Feedback from Families and Multidisciplinary Team Members at Children's Advocacy Centers: Are there Differences across Groups?

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Today's Presenters

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Workshop Objectives:

1. Understand the history and purpose of the Outcome Measurement System (OMS).
2. Understand how feedback from families and multidisciplinary team members at Children's Advocacy Centers varies across team and center characteristics.
3. Explore implications for making data-informed improvements at Children's Advocacy Centers across the country.

The Outcome Measurement System (OMS)

- A standardized, research-based system of surveys designed measure CAC performance based on stakeholder satisfaction.
- Purpose of OMS is to help CACs evaluate their programs in order to:
  - Increase the quality of services provided to children and families.
  - Improve the collaborative efforts of MDTs.
- All NCA member CACs are eligible to participate, but are not required to do so in most cases.
  - Some states have linked participation to state funding streams and CACs may use results for other local government and private foundation grants.
  - Fulfills two components of NCA Accreditation Standards regarding team and client feedback

The Outcome Measurement System (OMS)

- Participating centers must use core OMS survey items for national comparisons (existing items cannot be deleted or reworded), but centers and states may request to add extra items relevant to projects or services specific to their area.
- Results are automatically compiled into aggregated reports for State Chapters, Regional CACs, and NCA, without any need for CACs to manually send reports to those organizations.
- NCA provides training and technical assistance to the CACs and State Chapters, as well as maintaining all data in a national online database.
- OMS offers an advanced system, without the expense or technical expertise that would be required for an individual CAC to develop such a system. It also connects CACs to a national network for benchmarking.

Development and Expansion of OMS

- OMS was originally developed from 2006 to 2009 by the CACs of Texas through collaboration with researchers at the University of Texas at Austin.
- Development was rigorous and evidence-based, involving an extensive literature review, instrument analyses, site visits, focus groups with CAC Directors, and pilot testing to ensure high statistical reliability & validity.
- NCA adopted the system to take nationally in 2012 as a pilot program.
- The program originally relied on State Chapters to provide a great deal of the training and technical support, which allowed the program to reach less than half of CAC.
- Seeing the need for more direct support, NCA created the OMS Coordinator position in 2014, which has lead to vast increases in CAC participation.

OMS by the Numbers

- **781 CACs** have participated in OMS as of December 2018.
- At least one center in **all 50 states** has participated in OMS since 2015, plus locations in Canada and Australia.
- **87%** of Accredited CACs use OMS.
- Over **350,000** surveys collected to-date (January 2012 to December 2018):
  - 233,000 Initial Visit Caregiver Surveys
  - 56,000 Caregiver Follow-Up Surveys
  - 72,000 Multidisciplinary Team Surveys

At CACs participating in the program, about **1 in 5 families** provide feedback through the OMS Initial Visit Caregiver Survey.

Children's Advocacy Center Outcomes

Two primary outcomes, measured by three surveys:

Outcome #1: The Children's Advocacy Center facilitates healing for the children and caregivers.

- Initial Visit & Follow-Up Caregiver Surveys

Outcome #2: The multidisciplinary team approach results in more collaborative and efficient case investigations.

- MDT Survey

Initial & Follow-Up Caregiver Surveys

Similar questions at two time points: Initial visit & follow-up approx. 2 months later

Child Demographics: Gender, Race, Age

Four Areas of Measurement – 1 to 3 multiple choice items in each group

Strongly Agree, Somewhat Agree, Somewhat Disagree, Strongly Disagree, Don't Know

- **The Child's Experience (caregiver perspective)**
- **Interactions with Center Staff / Overall Impression of Center**
- **Caregiver Access to Information & Services**
- **Preparing Caregivers for Challenges/Future Possibilities**

Open-Ended Questions – Examples:

- Optional comment boxes on all multiple-choice items
- "Would you have liked additional services (for your child/for yourself) that were not offered?"
- "What did you appreciate the most about your experience at the center?"
- "Was there anything that the center staff could have done better to help you or your child?"

Additional Service-Specific Questions on the Follow-Up Survey:

Satisfaction with specific services, including…

- **Forensic interview, Mental health services, Medical exam, Case info/updates**

Multidisciplinary Team (MDT) Survey

Offered to all CAC and partner agency staff with a role in the MDT process

Best practice is to offer the survey twice a year, approximately 6 months apart

Background Information:

- Professional Discipline
- Number of Years Working with the CAC Model at the Center
- County/Jurisdiction

Areas of Measurement: 14 multiple-choice items

Strongly Agree, Somewhat Agree, Somewhat Disagree, Strongly Disagree, Not Applicable

- **Communication**
- **Collaboration**
- **Structure (Environment/CAC Setting)**
- **Overall Effectiveness of the MDT**

Open-Ended Responses

- Optional comment boxes on multiple-choice items
- “Please share any additional observations, opinions, concerns and/or recommendations.”

Multiple Ways to Collect Surveys

Recommend using a variety of options to increase family and team member access to feedback opportunities

- On-site Options:
  - **Computers/Tablets**
  - **Paper Surveys**
- After Visit Options:
  - **Handout with survey link** (short link and QR code options)
  - **Emails**
  - **Telephone Calls** (training for confidentiality and bias reduction)
  - **Mailing Paper Surveys** (with postage paid envelope)
  - **Text Messages**

How can CACs use OMS results?

Improve Services

- Establish common goals, ensure all staff are working toward these goals
  - Communicate current trends and desired outcomes to staff members
- Identify strengths and areas for improvement – prioritize resources
  - Find out which parts of the CAC are working well
    - Continue or expand effective services
    - Provide positive feedback to staff, celebrate successes
  - Fix problem areas
    - Identify services with low numbers, get the data to back up "gut feelings"
    - Reconsider current practices that may be unsuccessful and show staff why "business as usual" is not working, with data to back it up
    - Make the case for additional funding, staffing, or other resources

How can CACs use OMS results?

Improve Services

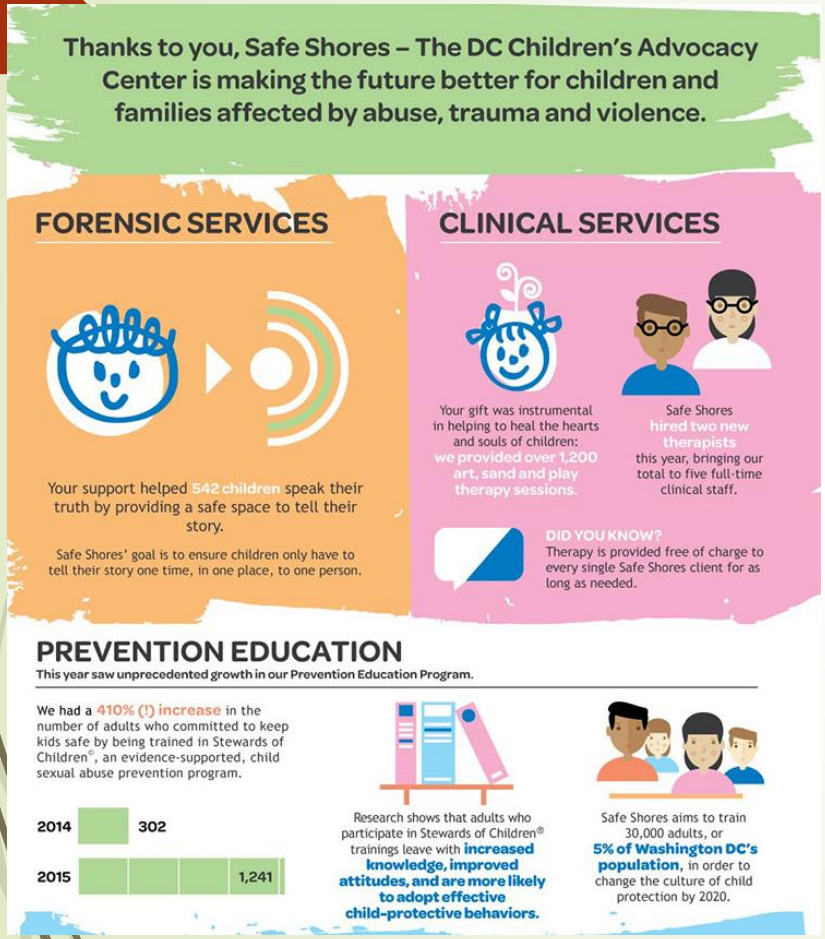
- Elements for CACs to consider when reviewing results:
  - **Demographics of Families/Team Members:** How representative are the results of all families served and all members of the team?
  - **Comparison to Past Timeframes:** Have some areas improved? Have others deteriorated? What may be the reason for this and how can the CAC change course?
  - **Comparison to State, Regional, and National Trends:** Every CAC has benchmarking tabs in online dashboards to see how they compare on every survey item vs. larger groups, including the ability to filter by timeframe, organizational structures, and family/team demographics
    - **NCA offers the annual "Healing, Justice & Trust" OMS report to dive into national trends and offer suggestions for improvements.**
  - **Ask the team for their insights:** Share the results with other staff and team members to see what stands out to them.

How can CACs use OMS results?

Raise Awareness & Engage Partners

- Combine with other data sources & show the impact of the CAC
  - Add statistics to public awareness campaigns and social media
  - Include results as part of flyers and brochures provided on-site or distributed by community partners
- Remind partners why the CAC is so important
  - Engage professionals from partner agencies to increase involvement in the MDT/CAC.
  - Show partners that your families value the services of your CAC, using feedback from clients and other data showing how many families benefit from this work.
- Engage board members
  - Attract new board members by showing the value of the CAC
  - Provide boards with information to use in planning and evaluation

Safe Shores (DC) Fundraising Materials



NCA Annual Brief Report

Healing, Justice, & Trust

A National Report on Outcomes for Children's Advocacy Centers 2016

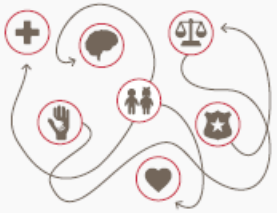
What is the National Children's Alliance?

NCA is the national association and accrediting body for a network of 822 Children's Advocacy Centers— CACs. We provide support, advocacy, quality assurance, and national leadership for CACs, all to help support the important work that CACs do in communities across the country. CACs provide a coordinated, evidence-based response to children who have been abused in all 50 states.

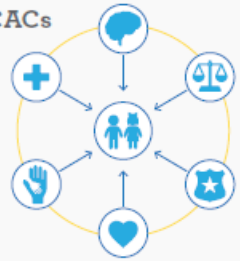
What are CACs and how do they help kids?

To understand what a CAC is, you must understand what children face without one. Without a CAC, the child may end up having to tell the worst story of his or her life over and over again, to doctors, police, lawyers, therapists, investigators, judges, and others. They may not get the help they need to heal once the investigation is over, either.

Without CACs



With CACs



CACs provide healing, justice, and trust for child victims of abuse

In 2016, CACs demonstrated that their model works through nearly 50,000 surveys from caregivers and MDT members. Here are some highlights that show our families and partners believe in the healing, justice, and trust we provide.

- **Healing:** 95% of caregivers agree that CACs provide them with resources to support their children.
- **Justice:** 98% of team members believe clients benefit from the collaborative approach of the MDT.
- **Trust:** If caregivers knew anyone else who was dealing with a situation like the one their family faced, 97% would tell that person about the center.

When police or child protective services believe a child is being abused, the child is brought to the CAC—a safe, child-focused environment—by a caregiver or other "safe" adult. At the CAC, the child tells their story once to a trained interviewer who knows the right questions to ask. Then, based on the interview, a multidisciplinary team (MDT) that includes medical professionals, law enforcement, mental health, prosecution, child protective services, victim advocacy, and other professionals make decisions together about how to help the child. Finally, they offer a wide range of services like therapy, medical exams, courtroom preparation, victim advocacy, case management, and more.

The CAC movement is growing and improving

With approximately **800 member CACs** serving **324,602 children** in 2016, NCA represents a growing movement providing more and better services to children and families nationwide.

In the last ten years, the number of NCA member centers serving kids has grown 35%

Since 2008, annually our member CACs have served...

- **60%** more child victims of physical abuse
- **70%** more child victims of neglect
- **111%** more child witnesses to violence
- **45%** more children endangered by drugs

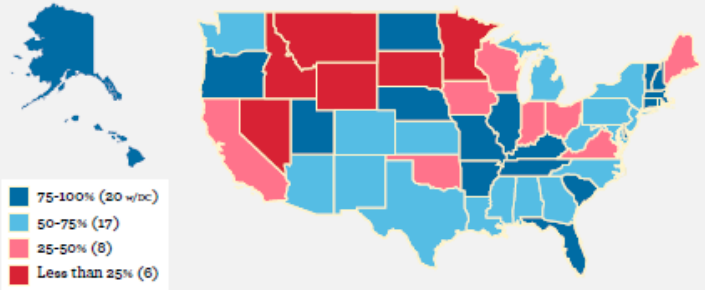
And provided...

- **28%** more children with counseling and other mental health services
- **44%** more children with onsite forensic interviews
- **256%** more children and family members with case management services
- **48%** more children, family members, and community members with prevention education

The need remains

Despite the success of the CAC model in helping children who have been victimized by abuse, there's still an outstanding need for more CAC coverage, and more support. States in red below have a lower proportion of counties covered by CACs, while states in blue have a higher proportion of CAC-served counties or have full coverage.

Proportion of Counties Covered by CACs, by State



CAC services are available to approximately 4 in every 5 U.S. children

But that still leaves **13,533,785** **children living in areas without a CAC.**

Funding and legislative support helps ensure children across the country have access to a CAC when they need it, and helps expand capacity and geographic coverage to reach more children and families with the services they need.

Thank you for your support of this crucial resource for children and families in communities across the country.

How can CACs use OMS results?

Increase Funding & Other Resources

- Improve likelihood of securing and retaining funding
  - Funders expect to see the numbers behind requests/reports
    - Data can be used for grant applications, including public and private grants
    - Individual and corporate donors also want to know how their money is being used.
    - Need to hire a new staff member? Show why, with a variety of data sources to back up the request, including feedback from families and team members.
- Build partnerships with other organizations
  - Show other organizations, such as other community-based programs and research institutions, that the CAC would make an effective partner.
    - See an funding opportunity related to your work? Consider partnering with another agency on the proposal and improve your chances of success.
    - OMS data can be used to demonstrate impact of services in CAC research.
- Support changes in legislation
  - CAC data is combined into state, regional, and national statistics used by State Chapters and NCA, which we use to show state and federal representatives why CACs are so valuable.

OMS Spotlight on a Participating CAC

How do you use your results? Who do you share them with and what has the reaction been?

Caregiver Surveys:

*"We have used the results of these surveys for funders. In particular, the Victims of Crime Act (**VOCA**) and [State] **Health and Human Services**. This is a great way to show the results of our services according to the families we serve! This **helps funders see what an amazing job we do** and helps our staff see what **areas we may need to improve in**."*

*"For our staff some of the great outcomes have been the **comments families leave**. This may show **themes** such as families wanting more services. Now the families can indicate what services they feel they need. So we have adjusted how we refer families to services and what services we need to have in our back pockets! This is also a **huge boost for morale** when you see how families are grateful for what we have helped with."*

OMS Spotlight on a Participating CAC

MDT Surveys:

*"In reviewing results we can **see where changes need to be made** with regards to the dynamics of a particular MDT. Its great to **hear from our partner agencies how we have helped them**, but it is necessary to hear what we need to improve upon to help them with these cases."*

Overall:

*"We have used comments and outcomes from all surveys to share with our **Board of Directors** how we are doing. We have used this as **kudos amongst our staff** as well."*

*"With everyone requiring agencies to SHOW how you make a difference, utilizing OMS and getting some values on **how we make a difference** and showing **how we have improved in particular areas** has been extremely helpful!"*

This center also uses quotes from caregivers and MDT members in their annual report, and other materials, to give context to other statistics.

Big Picture: How do State Chapters and NCA Use OMS Results?

- **Share outcomes with state funders**
  - As part of existing relationship or when requesting new/additional funding
- **Provide statistics on legislative visits to show value of CACs**
  - Stand out from other organizations competing for funding
- **Present results to boards, members, and the public**
  - Include results in annual reports, newsletters, and presentations
- **Identify struggling areas & offer training and technical assistance programs to CAC/MDT professionals**
  - Example: Training program for increasing victim advocates' skills in engaging families in mental health services

Trends from OMS: Family Engagement in Services

- On the OMS Caregiver Follow-Up Survey, caregivers are asked if they were given information about how to get services for children and themselves, such as counseling and family support.
- Most caregivers indicate, yes, they have been provided with this information. In this case, a follow-up question is asked regarding whether the services were used.
- Since 2014, there has been a trend with fewer families going on to use services, despite referral rates remaining steady or increasing.
  - 56.4% of children referred to services went on to use them in 2018, down from 69.1% in 2014
  - 32.4% of caregivers referred to services went on to use them in 2018, down from 47.6% in 2014.

Trends from OMS: Family Engagement in Services

- In other data collection from CACs, concrete barriers such as service location/transportation are estimated to be significant barriers by almost 50% of CACs (2018 NCA Member Census).
- However, OMS Caregiver Follow-Up Surveys indicate that very few caregivers see location/transportation as a barrier for accessing services (1.9% child barriers, 1.5% caregiver barriers).
- Instead, the most common barriers reported by caregivers are more perceptual in nature and indicate low buy-in to the importance of services.
  - Caregivers do not think children need the services (22.4%) or do not think they need services for themselves (51.3%)
  - Children are already receiving similar services elsewhere (24.9%) or caregivers are using similar services elsewhere (12.4%)
    - Services caregivers see as "similar" may not be evidence-based
  - Caregivers have not had time/have not made appointments yet (12.9% of barriers for children's services; 16.3% of barriers for caregiver services)

To address these issues, NCA is partnering with the University of Oklahoma Health Sciences Center on a NIMH grant to create a curriculum and train victim's advocates on engaging children and families in mental health care.

Improvements to OMS Over Time

- Feedback is routinely gathered from OMS users and this, along with research from the field, is used to revise the surveys.
- Revisions are generally slight, to allow long-term comparisons, but may include clarifying wording, consolidating duplicative items, separating double-barreled questions, and changing the format/order of items.
  - From 2013-2014, NCA worked with researchers from UNH to make the first significant national revisions. Revised surveys were released in July 2014 through the first online platform (FluidSurveys).
  - OMS moved from FluidSurveys to Qualtrics in September 2017.
  - NCA partnered with Drs. Wendy Walsh (UNH) and Ted Cross (UIUC) to conduct a second round of revisions, which were launched to the field in January 2018.
  - As an extension to the last revision, NCA and the researchers endeavored to answer questions about potential differences in satisfaction and service usage across different groups of families, team members, and CACs.

OMS Research Samples

Initial caregiver survey	• 1/1/18 to 3/5/18 • N= 7,017
Follow-up caregiver survey	• 1/1/18 to 6/30/18 • N= 5,184
MDT survey	• 1/1/18 to 3/5/18 • N= 2,588

Initial caregiver survey responses

Initial Caregiver Survey Sample Characteristics (N=7,017)

Case characteristic	Percentage
Child gender	Female – 72% Male – 28%
Child race/ethnicity	White – 59%, Black – 15%, Hispanic – 17%, Other – 9%
	Hispanic – 17% non-Hispanic – 83%
Child age	0 to 5 – 19%, 6 to 12 – 47% 13 to 17 – 33%
Caregiver language	English – 97% Spanish – 3%

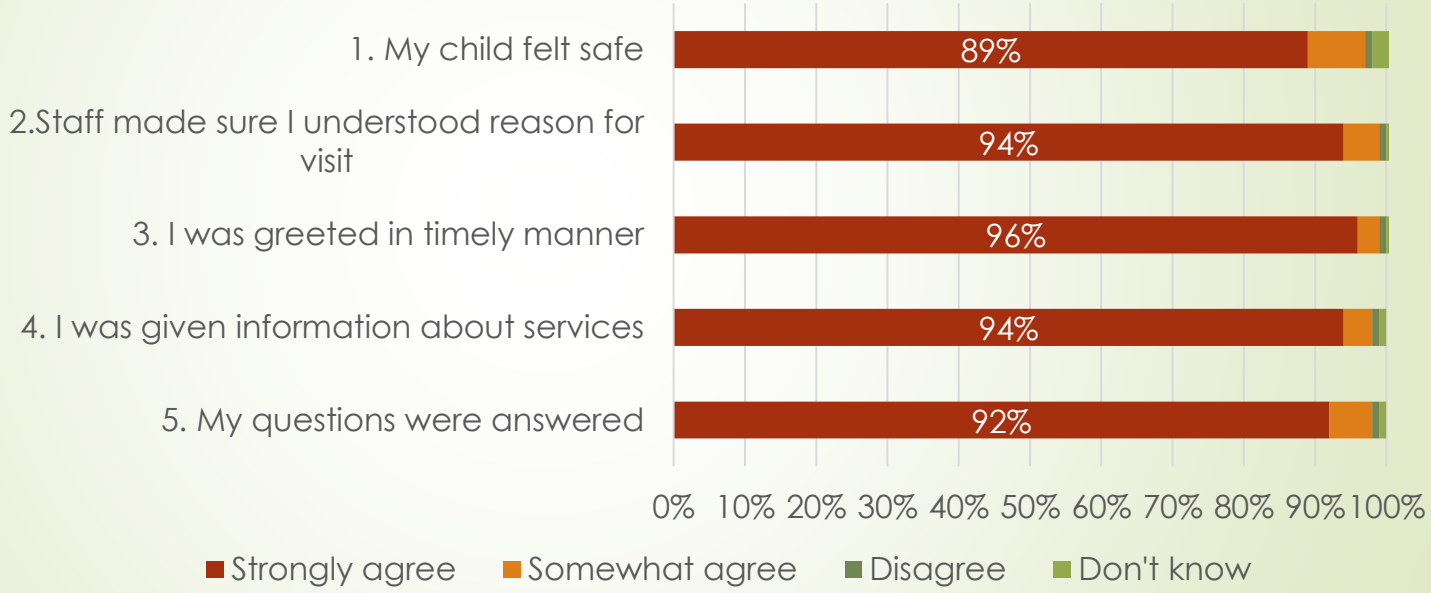
Initial Caregiver Survey Sample Characteristics (N=7,017)

CAC characteristic	Percentage
Regions	Midwest – 28%, NE – 9%, Southern – 45%, Western – 17%
Organizational Types	Nonprofit – 77%, Government – 11%, Hospital – 13%
Membership Status	Member – 98%, No – 2%
	Accredited – 86%, No – 14%
	Accredited – 86%, Other – 12% (Affiliate, Associate, Satellite), Nonmember – 2%

Initial Caregiver Survey Sample Characteristics (N=7,017)

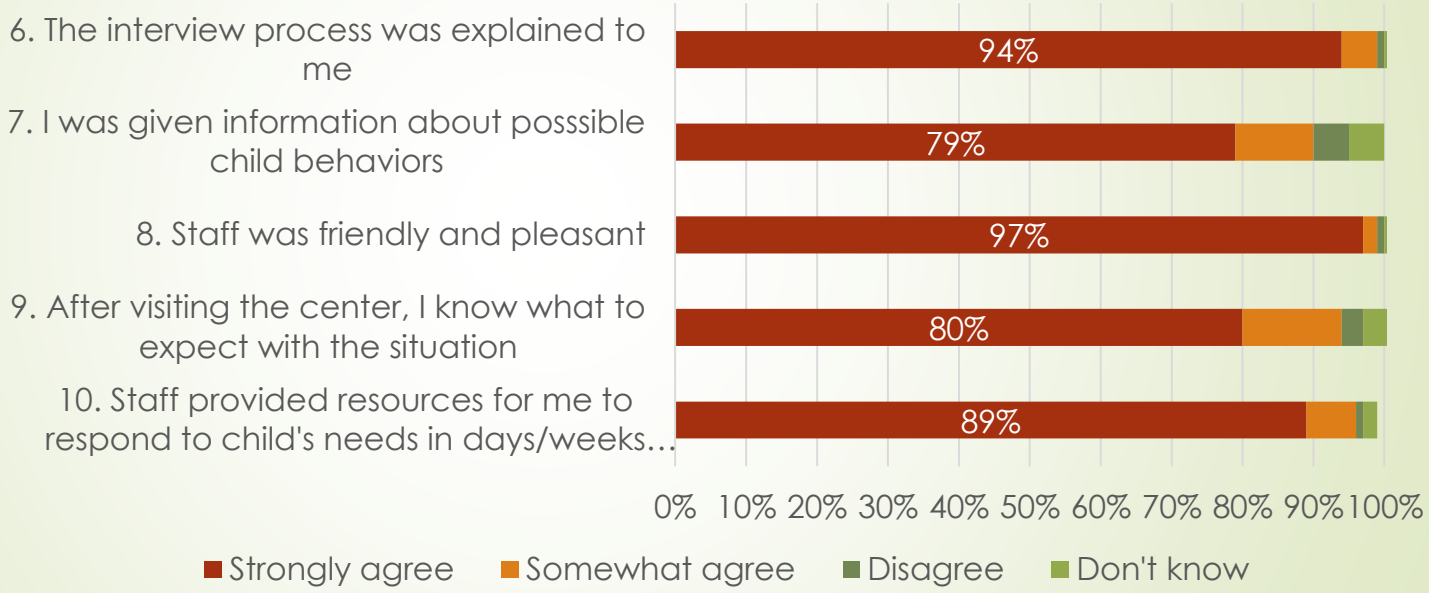
CAC characteristic	Percentage
Location	Rural – 43%, Suburban – 31%, Urban – 26%
Budget	$99,000 or less – 2%, $100,000 – 499,000 – 50%, $500,000 or more – 48%
Number of children served	199 or fewer – 16%, 200-499 – 40%, 500 or more – 44%
Colocation	Yes – 28%, No – 72%

OMS Initial Caregiver Survey (N=7,017)



No significant differences by case or cac characteristics

OMS Initial Caregiver Survey (N=7,017)



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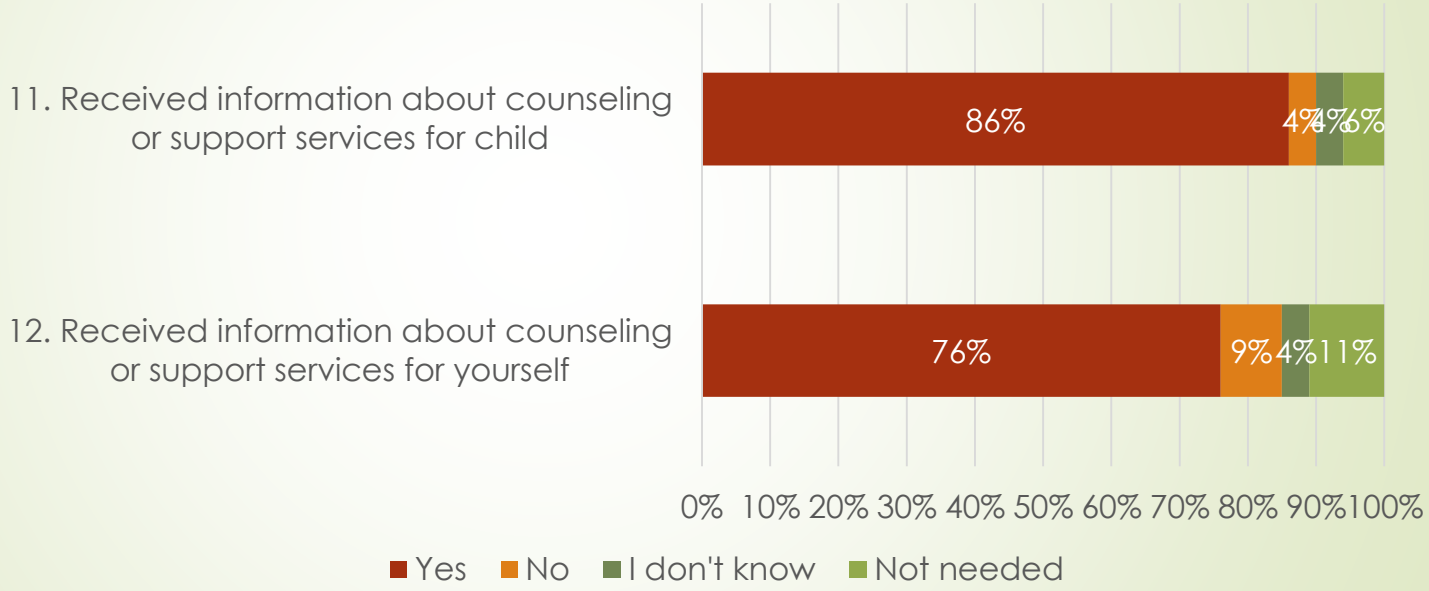

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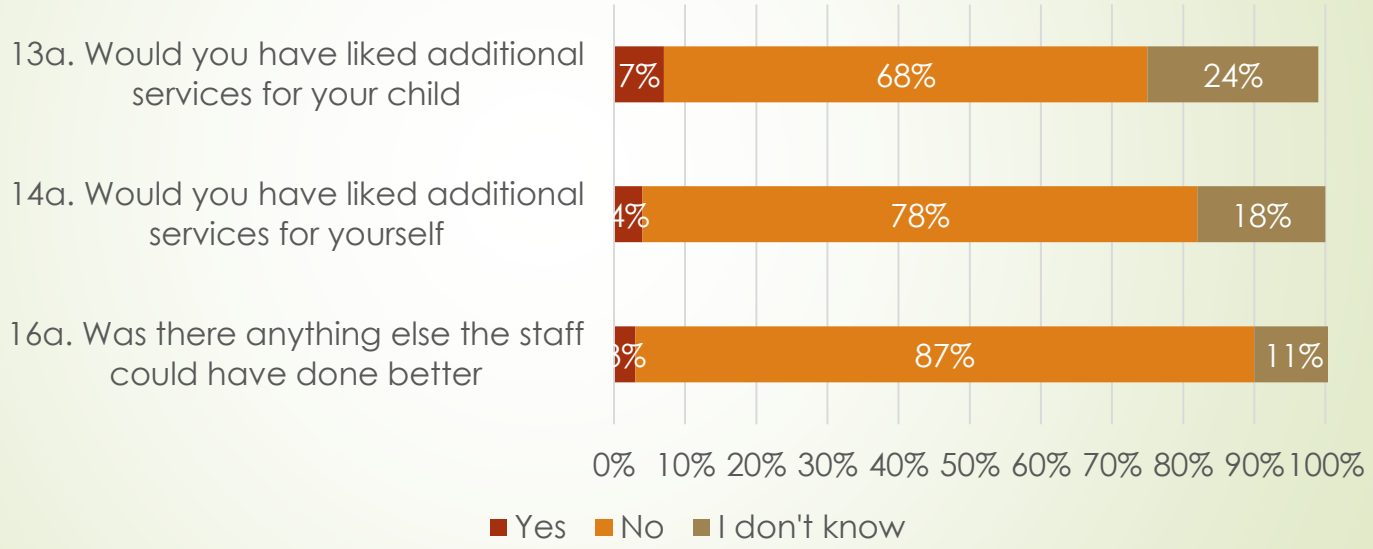


Spanish speaking caregivers want additional services for child compared to English speaking caregivers (17% vs. 7%)

Follow-up caregiver survey responses

Follow-up Caregiver Survey Sample Characteristics (N=5,184)

Case characteristic	Percentage
Child gender	Female – 72% Male – 28%
Child race/ethnicity	White – 63%, Black – 13%, Hispanic – 14%, Other – 10%
	Hispanic – 14% non-Hispanic – 86%
Child age	0 to 5 – 17%, 6 to 12 – 49% 13 to 17 – 34%
Caregiver language	English – 98% Spanish – 2%

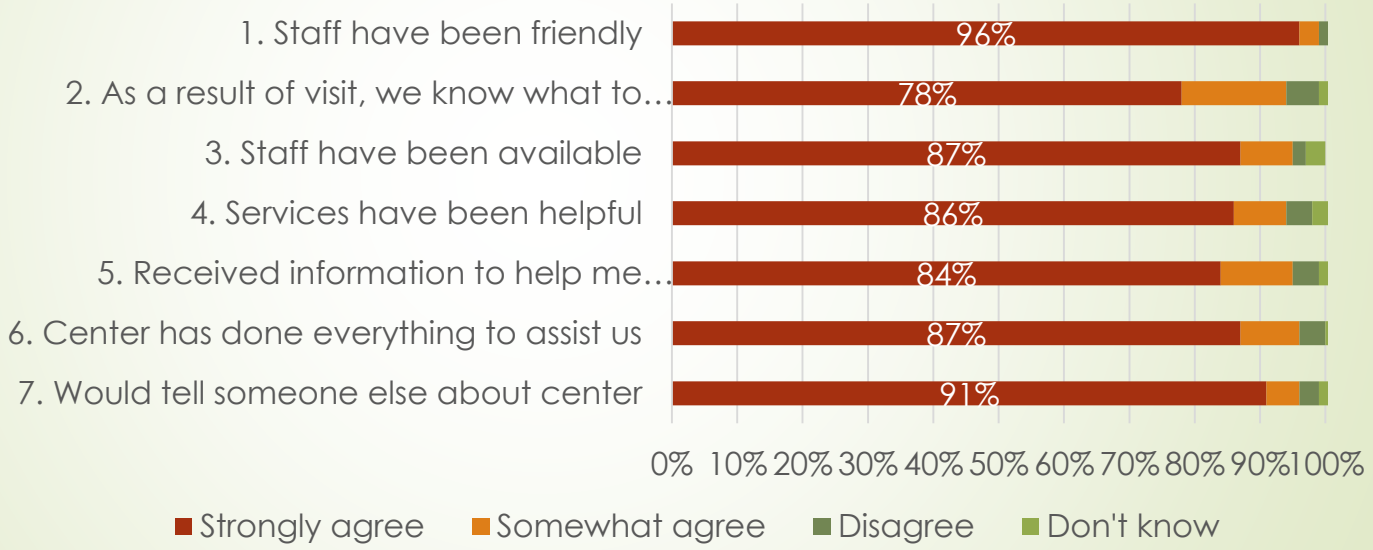
Follow-up Caregiver Survey Sample Characteristics (N=5,184)

CAC characteristic	Percentage
Regions	Midwest – 25%, NE – 6%, Southern – 56%, Western – 13%
Organizational Types	Nonprofit – 77%, Government – 11%, Hospital – 13%
Membership Status	Member – 98%, No – 2%
	Accredited – 89%, No – 11%
	Accredited – 89%, Other – 9% (Affiliate, Associate, Satellite), Nonmember – 2%

Follow-up Caregiver Survey Sample Characteristics (N=5,184)

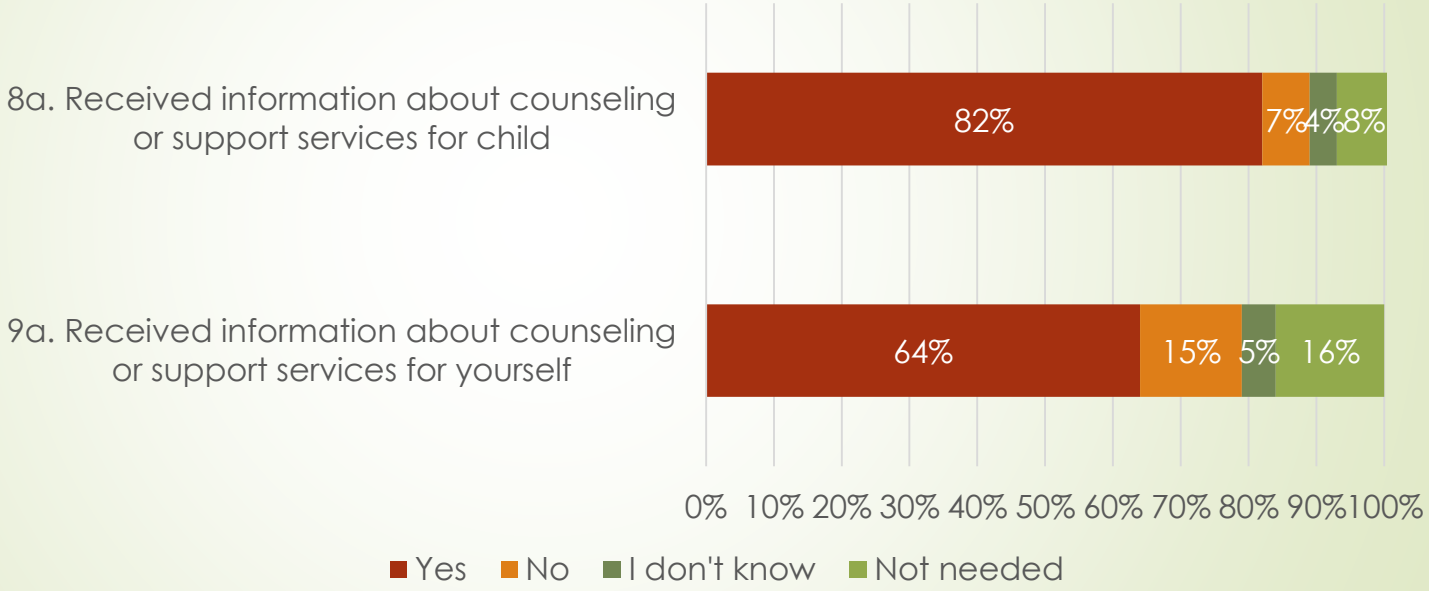
CAC characteristic	Percentage
Location	Rural – 43%, Suburban – 36%, Urban – 21%
Budget	$99,000 or less – 2%, $100,000 – 499,000 – 47%, $500,000 or more – 51%
Number of children served	199 or fewer – 16%, 200-499 – 39%, 500 or more – 45%
Colocation	Yes – 30%, No – 70%

OMS Follow-up Caregiver Survey (n=5,184)



No significant difference case or cac characteristics

OMS Follow-up Caregiver Survey (n=5,184)



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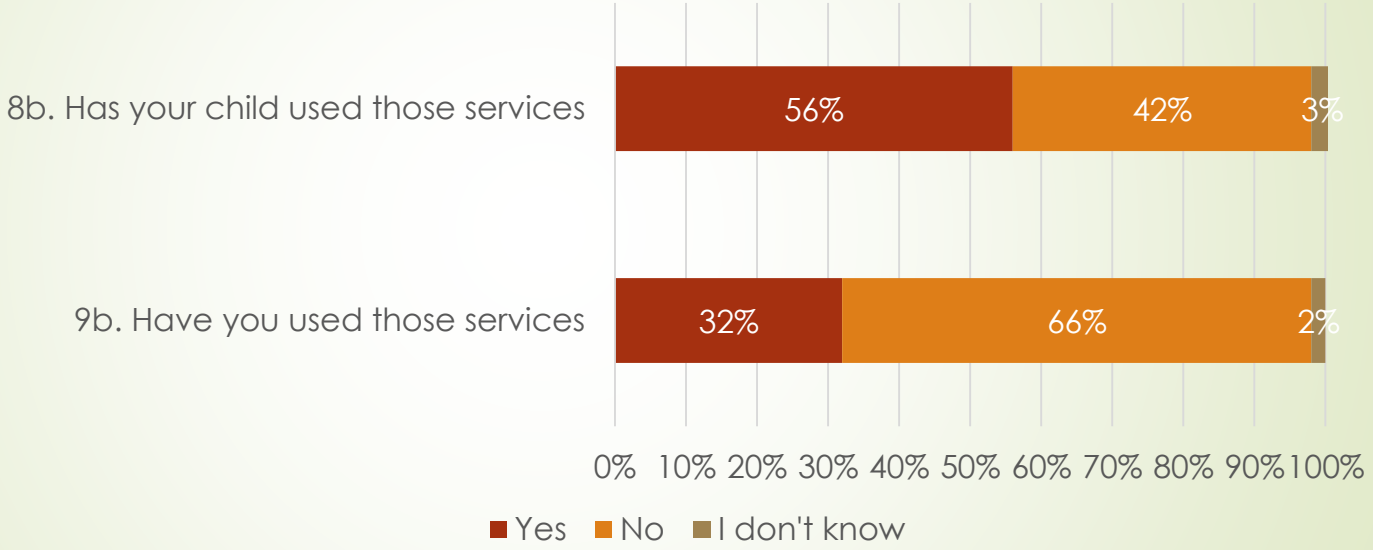
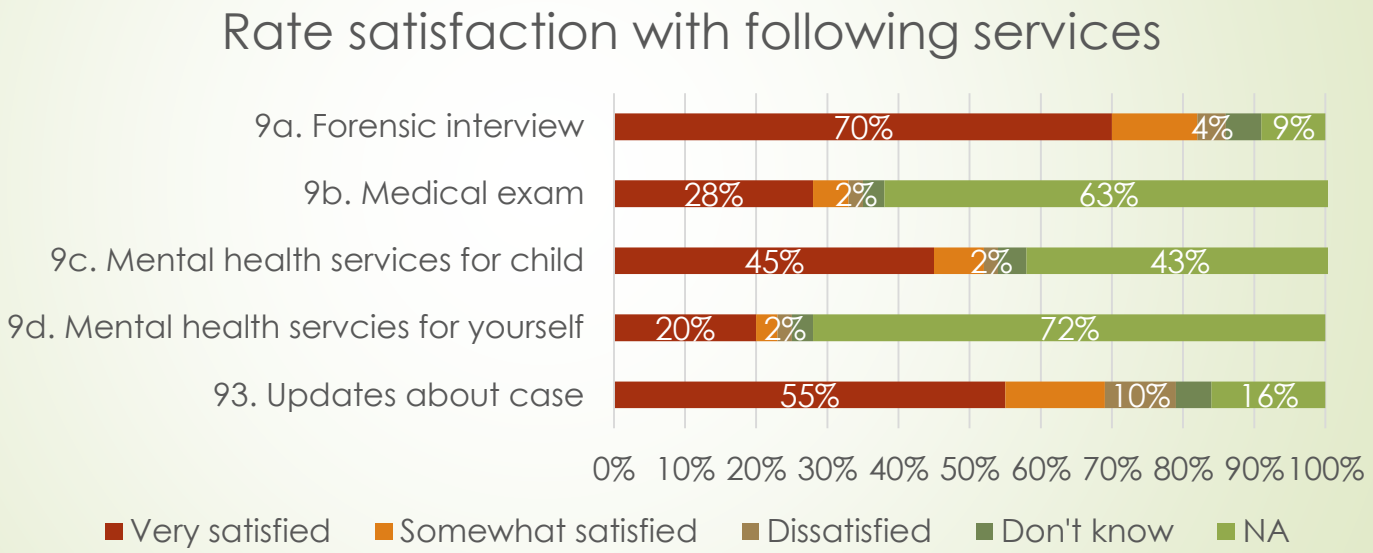


Children (61% v 54%) and caregivers (38% v 29%) served by co-located cacs use services more than those at non co-located cacs

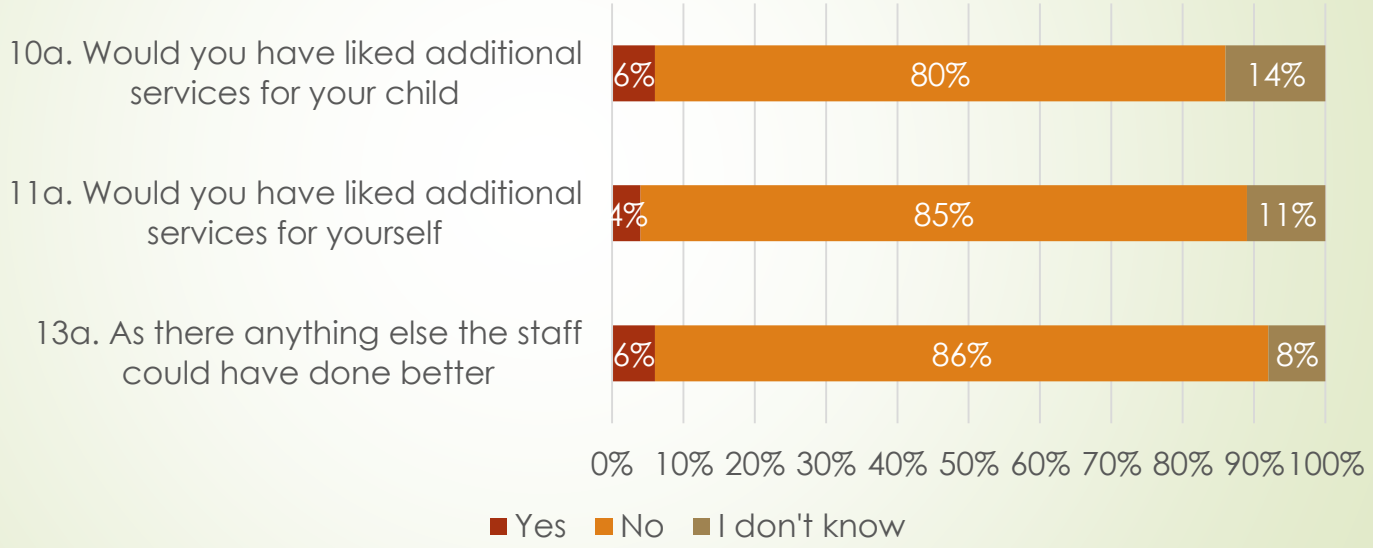
Hispanic caregivers(41% v 25-32%) and Spanish speaking caregivers (59% v 31%) use services for themselves more than other caregivers

OMS Follow-up Caregiver Survey (n=5,184)



No significant differences by case or cac characteristics

OMS Follow-up Caregiver Survey (n=5,184)



No significant differences by case or cac characteristics

MDT survey responses

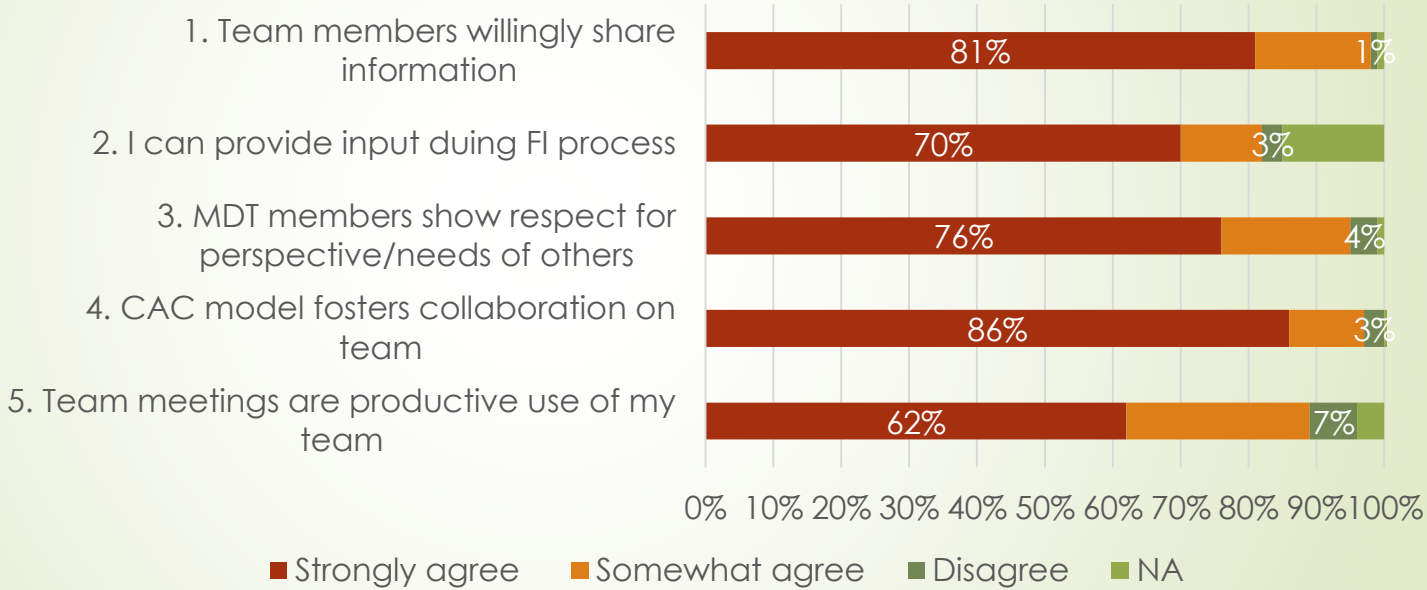
MDT Sample Characteristics (N=2,588)

Characteristic	Percentage
Professional discipline	LE/ prosecution - 44%, CPS – 21%, Advocate – 10%, CAC – 7% ,Other 17%
Years working with this CAC	<1 year – 16%, 1-3 years – 35%, 4-6 years, 19%, 7 or more – 29%
Regions	Midwest – 25%, NE – 15%, Southern – 46%, Western – 14%
Organizational Types	Nonprofit – 75%, Government – 13%, Hospital – 11%
Membership Status	Member – 97%, No – 3%
	Accredited – 85%, No – 15%
	Accredited – 85%, Other – 12% (Affiliate, Associate, Satellite), Nonmember – 3%

MDT Sample Characteristics (N=2,588)

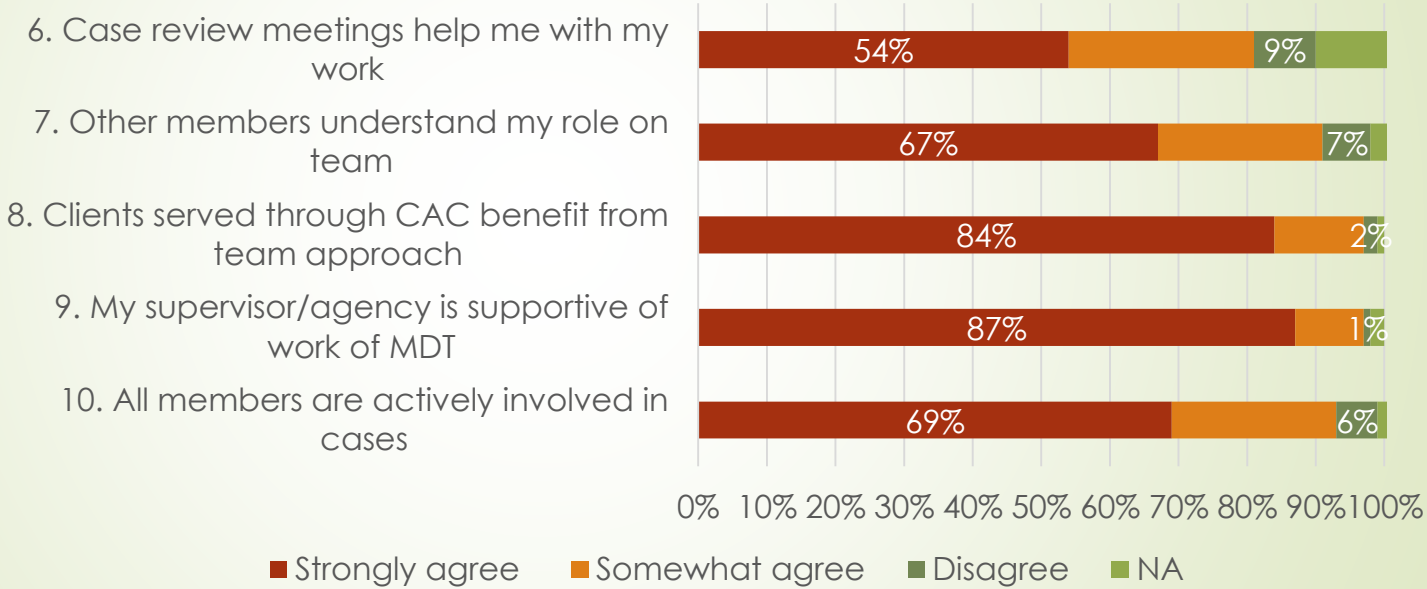
Characteristic	Percentage
Location	Rural – 47%, Suburban – 33%, Urban – 19%
Budget	$99,000 or less – 3%, $100,000 – 499,000 – 58%, $500,000 or more – 39%
Number of children served	199 or fewer – 19%, 200-499 – 39%, 500 or more – 43%
Colocation	Yes – 37%, No – 63%

OMS Multidisciplinary Team Survey (N= 2,588)



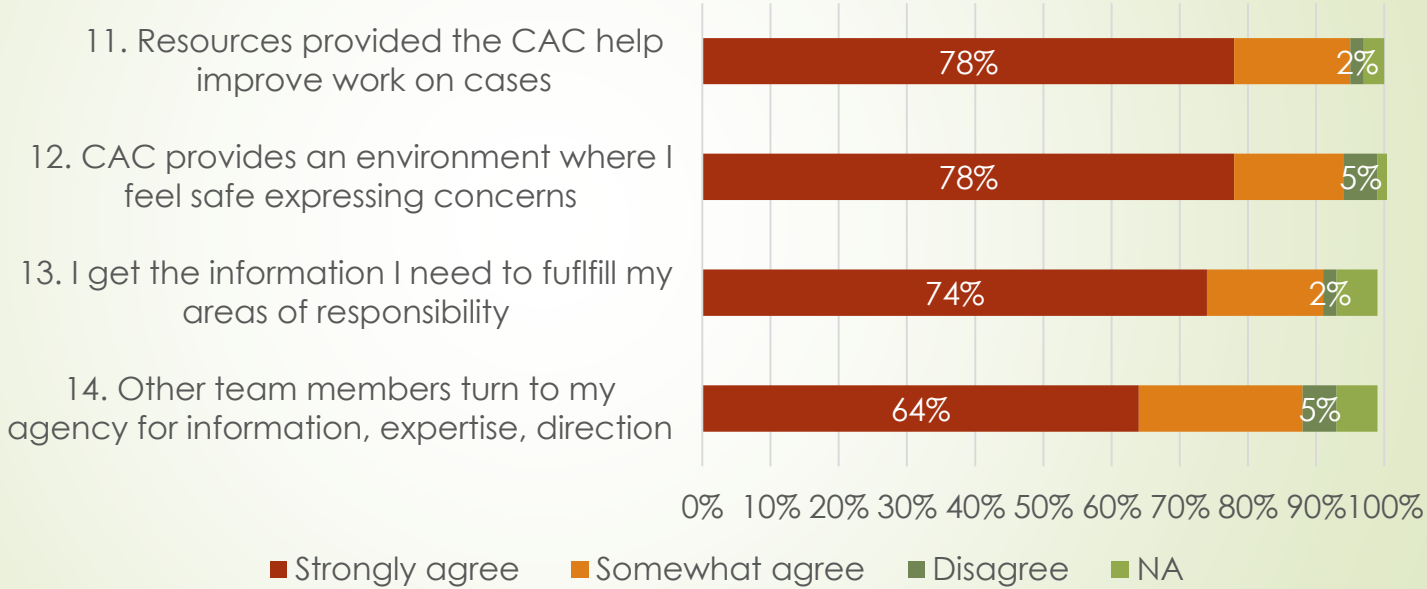
No significant differences by respondent or cac characteristics except -- Q1. Nonmember CACs (91%) less likely to agree that members willingly share information compared to member CACs (99%)

OMS Multidisciplinary Team Survey (N= 2,588)



No significant differences by respondent or cac characteristics except -- Q10. Nonmember CACs (81%) less likely to agree that all members are actively involved compared to member CACs (94%)

OMS Multidisciplinary Team Survey (N= 2,588)



No significant differences by respondent or cac characteristics except -- Q14. Nonmember CACs (79%) less likely to agree that other members turn to agency compared to member CACs (95%)

Summary of Findings:
Respondent characteristics and survey results

	Initial caregiver	Follow-up caregiver	Multidisciplinary survey
Child gender	--	--	NA
Child race/ethnicity	--	Hispanic crgs use more services for themselves (41% v. 25-32%)	NA
Child age	--	--	NA
Caregiver Language: Spanish speaking (vs. English speaking)	Spanish speaking crgs want more services for child (17% v. 7%)	Spanish speaking crgs use more services for themselves (59% v. 31%)	NA
MDT Professional discipline	NA	NA	--
MDT years working at CAC	NA	NA	--

Summary of Findings:
CAC characteristics and survey results

	Initial caregiver	Follow-up caregiver	Multidisciplinary survey
Regions	--	--	--
Organizational Type: Gov and nonprofit vs hosp	--	--	--
Membership Status: Accredited vs other vs non Member vs non	--	--	Nonmember CACs less likely agree share, all active, turn to agency (79-91% v. 93-99%)
Location	--	--	--
Budget Size	--	--	--
Number of Children Served	--	--	--
Colocation	--	Children (61% v 54%) and crgs (38% v 29%) at co-located CACs use services more than those at non co-located CACs	--

Take home messages

- ✓ Most responses on all surveys extremely positive
  - Initial caregiver survey: 94% - 99% agree
  - Follow-up caregiver survey: 95% - 99% agree
  - MDT survey: 90% -98% agree
- ✓ Quite an accomplishment to have thousands of response all so positive: CACs should celebrate
- ✓ Little variation across CAC characteristics – but there is a need to understand more in-depth how variation across CACs impacts outcomes
- ✓ Given the uniformity in OMS results, do we need additional outcome measurement to support program improvement?

Making data-informed improvements at Children's Advocacy Centers

Outcomes for many CAC functions are understudied

- Family advocacy
- Case review
- Linkage to mental health services
- Forensic medical examinations
- Criminal investigation
- Child protection investigation
- Forensic interview peer review

- Below we report on two initiatives to stretch the boundaries on CAC outcome measurement

Providing Access Toward Hope and Healing

A CAC Based Initiative to Increase Access and Engagement in Children's Mental Health Services Following Sexual Abuse Allegations

Stephen Budde, PhD, LCSW, Juvenile Protective Association

Wendy Walsh, PhD, Crimes against Children Research Center, University of New Hampshire

Includes contributions from:

Jan Waters, M.S., L.C.P.C., ChicagoCAC

Katy Irving, M.S., L.C.S.W., ChicagoCAC

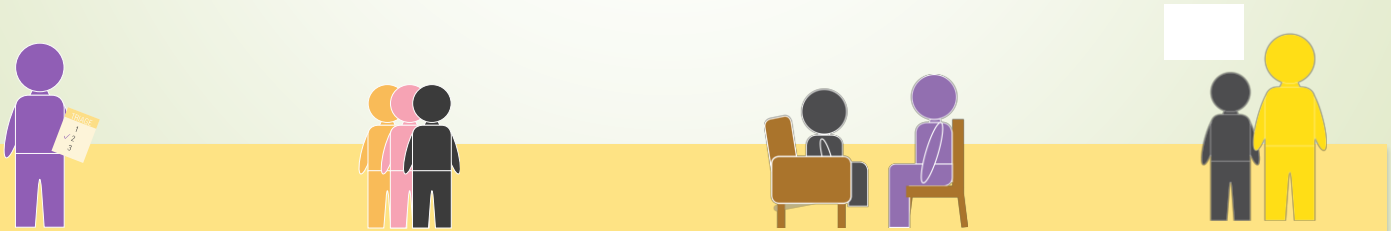
Akadia Kacha-Ochana, ChicagoCAC

PATHH Goals

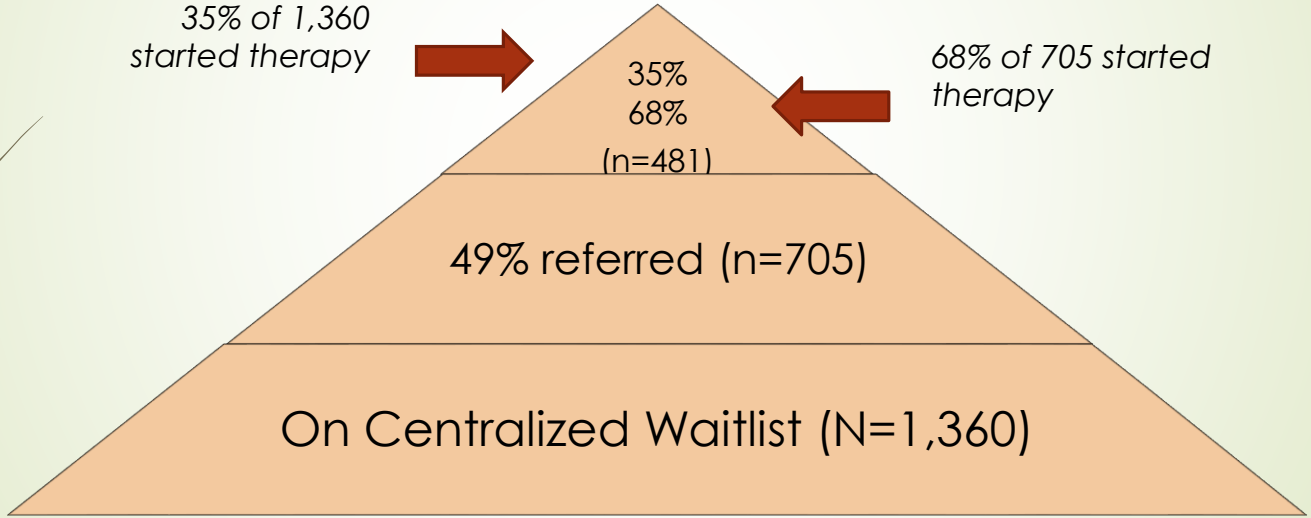
1. Understand current capacity and need for mental health treatment in the city of Chicago
2. Improve accessibility of victims of sexual abuse to evidence-based, trauma-informed treatment through effective case coordination, improved service delivery and expansion of resources
3. Increase knowledge and awareness of child sexual abuse among families in Chicago that have been impacted
4. Measure and seek to improve efficacy of services provided to children who have experienced sexual abuse in the city of Chicago and increase access to trauma-informed treatment

PATHH Strategies

1. **Enhanced family advocacy services**
   a. Family screening tool
   b. Motivational Interviewing
2. **Improved referral system**
   a. Triage
   b. Centralized wait list
   c. Consistent follow-up
3. **Expanded capacity**
   a. Funded slots
   b. Hope and Healing groups
   c. Learning Community
4. **Enhanced evaluation and case tracking**



Sample & Rates of Engagement



Data is from April 2012 to July 2015

Developing a methodology for assessing the contribution of multidisciplinary teams

Elizabeth Cross, Cross Associates

Theodore Cross, University of Illinois

Carol Berger, Wynona's House, Newark, NJ

Developing a conceptual model

- Observation of multidisciplinary case review teams
- Collaboration with MDT Coordinator
- Identifying specific ways in which MDTs help children and families
- Future goals
  - Develop a conceptual model of MDT functioning
  - Conduct research to assess the effect of MDTs

Key component of the conceptual model: A taxonomy of MDT functions (draft)

1. Providing information
2. Sharing expertise.
3. Monitoring the child and family.
4. Holding team members accountable
5. Supporting team members

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