CRIMINAL INVESTIGATIONS OF CHILD ABUSE
The Research Behind "Best Practices"

LISA M. JONES
THEODORE P. CROSS
WENDY A. WALSH
MONIQUE SIMONE
University of New Hampshire

This article reviews the research relevant to seven practices considered by many to be among the most progressive approaches to criminal child abuse investigations: multidisciplinary team investigations, trained child forensic interviewers, videotaped interviews, specialized forensic medical examiners, victim advocacy programs, improved access to mental health treatment for victims, and Children's Advocacy Centers (CACs). The review finds that despite the popularity of these practices, little outcome research is currently available documenting their success. However, preliminary research supports many of these practices or has influenced their development. Knowledge of this research can assist investigators and policy makers who want to improve the response to victims, understand the effectiveness of particular programs, or identify where assumptions about effectiveness are not empirically supported.

Key words: *child abuse, investigations, criminal justice*

SOON AFTER THE WIDESPREAD ACKNOWLEDGMENT of child sexual abuse in the 1970s and 1980s came the realization that traditional investigation methods risked traumatizing victims further (see, e.g., Whitcomb, 1992). Many professionals did not know how to conduct effective and child-sensitive forensic interviews and medical examinations, and uncoordinated investigations could lead victims to have to "tell their story" about the abuse repeatedly. There was a paucity of support and treatment services for victims and their families. Problems with the investigation could make the inherent difficulty of prosecuting child sexual abuse even harder.

Many jurisdictions in the United States have implemented reforms designed to reduce the stress on victims and improve the effectiveness of criminal justice investigations of child abuse. This article reviews research related to seven reforms considered "best practice" for child abuse investigations (Lanning, 2002; Pence & Wilson, 1994a, 1994b; U.S. Department of Justice, 1999; Winterfeld & Sakagawa, 2003): multidisciplinary team investigations, trained child forensic interviewers, videotaped child interviews, specialized medical forensic exams, victim advocacy and support programs, improved access to mental health treatment for victims, and Chil-

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KEY POINTS OF THE RESEARCH REVIEW

- Many innovative child abuse investigation methods are being recommended as "best practice," but the level of research support for these practices varies widely.
- Although mostly preliminary, research suggests the value of many investigation reforms.
  - Multidisciplinary teams (MDTs) can improve investigation quality and case outcomes. Research is mixed on whether MDTs are effective at minimizing the number of interviews children experience.
  - Trained child forensic interviewers are taught research-based methods for improving investigations; these skills have decreased interview errors in laboratory settings. Training appears to be effective when highly structured protocols are used and regular supervision is provided.
  - Videotaping child interviews is more accurate than verbatim notes, and the majority of children report no problems with videotaping.
  - Specialized medical forensic examiners provide higher-quality examinations and more consistent decision making in cases of sexual abuse. Increased preparation for the exam can reduce stress for children and their caregivers.
  - Victim advocacy and support programs are needed; victims and families find the investigation and prosecution process stressful. One study found a court preparation program effective in improving outcomes for children.
  - Mental health treatment can reduce abuse-related emotional difficulties for children and nonoffending caregivers. Research is needed on increasing victim access to empirically supported treatments.
  - Children's Advocacy Centers (CACs) may improve communication among professionals and outcomes such as substantiation and prosecution rates, but findings are mixed and more outcome research is needed.

dren's Advocacy Centers (CACs). We use the term *best practice* loosely to refer to procedures for improving child abuse investigations endorsed by a substantial number of policy makers and professionals. Strong professional endorsement, however, does not necessarily mean that outcome research has established a program's efficacy. In some cases, research is available but preliminary. In other cases, judgment about a practice may be based on the accrual of practitioner reports of its success. Like many social interventions, the innovations reviewed here were implemented primarily in response to identified needs and much less so to research evidence.

Bursts of innovative program development are encouraging, but child abuse professionals now need to educate themselves on the research behind these developments. Given tight resources for children's services, funders are more frequently requesting evidence for the efficacy of proposed programs. More important, the child abuse professional field is becoming mature, and these reforms are increasingly being implemented in the United States and in other nations as well. Now it is time to look carefully at the research to assess whether these new approaches solve the problems they were designed to fix and for clues on how they can be further refined to improve the response to children, families, and communities.

MULTIDISCIPLINARY TEAM (MDT) INVESTIGATIONS

Given the number of professionals involved in child abuse investigations, there have been increasing efforts to coordinate investigator activities, particularly those of law enforcement and child protective services (CPS). Virtually nonexistent 25 years ago, hundreds of multidisciplinary teams (MDTs) are in use across the country (Kolbo & Strong, 1997). As of 1999, 36 states had legislation requiring MDTs on cases of child abuse (U.S. Department of Health and Human Services, 1999), and as of 2002, 50 states had legislation requiring cross-referral of these cases among professional agencies (U.S. Department of Health and Human Services, 2002). However, in practice, the nature and purpose of interagency collaboration varies widely. Models range from minimal cross-referral protocols with infrequent col-

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laboration to integrated teams that work closely together on investigations.

One goal of MDT investigations is to eliminate the need for multiple, duplicative interviews and thereby reduce children's distress related to repeatedly "telling their story" of abuse. For example, many MDTs conduct joint forensic interviews in which one interviewer talks to the child while other investigators watch via a one-way mirror or closed-circuit TV, occasionally advising the interviewer on which questions to ask. Concern about the impact of repetitive interviews on children may be warranted. Two small studies (Berliner & Conte, 1995; Tedesco & Schnell, 1987) found that the greater the number of interviewers children reported, the more likely the child was to perceive the investigation experience as harmful. Another found a significant correlation between the number of interviews and the level of trauma symptoms experienced by children, even after controlling for several potential confounding variables (Henry, 1997). Fewer interviews may also improve the quality of children's testimony, increasing the strength of the case. Laboratory research has found that repeated questioning of a young child witness increases the likelihood of inaccurate or false details (Bruck, Ceci, & Hembrooke, 1998).

Although there may be some support for the goal of reducing interview redundancy for children, research is mixed on whether MDTs accomplish this goal. Two studies found that MDTs reduced the number of interviews per child in their child abuse investigation programs (California Attorney General's Office, 1994; Jaudes & Martone, 1992). Another study (Henry, 1997) found that children from a community with greater investigator coordination were interviewed fewer times on average than those from a community with a less coordinated system. However, two evaluation studies found no differences in the number of interviews between cases seen by an MDT in a CAC and non-MDT cases (Hicks, Stolfi, Ormond, & Pascoe, 2003; Steele, Norris, & Komula, 1994). These evaluations are described more below, but the lack of findings might be partially explained by implementation problems.

MDT investigations are thought to improve investigations in other ways as well. Interagency communication on cases should be greater for MDTs, which could in turn improve child safety by keeping cases from "falling through the cracks." Shared information could also reduce gaps in evidence collected by different investigators. In addition, increased communication between law enforcement, CPS, and other professionals is designed to reduce the degree to which multiple investigations interfere with each other (Lanning, 2002; Myers, 1998; Pence & Wilson, 1994a).

Research indicates that the impact of MDTs on investigation process and case outcomes may be significant. Respondents to a survey of professionals for the California Attorney General's Office (1994, pp. 84-85) felt that the team approach to decision making led to more effective and efficient decisions and "quicker resolution[s]." A study of daycare sexual abuse investigations (Finkelhor & Williams, 1988) found professional satisfaction levels higher for MDT investigations compared with traditional investigations. This study also found that team investigations had fewer "weaknesses" than traditional investigations, as rated by investigators (such as problems with parental cooperation and weak interviewer skills), and resulted in higher conviction rates and more frequent suspension of day care licenses. Two additional studies also found that MDTs improved case outcomes. Jaudes and Martone (1992) found that joint investigations increased the likelihood that police and prosecutors would identify and charge perpetrators and that CPS would substantiate allegations. Tjaden and Anhalt (1994) also found that greater coordination within a community was positively related to a number of case outcomes, such as victim corroboration, perpetrator confession, criminal charges, and conviction rate. However, this study did not control for preexisting differences between cases that received independent versus joint investigations, and no differences in outcomes were found between more coordinated and less coordinated communities.

Proponents of MDT investigations claim that reducing the number of victim interviews is one of the primary benefits of coordination. Re-

search may yet show that MDTs can provide this benefit, but the current mix of findings indicates that this question needs to be better explored. There may be certain models of multidisciplinary coordination that have more success in reducing interviews. Differences in the quality of the collaboration may also explain some of the varied findings. In addition, researchers might need to identify more sensitive measures of interview redundancy than the number of interviews per se. For example, the number of times children must repeat themselves when speaking to different investigators might serve as a better measure. Meanwhile, an encouraging number of studies suggest that MDTs can improve overall investigation quality, an outcome with an arguably greater impact on the well-being and safety of children. Practitioners and policy makers can look to this research as offering support for the effectiveness of multidisciplinary teamwork.

TRAINED CHILD FORENSIC INTERVIEWERS

There has been increasing recognition of the skill and sensitivity required to conduct effective and humane forensic interviews of alleged child victims. Poor interviewing can alienate and distress children, lead to inaccurate assessments about allegations, and create opportunities for defense attorneys to attack interviews as suggestive and misleading (Wood & Garven, 2000). A number of training programs have been developed to increase interviewer skills (see, e.g., the programs cited below). Specialized interviewers are employed in many jurisdictions for their abilities to work with children and their training in child forensic interviewing. It is very likely, however, that many police and child protective investigators who interview children still lack this training.

Extensive research has identified several common interviewing mistakes that affect children's openness and accuracy and the amount of useful detail they provide (see Wood & Garven, 2000). A number of studies demonstrate that suggestive interviewing can lead some, primarily younger, children to make misleading or false statements inadvertently (see Ceci & Bruck, 1993; Poole & Lamb, 1998). Reinforcing children for certain answers (e.g., implying that the child can demonstrate helpfulness by disclosing abuse) can increase false reports. Interviewers who tell children what others believe about the allegations can influence children to make false statements out of a sense of compliance. Insensitive interviewers can distress already traumatized children and lead them to "close up" to interviewers. Poor interview questions can lead children to disclose too little information.

Considerable research supports specific methods for conducting interviews. Being interviewed in a warm, supportive way, with attention to building rapport at the beginning of the interview, leads children to provide more accurate, more detailed reports (Carter, Bottoms, & Levine, 1996; Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991). Children's positive associations with the investigation increase when they feel the interviewer has been emotionally supportive (Berliner & Conte, 1995; Henry, 1997; Tedesco & Schnell, 1987). Open-ended questions that ask children to tell what happened from beginning to end produce longer responses with more detail than focused questions (Hershkowitz, Lamb, Sternberg, & Esplin, 1997; Lamb et al., 1996; Sternberg et al., 1997). Age-appropriate language increases the accuracy and credibility of children's responses (Perry, McAuliff, Tam, & Claycomb, 1995; Saywitz, Jaenicke, & Camparo, 1990).

Leading training programs all teach interviewing methods that are based on or influenced by this research. These include the CornerHouse Forensic Interview (www.cornerhousemn.org), the American Prosecutor Research Institute's *Finding Words* course (www.ndaa.org/apri/), Forensic Interviewing of Children Training at the National Children's Advocacy Center Academy (http://www.nationalcac.org/academy/forensic_children.html), and the Forensic Interview Clinics of the American Professional Society on the Abuse of Children (www.apsac.org). Michael Lamb and colleagues at The National Institute for Children's Health and Development (NICHD) have developed an entire interview protocol based on their interviewing research (Orbach et al., 2000). These methods train interviewers to develop

rapport with children, use age-appropriate language, and eliminate pressures and reinforcements that would lead children to respond in misleading ways.

However, training interviewers to improve their interviewing is not easy or straightforward. Research has found that training programs increase attendees' knowledge but have only limited success improving interviewing skills (Memon, Bull, & Smith, 1995; Memon, Holley, Milne, Koehnken, & Bull, 1994; Stevenson & Leung, 1992; Warren et al., 1999). Some skills might be more easily taught than others. Wood and Garven (2000) have concluded, based on their experience training CPS and law enforcement, that more serious interviewing errors such as suggestiveness and improper reinforcement can be eliminated with short training programs. Improving other interview skills, such as rapport building and the use of open-ended questions, may require more extensive supervision and frequent feedback sessions. In fact, research by Lamb and colleagues have demonstrated that interviewers who use a highly structured protocol and receive regular supervision and feedback substantially improved the quality of their interviews (Lamb, Sternberg, Orbach, Esplin, & Mitchell, 2002; Lamb, Sternberg, Orbach, Hershkowitz, et al., 2002). Further research is needed to explore whether regular supervision and feedback is key to cementing what is learned in other training programs as well.

VIDEOTAPING CHILD INTERVIEWS

Many professionals consider it best practice to videotape child forensic interviews, and hundreds of jurisdictions routinely videotape interviews. Other professionals, however, oppose it vigorously (see Myers, 1993). Advocates argue that recording investigative interviews yields a more accurate and credible rendering of the alleged abuse, including children's demeanor when they disclose it (Berliner, 1992; Broderick, Berliner, & Berkowitz, 1999; MacFarlane & Krebs, 1986). Videotapes make interviewers more accountable and facilitate training and supervision of their work. Videos, they claim, help families overcome denial, convince perpetrators of the strength of the case against them, and help victims remember and avoid recantations. The result, they report, is greater family support and more perpetrator confessions. Videotaping can help make additional interviews unnecessary and can sometimes be entered as evidence in court, saving child victims from the need to testify.

Opponents argue that legal proceedings become overly focused on the videotape. Defense attorneys, they say, can focus on children's inconsistencies and interviewers' mistakes rather than children's stories and can speciously but effectively attack details of interviews (Martin & Besharov, 1991; Stern, 1992). Vieth (1999) argued that videotaping is often detrimental unless investigators are well trained in interviewing and prosecutors, defense attorneys, and judges are trained to evaluate the recording. Concern has also been raised about child interviewees becoming embarrassed or frightened or reacting behaviorally to the fact of being videotaped (Martin & Besharov, 1991; see Myers, 1993).

Research on videotaping is only at a beginning stage but has addressed some important questions. Two studies found that videotapes were more accurate than verbatim notes (Berliner & Lieb, 2001; Lamb, Orbach, Sternberg, Hershkowitz, & Horowitz, 2000). In the Lamb et al. (2000) study, interviewers tended to report in their notes that they obtained details from less leading questions that the videotapes revealed were, in fact, obtained from more leading questions. Two studies found that the majority of videotaped children reported experiencing no more than minor discomfort or even found videotaping helpful (Berliner & Lieb, 2001; Henry, 1999). Henry (1999) found that children were interviewed fewer times on average in one county that videotaped than in two other counties in the same state that did not, but this comparison is confounded by other differences between the jurisdictions.

An evaluation team with the California Attorney General's Office (1994) surveyed professionals' opinions in two counties that had recently introduced videotaping as part of the implementation of an MDT. Of those responding, 88% felt that videotaping was useful and

30% that it was harmful (respondents could identify both positive and negative effects), and 95% responded that they recommend videotaping routinely or selectively in the future. Wilson and Davies's (1998) study of British police investigations had a mundane but telling finding: A large minority of videotapes had poor sound and visual quality, making it difficult to see and hear children.

Thus, research suggests that videotaping indeed provides substantially more accurate documentation than even the best note taking and that the emotional effect on children is minimal. Professionals generally report finding videotaping useful in practice, although the technical quality of the videotapes is important. However, there is only minimal research on most of the stated advantages and disadvantages of videotaping, especially on the effects of videotaping on criminal justice outcomes.

FORENSIC MEDICAL EXAMS

Forensic medical examinations are typically requested in child abuse investigations to identify physical evidence of abuse for the prosecution of the alleged offender, to screen for medical conditions related to sexual contact, and to reassure victims and parents about the child's physical well-being (Britton, 1998). Although only a small minority of cases of suspected sexual abuse result in physical evidence (see reviews in DeJong, 1998; Hegar, Ticson, Velasquez, & Bernier, 2002), medical findings are related to an increased likelihood of successful criminal prosecution (Bradshaw & Marks, 1990; Cross, DeVos, & Whitcomb, 1994; Palusci et al., 1999).

Child forensic medical exams require specialized knowledge. Most pediatricians do not have the skills to identify the subtle signs needed to make a differential diagnosis between abuse and other conditions. Many do not know how to collect and use forensic evidence or how to testify effectively in court. There is growing interest in improving medical examiners' skills through training and education. Research supports this development. Several studies indicate that specialized and experienced medical examiners provide higher quality and more consistent decision making in cases of suspected sexual abuse (Adams & Wells, 1993; Brayden, Altemier, Yeager, & Muram, 1991; Paradise et al., 1997; Paradise, Winter, Finkel, Berenson, & Beiser, 1999). Experienced medical personnel might also be more comfortable with the exam process and more aware of information needed by patients, thereby reducing stress levels for children and their caretakers. However, research has not documented whether training for medical personnel improves victims' experience of the examination (Britton, 1998; DeJong, 1998; Dubowitz, 1998).

The use of new technologies in forensic medical exams is also considered to be best practice (Adams, 1997; Finkel, 1998). Photocolposcopy, videocolposcopy, and computer imaging technology are described as improving the diagnostic abilities of medical practitioners and possibly improving the experience of patients. These technologies, which magnify tissue and provide enhanced visual images, are quickly becoming standard practice among specialized medical examiners. A survey by the Section on Child Abuse and Neglect of the American Academy of Pediatrics (AAP) found that 70% of the 170 members who responded to the survey used the colposcope and interpreted colposcopic findings (Adams, 1997). It is likely, however, that many medical forensic examiners rely on more traditional technologies. New technologies are costly and require trained personnel. Research is needed to help practitioners and communities weigh the costs and benefits of incorporating tools such as the colposcope into clinical practice (Adams, 1997; Finkel, 1998; Levitt, 1998).

Although one of the most important outcomes of the exam may be to reassure victims of their physical integrity, this has to be weighed against evidence that children may experience the exam as invasive and stressful. Although most children do not report difficulty with exams, approximately a third of children undergoing an examination report a negative experience of some kind (Allard-Dansereau, Hebert, Tremblay, & Bernard-Bonnin, 2001; Britton, 1998; Davies & Seymour, 2001; Lazebnik et al., 1994; Prior, 2001). Research points to several ways to improve the experience for children.

There is evidence that the emotional support provided by the medical professional is important to the child's overall experience of the exam (Allard-Dansereau et al., 2001; Davies & Seymour, 2001). Furthermore, children and caregivers are often poorly prepared for what the exams entail and the less information they have, the greater their anxiety (Steward, Schmitz, Steward, Joye, & Reinhart, 1995; Waibel-Duncan & Sanger, 1999). Practitioners could reduce children's anxiety by explaining procedures and purposes to children prior to the exam.

VICTIM ADVOCACY AND SUPPORT PROGRAMS

Legal proceedings are also stressful for child victims and their families. The numerous delays can be frustrating, the time requirements onerous, and the settings, "legalese," and adversarial nature of the process intimidating. In addition, professionals have expressed concern that children may experience secondary trauma from testifying about painful and personal victimization experiences and from facing the accused in court (e.g., DeFrancis, 1969; Newberger, 1987; Weiss & Berg, 1982).

Although no general or lasting negative effects of prosecution on children have been found, there are indications that certain aspects of trial and pretrial experiences can have a negative impact (Goodman et al., 1992; Runyan, Everson, Edelsohn, Hunter & Coulter, 1988; Whitcomb, Runyan, et al., 1994; see also Whitcomb, Goodman, Runyan, & Hoak, 1994). In particular, multiple testimonies (Goodman et al., 1992; Whitcomb, Runyan, et al., 1994) and long and harsh cross-examination have been found to increase distress for children (Whitcomb, Runyan, et al., 1994). Furthermore, children report experiencing high levels of fear prior to and during legal proceedings, and families report frustrations with the numerous delays of the legal process and dissatisfaction with prosecution outcomes (Berliner & Conte, 1995; Goodman et al., 1992; Sas, Hurley, Hatch, Malla, & Dick, 1993).

Currently, no outcome research that we are aware of is available on the effectiveness of general victim/witness programs, but one initial study has demonstrated that court preparation can be effective in improving outcomes for children.

To increase information and support to victims and their families, many court systems provide victim advocacy programs. These programs are designed to prepare victims, witnesses, and their families for the court process. They may also provide emergency services, counseling, personal advocacy, claims assistance, and other court-related services. District attorneys' offices in some jurisdictions have victim witness advocates on staff to help children and families in these ways (see, e.g., Spath, 2003). Some legal systems also provide court preparation programs for children that are designed to reduce children's anxiety and help them testify effectively. These programs involve talking over the legal process with children, familiarizing them with the roles of different legal professionals, and educating them about what to expect if they testify. Educational materials or strategies might include reading materials, toys, role-playing, and/or tours of the courtroom.

Currently, no outcome research that we are aware of is available on the effectiveness of general victim/witness programs, but one initial study has demonstrated that court preparation can be effective in improving outcomes for children. This evaluation (Sas, n.d.) found that a court preparation program improved children's knowledge about the court process and reduced their anxiety about testifying. More research is needed to understand the scope of legal supports available to child victims and families and to better understand the impact of these programs.

ACCESS TO MENTAL HEALTH TREATMENT

Child abuse can have devastating effects on the mental health of children and families, and for some children, investigation and prosecution can exacerbate these problems. Child victims commonly have symptoms of anxiety and depression and experience high rates of posttraumatic stress disorder (PTSD) (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Mannarino, Cohen, & Gregor, 1989). It is considered best practice to evaluate children's mental

health as a component of a comprehensive investigation and to refer troubled children for mental health treatment as soon as possible. To this end, many investigative agencies have developed referral links with treatment providers.

Research reviews have identified several therapeutic approaches that are successful in reducing symptoms of anxiety, depression, and PTSD in abused children and improving caregiver skills (Chadwick Center for Children and Families, 2004; Saunders, Berliner, & Hanson, 2002). A particularly strong record of effectiveness has been established for trauma-focused cognitive-behavioral therapy (e.g., Cohen & Mannarino, 1996; Deblinger, Steer, & Lippmann, 1999), cognitive-behavioral therapy for physical abuse (Kolko & Swenson, 2002); and parent-child interaction therapy (PCIT) (Borrego, Urquiza, Rasmussen, & Zebell, 1999).

There is also evidence for the need to improve nonoffending caregiver support for children (see N. A. Elliot & Carnes, 2001 for a review of this literature). Maternal support has been shown to be predictive of greater resiliency in child abuse victims (Spacarelli & Kim, 1995), less child distress (Morrison & Clavenna-Valleroy, 1998), and reduced child behavior problems (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Goodman et al., 1992; Whitcomb, Runyan, et al., 1994). Children with supportive caregivers also appear more likely to have their cases prosecuted and are less likely to be removed from the home (Cross et al., 1994; Cross, Martell, McDonald, & Ahl, 1999; DeVos, Cross, Peeler, Whitcomb, & Stober, 1992; Everson et al., 1989). Other research has found that disclosures are more likely and recantations less likely with greater parental support (D. M. Elliot & Briere, 1994; Lawson & Chaffin, 1992; Sorenson & Snow, 1991). Outcome research on treatment programs for nonoffending caregivers has thus far been limited mostly to cognitive-behavioral treatment programs, but these data indicate that such programs can improve caregivers' emotional functioning and increase their support of their children (e.g., Celano, Hazzard, Webb, & McCall, 1996; Deblinger et al., 1999; Deblinger, Stauffer, & Steer, 2001).

Although a number of therapies have been shown to be effective in improving the well-being of victims and their families, it is not known how many communities offer such treatment options. Most children likely receive therapeutic treatments with little or no empirical support for treating abuse-related difficulties; many more may be offered no therapeutic support at all. An important first step is to identify methods to match children in need of treatment with appropriate services in their community. Although establishing referral protocols between investigating and therapeutic agencies would seem a likely strategy for improving victim access to treatment, no research documents the use of referral protocols or explores their effectiveness. Case review, or other follow-up procedures may be necessary to ensure that children receive needed services. In addition, communities need to increase the availability of treatment providers trained to offer empirically supported treatments for child abuse and trauma (Chadwick Center for Children and Families, 2004). Increasing education and training opportunities for professionals would be one method for improving this availability.

CHILDREN'S ADVOCACY CENTERS

The CAC model incorporates many of the innovations described above as standard elements of practice in specialized nonprofit agencies or departments (Simone, Cross, Jones, & Walsh, 2005). CACs aim to provide a child-friendly environment, use team interviews conducted by trained child forensic interviewers, offer medical and therapeutic services on-site or through referral protocols, and provide victim advocacy and sometimes court education programs as well. A CAC membership organization, the National Children's Alliance (NCA), was developed in the United States, in part to establish and oversee standards of practice for member CACs (see http://www.nca-online.org/). Membership in the NCA has increased from 34 registered centers in 1993 to more than 478 full or associate centers in 2003 across 49 states (National Children's Alliance, 2003). A survey of a representative sample of NCA member CACs found that they provided the following services (Jackson, 2004):

- One hundred percent reported having a child-friendly facility.

- All CACs surveyed had a multidisciplinary team with an average of 7 members, typically including law enforcement, CPS, prosecution, health care, mental health, and victim advocates.
- A majority (68%) had specially trained interviewers on-site and 100% provided ongoing training for CAC staff.
- One hundred percent reported that they provided children and families with access to mental health services, with 51% providing these services on-site.
- Approximately half (53%) provided on-site medical exams, with the vast majority (90%) of exams conducted by physicians.
- Almost all CACs (92%) reported having multidisciplinary case review procedures.
- The vast majority (94%) helped clients obtain victim advocacy services, and 48% provided victim advocacy services on-site.
- Ninety-two percent reported a case tracking system, with 65% having a computerized system.

To the extent that CACs make use of innovative practices such as multidisciplinary teams and increased training, they should expect to see related improvements in investigation outcomes. There may also be additional positive outcomes resulting from their efforts to provide child-friendly interview environments and to consolidate services in one location, for example. However, the impact of CACs has not been adequately evaluated. The few existing evaluation studies have disparate results, in part because of limited research methods and measures but perhaps more because of actual differences between the CACs studied. Although the NCA ensures that its member CACs meet certain standards of practice, the agencies vary widely in their goals and agency involvement and also play different roles in their communities (see Walsh, Jones, & Cross, 2003). Given these differences, the impact of CACs can be expected to vary as well.

Kenty and Meyers (1991) contrasted sexual abuse cases handled by a fledgling CAC to a group of non-CAC police and CPS cases from the same community. The CAC greatly facilitated joint police-social worker communication and featured joint police-CPS interviews (reducing the need for redundant interviewing) in 59% of cases versus 0% in the comparison. The CAC group had more thorough investigations, more frequent supportive contacts with the victim and family members, and increased service delivery and medical consultation in cases. There were no significant differences on arrest and prosecution. The nature of this CAC makes it difficult to generalize these results to other CACs, however. A major component was a new, specialized sexual abuse intake unit of the state child protective agency—unusual for most CACs. It is difficult to know to what extent the advantages of the new program were because of the CAC per se versus the specialized CPS unit.

As noted above, Steele et al. (1994) found no difference between CAC and non-CAC cases on number of interviews in one community. More agencies actually conducted interviews in CAC cases, on average, than in comparison cases. Steele and colleagues suggest that greater comprehensiveness of the CAC evaluations may explain the greater number of agencies interviewing a child, on average. But their interviews with professionals involved with this newly established CAC also suggested that professionals were sometimes required by their agency to conduct a separate interview themselves, although in many cases it was a cursory interview designed to minimize children having to retell the story of their abuse. Large caseloads and scheduling problems also led some professionals to interview children separately and not use the team interview, which can take more of a professional's time and require adapting to other professionals' schedules.

Another evaluation study similarly found no differences between a sample of CAC clients and a comparison sample in the number of investigative interviews conducted with children, the number of days from disclosure of abuse to medical exam, or the caregivers' experience with the investigator's handling of the case (Hicks et al., 2003). This evaluation did find, however, that significantly more CAC clients were referred for counseling than in the comparison sample.

The impact of CACs on criminal justice outcomes varied across studies. Two studies (Jenson, Jacobson, Unrau, & Robinson, 1996; Kenty & Meyers, 1991) found no effect of their CACs on criminal justice outcomes, but Steele and colleagues (1994) found that prosecution and incarceration were greater for the CAC group than the comparison.

Professional and parent satisfaction with CACs was positive, on average, across the studies that measured it (Jenson et al., 1996; Steele et al., 1994), although Jenson and colleagues found that parent satisfaction declined somewhat at 3-month follow-up, indicating the need for more intensive follow-up services. Jenson and colleagues also found that children were satisfied with their experiences at the CAC.

More evaluation research on CACs with better comparisons is badly needed, especially because most of the above-mentioned research is 7 to 8 years old and does not reflect the greater program development of CACs in this decade. A multi-site CAC evaluation project is currently under way (Cross & Jones, 2002), and there are efforts to bring together additional outcome data on CACs (C. Kirchner, personal communication, March 2003). CACs themselves are working to increase the quality of their information databases with an eye toward improving outcome data in the future.

Even with direct outcome research still in development, it is evident that CACs incorporate many current best practices. As described above, many of these practices are supported by or influenced by existing research. The current state of knowledge suggests that CACs, as well as other agencies that include these practices in their standards, are more likely to see favorable outcomes than agencies that do not use these practices. Whether CACs represent an effect that is more than the sum of their parts and have a clear impact on important child, family, and social outcomes will need to be examined further.

CONCLUSION

Although new procedures in child abuse investigations need to be evaluated carefully, existing research offers some support for many current practices. Even though field research on child abuse investigations is still in its infancy and outcomes are only beginning to be studied, there is an empirical basis for many areas of practice, and new research shows the potential to guide practice in the near future. Practitioners following many best practices can argue that much of their work has at least preliminary scientific support. For example, multiple studies have documented the problems of using inappropriate interview techniques with children and the corresponding improvements when developmentally appropriate questioning is used. Agency practices linked to this research, such as the use of specialized training for forensic interviewers, can clearly be described as research-based best practice.

Research on other investigation practices described in this article is still in early stages of development. However, given that policy must be made and practice carried out regardless of the state of research, even preliminary findings can provide some guidance and bolster arguments for best practice. For example, some findings suggest that multidisciplinary teams can have positive effects on assessments and prosecution outcomes. Likewise, the limited available research indicates that child abuse medical examiners who are specially trained will be more likely to collect better evidence and make more consistent decisions. Some research also indicates that social and emotional support can improve children's experiences with the court process and that child mental health treatment can help child victims recover. Data also suggest that interventions with nonoffending caregivers can help improve their mental health and increase their support for their children.

Research is only beginning to clarify areas in which professionals disagree on what constitutes best practice, but it is clear that research can help resolve these in the future. One of the problems is that research is often still too fragmentary to examine thoroughly both sides of the debate. Some studies already suggest that some of the fears about videotaping child interviews are unfounded, but most of the concerns about this practice have not been empirically tested. Similarly, research allays some of the concern about the emotional impact of forensic medical examinations, but has not identified the universe of cases for which the benefits of forensic medical examinations outweigh the costs. Nevertheless, investigators can bring to the discussion objective information from research.

This review has useful implications for investigation agencies. The investigation practices described above are complementary and can be

incorporated individually or in combination. The CAC model, by definition, aims to put into practice a number of different investigation reforms. Child abuse investigators can use the information included in this report to assess investigation practices in their community and make decisions about next-step reforms based on the research evidence. The information reviewed here can also help defend existing practice. Many CACs, for example, worry that current and potential funders want to see outcomes to justify their investment, yet there are few evaluations that CACs can cite, and CACs often lack the resources and skills to do outcome research. It is important to increase resources for outcome research and recruit people with skills to do it. New research is in progress (Cross & Jones, 2002; C. Kirchner, personal communication, March 2003). In the meantime, investigation professionals need to identify all the areas in which their practice is consistent with the latest research.

New research is needed in every area discussed here, particularly on medical examinations, multidisciplinary teams, investigation methods, and interventions to support and treat children and families.

This review focuses on what has been accomplished. But there is no denying that the proverbial glass is perhaps only one quarter full, and what has been accomplished should not invite complacency. We have highlighted what researchers already offer practitioners, but it is clear that they owe them so much more. New research is needed in every area discussed here, particularly on medical examinations, multidisciplinary teams, investigation methods, and interventions to support and treat children and families. Practitioners should not have to answer questions about practice or respond to the demand for outcome data all by themselves. We call on researchers to do more to serve the needs of professionals responding to child victimization.

Yet is unrealistic to expect that all new practices have solid empirical support prior to widespread dissemination. Research and practice innovations move at a different pace and respond to different demands. However, children and society benefit when there is increased dialogue between those who provide the public with the best services they have to offer and those who study the best ways to serve the public. Such an exchange can move the child abuse professional field closer toward protecting children and helping them recover from victimization.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Child abuse professionals and policy makers should not assume that investigation "best practices" have strong outcome research establishing their efficacy. In reality, little outcome research on these practices has been conducted.
- However, policy makers and practitioners can cite preliminary research that supports the goals and directions for many innovative investigation methods and programs.
- There is evidence to recommend the use of multidisciplinary teams, trained forensic interviewers, and trained and experienced medical examiners in child abuse investigations.
- There is also evidence that some mental health treatment approaches can reduce stress and improve emotional well-being for victims and their families.
- More research is needed on successful methods for increasing availability of and access to such services.
- For some popular practices, such as the use of videotaped testimony, victim advocacy programs, and Children's Advocacy Centers (CACs), more research is necessary before their impact can be fully understood.
- Practitioners and policy makers need to know about relevant research when considering or implementing new practices and programs. Regularly including brief research summaries in professional newsletters is one recommended way of increasing access to such information.
- Researchers must play an equally active role in disseminating research outcomes to practitioners. Researchers should increase efforts, for example, to submit summary forms of their findings to publications with a broader, more practitioner-oriented readership.

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SUGGESTED FUTURE READINGS

Lanning, K. V. (2002). Criminal investigation of sexual victimization of children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 329-347). Thousand Oaks, CA: Sage.
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Lisa M. Jones, Ph.D., is a research assistant professor of psychology in the Crimes Against Children Research Center at the University of New Hampshire. She is assistant director of the Multi-Site Evaluation of Children's Advocacy Centers. Other research projects include studies of child abuse trends, foster parenting, and the process of change for abusive parents. She received her degree in clinical psychology from the University of Rhode Island in 1999.

Theodore P. Cross, Ph.D., is the director of the Multi-Site Evaluation of Children's Advocacy Centers in the Crimes against Children Research Center at the University of New Hampshire. He has been conducting research on system response to troubled children for more than 10 years, including studies of prosecution of child abuse, outcomes of foster care, and the organization of children's mental health services. He also teaches graduate-level statistics and maintains a private practice in child clinical psychology.

Wendy A. Walsh, Ph.D., is a research assistant professor of sociology in the Crimes against Children Research Center at the University of New Hampshire. She is currently working on the Multi-Site Evaluation of Children's Advocacy Centers. Other projects include the prosecution of child abuse and Internet-related child victimization. She has worked on program evaluations of CPS, child welfare risk assessment systems, and family resource centers.

Monique Simone, M.S.W., is a research associate in the Crimes Against Children Research Center at the University of New Hampshire for the Multi-Site Evaluation of Children's Advocacy Centers. She has worked on program evaluations for rape crisis centers and child advocacy centers. Other projects have concerned prosecution case flow and outcomes.