Dickerson, Esq., Deputy Attorney General and Captain Tina Shughart, New Castle City Police Department. The following tasks were assigned to the workgroup:

- Identify extrafamilial/school/IA system areas that need improvement and create a prioritized action plan.
- Examine criminal and civil responses to extrafamilial cases, school cases, and IA cases.
- Address development of time-sensitive priority response protocols for investigation, monitoring and review of cases (for both civil/IA and criminal agencies) to avoid delays.
- Address appropriate oversight/monitoring of cases when DFS or CAC not involved.
- Review federal and administrative requirements of schools.
- Develop a streamlined process for hotline referrals to LE from DFS and the need for LE jurisdictional map.
- MOU: review sexual abuse protocols and update/edit as needed.
- Address any other issues as the workgroup deems necessary.

3. Medical, Mental Health, and Prevention Response ("Med/MH/Prevention"): Co-Chairs appointed were Dr. Stephanie Deutsch, Nemours CARE Team Co-Director and Jennifer Kline, Esq., Deputy Child Advocate. The following tasks were assigned to the workgroup:

- Identify mental health/medical/prevention system areas that need improvement and develop a prioritized action plan.
- Address the critical points for intervention/prevention opportunities in the life of a child victim.
- Examine availability of mental health services (including minority populations) for child victims.
- Examine the existence/availability of specialization programs for mental health services for child victims.
- Youth offenders: mental health treatment/availability of services – what is best practice?
- Examine current best practices for medical care serving child victims.
- Sexual abuse and prevention education for families.
- Victim Services: ideas on continuity/centralized system.

VII. DATA

The Investigation Coordinator's Office conducted data analysis of child sexual abuse cases closed between January 1, 2020 and December 31, 2021 and presented the findings to the Committee on December 8, 2022. The data included demographic information for child victims and suspects, relationships between victims and suspects, specific data regarding civil and criminal investigations, and civil and criminal case outcomes. The data set included 753 closed cases of alleged penetration, with 637 suspects and 759 victims. The main findings were as follows:

- 83% of victims were female, primarily between ages of 12 and 16
- 91% of suspects were male, primarily between ages of 20 and 39
- 65% of cases involved a non-relative suspect who was known by the victim[2]
- 35% of the cases involved a relative suspect[3]
- 67% of the intrafamilial cases had a joint response by DFS and LE
- 37% of the intrafamilial cases resulted in civil substantiations by DFS
- 22% of suspects were criminally charged
- Of those 22% of suspects charged, 88% were convicted

[2] Total non-relative suspects = 359. 39% are acquaintances, 34% paramour of a parent, 14% assumed kin
[3] Total relative suspects = 192. 51% are parents, 16% aunt/uncle, 13% cousin, 10% sibling

VIII. ACTION PLAN

The Committee created and adopted the following abbreviated Action Plan for each Committee charge with the Workgroup charges embedded in the Action Steps:

Charge 1: Identify system weaknesses and areas that need improvement in the investigation, prosecution, and treatment of child sexual abuse cases.

ACTION STEPS	Lead Workgroup	Progress	Completion Date
1. Prepare and distribute a Cross System Survey to all committee members.	Co-Chairs H. King and J. Donahue	Comprehensive survey adapted from VA Department of Criminal Justice Services distributed to Committee members. Answers analyzed and incorporated into a PowerPoint.	Completed 12/9/2020: survey results reviewed by Committee.
2. Prepare prioritized Action Plan for each workgroup based upon survey results.	All Workgroup Co-Chairs	All 3 workgroups developed action plans.	Completed 2/2022.
3. Review IC data and findings on sexual abuse case outcomes.	All Committee Members	Data PowerPoint reviewed at Committee meetings on 12/9/2020 and 12/8/2022.	Completed 12/8/2022.

Goals Achieved: All three action steps were completed.

Recommendations:

1. ***The Committee emphasizes the importance of ongoing evaluation of the effectiveness of Delaware's child welfare system, both civil and criminal. The Committee recommends that the Office of the Investigation Coordinator distribute a cross-system survey to MDT members every 3 years to identify any new system weaknesses and areas that need improvement. Survey results, with associated data, should be presented to CPAC for discussion.***

Charge 2: Review, update and modify the MOU as needed to address the investigation, prosecution, and treatment of child sexual abuse cases, including differentiating between the various types of sexual abuse and building a response system unique to each.			
ACTION STEPS	**Lead Workgroup**	**Progress**	**Completion Dates**
1. Develop and implement Student Sexual Violence Guidelines for schools and law enforcement. Include as Addendum to MOU.	Extrafamilial/School Response	Draft protocol adapted from San Mateo, CA; Coordinate with DVCC in developing joint protocol for misconduct between students. CPAC/DVCC Model Policy for Responding to Student Misconduct in Schools approved by Committee in May, 2023. CPAC Model Policy for Responding to Adult Sexual Misconduct in Schools approved by Committee in August, 2023.	CPAC approved both model policies at its August 2023 meeting. DVCC approved the student misconduct model policy at its meeting in September 2023.
2. Consider differential response track for the different types of sexual abuse cases.	MDT/MOU Response	Develop Flow Charts on processing each type of sexual abuse case; full MDT handling intrafamilial cases; IC MAII monitoring all extrafamilial cases.	Flow Charts Completed June, 2023.
3. Review the current MOU Sexual Abuse Protocol to determine necessary changes in accordance with finalized Flow Chart.	All Committee members	No changes recommended to MOU.	Completed June, 2023.

Goals Achieved:

1. ***The MDT/MOU Compliance Workgroup developed Flow Charts for the MDT Response of Child Sexual Abuse Cases as a guide for MDT members. Each chart is tailored to the specific type of sexual abuse allegation, including Child on Child, Teen on Teen, Teen on Child, Childhood Abuse Reported as an Adult, Late Reported Sexual Abuse, Reports involving Rape, Reports involving USC, and a School Reporting Diagram. (See Exhibit A). During the creation of these charts, the workgroup did not identify any system gaps but there were delays by LE in completing the investigation and by DOJ in charging decisions. The workgroup concluded that these issues ultimately arise from lack of resources and positions required to efficiently process the volume of child sexual and physical abuse cases.***
2. ***The Committee confirmed improved MDT compliance with the MOU for intrafamilial child sexual abuse cases through regular MDT Case Review Meetings, IC monitoring, and individual agency outreach for training by the OCA Training and Policy Administrator.***
3. ***A specialized position, Management Analyst II, through the IC's office was established to monitor all extrafamilial sexual abuse cases to ensure a prompt response and investigation.***
4. ***The Model Policy for Responding to Adult Sexual Misconduct in Schools has been adopted and will be shared with school districts in October 2023. Implementation and training on the Model Policy is being handled by the CPAC Education Committee: Adult Sexual Misconduct Workgroup.***
5. ***The Model Policy for Responding to Student Misconduct in Schools has been adopted and will be shared with school districts in October 2023. Implementation and training on the Model Policy is being handled by the DVCC through its staff and the Children & DV Committee in partnership with the CPAC Education Committee: Adult Sexual Misconduct Workgroup.***
6. ***The Extrafamilial/School Workgroup partnered with the Department of Education to discuss the implementation of the Student Services Permit program which would require all non-certified school employees to undergo a background check, be issued a permit and be placed in the DEEDS system for tracking and monitoring.***

Recommendations for System Change:

1. ***The Committee recommends that CPAC continue to partner with the DOE for the drafting of legislation, and implementation of the Student Services Permit program which would require all non-certified school employees to undergo a background check and be placed in the DEEDS system for tracking and monitoring.***

Charge 3: Develop time-sensitive protocols to ensure cases of child sexual abuse progress promptly and effectively through both the civil and criminal system while seeking safety, justice and timely resolution for these victims.			
ACTION STEPS	**Lead Workgroup**	**Progress**	**Initiation and Completion Dates**
1. Regular monitoring of extrafamilial sexual abuse cases where DFS is not involved and there is no forensic interview triggering the MDT case review process.	Extrafamilial/School Response	1. IC to add complex extrafamilial cases to the monthly MDT Case Review meetings in each county; Special case reviews will also address complex cases. 2. IC MAII hired in November 2022 to handle all extrafamilial sexual abuse cases.	Completed June 2023.
2. Explore a "Child Abuse Taskforce" pilot program in NCC.	All Committee Members	Obtain information about the Delaware County, PA taskforce. Presentation by Asst. DA Kristen Kemp 12/9/2021.	Completed. No changes to current MDT model adopted.

ACTION STEPS	Lead Workgroup	Progress	Initiation and Completion Dates
3. Monthly MDT Case Review Meetings for sexual abuse victims who underwent a forensic interview at the CAC.	All Committee members	IC facilitating statewide.	Completed & ongoing.
4. Quarterly Meetings with IC, DOJ and LE to discuss cases delayed in the system.	Co-chairs, H. King and J. Donahue	IC facilitating statewide.	Completed & ongoing.
5. Discuss feasibility of benchmarks for law enforcement investigations and DOJ charging decisions.	MDT/MOU workgroup	Research best practices for the timely investigation of sexual abuse cases.	Completed. No changes to current MDT model adopted.

Goals Achieved:

1. ***The MDT/MOU Workgroup struggled with developing time-sensitive protocols or investigative timelines for DFS, LE and DOJ due to the large number of case variables. Ultimately, it was determined that there is not one uniform protocol or timeline that would be appropriate for every sexual abuse case; however, the key is to maintain consistent communication between MDT members throughout the life of the case.***
2. ***A specialized position, Management Analyst II, through the IC's office was established to monitor all extrafamilial sexual abuse cases. The Committee anticipates that the specialized position will effectively monitor the extrafamilial cases where there are fewer MDT members involved (i.e. when DFS is not involved, or the child is not interviewed at the CAC). Monitoring will include the calling***

of special case review meetings for complex or lingering cases to better ensure timely decision making.

3. *A Geo-Locator Tool was developed by Delaware State Police to assist the MDT members in identifying the correct law enforcement agency and jurisdiction for incidents of child abuse. This tool will greatly assist DFS with forwarding the hotline reports promptly to the correct LE jurisdiction.*
4. *The Office of the Investigation Coordinator facilitates monthly MDT Case Review Meetings in each county to ensure cases are regularly reviewed and monitored through the system.*
5. *The Office of the Investigation Coordinator schedules and facilitates Special Case Review meetings with MDT members for complex or lingering sexual abuse cases to foster communication and case resolution. See #2 above as well.*

Recommendations for System Change:

1. *The Committee recommends that the OCA Training and Policy Administrator maintain a statewide MDT Member Contact List to enable better communication and collaboration between the appropriate MDT members investigating or prosecuting a case. The list should be updated semi-annually to account for changes in staffing and administration.*
2. *The Committee recommends that the Department of Justice implement a statewide case management system (preferably adopting the existing Apricot data management system utilized by OCA) for child victims of abuse to collect data on charging decisions and prosecutorial outcomes, as well as to ensure documentation and monitoring of cases pending investigation with LE.*
3. *The Committee recommends that a review and update of the criminal code regarding child victims of sexual abuse be commenced.*

Charge 4: Ensure that child victims of sexual abuse have access to and referrals for appropriate mental health services, medical care and forensic interviews.			
ACTION STEPS	**Lead Workgroup**	**Progress**	**Initiation and Completion Dates**
1. Determine availability of child-specific MH services through community-based services and law enforcement-based victim Services.	MH/Medical/Prevention Workgroup	Compiling list of services.	Completed October 2023.
2. Reinforce need for victims of student sexual violence to be referred to CAC for forensic interview.	Extrafamilial/School Response Workgroup	Student Sexual Violence Guidelines for LE and Schools; included in the Model Policies on Responding to Adult Sexual Misconduct and Student Misconduct in Schools.	Completed June 2023.
3. Ongoing collaboration between law enforcement-based victim services, DFS related services and CAC referral services.	All Committee members	LE-based victim services to attend monthly MDT case review meetings; determine which cases should include a second referral to LE-based services.	Completed October 2023.
4. Ensure medical care for victims of sexual abuse.	MH/Med/Prevention Workgroup	Identify the availability of specialists. Confirm medical exam of victim at MDT case review meeting.	Completed June 2023.

ACTION STEPS	Lead Workgroup	Progress	Initiation and Completion Dates
5. Consider centralized system for continuity of services for victims: Office of Victim Advocate.	All Committee members	Not fiscally feasible at this time.	No further action, June 2023.

Goals Achieved:

1. ***The MH/Med/Prevention Workgroup engaged in discussion with mental health professionals from private practices and public agencies, participated in informational sessions delivered by Dr. Alison Dovi on evidence-based interventions for treatment of child sexual abuse, and by representatives from the Division of Prevention and Behavioral Health (PBH) and private mental health agencies. The Workgroup concluded that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the "gold standard" treatment model for childhood sexual abuse. (See Workgroup Report as Exhibit B).***
2. ***The MH/Med/Prevention Workgroup determined that the identification of TF-CBT providers in Delaware was challenging due to the absence of a centralized directory. However, the Workgroup discovered that PBH has a TF-CBT clinical training program for mental health professionals with a roster of 94 professionals as of June 29, 2023. (See https://takecaredelaware.org/TF-CBT-roster-php and https://TC.CBT.org for a national list containing 6 Delaware therapists).***
3. ***The MH/Med/Prevention Workgroup developed and sent out a survey for mental health professionals in Delaware to obtain more information about treatment for victims of child sexual abuse. The Workgroup received 30 individualized responses with the following themes: fewer therapists have expertise working with younger children; many therapists are skilled at treating a variety of trauma types and many use techniques other than TF-CBT; and treatment duration and content varies among therapists. (See Workgroup Report as Exhibit B).***
4. ***The MH/Med/Prevention Workgroup conducted research and outreach and concluded that there is a statewide shortage of resources to treat children with Problematic Sexual Behaviors (PSB) and a lack of resources on psycho-education regarding PSB. Furthermore, there are challenges in finding appropriate caregivers to fully participate in TF-CBT for children in foster care with PSB or other identified traumas.***

5. *A Medical Services Sub-Group was convened ad hoc to assess the availability of hospital-based medical providers across the state with expertise in evaluating, diagnosing, and treating child sexual abuse victims. The group concluded that Delaware currently offers medical services to child sexual abuse victims in both emergency departments and outpatient settings with the current epicenter of expert outpatient services located in New Castle County and associated with Nemours Children's Health (CARE Team Program). (See Workgroup Report as Exhibit B).*

Recommendations for System Change:

1. *The Committee recommends an inquiry to the Sex Offender Management Board to obtain information about the requirements established for therapists who are providing treatment to juvenile sex offenders. Opportunities to increase the number of qualified therapists should be prioritized by utilizing tuition reimbursement incentives, especially those willing to reside in Kent or Sussex Counties as under-served areas.*
2. *The Committee determined an urgent need to recruit, train and retain mental health providers to treat childhood sexual abuse with an emphasis on TF-CBT with expertise to appropriately treat special populations. Delaware should consider pursuing loan forgiveness, tuition reimbursement, scholarships and grant opportunities for therapists who commit to working in the field of child abuse and trauma treatment. Certification of a child sexual abuse subspeciality within TF-CBT should be explored. Support of the CAC grant application to provide more specialized direct mental health services to statewide child sexual abuse victims should continue.*
3. *The Committee recommends an ongoing assessment of mental health service provider availability across the state to specifically identify and address resource gaps for children who have been sexually abused. In addition, a comprehensive directory of TF-CBT therapists is needed to help parents and caregivers locate appropriate providers. Management and oversight of the directory could be accomplished by a state agency or division such as PBH. Funding and development of an online mental health services directory, like Network of Care, has been suggested for decades and should be implemented in accomplishing this recommendation.*
4. *The Committee recommends a longitudinal case tracking system to identify mental health services eligibility, receipt of services, and any revictimization to address gaps in service linkage and effectiveness. As PBH currently provides care coordination for children and families eligible for services, PBH could be considered in exploring this potential case tracking system.*
5. *The Committee recommends that resources should be allocated to increase the number of skilled medical providers, especially in the lower counties, to meet the needs of children who have been*

sexually abused, including forensic nurse examiners, nurse practitioners and board-certified child abuse pediatricians. The Committee further recommends a periodic case review system involving identified providers to review abnormal or unusual cases and to ensure a standardized testing protocol is followed.

Charge 5: Identify and review existing prevention initiatives related to child sexual abuse.

ACTION STEPS	Lead Workgroup	Progress	Initiation and Completion Dates
1. Prevention in schools: reinstate the requirement that substitute teachers must have a valid permit/certification regulated by Professional Standards Board.	Extrafamilial/School Response Workgroup	Discussion with DOE and DOJ regarding Student Services Permit. Draft legislation in progress.	In progress; anticipated that bill will be introduced in 2024 as a joint collaboration between DOE and CPAC.
2. Prevention overall: analyze current training programs for community and families of victims. Consider additional trainings if needed.	MH/Med/Prevention Workgroup	Evaluation of all current programs completed.	Completed June 2023.

ACTION STEPS	Lead Workgroup	Progress	Initiation and Completion Dates
3. Incorporate SB 290 and SB 291 requirements of additional training of school employees and students on sexual grooming and adult misconduct in schools into the Student Sexual Violence Guidelines.	Extrafamilial/School Response workgroup	Included in the Model Policies on Student Misconduct and Adult Sexual Misconduct in Schools. Included in the annual mandatory reporting training for educators. New CPAC trainings developed for school administrators and counselors. Pilot programs for education of grades 7 through 12 to begin in January 2024.	Completed June 2023. Ongoing duties to be completed by the CPAC Education Committee: Adult Sexual Misconduct Workgroup.

Goals Achieved:

1. ***The Committee supported the passage of SB 290 and SB 291 requiring additional training for school employees and students on grooming and adult sexual misconduct.***
2. ***The Committee supported the CPAC Education Committee: Adult Sexual Misconduct Workgroup in adopting curriculums that will meet Erin's Law mandates and educate an additional 60,000-70,000 students in grades 7-12 statewide.***
3. ***The MH/Med/Prevention Workgroup determined that there are two non-profit organizations that currently support school-based educational initiatives: Prevent Child Abuse Delaware delivers the evidence-based program, BE SMART, to approximately 37,000 school-aged children, and the Beau Biden Foundation delivers the Shield of Protection program to schools and youth-serving organizations to ensure adult staff members working with children can recognize and respond to all types of child abuse and neglect.***
4. ***The MH/Med/Prevention Workgroup identified Project THRIVE as a grant-funded program by the DOE that contracts with 26 mental health providers to provide trauma-based services to eligible students.***

Recommendations for System Change:

1. ***The Committee recommends that prevention education materials should be shared with children and families by the family resource advocate at the CAC, and in the school setting through required educational programming.***
2. ***The Committee recommends that CPAC continue to partner with the DOE for the drafting and implementation of the Student Services Permit program which would require all non-certified school employees to undergo a background check, receive a permit and be placed in the DEEDS system for monitoring.***

Charge 6: Advocate for increased resources to those agencies that need further support in the investigation, prosecution or treatment of child sexual abuse cases.

ACTION STEPS	Lead Workgroup	Progress	Initiation and Completion Dates
1. Law Enforcement	Deferred.	Deferred.	Deferred.
2. Mental Health Agencies	Deferred.	Deferred.	Deferred.
3. DFS	Deferred.	Deferred.	Deferred.
4. DOJ	Deferred.	Deferred.	Deferred.
5. Other	Deferred.	Deferred.	Deferred.

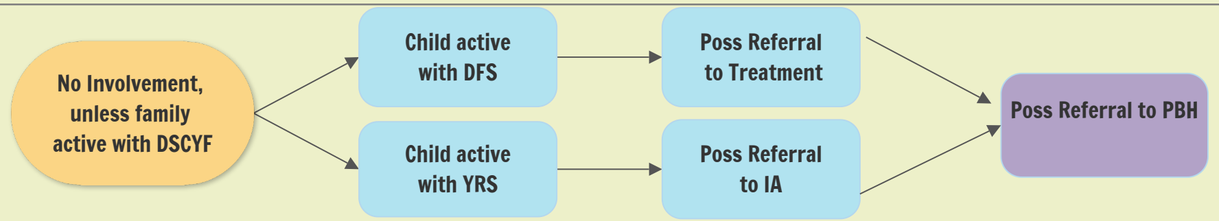
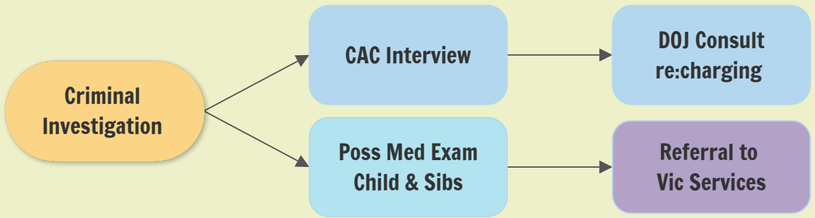
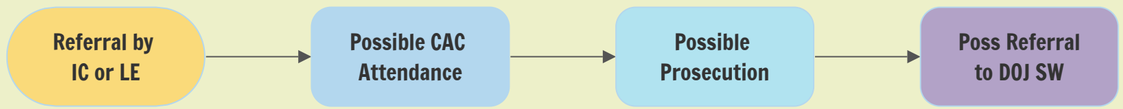
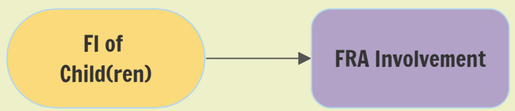
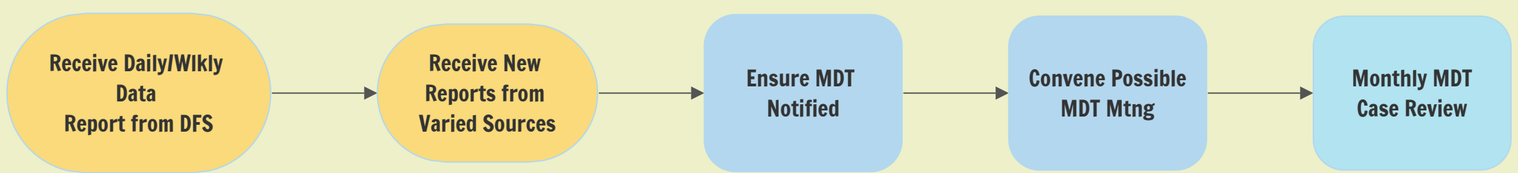
Goals Achieved: deferred to CPAC.

Recommendations for System Change: The Committee requests that CPAC advocate for increased resources for over-burdened law enforcement agencies, DOJ prosecutors and staff. Additional resources and incentives should be considered for mental health providers to implement child-specific therapy programs, including the specialized treatment of child sexual abuse. While sufficient DFS positions exist, the Committee remains concerned with the vacancies within DFS and recommends further discussion at CPAC and its Joint Retreat regarding recruitment and retention strategies.

IX. CONCLUSION

The Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse was created to assess the current effectiveness of Delaware's multidisciplinary team (MDT) response to child sexual abuse cases and to provide recommendations to improve identified system areas needing intervention. The Committee members attended quarterly meetings for over 3 years, actively participated in additional meetings with their identified Workgroups, and dedicated their time and expertise in developing goals and recommendations for change for the betterment of Delaware's children. On behalf of the Committee members, we are hopeful that CPAC will champion the recommendations contained in this report and the executive summary to make further improvements to how Delaware protects, responds, and advocates for child victims of sexual abuse.

Child on Child Extra-familial SA

DFS	
LE	
DOJ	
CAC	
IC	
Medical	

Child on Child Intra-familial SA

DFS	Civil Investigation → CAC Interview → Poss Case Transfer to Treatment → Poss Referral to PBH Civil Investigation → Medical Exams of Child & Siblings
LE	Criminal Investigation → CAC Interview → DOJ Consult re:Charging Criminal Investigation → Referral to Vic Services
DOJ	Referral by IC or LE → Possible CAC Attendance → Possible Prosecution → Poss Referral to DOJ SW
CAC	FI of Child(ren) → FRA Involvement
IC	Receive Daily/WIkly Data Report from DFS → Receive Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	Child Presents to Facility → Report to DFS & Possibly LE → Possible Referral to Hotline/Crisis Line

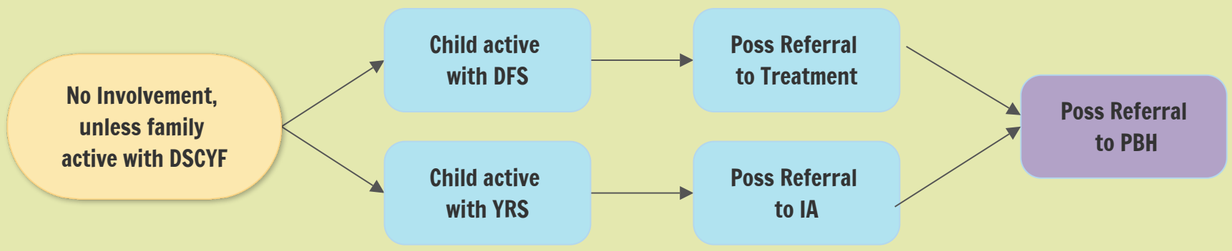
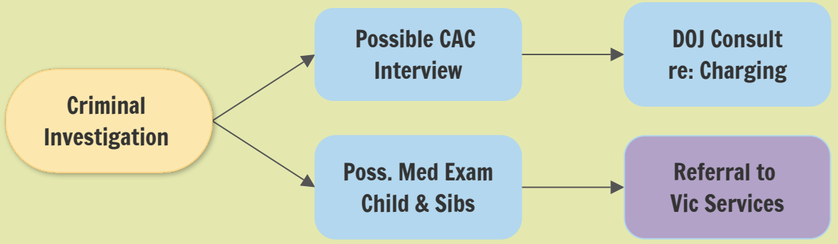
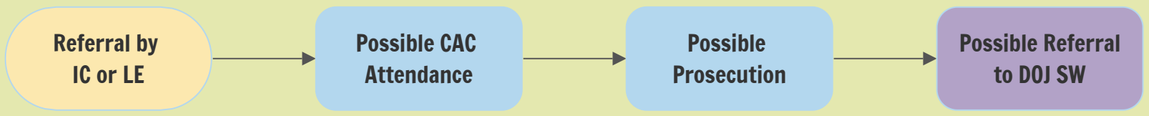
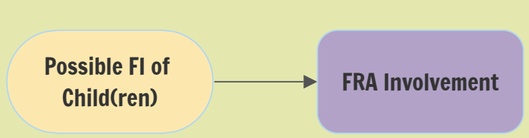
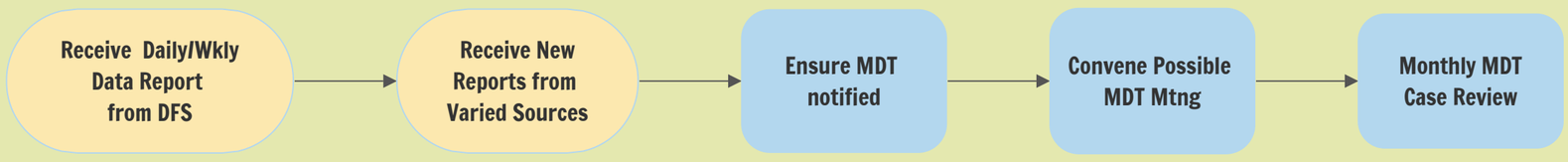
Childhood SA Reported as an Adult

DFS	No Involvement → Noted if susp on Child Abuse Registry
LE	Contact with Victim → Possible Vic Interview → Determine if Susp has access to Children → Consult with DOJ re: Charging; Possible Vic Interview → Referral to Vic Services
DOJ	Referral by IC or LE → Possible Prosecution → Possible Referral to DOJ SW
CAC	No FI-- adult victim
IC	Receive Daily/Wkly Data Report from DFS → Receive New Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	No Medical Component-- Late Reported
DOE	If Susp is DOE certified/permitted, DOE to conduct internal investigation

Juvenile Trafficking/CSEC

DFS	Receive Report at Hotline → CSE-IT Completed → Possible Civil Investigation-- to include FI at CAC → 48-72 HR MDT Meeting → Needs Assessment-- Medical & Social Svc; PBH Engagement
LE	Criminal Investigation → Poss Collaboration With Fed LE → DOJ Consult → 48-72 HR MDT Meeting; Victim Medically Examined → CAC Interview, Vic Coop Permitting → Referral to Vic Services
DOJ	Referral by IC or LE → CAC Interview, Vic Coop Permitting → 48-72 HR MDT Meeting → Possible Prosecution → Possible Referral to DOJ SW
CAC	Possible FI, Vic Coop Permitting → Possible FRA Involvement
IC	Receive Daily/Wkly Data Report from DFS → Receive New Reports from Varied Sources → Ensure MDT notified → Convene 48-72 HR MDT Mtng → Monthly MDT Case Review → JTOT Meeting
Medical	Child Presents to Facility → Report to DFS & Possibly LE → Possible Referral to Hotline/Crisis Line → CARE Team Consult/ Follow-UP
DOE	Receive Report from Student/Staff → Notify LE & DFS → Identify possible witnesses--do not obtain statements

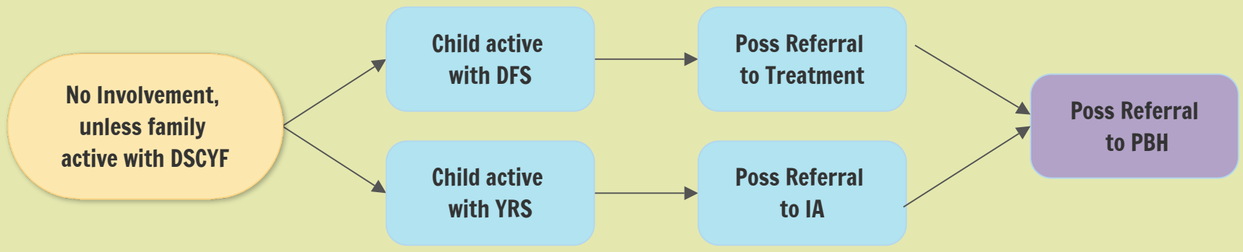
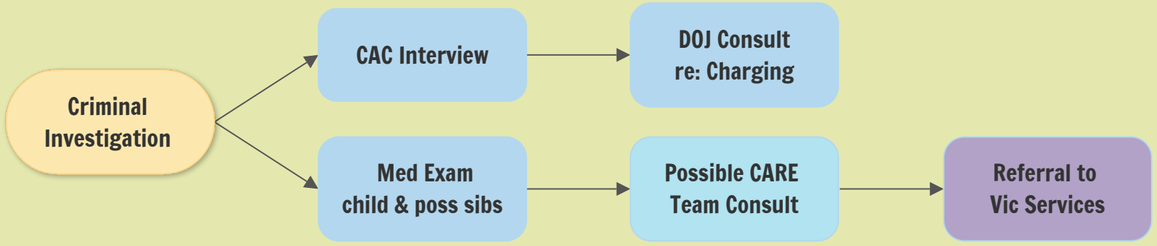
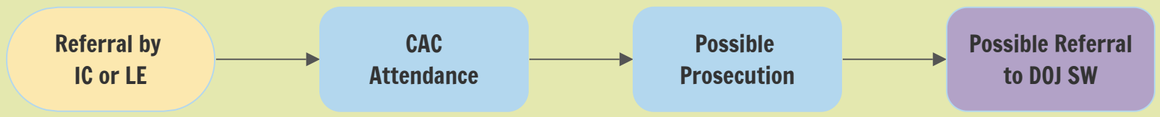
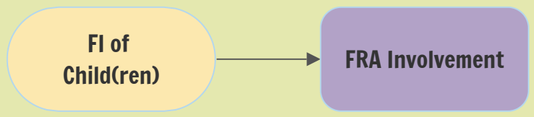
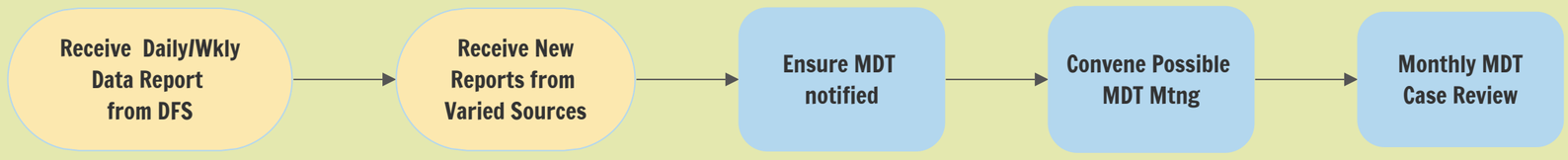
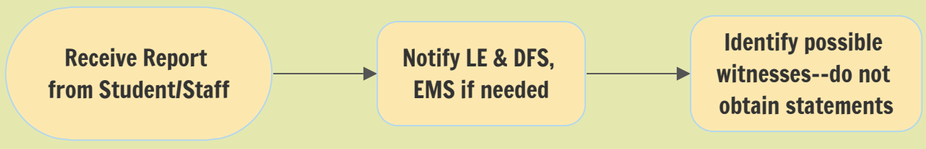
Late Reported Extra-familial SA

DFS	
LE	
DOJ	
CAC	
IC	
Medical	
DOE	

Late Reported Intra-familial SA

DFS	Civil Investigation → Possible CAC Interview → Poss Case Transfer to Treatment → Poss. Referral to PBH Civil Investigation → Possible Med Exams of Child & Siblings
LE	Criminal Investigation → Possible CAC Interview → DOJ Consult re: Charging Criminal Investigation → Referral to Vic Services
DOJ	Referral by IC or LE → Possible CAC Attendance → Possible Prosecution → Possible Referral to DOJ SW
CAC	Possible FI of Child(ren) → FRA Involvement
IC	Receive Daily/Wkly Data Report from DFS → Receive Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	Child Presents to Facility → Report to DFS & Possibly LE → Possible Referral to Hotline/Crisis Line
DOE	Receive Report from Student/Staff → Notify DFS & LE → Identify poss. witnesses--do not obtain statements

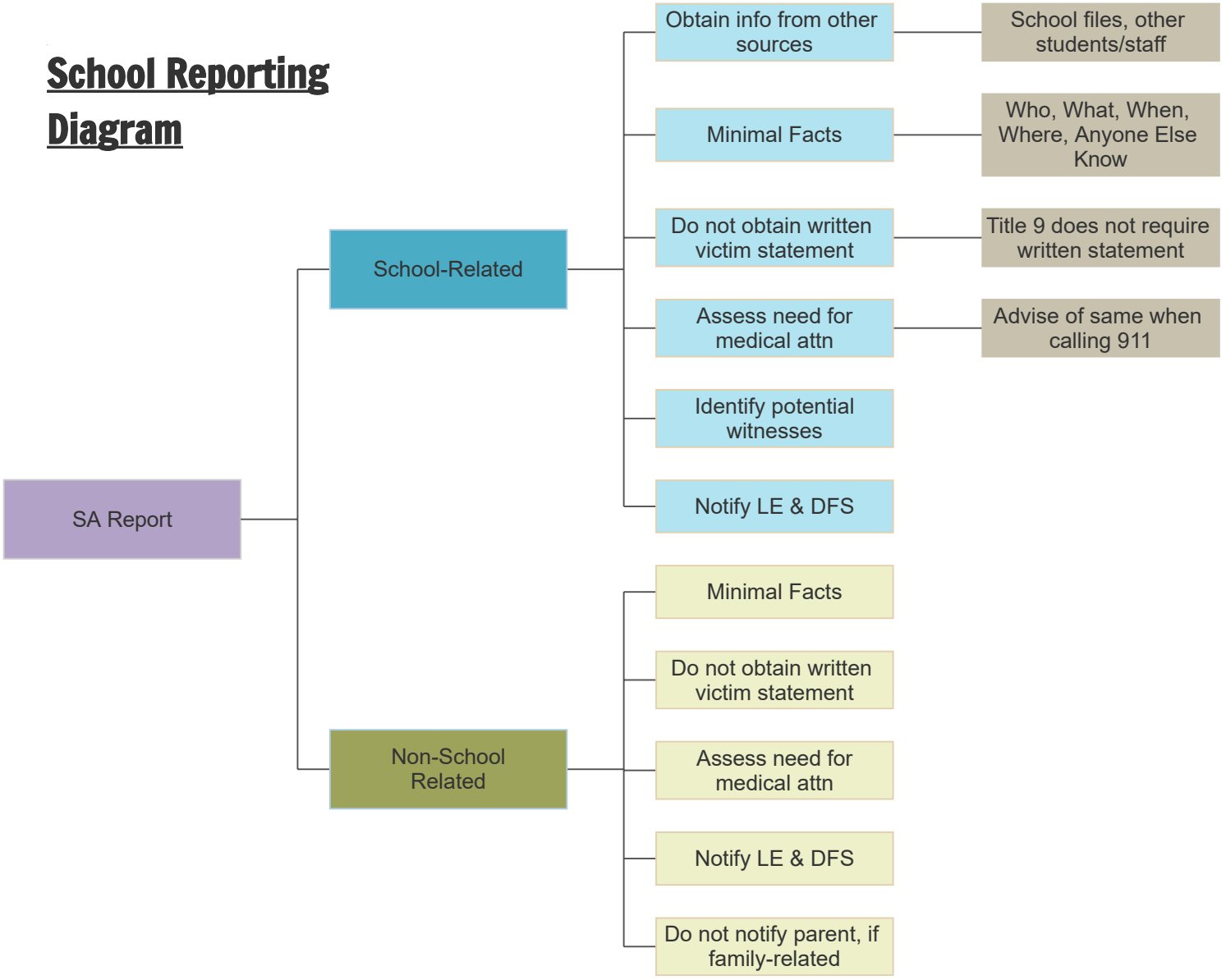
11/770-773 Extra-familial

DFS	
LE	
DOJ	
CAC	
IC	
Medical	
DOE	

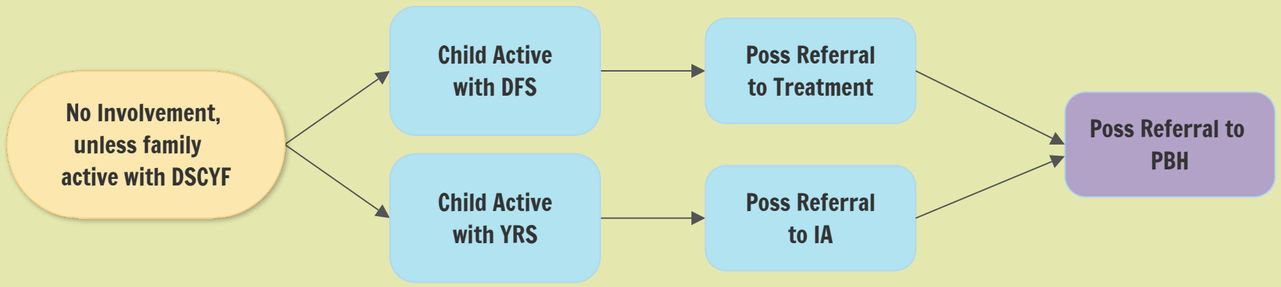
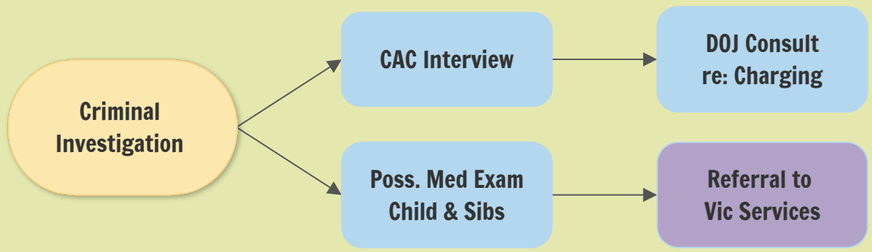
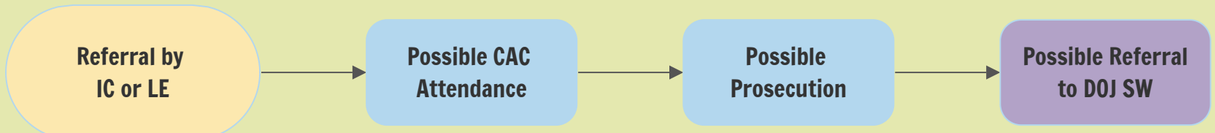
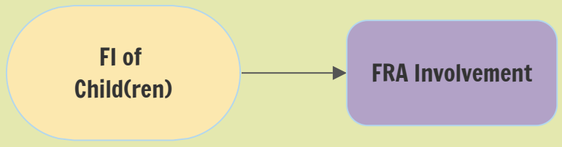
Teen on Teen Intra-familial SA

DFS	Civil Investigation → CAC Interview → Poss Case Transfer to Treatment → Poss. Referral to PBH Civil Investigation → Medical Exams of Child & Siblings → Poss CARE TEam Consult
LE	Criminal Investigation → CAC Interview → DOJ Consult re: Charging Criminal Investigation → Referral to Vic Services
DOJ	Referral by IC or LE → CAC Attendance → Possible Prosecution → Possible Referral to DOJ SW
CAC	FI of Child(ren) → FRA Involvement
IC	Receive Daily/Wkly Data Report from DFS → Receive Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	Child Presents to Facility → Report to DFS & LE if parent transported child → Possible Referral to Hotline/Crisis Line
DOE	Receive Report from Student/Staff → Notify DFS & LE, EMS if needed → Identify possible witnesses--do not obtain statements

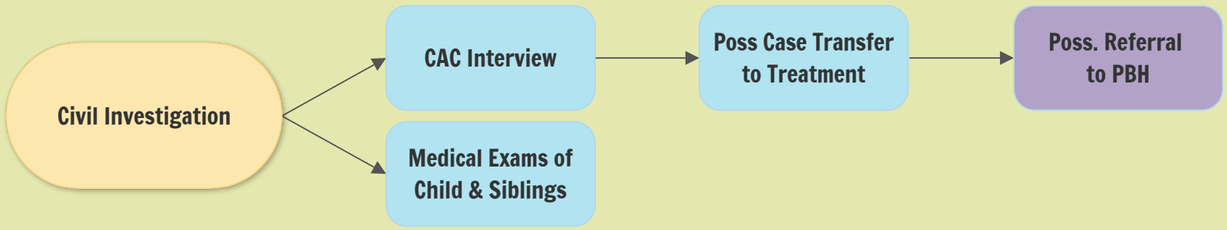
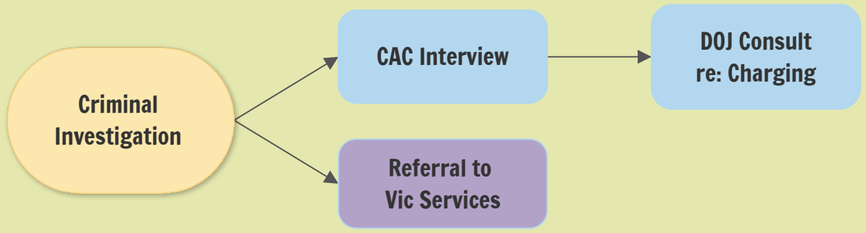
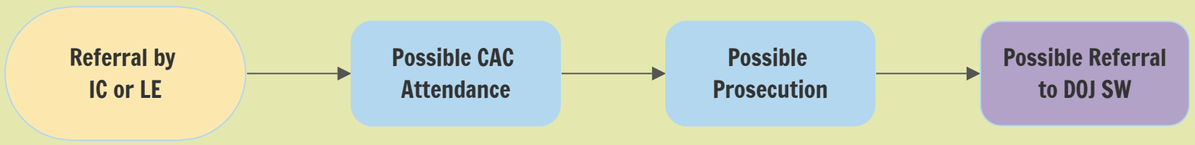
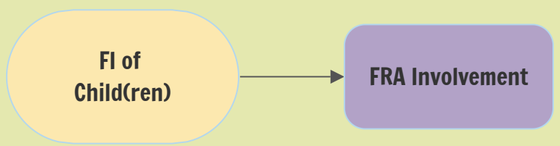
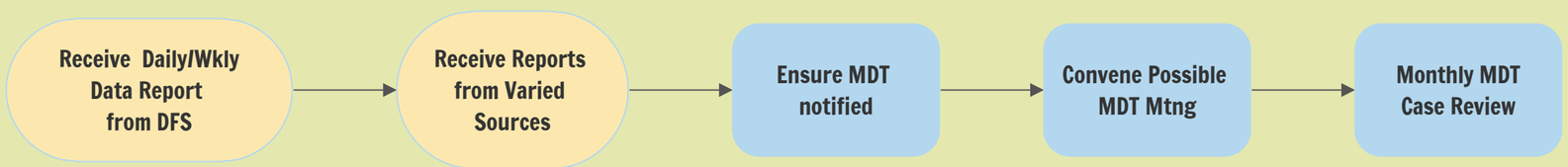
School Reporting Diagram



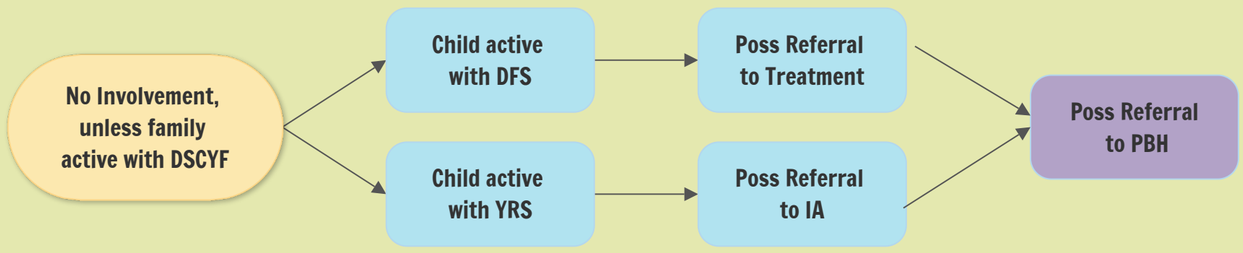
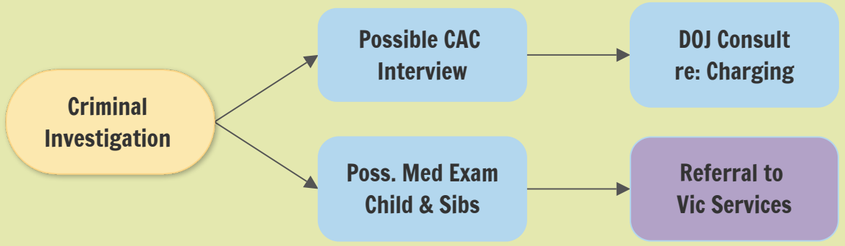
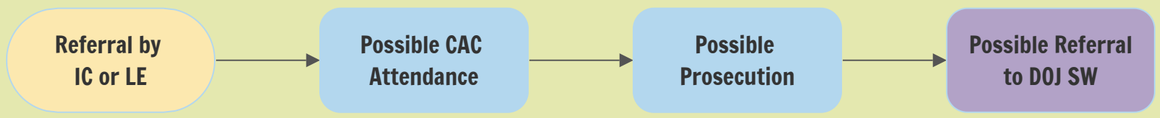
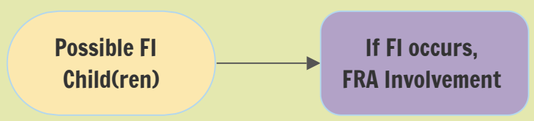
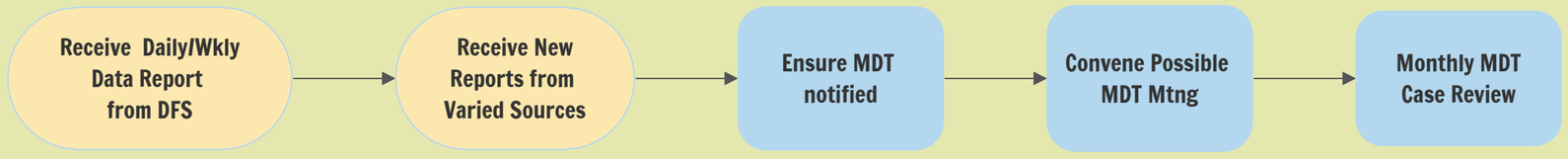
Teen on Child Extra-familial SA

DFS	
LE	
DOJ	
CAC	
IC	
Medical	

Teen on Child Intra-familial SA

DFS	
LE	
DOJ	
CAC	
IC	
Medical	

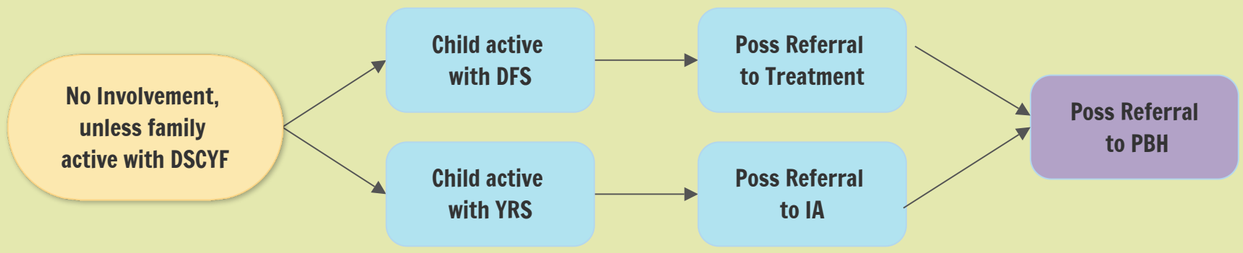
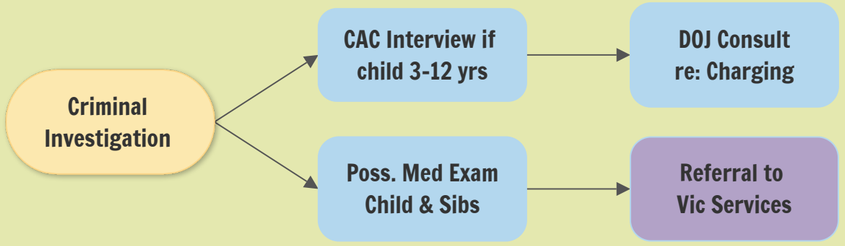
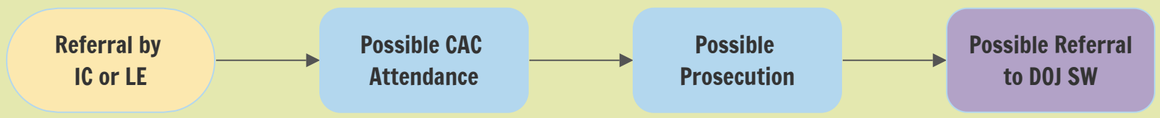
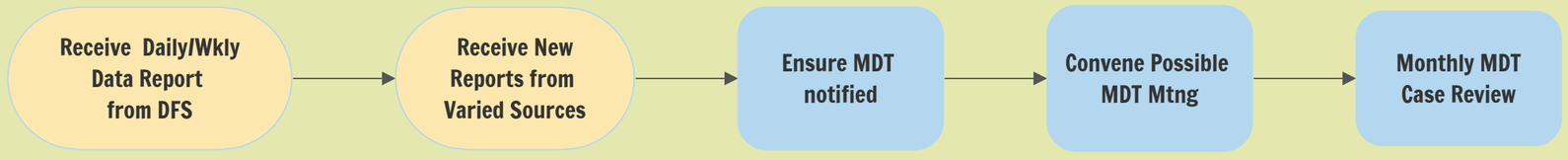
Teen on Teen Extra-familial SA

DFS	
LE	
DOJ	
CAC	
IC	
Medical	
DOE	

Teen on Teen Intra-familial SA

DFS	Civil Investigation → Possible CAC Interview → Poss Case Transfer to Treatment → Poss. Referral to PBH Civil Investigation → Medical Exams of Child & Siblings
LE	Criminal Investigation → Possible CAC Interview → DOJ Consult re: Charging Criminal Investigation → Referral to Vic Services
DOJ	Referral by IC or LE → Possible CAC Attendance → Possible Prosecution → Possible Referral to DOJ SW
CAC	Possible FI of Child(ren) → If FI occurs, FRA Involvement
IC	Receive Daily/Wkly Data Report from DFS → Receive Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	Child Presents to Facility → Report to DFS & Possibly LE → Possible Referral to Hotline/Crisis Line
DOE	Receive Report from Student/Staff → Notify DFS & LE → Identify possible witnesses--do not obtain statements

USC Extra-familial

DFS	
LE	
DOJ	
CAC	
IC	
Medical	
DOE	

USC Intra-familial

DFS	Civil Investigation → CAC Interview if child 3-12 yrs → Poss Case Transfer to Treatment → Poss. Referral to PBH Civil Investigation → Medical Exams of Child & Siblings
LE	Criminal Investigation → CAC Interview if child 3-12 yrs → DOJ Consult re: Charging Criminal Investigation → Referral to Vic Services
DOJ	Referral by IC or LE → Possible CAC Attendance → Possible Prosecution → Possible Referral to DOJ SW
CAC	FI of Child(ren) → FRA Involvement
IC	Receive Daily/Wkly Data Report from DFS → Receive Reports from Varied Sources → Ensure MDT notified → Convene Possible MDT Mtng → Monthly MDT Case Review
Medical	Child Presents to Facility → Report to DFS & Possibly LE → Possible Referral to Hotline/Crisis Line
DOE	Receive Report from Student/Staff → Notify DFS & LE → Identify possible witness--do not obtain statements

Charge # 1	Examine the Existence and Availability of Specialization Programs for Mental Health Services for Child Sexual Abuse

Actions to Address Charge: The work group engaged in discussion with mental health professionals from private practices and Delaware public agencies and participated in informational sessions delivered by Allison Dovi, Ph.D. on evidence-based interventions for treatment of trauma and child sexual abuse and by representatives from both the Division of Prevention and Behavioral Health Services (PBH) and Delaware based private practices.

Determinations:

- Mental health interventions to treat childhood sexual abuse should be evidence based. "Evidence-based" means the intervention is considered the best practice in the field and at least three randomized controlled trials have found the treatment to help a specific population.

- Based on the extensive research evidence base, the group concluded trauma focused cognitive behavioral therapy (TF-CBT) is the "gold standard" treatment model for childhood sexual abuse. Multiple studies involving TF-CBT demonstrate positive outcomes in children who have been sexually abused. Regarding the history of TF-CBT, this therapy modality was originally designed to treat sexual abuse, and has since been adapted to address other trauma types. TF-CBT was developed by Esther Deblinger, Ph.D., Judith Cohen, M.D. and Anthony Mannarino.

- Reputable national organizations, including The National Child Traumatic Stress Network describe TF-CBT as a leading method for treating child sexual abuse:

https://www.nctsn.org/what-is-child trauma/trauma-types/sexual-abuse/interventions

> *"TF-CBT has the strongest research evidence of any treatment model for traumatized children. Multiple randomized controlled trials and replication studies, including international studies, have been conducted documenting the effectiveness of TF-CBT for improving a range of problems for [traumatized] children".* [Source: NCTSN]

> *"TF-CBT is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents and is listed as an evidence-based practice on the U.S. Substance Abuse and Mental Health Services Administration website: the National Registry of Evidence-based Programs and Practices (NREPP) with a quality of research rating of 3.8 on a scale of 4.0. The link to the website for TF-CBT is: http://www.nrepp.samhsa.gov/"* [Source: Delaware Division of Prevention and Behavioral Health Services]

- The following are features of TFCBT utilized for children ages 3 to 21 and their caregivers. The typical treatment length is 12 to 20 sessions for 60-90 minutes a session.

- TF-CBT is most effective when: (1) the child is not having contact with the perpetrator; (2) the child can benefit from cognitive behavioral therapy approach; (3) the family or caregivers can commit to attending sessions consistently; (4) the child has significant post-traumatic stress

symptoms; (5) the behavioral problems are secondary to the trauma; (6) life is relatively stable, and trauma has ended; (7) there is minimal legal involvement; and (8) the child has a supportive caregiver to regularly participate in treatment. [Source: Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. *Depression and anxiety*, *28*(1), 67-75].

- Identification of TF-CBT providers within the State of Delaware is difficult for several reasons. First, the absence of a centralized directory for TF-CBT trained therapists creates challenges in locating them effectively. It is also challenging to confirm a therapist's certification for TF-CBT, particularly online, as providers organize information on their websites differently.

- The National Therapist Certification Program (NTCP) lists 6 Delaware therapists as certified in TF-CBT at: https://TC.CBT.org.

- PBH has a clinical training program in TF-CBT for mental health professionals with at least a master's level degree and opportunities to use TF-CBT. As of 6/29/2023, PBH's roster lists 94mental health professionals who completed the TF-CBT program. The roster is found at: https://takecaredelaware.org/TF-CBT-roster-php.

- There are likely other mental health professionals in Delaware with TF-CBT certification and/or experience; however, the above-mentioned barriers render it difficult to specifically and easily locate them.

- Alternate treatment approaches to TF-CBT exist for children who have been sexually abused. When TF-CBT is not appropriate for a child, other evidence-based interventions effective for treating childhood sexual abuse include:

  - Cognitive behavior therapy (CBT). The treatment length for CBT is typically 6 to 8 sessions for 60 to 90 minutes a session. CBT is most effective when: (1) the child may be having regular contact with the perpetrator; (2) the child has slight elevations of post-traumatic stress symptoms or parent-only reported post-traumatic stress symptoms; (3) the allegation was unfounded and emotional distress is present; and (4) the child experiences chronic stressors.

  - Cognitive Processing Therapy (CPT) for Post Traumatic Stress Disorder. The treatment length for cognitive CPT is typically 6 to 8 sessions for 60 to 90 minutes a session. CPT is most effective when: (1) the child is age 14 or older and willing to do homework and highly motivated; (2) the child has a good relationship with the caregiver; and (3) the child has an unsupportive or unavailable caregiver.

  - Parent Child Interaction Therapy (PCIT) with Trauma Focus. PCIT is primarily for children ages 2 to 6 years, 11 months. PCIT is most effective when: (1) the child is within the appropriate age range; (2) a consistent caregiver is present; (3) the primary concerns are

behavioral; (4) the family would benefit from stronger relationships; and (5) the therapy is addressing childhood trauma.

- Work group members discussed eye movement desensitization and reprocessing (EMDR) as an alternative approach to treating child sexual abuse, as well as child and family traumatic stress intervention (CFTSI). CFTSI is a therapeutic approach to help children and families cope with traumatic events, including childhood sexual abuse. PBH contracts with a A Seed of Hope Counseling to provide CFTSI to families in Wilmington and hopes to be able to expand to Dover and Georgetown.

Charge # 2	Examine the Availability of Mental Health Services for Treatment of Childhood Sexual Abuse, Including Minority Populations

Actions to Address Charge: To explore this charge, the work group reviewed compilations of mental health provider lists used by various organizations (The Children's Advocacy Center/CAC, law enforcement-based victim advocates, Nemours Children's Health) working with Delaware's children. Each list is included with this report.

Determinations:

- The CAC organizes their referral lists by county. Representatives from the CAC discussed how the CAC refers children and families to mental health providers. The CAC has "Mental Health Services Linkage Agreements" with select mental health providers to serve children seen at the CAC.

- Delaware law enforcement-based victim advocates presented their lists of mental health providers to refer children and families to providers.

- PBH representatives provided PBH's "Directory of Authorized Service Providers" for agency staff, stakeholders and families to access mental health treatment.

- Available lists include names and contact details for therapists, and are valuable for that purpose. However, the lists do not indicate whether the provider treats child sexual abuse, the therapeutic interventions used by the therapist (such as TF-CBT), the provider's availability, office location, age groups treated, languages spoken, insurances accepted, special populations treated, and other factors.

- Such detailed information is necessary for a parent or caregiver to make an informed preliminary decision about the providers qualifications and appropriateness to treat sexual abuse and increases the likelihood of finding a therapist who meets the needs of the child. Lists containing names of therapists and contact information do not capture the additional helpful detail.

- The workgroup therefore created a questionnaire to survey mental health professionals, including the following inquiries:

(1) Does the provider treat children who have been sexually abused?
(2) What educational degree does the provider hold?
(3) What license the provider holds and in what state?

(4) What age group of children the provider treats?
(5) What trauma types the provider is competent in treating?
(6) Whether the provider is proficient in providing trauma therapy in other languages?
(7) Is the provider is certified in TF-CBT?
(8) What other evidence-based trauma treatments the provider is certified and experienced in?
(9) Is the provider in the process of pursuing certification for other evidence-based trauma treatment?
(10) What is the provider's average length of time is for treating the trauma?
(11) Does the provider include a supportive & non-offending caregiver in the treatment?
(12) How often does the provider can have sessions with the child and the caregiver?
(13) How long each session is?
(14) Does the provider hold sessions in-person or virtually?
(15) What forms of payment does the provider accept?
(16) What special populations does they provider feel competent in treating, including problematic sexual behaviors, intellectual disability, autism spectrum disorder, AD/HD, LGBTQ, youth who are non-verbal, youth who have been trafficked, physical disabilities, co-occurring behavior concerns, substance use, foster care/adoption, non-offending parents or caregivers, Hispanic or Latino, undocumented immigrants & refugee populations, African American?

- The work group sent the questionnaire by electronic mail to mental health organizations and practice groups in two waves. Each organization was asked to distribute the questionnaire to therapists within their practice groups for individual responses. While the questionnaire was set up to be answered efficiently, the overall response rate to the questionnaire was very low.

- For the first wave, the questionnaire was sent to 32 mental health organizations, and 12 individual therapists responded. For the second wave, it was sent to 25 mental health organizations, and 18 individual therapists responded. In total, the questionnaire was sent to 57 mental health providers (organizations and practice groups) and 30 individual therapists responded.

- The work group hypothesized possible reasons for the low response rates to include survey fatigue, high electronic mail volume, time consuming, or spam/privacy concerns. From the 30 individual responses received, the work group also identified themes:

- Fewer therapists have expertise treating younger children.
- Fewer therapists are proficient in languages other than English.
- Most therapists who responded are skilled at treating a variety of trauma types, and many use techniques other than TF-CBT.
- Treatment duration and content varies among the therapists who responded.

Charge # 3	Availability of Mental Health Services for Youth Offenders and Best Practices ,

Actions to Address Charge: The work group engaged in discussion with mental health professionals from private practices and Delaware public agencies and participated in a presentation delivered by Lauren Nestel, LPC, in New Jersey and Pennsylvania, who works extensively with children and youth with problematic sexual behaviors.

Determinations:

- Mental health interventions to treat children and youth with problematic sexual behaviors should be evidence based. Further, trauma focused cognitive behavior therapy (TF-CBT) is the "gold standard" treatment model for treating children and youth with problematic sexual behaviors.

- TF-CBT is used when traumas are identified and concerns about problematic sexual behaviors are expressed. Safety is addressed before psychoeducation, and the first treatment session involves the caregiver. Effective treatment includes review sexual behavior roles and what is appropriate and not appropriate. A supervision plan is developed and "okay" and "not okay" touches are reviewed. Sexual behavior rules are developed and reviewed for the family use, understand, and practice in the home setting. Caregivers equally need support as they are often in denial or blame themselves for their child's PSBs.

- Language choice is critical. Caregivers will often use terms such as "offender", "pedophile", and "perpetrator". Research supports the notion such terms, especially when talking about youth, has led to harsher responses than terms that separate the youth from the behavior. The term "child sex offender" is not endorsed and is more appropriately termed "youth with problematic sexual behavior. Terms that separate the youth from the behavior, especially within the juvenile justice system, are preferred.

- There is a limited availability of mental health professionals throughout the State of Delaware who use evidence-based interventions to treat children with problematic sexual behaviors. Locally, the Joseph J. Peters Institute (JJPI) in Philadelphia is a leading local organization with on-staff clinical staff treating survivors of sexual assault, adults, and children with problematic sexual behaviors. JJPI uses evidence-based social and psychological services, training, education, evaluation, consultation, and prevention approaches. Other organizations in New Jersey provide treatment for youth and problematic sexual behaviors, including: (1) Center for Family Services: Providing Adolescents with Second Opportunities (PASO); (2) Child Abuse Research Education and Service Institute (CARES); (3) Catholic Charities Diocese of Trenton; and (4) Children's Aid and Family Services. The University of Oklahoma Health Services Center also provides CBT training for treatment of children with problematic sexual behaviors.

- Ms. Nestel referenced online resources and various books on PSBs in children to include: (1) National Center on the Sexual Behavior of Youth at www.NCSBY.ORG; (2) National Child Traumatic Stress Network at www.NCTSN.org; (3) "What Do You Know?" Cards; (4) "Understanding Children's Sexual Behaviors: What's Natural and Healthy?"; (5) Personal Space

Camp; (6) “Where Did I Come From”; (7) “Amazing You”; (8) www.TheMamaBearEffect.org; and (9) www.Amaze.org.

- Delaware does not have an organization similar to JJPI, and there are too few therapists known and available to treat children with problematic sexual behaviors, especially in Kent and Sussex counties. The group agreed there is a statewide shortage of resources to treat children with PSBs, and a lack of resources on psychoeducation around problematic sexual behaviors, and healthy versus non-healthy sexual behaviors in children based on age and development.

- There is also a limited number of therapists known and available in Delaware who can provide consultation to other therapists who have child clients with problematic sexual behaviors. It was noted some therapists will apply the adult sex offender treatment approach to children with problematic sexual behaviors, which is not appropriate.

- In particular, there are challenges in finding appropriate caregivers to fully participate in TF-CBT and CBT for children in foster care with problematic sexual behaviors or other identified traumas. The TF-CBT and CBT treatment models require a caregiver to participate with the child in parallel and joint sessions. Children in foster care are often residing in temporary foster homes or group homes, and often do not have appropriate caregivers to participate in the full course of treatment.

- An inquiry to the Sex Offender Management Board about the requirements that were established for therapists to treat sex offenders should be considered.

- PBH has contracts for multisystemic therapy supports and some providers in the network are certified to treat problematic sexual behaviors, but there are barriers to access, such as the type of insurance the child has and whether the child is open with PBH. PBH performs psychosexual assessments for children with problematic sexual behaviors, but only for children who are court ordered through PBH.

- Delaware should consider pursuit of tuition reimbursement incentives for therapists, especially those willing to live in Kent and Sussex counties as under-served areas. The provision of tuition reimbursement would be an efficient way to attract quality therapists who complete graduate programs to serve areas most in need. The group agreed it is timely to pursue these incentives as society is becoming more attune to the importance of about mental health treatment and its necessity.

Charge # 4	Address the Critical Points in a Child’s Life for Intervention and Prevention Opportunities

Actions to Address Charge: The workgroup received presentations from Prevent Child Abuse Delaware, Beau Biden Foundation, and Project THRIVE.

Determinations:

- With more accessibility to the internet, online chatting, and social media, children have a greater risk of exposure to adult to child sexual abuse, online sexual abuse, and child to child sexual abuse.

- Critical junctures in a child's life for intervention and prevention should include: (1) early childhood, (2) school aged levels, and (3) adolescence. The current prevention education programs are discussed under Charge #5.

Charge # 5	Sexual Abuse and Prevention Education for Families

Actions to Address Charge: The workgroup received presentations from Prevent Child Abuse Delaware, Beau Biden Foundation, and Project THRIVE.

Determinations:

- Children spend most of the day in classroom/educational settings. Current Delaware school-based programs focused on sexual abuse prevention, recognition, identification. School-based initiatives to support children impacted by trauma are common current tactics to ensure Delaware children and youth-serving professionals receive education and can access intervention services.

- Two large non-profit organizations in Delaware currently support school-based educational initiatives:

  - Prevent Child Abuse Delaware delivers the evidence-based B.E.S.M.A.R.T. program to approximately 37,000 school-aged children focused on identifying dangerous situations, how and when to seek help and how to overcome feelings of confusion and anxiety when reporting abuse.

  - The Beau Biden Foundation offers the Shield of Protection program to schools and youth-serving organizations to ensure adult staff members working with children can recognize and respond to all forms of child abuse and neglect. Programs delivered by Beau Biden Foundation are individually tailored to the specific needs of the person or organization receiving the training.

- Recent expansion of Erin's Law mandates that a curriculum be developed and maintained for Delaware's public schools that educates students, public school employees and parents about personal body safety, child abuse, abuse detection and reporting. The statutory amendment expands Erin's Law to apply to children in 7th through 12th grades. The instruction must build upon skills learned the previous school year.

- The Child Protection Accountability Commission Adult Sexual Misconduct Workgroup has explored curriculums that can be adapted to meet Erin's Law mandates and educate an additional 61 to 71,000 students statewide.

- Project THRIVE is a trauma recovery demonstration project developed by the Delaware Department of Education, funded through a 5 year grant from the U.S. Department of Education to facilitate linkage of school-aged children to trauma informed support within their schools and local community. Delaware Department of Education contracts with 26 mental health providers to provide trauma-based services to eligible students; Project THRIVE covers the cost of mental health services if the child has no insurance coverage, including co-pays or when Medicaid coverage has been exhausted. Children eligible for supportive services include those exposed to traumatic situations and adversity including physical or emotional abuse, community violence, racism, bullying and trauma that can ultimately limit school success. Referrals to Project THRIVE can be initiated by any community member including members of the general public. Surveys are utilized by Project THRIVE to gauge participation impact.

- For children seen at the Children's Advocacy Center, the Family Resource Advocate makes initial telephone contact with the child's caregiver several days prior to the child's forensic interview. The family resource advocate meets with the child's caregiver both before and after the forensic interview and assists families with a broad range of services including linkage of mental health services, food, clothing, housing and information about protection from abuse orders. However, materials related to child sexual abuse education prevention are not specifically provided by the family resource advocate. Prevention education materials should be shared with children and families by the family resource advocate, especially given the child's recent victimization.

- Only children ages 3 to 12 are interviewed at the Children's Advocacy Center related to sexual abuse. The Family Resource Advocate will refer them to mental health services, but older youth do not receive the support from the Children's Advocacy Center, including no longitudinal follow-up to ensure they receive appropriate mental health services.

Charge # 6	Examine Current Best Practices for Medical Care for Child Sexual Abuse

Actions to Address Charge: A medical services subgroup was convened ad hoc, inclusive of existing Nemours Children's Health-based work group members involved in the direct medical assessment of child sexual abuse victims (physician lead, nurse practitioner, forensic nurse examiner program coordinator and children's hospital social worker). The group assessed the availability of hospital-based medical providers across the state with expertise in evaluating, diagnosing and treating child sexual abuse victims. The group indicated:

Determinations:

- Management of acute sexual assault involving a child victim necessitates time sensitive forensic evidence collection, lab testing for sexually transmitted infections and medication management (prophylaxis and treatment); acute sexual assault care is frequently rendered in emergency department settings.

- Non-acute sexual abuse can be medically evaluated in a trauma informed outpatient setting by a qualified medical provider with experience diagnosing genital injuries, identifying normal genital variants, managing sexually transmitted infections and mental health concerns.

- Delaware currently offers medical services to child sexual abuse victims in both emergency department and outpatient settings. Whereas emergency department-based medical provider services are more available, expert outpatient services are limited. The current epicenter of expert outpatient services is geographically located in New Castle County and associated with Nemours Children's Health (The Nemours CARE Program).

- The group identified that Nemours and Nanticoke respectively employed <5 forensic nurse examiners at the time of the query. Bayhealth employed <10 forensic nurse examiners, and Christiana employed <25 forensic nurse examiners. However, both Bayhealth and Christiana sites employed disproportionately few forensic nurse examiners specifically qualified to treat pediatric sexual assault victims versus adult victims.

- Existing forensic nurse examiner programs vary in coverage models, including varied in-house staffing hours, home call and weekend coverage availability.

- Nemours Children's Health located in New Castle County, Delaware, experienced an increase in number of child abuse victims seeking services who reside in southern counties, due to limited medical provider availability local to their residence.

- There are currently only 2 pediatricians in the state sub-board certified specifically in Child Abuse Pediatrics; both staff the Nemours CARE Program and are located at Nemours Children's Health in Wilmington, Delaware.

- The number of children treated for alleged child sexual abuse at Nemours Children's Health has increased from 2016 through 2020.

- A resource list of medical providers to treat child sexual abuse victims was located by the Subgroup through an internet search, published one decade earlier and listing outdated services across hospital sites that may adversely impact a family's ability to seek appropriate medical services for a child sexual abuse victim.

Charge # 7	Victim Services: Ideas on Continuity and Centralized System (i.e., Office of Victim Advocate)

Actions to Address Charge: The workgroup invited a series of agencies, both intra and extra-jurisdictional (Chester County Crime Victims Center; Delaware law enforcement-based advocacy agency; Delaware Domestic Violence Coordinating Council; Delaware Children's Advocacy Center), to present on their victim services/victim advocacy models, compare similarities and differences and identify systems gaps in Delaware.

Determinations:

- Chester County Crime Victims Center and Chester County Children's Advocacy Center located in Chester County, Pennsylvania developed a longitudinal, 2 advocate model. During the intake process at the Children's Advocacy Center, two victim advocates are assigned to a case involving child sexual abuse, intended to provide support to both the victim and their family. Both victim advocates are present during the forensic interview process, assist families with scheduling medical and mental health appointments, accompany families to medical appointments and offer assistance in court testimony preparation if needed. The victim advocates are employed by the Crime Victims Center which is geographically in close proximity to the Children's Advocacy Center and criminal justice center in Chester County, Pennsylvania.

- Law enforcement-based victim services in Delaware exist on a statewide basis and are located within police departments and the Delaware Victim Crime Center. Referrals are received from a variety of sources including law enforcement officers, reports, community members, rape crisis centers, the Children's Advocacy Center, walk ins and through 911 emergency calls.

- Victim service advocates are employed by the law enforcement department and required to disclose certain information shared by victims to law enforcement if related to a crime.

- Law enforcement-based victims services utilize a victim services coordinator to review case intakes, determine who is active with the case from which agencies and whether additional victim advocacy services are needed. Victim advocates do not engage longitudinally with families or provide intensive case management and refer victims to agencies who can help them access services. Victim advocates do routinely refer victims to mental health services. But for children, law enforcement advocates will defer to the Division's social workers for referring and linking children to services. It was noted by the workgroup that multiple members of the workgroup had limited knowledge and familiarity with law enforcement-based victim advocacy services, which was attributed to the relatively small number of children served by law enforcement-based advocates versus Delaware adults who have been impacted by crime. Law enforcement-based victim advocates typically do not attend forensic interviews of children at the Children's Advocacy Center unless directly requested to.

- Creation of a monitoring unit within the Division of Family Services to monitor child abuse victims for one year to address engagement in mental health services or implementation of a case review specialist, case review coordinator or victim advocate to remain longitudinally involved with the child victim and their family, respond to mental health needs over time, make referrals, confirm access to and engagement with services and monitor for effectiveness could address current system gaps should be considered.

- Delaware Domestic Violence Coordinating Council has worked historically to establish a Family Justice Center and a Family Justice Center Steering Committee was recently convened in September 2021. The Steering Committee aims to centralize services for survivors of abuse and their families, primarily domestic violence, described as "one stop shop" co-location of agencies addressing medical, mental health, legal and social service needs. A centralized location would enhance communication between involved agencies. Representatives from the Delaware Children's Advocacy Center discussed their stepwise intake process and assignment of a skilled •

Family Resource Advocate to contact the family of a child victim of suspected sexual abuse both before, during and after the child's forensic interview. The Family Resource Advocate assessed social, medical and mental health needs of the child and family. The Family Resource Advocate works with Division of Family Services investigators to confirm referrals to mental health services have been made for child victims of sexual abuse. The Family Resource Advocate assists families with a broad range of services (food, clothing, housing, protection from abuse orders) and utilizes a checklist as guidance to address multiple domains. The Family Resource Advocate attempts telephone contact with a family for up to 45 days following a child's forensic interview to ensure linkage to services.

- Representatives from the Delaware Children's Advocacy Center and law enforcement based victim advocacy services convened an ad hoc working group to enhance communication across both groups, reduce duplication of efforts to refer families to services and participation in the case review process.

- There are multiple agencies across Delaware currently providing victim advocacy services to child victims of sexual abuse and their families. Improved communication across agencies could reduce redundancy of efforts and enhance coordination of service provision. Delaware's current structure involving multiple agencies with existing multiple victim advocates providing a multiplicity of existing services pose challenges to a centralized model. The workgroup discussed a case tracking specialist may need to be employed by an independent agency or oversight body but would necessitate coordination among existing agencies; whether the case tracking specialist should have any direct contact with the family was discussed, as this may be more appropriate for a centralized victim advocate.

Charge # 8	Identify Mental Health, Medical, and Prevention System Areas Needing Improvement and a Prioritized Action Plan

Actions to Address Charge: Through comprehensive discussion and consensus development, the workgroup formulated the following recommendations:

<u>Mental Health System Area</u>

Background: Children who experience sexual abuse require mental health treatment from professionals with experience and trauma training in evidence-based techniques. There is a limited availability of Delaware mental health professionals who specialize in treatment of childhood sexual abuse and have expertise in evidence-based techniques, including TF-CBT. Furthermore, special populations, including children with special healthcare needs, disabilities, LGBTQ youth, and children from diverse cultural backgrounds, often have unique vulnerabilities that impact their experiences and response to childhood sexual abuse. Specialized providers with training and expertise to offer culturally competent therapeutic interventions to treat child sexual abuse are also limited in availability. Availability of mental health services and group session support for non-offending parents and caregivers is geographically limited, especially in Kent and Sussex counties.

Recommendation 1: There is an urgent need to recruit, train, and retain mental health providers to treat childhood sexual abuse using evidence-based techniques, with emphasis on TF-CBT, and

with expertise to appropriately treat special populations, whose practice locations are geographically diverse across the state.

Recommendation 2: To address the gaps in available services, opportunities to incentivize mental health professionals to practice in the field should be prioritized. Considerations should include:

- Loan forgiveness and tuition reimbursement programs offered to therapists who commit to working in the field of child abuse and trauma treatment.

- Scholarship awards and grants for students pursuing certification in the field of child abuse and trauma treatment.

- Expansion of professional development and opportunities for therapists to receive specialized training and continued education at reduced or no cost

- Recognition and award for those therapists who work in the field of child abuse and trauma treatment, including salary bonuses.

Recommendation 3: Ongoing assessment of mental health service provider availability across the State of Delaware is urgently needed to specifically identify and address resource gaps for children who have been sexually abused and based on geographical locations. Compiling accurate data from mental health professionals across the State is challenging. Identification of standardized, robust methods should be prioritized. Online descriptions of mental health providers vary based on the organization. Locating all Delaware providers who are trained and experienced in TF-CBT and treat children and youth was a task the work group could not accomplish.

Recommendation 4: A comprehensive directory base listing all therapists certified and/or trained in TF-CBT, along with relevant and consistent profile information, is urgently needed to help parents, caregivers, and others locate providers appropriate to their children's needs. This may additionally destigmatize the process of therapist identification and normalize provider identification for families. A directory can also help individuals in underserved areas more readily locate TF-CBT providers in their geographical areas.

Recommendation 5: Management and oversight of the directory could be accomplished by a state agency or division, and PBH should be considered. Ideally, the directory would include information about a provider's experience working with diverse populations, including children with disabilities who experienced sexual abuse, and children with specific language needs. It would also address what insurances the provider accepts and payment plans. An inventory of mental health providers is urgently needed that is current, includes therapists' qualifications, certification, and subspecialty areas, and is easily accessible to families and multidisciplinary partner agencies. Such a resource list necessary to facilitate timely connections to mental health services. Barriers to survey dissemination and completion by eligible providers experienced by the work group during the pilot attempt suggests the need for a professional regulatory body, licensing agency, or other authority to develop, disseminate, compile, monitor and update data regarding provider availability across the State.

Recommendation 6: A longitudinal case tracking system to identify mental health services eligibility, receipt and any revictimization is urgently needed to address gaps in service linkage and effectiveness. Families may initially decline mental health services following a forensic interview or during an active investigation related to child sexual abuse; a case coordination mechanism whereby repeated attempts at engagement of victims and families is needed. Case tracking could be accomplished by a case review specialist, case review coordinator, or victim advocate. As PBH currently provides a care coordination team for children and families who are eligible for services, PBH could be consulted and considered in exploring this important and potential case tracking system.

Recommendation 7: For children with problematic sexual behaviors, measures should be taken to educate people about using terms that separate the youth from the behavior, especially within the juvenile justice system. The term "child sex offender" is not endorsed and is more appropriately termed "youth with problematic sexual behavior".

Recommendation 8: Opportunities to increase the number of qualified therapists who treat problematic sexual behaviors should be prioritized. Tuition reimbursement incentives should be considered for therapists, especially those willing to live in Kent and Sussex counties as under-served areas.

Recommendation 9: Additional services are needed on a statewide basis to support non-offending parents and caregivers of children and youth who have been sexually abused. More support groups are needed in therapeutic settings. Group therapy settings can provide emotional support to non-offending parents and caregivers to share their feelings, make them feel less isolated, and more understood. It also provides opportunities for further education about childhood sexual abuse, helps to reduce the stigma, and contributes to emotional healing and connections to others with similar experiences.

<u>Medical System Area</u>

Background: There is currently a limited number of medical providers throughout the State who can provide medical care and assessment for child sexual abuse. The Nemours CARE team staff is located in Wilmington, and less accessible by children and families in Kent and Sussex counties. Nemours CARE clinic receives non-standardized referrals highlighting the need for standardized practices. Standardized protocols across all adult and pediatric settings should be implemented, including testing for sexually transmitted infections and evidence collection at Nemours CARE clinic.

Recommendation 1: There is an urgent need to increase the number of skilled medical providers statewide to meet the needs of children who have been sexually abused, including forensic nurse examiners, nurse practitioners, and board-certified child abuse pediatricians.

Recommendation 2: Periodic case review system should be developed and implemented involving identified providers to review abnormal or unusual cases and to ensure a standardized testing protocol is followed.

<u>Prevention and Education System Area</u>

Background: Education for children related to sexual abuse victimization, personal body safety and actions a child can take to be protected from sexual abuse are topics that should be prioritized by schools and are relevant to students of all ages, regardless of grade level.

Recommendation 1: Further educational opportunities are needed within community settings for parents and caregivers related to child sexual abuse and how to respond if disclosure is made. Education should include empower parents to talk at home with their children first about genitalia and sexual activity.

Recommendation 2: Specific education tailored for older adolescents focused on social media issues, grooming, and sextortion is needed. Interventions should focus on providing age-appropriate sex education to children, while teaching them the important distinction between sex and consent.

Recommendation 3: Prevention education materials should be shared with children and families by the family resource advocate at the Children's Advocacy Center when there are opportunities to do so.

Recommendation 4: Primary care providers and other medical providers who have contact with children and youth should screen adults and children separately about sexual abuse in developmentally appropriate ways.