PROTOCOL

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COUNTIES RESPOND TO MDT LEGISLATION

Last year the Idaho legislature passed legislation requiring every county to investigate allegations of child maltreatment using a multidisciplinary team (MDT) (see I.C. 16-1609A). This legislation became effective January 1, 1997. In the past, approximately one half of the 44 Idaho counties had functioning MDT's. In an effort to determine the current status of MDT's POST is conducting a survey of each county prosecutor to determine the status of an MDT in their county. Preliminary results suggest that a majority of the counties are taking the legislation seriously and have formed MDT's or are in that process.

Coupled with the survey results, requests for MDT development grants have increased, which suggests that more teams are starting up and are in need of assistance to become functional. MDT development grants are still available through POST. These grants are intended to assist in the development of MDT's. Guidelines are, in order to request funding (normally for $1,000.00 or less) a county must have a team in place or be actively creating a team. This means informal agreement minimally by the prosecutor, law enforcement, and child protective services, to begin discussions on formulating an MDT and creating a formal "protocol" to investigate child maltreatment cases.

If you would like a grant application or more information on MDT Development grants contact Doug Graves at POST Academy (208) 884-7250.

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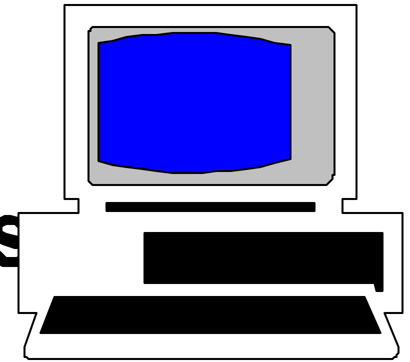
TECHNOLOGY: Getting Connected: Child Abuse Resources on the Internet



Cruising the information superhighway? Still waiting to see if it turns out to be a fad? This article will tell you how to gain access to some of the information about child maltreatment already available to users of the Internet.You do not have to be proficient with computers to learn about some of the interesting sites on child abuse you can access with fairly simple equipment and a little patience. Your investment in time now can pay big dividends later. Inevitably, communications and education will increasingly involve the Internet and the World Wide Web.

What is the Internet? The World Wide Web?

The Internet is the term for the vast interconnection of computers worldwide that are linked through many different types of data transmission lines, from satellites and fiber optics to simple telephone lines. Through the Internet, you can e-mail colleagues in the next office or across the world, electronically transfer entire book manuscripts, and search the card catalog in the Library of Congress. One of the most versatile and exciting applications in the Internet is the Web. Through the Web, users can use "hypertext" to access information. Hypertext consists of text in which some of the terms are highlighted. When selected, these highlighted terms, or links, will automatically link or transfer information related to that term. A user will not only have access to text through these links, but in many cases also have access to multi-media-formatted information such as pictures, sound, and brief videos. Hypertext allows all of the child abuse resources on the Internet to be connected, as explained next.

How do I access the Internet and the Web?

Virtually any personal computer (PC) can tap into this communication network with the proper software and hook-ups. However, the type of physical connection between the computer to the outside and the software on your PC makes a significant difference in exactly what can be accessed. (For a full discussion of how to choose modems and software, ask your local bookseller for the best books on the topic.) Briefly, you need a personal computer, a modem or a direct connection to the Internet, and communications software. If you do not have a direct connection to the Internet, which is available at many universities, and some businesses, you can use a modem, which uses telephone lines to send and receive signals. The Internet may be accessed more quickly and efficiently depending upon your computer's memory capacity and processing speed as well as the speed of your modem. If your computer transmits sound and video, you will be able to take full advantage of the Internet and the Web. Cable TV and other options might be developed in the near future that will provide better connections than phone lines, allowing even more users to benefit from all the features of the Web.

Your computer and modem will need software to enable your system to dial out and make the Internet connection. Most computers that come with modems also have pre-installed software for an Internet subscription service such as America Online, CompuServe, or Prodigy. Newer services include Apple's eWorld, the Microsoft Network, and AT&T's Interchange. Subscription services generally provide instructions that are easy to follow. Software for "browsing" the Web, such as Netscape, is also desirable, allowing a user to view graphic information as well as text. Browser software can also be provided by subscription services.

How do I find specific sites on the Internet?

Each site on the Net (or Web) has its own electronic address, known as a Uniform Resource Locator (URL) - an often complex, and somewhat intimidating, collection of letters and symbols (e.g., http://). Most systems save you the trouble of typing the address each time by allowing you to save addresses as "bookmarks."

But what if you don't know a site's URL? Does the Web provide directory assistance? Yes - there are many different ways to search the Internet-most of them easy. One of the most obvious is to search by key word, saving a URL as a bookmark when you've found a particular interesting site. Through the Web you can virtually travel to other countries. You can also sample data sets about many different subjects, and save files or print the information contained in the sites. For example by typing "NASA" into a search function, you could quickly find a picture of the earth as seen from the moon, which could be printed on your own printer. Similarly, child abuse information is proliferating on the Internet.

Child abuse and neglect information

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sites on the internet

Any description of sites on the Internet begins to be outdated as soon as it is written. In some dynamic sites, information is added frequently enough that the format and content continually evolve.

Several key offerings in child abuse and their address are described below. This list is by no means all-inclusive, nor is it an endorsement of the sites listed. It is just a small sampling of the resources the authors have found available on the Internet.

Child abuse on the Virtual Hospital URL: http://vh.radiology.uiowa.edu/Providers/ChildAbuse/CAHomepg.html

The Virtual Hospital was developed through a National Library of Medicine grant to the Radiology Department of the University of Iowa. Individual medical departments, multimedia textbooks, and connections to other sites are available for patients, healthcare providers, and others. This extremely busy site on the Web has about 250,000 contacts per week.

Within the Virtual Hospital is a child abuse home page that provides reference and interactive materials designed to increase awareness and understanding of child abuse and neglect (the URL address noted above). This site was developed in part with the cooperation of the Iowa Child Protective Training Academy (CPTA), a multiuniversity collaboration that provides extensive training for child protective service investigators. The bimonthly newsletter of the CPTA is available, as are other sources of information such as *Child Abuse: A Guide for Mandatory Reporters.* This publication, from the Iowa Department of Human Services, provides detailed information for mandatory reporters of child abuse in the state of Iowa about the Iowa Child Abuse Reporting Law, Iowa Code Section 232.67 through Section 232.68. Information about Iowa's Dependant Adult Abuse Reporting Law, Iowa Code Section 235B is also included.

Coordinated by Randell Alexander MD, Ph.d., this site may eventually connect to all significant child abuse efforts on the Internet worldwide. Currently the entire text of the most recent report from the U.S Advisory Board on Child Abuse and Neglect, *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*, is available on the Web only at this home page. Information about the National Center on Child Abuse and Neglect (NCCAN) and material from the National Committee to Prevent Child Abuse (NCPCA) can also be obtained. Soon you will be able to hyperlink to NCPCA's own home page through the Virtual Hospital Child Abuse home page. Other national organizations are preparing to locate information or their basic Web operations at this URL. With linkages in development to other sites, keeping this URL as a bookmark should allow easy accesss to all important child abuse and neglect information on the Internet.

The American Professional Society on the Abuse of Children (APSAC) has its most extensive presence on the Web as part of the Virtual Hospital Child Abuse home page. This location includes an introduction to the organization as well as information about APSAC publication, task forces, state chapters, legislative relations, and other APSAC activities.

This section will be regularly updated. For example, extensive information about child death review teams should be available soon. Brochures about upcoming APSAC Colloquiums can be reviewed, and the registration forms can be printed on your own computer to be filled out and sent in.

***Child Maltreatment* home page URL: http://oz.ach.uams.edu/fmt/cmhome.htm or through the Virtual Hospital Child Abuse home page**

APSAC's new journal is highlighted at this Web site, located at the University of Arkansas. Mark Chaffin, Ph.d., is both Editor-in-Chief for the journal and administrator of this site. Features include an explanation of *Child Maltreatment*'s mission and format, listings of the *Child Maltreatment* Editorial Board, instructions for authors, and other related information.

CANet

CANet is a service of the National Center on Child Abuse and Neglect and is operated by the National Clearinghouse on Child Abuse and Neglect Information. To utilize CANet one must first obtain a password, free of charge, from the NCCAN system administrator at telephone number (800) FYI-3366 or e-mail nccanch@clark.net. This electronic bulletin board system gives professionals working in the fields of child maltreatment and child welfare easy access to information from the Clearinghouse and NCCAN, on line forums for professionals, information on upcoming conferences and trainings, and lists of related electronic networks.

Reprinted from APSAC Advisor Vol. 9 Number 1 Spring 1996 *Randell Alexander, MD, Ph.d., is Associate Professor of Pediatrics and Director of the Iowa Child Protective Training Academy in Iowa City, and a member of APSAC's Executive Committee.*

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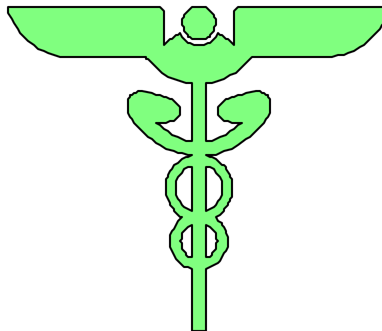
Questionable "Brittle Bone Disease"

Recent calls to the Center indicate two related defenses are becoming increasingly common in child physical abuse cases - osteogenesis imperfecta and "temporary brittle bone disease" (TBBD). Raised in an attempt to show that unexplained fractures and bruises are caused by a medical condition rather than a non-accidental injury (NAI), these defenses warrant careful scrutiny and, in the case of TBBD, outright challenge.

Osteogenesis imperfecta (OI), sometimes referred to as brittle bone disease, is a rare genetic disorder that results from abnormal collagen formation and is characterized by increased bone fragility and frequent fractions. This disorder is rare and occurs, according to most experts, in only one in 20,000 births. Others place the incidence at closer to one in 100,000. Although the disorder may not be readily diagnosed on presentation of the child, it should be considered in the differential diagnosis in cases of unexplained fractures. The fact that OI characteristics may be delayed can complicate an accurate initial diagnosis. However, there is general agreement that the vast majority of OI cases are obvious and/or present no diagnostic difficulty if a thorough examination is conducted by a qualified physician.

Four major types (Types I-IV) of OI have been clinically defined, with these types and their respective subtypes differing in severity and in the likely presence of diagnostic features or characteristics. Diagnostic features of OI include blue discoloration of the sclerae (whites of the eyes), discolored and worn teeth, hearing impairment, and growth retardation. Other typical characteristics include increased joint flexibility, increased tendency toward bruising, excessive bone fragments between the sutures of the skull (wormian bones), and a positive family history for the disease. In extremely rare cases (estimated at one in three million births or one case every 100 to 300 years in a city of 500,000 persons), it may be difficult to distinguish this disorder from NAI. In these cases, the child typically presents with fractures and bruises resulting from a mild case of OI, but lacks a history of trauma and many of the other characteristics associated with OI. While the potential for misdiagnosis remains exceedingly



remote, it is this kind of case that creates the most controversy.

If OI is suspected yet remains uncertain, a thorough review of the child's physical examination, clinical history, family history, and radiographic skeletal survey may be necessary. Prosecutors should consult with a pediatrician, radiologist, geneticist and, if relevant, a dentist. In rare cases in which diagnosis difficulties persist, a skin biopsy may be tested and is likely to detect collagen abnormalities in 85 percent of OI cases. The results of the test, however, may take up to three months to obtain. "If the child has other clinical manifestations of physical abuse, such as bruises not associated with the site of a fracture, intracranial injuries, or retinal hemorrhages, it is extremely unlikely that the fractures are due to OI....the child who has multiple unexplained fractures in one environment and then has no further fractures when removed from that environment should be suspected of having nonaccidental trauma." Jan Bays, Conditions Mistaken for Child Abuse, in *Child Abuse: Medical Diagnosis and Management 380* (Robert M. Reece ed., 1994).

Temporary brittle bone disease, also raised as a defense in cases involving unexplained injury, is not an accepted clinical diagnosis. The term "TBBD" has been introduced to describe OI-like disorders currently attributed to temporary defects in the maturation of collagen: characteristics are said to include fractures (occurring within the first year of life, usually within the first six months of life), metaphyseal abnormalities, periosteal reaction, anterior rib changes, delayed bone age, vomiting, diarrhea, apnea, enlargement of the liver, anemia, and prematurity. Many of these characteristics are also associated with physical abuse or NAI.

Theories explaining TBBD include "faculty fetal packing" resulting from limited movement in utero causing bones to be inadequately mineralized. To date, there are insufficient scientific controls in bone "densitometry" studies to support diagnoses of this disorder. The bottom line is that TBBD is not accepted in the scientific community. The notion of a temporary, self-limiting disease which occurs and disappears with no proven medical explanation does not have scientific credibility. TBBD

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remains an unsubstantiated hypothesis lacking empirical support. If TBBD is raised as a defense in your jurisdiction, it most certainly should be challenged. The Center can provide references to medical specialists for consultation.

While TBBD is not a recognized disorder, OI is a disease that is most often diagnosed without difficulty after a comprehensive medical examination. Statistically, it makes no sense for the defense to claim the OI can easily be mistaken for child abuse. Its occurrence is rare while the occurrence of non-accidental injury in children is all too common. Further, even if a child truly does suffer from OI, there is a possibility that the child is also a victim of abuse.

The resurgent popularity of these defenses highlights the importance of a multidisciplinary approach to investigation of child physical abuse cases. We welcome your materials on OI or TBBD and information on experts testifying in such cases.

Reprinted from UPDATE - National Center for Prosecution of Child Abuse Vol 8, Number 10 October 1995

Available From POST!

In February POST will have the first 7 booklets from the Office of Juvenile Justice and Delinquency Prevention program entitled :*Portable Guides to Investigation Child Abuse.* The booklets available through POST are:

Recognizing When a Child's Injury or Illness is Caused by Abuse

Sexually Transmitted Diseases and Child Sexual Abuse

Photodocumentation in the Investigation of Child Abuse

Diagnostic Imaging of Child Abuse

Battered Child Syndrome: Investigating Physical Abuse and Homicide

Interviewing Child Witnesses and Victims
of Sexual Abuse

Child Neglect and Munchausen Syndrome by Proxy

To Order Return to: POST ACADEMY, Attn. Vicki Pence, POB 700, Meridian ID 83680

Please send me the following Pamphlets:

1.__________________________ 5.________________________

2.__________________________ 6.________________________

3.__________________________ 7. ________________________

4.__________________________

Please Mail to:____

Your Agency Name
____

Your Team Name:
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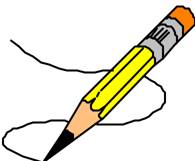

Multidisciplinary Team Approaches to the Investigation and Resolution of Child Abuse and Neglect: A National Survey

Many benefits have been attributed to multidisciplinary team (MDT) approaches used in the investigation and resolution of child abuse and neglect. Yet more than a decade has passed since the nature and characteristics of MDT's have been examined. Findings presented in the article suggest the MDT's vary according to configuration, legislation, function, composition, and training. Current approaches are distinctive when compared with approaches found in previous national surveys. Specifically, the past 10 years have been characterized by the creation of a variety of MDT configurations, a dramatic expansion of legislation permitting or mandating MDT use, and increased diversity of MDT functions, a broader spectrum of discipline representation on MDT's, and an augmented use of training to implement and maintain MDT's. Results described here enable comparison with previous national surveys to shed light on the evolution the MDT system design and to suggest an agenda for future research.

In the past decade, the number of reports of suspected child abuse and neglect in the United States has increased from 1.9 million in 1985 to more than 3.1 million in 1994, a 63% increase (National Committee to Prevent Child Abuse, 1995). With an average of 33% of all reports filed being substantiated, the National Committee to Prevent Child Abuse (NCPCA) estimates that over a million children were confirmed as victims of child maltreatment in 1994. The expansion of protective service programs over the past 10 years demonstrates sensitivity to the increase in the number of reported and substantiated cases of child maltreatment. However, funding caps and cutbacks have restrained this growth, placing an increased burden on caseworkers and challenging the ability of the child protective system to provide quality services to children whose maltreatment is suspected but not confirmed (Besharwov, 1988; Burt & Pittman, 1985). Of those cases in which maltreatment has been confirmed, a small percentage of children receive supportive services (Fall, 1985; Meriwhether, 1988). An estimated 28% to 60% receive essentially no services to remediate the consequences of the abuse or neglect (Meddin & Hansen, 1985; Salovitz & Keys, 1988).

Harm to children occurs not only as a result of the maltreatment itself but also because of systematically insensitive procedures used to address reported maltreatment. These procedures include multiple interviews, intrusive medical procedures, separation from support systems, intimidating courtroom procedures and tactics, and lack of system communication (Jones, 1991; Tedesco & Schell, 1987). A system that is unable to keep pace with the increased demand for services is likely to be ill equipped to counteract the effects of such procedures.

Multidisciplinary team (MDT) approaches are being recognized by an increasing number of professionals as a viable community response to the concern that a system designed to protect children may, in fact, be causing additional harm to child victims. A review of previous national surveys indicates that the number of MDTs has increased dramatically as the concept and its implementation have evolved over the past four decades. Three MDTs were in existence in 1958, 471 in 1977, and more than 1,000 in 1985 (American Humane Association [AHA], 1979; Krugman, 1988).

A growing body of literature on MDTs describes them as a more effective and efficient means of delivering services. MDTs are believed to result in more accurate assessment and prediction of risk; more adequate intervention (Berthier et al., 1993; Chadwick, 1996; Goldstein & Griffin, 1993; Gray & Fryer, 1991;Pardess, Finzi, & Sever, 1993; Pence & Wilson, 1994); decreased fragmentation in the delivery process ; less role confusion among different disciplines; reduced duplication of services among agencies (California Attorney General's Office

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[CAGO], 1994; Pence & Wilson, 1994; Rogan, 1990; Sas, 1991, 1993; Skaff, 1988); enhanced quality of evidence for lawsuits or criminal prosecutions (American Prosecutors Research Institute [APRI], 1993; Dinsmore, 1992-1993), and improved quality of services (Cohn, 1982; Hochstadt & Harwicke, 1985). MDTs have been associated with reducing the traumatization of children and the contamination of evidence gathered as part of the investigative and judicial process (Sas, 1991. 1993; Saywitz & Goodman, 1996). They have also been found to be effective in addressing diagnostically difficult cases, such as Munchausen Syndrome by Proxy (Mercer & Perdue, 1993; Roane, 1992) and are believed to influence the development and use of additional services and resources at both the local and state level (CAGO, 1994; Krugman, 1988; Whitworth, Lanier, & Haase, 1988).

Findings described in the literature reviewed suggest an increasing interest in the potential benefits of MDTs' however, unanswered questions remain concerning trends in MDT system design and their effect on these benefits. The purpose of this article is to address the first of these two issues as a step toward being able to address the latter. What are the trends in team composition and representation? What do current system configurations look like? What functions do MDTs undertake? How does legislation define the parameters and support the mission of MDTs? What training is offered to enable MDTs to function with knowledge and skill? More than a decade has passed since a national survey was conducted to examine these issues. The survey described here enables comparative analysis with previous national surveys to shed light on the evolution of MDT system design and to suggest an agenda for future research in this area.

METHOD

Subjects

Survey respondents were restricted to individuals knowledgeable about the use of MDT approaches in each of the 50 states. Relying on the same list of state offices that was used for the most recent national survey (Krugman, 1988), the interviewer contacted the person currently in the position listed and requested a conference with the person most knowledgeable about the subject. This person was informed that the purpose of the survey was to obtain information related specifically to multidisciplinary team approaches used in the investigation and resolution of child abuse and neglect. The person was asked whether he or she was the most knowledgeable person or whether someone else should be contacted. This process was repeated until the person to whom the question was posed agreed that he or she was the most knowledgeable person in the state. In some states, several referrals were made before this person finally was identified. Table 1 provides a breakdown of the positions held by survey respondents.

Forty-six of the respondents were state-level child protective services (CPS) staff. Nineteen of these were police or program specialists, 16 were middle managers (e.g., assistant directors or supervisors), and 11 were state directors. Two respondents were local CPS directors, and another two respondents were middle mangers in their state Attorney General's offices.

Procedure

This method used in the current study involved both a telephone and written correspondence. A graduate research assistant who observed two pilot interviews conducted by the first author was responsible for the remaining telephone interviews. The pilot resulted in only minor grammatical changes to the interview schedule.

Survey respondents were asked a set of open-and closed-ended questions. The questions were designed to provide data for comparative analysis with the results of previous national surveys to identify trends in the evolution of MDTs. Because the concept of a MDT is evolving, the term takes on different meanings in various states and local communities. For purposes of consistency in the survey, a MDT was defined for the key respondents as "a functioning unit composed of professionals or representatives of service agencies who work together to communicate, collaborate, and consolidate knowledge from which plans are made, actions determined, and future decisions influenced" (Kaminer, Crowe, & Bude-Giltner, 1988, pp. 548-549).

The first question was whether MDT approaches to the investigation and resolution of child abuse and neglect cases were in operation in that particular state. If the answer to that question was affirmative, the interview continued and the respondent was then asked to describe MDT approaches in the state in terms of their origin, system design, perceived benefits and challenges, and the availability of training.

Various follow-up questions yielded greater detail in support of the responses. For example, if MDTs originated through legal mandate or departmental regulation or directive, the respondents were asked to describe relevant legislation, regulations, and procedures.

At the conclusion of the interview, the respondents were asked to submit copies of relevant materials (i.e., Legislation, written protocol, training materials) referred to in the interview. A follow-up letter was sent to respondents reinforcing the importance of submitting written materials. Upon receipt, these materials were used to confirm and clarify responses received during the phone survey. For example, copies of state legislation frequently specified MDT functions and composition. When a discrepancy existed between responses received in the phone survey and the written materials, information from the written materials was used. Thus results of this survey favored description of system design over lived experience when discordancies between verbal and written information occurred.

RESULTS

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Respondents from all 50 states (100%) completed the phone survey. A total of 40 respondents (80%) returned materials that had been requested in the phone interview and follow-up letter. When specific questions were unanswered or the respondent was unsure about the answer, the responses were coded as missing. Unless otherwise noted, findings reported here reflect response for all 50 respondents. (A breakdown of data by state, names, and addresses of survey respondents, and lists of relevant materials submitted, are presented in Kolbo, Lowe, Wook, Efaw, & Strong, 1994). Trends and patterns supported by the data are summarized here.

Configuration

Of the 50 respondents, 33 (66%) reported that their states have "statewide participation" in the multidisciplinary response to child abuse and neglect (see Table 1). With the exception of Colorado and Iowa, in which counties with fewer than 50 reports of abuse or neglect per year are exempted, statewide participation means that each child in these states is afforded the benefit of a multidisciplinary approach to addressing child abuse and neglect, without regard to where the child lives or where the alleged maltreatment occurred.

Table 1 describes the most prominent geographical divisions used in each state. The geographical plan for implementation may be centralized at the state level or may be established by each local community, county, or region. Various combinations of the geographic division have been devised by different states to address idiosyncratic needs, such as population density in urban versus rural areas. For local initiatives, the boundaries depend on the intentions and the degree of influences held by the initiators of the effort.

Thirteen states (26%) have implemented a tiered system of teams, with each assuming one or more roles, such as investigation or monitoring of complex cases or child fatality cases, training, or social planning. The term *tiered* is used to describe states in which the catchment areas of teams do not coincide but do overlap.

Configuration of MDTs is not limited to specific geographic divisions. For example, Child Advocacy Centers have been implemented in nine states either through the use of state and federal grants or through local initiative (see Table 1). Based on the Huntsville, Alabama, model (Amacher, Cramer, Hall, & Lind, 1990), these centers are centrally located, child-friendly sites used for child interviews in cases of child sexual abuse. Such sites are furnished in an age-appropriate way and are equipped to enable CPS, law enforcement, and the prosecuting attorney to gain needed information from a single child interview.

Legislation and Protocol

Use of state statute to accomplish participation is common. Of the 33 states having statewide participation, 30 have implemented the multidisciplinary approach using legislative mandate, whereas three (i.e., Connecticut, Delaware, Idaho) have used departmental regulation or directive. Of the 17 states not requiring statewide participation, 11 have recognized the value of such efforts by enacting statutes permitting or encouraging the development of teams or the sharing of information under specific conditions. Only six states (12%) depend entirely on voluntary , community-level recognition of the value of such efforts to instigate MDT approaches.

Twenty-six states (52%) have developed a manual, handbook, or protocol to guide local MDTs. These are generally in a format that allows for local adaptation. In the remaining states, local MDTs develop their own protocols within the limitations of state statute. The protocols adapted by West Virginia, for example, are designed to guide local efforts in developing and implementing MDTs. Protocols are suggested for three different teams: investigation, treatment, and case oversight. These protocols delineate procedures involved in criminal and civil cases. Appendices to the protocols include interagency agreements, state codes, guidelines for interviewing children and conduct evidentiary examinations, a checklist of terms and conditions, and diagrams detailing the investigation and treatment process.

Functions

MDTs may be responsible for any one or several of the following activities: investigation of reported cases, treatment planning, provision of direct service to victims, advising and consultation for prosecution decisions and treatment planning, community education, monitoring of case resolution, or social planning (i.e., identifying and assessing needed versus available resources) to identify gaps in the service delivery system. As indicated in Figure 1, respondents identified the investigation of reported cases, treatment planning, and advising and consultation of the most common functions. Teams that handle these functions are generally case specific, existing primarily for the purpose of responding to a particular case of abuse or neglect. Social planning, community education, monitoring of case resolution, and direct service to victims, these latter functions are generally handled by standing teams.

Activities related to the issue of child abuse and neglect are frequently divided among two or more teams. In nine states, several teams are organized within the same geographic area, each having distinct responsibilities. For instance, Delaware and Nebraska have two MDTs per county: one to handle investigation and the other to handle treatment planning.

Composition and Representation

Composition of MDTs naturally depends upon function. Of the 45 respondents who were able to identify team composition in their states, team members were most likely to represent (in descending order of involvement) CPS, law enforcement, and the legal system. The professions of medicine, education, mental health, public health, and juvenile corrections were the next most commonly represented professions (See Figure).

Psychologists or psychiatrists, guardians ad litem, juvenile corrections officers, family support and child care agency workers, and court-appointed special advocates were less frequently represented on teams.

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Benefits and Challenges

Two thirds of those surveyed reported one or more benefits of MDT use. A majority of these responses related to an increase in coordination and collaboration between agencies. According to the survey respondents, through the use of MDTs a broader range of viewpoints on problems is considered in the decision-making process, more decisions are made jointly, otherwise unknown resources are identified, and ultimately, better assessments, treatment plans, and services are provided. In addition, more cases are actually reviewed, fewer cases "fall through the cracks," and more cases reach successful resolution. Positive secondary effects include a greater sense of accomplishment among the professionals responsible for the case and improve interagency relationships.

The use of MDTs presents challenges as well. Many of the respondents indicated that collaboration was not always easy. Initially, certain individuals and agencies were hesitant or resisted becoming involved. While MDTs were perceived as helping to lessen the burden on CPS workers, some of these workers were then confused about leadership roles, questioned the ownership of the case, and felt additional scrutiny of their work. Others felt that interdisciplinary decision making can be more time-consuming than traditional approaches, at least initially.

Training

By far the most frequently cited strategy for addressing the challenges just described is the provision of initial and ongoing training. Yet, as reflected in Table 1, only 30% of the respondents reported that their respective states regularly planned and provided ongoing training to team members and potential team members. Thirty-eight percent reported that their states provided initial training and supported ongoing training as funds became available. Another 32% responded that teams train each other locally and informally without statewide initiative.

The availability of ongoing support and training is handled creatively in various states. Missouri established a multidisciplinary State Technical Assistance Team (STAT) to offer initial and ongoing training to local teams. In Idaho, the Child Abuse Response Team (CART), a multidisciplinary state-level team, trains new local teams by investigating one case for the local team, investigating a second case with the local team, and then overseeing the local team's investigation. Oklahoma established the Child Abuse Training and Coordinating Council (CATCC), a multidisciplinary state-level team, to provide extensive ongoing and customized training to new local teams. Nevada, Florida, and Vermont contract with consultants to be available on teams on an as-needed basis as well as to provide ongoing training.

Discussion

Initiatives to take a multidisciplinary approach to the investigation and resolution of child abuse and neglect exist in all 50 states; however, the approach taken in each state is unique. Even though some states have modeled their approaches on those of other states (e.g., New Hampshire approach is patterned after Vermont's), none is a carbon copy of any other. Frequently, several different approaches are used within a particular state, as seen in the tiered model for implementation, the training models developed in various states, and teams whose catchment areas differ depending on density of population.

A recent shift in the use of legislative statuyes to mandate or permit the implementation of MDTs is apparent. In 1979, the Education Commission of the States (reported in Pettiford, 1981) found that 12 states had legislatively mandated MDTs. A 1985 survey by Younges and Besharov (1988) found a total of 16 states with legislation mandating the operation of MDTs, and another 12 states where MDTs were legislatively permitted. The current survey indicates that 30 states (60%) have mandated MDTs and another 11 states (22%) legislatively permit their use. Of the states with legislation, all but one have been enacted or revised in the past decade.

MDTs have been viewed by many as a grass-roots, community-level response to a local problem. Increased use of state-level legislation to implement and maintain MDTs suggests increased sensitivity to the scope of the problem, a wider base of support, and more formal commitment to address and resolve the issue of child abuse and neglect.

Federal-level legislation also played a significant role in the expansion of MDTs. For example, the Victims of Crime Act of 1984 and the Children's Justice Assistance Act of 1986 authorized Children's Justice Act Grants with the purpose of developing state-level multidisciplinary task forces. These state-level task forces assisted in the development of MDTs at the local level and, in a number of states, the mandated development of statewide MDTs (National Center on Child Abuse and Neglect, 1992)

Further, interagency coordination has been encouraged and supported through the dissemination of state statutes and relevant case law (American Prosecutors Research Institute, 1994); written guidelines for developing a shared investigative process; summaries of multidisciplinary efforts in which professionals have demonstrated a history of working together as teams (APRI, 1993); and training in multidisciplinary approaches, team building, and interagency collaboration (U.S Department of Justice 1993).

Since their inception, MDTs have been used most often in an advisory capacity, providing consultation to the CPS workers involved in the investigation of suspected abuse or neglect (AHA, 1979; Kaminer et al., 1988: Selinske, 1981). Treatment planning consistently has been presented in previous surveys as secondary to advising and consultation. Social planning, community education, and monitoring of case resolution have been the least common activities performed by MDTs.

A review of findings from previous

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surveys indicates a change in emphasis regarding MDT functions. In 1979, the American Humane Association (AHA) found that 59% of MDTs provided advice and consultation. Another 23% provided a mixture of consultation, case review, and direct decision making in treatment planning. Selinske (1981) found that all of the 19 teams in 16 states surveyed used MDTs for consulting. Only 11 teams provided diagnosis or treatment planning. Kaminer et al. (1988) found that 85% of the states primarily used a case consultation model. Fifty-four percent used MDTs for diagnosis and treatment planning. Another 52% emphasized the development of resources and the planning and coordination of community action. Sixty-two percent of the states reported some mix of these different functions.

The current study suggest that investigating and treatment planning have surpassed advising and consulting as the primary functions undertaken by MDTs. Community education and monitoring the resolution of cases have also become more prominent functions of MDTs. Thus current expectations of MDTs include the more direct and active participation of different disciplines in addressing a variety of tasks related to the resolution of cases. Expansion of the functions of treatment planning and the monitoring of case resolution in MDTs is likely to play an important role in efforts to counteract the current unfortunate phenomenon: A smaller percentage of confirmed cases is receiving services.

According to surveys conducted in previous decades, MDTs have generally been composed of representatives from (in descending order of amount of involvement) child protection, mental health, health care, legal or judicial, education, law enforcement, and support services (Kaminer et al., 1988; Selinske, 1981). This study indicates (see Figure 2) that representatives from law enforcement and legal services have recently taken over larger roles than mental health, health care, and education. The fact that protective services, law enforcement, and legal services are most likely to be represented on MDTs is in line with the finding that investigation is currently the most common function. However, the importance and influence of other disciplines are in no way diminished. In fact, as treatment planning becomes more common than advice and consultation, and additional responsibilities are taken on by MDTs, other disciplines are becoming more actively and directly involved in the resolution of cases.

The composition of MDTs depends on function. Activities taken on by MDTs have been largely determined by legislation. Because most of the existing state statutes specify and emphasize the investigative function, one would expect that the disciplines represented on investigative teams would be the most frequently identified disciplines on MDTs. The increased participation of disciplines involved in treatment planning and case resolution also reflects recent changes in state statutes. Legislation legitimizes the work and roles of those involved . As state statutes are modified to emphasize the resolution of cases, more frequent identification of different disciplines should be expected.

Training is recognized as key to overcoming turfism, language barriers, role confusion, misconceptions about the function and value of other disciplines, and other obstacles to successful implementation of MDTs (Kolbo et al., 1994). Fortunately, some progress toward more formalized statewide training is indicated. Only 10 of the respondents in the study by Selinske (1981) reported that MDTs received initial training, and 9 had received ongoing training. Kaminer et al. (1988) reported that initial training was provided to teams statewide in only 11 cases. Currently, 33 states (66%) report either initial or ongoing training. The 17 remaining states without formal, statewide training reported localized efforts among MDTs to train new members and teams.

Summary and Conclusions

This article presents an overview of the current nature and characteristics of MDT approaches to the investigation and resolution of child abuse and neglect. MDT system designs vary according to configuration, legislation and protocol, functions, composition and representation, and training. Current approaches are distinctive when compared to findings of surveys conducted in previous decades. Specifically, the past 10 years have been characterized by the creation of a variety of MDT configuration, a dramatic expansion of legislation permitting or mandating MDT use, an increased diversity of MDT functions, a broader spectrum of discipline representation on MDTs, and an augmented use of training to implement and maintain MDTs successfully.

This study was based primarily on prior national surveys. Two measures were taken in designing the study to ensure that the differences in findings reflect programmatic changes over the years rather than differences in the methods employed in this and previous studies. The list from which the survey respondents were generated came from the list used in the most recent survey (Krugman, 1988). In addition, this study used the same operational definition of MDTs that was used in prior surveys (Kaminer et al., 1988).

Some caution in drawing inferences through comparative analysis is warranted. The exact wording and sequence of questions in the present study were not consistent with previous surveys. Further, the methods used in the various surveys differ, with some using telephone interviews and others using mailed questionnaires. A telephone/mail survey was selected in the current study to achieve a higher response rate and to increase the chance of obtaining material that could be used to validate interview responses. The psychometric properties of the survey instrument, however, are currently unknown.

In this study, 92% of the respondents were state-level CPS staff. It would be reasonable to expect that these respondents could accurately report on system design characteristics of MDTs (e.g., police matters, procedures, legal mandates), which are the same characteristics that were studied in previous surveys. It is possible that local or frontline staff would

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have reported differently, particularly to questions of actual operation and the impact of the MDTs. Future studies addressing frontline response may shed additional light on these aspects of evolution of MDTs.

This study suggests that team effectiveness is enhanced through legislative support; broader representation of and active participation by different disciplines; use a variety of teams and configurations that best fit the needs of each state, region, or local community; and the provisions of initial and ongoing training. Yet much more research is needed to identify and determine casual relationships between MDT system designs and team effectiveness. Further, future research needs to examine which aspects of MDTs (a) encourage appropriate reporting, (b) generate legally admissible evidence, (c) resolve cases in a timely manner and in the best interest of the child victim, and (d)respond to the needs of child victims and the potential victims of future maltreatment.

The high rate of both verbal and written response to this survey reflects an openness to share insights that is rooted in a common interest in the welfare of children. The generosity and commitment of professionals who hold to ideals while struggling to bring about change are improving systemic responses to current serious threats to children's well-being, despite the ever-present scarcity of funding to support such efforts.

The increase in the number of MDTs and the number of states that are formally implementing a system of MDTs attests to the benefits of an MDT approach. The challenges faced by MDTs are the very catalysts that have generated the rich variety of approaches currently in operation in the United States. As these multidisciplinary approaches are refined over time, they will become an invaluable resource for all who search for effective ways to protect our children.

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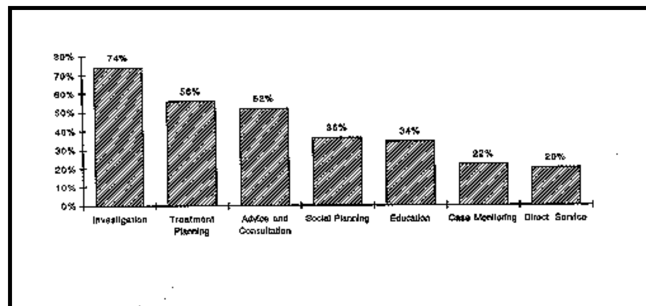

Figure 1: Functions of Multidisciplinary Teams

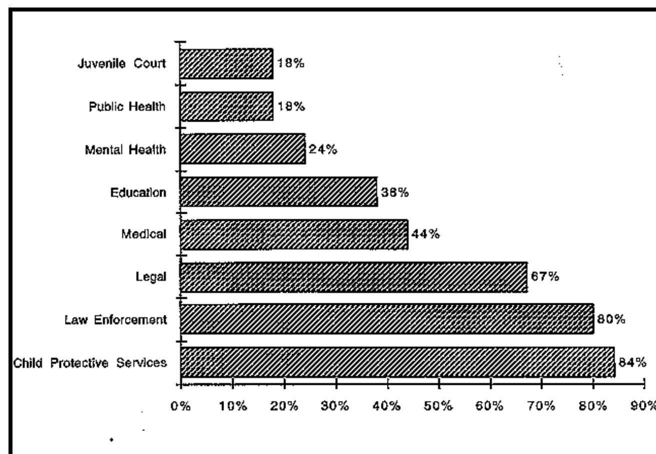

Figure 2: Composition of Multidisciplinary Teams

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