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Practice in U.S. Children's Advocacy Centers: Results of a Survey of CAC Directors

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Children's Advocacy Centers (CACs) are central to the response to child sexual abuse and other child maltreatment in the United States. CACs coordinate the investigative and service response to child victimization, and support child survivors and their families to reduce the stress that follows a child maltreatment allegation. Multidisciplinary teams (MDTs) are the mechanism CACs use to coordinate investigation and service delivery in a centralized, child-friendly setting. CACs use forensic interviewers specially trained to work with children; and offer children and families medical, therapeutic, advocacy services, and other services. (Cross et al., 2008; National Children's Alliance, 2019b). CACs help adult family members as well as children, because child victimization is traumatic for the entire family (van Toledo & Seymour, 2016), and because this helps bolster the non-offending caregivers' support for the child, which research shows is important for reducing the impact of child victimization and improving outcomes (see Malloy & Lyon, 2006; National Children's Alliance, 2017). In its 2020 annual report, the National Children's Alliance (NCA), the accrediting organization for CACs, reported 924 CACs in the U.S. (National Children's Alliance, 2020). Canada and Australia have developed similar networks of children's advocacy centers (Child & Youth Advocacy Centers, 2021; Hall, 2021), and a CAC was established in Israel 20 years ago (Taylor et al., 2021). A related approach, the Barnahus model, originated in the Nordic countries, and is now spreading throughout Europe through the efforts of the PROMISE Barnahus network (Johansson & Stefansen, 2020).

Most research on CACs has examined individual CACs or small sets (see Elmquist, et al., 2015; Herbert & Bromfield, 2016), so data are limited on practice across the range of CACs in the United States. Presenting results from a U.S. survey of CAC directors, the current study focuses on the composition of MDTs and the forms of assistance CACs provide.

The NCA (2017) has a set of standards that CACs must meet to be accredited. These standards set expectations about what CAC practice should look like. The standards state that the core MDT for CACs must include representatives from law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and CAC staff, and may be expanded to include other professionals as well. Involvement of other agencies may be indicated given that CACs are dealing with an increasingly wide range of victimization. The original article on Children's Advocacy Centers focused on child sexual abuse (Cramer, 1985), but CACs deal with physical abuse, child witnessing of violence, neglect, drug endangerment (National Children's Alliance, 2021), commercial sexual exploitation of children (Brandt, et al., 2018), and domestic violence (Thackeray, Scribano, & Rhoda, 2010). Research internationally has found that domestic violence

(now more commonly called *intimate partner violence*) often co-occurs with child abuse (Appel & Holden, 1998; Sijtsema, Stolz, & Bogaerts, 2020). CACs are also devoting increased attention to sexual abuse perpetrated by children and youth (Sites & Widdiefield, 2020), including sibling abuse (Taylor, et al., 2021).

The NCA also has standards about what services a CAC needs to offer children and caregivers. One standard states that "All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a provider with specialized training" (National Children's Alliance, 2017, p. 52). Another standard states that an MDT in a CAC must provide "evidence-based, trauma focused mental health services for child victims and caregivers" (National Children's Alliance, 2017, p. 65). Some CACs provide mental health services themselves and other CACs ensure that other organizations in the MDT provide mental health services (Cross, et al., 2008). The provision of victim advocacy is another NCA standard that encompasses several specific types of assistance that a victim or family advocate provides to children and caregivers. Among the specific supports, interventions and services included within victim advocacy are the following: crisis assessment and intervention; risk assessment; safety planning and support for children and family; assessment of individual needs and cultural considerations; provision of education and access to victims' rights and crime victims' compensation; help with getting concrete services (such as housing, protective orders, domestic violence intervention, food, transportation, and public assistance); access to transportation to interviews and services, treatment and other case-related meetings; engaging children and families in the investigation and/or prosecution; updating the family on legal actions; court education and courthouse/courtroom tours, support, and accompaniment; and case management (see NCA, 2017, p. 47). However, it is not clear how frequently CACs provide specific services included within the broad rubric of victim advocacy. For example, some CACs offer structured programs to educate child survivors about court (e.g., Lifehouse Child Advocacy Center, 2013) and some lack these programs. Some CACs provide support groups for caregivers (e.g., Children's Advocacy Center of the Bluegrass, 2021) and other CACs do not. Thackeray and colleagues 2010 survey (Thackeray, et al., 2010) found that less than one-third of CACs implemented universal assessment of domestic violence with caregivers.

Two surveys of CACs have examined what disciplines were represented on MDTs and the services CACs provided. Jackson (2004) conducted semi-structured interviews with 117 CAC directors selected by stratified random sampling. Consistent with the NCA standard, all CACs in the sample had law enforcement, child protective services and prosecution representation on their MDT. Large majorities also had representation from mental health professionals (87%), medical professionals (86%), and victim advocates (80%). Other professions were represented on a minority of multidisciplinary teams: schools (21%), juvenile courts (17%), assistant district attorneys (17%), probation and parole officers (10%), court-appointed special advocates (9%), and domestic violence providers (6%). The following components were each present in 92% to 100% of CACs in the sample: child-friendly facility, multidisciplinary team, child investigative interviewing, medical examinations, mental health services, victim advocacy, case review, and case tracking.

Herbert, Walsh, and Bromfield, (2018) found that the following disciplines participated in multidisciplinary teams routinely in 90% or more of CACs: child protective services, police, forensic interviewer, prosecutors/district attorney, and mental health professionals—again, consistent with the NCA standard. It was also common for medical professionals to participate in MDTs (79%), while other disciplines participated in MDTs in fewer CACs: juvenile court (35%), rape crisis counselors/advocates (30%), domestic violence counselors/advocates (25%), and other agencies (26%). The relatively large percentage in the "other" category suggests that more can be learned about other specific agencies that may participate in the MDT in a meaningful proportion of CACs.

Herbert et al. (2018) also provided information from the survey on how frequently seven different categories of services were provided at the CAC off-site by other agencies. The CACs almost universally provided forensic interviewing (> 99%), victim advocacy (99%), mental health services (95%), and medical services and/or examinations (95%). A majority provided rape crisis services (57%) and domestic violence services (52%), and 41% provided other services, which were not specified in the research.

Herbert et al. (2018) conducted a cluster analysis that sorted CACs into three groups. Basic CACs provided basic CAC functions with less agency participation in MDTs and fewer services. Aggregator CACs had more services but lower participation on the MDT. Full-Service CACs had extensive co-location, participation in the MDT, service delivery and governance structures. The NCA compiles statistics from the individual CACs about CAC cases. In 2020, 64% of CAC cases involved sexual abuse, 20% physical abuse, 8% witness to violence, 7% neglect, 3% drug endangerment, and 7% other types of abuse (National Children's Alliance, 2021). NCA statistics are also available on the frequency of the following services: onsite forensic interviewing (67% of children), referral to counseling (30%), counseling or therapy (29%), medical exams and/or treatment (24%), and offsite forensic interviews (4%).

These results leave several questions about Children's Advocacy Centers' practice unanswered, however. The biggest gap is the limited information about the specific forms of assistance that Children's Advocacy Centers provide to child victims and their families. The NCA Standards require CACs to provide victim advocacy, but it is not clear how frequently CACs provide the different specific supports, interventions, services encompassed by the term victim "advocacy." In addition, Herbert and colleagues (2018) cluster analysis suggests that CACs vary on which forms of assistance they will provide depending on whether they are a Basic, Aggregator, or Full Service CAC. Information about this assistance could provide a more complete profile of what CACs offer. This could help identify strengths across the community of CACs nationally and gaps that could be addressed with further program development. One particular value of assessing strengths and gaps for CACs is to help us understand how prepared the community of CACs is to deal with the increasingly wide range of victimization for which MDTs and a coordinated approach are recommended. The survey conducted for the present article replicates some of the questions from previous surveys, but also provides more detailed information on the kinds of help that CACs provide child victims and their families. In addition, it replicates Herbert and colleagues' (2018) assessment of representation on MDTs in CACs but provides more options to

specify which agencies are represented on the MDT, enabling us to learn more about the range of agencies that might participate.

Method

The first and second authors conducted a national online survey of CAC directors in the Spring of 2015. Questions for the survey were developed by consulting multiple published sources on the children's advocacy centers and by talking with numerous content experts. The authors also drew on their combined experience of over forty years of studying CACs.

At the authors' request, the NCA distributed an email invitation via its membership list to recruit participants. The email inviting participation included a link to a survey webpage in the Qualtrics online survey system (see www.qualtrics.com). Two reminder emails were sent out at regular intervals. The survey was kept open for approximately three months, and 222 CAC directors responded. The National Children's Alliance reported a total of 777 CACs at the end of 2014 (National Children's Alliance, 2014.) Thus, our sample represented approximately 28.6% of the CACs in the United States at that time. The research was approved by the Institutional Review Board of University of Illinois at Urbana-Champaign.

This article presents results from the survey regarding representation on the CAC's MDT and from questions about the services provided to children and to caregivers. To assess representation on the MDT, respondents were asked "Which of the following disciplines are represented on your team? (check all that apply)" and were presented with a list of 16 different types of professionals (listed in Table 1), as well as an "other (specify)" category. To assess the provision of different forms of assistance to children and caregivers, respondents were asked "How often does your Center offer each of the following types of assistance for child victim/witnesses?" and "How often does your Center offer the following types of assistance for involved caregivers (sometimes referred to as non-offending parents)?" The options presented to respondents for each of these questions are listed in Table 1. Note that using the wording "does your Center offer" meant that most items could encompass assistance on-site or off-site, provided by a CAC staff member or someone else, or provided by a partner agency based at the CAC. The wording of some items did distinguish between assistance offered at the Center versus externally.

Table 1

Types of Assistance Listed in the Survey

How often does your Center offer each of the following types of assistance for child victims/witnesses?
Individual counseling at the Center
Preparation for court appearances
Support groups at the Center
Medical exams
Legal assistance (e.g. related to dependency or juvenile court proceedings)
Case management
Safety planning
Referral to external sources for mental health services
Referrals to external sources for other support services (e.g., medical or substance abuse treatment)
Information about crime victim/witnesses' legal rights
Victim compensation application
Other (specify)
How often does your Center offer the following types of assistance for involved caregivers (sometimes referred to as non-offending parents)?
Individual counseling for parents at the Center
Preparation of parents for child's court appearances
Crisis intervention
Case management
Legal assistance for parents
DV risk assessment and safety planning
Referrals for DV services
Obtaining protective orders
Referral of parents to external sources for counseling or support services
Access to services (e.g., transportation, housing, financial, food assistance)
Information about victim/witnesses' legal rights
Information about civil remedies
Victim compensation application
Other (specify)

Results

Table 2 shows the percentages with which different disciplines were represented in the MDTs on the CACs in our sample. Large percentages (83.8% to 98.2%) of CACs had representation from all the core group of disciplines specified by the NCA standards (law enforcement, child protective services (CPS), prosecution, medical, mental health, victim advocacy, and CAC staff). Forensic interviewers were also represented on the vast majority of MDTs. Other professionals were represented in small percentages of MDTs.

Table 2

Disciplines Represented on Children's Advocacy Centers' Multidisciplinary Teams (N=222)

Variable	f	%
Law enforcement	218	98.2%
Child protection	217	97.7%
Prosecutor	214	96.4%
CAC staff	211	95.0%
Forensic interviewer	196	88.3%
Victim/witness advocate/assistant	192	86.5%
Health professional	186	83.8%
Mental health professional	202	91.0%
Juvenile court	85	38.3%
Rape crisis counselor/advocate	62	27.9%
DV counselor/advocate	50	22.5%
Schools	39	17.6%
Probation/parole	36	16.2%
GAL/CASA	35	15.8%
Other	22	9.9%
Sex offender treatment provider	14	6.3%
Child's attorney	8	3.6%

The following services were provided often or routinely to children by a majority of CACs: individual counseling at the CAC, preparation for court appearances, medical examinations, case management, safety planning, referral to external mental health providers, referral to other services, information on crime victim and witnesses legal rights, and victim compensation applications. The following services were provided often or routinely to caregivers by a majority of CACs (see Figure 2): crisis intervention, case management, referrals for domestic violence services, referrals for counseling or support services, providing access to other services (e.g., transportation, housing, financial, food assistance), information about victim/witnesses' legal rights, and victim compensation applications. Interestingly, even though most CACs provided children individual counseling on-site, more than one-quarter never did this, presumably because they did not have this capacity on-site and relied instead on their partnership with off-site mental health providers.

Figure 1

Assistance for child victim

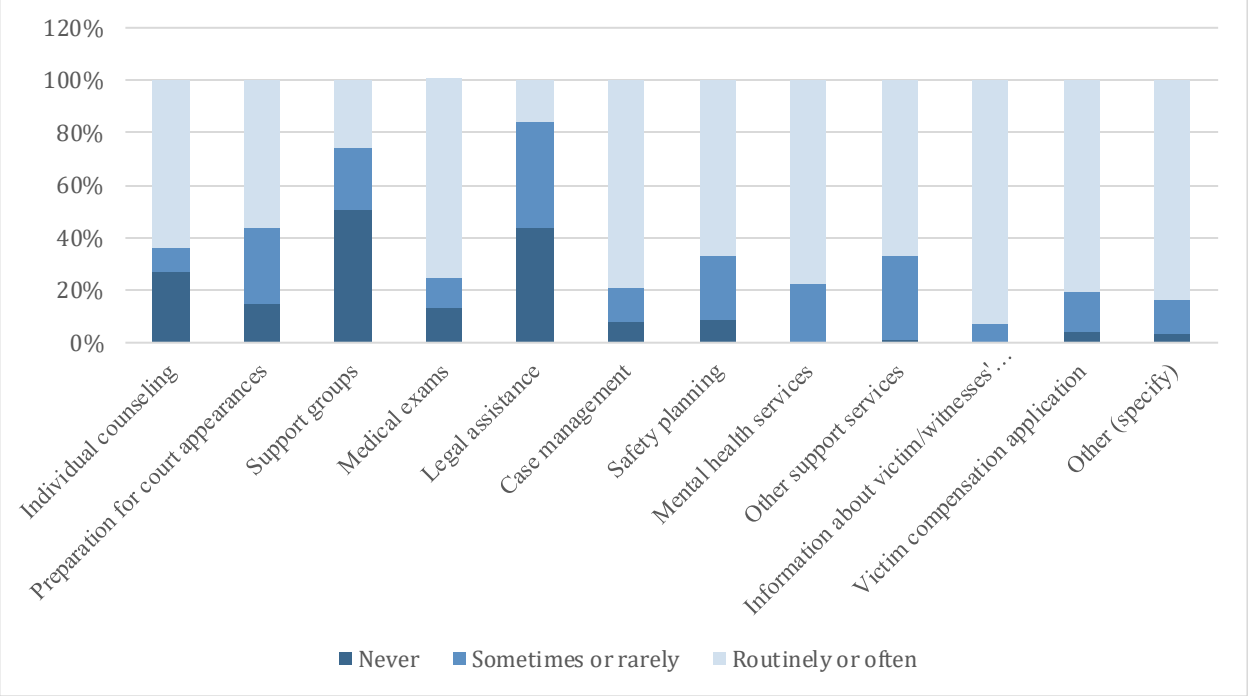
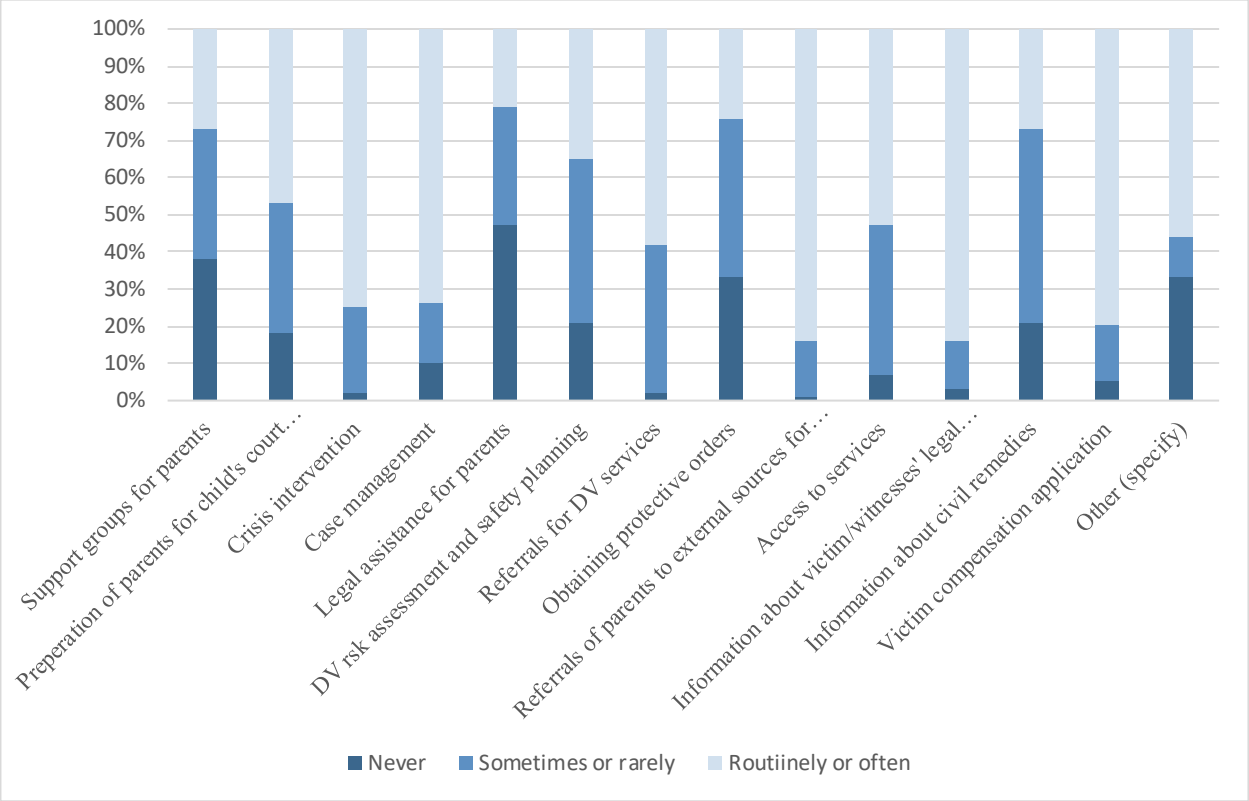


Figure 2

Assistance for caregivers



The availability of other types of assistance varied considerably across CACs. Over one-quarter of CACs often or routinely offered support groups for children, but almost half never offered this. Over one-quarter often or routinely offered support groups for caregivers, but more than one-third never did. Over one-third offered domestic violence risk assessment and safety planning, but more than one-third never offered this. Over one-quarter helped caregivers obtain protective orders, but almost one-half never did this. Over one-quarter provided caregivers information about civil remedies, but nearly half never provided this. Many respondents reported that they never offered children and caregivers legal assistance.

Discussion

The MDT core group of disciplines specified by the NCA standards are represented in the vast majority of CACs, with other disciplines represented in small proportions. These results are very similar to findings by Jackson (2004) and Herbert et al. (2018). These results suggest that CACs are generally successful at developing an MDT that meets standards in terms of representation and have the human capital to develop a coordinated response to child maltreatment.

The current study is unusual in that it provides statistics on the percentages of CACs offering a range of specific forms of assistance to children and their caregivers. It provides evidence of the wide range of actions CACs take to help, all consistent with the NCA standards.

The variability in the specific forms of assistance that CACs provide suggests that CACs develop in different ways. This variability is consistent with Herbert et al.'s (2018) distinction between Basic CACs and Aggregator and Full-Service CACs. It is unclear to what extent not providing a service stemmed from lack of capacity versus a CAC not including a service within its mission. The fact that a CAC did not provide a specific form of assistance does not necessarily mean that children and caregivers lacked that type of help in their community—a CAC could refrain from providing a service because another agency in the MDT is already providing it.

Small but meaningful proportions of CACs have representation on their MDTs from disciplines that are not typically centrally involved in child maltreatment investigation and services but could play a critical role in some cases. One can imagine the benefit. For example, if the offender in a child sexual abuse case is a minor, it can be useful to collaborate with juvenile court professionals. If the victim in a sexual abuse case is an adolescent, both rape crisis centers and CACs may respond at different points, and it may help the youth if they share information and coordinate service delivery. More research is needed on what it means functionally to participate in an MDT and specifically how it affects the quality of the response, and whether lack of representation on an MDT diminishes coordination in a way that reduces the quality of the response to victims or is compensated by other linkages that CACs have with other disciplines. More research is needed in general on the coordination between the CAC response and other disciplines.

One noteworthy finding is how commonly a response to domestic violence is a feature of CAC practice. Over half of CACs conducted interviews for exposure to domestic violence. Over half of CACs often or routinely provided referral for domestic violence services and over one-third often or routinely provided domestic violence safety planning. This attention to domestic violence services is not surprising given the considerable overlap between cases of child abuse and domestic violence. Research in several countries has identified a need for a coordinated response to child abuse and domestic violence, and assessed programmatic innovations to provide it, in such countries as Australia, Canada, New Zealand, and the United States (Cross, et al., 2012; Nikolova, et al., 2021; Wills,Ritchie, & Wilson, 2008). Yet a number of CACs never provided assistance related to domestic violence. CACs' variability in the response to domestic violence is consistent with Thackeray and colleagues (2010) survey results. Despite the overlap between child abuse and domestic violence and the frequency with which CACs respond to domestic violence, only 10.1% of CACs in our sample had domestic violence advocates on their MDTs. One factor may be what has been described as "troubled relationships" between CPS workers and domestic violent professionals (Postmus & Merritt, 2010, p. 310), who may clash because of their differing emphasis on the safety of the children and the safety of the caregiver. Given the profile of domestic violence among the problems that CACs deal with and the number of CACs that are not providing services related to domestic violence, it may be beneficial if domestic violence advocates were more frequently represented on multidisciplinary teams.

Limitations

We need to take study limitations into account in interpreting the results of this research. Only a minority of CAC directors participated in the research, and the CACs in the sample may not be

representative of the entire population of CACs. Another limitation is that the data were collected five years prior to the writing of this article. NCA standards have changed since then; for example, the 2017 revision made such changes as establishing clearer benchmarks for meeting standards and adding training requirements for the victim advocacy standard (National Children's Alliance, 2017). However, the changes in the standards do not seem likely to alter conclusions from our findings substantially.

An additional limitation is some ambiguity in how we interpret results on types of assistance for children and caregivers. We do not know to what degree respondents' ratings of frequency of offering assistance is affected by the frequency with which a child or family needs that assistance. Yet another limitation of the survey is that it did not assess the strengths of CACs' partnerships with allied agencies, which may compensate for missing services at the CAC. These limitations suggest that we cannot fully assess what CACs offer children and families without more in-depth research about how cases are handled and what specific supports, interventions and services are provided by every member of the MDT that responds once a CAC case is initiated.

Conclusion

The current research suggests that CACs are meeting NCA standards but vary to some degree in the specific forms of assistance they provide. They also suggest that CACs may want to consider adding more types of professionals to their MDTs, such as rape crisis counselors, juvenile court professionals, and domestic violence service providers. Yet much remains to be learned. Unfortunately, conducting research on CACs is difficult, since most CACs are not affiliated with research institutions, they lack resources to fund research, and CAC research has not been a priority of research funding agencies. We recommend that CACs develop stronger links with university departments and advocate for more research funding, to address the limitations in knowledge about the functioning and impact of CACs. One important topic is the linkage between CACs and domestic violence. Developing greater knowledge about how CACs can help children and families is likely to improve services for thousands of children and families across the country.

Recommended Citation

Cross, T.P., Whitcomb, D. & Maran, E. (2022). *Practice in U.S. Children's Advocacy Centers: Results of a Survey of CAC Directors*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Acknowledgments

The authors are grateful to Teresa Huizar for her assistance in conducting this research.

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