UNIVERSITY of DENVER

COLORADO EVALUATION AND ACTION LAB

Working Together:

The Impact and Caregiver Perceptions of a Multidisciplinary Team (MDT) Response to Child Abuse and Neglect Investigations

Report Highlights:

A multidisciplinary team (MDT) approach to child abuse and neglect investigations is associated with higher substantiation rates of abuse and/or neglect. Relative to comparison cases, an MDT approach had 3.06 times higher odds of substantiation. MDT investigations were also more thorough and more likely to involve kin out-of-home placements than comparison cases.

Caregivers perceive strengths to leverage and limitations to address in the MDT process. Caregivers perceive MDT members as supportive, validating, and respectful when they engage in actions such as offering resources, listening, answering questions, and conveying empathy. MDTs can enhance communication and follow-up strategies to engage caregivers during investigations.

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Report Number: 18-05A **Date:** October 2019

Abstract

This study assessed the impact of a multidisciplinary team (MDT) response used in an urban county as well as caregiver perceptions of the investigation process. Following child abuse and neglect reports, children and their families can become involved in investigations that span multiple government systems including child welfare, criminal justice, and health agencies. The multi-system response may require families to interact with police officers, child welfare workers, and health providers.

Data were analyzed in a single urban county in which families were ordered by law enforcement to meet the following day with representatives from the MDT agencies. In addition to coordinating the multi-system investigation, the MDT sought to ensure that caregivers understood the investigation process and could participate fully in efforts to meet their children's needs. Interviews with 32 caregivers were used to assess perceptions of the investigation.

Analyses of administrative data revealed that, relative to comparison cases, MDT cases were three times more likely to result in substantiated allegations; took an average 1.72 days longer to investigate than comparison cases; had more documented contacts during the investigation; and resulted in more out-of-home placement in the first 90 days after the referral allegation. Caregiver interviews revealed that participants perceived both strengths and limitations of the MDT response. Participants' responses emphasized that clear communication is essential to caregiver engagement, during the initial days when the investigation begins, and over time.

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Acknowledgements

This research was supported by the Colorado Evaluation and Action Lab of the University of Denver. The opinions expressed are those of the authors and do not represent the views of the Colorado Lab or the University of Denver. Thank you to Kristin Klopfenstein for feedback on the project; undergraduate research assistants from the Traumatic Stress Studies Group (Margaret Port, Francesca Dino, Hannah Branit, Avery Stackle, Madison Hakey, Sandra Dominguez, Veronique Calmels, and Halley Pradell); participants; and government partners who made this work possible.

Data Sources

Two types of data were used. First, administrative data from an urban county's child welfare division included all child abuse and neglect referrals since 2017. In addition, administrative data from this urban county's law enforcement department contained detailed information on all child abuse and neglect cases involving multidisciplinary teams. Lastly, interviews were conducted with 32 caregivers involved in investigations focusing on perceptions of the investigative process.

Suggested Citation

DePrince, A., Dmitrieva, J., Christl, M-E, Olomi, J., Rosenthal, A., & Wright, N. (October 2019). *Working together: The impact and caregiver perceptions of a multidisciplinary team (MDT) response to child abuse and neglect investigations* (Report No. 18-05A). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver.

Introduction

Child abuse and neglect put children at risk for poor health and academic outcomes as well as juvenile justice involvement.[1,2] Child welfare services may help mitigate negative outcomes[3] although services such as non-kin out-of-home placement have been linked to deleterious child outcomes.[4] Caregiver engagement with the child welfare system averts out-of-home placements and improves child outcomes,[5] pointing to the importance of engaging caregivers.

The MDT approach to reports of child abuse and neglect differs from "business as usual" by prioritizing coordination…

When child abuse and neglect are reported, child welfare is only one of the systems that responds. The criminal justice and health systems are also usually required to be involved. The multi-system response can require children and families to interact with police officers, child welfare workers, and health providers for forensic exams. In the face of this complex investigation process, caregivers may become overwhelmed, confused, intimidated, or alienated, which can decrease their engagement with child welfare action plans.[6] Decreased caregiver engagement can negatively affect child outcomes, including increasing out-of-home placements.[7]

Recognizing the complexity of multi-system responses, practitioners and policymakers have long called for a multidisciplinary team (MDT) approach to better coordinate across systems. The MDT approach differs from "business as usual" by prioritizing coordination across the different professionals involved in the investigation. For example, MDT approaches might involve sharing information about cases or coordinating interviews with families at a single location or on the same day.

When research has considered MDT approaches to child abuse, studies have tended to focus on child advocacy centers responding to child sexual abuse.[8] Little research has assessed the impact of MDT approaches to child abuse broadly in a way that can guide policy and practice.[9,10,11] Furthermore, little is known about caregiver perceptions of MDT investigations.

Unfortunately, government agencies currently have little research available to guide them in terms of the impact of MDT responses to child abuse generally.

The purpose of this study was to assess the impact of a coordinated MDT response following suspected child abuse and neglect reports. In the urban county studied here, the MDT response was initiated when families were ordered by law enforcement to meet the following day with representatives from three agencies spanning child welfare, law enforcement, and health. These agencies comprised the MDT. In addition to coordinating the multi-system investigation, the MDT sought to ensure that caregivers understood the investigation process and could participate fully in efforts to meet their children's needs, which was anticipated to decrease out-of-home placements.

Part 1 of this study examined the impact of the MDT approach on case outcomes (substantiation, investigation time) and child/family outcomes (out-of-home placements). Part 2 gathered caregiver perceptions of the MDT investigation. The results can guide the refinement of protocols and procedures to support children and families during investigations. The research questions and methods were developed with the MDT agencies to directly address their local policy and practice questions while identifying implications for jurisdictions nationally. For example, caregiver perceptions are relevant to the study partners' ongoing refinement of their MDT practice and co-location.

Description of the Study

> **Part One (Research Question One): Relative to comparison cases, does the MDT approach predict higher child abuse and/or neglect substantiation rates? What is the impact of the MDT approach on investigation time and out-of-home placements?**
>
> **Part Two (Research Question Two): What are caregiver perceptions of the MDT approach in a child abuse and/or neglect investigation?**

This two-part study addressed two questions about MDT responses to child abuse and neglect allegations. In Part 1, we tested the impact of the MDT approach on case (substantiation, investigation time) and child/family (out-of-home placements) outcomes in a single county. Using administrative data from child welfare and law enforcement, 1,237 cases that involved the MDT approach were compared to 1,237 comparison cases that did not involve an MDT approach. Comparison cases were matched to MDT cases on referral allegations (e.g., physical abuse, sexual abuse, domestic violence) and the person who reported the alleged incident (differentiating mandated reporters, such as school staff, law enforcement officers, and counselors/therapists; from other reporters, such as family members, neighbors, and friends). In Part 2, we recruited 32 caregivers from the same county who were involved in a child abuse and neglect investigation. Participants were asked to respond to survey and open-ended questions that focused on their perceptions of the investigation.

Key Findings

The MDT approach is associated with higher substantiation rates.

> **Compared to comparison cases, an MDT approach was associated with 3.06 times higher odds of substantiation. MDT investigations were also more thorough and more likely to involve kin out-of-home placements.**

Regression analyses controlled for the effect of referral type (physical abuse, sexual abuse, domestic violence) and reporter (mandated reporter or not) to test the differences in the investigation process between the MDT and comparison cases. Relative to comparison cases, MDT cases had 3.06 times higher odds of substantiation. Substantiation means that the assessment of abuse and/or neglect by a child protection worker established that an incident of abuse and/or neglect occurred based on a preponderance of the evidence. The MDT investigation process was also more thorough than comparison cases. MDT investigations took 1.72 days longer and involved more investigative contacts (e.g., 21 vs. 16 total contacts for the MDT vs. comparison investigations, respectively). Finally, relative to children in comparison cases, children in the MDT investigations had two times higher odds of being moved to kin

out-of-home placements but were not different from comparison cases in the odds of non-kin out-of-home placements.

Caregivers perceive strengths to leverage and limitations to address in the MDT approach.

Caregivers perceive MDT members as supportive, validating, and respectful when they engage in actions such as offering resources, listening, answering questions, and conveying empathy.

MDT members can build on communication and follow-up strategies to engage caregivers during investigations.

Caregiver interviews emphasized that clear communication is essential to caregiver engagement, both during the initial days when the investigation begins as well as over time. Communication was central to caregiver perceptions of support and respect as well as lack of support and disrespect. For example, concrete actions such as returning phone calls (or not) or providing updates (or not) on cases affected whether caregivers perceived validation and support (or not).

Implications

Communities should consider investing infrastructure and resources in building MDTs to conduct child abuse and neglect investigations.

Caregiver experiences can be improved with better communication and follow-up strategies.

Specific areas for improving communication include providing:

- **multiple opportunities for families to receive verbal and written information;**
- **clear information about each team member's role in the investigation process;**
- **information regarding the caregiver's role in the investigation;**
- **clear information regarding the investigation timeline; and**
- **context that honors family privacy in the waiting room.**

The analysis of MDT versus comparison cases using administrative data revealed that professionals working within an MDT to respond to child abuse and neglect allegations do their work differently than those working independently. The investigations involve more contacts and take longer. While this study could not determine the exact reasons for more contacts and longer investigation time, one potential explanation for this finding is that an MDT approach involves a more thorough investigation that includes more investigative contacts and consequently takes longer. Alternatively, this finding may reflect the greater amount of time required for additional coordination and sharing of information among the team members. With higher rates of substantiation, opportunities expand for MDTs to turn their attention to supporting child victims and their families in healing and safety. This research is in line with other evidence that MDTs are associated with improved responses to violence and abuse.[12,13,14] Therefore, communities

should consider investing in the infrastructure and resources, including time, that allow professionals working from different systems to coordinate child abuse and neglect investigations through an MDT. Child abuse and neglect investigations are stressful and confusing to caregivers whether they are the target of the investigation or not. Many caregivers have their own histories of abuse, which can make memory and attention, as well as emotion regulation, tasks challenging.[15,16] Caregiver interviews emphasized the importance of MDT members communicating accurate and accessible information with compassion. They recommended that MDT members make clear that someone will walk them through the process and that they are supported and not blamed. Further, MDT members should recognize that all families are unique and convey that the investigator has the necessary knowledge (of past cases, of trauma-informed approaches). Many caregivers reported that they did not know what their role in the investigation was or thought that they did not have a role. Taken together, these observations suggest that MDTs may consider integrating multiple strategies to convey information about the investigation (e.g., who is on the team, how the team works together, what the caregiver's role is, what the next steps are) and about resources.

> *"The detective was more just willing to listen and not – he asked the questions, but he would listen more than he would ask questions."*

Given the potential for stress to disrupt memory and attention, and the sometimes distressing nature of the investigation, information should be repeated several times throughout the process. MDT members may want to set clear expectations with families about what information will be shared with them and when, and when families can expect follow-up. Providing this information both verbally and in writing may help caregivers keep track of what has been provided. Further, survey measures can be integrated into practice to assess caregiver perceptions of the MDT team, allowing MDTs to refine their practices over time.

Methods

All study procedures were reviewed and approved by the University of Denver Institutional Review Board.

Study Site

The study site was situated in an urban county. In 2017, the child welfare hotline in this county processed more than 13,000 referrals, of which 4,700 referrals involving more than 9,800 children were assigned for assessment for potential child abuse and neglect. An MDT approach was established in the county prior to the start date for data included in this evaluation (i.e., January 2017); however, the MDT agencies moved to be housed together in a co-located space in September 2017.

Administrative data included cases initiated between January 2017 and September 2018 with 90 days of follow-up data to inform substantiation and out-of-home placements. Caregiver interviews were conducted between January and June 2019.

Part 1: Administrative Data

Study Sample

The study sample was drawn from all child welfare cases involving allegations of child abuse and neglect referred for investigation from January 2017 to September 2018. Administrative data were included from January 2017 to December 2018 so that all cases had at least 90 days of follow-up data available from the start of investigation. This 90-day period ensured that the majority of cases had their investigation completed (the maximum investigation period is 60 days by state law) and had information for child out-of-home placements within 90 days from the start of investigation. Cases were included if they involved "child protection" referrals and their investigation had been completed by the end of December 2018. As a result, referrals for "youth in conflict," "institutional abuse," and open investigations were excluded from the study sample.

Of the 26,838 total cases, 7,512 met the inclusion criteria. An MDT response was involved in 1,237 cases and 6,275 cases involved a traditional (not multidisciplinary) approach. Comparisons of these two groups revealed significant differences in case characteristics. As can be seen in Table 1, MDT cases were more likely to be referred by a mandated reporter and involve more severe types of abuse allegations (i.e., more physical and sexual abuse referrals and fewer neglect, emotional abuse, and domestic violence referrals). The two groups did not differ on victim demographics. One small difference was present for child age—8.91 years for the comparison group and 8.73 years for the MDT group. However, the effect size for this difference was only at Hedge's $g = 0.08$ (below the recommended 0.25 criterion); thus, child age was not considered for case-control matching.

Table 1. Comparison of the Multidisciplinary Team (MDT) Sample to Other Child Abuse Cases in the TRAILS Dataset

	MDT Cases	**All Non-MDT Cases**	**Matched Non-MDT Cases**	**χ^2 for MDT vs All Non-MDT**	**Cox's *d* for MDT vs. All Non-MDT**
	%	**%**	**%**	**(*df* = 1)**	**(effect size)**
Characteristics of Case	(*N* = 1,237)	(*N* = 6,275)	(*N* = 1,237)		
Mandated reporter	91	83	91	59.46***	0.44
Physical abuse	38	28	38	59.38***	0.28
Neglect	43	57	43	73.23***	0.34
Emotional abuse	2	4	2	8.58**	0.43
Sexual abuse	23	8	23	243.70***	0.75
Domestic violence	8	23	8	145.28***	0.75
Characteristics of Victim	(*N* = 1,849)	(*N* = 13,559)	(*N* = 1,750)		
Female	52	50	50	2.62	0.05
Hispanic	50	51	51	2.03	0.02
Black	31	31	30	0.01	0.00
White	69	70	70	2.14	0.03
	M (SD)	*M (SD)*	*M (SD)*	*t*	Hedge's *g*
Child age	8.73 (5.30)	8.91 (5.22)	8.67 (5.30)	2.11*	0.08

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

We matched MDT cases to comparison cases based on all variables that differed at or above the effect size of 0.25. Therefore, we performed exact case/comparison group matching without replacement on referral allegations and type of referring contact. Each of the 1,237 MDT cases were matched one-to-one to a comparison case. We next examined whether the two matched samples were still similar on child and perpetrator demographic characteristics. For all categorical variables, the Cox index was below 0.10 and Hedge's *g* was at 0.03 for child age and at 0.01 for perpetrator age.

Measures

Substantiation of referral allegations was the main outcome variable, coded as 1 for substantiated cases and 0 for not substantiated cases.

Referral Type was assessed at a case level. Three 0/1 coded variables encoded for presence of *physical* abuse, *sexual* abuse, and *domestic violence* allegations at referral time. The *mandated reporter* variable indicated whether referral originated from a mandated reporter or not.

Investigation Time indicated the number of days the case was investigated.

Investigative Contacts. The number of total, face-to-face, impersonal (phone, letter, text, email), failed (attempted contacts), and background check investigative contacts were computed for each case.

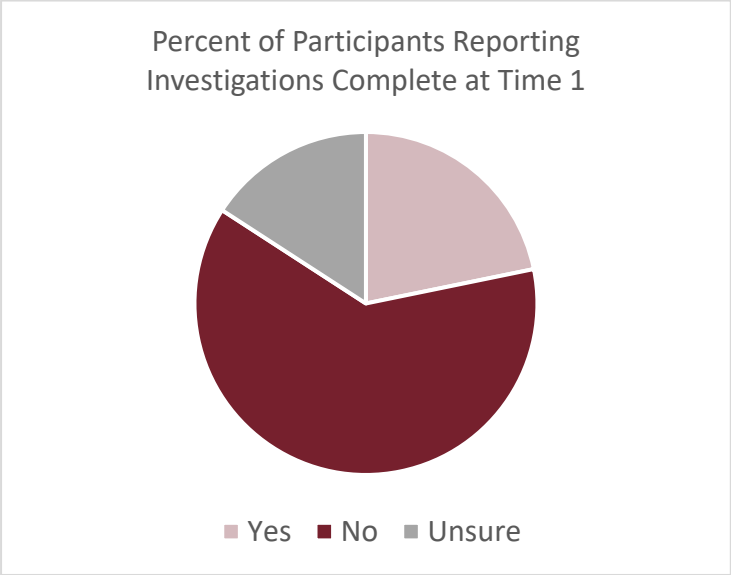
Out-of-Home Placements assessed whether each child experienced any, kin, or non-kin out-of-home placement within the 90-day investigation period. These three variables coded for the occurrence of out-of-home placement, with 1 for out-of-home placement, and 0 for no out-of-home placement.

Part 2: Caregiver Interviews

Participants

Participants (*N* = 32) were recruited from child welfare cases involved in child abuse and neglect investigations in a single urban county. Participants identified as 50% Mexican American, 28% African American, 16% White, 13% Native American, 3% Central American, 3% Filipino/Pacific Islander, and 9% Other.

Participants could select more than one racial/ethnic group. Latinx participants were *not* required to select White for race. The caregiver sample was generally reflective of the racial/ethnic groups of caregivers in the administrative data (50% Hispanic/Latinx, 30% Black, 2% Asian, 1% Pacific Islander).



The majority of caregivers identified as women (94%). Participants' ages ranged from 19 to 60 years old with an average age of 31 (*SD* = 9.40) years.

At the initial interview (referred to as Time 1), the majority of participants indicated that their cases were still under investigation. Half (*n* = 16) of participants indicated that they were the subject of the investigation and half indicated that someone else was. A majority (63%) of participants reported a history of experiencing interpersonal violence perpetrated by someone close (e.g., caregiver, partner). During the initial interview, which took up to two hours, participants were asked to respond to surveys (including measures of perceptions of the investigation process, demographics, caregiver trauma history, and perceptions of the research study) and open-ended interview questions. One month later, caregivers were contacted by phone for a follow-up interview (Time 2) that involved questions about the investigation. The follow-up interview took up to one hour.

Modified Survey Measures

As described below, four survey measures were administered to assess caregiver perceptions of the investigation. All survey measure instructions were modified to ask participants to think about the MDT team, including criminal justice, child welfare, and/or medical providers with whom they interacted.

- *Family Feedback on Child Welfare Services (FF-CWS).*[17] The FF-CWS is a measure used to indicate the efficacy of family-centered practice. In this study, caregivers responded to 14 items to assess their perceptions of the efficacy of the MDT investigating the case while keeping in mind all of their interactions with each entity (caseworkers, police, and medical team). Participants responded on a four-point Likert scale (1 = not at all, 2 = a little, 3 = fairly, 4 = a lot) to items on three dimensions: Intervention Efficacy scale, Perception of Workers scale, and Satisfaction with Intervention Process. These three subscales have been found to show good reliability, convergent, and criterion-related validity. Internal consistency for the scales in this study ranged from 0.72 to 0.92.

- *Investigation Satisfaction Scale (ISS).*[18] The ISS was developed to assess caregivers' satisfaction with child abuse investigations and caregivers' perceptions of how well the investigation team treated the children and caregivers involved. Participants responded to 14 items using a four-point Likert scale where scores of 1 indicate low satisfaction and scores of 4 indicate high satisfaction (1 = not at all or very poorly, 4 = very supportive or very well). The ISS consists of two subscales. The Investigator Response subscale is a nine-item subscale pertaining to caregivers' satisfaction with the investigation (e.g., "In your opinion, how thorough and complete was the information that investigators collected during the investigation?"). The Interview Experiences subscale is a five-item scale used to assess caregivers' perceptions of how well they and the children involved were treated by the investigators (e.g., "How safe and secure do you think your child felt during the interviews?"). Both subscales have shown good reliability and construct validity. Internal consistency for the scales in this study were 0.81 and 0.90.

- *Strengths-Based Practices Inventory (SBPI).*[19] The SBPI examines how effectively programs deliver services in terms of supportiveness, strength-based qualities, and cultural competencies. Responses to 16 items are recorded pertaining to four subscales: Empowerment Approach, Cultural Competency, Staff Sensitivity-Knowledge, and Relationship-Supportive. The Empowerment Approach subscale measures whether services were delivered to families focusing on families' strengths and motivating them to do things for themselves. The Cultural Competency subscale assesses whether programs included families' culture as a source of strength. The Staff Sensitivity-Knowledge subscale assesses program staff knowledge of other resources and sensitivity to families' decisions. The Relationship-Supportive subscale assesses whether program

services encourage families to enlist other social supports such as family, friends, and other parents in the community. Responses were recorded using a seven-point Likert scale. The SBPI has shown good reliability. Internal consistency for the scales in this study ranged from 0.80 to 0.90.

- *Procedural Justice.*[20] Fifteen items were adapted to assess participants' perception of procedural justice surrounding the child abuse investigation. A six-point Likert scale was used to examine agreement with lower ratings indicating lower agreement (1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, 6 = strongly agree). Example items include: "The staff decisions are made based on facts, not their own personal biases" and "The staff treat me with respect and dignity." The latter item was also modified to reflect participants' perceptions of how well each group within the MDT treated them. For example, "The police officers or detectives treat me with respect and dignity" was included to gauge participants' perceptions of how they were treated by police and/or detectives. Two other items were included to assess perceptions of how child welfare caseworkers and medical personnel treated families as well.

Open-Ended Questions

Eight open-ended questions were included to allow participants to share their own specific experiences and feedback of the MDT investigation process. Questions were adapted from Gagnon et al. (2018)[21] and included: 1) What did the caseworkers/police/doctors tell you was your role in the investigation?; 2) What things do you think influence the outcome of the investigation?; 3) In what ways has the response team made you feel validated (or supported)? This could be case workers, doctors, police officers, family advocates, lawyers or judges.; 4) In what ways has the case made you feel invalidated (or unsupported)? Again, this could be caseworkers, doctors, police officers, family advocates, lawyers or judges.; 5) In what ways have the investigators followed through on the decisions and promises they make? Think about caseworkers, police officers, family advocates, lawyers or judges.; 6) What do you think should be the proper state response in the investigation process?; 7) In what ways have people in the system shown you that they respect you? This could be caseworkers, police officers, family advocates, lawyers or judges.; and 8) In what ways have you felt disrespected? Responses were recorded and transcribed. These questions were initially asked at Time 1. One month later (Time 2), participants were asked open-ended questions to ascertain whether they had additional feedback on the investigation beyond that which they reported at Time 1.

A coding system was developed for the content analysis.[22] Initial coding categories were identified from the available literature and through research team discussion about the interview content. Using the initial coding system, two graduate research assistants coded a randomly selected subset of transcripts and refined the coding manual. Six broad thematic categories were specified: role in investigation, factors that affect investigation, validation-support-respect, invalidation-lack of support-disrespect, follow-through, and government responses. Within each theme, specific subcategories were coded using both bottom-up and top-down approaches. For example, subcategories were drawn from Gagnon et al. (2018);[23] subcategories were added and refined by the research team after the initial coding of randomly selected transcripts. Once a final coding manual was established, transcripts were all re-coded. The two raters displayed good agreement for all subcategories analyzed (kappas ranged from 0.6 to 1).[24] Finally, the coders discussed all coding discrepancies to arrive at consensus codes. Organization and coding of the qualitative data utilized QRS NVivo qualitative analysis software, Version 10. SPSS software, Version 24, was used to calculate inter-rater reliability and frequency of codes.

Because no new substantive information about perceptions emerged from Time 2 interviews, the presentation of results focuses on Time 1.

Other Measures

Participants were asked to report on demographic variables.

In addition, the *Brief Betrayal Trauma Survey (BBTS)*[25] was administered to assess for history of interpersonal trauma among caregivers, including physical abuse, sexual assault, witnessing domestic violence by someone close before or after age 18. Good construct validity has been established for the BBTS.

The *Response to Research Participation Questionnaire* (RRPQ)[26] was used to monitor ongoing participant perceptions of costs and benefits of research participation.

Procedure

English- and Spanish-speaking caregivers with a child involved in a child abuse/neglect investigation were invited to a participate in two separate interviews focused on their feedback and experiences of the MDT investigation process. Participants were recruited through flyers made available to families involved in investigations. From March through June, graduate student research team members were on site at the co-located MDT building to answer questions about the study from potential participants. Caregivers interested in the study contacted the research team to schedule the interview.

The Time 1 interview was conducted in person in a private room at the location preferred by the participant, ranging from the research team's university offices (*n* = 8), co-located MDT site (*n* = 3), or a public library (*n* = 21). The interview lasted approximately two hours. Participants were offered a ride through a car ride service and childcare as necessary. Participants received $60 for the first in-person interview and were reimbursed an additional $20 if they used their own transportation. The Time 2 interview took place one month after the initial interview over the phone. The second interview lasted approximately one hour and participants were paid $30.

At the start of the scheduled interview, a graduate-level, woman interviewer reviewed consent information verbally and provided a consent form; caregivers were encouraged to ask questions. Next, caregivers were asked questions to assess their understanding of the consent information.[27] Caregivers had to correctly answer consent questions to be considered consented into the study; all participants did. After the consent process, the interviewer administered the survey and interview questions. Open-ended responses were audio-recorded for transcription and coding. Participants filled out the Response to Research Participation Questionnaire (RRPQ) at the end of the interview to monitor perceptions of the research protocol.

Results

Part 1: Administrative Data

Does the MDT approach result in higher rates of child abuse and maltreatment investigation substantiations?

Logistic regression analysis was used to predict the probability of the referral allegations being substantiated with MDT involvement as a predictor and referral type as control variables. As can be seen in Table 2, MDT cases had 3.06 times higher odds of resulting in substantiated allegations than comparison cases. This odds ratio corresponds to 16% substantiation rate for control cases and 37% substantiation rate for MDT cases. This difference illustrates a clinically meaningful increase in case substantiation rates.

Table 2. Logistic Regression Coefficients for the Probability of Allegation(s) Substantiation (N = 2,474)

	b	***SE***	***OR***	**95% CI for *OR***
MDT	1.12***	0.09	3.06	(2.57; 3.67)
Mandated reporter	0.45**	0.17	1.57	(1.12; 2.20)
Physical abuse	-0.54***	0.10	0.58	(0.48; 0.71)
Sexual abuse	-0.03	0.12	0.97	(0.77; 1.22)
Domestic violence	0.54**	0.17	1.71	(1.23; 2.37)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Does the MDT approach result in different investigation practices?

Ordinary Least Squares regression model was used to investigate the effect of MDT involvement on the investigation time, controlling for referral type. As can be seen in Table 3, MDT cases took on average 1.72 days longer to investigate. One possible explanation for longer investigation time is that MDT cases were more thoroughly investigated. On the other hand, it is also possible that coordination and information sharing involved more time for the MDT cases.

Table 3. Investigation Time Regressed on MDT Involvement and Referral Type (N = 2,474)

	β	***b***	***SE***	***t***
MDT	0.05*	1.72	0.72	2.40
Mandated reporter	0.03	1.81	1.27	1.42
Physical abuse	0.00	0.10	0.80	0.13
Sexual abuse	0.11***	4.51	0.93	4.83
Domestic violence	0.01	0.56	1.40	0.40

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The next set of analyses examined whether the MDT approach had an effect on the number of investigative contacts. A Poisson loglinear regression was used to model the number of investigative contacts. A separate model evaluated the effect of MDT approach for each contact type. The models controlled for referral type.

As can be seen in Figure 1, MDT cases were associated with more investigative contacts, $b = 0.26$, $p < 0.001$. Comparison cases on average involved 16 investigative contacts, whereas MDT cases involved, on average, 21 investigative contacts. These differences were also present for face-to-face contacts ($b = 0.47$, $p < 0.001$), impersonal contacts ($b = 0.11$, $p < .001$), and background check contacts ($b = 0.56$, $p < 0.001$); but not for failed contacts ($b = -0.03$, *n.s.*). These findings suggest that MDT cases did not simply take longer due to extra time demands involved in managing an MDT investigation, but rather involved more investigative contacts and potentially a more thorough investigation.

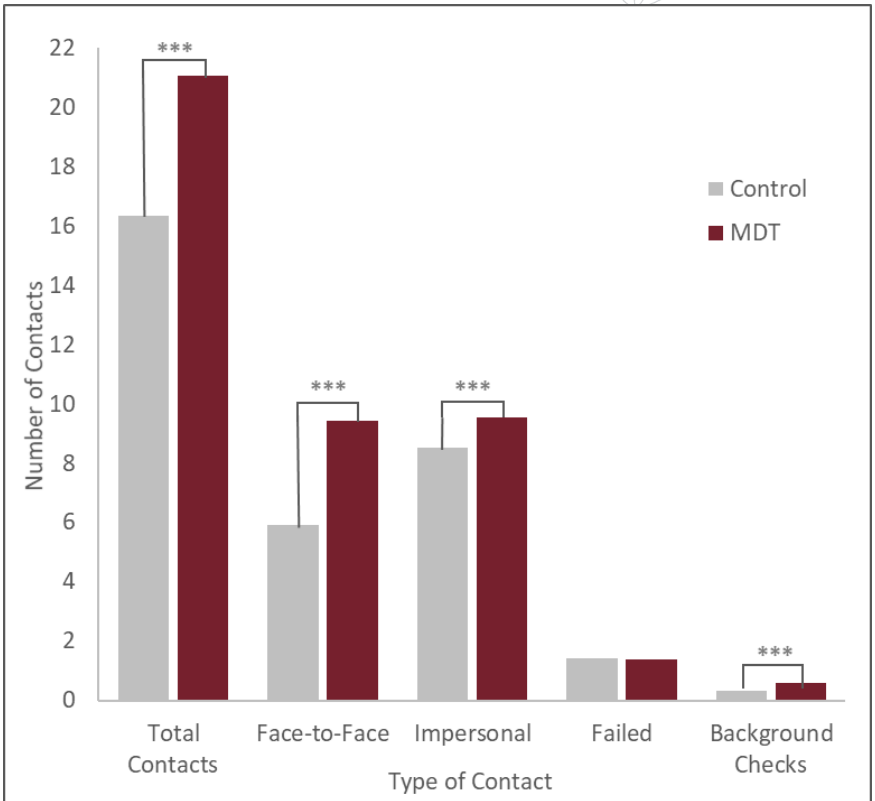


Figure 1. ***The Number of Investigative Contacts for MDT vs Control Cases***
* $p < .05$, ** $p < .01$, *** $p < .001$

Does the MDT approach influence the number of out-of-home placements?

A series of multilevel logistic regression models investigated the impact of MDTs on the probability of any, non-kin, and kin out-of-home placements during the 90-day investigation period. The models controlled for referral type. Because substantiated cases (i.e., cases showing evidence of child abuse and neglect) are more likely to result in out-of-home placements, the models included substantiation status as a covariate and investigated the effect of MDTs on out-of-home placements over and above the effects of case substantiation. Furthermore, given that cases involved multiple children with different out-of-home placement experiences, the models statistically accounted for nesting of children within cases. For all models, the out-of-home outcome was modeled at the child level (Level 1), whereas the effects of covariates were modeled at the case level (Level 2).

MDT involvement was not associated with non-kin out-of-home placements during the 90-day investigation period (Table 4). However, as would be expected, children in substantiated cases had 3.57 times higher odds of having a non-kin out-of-home placement than children in unsubstantiated cases regardless of participation in MDT. Whereas slightly over 3% of substantiated cases involved non-kin out-of-home placements, less than 1% of unsubstantiated cases involved non-kin out-of-home placements. This difference illustrates that both MDT and non-MDT investigators were more conservative in making a decision to move children into non-kin out-of-home care in cases that did not result in substantiation (i.e., cases with fewer evidence of child abuse and maltreatment).

Table 4. Multilevel Logistic Regression Model for the Probability of a Non-Kin Out-of-Home Placement (N=3,579)

	Main Effects			Interaction		
	b	***Odds Ratio***	**95% CI**	***b***	***Odds Ratio***	**95% CI**
Mandated reporter	0.21	1.23	(0.49,3.08)	0.21	1.24	(0.52,2.93)
Physical abuse	-0.32	0.72	(0.44,1.19)	-0.33	0.72	(0.43,1.203)
Sexual abuse	-0.75*	0.47	(0.24,0.93)	-0.75*	0.47	(0.24,0.94)
Domestic violence	-2.60*	0.07	(0.01,0.55)	-2.59*	0.07	(0.01,0.55)
Substantiated	1.27***	3.57	(2.20,5.80)	1.19**	3.30	(1.54,7.07)
MDT	0.18	1.20	(0.76,1.90)	0.11	1.11	(0.53,2.35)
MDT x Substantiated	--	--	--	0.13	1.14	(0.42,3.09)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

In contrast to non-kin placements, MDT involvement was associated with more kin out-of-home placements during the 90-day investigation period (Table 5). Children in MDT cases had 2.12 times higher odds of having a kin out-of-home placement than children in comparison cases. That difference corresponded to about 0.5% of children being placed into kin out-of-home placements among the comparison cases and 1% of children placed into kin out-of-home placements among the MDT cases. Similar to our results for non-kin out-of-home placements, children in substantiated cases had 4.22 times higher odds of having a kin out-of-home placement than children in unsubstantiated cases. About 0.5% of children in unsubstantiated cases were placed into kin out-of-home placements, whereas about 2% of children in substantiated cases were placed into kin out-of-home placement, again highlighting both MDT and non-MDT investigators' conservative approach to making decisions on kin out-of-home placements in cases that did not result in substantiation. The effect of MDT involvement on non-kin out-of-home placement did not vary by case substantiation status.

Table 5. Multilevel Logistic Regression Model for the Probability of a Kin Out-of-Home Placement (N=3,579)

	Main Effects			Interaction		
	b	***Odds Ratio***	**95% CI**	***b***	***Odds Ratio***	**95% CI**
Mandated reporter	-0.03	0.97	(0.39,2.39)	-0.03	0.97	(0.39,2.39)
Physical abuse	-0.26	0.77	(0.46,1.29)	-0.25	0.78	(0.46,1.32)
Sexual abuse	-1.05*	0.35	(0.14,0.87)	-1.05*	0.35	(0.14,0.87)
Domestic violence	-2.43*	0.09	(0.01,0.62)	-2.44*	0.09	(0.01,0.62)
Substantiated	1.44***	4.22	(2.34,7.61)	1.65**	5.21	(1.81,14.99)
MDT	0.75*	2.12	(1.17,3.83)	0.93†	2.53	(0.93,6.90)
MDT x Substantiated	--	--	--	-0.30	0.74	(0.21,2.63)

† $p = 0.06$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Finally, examination of the effect of MDT on total out-of-home placements (both kin and non-kin) revealed that MDT involvement was not associated with higher probability of any out-of-home placement during the 90-day investigation period.

Part 2: Caregiver Interviews

Descriptive data for surveys assessing perceptions of the MDT response are as follows:

Table 6. Descriptive Data for Caregiver Surveys

		N	*Range*	*Mean*	*SD*
Family Feedback on Child Welfare Services *(response scale 1 not at all - 4 a lot; higher scores are more positive)*	Intervention Efficacy	32	1.00-4.00	2.86	0.94
	Perception of Workers	32	1.00-4.00	2.69	1.05
	Satisfaction with Intervention Process	32	1.00-4.00	2.59	1.00
Investigation Satisfaction Scale *(response scale 1 very - 4 not at all; lowers scores are more positive)*	Investigator Response	32	1.00-3.56	2.20	0.86
	Interview Experiences	31	1.00-3.40	2.00	0.62
The Strengths-Based Practices Inventory *(response scale 1 strongly disagree - 7 strongly agree; higher scores are more positive)*	Empowerment Approach	32	1.00-7.00	4.23	1.84
	Cultural Competency	32	1.00-6.67	3.88	1.52
	Staff Sensitivity and Knowledge	32	1.00-6.75	3.36	1.58
	Relationship-Supportive	32	1.00-7.00	4.57	1.73
Procedural Justice *(response scale 1 strongly disagree - 6 strongly agree; higher scores are more positive)*	Overall	32	1.33-6.00	3.99	1.42
	MDT: Respect & Dignity	32	1.00-6.00	4.47	1.34
	Child Welfare: Respect & Dignity	28	1.00-6.00	4.46	1.69
	Medical: Respect & Dignity	23	1.00-6.00	5.27	1.16
	Police: Respect & Dignity	28	1.00-6.00	4.46	1.60

The most common responses within each thematic category are presented next. Caregivers varied in their perceptions of their personal roles in the investigation, as illustrated in Table 7.

Table 7: Caregiver Perceptions of Their Personal Role in Investigations

Role in Investigation	***n***	**%**	**Illustrative Example**
No role	6	19	"Yeah that's how I feel like I didn't have a role at all, they pretty much told me what was gonna happen and I had to go with it."
Big role	4	13	"I'm really involved in everything they made sure I was notified of everything."

Table 7: Caregiver Perceptions of Their Personal Role in Investigations

Role in Investigation	***n***	**%**	**Illustrative Example**
Uncertain/confused about role	2	6	"...I just felt like it should have been a little bit clearer understanding of the role that other family members outside of who was all involved, that could have been a bit clearer."
Never told role	15	47	"They really didn't let me know my role. They kind of just questioned me."
Caregivers provided descriptions of actions they took in their roles	16	50	"I was definitely there to answer questions." "To show up to court and to [co-location site]." "That is my job is to be [child victim]'s voice... "

Caregivers' perceptions of factors that affect the outcomes of investigations focused on coordination, the quality of the team's work, and the evidence available to substantiate the investigation.

"I think the coordination between the medical provider and the detective and probably even the caseworkers; they all kind of got all their professional opinions and came to a conclusion on what they thought the end result would be."

More than a third of caregivers (38%) described diverse factors that influenced the outcome of the investigation, including coordination and communication across the team. This was illustrated by participants who described, "I think the coordination between the medical provider and the detective and probably even the caseworkers; they all kind of got all their professional opinions and came to a conclusion on what they thought the end result would be." Another described, "Communication- they all need to communicat[e], make sure everybody's on the same page on what's going on, what happened." Nearly a third (31%) of participants indicated that the amount of evidence affected outcomes and specific types of evidence were cited as important (e.g., video, home visit). Participant responses less often referred to beliefs that personal opinions of investigators or demographics factors drove investigation outcomes. For example, less than 10% of participants indicated that investigators' personal beliefs (6%) or the child/offenders' race/class (9%) affected outcomes.

Participants cited a range of MDT members' actions that communicated support-validation-respect, as illustrated in Table 8.

Table 8. Caregiver Perceptions of Support, Validation, and Respect

	n	%	Illustrative quotes
Overall sensitivity and care	25	78	"The officer was understanding of what's going on. He showed respect, he wasn't mean about it or anything..." "The way that I'm greeted and eye contact, and just tone of conversation [conveyed sensitivity and care]." "[The MDT member] also had children so they could kind of relate and understand how I was feeling" "He made me feel very comfortable and the decisions that he made, I was very pleased with them. He didn't put on this 'I'm an investigator, I'm a tough guy'. You know, make you feel unsafe, you know. He made me feel very comfortable."
Caseworker-specific support/ validation	15	47	"The caseworker said she was gonna call around for some daycares for me to see if they were accepting but I already know they're not. She was supportive, though, she tries." "They seem to like really listen to what the problem is and do their best to fix it, and listen to what I think would help fix it." "Well the case manager, she was always polite and didn't overtalk me."
Police-specific support/ validation	12	38	"I think the biggest office that's helped me has been the police office, the detectives. They have really helped to answer my questions and really have been the ones that have encouraged me to keep, keep moving forward with reporting things and ya know going through the proper channels to report and keep talking. Really it's been the detectives that have encouraged that the most. And I think that's where I felt the most supported, was when I've been encouraged to keep fighting." "The police officer was very respectful 'cause he kind of showed a little empathy."
Other validation/ support (not coded elsewhere)	10	31	"[The MDT member] was pretty busy so she's multitasking, but she did stop to [talk] with me, talk to my mother on the phone." "I guess they try to calm me down like when I'm being upset in a situation…"
Offering resources	10	31	"[The MDT member] went out of their way to get me in [services] and get me started."
Believing/not blaming	7	22	"The detective goes – he had said after we had finished he turned off the recording and he was like, 'I believe you 100%,' you know. He said, 'You seem like an amazing mom.' So that right there I was like thank God." "And not like treating me like a criminal…"

Participants also described actions during the investigation that communicated lack of support, invalidation, and/or disrespect. Half (50%) of participants indicated actions that were dismissive of the caregiver (e.g., "…talking to me like I'm really a layperson, like I'm really the dumbest person on the face of the earth."). Nearly a third (31%) of participants referenced examples of not being believed or their child not being believed that conveyed disrespect. Illustrating this, one caregiver noted, "And then they really do just try to villainize you. Like, as soon as things go wrong, you're immediately the bad guy." Another said, "…What bothered me was 'Are you sure your daughter wouldn't make something up like this?'" One in five participants (22%) described that lack of information and updates on cases and decisions made them feel disrespected/unsupported.

For example, one participant described that the person who reported the incident might not learn the outcome of the investigation: "And the person that is the victim of this, doesn't get a word. Doesn't get a peep. Doesn't get any information, doesn't get told anything…The person that reported it doesn't get—doesn't even, I mean it's radio silence." Twenty-two percent of participants referenced general insensitivity and carelessness that affected their perceptions of the investigation, as illustrated by, "Nothing about that situation was comfortable. Nothing about this whole situation felt like they actually cared about [the child's] wellbeing. It was just a mess." Another participant described, "They don't care how much stress they put caregivers under." Nearly one in five participants cited lack of follow-through and lack of contact as contributing to their sense of disrespect/lack of support. One participant expressed frustration at the time required of them during an investigation: "…there's no response, like they give you their card and then they don't respond to you? … It's very time consuming and then to lose the time that you had." Further, participants cited lack of criminal justice progress as making them feel unsupported. For example, "Because that report goes nowhere except for in the file, and then what? It sits on a shelf because the victim, over here, doesn't get notified that you've made a decision. The offender, over here, gets told you made a mistake, you're a child abuser. Shame on you. Don't do it again."

Participants' characterizations of follow-through varied, with some caregivers frustrated at lack of updates and contacts (see above) and others describing good follow-through. For example:

- "So I think the follow-through actually has been decent, in terms of like—getting us to like informing us to go to the [co-location site], coming, or asking us to come to the house. Ya know, following up with phone calls in terms of—you know you need to provide these documents, you need to ya know, you need to show up to you know not only the [co-location site] to meet with the detective or you need to go to the police station to make a report."

- "They told us right away that as long as we are doing what we are supposed to be doing that it could move quickly and so far its moved very quickly. It's been less or a little over a month and I already have overnights back. So things are moving quickly like they promised me."

Across open-ended responses, caregivers' recommendations for government responses to child abuse and neglect allegations focused on communication: providing information to families and to other members of the MDT, compassion, support/not blame, recognition that families are unique, and investigator knowledge. References to investigator knowledge included awareness of past cases, training in abuse and neglect, as well as victim-centered, trauma-informed approaches.

Conclusions

Child abuse and neglect investigations can span multiple systems, from child welfare and health to criminal justice. Given the complexity of such multi-system responses, practitioners and policymakers have called for personnel from different systems to coordinate their investigations and responses to families through MDTs. Until now, policymakers did not have empirical results to guide their work. This study addressed this research gap by testing the impact of an MDT on case outcomes following child abuse and neglect allegations and gathering caregiver perceptions of the MDT response.

These findings indicate that professionals working within an MDT to respond to child abuse and neglect allegations do their work differently than those working independently.

Analyses of administrative data revealed that, relative to comparison cases, MDT cases:

- were three times more likely to result in substantiated allegations;
- took on average 1.72 days longer to investigate than comparison cases;
- had more documented contacts during the investigation; and
- resulted in more kin out-of-home placements in the first 90 days after the referral allegation.

These findings indicate that professionals working within an MDT to respond to child abuse and neglect allegations do their work differently than those working independently. The investigations involve more contacts and take longer, perhaps reflecting the time required for additional coordination and sharing of information. The differences in investigative contacts were especially striking for face-to-face contacts, suggesting that multidisciplinary teams have more opportunities to engage with families. With higher rates of substantiation and more face-to-face contacts, opportunities expand for MDTs to turn their attention to supporting child victims and their families in healing and safety.

The study results are in line with other research that shows MDT collaboration is linked with how providers do their work and case outcomes across other types of abuse and violence.[28, 29, 30] Thus, communities should consider investing in the infrastructure and resources, including time, that allow professionals working from different systems to coordinate child abuse and neglect investigations through an MDT.

Interviews with caregivers revealed important context that should inform consideration of the implications of these findings. First, the majority of caregivers interviewed had their own histories of experiencing intimate violence by someone close, such as a caregiver or partner. Histories of intimate violence can make attention and memory, as well as emotion regulation, tasks difficult.[31,32] Second, the onset of a child abuse and neglect investigation is stressful, whether an allegation is leveled against the caregiver or someone else. Third, the MDT response is confusing to understand. Together, this context suggests that MDTs may want to consider approaches that plan for challenges related to attention and memory, confusion about systems and roles, complex emotions, and prior experiences and expectations.

Keeping that context in mind, the findings from the interviews suggest that MDTs have strengths to build upon. Even when caregivers are facing the stress of an unexpected investigation to which they have been ordered to respond, they often convey beliefs that the investigation's outcome is dependent upon the team's coordination. This makes it all that more important that families understand who is on the team and how they work together, including how they communicate with one another. Emphasizing and explaining the collaboration may leverage beliefs that caregivers hold about the importance of coordination for outcomes. Providing information verbally and in writing about which disciplines their team members represent may support caregiver understanding during what can be a stressful time. Further, MDTs might consider how they communicate the caregiver's role in the investigation and take steps to reinforce the messages given to caregivers.

> *"There needs to be a way that the victim is in the loop of what the entire process is from start to finish. So that, once…an investigation starts, the victim needs to be able to know…Does it get opened? Does it get closed? Does it go from the caseworker to the police? Does it get sent for adjudication? What is the process?"*

A striking theme from across interviews is the importance of clear communication with families, during the initial days when the investigation begins as well as over time. Communication was central to caregiver perceptions of both support and respect as well as lack of support and disrespect. For example, concrete actions such as returning phone calls (or not) or providing updates (or not) on cases affected whether caregivers perceived validation and support (or not). Given potential consequences of stress on memory and attention, MDTs might want to consider multiples forms of communication as well as plans to repeat communications.

Across the interviews, participants described many actions that investigators could take to convey support, validation, and respect. In particular, offering resources conveyed support and validation, suggesting that MDT members can emphasize resources as part of their interactions with caregivers. Other actions included listening, explaining steps in the investigation, answering questions, conveying belief (versus treating caregivers like "criminals"), empathy, and encouragement. This suggests that implementation of an MDT requires ongoing training for MDT members in interpersonal skills, such as active listening and conveying compassion.

The findings suggest that pursuing approaches that allow MDT members to convey care and sensitivity to the family's unique circumstances while pursuing the investigation may be important. For example, half of participants described concerns about actions that were dismissive of the caregiver, and one in five described feeling as if the team was insensitive. This is consistent with other research on sexual assault survivors' perceptions of victim services (including criminal justice).[33] In prior work with sexual assault survivors, we learned that their perceptions of criminal justice and health-related services often started in the waiting room.[34] MDTs serving children may have similar opportunities to set the stage for the investigation in ways that emphasize family privacy in the waiting room (e.g., in how families sign-in) and centers around the child (e.g., in the degree to which the room is child friendly).

Some caregiver concerns may seem outside the control of the MDT. For example, more than a third of participants expressed frustrations around issues related to the tensions between criminal and civil legal systems (e.g., protection orders), inaccessible language used in the investigations, and lack of offender accountability. While the MDT cannot control consequences for offenders, the team can emphasize educating families about the criminal justice process, including terms used and timelines.

In addition to gathering insights from caregivers, this study offered an opportunity to pilot survey measures for possible use in the ongoing evaluation of MDTs to assess different dimensions of caregiver perceptions of the MDT process. Measures, modified in this study to ask participants to think about all team members, were internally consistent and captured variance in caregiver perception. The *Investigation Satisfaction Scale* may be particularly useful to MDTs seeking to benchmark and evaluate co-located investigations over time, given the measure's emphasis on experiences during the investigation interviews. Procedural justice items, particularly asking about respect and dignity, can be used to measure caregiver perceptions of how they were treated, separate from the outcome of the case.

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