Pergamon

Child Abuse & Neglect 28 (2004) 411–421

Child Abuse & Neglect

A USA national survey of program services provided by child advocacy centers☆

Shelly L. Jackson*

Institute of Law, Psychiatry and Public Policy, University of Virginia, Charlottesville, VA, USA

Received 17 June 2002; received in revised form 28 July 2003; accepted 21 September 2003

Abstract

Objective: Child Advocacy Centers (CACs) are designed to improve the community collaborative response to child sexual abuse and the criminal justice processing of child sexual abuse cases. CACs, in existence for 16 years, now have standards for membership developed by the National Children's Alliance (NCA) that include nine core components. And yet no systematic examination of the CAC model exists. The purpose of this paper was to assess the variations within these core components as they exist in the field.

Method: Using a stratified random sampling design, 117 CAC directors were interviewed using a semi-structured interview that was based on the NCA's standards for membership. The eight core components of the CAC model examined in this study include: a child-friendly facility, a multidisciplinary team, an investigative child interview, a medical examination of the child, provision of mental health services, victim advocacy, case review, and case tracking.

Results: Results reveal the CAC model has been widely adopted by both member and nonmember centers, although variations in implementation exist.

Conclusions: Future developments in the CAC model must include evaluation of the model.

Keywords: Child advocacy centers; Child sexual abuse; Multidisciplinary response

☆ Work on this project was completed while the author was a Society for Research in Child Development Executive Branch Policy Fellow at the National Institute of Justice (NIJ). Funding for this project was provided by NIJ's Visiting Fellow's program. Opinions and points of view expressed in this document are those of the author and do not necessarily reflect the official position of US Department of Justice.

* Corresponding author address: Institute of Law, Psychiatry and Public Policy, P.O. Box 800660, University of Virginia, Charlottesville, VA 22908-0660, USA.

0145-2134/$ – see front matter © 2004 Elsevier Ltd. All rights reserved.
doi:10.1016/j.chiabu.2003.09.020

Introduction

Child Advocacy Centers (CACs) are community-based, child-focused, facility-based programs in which representatives from multiple disciplines work together to investigate, treat, manage and prosecute child sexual abuse (CSA) cases (Wolf, 2000). The unifying philosophy among the CACs is that CSA is a multifaceted community problem that requires a multidisciplinary response.

In the United States, an allegation of CSA results in a police and/or a child protective services (CPS) investigation. CACs were developed in the 1980s in response to the criticism that a CSA investigation was another form of child abuse (i.e., system-induced trauma). According to Yeaman (1986), CSA victims were not being treated well by the various agencies handling CSA cases (i.e., courts, prosecutor's offices, CPS agencies, and police departments). For example, during the investigation children were taken from one unfamiliar location to another for interviews, medical examinations, and court appearances. Such practices were considered detrimental to both the children involved and the prosecution of these cases. CACs initially focused on CSA cases because these cases tended to involve criminal charges in which there was little or no corroborating or medical evidence, making it more likely that children involved in these types of cases would have to testify. Therefore, eliciting accurate information from these children was critical to the successful prosecution of these cases.

In response to these problems, the first CAC was established in 1985. The purpose of the CAC was to improve the community collaborative response to CSA and the criminal justice processing of CSA cases in such a way that would not further harm the children involved. Since that time, the number of CACs has increased dramatically to over 400 existing centers and over 200 additional centers in various stages of development (B. Murray, Personal Communication, April 11, 2002; Murphy Healy, 1997). In addition to individual centers, there are four regional centers and a parent organization called the National Children's Alliance (NCA). In 1990, a federal law (P.L.101-647) ensured that the NCA would receive some federal funds to provide support, resources, and training and technical assistance to centers.

The CAC concept has evolved from a fledgling idea into a model with nine core components and standards for membership in the NCA (adopted in 2000). The nine core components include: a child-friendly facility, a multidisciplinary team, an investigative child interview, a medical examination of the child, provision of mental health services, victim advocacy, case review, case tracking, and organizational structure (Wolf, 2000). This paper focuses on the first eight components that directly impact the child (see Cain & Duhon, n.d., for a discussion of organizational development). It is noteworthy that since these data were collected, the NCA has included cultural competency and diversity as a standard.

A best practices guidebook for the development of a CAC is available through the NCA (Chandler, 2000). Variations in implementation are expected as each center responds to the unique needs of the community in which it is developed. However, the extent of the variation is unknown. This paper will provide results of a survey assessing variations in eight of the nine core components as they exist in the field.

Method

Participants

Participants were 117 (71 members and 46 nonmembers) CAC directors. A list complied by the NCA of member ($N = 283$) and nonmember ($N = 224$) center directors comprised the pool of potential

participants. Member centers consist of full and associate members who have complied with some or all the NCA's standards for membership. Nonmember CACs self-identify as a CAC, but have not had to comply with NCA standards. Nonmembers are important, prominent and functioning entities, many of which do become members.

Participant selection was determined using a stratified random sampling design, stratified by state, member/nonmember status, number of children served (as an indicator of size of the center), and ethnicity of children served (to capture CAC practices that might differ among ethnic groups). Ultimately, contact was made with both a member and nonmember center director in each state (where that was possible) with the exception of a member center in Montana and a nonmember center in Indiana, South Carolina, Utah, Colorado, and Vermont. Where more than one option was available within a state, random selection was used.

Participants had been the director of a CAC for an average of 4.36 years (range from less than 1 year to 14 years) for member directors and 4.10 years (range from less than 1 year to 12 years) for nonmember directors. The majority of directors were female (90% for member and 87% for nonmember centers) with a social work or social work and business background (56% for member and 59% for nonmember centers). Director's education varied tremendously, although the most common degree was a Master of Arts or Science in Social Work (22% for both member and nonmember centers).

Semi-structured interview

The investigator developed a semi-structured telephone interview for use in this study. The interview, based on the NCA's standards for membership (Wolf, 2000) was developed to examine the variability within eight of the nine core components of the CAC model. The interview consisted of the investigator asking a question, writing down the response, and then either discussing the issue more fully (including probing for more information) or moving on to the next question. The semi-structured interview consisted of two parts: services provided and experiences with CAC program evaluation. Results of the first part of the interview are reported in this paper and results from the second part are reported elsewhere (Jackson, n.d.).

Procedure

Letters of invitation were sent to 142 directors. Follow-up telephone calls were then made to directors to schedule telephone interviews. There was an 82% response rate (25 directors, 9 member and 16 nonmember centers, were not included in the study for a variety of reasons such as unable to contact, the program is not really a CAC). Interviews lasted between 30 and 120 minutes, with an average of 64 minutes for member and 49 minutes for nonmember directors. The research design was reviewed and approved by the University of Nebraska-Lincoln's institutional review board.

Results

The results of the semi-structured interview, presented by member and nonmember status, are discussed in the following order: child-friendly facility, multidisciplinary team, child investigative interview, medical examination, mental health services, victim advocacy, case review, and case tracking.

Child-friendly facility

A child-friendly facility is intended to provide children and families with a safe, comfortable and neutral environment for conducting child interviews, as well as providing other important services (Wolf, 2000). This comfortable environment is believed to contribute to children's accurate reports of an event (Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991). Based on the perceptions of the CAC administrators, all member and 89% of nonmember centers have a child-friendly facility.

Developmental appropriateness. Ideally, the play area should be developmentally appropriate, with different furnishings, accommodations for children with special needs, decor that recognizes diverse cultures, and activities for children of all ages and adolescents. However, over half (52%) of both member and nonmember centers have waiting rooms and/or play areas that are geared towards younger children, with the remaining centers having waiting rooms and/or play areas that have activities available for all ages of children and adolescents.

The multidisciplinary team

A multidisciplinary team (MDT) is a group of professionals who represent various disciplines and work collaboratively to promote a thorough understanding of case issues and assure the most effective system response possible (Wolf, 2000). All member and 98% of nonmember centers have a MDT.

MDT representatives. At a minimum the MDT should include representatives from law enforcement, CPS, prosecution, mental health, medical, victim advocacy, and the CAC (Wolf, 2000). The results of this study found that MDTs have representatives from the disciplines listed in Table 1. The average number of standing MDT members at a member center is 6.75 (range from 4 to 13) and 6.67 (range from 4 to 12) at nonmember centers.

Table 1
The profession of representatives on the multidisciplinary team

Profession of representative	Member (%)	Nonmember (%)
Law enforcement	100	98
CPS	100	96
Prosecution	100	93
Medical	86	77
Mental health	87	80
Victim advocate	80	80
Other representatives		
Schools	21	23
Juvenile courts	17	7
Assistant Attorney General	17	0
Probation and parole	10	18
Domestic violence providers	6	18
Court-appointed special advocates	9	11

MDT functioning. According to the perceptions of the CAC administrators, the majority of MDTs are functioning very well (54% of member and 61% of nonmember centers), although a large minority of directors believe the MDT needs improvement (41% of member and 29% of nonmember centers), and a few directors believe the MDT is doing poorly (5% of member and 10% of nonmember centers).

Interagency agreements. An interagency agreement is a formal agreement between the CAC and a variety of government agencies and community organizations that will be involved with the CAC in investigating and prosecuting CSA cases. The interagency agreement delineates which types of cases will be referred to the CAC. The categories include referrals for: CSA cases exclusively (18% of member and 38% of nonmember centers), both CSA and severe physical abuse cases (24% of member and 38% of nonmember centers), and almost any type of case (e.g., witnessing violence, child homicide, family violence, child neglect) (48% of member and 24% of nonmember centers). However, even with an existing interagency agreement, 74% of member and 82% of nonmember directors reported that agencies and organizations determine on a case-by-base basis which cases to refer to the CAC.

The interagency agreement also often specifies from whom a referral can originate. Centers receive referrals from: law enforcement (96% of member and 88% of nonmember centers), CPS (96% of member and 83% of nonmember centers), medical profession (21% of member and 25% of nonmember centers), prosecutor's offices (20% of member and 40% of nonmember centers), families or the community (18% of member and 18% of nonmember centers), mental health professionals (10% of member and 10% of nonmember centers), and schools (9% of member and 20% of nonmember centers).

Child investigative interview

The purpose of a child investigative interview is to assess the child's safety and attempt to determine whether a crime has been committed. This component places much emphasis on having specially trained child interviewers conduct legally defensible interviews with these children. All member and 91% of nonmember centers have a child investigative interview component.

The interviewer. Ideally, all CACs have on staff a specially trained child interviewer; however, this is not feasible for all centers. Indeed, only 68% of member and 41% of nonmember centers have a specially trained interviewer on site. Of those centers with on-site interviewers, the number of interviewers employed by member centers averages 2.73 (range from 1 to 13, Mode = 1, Median = 2) and 2.23 (range from 1 to 6, Mode = 1, Median = 2) for nonmember centers.

Law enforcement and CPS conduct some interviews at the majority of centers (86% of member and 83% of nonmember centers). There are some centers in which child interviews are conducted exclusively by law enforcement and/or CPS (29% of member and 55% of nonmember centers). However, many centers determine on a case-by-case basis the most appropriate interviewer (54% of member and 31% of nonmember centers).

Interviewer training. Interviewer training is considered critical to obtaining accurate information from children. Interviewing techniques should be empirically derived and developmentally appropriate (see, e.g., Poole & Lamb, 1998). All member and 91% of nonmember centers provide periodic and ongoing training for their child interviewers.

Observing the child interview. Ideally, one interviewer interviews the child at the CAC while some members of the MDT actively observe the interview. At some point during the interview, the observers have an opportunity to communicate with the interviewer. This approach enables children to tell their story only one time to one person, thereby increasing their credibility, and ensures that the appropriate team members obtain the information they need without repeatedly interviewing the child. The majority of centers (83% of member and 87% of nonmember centers) have adopted this method.

Official interview record. CACs use different methods of recording the interview that ultimately becomes the official record of the interview. Official records may take the form of written reports (28% of member and 31% of nonmember centers), videotaped interviews (30% of member and 28% of nonmember centers), audiotaped interviews (6% of member and 3% of nonmember centers), a combination of videotape and audiotape (14% of member and 21% of nonmember centers), with the remaining centers using some combination of these methods. The official records of interviews may be considered evidence, which means the records may be discoverable if retained by the center. Regardless, a large number of centers do retain official records at the CAC (57% of member and 36% of nonmember centers). Of centers that do keep official records, at least 5% of member and 20% of nonmember centers have a mechanism in place to ensure that the documents are the legal property of an agency (e.g., such as law enforcement, CPS, or the district attorney), rather than the property of the CAC to preclude their discoverability.

Medical examination

The purpose of a medical examination is to obtain medical evidence to assess and treat the child and to facilitate prosecution of CSA cases (De Jong, 1998; Finkel, 1998). Ninety-nine percent of member and 100% of nonmember centers have a medical examination component, albeit not necessarily on-site at the CAC.

Location of medical examination. Centers may provide medical services on-site (53% of member and 29% of nonmember centers), refer families to hospitals (34% of member and 26% of nonmember centers), to clinics (12% of member and 36% of nonmember centers), or to both hospitals and clinics (1% of member and 9% of nonmember centers).

Colposcope. A colposcope is a technical device used to illuminate and magnify the child's genitals that are being inspected by a health care professional. The colposcope enables the examiner to detect microscopic injury, and it reduces the need for repeated examinations. It has the added benefit of attaching to a 35 mm or video camera for documentation of the injury when evaluation by other medical experts is needed, or as evidence for prosecuting cases (Finkel, 1998). The vast majority of centers (90% of member and 79% of nonmember centers) have a colposcope available either on-site (44% of member and 32% of nonmember centers), at referral sites (40% of member and 47% of nonmember centers), or both on-site and at referral sites (6% of member and 0% of nonmember centers).

Number and profession of health care providers. The number of medical personnel available to conduct medical examinations either on-site or off-site averages 2.33 (range from 1 to 14) for member centers and 1.77 (range from 1 to 5) for nonmember centers. The majority of health care providers conducting medical examinations for centers are physicians (e.g., pediatricians and general practitioners) (90% of

member and 72% of nonmember centers). However, other centers employ nurse practitioners and SANE nurses (10% of member and 7% of nonmember centers), or a combination of both nurses and physicians (0% of member and 21% of nonmember centers).

Mental health services

Mental health services are believed to reduce the emotional impact of disclosure, to mediate the long-term effects of abuse and disclosure, and to reduce or eliminate the risk of future victimization. All member and nonmember centers provide mental health services for children. As children's recovery may be dependent to some extent on their parent's mental health, the vast majority of centers (93% of member and 92% of nonmember centers) also provide services (either on-site or referrals) for nonoffending parents.

Location of mental health services. Centers may provide mental health services either on-site (51% of member and 27% of nonmember centers) or through referrals to the community (49% of member and 73% of nonmember centers). Of centers that provide on-site therapy, many also make referrals for community mental health services (31% of 51% member and 15% of 27% nonmember centers).

Number and education of on-site therapists. The number of therapists located on-site at member centers averages 2.87 (range from 1 to 8, Mode = 2) and 1.42 (range from 1 to 4, Mode = 1) for nonmember centers. The most common degrees among on-site therapists are Master of Arts or Science only (67% of member and 33% of nonmember centers) or a combination of Master or Bachelor of Arts or Science (25% of member and 50% of nonmember centers).

Victim advocates

Child advocacy typically means having the ability to refer families for a range of services. Ninety-four percent of member and 95% of nonmember centers have someone to assist families with referral services, often referred to as a victim advocate.

Victim advocate's affiliation. Only 48% of member and 38% of nonmember centers have a victim advocate located at the CAC, with some of these individuals doubling in some other capacity at the CAC (9% of member and 5% of nonmember centers) such as a case manager or a child interviewer. Often, victim advocates are affiliated with other agencies such as the prosecutor's office (51% of member and 45% of nonmember centers) or law enforcement (1% of member and 17% of nonmember centers).

Case review

Case review is a process by which the MDT regularly convene to discuss the family's well-being, to share information efficiently, to determine what additional information is needed, and to assign specific tasks to the appropriate individuals. These procedures allow team members to draw on the knowledge and experience of the other disciplines attending the case review meeting. A large majority of centers (92% of member and 84% of nonmember centers) have case review procedures.

Case review participants. Typically, line employees attend case review because they are most familiar with the case (56% of member and 74% of nonmember centers), although at some centers both line employees and supervisors attend (33% of member and 21% of nonmember centers), and at some centers only supervisors attend (12% of member and 5% of nonmember centers).

Timing and purpose of case review. The vast majority of centers (90% of member and 97% of nonmember centers) review cases during the investigation to expedite the investigation and to ensure that families are being referred for the appropriate services. However, a few centers (5% of member and 3% of nonmember centers) review cases only after the investigation has been completed in an effort to enhance future investigations. The remaining centers review cases both during and after the investigation (5% of member and 0% of nonmember centers).

Frequency of case review meetings. Case review meetings occur: twice a week (2% of member and 0% of nonmember centers), once a week (36% of member and 24% of nonmember centers), every other week (28% of member and 18% of nonmember centers), once a month (23% of member and 53% of nonmember centers), every other month (3% of member and 0% of nonmember centers), or on an as-needed basis (7% of member and 5% of nonmember centers).

Case tracking

The NCA requires that member centers develop a case tracking system useful for both management decisions and some type of evaluation. The majority of member (92%) and nonmember (84%) centers have some type of case tracking system.

Computer versus manual case tracking system. The majority of centers use a computerized case tracking system (67% of member and 62% of nonmember centers), although a large minority use manual methods of case tracking (22% of member and 35% of nonmember centers), and a few centers use both (11% of member and 3% of nonmember centers).

Length of case tracking. Centers track cases: (1) through initial intake at the CAC (10% of member and 19% of nonmember centers), (2) until the case is closed (78% of member and 67% of nonmember centers), or (3) for some period of time after the close of the case (e.g., to the end of counseling) (4% of member and 0% of nonmember centers).

Collecting case tracking data. Strategies for obtaining case tracking data include: collecting information at case review (29% of member and 31% of nonmember centers), agency-completed forms that are returned to the center (18% of member and 23% of nonmember centers), telephoning the agency directly (11% of member and 0% of nonmember centers), appointing a staff member (e.g., the victim advocate) to collect the information (10% of member and 15% of nonmember centers), use of a combination of methods (32% of member and 31% of nonmember centers).

Summary. In sum, as can be seen in Table 2, the majority of both member and nonmember centers have adopted the CAC's standards for membership. However, results confirmed that variations within these components do exist.

Table 2
Eight components of the CAC model

Component	Member (%)	Nonmember (%)
Child-friendly facility	100	89
Multidisciplinary team	100	98
Child investigative interview	100	91
Medical examination	99	100
Mental health services	100	100
Victim advocacy	94	95
Case review	92	84
Case tracking	92	84

Discussion

The results of this survey confirm that the vast majority of both member and nonmember centers have adopted the NCA's standards for membership, even if adherence is not a requirement. In addition, this research documents the variations in ways CACs respond to victims of CSA. This variation likely reflects the unique nature of the community in which the CAC is developed.

The similarities between member and nonmember centers are likely due to the fact that participants were all somehow affiliated with the NCA. However, it is important to note that any community interested in establishing a CAC would most likely contact the NCA for program development guides, and, therefore it can be inferred that this sample is representative of all CACs. Differences that do exist (e.g., more law enforcement and CPS conduct child interviews at nonmember centers; more nonmember centers refer children for medical examinations; nonmembers convene case review meetings less frequently) may be due to the fact that proportionally more nonmember CACs are government-affiliated rather than private (9% of member and 36% of nonmember centers).

The results confirm marked variability in the implementation of these core components in the field, which is consistent with the philosophy of the model that all centers are designed to meet the unique needs of the community and investigative entities. Variability is a major strength of the model in that it allows centers to be responsive to the needs of the communities in which they are located. For example, the composition of the MDT may depend on which disciplines are located in the community; the frequency of case review meetings may depend on the availability of the MDT members.

Little systematic research has been done on many of the components of the CAC model. However, MDTs in general (i.e., not necessarily affiliated with a CAC) have received some attention and results are remarkably similar to the current findings. For example, Kolbo and Strong (1997) found that the most commonly represented professions on MDTs from all 50 states included: CPS, law enforcement, medicine, education, mental health, public health, and juvenile corrections. An older national survey also found that MDT representatives consisted of: social worker, psychologist, nurse, physician, lawyer, educator, public health representative, law enforcement representative, judicial representative, psychiatrist, lay representative, developmental specialist, day care worker, homemaker, minority representative, politician, and other (Kaminer, Crowe, & Budde-Giltner, 1988). Thus, the CAC MDTs are quite similar in composition to MDTs in general.

There are two important limitations to note. First, the interviewer did not use specific criteria for assessing, for example, whether a center was actually child-friendly. Rather, a determination of child-friendliness was based on the perceptions of the CAC director, which is the second limitation. That is, the results are based on director's perceptions and have not been independently validated through site visits or interviews with other relevant individuals.

In sum, the CAC concept has become a highly developed model for processing CSA cases, due in part to the service provider's experiences in the field. The next generation of developments in the CAC model, however, should include extensive evaluation. Until now, the model has never been empirically compared to other forms of case processing, including traditional methods of case processing through police departments. In addition, no evaluation has examined the various components of the CAC model to determine which components are absolutely necessary for reducing child stress and facilitating prosecution. Finally, although this study confirmed the existence of variations in implementation of the various components, this study did not determine which variations work best under which circumstances. Indeed, there remain ongoing controversies associated with these variations that are often played out at the local level. For example, there has been a long-standing controversy over whether there should be a designated child interviewer or whether CPS and/or law enforcement are acceptable child interviewers. Also controversial is whether prosecutors should be involved in the multidisciplinary process that has a largely therapeutic mission. In addition, significant controversy surrounds how to respect the privacy of the child while sharing information among the MDT. These and other issues deserve considerable empirical attention. Currently, there is a four-site evaluation underway conducted by David Finkelhor at the University of New Hampshire's Crimes against Children Research Center (CCRC) that should be an important step toward answering some of these questions.

Acknowledgments

The author thanks the Child Advocacy Center directors for their time and attention without which this research could not have been accomplished.

References

Cain, T., & Duhon, L. (n.d.). *Organizational development for children's advocacy centers*. Washington, DC: National Children's Alliance.

Chandler, N. (2000). *Best practices for establishing a children's advocacy center program*. Washington, DC: National Children's Alliance.

De Jong, A. R. (1998). Impact of child sexual abuse medical examinations on the dependency and criminal systems. *Child Abuse & Neglect*, *22*(6), 645–652.

Finkel, M. A. (1998). Technical conduct of the child sexual abuse medical examination. *Child Abuse & Neglect*, *22*(6), 555–566.

Goodman, G. S., Bottoms, B. L., Schwartz-Kenney, B., & Rudy, L. (1991). Children's memory for a stressful event: Improving children's reports. *Journal of Narrative and Life History*, *1*, 69–99.

Jackson, S. (n.d.). *A resource for evaluating child advocacy centers*. Manuscript prepared for publication.

Kaminer, B. B., Crowe, A. H., & Budde-Giltner, L. (1988). The prevalence and characteristics of multidisciplinary teams for child abuse and neglect: A national survey. In D. C. Bross, R. D. Krugman, M. R. Lenherr, D. A. Rosenberg, & B. D. Schmitt (Eds.), *The new child protection team handbook* (pp. 548–567). New York: Garland Publishing.

Kolbo, J. R., & Strong, E. (1997). Multidisciplinary team approaches to the investigation and resolution of child abuse and neglect: A national survey. *Child Maltreatment*, *2*(1), 61–72.

Murphy Healy, K. (1997, October). *Policies, practices and statutes relating to child abuse and neglect*. Paper presented at the National Institute of Justice Child Abuse Intervention Strategic Planning Meeting. Washington, DC: Abt Associates Inc.
Poole, D. A., & Lamb, M. E. (1998). *Investigative interviews of children*. Washington, DC: American Psychological Association.
Wolf, M. (2000). *Putting standards into practice: A guide to implementing NCA standards for children's advocacy centers*. Washington, DC: National Children's Alliance.
Yeaman, J. M. (1986). Facilitating prevention and prosecution of child sexual abuse through the multi-disciplinary assessment team. *Current Municipal Problems*, *13*(2), 228–233.

Résumé/Resumen

French and Spanish language abstracts not available at time of publication.