Expanding the Knowledge Base about Child Advocacy Centers

National Institute of Justice
Evaluation of Services for Victims of Crime
Final Summary Overview

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Project Harmony®
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Executive Summary

Background

Children's advocacy centers (CACs) were established to provide a coordinated, multidisciplinary, and child-focused response to allegations of child maltreatment (Chandler, 2000). The CAC model involves a combination of services uniting professionals from various fields, including law enforcement, the district attorney's office/prosecution, child welfare/child protection, victim advocacy, medical, and mental health (Chandler, 2000; Cross et al., 2008; Newman et al., 2005). In this way, CACs are able to provide support through comprehensive and coordinated services for the child and family in one facility (Chandler, 2000; Cross et al., 2008; Newman et al., 2005).

Given the goals of CACs to assist children and their families, researchers and practitioners have sought to assess the effectiveness of these initiatives. Some studies have examined existing CAC models and standards in practice, such as variations in CAC characteristics (e.g., Herbert et al., 2018) and variations across implementation of the CAC standards (e.g., Jackson, 2004a). Although core CAC components are widely implemented within centers (Herbert et al., 2018; Jackson, 2004a), variations do exist (e.g., non-NCA members having lower rates of adherence to the standards such as having a child investigative team). The majority of extant CAC research, however, exclusively examines outcomes, such as services and referrals provided to children and families (e.g., Edinburgh et al., 2008; Jenson et al., 1996), and prosecutions (e.g., Cross et al., 2008; Edinburgh et al., 2008; Wolfteich & Loggins, 2007). Other work has focused on the benefits of the multidisciplinary team process (Jackson, 2004a), victims' and families' satisfaction with the investigation and the CAC (Cross et al., 2012), the CAC's response to child maltreatment cases compared to traditional child protective services (Smith et al., 2006), and the arrest and prosecution rates of offenders (Cross et al., 2008; Faller & Palusci, 2007; Wolfteich & Loggins, 2007). Generally, these studies have demonstrated that CACs are successful at achieving their measured outcomes and providing services that children and/or caregivers perceive as satisfactory.

While previous work has assessed various outcomes of CACs (e.g., child and family satisfaction with services, prosecution outcomes), few have examined program operations, despite the importance of exploring the processes that lead to these outcomes. By first assessing the operations that are characteristic of each CAC, a more holistic understanding can be gained regarding how these procedures lead to service outcomes. It is with this backdrop that Project Harmony, a large child advocacy center in Nebraska, underwent a formative evaluation and evaluability assessment of five core CAC services to better understand this model and lay the groundwork for subsequent outcome evaluations.

Current Study

This study used a two-phased approach to conduct a formative evaluation and evaluability assessment of Project Harmony's core services. The core services are divided into five areas: (1) forensic interviewing, (2) advocacy services, (3) medical evaluations, (4) mental

health care, and (5) multidisciplinary teams. Broadly, the goal of the Formative Evaluation (Phase I) was to assess the policies, procedures, and perceptions of work being done within these five service areas (e.g., James Bell Associates, 2018). Additionally, the goal of the Evaluability Assessment (Phase II) was to determine the "evaluation readiness" of each service area for an outcome evaluation. The research was be guided by the following five research questions within the two phases:

Phase I: Formative Evaluation

1. How are Project Harmony's core services being implemented? What are the key elements of each program? Are core services being implemented according to the NCA standards?
2. What protocols exist to guide service delivery, and how are these protocols followed by Project Harmony employees and agency partners (i.e., child protective services, law enforcement, county attorneys)?
3. What tools can be utilized to assess implementation fidelity?

Phase II: Evaluability Assessment

4. What is the "evaluation readiness" of each core service?
5. How can "evaluation readiness" be improved for each core service in order to facilitate a formal outcome evaluation of each core service?

Method and Analysis

Phase I: Formative Evaluation

As noted, the goal of the Formative Evaluation was to assess the policies, procedures, and perceptions of work being done within these five service areas. To complete Phase I, then, data were collected across four main sources that built off the previous data collection effort: (1) literature review, (2) Project Harmony document reviews, (3) focus groups, and (4) surveys. A broad overview of each of these sources is provided below.

The research team conducted a **literature review** of existing research on Child Advocacy Centers (CACs) to (a) assess the state of the current evaluation literature on CACs and (b) identify findings that could be used to guide the current evaluability assessment (i.e., focus group protocol, survey). Once the literature review was completed, the research team reviewed **Project Harmony's documents** (e.g., service area narratives, service area protocols and procedures) and compared them to the 2017 National Children's Alliance (NCA) Standards that CACs need to meet for accreditation. The purpose of this step was (a) to conduct qualitative content analysis to identify key themes that describe the programs and their current operations in detail and (b) to determine whether there were gaps or inconsistencies that might require further exploration during data collection. To gather contextual information around program implementation and associated processes, the research team then conducted **focus groups separately** with internal CAC staff and external agency partners. To account for any perspectives not captured in the focus group sessions (e.g., participants not being able to join, participants had additional thoughts to share), a follow-up survey was administered to the same individuals invited to the focus groups with the same focus group questions. After reviewing focus group findings, a second survey—referred to as **survey II**—was developed to gather additional contextual information around program implementation, associated processes based on the focus group

findings, and any areas of discussion that required additional clarification. Individuals invited to the focus group sessions received an email to participate in survey II.

Phase II: Evaluability Assessment

Once all data from the Phase I: Formative Evaluation were collected and analyzed, the research team moved into Phase II: Evaluability Assessment for all five service areas. The purpose of this phase was to determine the evaluation "readiness" for each program area. To ensure adherence of the steps to conducting an evaluability assessment, evaluability assessment checklists adapted from prior research (Campagna et al., 2020) were used to aid the research team in their assessment of the program coherence and evaluation capacity for each service area. Once these checklists were completed, an evaluation plan was developed for each individual service area, including justifications and recommendations for the program's evaluability. Finally, the research team conducted two Evaluability Assessment Workgroup (EAW) meetings to receive feedback on the findings and recommendations from internal staff and external agency partners. Specifically, the purpose of these meetings was to (1) involve key stakeholders to help guide the evaluability assessment, (2) provide an overview of the grant products/deliverables, and (3) receive input from key stakeholders on these deliverables, including any information that may have been missing or incomplete.

Overview of Findings

Provided below is a summary of findings across all data sources and organized by Phase of the project.

Phase I: Formative Evaluation

Literature Review

- There were relatively few research articles examining evaluations of CACs
- Most evaluations that exist were focused on the perceptions of agency staff, agency partners, or the clients that they serve
- There were no evaluability assessments of CACs identified in the extant research that matched the current project
- Some information from the literature review was used to guide topics included in the focus group protocol and survey that Project Harmony staff and agency partners completed (e.g., what is the most important outcome for each service area, training needs) (e.g., Jackson, 2012)

Project Harmony Document Reviews

- Most of the National Children's Alliance (NCA) Standards were met or partially met by Project Harmony, as evidenced in the service area narratives and supporting documents
- There were some narratives and/or supporting documents that stated that the NCA Standards were being met but with minimal details on how those processes were monitored and documented. Notably, this does *not* mean that these Standards were not being met. Rather, it may be that research team did not have access to adequate documentation of this adherence.
- Some of the items where there were minimal details across specific service areas revolve around the coordination with the multidisciplinary team (MDT)

Focus Groups

- Internal staff and external partners often felt intended outcomes were being met
- Common barriers included burnout, secondary trauma, and the impact of the COVID-19 pandemic
- Common strengths included strong relationships among staff and partners and staff providing high quality services
- Internal staff were familiar with NCA Standards, whereas external partners were less familiar

Survey II

- Participants often agreed that internal staff have received adequate training overall
- All internal participants believed NCA Standards were being met
- Both internal staff and external partners identified effective collaboration/coordination as a strength between the CAC and external partners
- Turnover was identified as a challenge

Phase II: Evaluability Assessment

In general, all service areas "generally met standards for evaluability" for most indicators of program coherence. Issues of concern relate to limited documentation available to the researchers or access to documentation on evidence of implementation and certain outcomes not being captured within the current data management system. While these themes are evident across all service areas, additional findings unique to each service area were also identified. These nuances are outlined within the report. The EAW meetings with internal staff and external agency partners provided additional insights into factors that should be considered for future outcome evaluations. Moreover, an additional interview with the Executive Director provided leadership-level considerations for future evaluations of the agency.

Summary of Recommendations

Overall, evaluability assessment recommendations endorsed further evaluation across all service areas with the caveat that some recommendations should be implemented prior to outcome evaluations. Although certain fields related to outcomes appear to be measured within the current data management system, other data fields related to outcomes are not clearly captured. Further evaluation is feasible, then, pending additional documentation and tracking efforts. ***Broadly, all service areas must (1) ensure that processes are being implemented consistently across programs, (2) identify specific client outcomes to focus on, and (3) guarantee that these client outcomes are capable of being captured using the central data management system for future analyses.*** If a central data management system is not used, then data collection efforts should be consistent and accessible to others within the agency. Although the overall recommendations are provided, there are factors that should be considered when developing future outcome evaluations, including additional data that may be useful to integrate (e.g., data management system, additional tracking), agency operations (e.g., ability to hire staff, funding), and ways in which assessments could be conducted (e.g., quantitative and qualitative data).

Expanding the Knowledge Base about Child Advocacy Centers: Findings from an Evaluability Assessment of Five Core Service Areas

Statement of the Problem

Children's advocacy centers (CACs) were established to provide a coordinated, multidisciplinary and child-focused response to allegations of child maltreatment (Chandler, 2000). The CAC model involves a combination of services uniting professionals from various fields, including law enforcement, the district attorney's office/prosecution, child welfare/child protection, victim advocacy, medical, and mental health (Chandler, 2000; Cross et al., 2008; Newman et al., 2005). In this way, CACs are able to provide support through comprehensive and coordinated services for the child and family in one facility (Chandler, 2000; Cross et al., 2008; Newman et al., 2005).

Since their development in 1985, over 1,000 CACs have been developed across the country, with at least one CAC in every state (National Children's Advocacy Center, 2021; Tavkar & Hansen, 2011). Despite the rapid proliferation, however, there is a lack of empirically rigorous studies examining CACs and their component services (Elmquist et al., 2015). Given the importance of this work and the substantial resources provided to these centers, examination of their program operations is essential. Additionally, as no two CACs are alike, assessment of each agency's policies and procedures can ensure that they are appropriately meeting the needs of their unique community.

While previous studies have assessed various outcomes of CACs (e.g., child and family satisfaction with services, prosecution outcomes), few have examined program operations, despite the importance of exploring the processes that lead to these outcomes. By first assessing the operations that are characteristic of each CAC, a more holistic understanding can be gained regarding how these procedures lead to service outcomes. It is with this backdrop that Project Harmony, one of the largest child advocacy centers in the country, underwent a formative evaluation and evaluability assessment of five core CAC services to better understand this model and lay the groundwork for a subsequent outcome evaluation.

An Overview of Child Advocacy Centers

Recognizing the significant issues among traditional law enforcement and child protection response to child sexual abuse allegations (e.g., re-victimization of the child, low prosecution rates), CACs were created to improve system response to these cases (Cross et al., 2008; Jackson, 2004b). The first CAC was developed in 1985 in Huntsville, Alabama with the aim of responding more effectively to cases of child sexual abuse and ensure that the children involved in these cases would no longer be re-victimized by existing systems and processes (Cross et al., 2008). The National Children's Alliance (NCA) was later founded in 1988 as a membership organization for CACs, which promoted accreditation standards (Wolf, 2000).

The early success of the first CAC in Alabama and subsequent creation of the accrediting body, the National Children's Alliance (NCA), led to the rapid development and expansion of the CAC movement. Ultimately, the objectives of CACs expanded to aid child victims who

were exposed to physical assault, domestic violence, neglect, and other forms of abuse (Jackson, 2004b; Walsh et al., 2003). Today there are over 900 accredited CACs in the United States, reflecting the value of coordinated child abuse investigations, prosecutions, and treatment for child victims and their non-offending caregivers (NCA, 2022).

Under the CAC model, 10 standards were designed to best meet the needs of clients and improve outcomes for children and families (Cross et al., 2007; NCA, 2017). Accreditation is provided by the NCA (Jackson, 2004b) based upon requirements for each of the 10 standards (Chandler, 2000; Herbert & Bromfield, 2016; NCA, 2017), including multidisciplinary teams (MDT), forensic interviewing, victim advocacy, child-focused setting, mental health services, medical examinations, case review, case tracking, cultural competency and diversity, and organizational capacity. Among the scant systematic examinations of standard adherence (e.g., Jackson, 2004a), the literature shows that standards are widely implemented among NCA-member CACs. However, the ways in which the standards are implemented can vary greatly across locations.

Although there is variation in implementation, the NCA standard requirements exist across all CACs and guide the operations that take place within each service area. For example, services must be housed and offered in a child-friendly setting that is physically and psychologically safe (Cross et al., 2012). Furthermore, in addition to CAC staff members, various agencies are included in the CAC response, including law enforcement, child protection, prosecution, medical, mental health, and victim advocacy. Other professionals (e.g., health and social care professionals) may be and often are involved, as well (Cross et al., 2012; Tener et al., 2020). In fact, these agencies are often co-located within the CAC to facilitate coordination on cases (Cross et al., 2012).

Notably, while these requirements are in place for all CACs, it is recognized that the CAC model can and should be adapted to different communities (Walsh et al., 2003). CACs were developed to meet the needs of diverse communities, and as such, reveal variations in structure and processes. That is, some provide only forensic interviewing and advocacy services; some refer to community agencies for core components such as advocacy, medical, or mental health care; and some provide most or all services on-site (Herbert et al., 2018). Therefore, although established criteria provide a basis for how CACs should function, they can also be supplemented, depending on the resources and needs of each unique community (e.g., community-based programs) (NCA, 2016). In this way, the NCA standards act as a minimum guideline for all accredited CAC operations.

Project Harmony

Project Harmony, a co-located child advocacy center, was founded in 1996 by a county attorney and community leaders who sought to improve the coordination of child abuse investigations and prosecutions in Nebraska. Project Harmony's catchment area includes two of the three largest counties in Nebraska—Douglas and Sarpy Counties, and 16 counties in southwest Iowa. In 1996, 60 children received forensic interviews and medical examinations; advocacy support and mental health care were not yet included in the service array. In subsequent years, Project Harmony services and staff grew to meet the growing demand. In

2004, the first case coordinator was hired to coordinate multi-disciplinary reviews of child abuse and neglect cases.

By 2006, Project Harmony added one family advocate, assigned to coordinate cases at intake and provide support to families. In 2007, Project Harmony created a training institute, charged with improving knowledge and skills in child abuse reporting and response. In 2008, the first child abuse pediatrician in Nebraska was hired by Project Harmony to provide prompt expert medical care to victims of abuse and neglect. In 2012, Project Harmony hired its first mental health therapist to provide on-site therapy to children assessed for maltreatment.

The number of Project Harmony staff, as well as the number of children receiving services, continues to increase each year. In 2018, Project Harmony added staff in all program areas, expanded business hours, and assessed and treated 4,149 unique children for alleged child abuse. The assessments included forensic interviews, family advocacy, medical examinations, mental health treatment, and multi-disciplinary case review. Of the children served in 2018, 24% were under age 6; 34% were between the ages of 7 and 12; and 42% were 13 years old or older.

Project Harmony is co-located with essential partner agencies, which allows for meaningful collaboration throughout the processing of child abuse and neglect cases at the CAC. Specifically, the Special Victims Unit and the Domestic Violence Unit of the Omaha Police Department (OPD) and several core Department of Health and Human Services (DHHS; child protective services) offices are located on-site at Project Harmony. Project Harmony staff work closely with these and other partners (i.e., District Attorney's Offices, other law enforcement agencies, community service providers) to share critical information, coordinate the investigation of cases handled within the CAC, and provide the necessary support to non-offending caregivers and child victims.

In terms of case processing, children and youth typically are referred to Project Harmony by law enforcement and/or DHHS for a forensic assessment. The first step is a forensic interview conducted by a specially trained interview specialist. Following the forensic interview, children receive a medical exam by the child abuse pediatrician or nurse practitioner to assess their overall physical and mental condition and, if necessary, to gather evidence. Concurrently, the family meets with an advocate whose role is to provide support, assist with referrals to therapy or other services, and keep the family apprised of the investigative process. Many families are also referred to trauma-informed therapy with Project Harmony therapists. For more complex cases, the county attorney convenes a multi-disciplinary team consisting of representatives from child welfare, juvenile justice, mental health, and other community agencies with a Project Harmony case coordinator assigned to facilitate case reviews. The goals of these meetings are to promote a coordinated effort among professionals and to ensure children and families are receiving appropriate services for their circumstances. Currently, Project Harmony facilitates 11 multi-disciplinary teams each month for Douglas and Sarpy Counties and 16 southwest Iowa counties.

Nebraska requires that law enforcement and child protective services utilize child advocacy centers to interview children suspected of abuse or neglect in cases of sexual abuse,

severe physical abuse and neglect, drug-endangered children, and serious or ongoing domestic violence (Nebraska Revised Statute 28-728). Nebraska law also requires that the CAC be utilized when DHHS determines the child is at high or very high risk for further maltreatment, and in any case in which a system-response issue has been identified. In recent years, the law has added the requirement that the CAC be consulted in cases in which the perpetrator does not reside in the child's home; and in cases involving status offenders and delinquent youth. Due to enhancements to the original law, combined with recognition of the many ways in which children can be victimized by trauma and violence, Project Harmony has expanded services to meet these emerging needs. Included are adolescents with problematic sexualized behavior; children involved in sex trafficking; youths who have "crossed over" from child welfare to juvenile justice services; and missing or runaway adolescents.

Assessing Child Advocacy Center Operations

Given the goals of CACs to assist children and their families, researchers and practitioners have sought to assess the effectiveness of these initiatives. Early research focused on the benefits of the multi-disciplinary team process (Jackson, 2004a), victims' and families' satisfaction with the investigation and the CAC (Cross et al., 2012), the CAC response to child maltreatment cases compared to traditional child protective services (Smith et al., 2006), and the arrest and prosecution rates of offenders (Cross et al., 2008; Faller & Palusci, 2007; Wolfteich & Loggins, 2007). Today, the majority of extant CAC research exclusively examines outcomes, such as services (e.g., medical exam) and referrals provided to children and families (e.g., Edinburgh et al., 2008; Jenson et al., 1996), prosecutions (e.g., Cross et al., 2008; Edinburgh et al., 2008; Wolfteich & Loggins, 2007), and disclosures during forensic interviews (e.g., Cross et al., 2007, 2008). Other studies have examined satisfaction in services among non-offending caregivers (e.g., Bonach et al. 2010; Cross et al., 2008; Jenson et al., 1996) and children (e.g., Cross et al. 2008; Jenson et al., 1996). Beyond these, some work has assessed CAC response in comparison to traditional child protective services response (e.g., Smith et al., 2006), as well as MDT processes (e.g., collaboration) (e.g., Bonach et al., 2010; Brink et al., 2015; Jackson, 2012; Jenson et al., 1996). Other outcomes, such as CAC child friendliness (e.g., Jenson et al., 1996) and mental health screening tools (e.g., Conners-Burrow et al., 2012) have also been examined. Generally, these studies have demonstrated that CACs are successful at achieving these measured outcomes and providing services that children and/or caregivers perceive as satisfactory.

In addition to these outcome evaluations, studies have also examined existing CAC models and standards in practice, such as variations in CAC characteristics (e.g., Herbert et al., 2018) and variations across implementation of the CAC standards (e.g., Jackson, 2004a). These studies have demonstrated that, while core CAC components are widely implemented within centers (Herbert et al., 2018; Jackson, 2004a), variations do exist (e.g., non-NCA members having lower rates of adherence to the standards such as having a child investigative team). But again, even among NCA member centers, variations existed in whether the center provided case review, case tracking, and victim advocacy services since the standards act as a minimum guideline (Jackson, 2004a).

While this literature provides important knowledge surrounding CACs, substantial limitations exist. That is, most studies were conducted on very small sample sizes, are cross-sectional, have come across mixed results, and/or cannot be generalized to larger populations (Conners-Burrow et al., 2012; Elmquist et al., 2015; Faller & Palusci, 2007; Smith et al., 2006). Additionally, the majority of literature about CACs was published in the early 2000s, and given the evolution of the movement, has not kept pace with the programmatic changes that epitomize child advocacy centers. For example, while early research noted that CACs lacked adequate staff availability, today the majority of CACs provide services on-call and on weekends (Newman et al., 2005). Furthermore, most early research tended to focus on the service array provided by CACs, characteristics of the multi-disciplinary team (MDT), and/or the degree of collaboration among agency partners (Jackson, 2004a; Newman et al., 2005). Since then, the services provided have expanded to include mental health services, training, and prevention; the multi-disciplinary team has become adept at identifying and recruiting needed experts; and agency partners have gained experience in coordinating and collaborating on cases.

Beyond these, most studies fail to examine the nuance of individual service areas of the CACs, but rather on the CAC as a whole (Herbert & Bromfield, 2017; Newman & Dannenfelser, 2005; Newman et al., 2005). Relatedly, certain service areas (e.g., mental health, advocacy) have received little to no empirical assessment within the CAC literature—areas that can and do operate in unique ways that are not being captured. Finally, current studies primarily focus on the perspectives of external agency partners (e.g., law enforcement personnel, child protective services workers), without considering the experiences of internal CAC staff members (Newman & Dannenfelser, 2005; Newman et al., 2005). Given the multidisciplinary nature of CACs, it is vital then that the processes and procedures implemented by CACs are examined to assess separate service areas and the unique challenges and strengths they may possess.

Despite these limitations—or perhaps as a result of them—scholars have stressed the importance of additional research on CACs. For example, one article reported that research is "urgently needed" to determine which components of the CAC contribute most to improving outcomes for the MDT and children and families (Herbert et al., 2018). Another article—a systematic review of CAC literature—argues that larger sample sizes and control groups are needed to reliably assess CAC effectiveness (Elmquist et al., 2015). The authors specifically call for an evaluation of programs and services that have not been evaluated—including on-site mental health treatment, victim advocacy services, and cultural and diversity awareness. They highlight the need for longitudinal assessments to measure client satisfaction, emotional and behavioral adjustment of child victims, revictimization of children, and service referral and receipt. Furthermore, there is a need to incorporate the perceptions of children, caregivers, and professionals working in and with CACs to inform service provision and effectiveness. Finally, CACs need to collaborate with one another on research agendas in order to determine which aspects of the model are most effective and which need to improve (Elmquist et al., 2015).

Current Study

Project Harmony's core services have been operational for over 25 years with expansions over time, and yet the core service areas have never been formally examined using formative or summative evaluation methods. That is, although Project Harmony has collected client data for 12 years, the primary purpose of data collection was compliance reporting to the NCA, other stakeholders, and funders. Therefore, very little was known about whether each core service was operating as intended or if the outputs and associated outcomes could be improved. Further, while program protocols have been developed for advocacy, forensic interviewing, medical, mental health, and multidisciplinary teams, gaps were evident in staff awareness of and utilization of these protocols. Further, data had not been collected to assess each service area's alignment with best practices.

Given these shortcomings, critical questions around program implementation, processes, and outcomes remained unanswered. This study thus sought to examine the five core service area's readiness for an outcome evaluation at Project Harmony by conducting a formative evaluation and an evaluability assessment in two phases. The formative evaluation and evaluability assessment thus provided the groundwork for the execution of a full-scale outcome evaluation. Additionally, information gathered from the current study was used to develop essential tools (i.e., products) that can be used by Project Harmony and other CACs to assess implementation fidelity and guide future evaluation efforts in this field.

Method

This project was carried out in two phases. Phase I included a formative evaluation that assessed the policies, procedures, and perceptions of the work being done across five service areas within Project Harmony (i.e., advocacy, forensic interviewing, medical, mental health, multidisciplinary teams). Phase II included an evaluability assessment to determine the "evaluation readiness" of each service area for an outcome evaluation, including recommendations for improving readiness. The research questions for these two phases are provided in Table 1, which also includes the method and corresponding products associated with each research question (see Appendix A).

Phase I: Formative Evaluation

To complete Phase I, the formative evaluation, data were collected across four main sources: (1) a literature review, (2) Project Harmony document reviews, (3) focus groups, and (4) surveys. Each step in this process was used to build a foundation for the subsequent step. Additional details on the purpose of each data collection effort and method are provided below.

Literature Review

As the first step of the project, the research team conducted a literature review of existing research on Child Advocacy Centers (CACs), including studies on evaluations, outcomes, and service provisions examined in this study (i.e., advocacy, forensic interviewing, medical evaluations, mental health services, multidisciplinary teams). The purpose of this step was to

Table 1. Data Sources, Methods, and Product by Research Question

Method	Product
Phase I: Formative Evaluation	
Research Question #1: *How are Project Harmony's core services being implemented? What are the key elements of each program? Are core services being implemented according to the NCA standards?*	
• Systematic review of organizational documentation compared to National Children's Alliance (NCA) Standards • Surveys and focus groups with staff and agency partners (interviews as needed) • Review of existing agency data collection database	Descriptive research of Project Harmony's core services leading to the development of program-specific **logic models**
Research Question #2: *What protocols exist to guide service delivery; How are they followed by employees and agency partners?*	
• Integration of findings from the literature review, document reviews, focus groups, and survey to provide an overview of findings	Development of a **summary guide** of findings for all five service areas
Research Question #3: *What tools can be utilized to assess implementation fidelity?*	
• Assessment of application of NCA Standards to Project Harmony • Integrate existing research to fit Project Harmony's core service needs	Development of **fidelity toolkits** for each core service area
Phase II: Evaluability Assessment	
Research Question #4: *What is the "evaluation readiness" of each core service?*	
• Development of evaluation assessment workgroup • Review of study findings and project products	**Evaluability assessment checklists** of core service area outcome evaluation readiness
Research Question #5: *How can "evaluation readiness" be improved for each core service, in order to facilitate a formal outcome evaluation of each core service?*	
• Examine systematic mechanisms to review reliability, validity, and implementation of the fidelity tool for each core service area to inform recommendations for improvement • Complete evaluability report for each core service area including assessment of the organizational culture and readiness for change	Recommendations for improvement included in the **evaluability assessment checklists**

Note: A description of all products is provided in Appendix A.

assess (a) the state of the current evaluation literature on CACs and (b) identify findings that could be used to guide the current evaluability assessment (i.e., focus group protocol, survey).

The literature search was conducted between November 27, 2019, and January 28, 2020, with additional relevant research incorporated into the review as it was identified. Search terms were combinations of various phrases that could be related to evaluations of CACs, including "children's advocacy centers," "evaluation," "implementation," "sexual abuse," "response," and/or "services." Searches were completed in multiple databases to increase the likelihood of identifying relevant studies (e.g., Google Scholar, University of Nebraska at Omaha Criss Library, Academic Search). Additional articles were located (a) by searching through the reference lists of identified relevant articles or systematic reviews and (b) by searching who had cited identified relevant articles in Google Scholar.

Project Harmony Document Reviews

The next step of the project was to review Project Harmony's documents (e.g., service area narratives, service area protocols and procedures, on-site peer review forms, release of information documents) for each of the five service areas and compare them to the 2017 National Children's Alliance (NCA) Standards that CACs need to meet for accreditation. The purpose of this step was (a) to conduct qualitative content analysis to identify key themes that describe the programs and their current operations in detail and (b) to determine whether there were gaps or inconsistencies that may have needed further exploration during data collection.

Project Harmony initially provided narratives in February and March 2020 for each of the five service areas—these narratives were used for NCA accreditation in 2017. As Project Harmony was undergoing the accreditation renewal process, updated narratives and supporting documents were provided to the research team between August and November 2020. These narratives and supporting documents were reviewed and organized into checklists that incorporated the NCA Standards so inconsistencies between documentation (i.e., narratives) and evidence of meeting the Standards (i.e., supporting documentation) could be noted. Both the narrative and the supporting documents were examined to assess whether Project Harmony was meeting NCA Standards.

Focus Groups

The next step of the project was to integrate the findings from the extant research and Project Harmony's documents to develop an interview protocol and conduct focus groups with internal CAC staff and external agency partners. The purpose of this step was to gather contextual and localized information around program implementation and associated processes.

In collaboration with Project Harmony leadership, both internal CAC staff and external agency partners who work with the five service areas were identified to participate in the focus groups. Leadership also sent out an email to encourage participation from external agency partners. Notably, while Project Harmony leadership assisted in identifying key stakeholders and staff to participate in focus groups, the research team organized and held all focus groups in a way that protected the identity of respondents (i.e., separated by internal/external status and service area, contact information was kept separate from de-identified transcripts). In other words, focus groups were divided by internal and external status, and by service area. That is,

the research team wanted external agency members to feel free to express themselves without having members of the CAC present. Similarly, with the internal groups, senior leadership was not involved in these groups so that staff could speak freely without having to censor themselves in front of their supervisor(s).

The interview protocol for the focus groups was developed to measure five overarching themes: (1) background and collaboration in organization, (2) implementation fidelity of existing protocol and modifications to service delivery, (3) perceptions of program operations and intended outcomes, (4) barriers to program implementation and fidelity, and (5) familiarity and adherence to the National Children's Alliance (NCA) standards. Although all participants were asked approximately the same questions, the interview protocols were tailored based on the service area and whether the focus group included internal CAC staff or external agency partners (see Appendix B for internal staff protocol items; see Appendix C for external staff protocol items). The follow-up survey mirrored the interview protocol questions.

The focus groups were divided by service area and whether the participants worked for Project Harmony (i.e., internal) or an external agency partner. Of the 81 participants who were invited, a total of 69 attended (85.2% response rate). More specifically, 32 out of 36 invited internal members attended (91.4% response rate) and 37 out of 45 invited external members attended (82.2% response rate). The largest focus group included nine participants, while the smallest focus group included two participants. Internal staff focus groups were 90 minutes long, while external agency partner focus groups were 60 minutes to be mindful of time. The focus groups were held in-person, online, and as a hybrid option between September and November 2020. Although most individuals worked primarily in one service area (e.g., advocacy), there were some who worked across multiple areas. Therefore, some groups were created to assess multiple service areas. To account for any perspectives not captured in the focus group sessions (e.g., participants not being able to join the session, participants who had additional thoughts to share), a follow-up survey was administered to the same individuals invited to the focus groups in December 2020 with the same focus group questions—a total of 22 follow-up surveys were returned and incorporated in the overall focus group findings.

Once the interviews were completed and the follow-up surveys were returned, the audio files were transcribed, de-identified, and subjected to thematic content analysis using MaxQDA 2020 (Braun & Clarke, 2006; VERBI Software, 2019). Cases were organized based on type of focus group (i.e., internal, external) and service area. Coding categories were then developed to mirror the five themes of the interview protocol to inform the responses regarding the policies and procedures across the service areas (Patton, 2002). Inductive coding was then used to identify sub-themes within these broader coding categories (Braun & Clarke, 2006). Coding classification issues were discussed among the research team. Inter-coder reliability was assessed by randomly selecting three transcription files and coding classifications; reliability was relatively high across two coders ($\kappa = .88$; O'Connor & Joffe, 2020). Notably, coding discrepancies were attributed to slight deviations in sub-themes, but all classifications fell under the same coding category themes across coders.

Survey II

The final step of the project was to develop and administer a survey following up on identified themes from the focus group sessions. The purpose of this was to gather additional contextual information around program implementation and associated processes based on the focus group findings.

Survey II was tailored and administered based on service area and whether the individuals were internal CAC staff or external agency partners. Internal staff members included those working at Project Harmony in either the Advocacy, Forensic Interviewing, Medical, Mental Health, and/or Multidisciplinary Team service areas. Conversely, external agency partners included professionals collaborating with one or more of these five service areas. Again, although most individuals worked primarily in one service area (e.g., Advocacy), there were some individuals who worked across multiple service areas. Therefore, some surveys were created to assess multiple service areas. The survey questions were developed based on the organizing themes discussed in the focus group protocols, and areas that required additional clarification. Specifically, Survey II included item themes on participants' perceptions of (1) training, (2) policies, (3) barriers, (4) strengths, (5) NCA Standards, (6) outcomes, and (7) closing thoughts (survey items are presented in Appendix D). Although all participants were asked approximately the same questions, Survey II was tailored based on the service area and whether the focus group included internal CAC staff or external agency partners. A total of 14 surveys were created to gather responses across the five service areas for internal and external participants (11 surveys total), and then three surveys for individuals who work across multiple service areas. Survey II was administered in June 2021.

The individuals who were invited to the focus group sessions also received an email to participate in this second survey (hereafter referred to as "Survey II"). Similar to the focus group sessions, Project Harmony leadership sent out an email to encourage participation from external agency partners. A total of 80 participants were invited to complete the survey (one fewer than the focus groups due to turnover). Overall, 42 individuals started the survey (52.5% response rate) and 31 completed the survey (38.8% response rate).

Phase II: Evaluability Assessment

Once all data from the Phase I: Formative Evaluation were collected and analyzed, the research team moved into Phase II: Evaluability Assessment for all five service areas. Broadly, the purpose of this phase was to determine the evaluation "readiness" for each program area (e.g., Wholey et al., 2004). To assess "readiness," the research team completed evaluability assessment checklists and held two Evaluability Assessment Workgroup (EAW) meetings to receive feedback on the findings and recommendations. These steps are described below.

Evaluability Assessment Checklists

Evaluability assessment checklists were used to aid the research team in their determination of the "evaluation readiness" of each program. Adapted from prior research, these tools were used to assess the program coherence and evaluation capacity for each service area (Campagna et al., 2020). Program coherence was measured across six dimensions, with multiple indicators within each dimension—the domains and operationalizations are presented in Table 2.

Table 2. Evaluability Assessment Checklist Domains

Domain	Definition	Indicators and Description
Program Goals/Objectives	The purpose behind each service area, including their focal aims or objectives	• *Clearly Specified:* Program goals and objectives are directly outlined within documentation • *Realistic to Achieve:* Program objectives are reasonable, feasible, and practical • *Shared by Stakeholders:* External partners share a similar conceptualization with internal staff of what the program goals/objectives are
Program Resources	The stock or supply of money, materials, staff, and other assets necessary for each service area to function effectively	• *Sufficient:* Resources are perceived as being both satisfactory and ample to fulfil the service area's goals and objectives • *Available:* Resources are consistently accessible for all internal and external staff • *Sustainable:* The agency is able to maintain the resources used to fulfil the service area's goals and objectives over time
Program Components	Were measured as the characteristics, features, and strategies that structure a program	• *Well-Defined:* Program components are directly and clearly outlined within documentation • *Realistic to Achieve:* Program components are reasonable, feasible, and practical
Implementation	The process of putting program components into effect as they were intended or how well program components are being executed	• *Complete:* There is evidence of implementation (e.g., documentation within spreadsheets, data management system) • *Consistent & with Fidelity:* Evidence of implementation (e.g., documentation within spreadsheets, data management system) that appropriately aligns with the program's goals, objectives, and components is routinely documented
Program Outputs	The activities and services that guide each service area and enable outcomes or products of the program components	• *Clearly Specified:* Program outputs are directly outlined within documentation (e.g., service manual, narratives, logic models) • *Measurable (theoretically):* Theoretically, the program outputs could be measured • *Comprehensive:* Program outputs are both inclusive and exhaustive • *Agreed-Upon:* An understanding of service area program outputs are similarly held across internal staff and external partners
Client Outcomes	Products and/or results related to each service area's intervention	• *Clearly Specified*: Desired client outcomes that align with the program's goals and objectives are identified during focus groups and surveys • *Measurable (theoretically):* Theoretically, the program outputs could be measured • *Measurable (empirically):* Client outcomes are being tracked within the Efforts to Outcomes (ETO) data management system • *Comprehensive:* Program outcomes are both inclusive and exhaustive • *Agreed-Upon:* Similar desired client outcomes are held across internal staff and external agency partners

All indicators were rated by the research team based on whether they (i) generally met standards for evaluability, (ii) partially met standards for evaluability, or (iii) generally did not meet standards for evaluability. Ratings were provided following a review of all data collected over the course of Phase I (i.e., Project Harmony document reviews, focus groups, survey). Additional notes were included for all indicators that received a rating below "generally met standards for credibility," providing a justification for the assigned rating.

Once all evaluability checklists were completed, an evaluation plan was developed for each individual service area, including justifications and recommendations for the program's evaluability. Within each service area's evaluation plan, we provided (1) conclusions regarding program evaluability (e.g., likeliness that the program can impact intended outcomes), (2) recommendations (e.g., necessary program modification), and (3) suggestions based on the evaluability assessment results (e.g., only specific program components should be evaluated).

Evaluability Assessment Workgroup

The next stage in Phase II involved incorporating feedback on all findings and products from key stakeholders. The research team worked with Project Harmony leadership to determine which internal staff and external agency partners should be included in the meetings. These meetings were referred to as the Evaluability Assessment Workgroup (EAW), with the purpose being to (1) involve key stakeholders to help guide the evaluability assessment, (2) provide an overview of the grant products/deliverables, and (3) receive input from key stakeholders on these deliverables, including any information that may have been missing or incomplete. Two EAW meetings were held—one with internal Project Harmony staff and one with external agency stakeholders.

The first EAW meeting was held at Project Harmony in April 2022 and included internal staff serving in an upper management position. Following an overview of the findings and grant products, input from the staff was elicited. This feedback was recorded, and changes were implemented to the products as needed following the meeting. In addition to providing an overview of and receiving feedback on the grant's products, this meeting was also used to identify all necessary external agency partners for the external EAW. The second EAW meeting was subsequently held at Project Harmony in May 2022. At this meeting, the external agency partners were provided an overview of the project and products, and then were given the opportunity to provide feedback.

Findings

A summary of findings for each step of the current project are provided below based on the overall findings and by service area (as applicable).

Phase I: Formative Evaluation Findings

Literature Review

The research team conducted a literature review of existing research on Child Advocacy Centers (CACs), including studies on evaluations, outcomes, and service provisions examined in this study. Provided below is a summary of key findings from the 21 articles that were reviewed.

- There were relatively few research articles examining evaluations of CACs
- Most evaluations that exist were focused on the perceptions of agency staff, agency partners, or the clients that they serve
- There were no evaluability assessments of CACs identified in the extant research that matched the current project
- Some information from the literature review was used to guide topics included in the focus group protocol and survey that Project Harmony staff and agency partners completed (e.g., what is the most important outcome for each service area, training needs) (e.g., Jackson, 2012)

Project Harmony Document Reviews

Project Harmony documents (e.g., narratives, supporting documents) for each of the five service areas were reviewed and compared to the 2017 National Children's Alliance (NCA) Standards. Provided below is a summary of key document review findings, organized by findings across service areas and by service areas. *Notably, the findings outlined below are based solely on the documents that were reviewed—later conversations with the Evaluability Assessment Workgroup (described in more detail below) indicated that partially met or unmet Standards may have additional tracking or documentation within the agency that was not provided to the research team.*

Summary of Findings across Service Areas

- Most of the National Children's Alliance (NCA) Standards were met or partially met by Project Harmony, as evidenced in the service area narratives and supporting documents
- There were some narratives and/or supporting documents that stated that the NCA Standards were being met but with minimal details on how those processes were monitored and documented
- Some of the items where there were minimal details across specific service areas revolve around the coordination with the multidisciplinary team (MDT)

Summary of Findings by Service Area

Advocacy

- Most of the NCA Standards were met or partially met by Project Harmony, as evidenced in the narrative and/or supporting documents

- There are minimal details on specific aspects of trainings, such as the hours spent on topics and the types of topics covered
- There are minimal details on the ongoing education that Project Harmony staff receive for a minimum of eight contact hours every two years

Forensic Interviewing

- Most of the NCA Standards were met or partially met by Project Harmony, as evidenced in the narrative and/or supporting documents
- There are minimal details on training content or protocols that forensic interviewers complete, even though training criteria are noted as being met by attending the Forensic Interviewing of Children training at the National Child Advocacy Center
- There are minimal details on the ongoing education that Project Harmony staff receive for a minimum of eight contact hours every two years
- There are minimal details on determining the criteria/process when a child has a subsequent interview

Medical Evaluations

- Most of the NCA Standards were met or partially met by Project Harmony, as evidenced in the narrative and/or supporting documents
- There are minimal details on whether medical evaluations are shared with multidisciplinary teams specifically in a routine, timely, and meaningful manner

Mental Health Services

- Most of the NCA Standards were met or partially met by Project Harmony, as evidenced in the narrative and/or supporting documents
- There are minimal details on how protocols and guidelines define the role and responsibility of the mental health professional on the multidisciplinary team (MDT) on how they are supporting the Multidisciplinary Teams (MDT) in monitoring the treatment progress and outcomes

Multidisciplinary Teams (MDT)

- Most of the NCA Standards were met or partially met by Project Harmony, as evidenced in the narrative and/or supporting documents
- There are minimal details on how CAC/MDT members participate in effective information sharing that ensures the timely exchange of case information within the MDT

Focus Groups

Focus groups with internal CAC staff and external agency partners were conducted to gather contextual information around program implementation and associated processes. Focus groups were divided by internal and external status and by service area and were held in-person, online, or as a hybrid option. Again, a total of 69 participants attended focus groups involving 32 internal and 37 external participants. Provided below is a summary of key focus group findings across service areas and organized by five themes, as well as findings by service area (see Appendices B and C for interview protocol themes and items by internal/external status).

Summary of Focus Group Findings across Service Areas and Organized by Themes

Implementation Fidelity of Existing Protocols and Modifications to Service Delivery

- Most policies/procedures that guide decision making and information sharing are state statutes (e.g., 1184 meeting), HIPAA, or policies that are informed by evidence-based/best practices
- Discretion is used frequently within decision making, depending on the case (e.g., child's age, child's development), with knowledge on how to respond appropriately improving with time

Perceptions of Program Operations and Intended Outcomes

- Strong relationships exist among Project Harmony staff and agency partners, with staff generally feeling supported and external partners regarding the agency highly (e.g., high quality services)
- Relationships between Project Harmony and external partners have improved over time, but some participants still struggle with trust and re-education due to staff turnover and changing legislators/policies
- Using a virtual platform has been mostly positive during the COVID-19 pandemic (e.g., convenience) but can also lead to a lack of engagement among virtual discussants and inhibits in-person connections that often help facilitate referrals and case discussions
- Intended outcomes vary among groups (e.g., quality of services, safety measures, supporting families) but are generally perceived as being successful by internal staff and external partners

Barriers to Program Implementation and Fidelity Within Project Harmony

- Some core service areas lack structure and consistency in their processes/procedures (**note that some of these issues may pertain to the field more broadly [e.g., defining role of advocates])*
- Burnout and secondary trauma, and staff turnover were noted as ongoing challenges (turnover among agency partners was also noted as an issue)
- COVID-19 pandemic complications (e.g., disrupting opportunity to learn processes and procedures in person (**note that trainers mitigated this concern by spending more time with new hires to answer questions)*
- The data management system (e.g., Effort to Outcomes [ETO] system) is not user friendly

Barriers to Program Implementation and Fidelity Among Collaborations with Agency Partners

- There was insufficient knowledge of the different roles, guidelines, standards, and procedures between Project Harmony and external agency partners
- Issues meeting time frames during early days of the COVID-19 pandemic (**note that these issues have since been resolved by opening more time slots, prioritizing essential cases, and conducting virtual interviews*)
- Different, and sometimes competing, philosophies between Project Harmony and external partners where partners sometimes feel they have to justify their decisions or agency feels they have to please partners

Familiarity and Adherence to National Children's Alliance (NCA) Standards

- Project Harmony staff noted feeling fairly familiar with NCA Standards, whereas external partners were less familiar with them, but nonetheless felt that adherence to Standards were important
- Because CACs differ from core service areas and regions, it can be difficult to account for these aspects throughout the NCA Standards
- Increasing aids and trainings on the NCA Standards, including the "why" of using them would enhance familiarity and adherence

Summary of Focus Group Findings by Service Area

Advocacy

- Great deal of passion for helping children and families that come to Project Harmony among staff
- Service area staff are culturally diverse and offer culturally sensitive services for families
- Service area staff tend to "take home" their work, which can result in extra burdens
- Lack of a standard, established description on what the role of the advocates entails, including effective staff caseloads

Forensic Interviewing

- Staff receive constant assistance and direction throughout stages of training
- There has been progression in relationships with external agency partners over the years
- There can be discrepancies between internal service area staff and external agency partners on what should be asked during interviews
- Request for more rigorous preparation on testifying in court (e.g., role playing, feedback)
- Lack of diverse and cultural resources (e.g., lack of male staff, no in-person interpretation services)

Medical Evaluations

- Staff recognized as being up to date on research
- Staff are noted as being "mindful" of their "scope" or role throughout CAC process
- Low rates of turnover among staff
- Staff tend to struggle with a lack of community education on child sexual abuse in general
- Differing perspectives on the purpose or necessity of a medical exam between internal and external staff

Mental Health Services

- Staff receive evidence-based training
- Staff have seen an increase in structure across the implementation of policies and procedures
- There is a need for more support staff to handle day-to-day tasks
- Collaboration between service areas has created logistical challenges since agency expansion has resulted in staff from some service areas moving to separate buildings
- There are limits on some resources (e.g., limited services and treatment for LGBTQ+ community)

Multidisciplinary Teams (MDT)

- MDT meetings provide a great deal of information sharing and central point for gaining information
- Relative consistency of schedule and daily tasks for staff
- Lack of knowledge regarding utility of referrals/recommendations after they are given
- Some issues in MDT meetings (e.g., re-addressing similar issues, lack of preparedness among some members)
- Lack of diversity on teams and among providers (e.g., gender, race/ethnicity, culture)

Multiple Service Areas

- Conditions have been improving over time (e.g., communication, implementation, information sharing, relationships with agency partners)
- Ongoing training for all staff (e.g., booster training) could be helpful on implementation (e.g., NCA Standards)
- Concerns that outside input or voice is not integrated or considered in agency decisions
- There can be different tools for determining child safety, which can affect decision making and whether to remove a child from their home

Survey II

After the focus group transcripts were analyzed, a survey (Survey II) was sent to focus group members to gather additional contextual information around identified themes on program implementation and associated processes. This survey was tailored and administered based on service area and whether the individuals were internal CAC staff or external agency partners. Overall, of the 80 individuals invited to take the survey, 42 individuals started the survey (52.5% response rate) and 31 completed the survey (38.8% response rate). Again, the survey questions were developed based on the organizing themes discussed in the focus group protocols, and areas that required additional clarification (see Appendix D for survey items). Provided below is a summary of key survey findings across services areas organized by these themes, as well as findings by service area.

Summary of Survey II Findings across Service Areas and Organized by Themes

Training

- Both internal staff and external partners agreed that internal CAC staff have received adequate training overall—yet, external partners tended to rate training adequacy lower than internal staff
- The majority of internal CAC and external partners agreed that internal CAC staff have received adequate training among specific topics—external partners tended to rate training lower than internal staff
- Training topics that received lower ratings across both internal CAC staff and external agency partners included safety planning, victim advocate's role, secondary victimization, crisis assessment and intervention, HIPAA, cultural considerations, coordinated MDT response, and victim's rights

Perceptions of Policies

- A majority of internal staff and external partners agreed that state statutes, policies, and agreements guide decision making, information sharing practices, and confidentiality protocols
- All internal participants believed NCA standards are being met, with the development of policies/procedures that adhere to the standards being the most common example of adherence (Note: only internal staff were asked about NCA Standard adherence)

Perceptions of Barriers within the CAC

- Both internal staff and external partners frequently recognized turnover as being a challenge
- Internal staff also identified burnout as being a significant challenge within the CAC

Perceptions of Barriers between the CAC and External Agency Partners

- While internal staff most often identified lack of knowledge on roles/polices/procedure and meeting time frames as challenges between the CAC and partners, external partners most often identified justifying their decisions to Project Harmony and lack of follow-up from Project Harmony as challenges

Perceptions of Strengths within the CAC

- Both internal staff and external partners most frequently identified passion among CAC staff and strength of relationships as being strengths within the CAC
- External partners also repeatedly identified expertise among CAC staff as being a strength

Perceptions of Strengths between the CAC and External Agency Partners

- Both internal staff and external partners commonly identified effective collaboration and coordination as a strength between CAC and external partners
- External partners also repeatedly identified confidence in high-quality services the CAC offers

Perceptions of Outcomes

- Most participants agreed upon the same one or two outcomes as being the most important for their respective service areas
- Most participants agreed that the outcome they selected as being most important was being met successfully
- While there was consistently high agreement among internal service area staff, internal staff and external partners generally identified different outcomes as being most important

Summary of Survey II Findings by Service Area

Advocacy

- Across all service areas and internal/external status, external advocacy members rated internal staff training the lowest
- Advocacy (external partners) were one of the only service areas to identify training as a barrier within the CAC
- Supporting and empowering children and families was most frequently identified as the most important outcome
- Advocacy was one of two service areas where internal and external staff agreed upon similar outcomes

Forensic Interviewing

- Forensic Interviewing (internal staff) was the only group to identify lack of follow-up as a barrier between internal staff and external partners
- Forensic Interviewing (external partners) was the only group to identify meeting time frame and different philosophies as barriers between internal staff and external partners
- The child having the opportunity to tell what happened was most frequently identified as the most important outcome
- Forensic Interviewing was one of two service areas where internal and external staff agreed on similar outcomes

Medical Evaluations

- Medical Evaluations (internal staff) was the only service area to report lack of structure in policies as a barrier within the CAC
- Patient feeling heard was identified most frequently as the most important outcome

Mental Health Services

- Mental Health Services was the only service area to report cultural diversity among internal CAC staff and providers as a challenge within the CAC
- Helping clients process and cope with trauma was most frequently identified as the most important outcome

Multidisciplinary Teams (MDT)

- MDT (internal staff) consistently rated their adequacy of training lower than other service areas
- MDT (external partners) was one of the only groups to identify training for internal CAC staff as a barrier within the CAC
- MDT was the only group to report both internal staff and external partners feeling valued as a strength between both CAC staff and partners
- Identifying or providing appropriate services/referrals was most frequently identified as the most important outcome
- When asked which outcomes are the most important, most other service areas agreed upon a smaller number (i.e., two to three), whereas those in the MDT service area reported eight different outcomes as being most important
- While most other service areas "agreed" or "strongly agreed" that their outcome was being met, some of the MDT partners reported that they "neither disagree nor agree" for the outcome selected

Multiple Service Areas

- Internal members were the only group to report the quality of work from CAC staff as a strength within the CAC

Phase II: Evaluability Assessment Findings

The purpose of the Evaluability Assessment phase was to determine the evaluation "readiness" for each program area. To assess the "evaluation readiness" of each program, the research team completed evaluability assessment checklists and held Evaluability Assessment Workgroups with key stakeholders. Recommendations for each service area, based upon program coherence and evaluation capacity, are provided below.

Program Coherence and Evaluation Capacity

Key findings from the evaluability assessment checklists are outlined below and organized by service area. As a reminder, all indicators were rated based on whether they (i) generally meet standards for evaluability (green highlight), (ii) partially meet standards for evaluability (yellow highlight), or (iii) generally did not meet standards for evaluability (orange highlight). The definitions of domains and indicators are. Additional details are provided for any domains and specific indicators that received a rating below "generally meets standards for evaluability." The rating for "Evaluation Capacity" considers readiness based on all domains and indicators.

Advocacy

As outlined in Table 3, most domains received a *generally meets standards for evaluability* rating for the Advocacy service area. However, two domains (i.e., Program Goals/Objectives, Implementation) were rated as *partially meets standards for evaluability*. Finally, one domain (i.e., Client Outcomes) was rated as *generally does not meet standards for evaluability*. Table 3 further summarizes these evaluations.

Table 3. Evaluability Assessment Summary: Advocacy

Domain	Rating	Indicators Falling Below "Generally Meets Standards"
Program Goals/Objectives		*Shared by stakeholders:* The role of the advocates may not be clear to some of the external stakeholders
Program Resources		
Program Components		
Implementation		*Consistent & with fidelity*: Limited documentation or access to documentation on evidence of implementation Note: Throughout focus groups, internal staff mention that "everyone does advocacy differently." Overall, the lack of definition surrounding advocacy and the role of the advocates leads to variability across implementation. Notably, this lack of structured definitions within the Advocacy service area is consistent within the field more generally
Program Outputs		
Client Outcomes		*Measurable (empirically):* While some outcomes are captured within ETO (i.e., referring necessary services), most other outcomes are not clearly captured in the current data system (i.e., meeting time frames, supporting and empowering families, referring necessary services, aiding families heal from trauma). Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS).
EVALUATION CAPACITY		

Notes: = generally meets standards for evaluability; = partially meets standards for evaluability; = generally does not meet standards for evaluability

Forensic Interviewing

Most domains received a *generally meets standards for evaluability* rating for the Forensic Interviewing service area (see Table 4). However, two domains (i.e., Implementation, Client Outcomes) were rated as *partially meets standards for evaluability*. Table 4 further summarizes these evaluations.

Table 4. Evaluability Assessment Summary: Forensic Interviewing

Domain	Rating	Indicators Falling Below "Generally Meets Standards"
Program Goals/Objectives		
Program Resources		
Program Components		
Implementation		*Consistent & with fidelity*: Limited documentation or access to documentation on evidence of implementation
Program Outputs		
Client Outcomes		*Measurable* (*empirically*): Some outcomes are captured within ETO (i.e., disclosure of abuse, child had opportunity to tell what happened to them, number of families receiving services, not repeatedly seeing children with problem sexual behaviors), whereas other outcomes are not clearly captured in current data system (i.e., conviction of the offender, employee satisfaction). Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS).
EVALUATION CAPACITY		

Notes: = generally meets standards for evaluability; = partially meets standards for evaluability; = generally does not meet standards for evaluability

Medical Evaluations

Most domains received a *generally meets standards for evaluability* rating for the Medical Evaluations service area. However, two domains (i.e., Implementation, Client Outcomes) were rated as *partially meets standards for evaluability*. Additional details are these ratings are outlined in Table 5.

Table 5. Evaluability Assessment Summary: Medical Evaluations

Domain	Rating	Indicators Falling Below "Generally Meets Standards"
Program Goals/Objectives		
Program Resources		
Program Components		
Implementation		*Consistent & with fidelity*: Limited documentation or access to documentation on evidence of implementation
Program Outputs		
Client Outcomes		*Measurable* (*empirically*): Some outcomes are captured within ETO (i.e., child treated for sexually transmitted infection [STI], number of exams completed, medical exam provided in a timely manner, evidence gathered for criminal case), whereas other outcomes are not clearly captured in current data system (i.e., patients feel heard, child got education and reassurance, meeting time frames). Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS).
EVALUATION CAPACITY		

Notes: = generally meets standards for evaluability; = partially meets standards for evaluability; = generally does not meet standards for evaluability

Mental Health Services

Most domains received a *generally meets standards for evaluability* rating for the Mental Health Services service area. However, two domains (i.e., Implementation, Client Outcomes) were rated as *partially meets standards for evaluability*. Table 6 further summarizes these evaluations.

Table 6. Evaluability Assessment Summary: Mental Health Services

Domain	Rating	Indicators Falling Below "Generally Meets Standards"
Program Goals/Objectives		
Program Resources		
Program Components		
Implementation		*Consistent & with fidelity*: Limited documentation or access to documentation on evidence of implementation
Program Outputs		
Client Outcomes		*Measurable* (*empirically*): Some outcomes are captured within ETO (i.e., client completes sessions, client returns for more than one session, reduction in symptomology and trauma symptoms), whereas other outcomes are not clearly captured in current data system (i.e., creating resilient adults, helping clients process and cope with trauma, preventing further trauma, referrals that include warm hand offs, sustainability in staff retention, engaging with the client [limited details on what this entails]). Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS).
EVALUATION CAPACITY		

Notes: = generally meets standards for evaluability; = partially meets standards for evaluability; = generally does not meet standards for evaluability

Multidisciplinary Teams (MDT)

As outlined in Table 7, most domains received a *generally meets standards for evaluability* rating for the Multidisciplinary Teams service area. However, three domains (i.e., Implementation, Program Outputs, Client Outcomes) were rated as *partially meets standards for evaluability*. Table 7 further summarizes these evaluations.

Table 7. Evaluability Assessment Summary: Multidisciplinary Teams

Domain	Rating	Indicators Falling Below "Generally Meets Standards"
Program Goals/Objectives		
Program Resources		
Program Components		
Implementation		*Consistent & with fidelity*: Limited documentation or access to documentation on evidence of implementation
Program Outputs		*Clearly specified:* Although team protocols outline each of the meetings (e.g., necessary team members for each team, time of meetings, necessary data collection), both internal and external focus groups mentioned difficulty in tracking success, lack of referrals/connections, little to no follow up on referrals and limited knowledge on everyone's roles
Client Outcomes		*Measurable* (*empirically*): Some outcomes are captured within ETO (i.e., attendance of all invited participants in MDT meetings, gathering different roles and perspectives together, identifying and providing appropriative services and referrals, Information sharing), whereas other outcomes are not clearly captured in current data system (i.e., addressing crisis situations, successful prosecution of cases, developing strategies to achieve permanency and long-term supports for the child, improving system barriers, successfully moving cases forward through the child welfare and juvenile justice systems).
EVALUATION CAPACITY		

Notes: = generally meets standards for evaluability; = partially meets standards for evaluability; = generally does not meet standards for evaluability

Evaluability Assessment Recommendations

Once program coherence and evaluation capacity were assessed for each service area, an evaluation plan was developed, including justifications and recommendations for each service area's evaluability. For each evaluation plan, we provided (1) conclusions regarding program evaluability (e.g., likeliness that the program can impact intended outcomes, (2) recommendations (e.g., necessary program modification), and (3) suggestions based on the evaluability assessment results (e.g., only specific program components should be evaluated). Each service area is reviewed below.

Advocacy

Although further evaluation is recommended for the Advocacy service area, there are some areas that require clarification and updated processes to ensure implementation fidelity. For example, current evaluability issues include a lack of clarity on the role of Advocates and some outcomes not being clearly captured in the data management system. Table 8 summarizes these findings in more detail.

Table 8. Summary of Evaluability Assessment for Advocacy

Evaluability Assessment Conclusions	*It is likely that the program can impact intended outcomes* • There is a lack of agreement across both internal and external partners on which outcomes are most important for the core service area • While some outcomes appear to be measured within the current data management system (i.e., referring necessary services), most other outcomes were not clearly captured in the current data system (i.e., meeting time frames, supporting and empowering families, referring necessary services, aiding families heal from trauma). • Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS) • Further evaluation is feasible, pending data collection and documentation efforts of process/implementation fidelity and incorporating identified client outcomes into the data management system
Evaluability Assessment Recommendations	*Further evaluation is recommended* • The service area must better outline the role of Advocates for all internal and external members • The specific roles and activities of Advocates must be identified, agreed upon, and clearly outlined before data collection for an outcome evaluation • The service area must identify client outcomes to focus on and ensure that these client outcomes capable of being measured using the data management system • Overall, this may include improving quality of data management and updating the current data management system
Suggestions Based on Evaluability Assessment Results	*The entire program should be evaluated* • Data necessary to complete a process evaluation may include Project Harmony documentation access to data management system records, while data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs • Data collection may include questionnaires or surveys for CAC staff and/or children and families, focus groups, a quantitative and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets) • Instruments/procedures may include tools (e.g., fidelity tools) or interview/survey protocols • Finally, data analysis may include mixed methodology analyses, including quantitative and qualitative analyses on program implementation and program outcomes

Forensic Interviewing

Further evaluation is recommended for the Forensic Interviewing service area. However, there are some areas that require clarification and updated processes to ensure implementation fidelity. For example, some outcomes not being clearly captured in the data management system. Table 9 summarizes these findings in more detail.

Table 9. Summary of Evaluability Assessment for Forensic Interviewing

Evaluability Assessment Conclusions	*It is likely that the program can impact intended outcomes* • Intended outcomes are clearly specified and theoretically measurable • There is agreement across both internal and external partners on which outcomes are most important for the core service area • Some outcomes are captured within ETO (i.e., disclosure of abuse, child had opportunity to tell what happened to them, number of families receiving services, not repeatedly seeing children with problem sexual behaviors), whereas other outcomes are not clearly captured in current data system (i.e., conviction of the offender, employee satisfaction) • Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS) • Further evaluation is feasible, pending data collection and documentation efforts of process/implementation fidelity and incorporating identified client outcomes into the data management system
Evaluability Assessment Recommendations	*Further evaluation is recommended* • Conclusions drawn from a collection of data sources (i.e., survey, document review, and focus groups) suggest that the Forensic Interviewing service area is generally ready for an outcome evaluation • The service area must show documentation for implementation fidelity, determine which client outcomes to focus on, and then ensure that the current data management system is capable of capturing those outcomes for an evaluation • This may include improving quality of data management and updating the current data management system
Suggestions Based on Evaluability Assessment Results	*The entire program should be evaluated* • Further evaluation (i.e., process evaluation, outcome evaluation) is recommended for Forensic Interviewing service area • Data necessary to complete a process evaluation may include Project Harmony documentation access to data management system records, while data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs (e.g., number of forensic interviews) • Data collection may include questionnaires or surveys for CAC staff and/or children and families, focus groups, a quantitative and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets) • Instrument/procedures may include measurement tools (e.g., fidelity tools) and interview and/or surveys protocols. • Data analysis may include mixed methodology analyses, including quantitative and qualitative analyses on program implementation and program outcomes

Medical Evaluations

Further evaluation is recommended for the Medical Evaluations service area. Nevertheless, there are some areas that require clarification and updated processes to ensure implementation fidelity. For example, some outcomes are not being clearly captured in the data management system. Table 10 summarizes these findings in more detail.

Table 10. Summary of Evaluability Assessment for Medical Evaluations

Evaluability Assessment Conclusions	*It is likely that the program can impact intended outcomes* • Intended outcomes are clearly specified and theoretically measurable • There is agreement across both internal and external partners on which outcomes are most important for the core service area • Some outcomes are captured within ETO (i.e., child treated for sexually transmitted infection [STI], number of exams completed, medical exam provided in a timely manner, evidence gathered for criminal case), whereas other outcomes are not clearly captured in current data system (i.e., patients feel heard, child got education and reassurance, meeting time frames) • Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS) • Further evaluation is feasible, pending data collection and documentation efforts of process/implementation fidelity and incorporating identified client outcomes into the data management system
Evaluability Assessment Recommendations	*Further evaluation is recommended* • Conclusions drawn from a collection of data sources (i.e., survey, document review, and focus groups) suggest that the Medical service area is generally ready for an outcome evaluation • The service area must show documentation for implementation fidelity, determine which client outcomes to focus on, and then ensure that the current data management system is capable of capturing those outcomes for an evaluation • This may include improving quality of data management and updating the current data management system
Suggestions Based on Evaluability Assessment Results	*The entire program should be evaluated* • Further evaluation (i.e., process evaluation, outcome evaluation) is recommended for the Medical Evaluations service area • Data necessary to complete a process evaluation may include Project Harmony documentation access to data management system records, while data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs (e.g., number of forensic interviews completed) • Data collection may include questionnaires or surveys for CAC staff and/or children and families, focus groups, a quantitative and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets) • Instrument/procedures may include measurement tools (e.g., fidelity tools) and interview and/or surveys protocols • Data analysis may include mixed methodology analyses, including quantitative and qualitative analyses on program implementation and program outcomes

Mental Health Services

Although further evaluation is recommended for the Mental Health Services service area, there are some areas that require clarification and updated processes to ensure implementation fidelity. For example, some outcomes not being clearly captured in the data management system. Table 11 summarizes these findings in more detail.

Table 11. Summary of Evaluability Assessment for Mental Health Services

Evaluability Assessment Conclusions	*It is likely that the program can impact intended outcomes* • Intended outcomes are clearly specified and theoretically measurable • There is agreement across both internal and external partners on which outcomes are most important for the core service area • Some outcomes are captured within ETO (i.e., client completes sessions, client returns for more than one session, reduction in symptomology and trauma symptoms), whereas other outcomes are not clearly captured in current data system (i.e., creating resilient adults, helping clients process and cope with trauma, preventing further trauma, referrals that include warm hand offs, sustainability in staff retention, engaging with the client [limited details on what this entails]) • Notably, caregiver and family satisfaction in services are also captured within the anonymous Outcome Measurement System (OMS) • Further evaluation is feasible, pending data collection and documentation efforts of process/implementation fidelity and incorporating identified client outcomes into the data management system
Evaluability Assessment Recommendations	*Further evaluation is recommended* • Conclusions drawn from a collection of data sources (i.e., survey, document review, and focus groups) suggest that the Mental Health Services service area is generally ready for an outcome evaluation • The service area must show documentation for implementation fidelity, determine which client outcomes to focus on, and then ensure that the current data management system is capable of capturing those outcomes for an evaluation • This may include improving quality of data management and updating the current data management system
Suggestions Based on Evaluability Assessment Results	*The entire program should be evaluated* • Further evaluation (i.e., process evaluation, outcome evaluation) is recommended for the Mental Health Services service area • Data necessary to complete a process evaluation may include Project Harmony documentation access to data management system records, while data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs (e.g., number of forensic interviews completed) • Data collection may include questionnaires or surveys for CAC staff and/or children and families, focus groups including internal CAC staff and external agency partners, a quantitative and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets) • Instrument/procedures may include measurement tools (e.g., fidelity tools) and interview and/or surveys protocols • Data analysis may include mixed methodology analyses, including quantitative and qualitative analyses on program implementation and program outcomes

Multidisciplinary Teams (MDT)

Further evaluation is recommended for the Multidisciplinary Team service area. However, there are some areas that require clarification and updated processes to ensure implementation fidelity. For example, current evaluability issues include a lack of agreement on which outcomes are most important, a lack of theoretically measurability among certain outcomes, and some outcomes not being clearly captured in the data management system. Table 12 summarizes these findings in more detail.

Table 12. Summary of Evaluability Assessment for Multidisciplinary Teams

Evaluability Assessment Conclusions	*It is likely that the program can impact intended outcomes* • Intended outcomes are clearly specified and comprehensive • There is a lack of agreement across both internal and external partners on which outcomes are most important for the core service area • Although most outcomes are theoretically measurable, some are not (i.e., improving system barriers). • Some outcomes are captured within ETO (i.e., attendance of all invited participants in MDT meetings, gathering different roles and perspectives together, identifying and providing appropriative services and referrals, Information sharing), whereas other outcomes are not clearly captured in current data system (i.e., addressing crisis situations, successful prosecution of cases, developing strategies to achieve permanency and long-term supports for the child, improving system barriers, successfully moving cases forward through the child welfare and juvenile justice systems) • Further evaluation is feasible, pending data collection and documentation efforts of process/ implementation fidelity and incorporating identified client outcomes into the data management system
Evaluability Assessment Recommendations	*Further evaluation is recommended* • Conclusions drawn from a collection of data sources (i.e., survey, document review, and focus groups) suggest that the MDT service area is generally ready for an outcome evaluation • The service area must better outline the role of all MDT members and necessary follow-up requirements. Additionally, the service area must identify client outcomes to focus on and ensure that these client outcomes are theoretically measurable and capable of being measured using the data management system • This may include improving quality of data management and updating the current data management system, as well as improved documentation on all MDT members and procedures that ensure adequate case follow-up
Suggestions Based on Evaluability Assessment Results	*The entire program should be evaluated* • Further evaluation (i.e., process evaluation, outcome evaluation) is recommended for the MDT service area • Data necessary to complete a process evaluation may include Project Harmony documentation access to data management system records, while data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs (e.g., number of forensic interviews completed) • Data collection may include questionnaires or surveys for CAC staff and/or children and families, focus groups including internal CAC staff and external agency partners, a quantitative and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets) • Instrument/procedures may include measurement tools (e.g., fidelity tools) and interview and/or surveys protocols • Data analysis may include mixed methodology analyses, including quantitative and qualitative analyses on program implementation and program outcomes

Summary of Recommendations

Overall, evaluability assessment recommendations endorsed further evaluation across all service areas with the caveat that some recommendations should be implemented prior to outcome evaluations. Although certain outcomes appear to be measured within the current data management system, other outcomes are not clearly captured. Further evaluation is feasible, then, pending additional documentation and tracking efforts. ***Broadly, all service areas must (1) ensure that processes are being implemented consistently across programs, (2) identify specific client outcomes to focus on, and (3) guarantee that these client outcomes are capable of being captured using the central data management system for future analyses.*** If a central data management system is not used, then data collection efforts should be consistent and accessible to others within the agency. As outlined above, these recommendations overlap across all service areas, but there are some specific details and recommendations that vary by service area. Although the overall recommendations are provided, there are factors that should be considered when developing future outcome evaluations. These factors include additional data that may be useful to integrate, agency operations, and ways in which assessments could be conducted.

Data Considerations

Notably, during the EAW meetings, some staff indicated that there are *tracking databases* being monitored by specific individuals within Project Harmony that address some implementation concerns, but that these tracking systems are not captured in the central data management system or in the documents provided to the researchers (e.g., staff tracking information in a separate Excel file). In this way, some of the existing processes may be well-equipped to be tracked by the agency through other mechanisms. These separate databases should be identified and examined in more detail. It is recommended that these mechanisms be integrated into the central data management system for consistency as applicable.

Another aspect discussed during the EAW meetings was that some service area outcomes are currently being tracked via the *Outcome Management System (OMS)*. The OMS was developed by the National Children's Alliance as a way for CACs to gather feedback from MDT members, caregivers, and children about their experiences with the center. All youth and caregivers receive an OMS survey at the time of their appointment and 30-45 days post-appointment. Here, caregivers and children are asked about the child's safety at the center, the services received, what they appreciated about the center, and what the staff could have done better to help the caregiver or child. **However, the OMS survey is anonymous and is not currently able to track specific clients over time.** Moreover, it focuses more explicitly on some service areas than others (e.g., advocacy), which would need to be considered in any future outcome evaluations. Still, these data could be useful for assessing the effectiveness of the agency at delivering services and client perceptions/outcomes.

Although Project Harmony currently has a *central ETO data management system*, the agency has indicated that this system is problematic. Specifically, issues have been identified where data can be inputted into the system but cannot be retrieved easily. This feature of the current system also means that, even if information is being tracked, the information may not be able to be analyzed for outcomes evaluations. **The agency, however, is acutely aware of these concerns and is currently in the process of replacing the data management system with a new operating system**. This new system allows for updates to how and what information is collected. In this way, the new data management system creates an opportunity to integrate the outcomes that each service

area wants to capture while simultaneously training all staff on the new data entry processes. For this reason, the new data management system is a positive change occurring within the agency.

Agency Considerations

To assess overarching agency considerations, a separate interview was conducted with Project Harmony's executive director. Notably, many themes of this interview overlap with the themes obtained from Project Harmony staff and external agency partners throughout focus groups and surveys, providing further support for our recommendations. Among these were both *strengths and barriers of Project Harmony operations*. For example, the solid structure of the policies in procedures within certain service areas (i.e., Forensic Interviewing, Medical Evaluations, Mental Health Services) was noted as providing an *infrastructure* to continue to build on, whereas other service areas could benefit from additional structure (i.e., Advocacy and Multidisciplinary Teams). In line with this, the *dedication of employees and staff* to deliver quality services was also noted as a core reason why Project Harmony is successful in responding to community needs. This level of dedication is integral to the processes of the agency, while being cognizant of the stress, burnout, and turnover that can accompany responding to trauma. In addition, the commitment to follow *national standards* across all service areas was also a recurring theme, which is meant to maximize efficiency in service delivery. Finally, the difficulties associated with *data management* was mentioned within this interview, serving as an overlapping theme across all data sources and a change being integrated to improve agency operations and tracking.

In addition to these themes that echoed previous data collection methods, high-level insights regarding Project Harmony's operations were also discussed. For example, Project Harmony is well situated to *hire staff* as needed. Specifically, the executive director made note that the agency will be hiring 20 new employees starting in September and January 2022. This may help reduce burnout and turnover among staff, and further facilitate effective service delivery. In addition, while the *OMS survey* had been mentioned in some capacity within other data collection stages, the executive director emphasized the importance of this evaluation system for Project Harmony, the positive responses to these evaluations, and how they compare their responses to other centers. In this way, the OMS survey was identified again as a component that should be considered for future outcome evaluation efforts. Another important agency consideration is *funding sources*. The challenges of sustaining funding were discussed, noting the heavily reliance of the CAC on private donors given the limited funds supplied under grants such as the Victims of Crimes Act (VOCA). Therefore, while the CAC has secured funding for the next few years, there may be gaps once this time period has ended. Still, Project Harmony has a positive *reputation* within the community and on the national level, which bodes well for continuing support to sustain the agency's ability to respond to the community's needs.

Assessment Considerations

In addition to these recommendations, the research team also has several suggestions for future evaluations based on results from the Evaluability Assessments. For example, the data necessary to complete a process evaluation may include Project Harmony documentation, requiring full access to the organization's data management system records. Conversely, the data necessary to complete an outcome evaluation may include perceptions from CAC staff and/or children and families and data management system inputs/outputs. As such, data collection may include *questionnaires or surveys for CAC staff and/or children and families, focus groups, a quantitative*

and/or qualitative review of data management system inputs, and/or case or document reviews for any data collection completed outside of data management system (e.g., spreadsheets). Instruments and/or procedures necessary to complete these stages of data collection may include *measurement tools (e.g., fidelity tools) and interview/survey protocols*. Finally, data analysis for future evaluations may include mixed methodology analyses, including *quantitative and qualitative analyses* on program implementation and program outcomes.

The research team has sought to help facilitate these recommendations and suggestions by developing the aforementioned deliverables to assist Project Harmony in these tasks (see Appendix A). Specifically, the *summary guide* offers a synopsis of all data collection efforts and agency factors that could act as barriers (e.g., turnover, staff burnout) and strengths (e.g., collegiality among staff, passion for the work) to tracking implementation processes for an outcome evaluation. The *logic model flow charts* provide a big-picture overview of each service area to highlight key goals and objectives for internal staff and external agency partners. The *fidelity tool kits* developed for each of the five service areas provide a mechanism whereby processes and implementation fidelity can be monitored by the agency. And the *evaluability assessment checklists* offer the specific next steps for Project Harmony to address prior to engaging in an outcome evaluation for each service area.

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Appendix A

Overview of Products

Through the efforts of Phase I and Phase II, four products were developed. These products include (1) a summary guide, (2) fidelity tool kits, (3) logic model flow charts, and (4) evaluability assessment checklists. The purpose and method for each product is outlined below.

Summary Guide

Purpose: The Summary Guide provides an overview of the key highlights from all data collection efforts (i.e., extant literature, document reviews, focus groups, survey) by service area.

Method: The findings from Phase I were organized within this report by (i) an executive summary and (ii) a summary of findings by data source/service area. The executive summary is included to provide a brief overview of key findings across all the data sources and service areas to highlight themes and takeaways for the project to date. Conversely, the summary of findings provide a more detailed overview of findings by data source and by service area, with supporting evidence presented in the appendices. Specifically, each section provides summary bullet points highlighting conclusions drawn from the data collection across all five service areas and, as applicable, by each service area. For more context, each data source also provides a brief review of the purpose of the data collection effort, the method used to facilitate data collection, and an overview of the data gathered. Data from the agency document reviews, focus groups, and surveys were divided by each of the five service areas so there are summary points across all service areas (i.e., takeaways from the data collection effort) and by service area (i.e., themes specific to each service area).

Fidelity Tool Kits

Purpose: The Fidelity Tool Kits provide a measurement instrument to be used by Project Harmony managers and/or directors to review, document, and improve implementation of the National Children's Alliance (NCA) Standards in a reliable and consistent way. Specifically, the fidelity tools outline NCA standards and methods to measure their adherence for each service area, including each NCA standard, supporting evidence on how these standards are met by Project Harmony, where adherence information can be found in documents, how often documents should be reviewed, and the level of adherence.

Method: To develop these tools, the research team thoroughly reviewed the NCA Standards, Project Harmony documents, and Project Harmony's data management system (i.e., Effort to Outcomes [ETO]). Each of these data sources were then used to develop checklists to help measure NCA Standard adherence. For each service area, an individual checklist was created, including (i) the NCA Standards and intent, (ii) Project Harmony supporting evidence, and (iii) fidelity adherence criteria.

The "Project Harmony supporting evidence" sections included specific examples for how Project Harmony may be ensuring that the NCA standards are being met. Project Harmony documents were reviewed in detail to obtain this information and provide explicit examples for this section. The "fidelity adherence criteria" were included to guide adherence ratings and included (a)

where to find the documents necessary to provide evidence for Standard adherence, (b) the rate of review in which the documents should be reviewed, and (c) an adherence rating that asks the reviewer to mark the degree to which they believe the Standard criteria is being met. Reviewers are provided with a range of anchors to rate standard adherence (0 = standard not met; 1 = standard partially met or the minimum criteria are met [e.g., at least 50%]; 2 = standard met or all essential components of the standard are met).

Logic Model Flow Charts

Purpose: The Logic Model Flow Charts provide a graphic depiction of the activities and their purposes that exist within each service area. These tools are meant to provide internal staff with a tool that summarizes the activities within each service area. These logic model flow charts can also provide context to external agency partners on the roles and responsibilities of each service area.

Method: These tools were developed by conducting document reviews of a wide variety of documents provided to the research team by Project Harmony (e.g., service area protocols, narratives, agreements between Project Harmony and external agency partners). The documents are divided by service area, outlining (i) the key individuals who work within each service area, (ii) their main roles and responsibilities, and (iii) the purpose behind these roles and responsibilities.

Evaluability Assessment Checklists

Purpose: Evaluability assessment checklists were used to aid the research team in their determination of the "evaluation readiness" of each program. Adapted from prior research, these tools were used to assess the program coherence and evaluation capacity for each service area (Campagna et al., 2020). Program coherence was measured across six dimensions, with multiple indicators within each dimension (see Table 2).

Method: All indicators were rated by the research team based on whether they (i) generally met standards for evaluability, (ii) partially met standards for evaluability, or (iii) generally did not meet standards for evaluability. Ratings were provided following a review of the data collected over the course of Phase I (i.e., Project Harmony document reviews, focus groups, survey). Additional notes were included for all indicators that received a rating below "generally met standards for credibility," providing a justification for the assigned rating.

Once all evaluability checklists were completed, an evaluation plan was developed for each individual service area, including justifications and recommendations for the program's evaluability. Within each service area's evaluation plan, we provided (1) conclusions regarding program evaluability (e.g., likeliness that the program can impact intended outcomes, (2) recommendations (e.g., necessary program modification), and (3) suggestions based on the evaluability assessment results (e.g., only specific program components should be evaluated.

Appendix B

Internal Staff Interview Protocol Themes and Items

[*Background and Collaboration in Organization*]

1. Please describe the essence of your work or "an average day."
    - *Potential prompts and follow-up questions:*
        - Tell us a little bit about your background, education or experiences that led you to your current career in working in child advocacy.
        - To better understand what you do, could you give us a general description of your job?
        - We are not very familiar with the process of your program. Can you provide an overview of your program area?
        - Can you walk us through the typical process of an intake/new case in your program area?
        - Can you describe the target population for the services you deliver?
        - What are the intended outcomes of your program area?
        - In your opinion, what is the core function of a Child Advocacy Center, such as Project Harmony?
        - How does your program area work or collaborate with other program areas in Project Harmony?

[*Implementation Fidelity of Existing Protocol & Modifications to Service Delivery*]

2. What policies and procedures do you use to guide decision making in your job?
    - *Potential prompts and follow-up questions:*
        - What types of assessments or protocols do you use to guide your decision making for a case?
        - Do you have a program manual to guide service delivery?
        - Do you understand the protocols within your program area?
        - How are changes to protocols communicated with staff?
        - How often do you use the protocols within your program area to guide decision-making?
        - How often do you think your team as a whole uses the protocols to guide decision-making?
        - When do you have to make decisions that do not align with protocol to best address the needs of your clients?
        - How do you document when you deviate from protocols when delivering services?
        - How much discretion do you *have* when applying protocols within your area of service?
        - How much discretion do you *use* when applying protocols within your area of service?
        - What other factors (outside of protocols) influence your decision-making?

[*Perceptions of Program Operations*]

3. What is going well in your department?
    - *Potential prompts and follow-up questions:*
        - What processes work well within your program?
        - Do you think collaborations work well within and between partnering agencies?
        - How successful do you perceive your program to be at achieving intended outcomes?
        - How successful do you think clients and partner agencies perceive your program to be at achieving intended outcomes?
        - What are perceived strengths (internal/external) to service delivery in your program area?
        - Are appropriate guidance materials available to support your work?
        - Are processes/procedures stable or flexible in your program area?
        - How does the team work together to deliver services?
        - Do you feel well-supported by your team, the supervisor, and the agency?
        - How are conflicts managed within your team?
        - How are decisions made between team members when there is a disagreement (e.g., protocols/guidelines, individual decisions)?
        - Are you aware of cultural differences and needs of clients in your program area?

[*Barriers to Program Implementation and Fidelity*]

4. What are your largest current challenges in your work in your department?
    - *Potential prompts and follow-up questions:*
        - What processes within your program need to be improved?
        - What do you think could be done differently to improve processes in your program area?
        - How do you perceive your program at achieving intended outcomes?
        - How do you think clients and partner agencies perceive your program at achieving intended outcomes?
        - What are perceived barriers (internal/external) to service delivery in your program area?
        - Are there any areas in your program that you think don't function as they should? How would you change it?
        - Are appropriate guidance materials available to support your work?
        - Do processes/procedures change often in your program area?
        - How does the team work together to deliver services?
        - Do you feel well-supported by your team, the supervisor, and the agency?
        - How are conflicts managed within your team?
        - How are decisions made between team members when there is a disagreement (e.g., protocols/guidelines, individual decisions)?
        - What do you do to accommodate the cultural differences of clients in your program area?
        - Are there any gaps in the services that your program provides? What would you add?

5. Do you believe you have received adequate training for all aspects of your job? If not, please describe what else would be useful.
    - *Potential prompts and follow-up questions:*
        - How are new staff trained on existing protocols?
        - Do you feel that you have enough training to successfully complete your tasks?
        - In terms of the training you have received, what 1-2 things have worked really well?
        - In terms of the training you have received, what 1-2 things could be done better or what do you need more of?
        - What would you like additional training on moving forward?

[*Familiarity and Adherence to NCA Standards*]

6. How would you each rate your familiarity with the National Children's Alliance (NCA) standards for your program area?
    - *Potential prompts and follow-up questions:*
        - Have you ever seen the NCA Standards before? Would you be able to list all or many of them without looking at the list?
        - Are you trained on NCA Standards for service delivery in your program area?

7. To what extent do you believe that staff in your program area adhere to these standards? What are the challenges or barriers that can sometimes lead to a lack of adherence to NCA standards?
    - *Potential prompts and follow-up questions:*
        - Why do you think that staff do/do not follow the standards?
        - Does management make it a priority to adhere to NCA standards?
        - Do staff take it seriously to adhere to NCA standards?
        - Do you think the NCA standards are useful for the types of cases you manage?
        - Would you make any modifications to the Standards? Why or why not?

8. In a perfect world, what would help staff in your program area adhere to NCA standards and produce best outcomes for the youth you serve?
    - *Potential prompts and follow-up questions:*
        - Do you think management should be more supportive of adhering to the NCA standards?
        - Do you think staff need more training to adhere to the NCA standards?
        - Do you think you need different resources (e.g., checklists, assessments, data collection fields) to make it easier to adhere to the NCA standards?
        - Do you think there are services being delivered by your program area that are not part of the Standards but that are important for the needs of the community (e.g., outreach, prevention education, after-hours work)?

9. What else would you like us to know about your successes or challenges of your work?
    - *Potential prompts and follow-up questions:*
        - Is there anything else about how your team works together that you think is important to discuss?
        - Is there anything else about your supervisor and/or upper management at Project Harmony that you think is important to discuss?
        - Do you think that your team is generally aiming to achieve the same goals?

Appendix C

External Staff Interview Protocol Themes and Items

[*Background and Collaboration in Organization*]

1. Please describe the essence of your work or "an average day" when collaborating with the CAC at Project Harmony
    - *Potential prompts and follow-up questions:*
        - How often do you work with Project Harmony on cases?
        - Tell us a little bit about how your job is expected to interact with the CAC at Project Harmony.
        - Can you provide an overview of your program area and how it works with the CAC?
        - In your opinion, what is the core function of a Child Advocacy Center, such as Project Harmony's CAC?

2. How is your work impacted or affected by the CAC's collaboration with your agency?
    - *Potential prompts and follow-up questions:*
        - How does working with CAC impact your ability to investigate/work on cases?
        - Does Project Harmony offer resources or assistance that influences your ability to do your job?

3. What do you think is the mission or philosophy of a child advocacy center?
    - *Potential prompts and follow-up questions:*
        - How does the Project Harmony CAC align (or not) with your vision of child advocacy centers?
        - Do you support the mission and philosophy of Project Harmony?
            - *Project Harmony Mission Statement*: To protect and support children, collaborate with professionals and engage the community to end child abuse and neglect

4. How important do you think your collaboration is to the CAC? That is, do you feel valued as a community partner? Why or why not?

[*Implementation Fidelity of Existing Protocol & Modifications to Service Delivery*]

5. What are the policies, procedures, and legal statutes that guide decision making in your job when working with the CAC?
    - *Potential prompts and follow-up questions:*
        - Do you have any guidelines from the CAC that help you collaborate together?
        - Are there policies or procedures at the CAC that affect how you collaborate?
        - What are the statutes that govern your working with the CAC?
        - Is your job shaped by policies or procedures at the CAC?

- How do you document when you deviate from protocols when collaborating/working with the CAC?
- How much discretion do you *have* when applying protocols to cases when collaborating with the CAC?
- How much discretion do you *use* when applying protocols to cases when collaborating with the CAC?
- What other factors (outside of protocols) influence your decision-making when working with the CAC?

[*Perceptions of Program Operations*]

6. What is going well in your department for cases that you collaborate on with the CAC?
    - *Potential prompts and follow-up questions:*
        - What processes work well when collaborating in these instances?
        - Do you think collaborations work well between your agency and the CAC?
        - What are the expected outcomes on cases when working with the CAC?
        - How successful do you perceive your collaboration to be at achieving intended outcomes with the CAC?
        - What do you think are clients' perceptions/thoughts about the collaboration between your agency and the CAC?
        - Are appropriate guidance materials available to support your work within the CAC?
        - How are conflicts managed between you and the CAC?
        - What, if anything, is done differently in your collaboration with the CAC when working with clients that have different cultural needs?

[*Barriers to Program Implementation and Fidelity*]

7. What are your largest current challenges in your work in your department when you work with the CAC?
    - *Potential prompts and follow-up questions:*
        - What processes in your collaboration need to be improved?
        - Do you ever feel "lost" or confused about next steps when collaborating on a case?
        - How do you perceive your collaboration at achieving intended outcomes?
        - How do you think clients/families and perceive your collaboration at achieving intended outcomes?
        - Are there any areas in your collaboration that you think don't function as they should? How would you change it?
        - Are appropriate guidance materials available to support your work?
        - How does the team work together to deliver services?
        - Do you feel well-supported by your team, the supervisor, and the agency?
        - What do you do to accommodate the cultural differences of clients?
        - Are there any gaps in the services that your collaboration provides? What would you add?

[*Familiarity and Adherence to NCA Standards*]

8. How would you each rate your familiarity with the National Children's Alliance (NCA) standards?
    - *Potential prompts and follow-up questions:*
        - Have you ever seen the NCA Standards before? Would you be able to list all or many of them without looking at the list?

9. If it was known that the CAC at Project Harmony was adhering to evidence-based practices and the NCA standards when serving families in the community, would it change how you view the CAC or the work they do? Why or why not? How might it change your views?
    - *Potential prompts and follow-up questions:*
        - Is there anything that the CAC could do to improve their ability to serve families in the community?
        - Is there anything that would change your perspective of the CAC and the work they do?

10. What else would you like us to know about your successes or challenges of your work in collaboration with the CAC?
    - *Potential prompts and follow-up questions:*
        - Is there anything else about how your team works together that you think is important to discuss?
        - Is there anything else about upper management at the CAC that you think is important to discuss?
        - Do you think that your department is generally aiming to achieve the same goals as the CAC on cases you work on together?

Appendix D

Survey II Themes and Items

Note: As mentioned above, Survey II was tailored and administered to participants, based on service area and whether the individuals were internal CAC staff or external agency partners. Thus, 14 surveys were created to gather responses across the five service areas for internal and external participants and for individuals who work across multiple service areas. Presented below is a broad template of Survey II, which includes all questions provided to respondents, regardless of their internal/external status and/or service area. Within the brackets, the specific language used for internal staff and external staff is presented.

Universal Questions

Based on our review of the National Children's Alliance Standards, Project Harmony documents, and findings from the focus groups, we are interested in learning more about formal trainings that [you/Project Harmony staff] have received. Please note that formal trainings are defined here as structured education opportunities.

Specifically, we are interested in learning about trainings, workshops, or other sessions (e.g., webinars, seminars) that you have attended for your position when working with the ***Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team*** *service areas of the CAC.*

[*Training: Barriers to Program Implementation and Fidelity*]
The following questions ask how strongly you agree or disagree with the following statements.
Q1. Prior to serving clients, [I/service area staff] have received training for my position within the CAC.

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

Q2. Of the trainings that I have been required to receive while in my position within the CAC, I feel like the training was adequate to prepare [me/service area staff] to serve clients.

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

[*Training Topics: Barriers to Program Implementation and Fidelity*]
Q3. Now, we would like to know more about your [experiences/perceptions] with specific training topics.

Below, we present you with various topics that [you/CAC staff] may or may not have received formal training on. The following items ask about the extent to which you agree or disagree that [you/service area staff] have ***received adequate training for each topic area in your current position.***

Please note that these trainings pertain to your [current position/collaborations] within the **Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team** service areas of the CAC.

I feel that I have received adequate training on this topic [label]

1. Assistance with access to treatment and other services
2. Caregivers
3. Child disclosures
4. Child maltreatment
5. Communication Skills
6. Court education, support, and accompaniment
7. Crisis assessment and intervention
8. Cultural Considerations
9. Dynamics of abuse
10. Empathy
11. HIPAA training
12. Professional ethics and boundaries
13. Risk assessment and safety planning
14. Role of the Victim advocate
15. Secondary victimization
16. Self-Care
17. System impacts on youth and families
18. Trauma-informed services
19. Understanding and promoting resilience
20. Understanding the coordinated multidisciplinary response
21. Victims' rights
22. Other (please specify)

[*Perceptions of Policies: Implementation Fidelity of Existing Protocol & Modifications to Service Delivery*]
Next, we would like to know more about how policies and procedures guide collaborations and decision making.

Please note that these questions pertain to your [current position/collaborations] within the ***Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team*** *service areas of the CAC.*

The following questions ask how strongly you agree or disagree with the following statements.
Q4. Based on my experiences, **state statutes (e.g., the 1184 statute, crime victim statues, child neglect statutes)** guide decision making when responding to clients/families within the CAC.

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

Q5. Based on my experiences, policies and agreements guide **information sharing practices (e.g., sharing case-specific information, staying up-to-date with case as it is processed)** during collaborations between external agency partners and the CAC.

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

Q6. Based on my experiences, policies and agreements guide **confidentiality protocols** during collaborations between external agency partners and the CAC.

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

[*Perceptions of Barriers: Barriers to Program Implementation and Fidelity*]
Now, we would like to learn more about perceived challenges and strengths of the CAC.

Please note that these perceptions are based on your [current position/collaborations] within the ***Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team*** *service areas of the CAC.*

Q7. Provided below is a list of *challenges* that were identified during the focus group sessions. Please select all areas that you perceive as being challenges **within the CAC**.

_____ Adequacy of training
_____ Burnout among service area staff at the CAC
_____ COVID complications (e.g., going virtual)
_____ Cultural diversity lacking among staff and providers
_____ Data management (e.g., Efforts to Outcomes (ETO) system)
_____ Lack of parental and community education
_____ Lack of structure in policies and procedures among core service areas
_____ Staff turnover

Q7b. Please rank order the perceived *challenges* you selected within the CAC by dragging and dropping each item into their preferred order, with "1" indicating the biggest challenge.

Q8. Provided below is a list of *challenges* that were identified during the focus group sessions. Please select all areas that you perceive as being challenges **between the CAC and external agency partners.**

_____ Different philosophies between service area staff at the CAC and external agency partners
_____ External agency partners feeling like they have to explain or justify decisions
_____ Lack of follow up
_____ Lack of knowledge on the roles, guidelines, standards, protocols, and/or procedures between service area staff at the CAC and external agency partners
_____ Meeting time frames and scheduling appointments

Q8b. Please rank order the perceived *challenges* you selected between the CAC and external agency partners by dragging and dropping each item into their preferred order, with "1" indicating the biggest challenge.

[Perceptions of Strengths: Program Operations and Intended Outcomes]

Q9. Provided below is a list of *strengths* that were identified during the focus group sessions. Please select all areas that you perceive as being strengths **within the CAC.**

_____ Expertise among service area staff at the CAC
_____ Passion among service area staff at the CAC
_____ Quality of work that comes from service area staff at the CAC
_____ Strength of relationships and support among service area staff at the CAC

Q9b. Please rank order the perceived *strengths* you selected within the CAC by dragging and dropping each item into their preferred order, with "1" indicating the greatest strength.

Q10a. Provided below is a list of strengths that were identified during the focus group sessions. Please select all areas that you perceive as being strengths **between the CAC and external agency partners.**

_____ Both service area staff at the CAC and external agency partners feeling valued by one another

_____ Effective collaboration and coordination
_____ External agency partners' confidence in the high-quality services that service area staff at the CAC offers
_____ External agency partners' confidence that service area staff at the CAC are instrumental in achieving partner outcomes
_____ Strength of the relationship between service area staff at the CAC and external agency partner staff

Q10b. Please rank order the perceived *strengths* you selected between the CAC and external agency partners by dragging and dropping each item into their preferred order, with "1" indicating the greatest strength.

[*Meeting NCA Standards: Familiarity and Adherence to NCA Standards*]

Q11. During the focus group sessions, the staff at the CAC discussed Project Harmony's adherence to the National Children's Alliance (NCA) standards. We are interested in learning more about how Project Harmony staff know they are adhering to the NCA standards that are supposed to guide evidence-based interventions for children and their families.

Please check all of the following that apply regarding why you believe that the NCA standards are being met by the **Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team** service areas that you work with at the CAC.

- ☐ Consistent direction and communication with supervisors and upper management on any changes made to protocols and procedures
- ☐ Developing policies and procedures that adhere to the NCA standards
- ☐ Formal meetings to discuss the importance of the NCA standards
- ☐ Internal audits to track progress on meeting NCA standards (e.g., self-review, peer-review, supervision)
- ☐ Involvement in NCA accreditation
- ☐ Ongoing discussions on the importance of the NCA standards
- ☐ The use of case management systems to ensure that all necessary tasks are being completed in a timely manner and that documentation requirements are being met
- ☐ The use of written agreements (e.g., signed linkage agreements, interagency agreements, and memorandum of understandings) that shape legal, ethical, and professional requirements outlined by existing policies and procedures that follow NCA standards
- ☐ Tools or instruments to track NCA standard adherence in everyday processes (e.g., forms, desk aids, flow charts)
- ☐ I do not believe that the NCA standards are being met for the service area(s) that I work with at the CAC

Service Area Questions

As part of the focus group sessions, we asked CAC staff about outcomes within each service area. We would like to know what you think are the most important outcomes for the service areas.

*Please note that these perceptions of outcomes are based on your [work/collaborations] with the **Advocacy, Forensic Interviewing, Medical Evaluation, Mental Health, and/or Multidisciplinary Team** service areas of the CAC. If you do not work with a specified service area, then please note that you have not worked with that service area enough to answer the question.*

[*Perceptions of Outcomes: Perceptions of Program Operations and Intended Outcomes*
Q12a. Which of the following do you believe is the **most important** outcome for the **Advocacy** service area of the CAC?

- o Aiding families to heal from trauma
- o Caregiver or family satisfaction in services
- o Meeting time frames
- o Referring necessary services
- o Supporting and empowering children and families
- o Other outcome not listed (please provide): _____
- o I have not worked with this service area enough to answer this question

Q12ai. You selected [***previous answer auto-populated based on skip-logic***] as the most important outcome. To what extent do you agree or disagree that the **Advocacy** service area of the CAC is successful in meeting this outcome?

- o Strongly disagree
- o Disagree
- o Neither disagree nor agree
- o Agree
- o Strongly agree

Q12b. Which of the following do you believe is the **most important** outcome for the **Forensic Interviewing** service area of the CAC?

- o Caregiver or family satisfaction in services
- o Child had opportunity to tell what happened to them
- o Client satisfaction
- o Conviction of the offender
- o Disclosure of abuse
- o Employee satisfaction
- o Not repeatedly seeing children with problem sexual behaviors
- o Number of families receiving services
- o Number of interviews conducted
- o Other outcome not listed (please provide): _____
- o I have not worked with this service area enough to answer this question

Q12bi. You selected [***previous answer auto-populated based on skip-logic***] as the most important outcome. To what extent do you agree or disagree that the **Forensic Interviewing** service area of the CAC is successful in meeting this outcome?

- o Strongly disagree
- o Disagree
- o Neither disagree nor agree
- o Agree
- o Strongly agree

Q12c. Which of the following do you believe is the **most important** outcome for the **Medical** service area of the CAC?

- o Caregiver or family satisfaction in services
- o Child treated for sexually transmitted infection (STI)
- o Evidence gathered for criminal case
- o Medical exam provided in a timely manner
- o Meeting time frames
- o Number of exams completed
- o Patients feel heard
- o Other outcome not listed (please provide): _____
- o I have not worked with this service area enough to answer this question

Q12ci. You selected [***previous answer auto-populated based on skip-logic***] as the most important outcome. To what extent do you agree or disagree that the **Medical** service area of the CAC is successful in meeting this outcome?

- o Strongly disagree
- o Disagree
- o Neither disagree nor agree
- o Agree
- o Strongly agree

Q12d. Which of the following do you believe is the **most important** outcome for the **Mental Health** service area of the CAC?

- o Caregiver or family satisfaction in services
- o Client completes sessions
- o Client returns for more than one session
- o Creating resilient adults
- o Engaging with the client
- o Helping clients process and cope with trauma
- o Preventing further trauma
- o Reduction in symptomology and trauma symptoms
- o Referrals that include warm handoffs
- o Sustainability in staff retention
- o Other outcome not listed (please provide): _____
- o I have not worked with this service area enough to answer this question

Q12di. You selected [***previous answer auto-populated based on skip-logic***] as the most important outcome. To what extent do you agree or disagree that the **Mental Health** service area of the CAC is successful in meeting this outcome?

- o Strongly disagree
- o Disagree
- o Neither disagree nor agree
- o Agree
- o Strongly agree

Q12e. Which of the following do you believe is the **most important** outcome for the **Multidisciplinary Team** service area of the CAC?

- o Addressing crisis situations
- o Attendance of all invited participants in MDT meetings
- o Developing strategies to achieve permanency and long-term supports for the child
- o Gathering different roles and perspectives together
- o Identifying and providing appropriative services and referrals
- o Improving system barriers
- o Information sharing
- o Successful prosecution of cases
- o Successfully moving cases forward through the child welfare and juvenile justice systems
- o Other outcome not listed (please provide): _____
- o I have not worked with this service area enough to answer this question

Q12ei. You selected [***previous answer auto-populated based on skip-logic***] as the most important outcome. To what extent do you agree or disagree that the **Multidisciplinary Team** service area service area of the CAC is successful in meeting this outcome?

- o Strongly disagree
- o Disagree
- o Neither disagree nor agree
- o Agree
- o Strongly agree

The final part of this survey is used to obtain any additional details that you think are important for us to consider about your work, but may not have been included in this survey.

Q13. What else would you like us to know about the successes or challenges of your [work/your work when collaborating with the CAC]? (Open Response)