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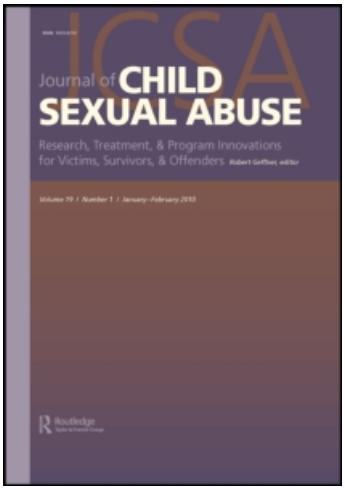

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Exploring Nonoffending Caregiver Satisfaction with a Children's Advocacy Center

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CHILD ADVOCACY CENTERS AND CREDENTIALING: ISSUES FOR PRACTITIONERS

Exploring Nonoffending Caregiver Satisfaction with a Children's Advocacy Center

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This study is a case evaluation research report on one Children's Advocacy Center that provides a coordinated response to allegations of child maltreatment, particularly sexual abuse. The data come from a mailed survey of nonoffending caregivers measuring their satisfaction with services provided through the Children's Advocacy Center. The results indicate overall satisfaction with the Children's Advocacy Center; however, they also suggest that the forensic interview may be perceived or experienced as distinct from the ongoing investigative and legal processes. Recommendations are made to better assess nonoffending caregiver satisfaction with Children's Advocacy Center services and to encourage consumer driven service improvement.

KEYWORDS child sexual abuse, children's advocacy centers, forensic interviews, consumer satisfaction, nonoffending caregiver, multidisciplinary team, program evaluation

INTRODUCTION

Children's Advocacy Centers (CACs) were first developed during the 1980s in response to a need for improvement in interagency coordination among

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responding child protective service agencies when allegations of abuse were made (Smith, Witte, & Fricker-Elhai, 2006). In the past, child victims of alleged abuse were questioned by professionals in several different agencies (police, social workers, doctors, and attorneys) and were thus asked to retell their stories over and over (Fontana, 1984; Pence & Wilson, 1992; Whitcomb, 1992, as cited in Cross et al., 2008), reliving the traumatic experience each time (Carnes, 2002). The CAC model was developed to create a more coordinated response and, consequently, a less stressful experience for children and families (Cross et al., 2008) through the use of trained forensic interviewers and multidisciplinary teams (MDTs), including staff from a CAC, child welfare, the district attorney's office, mental and medical health, law enforcement and, in some cases, victim advocacy (Newman, Dannenfelser, & Pendleton, 2005). The MDT approach presumes that professional collaboration improves the protection, treatment, and legal services received by children who are victims of abuse and their families. Past procedures for investigating allegations of abuse, characterized and criticized by medical professionals as furthering children's trauma, included multiple interviews and medical evaluations, removal of children from their homes, and extended criminal court proceedings (Jenson, Jacobson, Robinson, & Unrau, 1996). Furthermore, because the sexual abuse of one's child is a highly stressful experience, it is not surprising that many parents experience significant distress following the disclosure of the abuse, including disbelief and/or denial (Elliot & Carnes, 2001). Evidence from two decades of studies suggests that greater parental support is correlated with better adjustment in child victims (e.g., Cross et al., 2008; Elliott & Carnes, 2001; Jones, Cross, Walsh, & Simone, 2007; Jones et al., 2010). CACs are intended to improve community response to allegations of abuse and alleviate some of the distress experienced by children and their families by providing supportive services.

In comparison with past practices, CACs have greatly improved the satisfaction of nonoffending caregivers (Cross et al., 2008; Jenson et al., 1996; Jones et al., 2007; Snell, 2003). A Reason Foundation children's advocacy center executive director survey found that "more than 85% of centers reported measuring client and family satisfaction and using the results to help offer better services to children and families" (Snell, 2003, p. 11). One multisite study found that 84% of nonoffending caregivers were satisfied with the services received from CACs (Jones, Cross, Walsh, & Simone, 2007). It is less clear, however, how nonoffending caregivers perceive the parts of the investigative and prosecutorial processes and the performance of the various entities in the MDT delivering services, and scholars only recently have begun to study these issues (Jones et al., 2010).

A main goal of the CAC is to provide a comfortable environment to families and children, to provide a comprehensive and collaborative response to allegations of child abuse (Cross et al., 2008), and to serve as a "one-stop" center for abused children and their families (Snell, 2003). The forensic

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interview is carried out in a child-friendly setting, typically with the use of a one-way mirror, and sometimes video equipment is used to record the forensic interview. This arrangement allows members of the MDT involved in the investigative process to observe the interview from behind the mirror or through closed-circuit television. Evidence suggests that this approach to interviews is less frightening to children (Jones et al., 2007).

Ideally, the CAC model should work smoothly and improve outcomes when all involved agencies cooperate with the common mission of the CAC and have sufficient staffing to provide the necessary communication and services. Research indicates that CACs are more effective than communities without a CAC program in promoting interagency cooperation, in getting child victims removed from unsafe home situations and getting them medical and mental health care, and in increasing caregiver satisfaction with response to allegations of abuse (Cross et al., 2008). However, even under the best of circumstances, there is room for improvement in performance and assessment. Recent research indicates that although CACs have improved in areas that were problematic to nonoffending caregivers in the past, such as a lack of coordinated services and how long investigations lasted, some problems remain in regard to communication about the investigation and prosecution of abuse charges (Jones et al., 2010). Furthermore, qualitative comments by nonoffending caregivers reflect that their experiences varied with different parts of the investigation and with the different entities involved (Jones et al., 2010).

In the current study, we surveyed nonoffending caregivers about their satisfaction with specific entities within the MDT serving them as well as about their overall experience with the CAC. This allows us to extend current understanding of nonoffending caregiver satisfaction by examining how the performances of the different MDT agencies vary in the eyes of consumers and how they may relate to one another in shaping the consumer experience. Pinpointing ways that services through a CAC may be improved may allow CACs to address issues that might otherwise go unnoticed by MDT professionals and further refine service delivery. Maintaining and improving quality in CAC services is especially important in light of community perceptions of CACs as experts and leaders in the field of child sexual abuse (Jones, 2006).

PURPOSE OF STUDY

This study examines nonoffending caregiver perceptions of whether CAC and collaborating entities in the MDT accomplish their functions satisfactorily and how these perceptions relate to overall satisfaction with the CAC experience among nonoffending caregivers. CAC functions include providing adequate information pre- and postinterview to the nonoffending caregiver, conducting the forensic interview (see Haney, Vieth, & Campos,

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this issue, for a discussion of credentialing of forensic interviewers), assuring the comfort of the child and of the nonoffending caregiver, and offering a convenient time for the interview. All CAC and MDT members have a goal of performing their functions with courteousness, helpfulness, timeliness. The CAC that participated in this study is an accredited member of the National Children's Alliance and uses an MDT approach. The MDT in this case example includes members from mental and medical health, victim advocacy, law enforcement, the local district attorney's office, child welfare services, and the CAC staff. The results of this case study suggest potential improvements for future CAC MDT evaluations and, as we report, contributed to changes made by the CAC under study. These insights may be useful to other CAC and related agencies in efforts to better serve children and families in their communities.

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METHODS

The data for this case study come from the population served by a two-year-old CAC program in a rural community in the eastern region of the United States. Approximately 120 children had been seen at the CAC within the 24 months from the center's opening to the time of data collection. The CAC staff, MDT, and advisory panel sought an evaluation of the new program and asked the lead investigator of this study, who served on the advisory panel, to conduct a study of how satisfactorily the program was serving the families whose cases came through the CAC. The cases were in various stages, but all cases already had passed through the CAC forensic interview and the investigative process. To reduce possible bias and encourage responses, the survey was designed (collaboratively with the CAC) to be anonymous, and the distribution and collection of questionnaires was carefully devised to ensure respondent anonymity. The participating CAC's executive director set up a deidentified database such that each caregiver/case was identified only by a random number and only basic case information was included. The deidentified database was provided to the investigators who did not have access to the key that would identify individual caregivers/cases. The CAC mailed the survey questionnaires to the nonoffending caregivers since only the CAC had access to contact information. The researchers were not known to the respondents and had no involvement in their cases, and the investigators did not have access to identifying information about the families who were surveyed. The questionnaires were returned to the investigators rather than the CAC so that the CAC did not have access to any individual responses or raw data. Each questionnaire was labeled with the corresponding random case number assigned by the CAC so that the investigators could match responses with the basic case information in the deidentified database provided by the CAC. To further ensure respondent anonymity, once data

collection was completed, the investigators assigned a new, random case number to each case so that there was no way individual respondents could be identified, either by investigators or by the CAC. Because the survey was anonymous, no incentives for participation were offered, although this might have enhanced the response rate. The aggregated results of the survey were shared with the CAC and other members of the MDT in a presentation after the analyses were complete. The researchers' university institutional review board (IRB) approved the protocol for obtaining informed consent and protecting the participants prior to initiating the study.

Sample

A mailed survey questionnaire asking about satisfaction with the CAC and MDT services, along with a return postage-paid envelope, was sent to 108 nonoffending caregivers who had accompanied their child(ren) ($N = 120$) to the CAC for a forensic interview and other services. When more than one child from a family had been interviewed at the CAC, the nonoffending caregiver was surveyed only once. Cases in which child welfare served as the guardian of the child were not included in the study because child welfare personnel likely would have a different perspective on satisfaction with services than a family caregiver.

Procedure

To assess nonoffending caregivers' levels of satisfaction with CAC and MDT services, we conducted a mail survey. Although the widely used Tailored Design Method (Dillman, 2007) of conducting mail surveys includes multiple requests for participation and follow-up reminders to potential respondents as means of bolstering response rates, the sensitive nature of the respondents' connection with the CAC called for a more minimal procedure. First, we recognized that each contact from the CAC might serve as a reminder to nonoffending caregivers of a painful and traumatic event for their children and themselves. Second, we were aware that, in some cases, alleged offenders might still be present in the homes to which survey materials would be sent, and the receipt of the survey could be a potential source of conflict and confrontation in the household. We thus determined that fewer, rather than more, contacts might be in the best interests of the children and the nonoffending caregivers served by the CAC.

We began the data collection process by sending nonoffending caregivers a letter informing them that we would, within the following two weeks, send them a pencil and paper survey concerning their satisfaction with the CAC and the MDT process. This was followed up with an initial mailing of the survey questionnaire and cover letter. This first mailing yielded 21 completed questionnaires from those sent to the 108 responding

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nonoffending caregivers (reflecting a response rate of 19.4%). A second mailing yielded 5 more completed surveys. No further requests for participation were made. The final sample of 26 nonoffending caregivers represents 24.1% of the sample population of 108 nonoffending caregivers who voluntarily brought the child victim(s) to the CAC for allegations of sexual abuse. Although the sample is small, it is comprised of a substantial proportion of the entire sample population (rather than a fraction of a sample selected from a population). Nonetheless, respondents were compared with nonrespondents on key characteristics using the deidentified data provided by the CAC to identify potential differences between the two groups that might contribute to bias in the results.

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Variables and Measures

The survey questionnaire development process was informed by three strategies. First, we engaged in extensive consultation with the executive director and program coordinator of the CAC on program goals, objectives, and desired outcomes. Second, we adapted and sought to build on existing survey measures used by other CACs (Champaign County, IL) and resources in the field (Jackson, 2004). Third, we developed aspects of the survey based on reviewing the evaluation literature on CACs (Cross et al., 2008; Snell, 2003) with the goal of extending our understanding of nonoffending caregiver satisfaction to perceptions about the performance of particular collaborating MDT entities and how they may be related to overall satisfaction with services received through the CAC. Specifying ways to improve CAC programs and MDT performance is important since consumer satisfaction may play a role in generating referrals to CACs by clients and agencies in the community, the reputation of CAC programs among various constituent groups, and cultivating donors and organizational resources, more generally.

Dependent Variable

Overall satisfaction with CAC experience

The extent to which nonoffending caregivers are satisfied overall with the services they and their children received through the CAC MDT program was measured by a Likert-type item that asked, "Overall, how satisfied are you with the services you received through the children's advocacy center?" Participants chose from four response categories, ranging from *very satisfied* (4) to *very dissatisfied* (1). The item appears at the end of the survey questionnaire as the last quantitative item, after respondents have addressed items pertaining to individual aspects of the process and each of the MDT entities that collaborate in providing services through the CAC.

Independent Variables

A set of items asked respondents their level of agreement with statements regarding their experiences with the CAC, collaborating entities, and the processes involved with the cases related to their child(ren). These items were grouped as they related to each collaborating entity: the CAC, child welfare, law enforcement, the district attorney's office, medical services, and victim advocacy. The emphasis, however, was on services received at or coordinated through the CAC since the focus of the study was to examine client satisfaction with the CAC and the MDT approach coordinated through it.

Satisfaction with the CAC

Items related to the CAC were factor analyzed and factored into three dimensions. The first aggregate measure, CAC Information and Logistical Coordination, is comprised of the following four items (Chronbach's alpha = .83): "I was given enough information to know what to expect at the interview at the children's advocacy center," "I was given enough information about what would happen after the initial interview at the children's advocacy center," "My child was questioned by too many professionals" (reverse coded), and "The scheduling of the forensic interview was able to fit my schedule." Participants chose from five responses ranging from *strongly agree* (4) to *strongly disagree* (1), with *not applicable* coded as 0. Responses to the items were averaged and the mean response was 3.21 ($SD = .57$). The second aggregate measure, CAC Responsiveness and Providing for Clients' Comfort, is comprised of the following three items (Chronbach's alpha = .85): "CAC agency personnel acted in a timely manner," "My child(ren) was made to feel comfortable," and "I was made to feel comfortable." Again, responses to these items were averaged, with a mean score of 3.38 ($SD = .64$). The last measure pertaining to the CAC, CAC Staff Courteousness and Helpfulness, is the average of the following two items ($r = .85$, $p < .001$, Chronbach's alpha = .87): "CAC agency personnel were courteous" and "CAC agency personnel were helpful." The mean of this measure was 3.32 ($SD = .87$).

Satisfaction with collaborating multidisciplinary team entities

For child welfare and police/law enforcement, respondents were asked their level of agreement with the following three items: "Agency personnel were courteous," "Agency personnel were helpful," and "Agency personnel acted in a timely manner." The aggregated measures were factored unidimensionally for each agency and had an acceptable reliability coefficient (Chronbach's alpha) of .91 for child welfare and .89 for police/law

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enforcement. For the victim advocacy entity and the district attorney, two items were presented: "Agency personnel were courteous" and "Agency personnel were helpful." Because these entities provided follow-up services and the alleged cases of abuse were in various stages of the post-forensic-interview process, the item about acting in a timely manner was omitted for these entities since they may not yet have completed their work with the clients. The reliability coefficients (Chronbach's alpha) were .93 for the victim advocacy agency measure ($r = .94$, $p < .001$) and .92 for the district attorney measure ($r = .87$, $p < .001$). Participants were asked to indicate their the level of agreement with one statement about medical services: "If the child(ren) were referred to a physician for medical evaluation, the physician was helpful" ($M = 2.63$, $SD = 1.06$).

If respondents' favorably assess CAC-delivered services and the services provided by the other collaborating MDT members, those measures should be correlated with the respondent's overall satisfaction with the CAC MDT experience. However, from the consumer's point of view, some services may more closely relate to others, and some services may be more important than others in predicting overall satisfaction. The analyses of the quantitative data examine these issues. In addition to the quantitative items, as a final item the survey questionnaire an open-ended question asked respondents if there was anything else they would like to share about their experience with the CAC. Qualitative responses to this item were solicited to shed further light on the clients' experiences and potential areas for improvement for the CAC.

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RESULTS

The initial analyses involved examining the distribution of sociodemographic and case characteristics of the sample population, the sample of respondents, and comparing those with nonrespondents in sample population (see Table 1). The mean age of child victims in the sample population was 9 years of age versus 10.9 years of age for the study sample. The age of the children of the responding caregivers was 2.3 years older ($p < .05$), on average, than the age of children in the nonrespondent group (M age = 8.6 years). The sample was not significantly different from nonrespondent cases in regard to the sex of the child victim or age or sex of the alleged offender. Most of the children in the sample population were female (69%), most offenders were in their early 30s, and most offenders were male.

In the types of relationships between alleged offenders and victim children, about one in five offenders was the child's father; another one in five offenders was the child's brother, uncle, grandfather, or other male relative. Approximately one in six offenders was a stepparent or parent's paramour (mostly stepfathers and mothers' boyfriends). Two in five offenders were other persons known to the child victim and parent. The only significant

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TABLE 1 Descriptive Statistics for Population (n = 120), Sample (n = 26), and Comparison of Sample with Nonresponders

	Sample population	Study sample	Nonresponders	t^a	X^2	*df*
Child's Age	9.0 (4.3)	10.9 (4.4)	8.6 (4.2)	2.40*		34.5
Child's Sex (Female)	69%	58%	72%		1.65	1
Offender's Age	32.4 (17.6)	31.2 (15.8)	32.8 (18.2)	−3.91		35.1
Offender's Sex (Male)	89%	100%	86%		3.71	1
Offender's Relationship to Child						
Father	19.8%	21.7%	19.3%		.13	1
Mother	2.7%	0.0%	3.4%		.00	1
Stepfather or mother's boyfriend	14.4%	8.7%	15.9%		.65	1
Stepmother or father's girlfriend	0.9%	0.0%	1.1%		.25	1
Brother	8.1%	13.0%	6.8%		1.08	1
Other male relative (uncle, grandfather, great-grandfather)	10.8%	8.6%	11.3%		.09	1
Other known person	42.3%	43.5%	42.0%		.08	1
Unknown person	0.9%	4.3%	0.0%		4.03*	1
Referral Source						
Child Welfare	70.0%	45.8%	76.0%		8.34***	1
Police/Law Enforcement	22.5%	37.5%	18.8%		3.87*	1
Other	7.5%	16.7%	5.2%		3.63	1
Days from Referral to Forensic Interview	8.0 (8.0)	6.9 (6.5)	8.2 (8.4)	−.82		44.6
Disclosure by Child of Abuse	55.8%	70.8%	52.1%		2.74	1
Criminal Charges Were Filed	25.0%	33.3%	23.0%		1.11	1
Length of Time in Service (days)	116 (81)	119 (77)	115 (83)	.16		19.6

[a]Equal variances not assumed. *$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

differences ($p < .05$) between respondent cases and nonrespondent cases in victim–offender relationship was that there were no unknown offenders among the nonrespondents, while one offender in the cases from the responding caregivers was an unknown offender. The only other differences between the respondent and nonrespondent cases were in referral sources: responding caregivers were significantly less likely ($p < .001$) to have been referred to the CAC by child welfare (46%) than nonresponders (76%) and significantly more likely ($p < .05$) to have been referred by law enforcement (38%) than nonresponders (20%).

There were no statistically significant differences between the sample population and nonresponders in the number of days from referral to the forensic interview ($M = 8$ days); disclosure of sexual abuse by the child victim, which occurred in 55.8% of the cases; whether or not criminal charges were filed for prosecution (25%); and total length of time in service at the time of the survey (averaging just under four months at 116 days).

Because the sample differed from nonrespondents in that the average age of the victim child was older, presence of an unknown offender, and being more likely to have been referred by law enforcement and less likely to have been referred by child welfare, in all subsequent analyses we examined whether these factors, as well as the demographic and case characteristics on which they did not differ, are related to any of the satisfaction measures.

Table 2 reports the distribution of the study variables in the sample as well as the range and reliability coefficients (Chronbach's alpha). Across the

TABLE 2 Distribution of Variables in Study Sample (n = 26)

	M	*SD*	Range	# of items	Chronbach's alpha
Satisfaction with CAC Services					
CAC Information and Logistical Coordination	3.21	.57	1–4	4	.83
CAC Responsiveness and Providing for Clients' Comfort	3.38	.64	1–4	3	.85
CAC Staff Courteousness and Helpfulness	3.32	.87	1–4	2	.87
Satisfaction with Multidisciplinary Team Collaborating Entities' Services					
Child Welfare Services	2.93	.99	1–4	3	.91
Police/Law Enforcement Services	3.13	.98	1–4	3	.89
District Attorney Services	3.18	1.03	1–4	2	.92
Medical Evaluation Services	2.63	1.06	1–4	1	n/a
Victim Advocacy Services	3.43	.97	1–4	2	.93
Overall Satisfaction with CAC Experience	3.14	.99	1–4	1	n/a

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board, the means on the satisfaction measures are fairly high, ranging on a 4-point scale from 2.63 for medical evaluation services to 3.43 for victim advocacy services. Scores on measures pertaining to satisfaction with CAC are the highest, after the mean score for victim advocacy services, at 3.21 for logistical coordination and providing information, 3.38 for responsiveness and providing for child victim and caregiver comfort, and 3.32 for staff courteousness and helpfulness. Scores for child welfare, law enforcement, and the district attorney's office averaged 3 out of 4 points.

To first examine the relationships between demographic and case characteristics and satisfaction measures, we conducted bivariate correlations. There were no significant correlations between any of the child, offender, or case characteristics (as described previously and shown in Table 1) and any of the satisfaction measures. Thus, although the study sample varied from nonrespondents in the sample population on some sociodemographic and case characteristics, these variables are unrelated to satisfaction measures. For parsimony, these nonsignificant results are not shown in Table 3, which reports the correlations between the satisfaction measures, including several significant relationships.

As reported in Table 3, caregivers' overall satisfaction with services received through the CAC is significantly and positively related to the three individual CAC satisfaction measures: CAC information and logistical coordination ($r = .45$, $p \leq .05$), CAC responsiveness and providing client comfort ($r = .54$, $p \leq .01$), and CAC staff courteousness and helpfulness

TABLE 3 Correlations among Study Variables

Satisfaction with:	Overall satisfaction with CAC experience	1	2	3	4	5	6	7
1. CAC Information and Logistical Coordination	.45*							
2. CAC Responsiveness and Providing for Client Comfort	.54**	.06						
3. CAC Staff Courteousness and Helpfulness	.85***	.11	.68***					
4. Child Welfare Services	.76***	.32	.65**	.76***				
5. Police/Law Enforcement	.82***	.41	.67***	.81***	.87***			
6. District Attorney's Office	.29	.37	.36	.03	.29	.67**		
7. Medical Evaluation Services	.08	−.29	−.12	.05	−.11	−.20	−.33	
8. Victim Advocacy Services	.75***	.17	.49*	.78***	.69***	.75***	.30	.09

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

Note: In analyses not shown, neither victim nor perpetrator sociodemographic characteristics (age, gender, relationship) nor case characteristics (referring agency, disclosures of abuse, charges filed, length of time to forensic interview) were correlated with any measures of satisfaction with services.

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($r = .85$, $p \leq .001$) as well as satisfaction with child welfare services, law enforcement, and victim advocacy. Overall satisfaction with CAC services is not related, however, with either satisfaction with the district attorney's office or with medical evaluation services.

In examining correlations between each of the three individual CAC satisfaction measures and other study variables, CAC logistical coordination and information is unrelated to other variables, except for overall satisfaction. CAC responsiveness and providing for client comfort is positively related to CAC courteousness and helpfulness ($r = .68$, $p \leq .001$) and satisfaction with child welfare ($r = .65$, $p \leq .01$), law enforcement ($r = .67$, $p \leq .001$), and victim advocacy services ($r = .49$, $p \leq .05$). Similarly, CAC courteousness and helpfulness is positively related to satisfaction with child welfare services ($r = .76$, $p \leq .001$), law enforcement ($r = .81$, $p \leq .001$), and victim advocacy services ($r = .78$, $p \leq .001$). None of the CAC measures were related to satisfaction with the district attorney's office or medical evaluation services.

In regard to measures pertaining to other entities in the MDT, satisfaction with child welfare services and law enforcement were positively related to each other ($r = .87$, $p \leq .001$) and with victim advocacy ($r = .69$ and $r = .75$, $p \leq .001$, respectively). Satisfaction with victim advocacy services is positively related to all satisfaction measures, except satisfaction with CAC information and logistical coordination, the district attorney's office, and medical evaluation services. The only significant relationship between satisfaction with the district attorney and any other study variable is a positive correlation with law enforcement ($r = .67$, $p \leq .01$). Satisfaction with medical evaluation services was unrelated to any other study variable.[1]

We next used linear regressions to further explore the relative strength of relationships between overall satisfaction with the MDT services received through the CAC. We interpret the results cautiously because the sample is small. In analyses not shown because no results were significant, we regressed overall satisfaction on demographic characteristics of victims and offenders as well as (separately) case characteristics, and there were no significant relationships in the models. These results are not surprising given the absence of bivariate relationships between demographic and case characteristics and overall satisfaction with the CAC experience. Nonetheless, we explored whether some suppressed relationships might emerge once other variables were controlled. We also analyzed demographic and case characteristics in regressions that included the satisfaction measures for the MDT collaborating entities. Again, none of the demographic or case characteristics were significant and were therefore omitted from further analyses; for parsimony, we do not report the results in a summary table. However, there were significant results when we regressed overall satisfaction on the individual measures of satisfaction with CAC performance and satisfaction with each of the MDT entities, as indicated in Table 4.

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TABLE 4 Regression of Overall Satisfaction with Services Received through the CAC on Other Indicators of Satisfaction

	Model 1			Model 2		
	b	SE *b*	*Beta*	*b*	SE *b*	*Beta*
CAC Information and Logistical Coordination	.595***	.14	.361	.703**	.20	.427
CAC Responsiveness and Providing for Client Comfort	−.089	.17	−.060	−.187	.20	−.126
CAC Staff Courteousness and Helpfulness	.931***	.13	.852	.848***	.22	.776
Child Welfare Services				.009	.16	.008
Police/Law Enforcement Services				−.152	.24	−.143
District Attorney Services				.257	.16	.210
Victim Advocacy Services				−.003	.174	−.002
Medical Evaluation Services				.475	.327	.294
Intercept	−1.56*	.61		−2.921*	1.04	
F		39.07***			14.42***	
R^2		.854			.885	

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

Note: In analyses not shown, neither victim nor perpetrator sociodemographic characteristics (age, gender, relationship) nor case characteristics (referring agency, disclosures of abuse, charges filed, length of time to forensic interview) were significant predictors of satisfaction with services.

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Table 4 reports the results of two regression models. In the first model, overall satisfaction with the CAC experience is regressed on the three individual CAC-specific satisfaction measures. As shown in Model 1, although CAC information and logistical coordination was not related to overall satisfaction in bivariate correlations, once CAC responsiveness and CAC staff courteousness and helpfulness are controlled, the CAC information and logistical coordination variable is positively related to overall satisfaction ($b = .595$, $p \leq .001$), as is CAC staff courteousness and helpfulness ($b = .931$, $p \leq .001$). This model accounts for 85.4% of the variation in overall satisfaction ($R^2 = .853$, $F = 39.07$, $p \leq .001$).

The second model shown in Table 4 adds the satisfaction measures for each of the MDT entities collaborating with the CAC. None of these variables are significant, and the same two CAC variables remain significant. To check for instability in the model due to collinearity, tolerance and variance inflation factor scores were examined, and all were within acceptable ranges. Although the amount of variance in overall satisfaction explained by the

second model increases to 88.5%, this is not a significant change ($R^2 = .885$, $F = 14.42$, $p \leq .001$).

The final item on the survey questionnaire was a qualitative question that asked respondents if they wished to "share anything else about their experience" with the CAC. The results ($n = 13$) indicated that nonoffending caregivers were generally satisfied with the CAC. Thematic patterns of positive comments included praise for the CAC, thankfulness that the CAC services were available locally, and appreciation for the services provided. However, there were thematic patterns where nonoffending caregivers ($n = 8$) indicated frustration about inadequate communication about the process *after* the forensic interview. Although generally satisfied with their experiences through the CAC, 33% of respondents ($n = 8$) expressed the need for more communication from the district attorney's office regarding the prosecutorial process following the forensic interview at the CAC. The comments expressed the need for the district attorney's office to keep the child victim's caregiver informed, to provide status updates on the case, and to return phone calls in a timely manner. Some of these nonoffending caregivers indicated that they felt like they were "left hanging," given little or no information about the case during the prosecutorial process, and were not clear as to why pleas to lesser charges were accepted to resolve the legal case rather than the case going to trial.

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DISCUSSION

An important goal of the CAC is to decrease the trauma that child victims undergo during the investigative process when there is an allegation of abuse (The National Children's Alliance, 2009) and to provide more effective, coordinated responses of the agencies involved (Cross et al., 2008). This study sought to expand CAC evaluation beyond merely counting numbers of children served and funding acquired to examining consumer satisfaction with services and the ways in which clients' overall satisfaction may relate to satisfaction with different elements of the CAC process and MDT collaborating entities and adds to a growing literature on family satisfaction with CACs (e.g., Cross et al., 2008; Jones et al., 2007, 2010; Snell, 2003). The results of this study indicate that consumers were satisfied with their experience with the CAC and rate the performance of the MDT collaborating agencies fairly highly. These findings are consistent with the current literature on satisfaction with the coordinated services provided by the CAC in which nonoffending caregivers feel supported by CAC involved entities (Cross et al., 2008; Jenson et al., 1996; Jones et al., 2010; Kolbo & Strong, 1997; Snell, 2003).

The results of this study also suggest that although satisfaction with the individual MDT entities are related, it is satisfaction with services delivered

by the CAC (information and logistical coordination, responsiveness and provision of comfort for child victims and nonoffending caregivers, and staff courteousness and helpfulness) that is especially important to overall satisfaction with the CAC MDT experience. Although previous research highlights strong caregiver satisfaction with services received through CACs (e.g., Cross et al., 2008; Jones et al., 2010), earlier studies had not parsed CAC-delivered functions from those of other MDT agencies.

Even though measures of satisfaction with MDT members other than the CAC were not significant predictors of overall satisfaction when controlling for satisfaction with aspects of the CAC's performance, we do not conclude that they are unimportant. Rather, a larger sample likely would produce more robust data for ascertaining the relative influence on overall satisfaction of each entity's performance as perceived by caregivers. Despite the shortcomings of these data, the results suggest that consumer satisfaction with the provision of information and coordination of the forensic interview as well as accomplishing these in a courteous and helpful manner are critically important to consumers' overall satisfaction with the CAC experience.

Although the respondents were satisfied overall with the CAC experience, the findings here suggest that there may be some distinction in the minds of consumers between the services provided by the district attorney's office and those of all other MDT members, as reflected in the absence of correlation between satisfaction with district attorney's office services and overall satisfaction with the CAC experience[1] and qualitative comments offered by respondents. The net feedback from clients indicates that communication of information, particularly after the forensic interview, is of considerable importance in shaping their experience with the CAC MDT. Caregivers may view the post-interview legal procedures related to the case as separate from other CAC services. The qualitative data indicate that caregivers had insufficient communication from the district attorney's office *after* the forensic interview, leaving them feeling frustrated and uninformed about the prosecution of the case. This result is consistent with recent studies of CAC outcomes that found a majority of caregivers and children indicated satisfaction with CAC services but nonoffending caregivers often expressed a desire for more frequent communication about the prosecutorial process and the status of the case after the forensic interview (Cross et al., 2008; Jones et al., 2010). Although cases can move very slowly and often there may be nothing new to report to caregivers, it seems that families would rather receive an update informing them that there has been no movement in the case than hear nothing at all. In the case studied here, the district attorney's office was unaware that caregivers were frustrated and lacked adequate staff to provide frequent communication, but it made changes to better serve families as a result of this research.

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Limitations and Directions for Future Research

Nonoffending caregiver satisfaction has not been studied extensively since CACs are a fairly recent phenomenon, although it has been examined more recently (e.g., Cross et al., 2008; Jones et al., 2010). This study is an effort to extend the available information and build on prior studies on family satisfaction with CACs to advance progress in this area. Although this was a single evaluative case study and thus is limited in its investigative scope, results indicate that responding caregivers were satisfied overall with their experience at the CAC and the coordinated services provided. This adds to the growing body of evidence that families value CAC MDT services and the coordinated response of skilled professionals delivered through them (Cross et al., 2008; Jones et al., 2007; Snell, 2003). We offer recommendations for future research and strategies for assessing CAC caregiver satisfaction, adding to those of previous scholars (e.g., Cross et al., 2008; Jackson, 2004); we also describe how the CAC MDT in the case study used the results from this evaluation to improve their services by implementing protocols that address consumer concerns.

One limitation is that the majority of the survey used simple Likert-type items that have not been tested for reliability or validity outside of this study. Still, it provided the CAC in this study with a structured questionnaire for gathering information from consumers and produced sufficient data to facilitate changes to improve services and communication to families. The items are provided in the Appendix and can be adapted to suit the needs of other CACs. With continued use, expansion, and improvement of this and other instruments (see Jackson, 2004), reliability and validity of tools for assessing desired outcomes in CAC programs can be enhanced. Based on our experience with the survey, we suggest excluding "not applicable" response categories from the Likert-type items pertaining to satisfaction with services delivered to every client (child victim and/or nonoffending caregiver). This would require respondents to express a level of agreement with each statement and likely produce more robust data. We also recommend that the survey be adapted to add more detailed, specific questions about other CAC-coordinated services, particularly timeliness and adequacy of communication from the district attorney's office (or prosecution) and experiences with medical evaluation and mental health services. This would contribute to pinpointing levels of satisfaction with follow-up services and identifying ways the CAC-MDT can improve delivery of its mission.

A second limitation of this study is that the sample size is small and specific to the sample population of one CAC in the eastern region of the United States. In addition, some characteristics of the study sample were different from those of nonrespondents in the sample population; the results thus may not be representative of the sample population. However, the variables on which the sample differed from the nonrespondents were not related to the satisfaction variables of interest in this study. Nonetheless, the

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results of this study should not be generalized but rather considered guides for further exploration, both of the importance of client satisfaction in CAC evaluation and approaches for assessing it.

Implications for Practice

Sound evaluation requires getting feedback from the individuals served by a program. In this case study, we had difficulty getting nonoffending caregivers to respond to the survey. We had to balance the number of attempts to garner nonoffending caregivers' participation in the study with sensitivity to the negative emotions or potential conflict with a resident offender that receiving the questionnaire might evoke. Neither the researchers nor the CAC received negative reactions from caregivers or reports of the survey provoking problems when received by mail, perhaps because we alerted caregivers to expect a forthcoming survey. Based on our experience, we recommend that, as part of the information routinely provided to nonoffending caregivers by CACs regarding what to expect following the forensic interview, CACs let caregivers know to expect a survey in the near future and to routinely administer such surveys. CACs could then conduct initial evaluations of consumer satisfaction soon after the forensic interview, perhaps within a week to 10 days, while the information is readily recalled.

We also recommend a second evaluation after the case has closed to capture consumer feedback on the post-forensic-interview process. It may be, for example, that nonoffending caregivers feel one level of satisfaction with the forensic interview provided through the CAC and experience different levels of satisfaction with follow-up services that occur in the months afterward. Or they may perceive the interview as one event and the prosecution of the case—and other post-interview services—as separate from the CAC-MDT process. If such perceptual distinctions exist, it is important to tease them out in the evaluative process so that remedies to any shortcomings can accurately target concerns voiced by the nonoffending caregivers and benefit the MDT's mission. This would allow for separate analyses of satisfaction with the initial CAC-MDT services, such as the referral and forensic interview and the follow-up services that are provided after the forensic interview, such as the filing of criminal charges and prosecution, victim advocacy, and mental health counseling.

The goal of assessment is to improve the MDT members' effectiveness in their common mission to assist the child victim and family. Therefore, when evaluations expose dissatisfaction with either the MDT process as a whole or with services from an entity that is part of it, a collaborative approach to problem solving may be vital to improving the CAC MDT procedures, as was the case in this study example. The MDT worked together to develop a new follow-up communication protocol, not only to keep nonoffending caregivers informed about the status of their child's case but to include them in discussions concerning and decision making about the case when

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possible. This approach may avert caregivers having doubts about the commitment of investigators and prosecutors, as Jones et al. (2010) noted can sometimes occur.

Changes to the CAC under Study

Results of the CAC program evaluation elaborated in this study were shared with the participating CAC's advisory committee and members of the MDT. They discussed the issues raised by consumers and worked together to develop a remedy to improve follow-through by the criminal justice system for the good of the team and to better serve child victims and their families. The following paragraphs detail the new victim notification/information process in the district attorney's office that was generated and implemented to improve services to nonoffending caregivers during the prosecution stage. The "study driven" changes in protocol may be of interest to other CAC-involved entities.

At the CAC in the case study, the district attorney's office is often contacted by the investigating officer prior to the filing of charges. This contact is made to determine whether a prosecution is appropriate and, if so, what charges should be filed. In addition to speaking with the arresting officer, the district attorney's office now speaks with the nonoffending caregiver to keep him or her informed of the decisions regarding charges and the basis for these decisions. Once the charges are filed and a preliminary hearing is held, the new protocol in the district attorney's office includes involving the nonoffending caregivers in the discussions held at the hearings, talking with caregivers about the preliminary hearing process, and consulting caregivers in considering possible resolutions of the case. Prior practice in the district attorney's office was to contact the family when there was movement in the prosecution of the case, but otherwise there was no specific victim/family centered protocol in place.

As part of the newly implemented protocol, at the preliminary hearing stage (when the case is first received in the district attorney's office) one of the victim advocates in the district attorney's office makes contact with the child victim's family to ensure the accuracy of mailing and phone information. At the time of the call, the advocate explains to the caregiver the status of the case and the services that will be provided by the district attorney. If the district attorney's office is unable to reach the child victim's caregiver by phone, a letter is sent requesting the family contact the district attorney's office so that they can be informed about their case.

In the postevaluation protocol, on a routine basis the victim advocates from the district attorney's office continue to update child victims' caregivers on the case as it is processed through the court system. In this case example, the victim advocates from the district attorney's office work closely with other victim advocacy liaisons from a collaborating local domestic violence shelter that is part of the MDT of the CAC. The liaisons from the domestic

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violence shelter provide victim advocacy for the child and family in preparation for court proceedings. The goal of the changed protocol in the district attorney's office in response to the results of the evaluative case study is to have the nonoffending caregivers become a part of the criminal justice process in order to actively avoid the perception that they are victims of "the system."

In follow-up interviews with representatives of the CAC-MDT in this case study, the professionals delivering services indicated that it is important to have the MDT meet monthly and have regular reports from representatives from the district attorney's office to inform team members of the status of the cases, charges filed, and outcomes of the cases in the criminal justice system as a routine part of the meeting. Limited staff availability on the part of any of the entities can create an obstacle for routine, accurate follow-up at MDT meetings. The importance to the mission of the CAC-MDT of timely information sharing was clear to the entities collaborating with the CAC-MDT in the case study, and all of them committed to having a representative attend every MDT meeting. As a result of this evaluative study, the district attorney's office in this case study provided for a victim advocate to serve as a liaison with the families served by the CAC and with the MDT to promote communication about the ongoing prosecutorial process. This helps to ensure accurate communication not only among the team members but to the child victim's family as well.

Conclusions

The CAC MDT model is designed to offer a coordinated, child-friendly service that, when the process works well, should reduce stress for the child victim and family related to the investigative process of alleged sexual and other forms of abuse. Since CACs are fairly new, nonoffending caregiver satisfaction with the CAC model is only now being systematically studied (Cross et al., 2008; Jones et al., 2010; Snell, 2003); however, the number of CACs is growing rapidly. There are over 700 CACs nationwide and more are forming every year (National Children's Alliance, 2009). The results of this study add to evidence that consumers are satisfied with the CAC experience overall, and caregivers' assessments of CAC-delivered services are important to overall satisfaction. Improvements in the delivery services that follow the forensic interview are needed, particularly in communication about the prosecutorial process. More detailed and comprehensive evaluation studies of how consumers' experiences with different entities within MDTs are interrelated and contribute to overall satisfaction will help to refine program assessment instruments and CAC MDT service delivery. This case study offers CACs and affiliated individuals/agencies with information that can assist them with planning, implementing, and evaluating nonoffending caregiver satisfaction and to encourage consumer-driven service improvements to child victims and their families.

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NOTES

1. Satisfaction with medical evaluation services also was unrelated to overall satisfaction with the CAC experience; however, this likely is due to so few cases ($n = 6$) being referred for medical evaluation.

2. In Questions 1–3 in the Appendix, Child Welfare, Police/Law Enforcement, District Attorney, and Victim Advocacy are generic labels for typical agencies participating in CAC MDTs. In the original survey the specific names of agencies were used so that they were readily identifiable to respondents.

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APPENDIX: CHILDREN'S ADVOCACY CENTER NONOFFENDING CAREGIVER SATISFACTION SURVEY

Please indicate your level of agreement with the statements below by circling your response on the following scale:

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Not Applicable (0)
	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
1. Agency personnel were courteous					
Children's Advocacy Center	4	3	2	1	0
Child Welfare[2]	4	3	2	1	0
Police/Law Enforcement	4	3	2	1	0
District Attorney	4	3	2	1	0
Victim Advocacy	4	3	2	1	0
2. Agency personnel were helpful.					
Children's Advocacy Center	4	3	2	1	0
Child Welfare[2]	4	3	2	1	0
Police/Law Enforcement	4	3	2	1	0
District Attorney	4	3	2	1	0
Victim Advocacy	4	3	2	1	0
3. Agency personnel acted in a timely manner.					
Children's Advocacy Center	4	3	2	1	0
Child Welfare	4	3	2	1	0
Police/ Law Enforcement	4	3	2	1	0

4. I was given enough information to know what to expect at the interview at the children's advocacy center.

Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
4	3	2	1	0

5. I was given enough information about what would happen *after* the initial interview at the children's advocacy center.

4	3	2	1	0

6. If the child(ren) was referred to a physician for a medical evaluation, the physician was helpful.

4	3	2	1	0

7. My child(ren) was questioned by too many different professionals. [Reverse coded, 1–4.]

4	3	2	1	0

8. My child(ren) was made to feel comfortable.

4	3	2	1	0

9. I was made to feel comfortable.

4	3	2	1	0

10. The scheduling of the forensic interview fit my schedule.

4	3	2	1	0

11. The location of the children's advocacy center was convenient.

4	3	2	1	0

12. Overall, how satisfied are you with the services you received through the children's advocacy center?

Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
4	3	2	1

13. Is there anything else you would like to share with us? [Open-ended response.]

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