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**MASTER OF PUBLIC POLICY  
CAPSTONE PROJECT**

Legislative Barriers to Integrated Practice in Child Advocacy Centres

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Submitted in fulfillment of the requirements of PPOL 623 and completion of the requirements for the  
Master of Public Policy degree



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## **Capstone Executive Summary**

A significant portion of the Canadian population has experienced abuse in their childhood, with some studies claiming the prevalence being as high as 32% of Canadians (Afifi et al, 2014). The effects of child abuse-related trauma can be physical and mental and can last well into adulthood. There are also significant fiscal costs associated with child abuse and resultant trauma.

The current policy response in Canada is the adoption of Child Advocacy Centres (also known as Child Protection Centres or Youth Advocacy Centres). The Child Advocacy Centre model is based on integration, as agencies occupy the same space and share expertise in order to provide victims with the best possible care and resources. The goal of these centres is to create a “one-stop-shop” of services for victims of abuse. Several cost-benefit analyses of the currently operating centres suggest that they are positive models for streamlining child abuse cases and also have a significant social return on investment.

The goal of this study is to illuminate barriers that inhibit integration between organizations within these centres. How and when organizations are permitted to share information are important aspects of such integration. This

study analyzed the legislative frameworks that guide these operations and provided recommendations as to how this legislative foundation can be improved. The study looked in more depth at 3 specific Child Advocacy Centres (CACs), their levels of integration, their rules surrounding information-sharing and any barriers beyond legislation that they may encounter.

Through the comparative analysis, it was evident that legislation can be a major barrier to integration in CACs. Two recommendations are suggested; First, to create national standards for accrediting CACs in Canada and second, for provinces to provide a legislative foundation that predicates sharing information between experts on the basis of providing the best service provision to victims and not based on the victim's interaction with the justice system.

# Legislative Barriers to Integrated Practice in Child Advocacy Centres

## Introduction

### Child Abuse in Canada

The number of children affected by abuse in Canada is staggering. Twenty-one percent of Canadian females and thirty-one percent of males have experienced abuse during their childhood. In 2014, it was estimated that 53,600 children were victims of violent crime and although children make up only twenty percent of the Canadian population they experience fifty-five percent of all sexual assaults (Ibrahim and Karam, 2016).

There are four main categories of child abuse: emotional abuse, neglect, physical abuse and sexual abuse. Emotional abuse can range from verbal attacks, exposure to drugs or alcohol, or exposure to serious conflict in their home. Neglect includes both physical and emotional neglect. Physical neglect occurs when there is a failure to meet the child's daily basic needs such as nutrition or health care. Emotional neglect is when a child's emotional needs, such as the need to feel affection, are not met (Sheldon Kennedy Child Advocacy Centre, 2016). Experiencing abuse as a child can have profound effects on people not only throughout childhood and adolescence but also into adulthood. The facts below illustrate the longevity and severity of the negative effects of trauma.

Children who suffered abuse (Sheldon Kennedy Child Advocacy Centre, 2015):

- Are thirty percent more likely to drop out of high school

- Are twenty-six times as likely to be homeless
- Have four times as many experiences with mental health services
- Are twice as likely to be arrested as an adult and four times as likely to be arrested as a juvenile
- Are four times more likely to report self-harm or thoughts of suicide

Furthermore, adolescent boys who were abused as children are forty-five times more likely to engage in violent behavior in dating (Sheldon Kennedy Child Advocacy Centre, 2015).

Most citizens are aware of the short-term physical costs of child abuse. Physical harm is generally the most visible and detectable form of abuse. However many Canadians do not realize that abuse related trauma not only creates immediate physical harm but can also have long-term negative consequences for victims' mental health. Abuse-related trauma can include, "violent behaviour, including abuse of one's own children, increased rates of aggressive behaviour, including non-violent acts, higher rates of substance abuse, greater likelihood of criminal behaviour and significantly more emotional problems including anxiety depression, dissociation and psychosis" (Bowlus et al, 2003).

Child abuse has been linked to changes in victims' mental and behavioural development. This may lead victims of child abuse to be at greater risk to engage in dangerous behaviour (Odhayani, Watson and Watson, 2013). Indirect signs of child abuse include: acting out, withdrawal, aggression, anxiety, sleeping problems, changes in eating habits, self-destructive behaviour, and antisocial behaviour (Odhayani et al, 2013). Furthermore, studies have established links between



maltreatment in childhood and increased risks of chronic diseases such as diabetes (Felitti et al, 1998).

Child abuse in Canada creates substantial fiscal losses. In 1998 the estimate was approximately \$15.7 billion (Bowlus et al, 2003). This figure was arrived at by calculating costs of judicial and social services used by victims, the demand for special education services by victims, estimates of lost income, health costs such as immediate treatments required for victims and also long-term care as a result of trauma, as well as personal costs experienced such as legal fees, drugs, therapies, alcohol, transportation etc. (Bowlus et al, 2003). While studies have found that the majority of this cost to society burdened the victims themselves rather than government, the overall harm to society is undisputable. Personal hardships undoubtedly affect Canadian society as a whole, whether tangibly through financial strain or on a more abstract level as our collective social fabric is damaged.

The policy foundation regarding child abuse is based on provincial legislation (Canadian Child Welfare Research Portal, 2017). Child welfare policy remains under the jurisdiction of provincial and territorial governments, with the exception of services to First Nations peoples, which are regulated and funded by the federal government (Canadian Child Welfare Research Portal, 2017). For the purposes of this study, the legislative schemes of Ontario and Alberta have been analyzed in detail. The legislative document that governs child welfare in Alberta is *The Alberta Children First Act*. In Ontario the relevant legislation can be found in *The Municipal Freedom of Information Act Ontario and The Freedom of Information and Protection of Privacy Act*.

Recently in Canada the policy response to child abuse and neglect has been the adoption of Child Advocacy Centres. These centres across Canada have various titles (Child Protection Centres or Child and Youth Advocacy Centres for example) but will be referred to as CACs throughout this document. CACs emerged in the US and then subsequently in Canada to provide better coordination between agencies and to streamline services to improve the experiences of victims. They are designed to restructure child abuse investigations in order to reduce the trauma of re-victimization caused by multiple forensic interviews (Shadoin et al, 2006). Prior to the adoption of the CAC model, victims used to have to re-live their trauma multiple times in order to ensure that all the relevant authorities had the information they needed to proceed. CACs strive to create “wraparound” care for victims of abuse so that victims and their non-offending family members have access to all the resources and services they require in one location. Further, the professionals employed at CACs have access to one another and work in close proximity to each other.

### **The Policy Issue**

One of the greatest challenges in designing policy to address child abuse prevention and treatment is the coordination of service providers. This is in part why we have seen the emergence of Child Advocacy Centres. However the process is not performing optimally yet, and there is room to improve the collaboration between agencies within CACs. Having successful collaboration between agencies in order to improve the process for victims, remains at the core of this issue. The lack of information-sharing and coordination between organizations is the critical policy

issue that this study will address. Future policy must be designed to improve the efficiency and coordination of the CAC model so that centres can function at their best.

Addressing this issue in our society and investing in prevention efforts is not only the right thing to do for each individual child who, through no fault of their own, has been put in an abusive situation, but could also help decrease costs to society, and increase our productivity as a whole. It is imperative that the children and families who have experienced such trauma move in a positive direction.

### The CAC/CYAC Model

CACs were first introduced in the 1980s in the United States and are now widely used across Canada as well. There are currently 795 CACs in operation in the US (National Children's Alliance, 2016). The National Children's Alliance is the national association responsible for accrediting those CACs. In all 50 states, children who are abused can access a CAC for help (National Children's Alliance, 2016).

Their standards for accreditation include (National Children's Alliance, 2016):

- A multidisciplinary team (MDT), which includes law enforcement, child protection services, prosecution, mental health services, victim advocacy services, and CAC staff;
- Cultural competency and diversity;
- Forensic interviewing;
- Victim support and advocacy;
- Medical evaluation;

- Mental health services;
- Case review;
- Case tracking;
- Organizational capacity; and
- A child-focused setting

Canada is behind the US in the development of CACs. For example, there are no national accreditation standards like in the US, so CACs in Canada can vary greatly in their approaches. Because there are no officially recognized standards, CACs use the American standards as unofficial guidelines. In a report prepared for the Department of Justice in March 2015 researchers found that the six CACs studied differed immensely in their practices as well as in their organizational structure (Proactive Information Services, 2015).

### **Benefits of the CAC Model**

A 2006 cost-benefit analysis of community responses to child maltreatment by researchers in the United States found that for every one dollar invested in a CAC, there is a realization of 3.33 in benefits<sup>1</sup> (Shadoin et al, 2006). Along with being economically beneficial, investing in CAC is also a popular policy according to a Shadoin et al study that surveyed local residents. The idea of a program that reduces the burden on victims and their families was attractive to the vast majority of the 600 households polled in the study (Shadoin et al, 2006).

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<sup>1</sup> Benefits refer to cost savings in the following areas: health care, child welfare, law enforcement, and the judicial system.

Most academic studies on the success of the CAC model have come from the United States and generally support the notion that the CAC approach can improve system efficiency (the long-term marginal social benefits of CACs exceed the marginal social costs of switching to the CAC model) (Shadoin et al, 2006). There has been little research in this field in Canada, although preliminary evaluations of centres such as the one in Calgary, AB suggest similar results. However there remains many gaps in the research, especially in Canada. It has not been proven empirically that CACs lead to better judicial outcomes (higher conviction rates for example) (McDonald et al, 2013). The strongest conclusions coming out of the research in the US is that the CAC model leads to substantial cost savings as well as improved experiences for victims and their support systems (McDonald et al, 2013). One study found that investigations occurring under a CAC model provided 36% cost savings as compared to investigations conducted in a non-CAC setting (Shadoin et al, 2006). The primary source of these cost savings was time saved across different agencies as a result of the coordination provided by the CAC model.

Beyond the time saved and costs reduced by using a CAC, there is also substantial evidence of an improved experience for victims and their non-offending caregivers. CACs reduce the likelihood of re-traumatization<sup>2</sup> for victims (Proactive Information Services, 2015). When victims have to move from agency to agency to receive help they run an increased risk of re-traumatization as well as having the added cost of travel and wait times at each site. Further CACs help non-offending

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<sup>2</sup> Retraumatization is when someone is triggered to relapses into a state of trauma. It can be a conscious or unconscious reminder that causes an emotional re-experience of the original event.

caregivers navigate the system and provide them support as they move through their respective processes (Proactive Information Services, 2015).

A 2015 report from KPMG on the Social Return on Investment of the Sheldon Kennedy Child Advocacy Centre (SKCAC) in Calgary found the centre resulted in significant gains in productivity and efficiency. They approximated the productivity savings as a result of the centre across their stakeholder agencies to be \$550,000 annually (KPMG, 2015).

As well, the SKCAC model was found to save time in:

- Collecting data
- Travelling between organizations/agencies
- Unnecessary visits to the emergency department
- Assigning persons to the investigation of the case or treatment of the victim

Given that the estimated annual cost of child abuse in Alberta is approximately 2.4 billion dollars, the SKCAC would only need a 0.1% reduction in the annual costs of child abuse in the province in order to achieve a positive Social Return on Investment (KPMG, 2015).

### **Child Advocacy Centres in Canada**

There are 25 CACs in Canada that are either open or operating at the pilot/demonstration project level (Child and Youth Advocacy Centres, 2016).



**Table 1. Current CACs in Canada**

(Child and Youth Advocacy Centres, 2016)

<b>Centre</b>	<b>Location</b>
Sheldon Kennedy CAC	Calgary, AB
Zebra Child Protection Centre	Edmonton, AB
Caribou CYAC	Grande Prairie, AB
Alisa's Wish CAC	Maple Ridge, BC
Sophie's Place CAC	Surrey, BC
Vancouver CYAC	Vancouver, BC
North Okanagan CAC	Vernon, BC
ORCA CAC	Victoria, BC
The Policy Centre for Victim Issues	Department of Justice, Canada
Snowflake Place CYAC	Winnipeg, MB
SeaStar Centre CYAC	Halifax, NS
CAC Feasibility Study	Iqaluit, NT
CAC Feasibility Study	Yellowknife, NWT
Safe Centre of Peel CYAC	Brampton-Peel, ON
Koala Place CYAC	Cornwall, ON
Child Witness Centre CAC	Kitchener-Waterloo, ON
CAC Niagara	St. Catharines, ON
CAC of Simcoe Muskoka	Orillia, ON
CYAC Ottawa	Ottawa, ON
Feasibility Study for Remote North	Sioux Lookout, ON
CYAC at BOOST	Toronto, ON
Centre d'expertise Marie-Vincent	Montréal, Québec
Regina Police Services, Victim Services Unit	Regina, SK
Saskatoon Centre for Children's Justice	Saskatoon, SK
Project Lynx CAC	Whitehorse, YT

## Integrated Practice

The foundation of the CAC model is built around integration. The core belief is that complex problems can be better addressed when professionals can work collaboratively together and use several areas of expertise rather than working in isolation. This is the basis of the integrated model and the theoretical framework for CACs/CYACs nationwide. The hope is that such collaboration will create a process whereby the children entering centres are encircled by all the appropriate service agencies. With a single joint response, the focus of this model is to deliver child-centered support (KPMG, 2015). Given the proof that childhood trauma can affect so many aspects of a child's wellbeing and involves services that deal with health (both physical and mental), family relations, justice, and education it is important to consider all these aspects in the treatment and prevention when abuse does occur. The benefits of using a holistic approach include improved productivity, improved quality of treatment and service delivery, reduced costs of service delivery, reduced long-term impacts and improved productivity (KPMG, 2015).

## Co-location

Co-location (when organizations share the same space) is an important aspect of the integration at CACs. Having partner agencies actually share physical office space allows professionals to develop working relationships “in an organic way” (KPMG, 2015). It is especially important to highlight this finding on the importance of physical proximity of workspace in an area of Internet communication and satellite workspaces. In the CAC model in-office collaboration



and face-to-face contact amongst professionals are an important part of a functioning model for CACs.

The benefits of co-located organizations include:

- Professionals having access to one another as resources
- Shared meeting spaces
- Makes the process of engaging with service providers much more simplified for victims
- Reduces victims risk of retraumatization
- Reduces their travel and wait times

### **Multi-disciplinary Teams (MDTs)**

Multi-disciplinary teams refer to joint collaboration between agencies partnered in a CAC. MDT membership is made up of representatives from various agencies, this can vary from centre to centre. The MDT framework is an example of centres pulling expertise from their different partners in order to provide a specific service. An example of an MDT is The Joint Investigative Child Abuse Team at the Sheldon Kennedy CAC. JICAT has members from Calgary Police Services, Alberta Health Services, Child and Family Services, Victim Services, the RCMP and SKCAC Staff.

### **Information-sharing**

The crux of co-location and the use of MDTs revolves around the ability for experts from various fields to use each other as resources and through collaboration provide the best possible service for victims. The ability for these professionals to

share information is at the core of an integrated practice. It is essential that information can be shared or else collaboration can be lost.

## **Objective**

This study aims to illuminate the barriers to integrated practice in CACs. The study will focus on recommendations for CACs in major urban centres where co-location between agencies is most feasible. Although this study will touch on several barriers to integration, it will focus primarily on legislation and how it may or may not affect the CAC model of integration. First, this paper will analyze the various legislative frameworks for information-sharing in existence in Canada and then will analyze how different categories of legislation may help or inhibit the operation of a CAC.

## **Methodology**

The approach taken in this study is a comparative case study analysis of 3 different Child Advocacy Centres in Canada (2 in Alberta and 1 in Ontario). The goal of which is to illuminate the effect that different legislative frameworks may or may not have on the operation of each centre. The base case for comparison is the Sheldon Kennedy Child Advocacy Centre in Calgary . The SKCAC was evaluated in comparison to the Zebra Centre in Edmonton, AB and the BOOST Centre in Toronto, ON. These centres were chosen first to compare the SKCAC to a centre within the same jurisdiction and under the same legislative framework and to a centre operating under a significantly different provincial legislation. The rationale for

selecting these specific centres was also due to their locations within major urban centres. The feasibility of a CAC in a rural setting faces several challenges to co-location and integration that urban centres do not. For this reason this study will focus on those centres in major urban settings. The study will then offer a brief analysis of any additional barriers (beyond legislative framework) that may inhibit information-sharing and integration within CACs.

### **Analysis of Legislative Framework**

For CACs to improve integration and sustain such practices in the long-term, a strong legislative foundation must be established. Provinces need a comprehensive legislative framework that grants service providers involved in child abuse treatment and investigation, the ability to feel comfortable building upon this new model of practice. As previously mentioned, the current legislative frameworks for service providers vary significantly between provinces.

To simplify the range of legislation regulating information-sharing by service providers I have created two categories to differentiate frameworks: service-focused legislation and justice-focused legislation. Justice-focused legislation is any legislation by which the sharing of confidential information is predicated on the case's interaction with the legal system. In contrast, service-focused legislation gives permission for information-sharing when it is likely to improve the service provision and/or the well being of the victim. The two provincial legislative frameworks that will be further analyzed in this study fall into one of these two categories, with Alberta legislation being service-focused and Ontario legislation being justice-focused. Non-service based legislative frameworks tend to look at

disclosure of information in singular circumstances rather than as a continual process.

While an in-depth comparison of all of Canada's provincial legislative regimes is beyond the scope of this study, the service/judicial dichotomy is useful when looking across the country. Other provinces can for the most part be sorted into these contrasting groups with some falling somewhere in between the two. Manitoba for example is service-focused like Alberta, where BC falls in between the two categories. Non-service based legislative frameworks tend to look at disclosure of information in singular circumstances rather than as a continual process. While it is a ubiquitous aspect of Canadian law that provincial regulations vary from jurisdiction to jurisdiction, each province should still strive for provisions that allow for the best possible practices.

Second, legislation that applies vastly different expectations to the various agencies operating in Child Advocacy Centres can inhibit information-sharing and thereby inhibit integration. In addition legislation that lacks clarity can lead organizations to attempt to fill the gaps in legislation by drafting their own codes of conduct and practices. This can also lead to increased variation between organizations and push them further away from integrated practice. For CACs to grow into integration and sustain such integration in the long-term the first step is a strong legislative foundation.

### **Alberta Legislation**

*The Alberta Children First Act* was first introduced by the Provincial Government of Alberta in 2013. Included in this act were provisions to ensure that

agencies who are directly involved in the provision of services to and for children would be able to legally share information when it would benefit the well-being of the child and/or improve the services they receive. Section 5 (see below) of the *Alberta Children First Act* lays out the guidelines for the proper practice of sharing information.

*Section 5 Chapter C-12.5*

*Children First Act*

*Information-sharing for purposes of providing services*

*4(1) For the purposes of **enabling or planning for the provision of services or benefits to a child**, a service provider may collect and use either or both of the following:*

*...*

*(b) the service provider or custodian making the disclosure is of the opinion that the disclosure is in **the best interests of the child**.*

*...*

*(For all other instances where information-sharing is permitted under the *Children First Act* see Appendix 1)*

The Honourable Dave Hancock, Minister of Human Services explained in his introduction of the *Children First Act* to the Alberta Legislature, one of the primary

goals of Bill 25 was to ensure that there is “appropriate information-sharing between collaborative agencies, the police, education, health, child welfare, others in the community, who are working together on behalf of children and that they share the information that they have in the best interests of the child” (Alberta Legislature Debates, 2013). According to the Alberta Government the act served to, “guide and support the right kind of information-sharing between individuals and organizations that plan or provide critical programs and services for children” (Government of Alberta, 2016).

This legislation gives permission for service providers to use their best judgment in sharing information. Professionals have the ‘green light’ to disclose information when it is in the “best interests of the child”. This essentially passes authority to experts working within CACs, or collaborating with CACs, and grants them a high degree of freedom to exchange information with other experts.

### Ontario Legislation

*Sec. 32 g of Municipal Freedom of Information Act Ontario and sec. 42 g of Freedom of Information and Protection of Privacy Act*

*Where disclosure permitted*

**42 (1)** *An institution shall not disclose personal information in its custody or under its control except,*

...

***(g) where disclosure is to an institution or a law enforcement agency in Canada to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;***

...

(For all other instances where information-sharing is permitted under the *Municipal Freedom of Information Act Ontario and Freedom of Information and Protection of Privacy Act* see Appendix 2)

The legislation outlined in Ontario in The Municipal Freedom of Information Act Ontario and The Freedom of Information and Protection of Privacy Act specifies that information shared by an institution or a law enforcement agency can be disclosed if such information were disclosed “with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result”. This legislation gives a ‘green light’ for institutions to disclose information in the most serious of cases. However the many professionals that operate within CACs, beyond those involved in criminal investigations, may be limited in their ability to share expertise or “triage”<sup>3</sup> a case. This framework gives permission for information-sharing between partners but in a more limited scope than Alberta. There are more

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<sup>3</sup> Triaging of child abuse cases often involves members of various agencies (Police, Children’s Aid, Medical Practitioner, etc.) meeting, strategizing, sharing data and deciding next steps. An example of triaging by a Multi-disciplinary team can be found in Case Study #1 on the Sheldon Kennedy CAC (page 22).

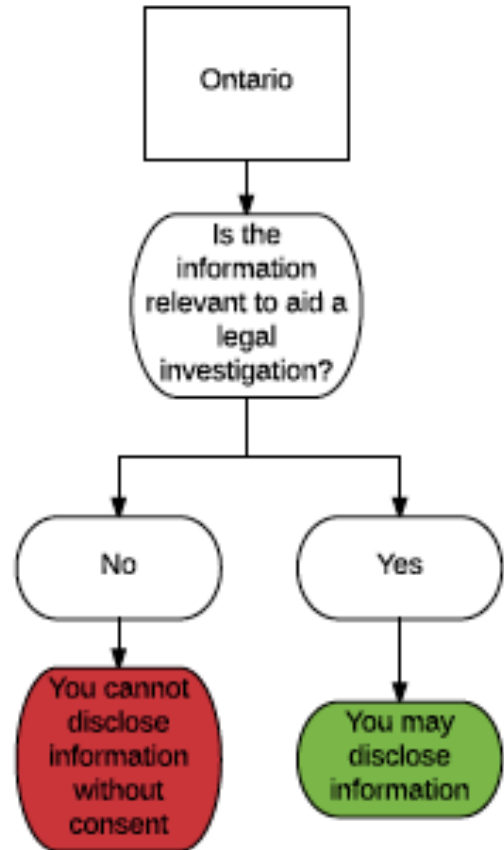
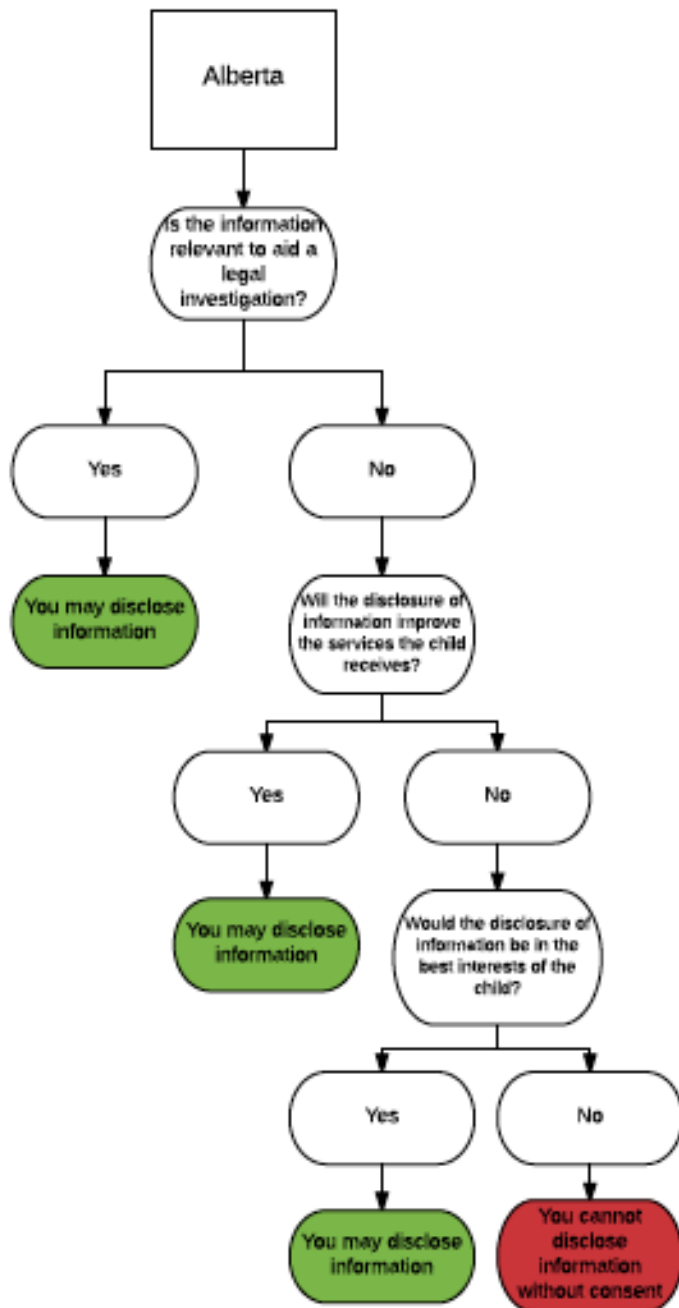
restrictions as to who can disclose information and a higher priority given to the privacy of confidential records.

In a document provided by Ontario's Provincial Advocate for Children and Youth for the jury presiding over the inquest into the death of Jeffrey Baldwin, a young boy who died tragically after suffering years of mistreatment by his guardians, the Provincial Advocate had several suggested improvements for Ontario's legislative framework. The document argues that s. 42.1 requires amendment and specifically argued for the inclusion of the phrase "or to aid a child protection investigation". However there has been no indication of such a change in the most current versions of both *The Municipal Freedom of Information Act Ontario* and *The Freedom of Information and Protection of Privacy Act*. In current versions of the documents (see Appendix 1) permission to share information remains conditional upon the engagement or suspected engagement that a victim will have with the legal system or compelling evidence of the child's health or safety being at risk. The diagram on the following page illustrates how service providers in both Alberta and Ontario would navigate disclosure based on their respective legislation.

If a provincial jurisdiction wishes to operate under a system with the greatest possible information-sharing and the most streamlined response to child abuse cases, then the service-focused approach should be adopted in their legislation. A further analysis of the operation of CACs under the respective legislative systems demonstrates why this policy approach is likely the better model.



## When can disclosure to another service provider occur?



## Case Studies

Three centres (the Sheldon Kennedy Child Advocacy Centre, the Zebra Centre and BOOST Child and Youth Advocacy Centre) were chosen for further analysis into their on-site operations and the level of integration between their partnered agencies. The goal of looking at these three centres in more depth was to illuminate if and/or how legislative foundation can affect the operation of a CAC.

### Case Study #1 (Base Case)- The Sheldon Kennedy Child Advocacy Centre, Calgary, Alberta

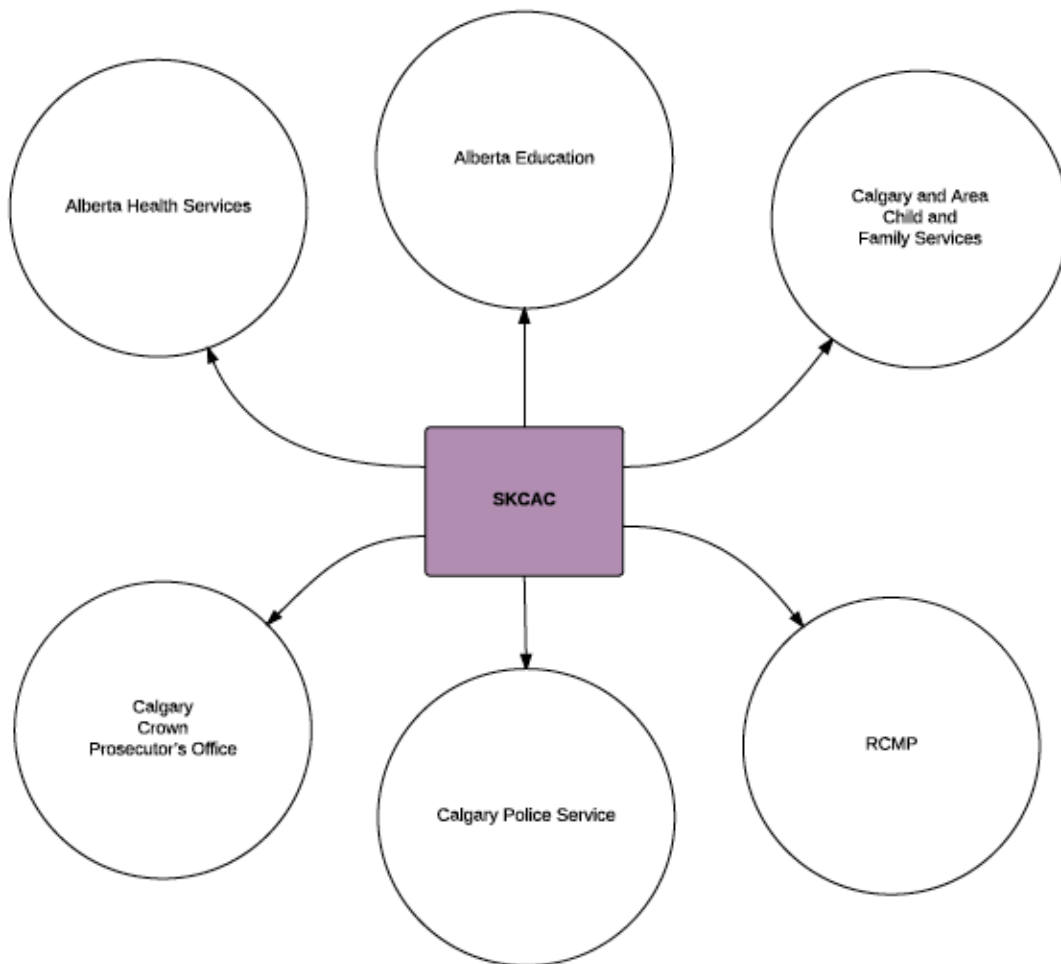
The Sheldon Kennedy Child Advocacy Centre treats victims of child abuse in Calgary, AB and the surrounding region. It's core functions include: forensic interviews, specialized medical assessment and treatment, specialized trauma and mental health services, case management, victim support and advocacy, and court accompaniment as well as specialized outreach services such as services for First Nations, Metis and Inuit (The Sheldon Kennedy Child Advocacy Centre, 2015). From its inception in 2013 to 2015 the SKCAC helped 2,907 youth who experienced cases of child abuse (The Sheldon Kennedy Child Advocacy Centre, 2015). The SKCAC receives, processes and treats approximately 124 children, infants and youth per month (The Sheldon Kennedy Child Advocacy Centre, 2015).

### Partner Organizations

The SKCAC is located in northwest Calgary and is the largest and most comprehensive centre of its kind in Canada. Under the umbrella of the SKCAC there are six agencies (The Sheldon Kennedy Child Advocacy Centre, 2016). These

agencies specialize in various aspects of child advocacy, are partnered with the Child Advocacy Centre and are all co-located within the centre. These agencies include: Alberta Education, Alberta Health Services, Calgary and Area Child and Family Services, Calgary Crown Prosecutor's Office, Calgary Police Service, and the Royal Canadian Mounted Police (The Sheldon Kennedy Child Advocacy Centre, 2016).

### Co-located Agencies



## Multi-disciplinary Teams

There are four Multidisciplinary Teams that work under the umbrella of the SKCAC: POST (Prenatal Outreach Support Team), AVIRT (Alberta Vulnerable Infant Response Team), CARRT (The Child At Risk Response Team), JICAT (The Joint Investigative Child Abuse Team). The following is a breakdown of the members of The Joint Investigative Child Abuse Team and their respective roles and functions:

Members of JICAT are from the following agencies:

- Calgary Police Service
- Alberta Health Services
- Child and Family Services
- Victim Services
- RCMP

The roles of each member agencies within JICAT are outlined in the following table (Chartier, 2016):

Joint Investigative Child Abuse Team	
Member Agencies	Roles
Calgary Police Service	<ul style="list-style-type: none"><li>• Conduct victim, witness, suspect interviews</li><li>• Gather evidence, medical records etc.</li><li>• Conduct neighbourhood inquiries where appropriate</li><li>• Get search warrants, conduct searches</li><li>• Help strategize with other team members prior to forensic interviews</li><li>• Evaluate interviews</li></ul>
Alberta Health Services	<ul style="list-style-type: none"><li>• JICAT pediatrician conducts sexual abuse exam as well as reviews medical history of patient</li><li>• Provide therapy services</li><li>• Arrange services for victims/parents closer to their community (reaching out to partners</li></ul>

	and services in rural communities)
Child and Family Services	<ul style="list-style-type: none"> <li>• Domestic violence planning with parents</li> <li>• Ensure continued safety of children</li> </ul>
Victim Services	<ul style="list-style-type: none"> <li>• Provide continued support in rural community</li> <li>• Provide court accompaniment and also help families and victims prepare for court date</li> <li>• Help with victim impact statements</li> <li>• Plan the logistics and travel for the victims and their families</li> </ul>
RCMP	<ul style="list-style-type: none"> <li>• Provide updates on safety concerns</li> <li>• Communicate with rural attachments</li> </ul>

Within each agency there can be various roles within JICAT. In addition to these roles the team also works in conjunction with the Crown. They have two Crown Prosecutors assigned to the team and they make visits to the centre on a weekly basis (Chartier, 2016).

### Information-sharing

The co-location of the six partner organizations allows for an efficient, streamlined service delivery and has allowed for productive information-sharing between experts. These members work together and communicate formally and informally to investigate and treat cases of child abuse that come through the centre. For the JICAT team, for example, the start of every day begins with a meeting in the morning where members meet and discuss cases (Chartier, 2016). This process is referred to as “triaging”. The triage process allows each facet of the MDT to share pertinent information, increasing everyone’s knowledge and understanding of each case. Usually the agency that initially received the report of child abuse presents the

case to the rest of JICAT at the morning triage meeting (Chartier, 2016). Following the triage meeting each agency conducts their own research, drawing on their specific database (Chartier, 2016).

This information can go a long way in assisting other members of JICAT in their own responsibilities within the case. For example the Calgary Police Service Detective was able to share with the Victim Support Coordinator that the travel to and from the SKCAC was creating a financial stress on the victim's parents (Chartier, 2016). This allowed the team to coordinate the interviews of the family's three children in one day to avoid unnecessary stress (Chartier, 2016). The advocate assigned by the SKCAC was also able to assist with this issue by assessing the children during their therapeutic play to see whether or not they would be ready emotionally and mentally, and also capable at their stage in development, to participate in a forensic interview (Chartier, 2016). Members of JICAT work together as a unit and work within the same building, allowing them to communicate with each other on a daily basis. These members work together and communicate formally and informally to investigate and treat cases of child abuse that come through the centre.

Further, all SKCAC staff sign a Memorandum of Understanding (MOU) that details how they are able to share information with other staff members. It is a "formal agreement signed between the partner organizations that outlines how they will work together and share information. This agreement removes barriers that previously existed between the partner organizations and promotes collaboration and integration of practices" (KPMG, 2015). While an MOU is not a legally binding

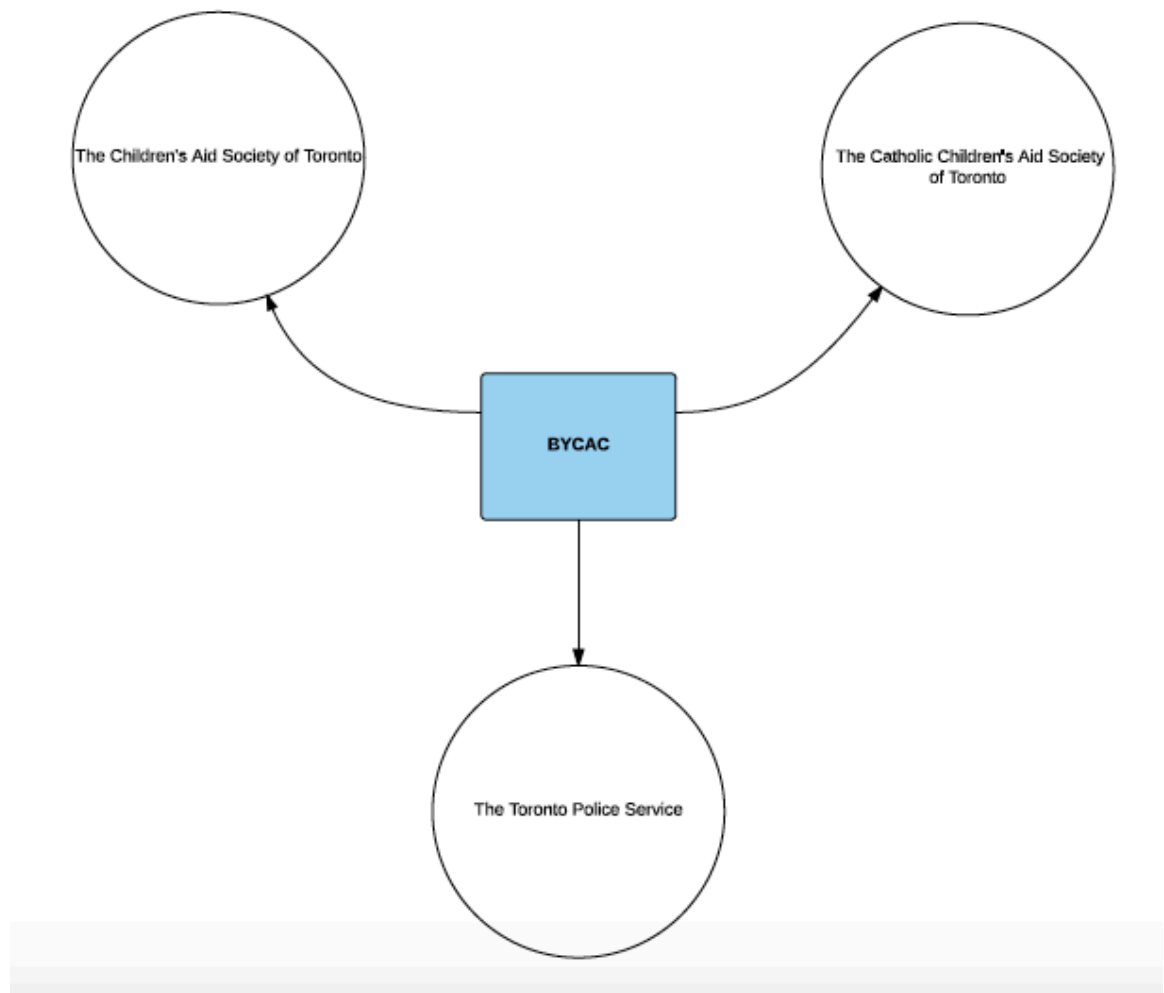
document, it establishes a way of thinking within the partner agencies that otherwise operate based on their internal policies, and not with a view to the greater scheme of the CAC. This is not a fix for any gap in legislation where a given agency is prohibited by law from sharing information in a given circumstance. It is however, an important tool for the development of the integrated approach, and ought to inform legislative changes in the future.

## **Case Study #2- The BOOST Child and Youth Advocacy Centre, Toronto, Ontario**

### **Partner Organizations**

The BOOST Child and Youth Advocacy Centre (BCYAC) is located in Toronto, Ontario and serves the Greater Toronto Area. The BCYAC works in conjunction with several Toronto-based community services. The following agencies are partnered with BOOST; The Children's Aid Society of Toronto, Catholic Children's Aid Society of Toronto, Jewish Family and Child, Native Child and Family Services, The Toronto Police Service, Child Development Institute, the SAFE-T Program (Radius Child and Youth Services) and the Suspected Child Abuse and Neglect Program (The Hospital for Sick Children) (BOOST Child and Youth Advocacy Centre, 2016). Of these organizations, the Children's Aid Society of Toronto, the Catholic Children's Aid Society of Toronto and the Toronto Police Service are the only to have offices located within The BCYAC. It also has partnerships with Crown Attorneys and the Victim Witness Assistance Program, although these organizations do not have an on-site presence (BOOST Child and Youth Advocacy Centre, 2016).

### **Co-located Agencies**



### Multi-Disciplinary Teams

Similar to the SKCAC, BCYAC uses multi-disciplinary teams made up of the aforementioned organizations to process the cases coming to the centre. MDTs can vary in their membership but most include at least one member from Medical, Police and Child Protection, and Counseling and are led by an Advocate. The Advocate is provided by the CYAC and their role is to work to coordinate the various team members.



When cases of child abuse are reported in Ontario, calls go through one of the four Children's Aid Societies listed above ("Reporting Child Abuse and Neglect: It's Your Duty", 2017). Cases are initially assessed and those with the highest risk, typically requiring 24-hour response are referred to BCYAC. A Children's Aid worker as well as a Police Officer would be assigned to the case and would work together to plan the investigation. If the child is going to be brought into the centre an Advocate from BCYAC will also be assigned (BOOST Child and Youth Advocacy Centre, 2017). Throughout this process the MDT members also have the option to consult with a medical practitioner or a mental health consultant.

### Information-sharing

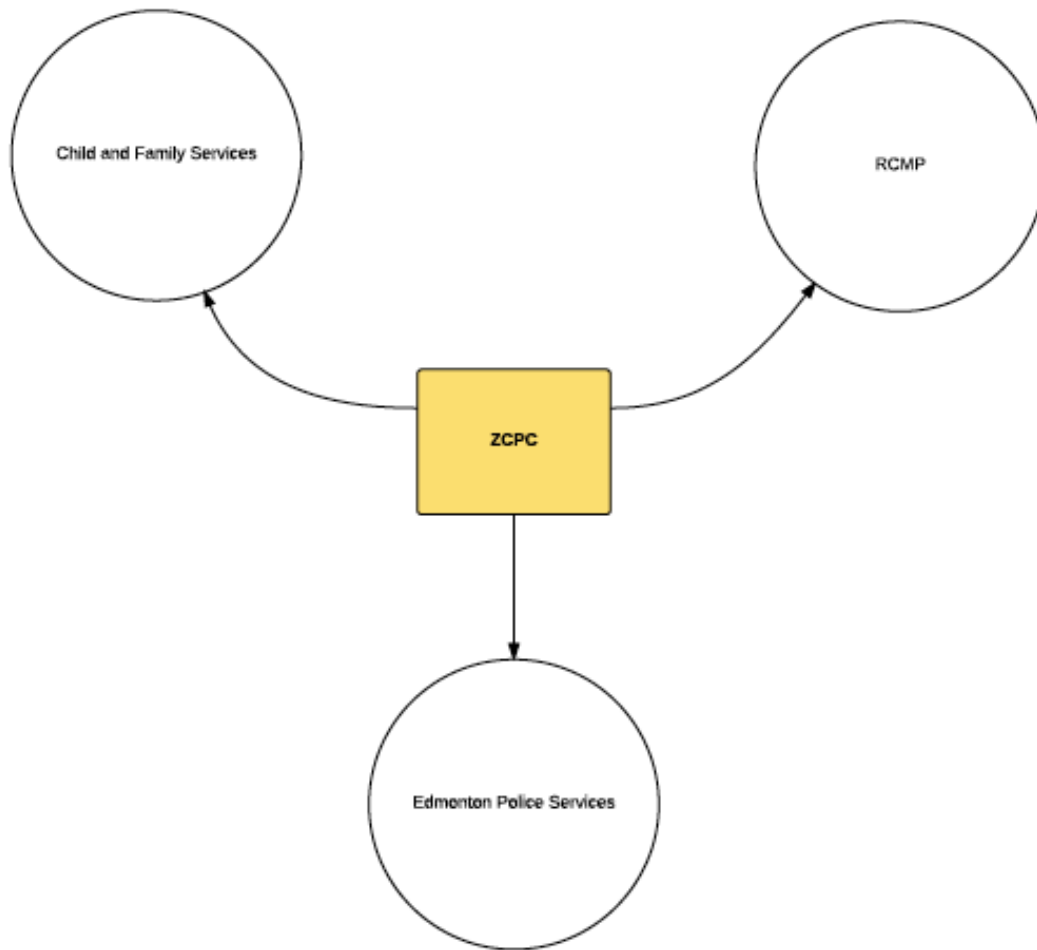
BCYAC does not specifically have training on information-sharing between partner agencies but they do have a comprehensive agreement for all their partner agencies. BCYAC refers to the Child Abuse Protocol in Toronto, a live document that offers guidelines to those interacting with child abuse cases. In terms of the information sharing allowed within BCYAC's MDTs, The Children's Aid worker and the Police Officer assigned to the case are not limited in what information they can share with each other. Once an investigation has concluded they would require consent from the victim's family (non-offending members). However, confidential information can only be shared with certain members of MDTs. Only members of the investigation team (Children's Aid and Police) have such access.

### Case Study #3 – The Zebra Child Protection Centre, Edmonton, Alberta

#### Partner Organizations

The Zebra Child Protection Centre (ZCPC) serves the Edmonton area and was opened in 2002, making it the first centre of its kind in Canada. The Zebra Centre's partners include: Alberta Health (Child Adolescent Protection Centre at the Stollery Children's Hospital), Alberta Human Services, Alberta Education, Alberta Justice and Solicitor General, the Edmonton Police Service, the Royal Canadian Mounted Police, and Edmonton Region Child and Family Services (the Zebra Child Protection Centre, 2017). Of these partnered organizations the Edmonton Police (Child At Risk Response Team), 2 RCMP officers, Child and Family Services, and 12 Zebra Centre Staff work together under one roof. They do not have an on-site forensic pediatrician for medical examinations but they do have one attend their morning meetings everyday.

## Co-located Agencies



## Multi-Disciplinary Teams

The ZCPC much like its counterparts uses multi-disciplinary teams to assess and deal with incoming files to the centre. Their MDTs consist of members from each on-site partner as well as a representative from the Child and Adolescent Protection Centre at The Stollery Hospital. They hold intake meetings every morning to review cases and decide in coordination what the next steps for each file may be. The intake coordinator compiles all referrals to ZCPC (coming from Child and

Family Services or the police) and is a member of the ZCPC Staff (The Zebra Child Protection Centre, 2017).

### Information-sharing

The ZCPC does not do ongoing training on how to share information specifically. MDTs at ZCPC, like the SKCAC experience very little limitations in what experts from different fields can share with each other. The “best interest” threshold allows all members of the MDT access to confidential information.

### Comparative Analysis

#### Partner Organizations

	<b>BOOST Child Advocacy Centre</b>	<b>The Zebra Child Protection Centre</b>	<b>Sheldon Kennedy Child Advocacy Centre</b>
<b>Local Police</b>	The Toronto Police Service	The Edmonton Police Service	Calgary Police Service
<b>brHealth Services</b>	The Suspected Child Abuse and Neglect Program (The Hospital for Sick Children)	Alberta Health Services	Alberta Health Services
<b>Child and Family Services</b>	The Children’s Aid Society of Toronto  The Catholic Children’s Aid Society of Toronto  Jewish Family and Child Services  Radius Child and Youth	Edmonton Region Child and Family Services	Calgary and Area Child and Family Services

	Services  Native Child and Family Services		
<b>National Police Services</b>		The RCMP	The RCMP
<b>Legal Services</b>		Alberta Justice and Solicitor General	Calgary Crown Prosecutor's Office
<b>Other</b>	The Child Development Institute	Alberta Education	Alberta Education

In comparison to both ZCPC and SKCAC, BYCAC has fewer partnered organizations co-located under its roof. For BYCAC and ZCPC it is important to note that all cases processed through BYCAC are investigations, there are no cases coming through the centre for treatment-only purposes, each case involves an investigation both by Children's Aid (looking into the protection and safety of the child) and a Police Officer (investigating criminal activity). Both ZCPC and BYCAC do not have a forensic pediatrician on-site for the purpose of medical examinations, although ZCPC does have access to medical practitioner in its morning meetings. This means in many cases it would be more difficult for both BYCAC and ZCPC to deliver a "one-stop shop" for victims.

### MDTs and Information-sharing

MDTs at the ZCPC, like the SKCAC experience very little limitations in what experts from different fields can share with each other. The "best interest" threshold outlined in provincial legislation (*The Children First Act Alberta*) allows all members of the MDT access to confidential information. Within the ZCPC all present agencies in their MDT meetings have the ability to share information. This is in contrast to

the experience at BYCAC where only members of the investigative team (Children's Aid Society and investigating Police) can share confidential information, unless the victim's family (non-offending members) grants permission. The only caveat for MDTs at ZCPC and SKCAC is that it is in the best interest of the child when confidential information is shared.

In comparison to the SKCAC it appears that MDTs within BYCAC are more limited in who can access confidential information. Only those members of the investigation team (Children's Aid and Police) have such access. This is likely due to the "justice-focused" Ontario legislation BYCAC must comply with. Only service providers directly involved in an investigation are granted access to confidential case information. For example the centre-appointed Advocate, the medical practitioner or the mental health consultant cannot access or share information unless given consent by the family. This can become problematic if there are families that do not want to give such consent, effectively reducing the professional resources available to the MDT. It can also be problematic when BYCAC staff wants to make a referral for a child to receive services outside the centre. For example if BYCAC made a referral for mental health counseling it could not provide any information to the mental health consultant they are referring the child to.

#### **National Children's Alliance Standards (United States)**

If we assess each centre based on the National Children's Alliance's ten required standards for accreditation, only the SKCAC would pass the test. Where the ZCPC and the BCYAC fall short is in the comprehension of their MDTs and in on-site medical evaluation.

<b>National Children's Alliance Standards</b>	SKCAC	ZCPC	BYCAC
A multi-disciplinary team which includes law enforcement, child protection services, prosecution, mental health services, victim advocacy services and CAC staff		×	×
Cultural competency and diversity			
Forensic interviewing			
Victim support and advocacy			
Medical evaluation		×	×
Mental health services			
Case review			
Case tracking			
Organizational capacity			
Child-focused setting			

## Other Barriers

The process of looking into these three centres in more depth also revealed some other important barriers to integration beyond legislation. Although this was not the focus of this study, awareness of these other barriers can help guide future policy decisions regarding CAC operations.

One important concern for most CACs in operation is access to consistent funding. CACs draw funding from a variety of sources such as corporations, organizations,

and government of all levels. There is an unpredictability of funding that most if not all CACs experience. For example, under Prime Minister Harper's federal government within the *Victim's Fund* there was a Child Advocacy Centre Initiative that provided substantial grants and funds to CACs. Government grants and funding initiatives change with each annual budget. Should government policy dictate a change in direction from one year to the next, programs such as *the Victim's Fund* inevitably find themselves unable rely on indefinite government funding. Not surprisingly, as government's change so do the funding streams for these centres (Department of Justice, 2016).

Secondly, in the Social Return on Investment study of SKCAC it was noted by staff members that on-going training on the proper execution of integration between agencies is crucial. A well-functioning integrated approach is a sharp directional change for many agencies who have been serving children and youth for decades. Changing the status quo of any organization can be difficult, let alone in an area that is as serious and grave as child abuse. Especially in an area such as child advocacy where cases are extremely sensitive in nature, an employee may harbour fears that they may overstep or share the wrong information with the wrong people. This is why education and training on proper collaboration with other professionals is essential for the integrated model to function. Providing on-going education to staff of Child Advocacy Centres and partnering agencies will further their comfort level of working in such an environment and likely help their ability to provide the best all-encompassing services to victims. This also ensures that with staff turnover,



new employees are receiving education on how to work in the CAC environment and there is no gap in service in an employee transition period.

Lastly, it is important to recognize that the ideal CAC model will have further challenges beyond the ones already addressed if serving a rural area. Co-location becomes more difficult in rural areas for a number of reasons. There may be multiple police units to coordinate between for example. Secondly, offering all services such as those outlined by the National Children's Alliance is a challenge even for urban centres. This would be even more difficult for a centre covering a more rural area as many would not have, for example, a forensic pediatrician present in their jurisdiction.

## **Policy Recommendations**

It is important to understand that by advancing policy to improve integration within CACs there is a trade-off in terms of privacy as it expands access to confidential information. However this improved access would be granted only to those working as professionals within Child Advocacy Centres. To arrive at the best policy for child abuse victim's we must weigh these concerns surrounding privacy rights against the benefits of an integrated CAC model. The integrated CAC model reduces chances of retraumatization, improves system efficiency for processing cases and improves the victim's overall experience in navigating through the justice and health care systems. As such, the following policies are recommended:

## **1. Create national standards for accreditation:**

There remains too much variation across the country between CACs. For high standards to be achieved nation-wide, so that children from every province and territory are able to receive comparable services, there must be national standards for CAC/CYAC accreditation. These standards can be based off of the US National Children Alliance criterion (see Appendix 3) but should also build further upon this foundation. Requiring co-location of agencies should be a prerequisite for accreditation for CACs based in major urban centres. This would include the ten requirements of the National Children's Alliance, such as on-site medical evaluation, forensic interviewing and Crown prosecutors. In addition to these standards, ongoing training on information-sharing and integrated practice should be required on an annual basis.

## **2. Provide the proper foundational legislation that is 'service-focused'**

Predicating collaboration between agencies based on the best interests of the child rather than engagement with the justice system is the next step for CACs to flourish. This allows the professionals involved in such centres to do their job as best they can while also allowing a CAC to foster an integrated environment. This would include amendments to the *Sec. 32 g of Municipal freedom of information Act Ontario* and *sec. 42 g of Freedom of Information and Protection of Privacy Act* in Ontario, as well as other provinces where legislation creates similar barriers to the integrated model.

## Conclusion

The in-depth analysis of the three CACs (SKCAC, ZCPC, and BYCAC) revealed that legislation specifically regarding information-sharing between service providers can have a large effect of the operation of CAC and the integration of its member agencies. It was found that the justice-focused legislation of Ontario, under which the BYCAC operates, did in fact inhibit the centre's MDTs, their make-up and member's ability to use each other's expertise. Further, comparing the selected CACs to the United States' national accreditation standards revealed that Canadian CACs vary in their ability to meet this criterion. Two of the three centres studied lacked two essential components of the CAC model, on-site medical examinations and MDTs with Crown prosecutors.

It is important that as a society we continue to improve our service provision for an issue as serious and consequential as child abuse. The effects of child abuse-related trauma can be physical and mental and can have long-lasting effects. The costs, both in quality of life of victims as well as monetary costs, provide additional motivation to ensure we are doing as much as possible to prevent child abuse and properly treat those who have already been affected. Establishing national standards for accreditation and amending the necessary legislation are good first steps to improving the CAC model and providing the best 'wrap-around' care possible to victims.

## **Appendix 1: Section 5 Chapter C-12.5 Children First Act Alberta**

*Section 5 Chapter C-12.5<sup>4</sup>*

*Children First Act*

*Information-sharing for purposes of providing services*

*4(1) For the purposes of enabling or planning for the provision of services or benefits to a child, a service provider may collect and use either or both of the following:*

*(a) personal information about the child or a parent or guardian of the child from another service provider;*

*2013*

*4*

*(b) health information about the child from a custodian.*

*(2) For the purposes of enabling or planning for the provision of services or benefits to a child,*

*(a) a service provider may disclose to another service provider personal information about the child or a parent or guardian of the child, and*

*(b) a custodian may disclose to another custodian or to a service provider health information about the child*

*if, in the opinion of the service provider or custodian making the*

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<sup>4</sup> *Alberta Children First Act, Statutes of Alberta 2013, C-12.5, <http://www.qp.alberta.ca/documents/Acts/c12p5.pdf>.*

*disclosure, the disclosure is in the best interests of the child.*

*(3) A service provider may disclose personal information and a custodian may disclose health information about a child to a guardian of the child if*

*(a) the disclosure is not contrary to the express request of the child, and*

*(b) the service provider or custodian making the disclosure is of the opinion that the disclosure is in the best interests of the child.*

**Appendix 2: Sec. 32 g of Municipal freedom of information Act Ontario and sec. 42 g of Freedom of Information and Protection of Privacy Act**

*Where disclosure permitted*

*42 (1) An institution shall not disclose personal information in its custody or under its control except,*

*(a) in accordance with Part II;*

*(b) where the person to whom the information relates has identified that information in particular and consented to its disclosure;*

*(c) for the purpose for which it was obtained or compiled or for a consistent purpose;*

*(d) where disclosure is made to an officer, employee, consultant or agent of the institution who needs the record in the performance of their duties and where disclosure is necessary and proper in the discharge of the institution's functions;*

*(e) for the purpose of complying with an Act of the Legislature or an Act of Parliament or a treaty, agreement or arrangement thereunder;*

*(f) where disclosure is by a law enforcement institution,*

*(i) to a law enforcement agency in a foreign country under an arrangement, a written agreement or treaty or legislative authority, or*

*(ii) to another law enforcement agency in Canada;*

- (g) where disclosure is to an institution or a law enforcement agency in Canada to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;*
- (h) in compelling circumstances affecting the health or safety of an individual if upon disclosure notification thereof is mailed to the last known address of the individual to whom the information relates;*
- (i) in compassionate circumstances, to facilitate contact with the spouse, a close relative or a friend of an individual who is injured, ill or deceased;*
- (j) to a member of the Legislative Assembly who has been authorized by a constituent to whom the information relates to make an inquiry on the constituent's behalf or, where the constituent is incapacitated, has been authorized by the spouse, a close relative or the legal representative of the constituent;*
- (k) to a member of the bargaining agent who has been authorized by an employee to whom the information relates to make an inquiry on the employee's behalf or, where the employee is incapacitated, has been authorized by the spouse, a close relative or the legal representative of the employee;*
- (l) to the responsible minister;*
- (m) to the Information and Privacy Commissioner;*
- (n) to the Government of Canada in order to facilitate the auditing of shared cost programs; or*

*(o) subject to subsection (2), an educational institution may disclose personal information in its alumni records, and a hospital may disclose personal information in its records, for the purpose of its own fundraising activities or the fundraising activities of an associated foundation if,*

*(i) the educational institution and the person to whom the information is disclosed, or the hospital and the person to whom the information is disclosed, have entered into a written agreement that satisfies the requirements of subsection (3), and*

*(ii) the personal information is reasonably necessary for the fundraising activities. R.S.O. 1990, c. F.31, s. 42; 2005, c. 28, Sched. F, s. 6 (1); 2006, c. 19, Sched. N, s. 1 (5-7); 2006, c. 34, Sched. C, s. 5; 2010, c. 25, s. 24 (12).*



### **Appendix 3: National Children's Alliance Standards for Child Advocacy Centres**

- A multidisciplinary team (MDT), which includes law enforcement, child protection services, prosecution, mental health services, victim advocacy services, and CAC staff;
- Cultural competency and diversity;
- Forensic interviewing;
- Victim support and advocacy;
- Medical evaluation;
- Mental health services;
- Case review;
- Case tracking;
- Organizational capacity; and
- A child-focused setting

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