CREATING THE MULTIDISCIPLINARY RESPONSE TO CHILD SEX ABUSE: AN IMPLEMENTATION GUIDE

by

Mary Ann Wycoff

with the assistance of Mary Kealoha

1987

POLICE
FOUNDATION
Washington, D.C.

CONTENTS

DEDICATION

This implementation guide is dedicated to

Johnny Mais

who was twenty-one months of age
at the time of his death.

AUTHORS' ACKNOWLEDGEMENTS

This volume has been produced under grant Number 90-CA-1056 to the Police Foundation from the National Center on Child Abuse and Neglect. Special thanks go to Laura Skaff and Cynthia Darling, the NCCAN project monitors who have graciously answered all questions and otherwise supported our efforts.

Working with the Police Foundation in the design of this volume, the videotape that accompanies it, and the technical assistance given to several communities were the National Legal Resource Center for Child Advocacy and Protection at the American Bar Association (ABA) and the American Public Welfare Association (APWA). Thanks go to Robert M. Horowitz of the ABA and Betsey R. Rosenbaum and Toshio Tatara of the APWA for their patience with the vicissitudes of multidisciplinary arrangements and for their many contributions to this effort.

We also are grateful for the time and insights of the members of the project's advisory committee. They are Donald C. Bross of the C. Henry Kempe National Center; Detective Robert Derbyshire of the Baltimore County Police Department; Dr. Shirley Fitz-Ritson, Director of Child Protection and Preventive Services for the State of South Carolina's Department of Social Services, and John Stein of the National Organization for Victim Assistance.

There would be no guide were it not for the full cooperation we received at each of the five exemplary sites. Dozens of people interrupted overburdened schedules to participate in

extensive interviews. As important as their generosity with time was their willingness to share with us both the high and low points in the histories of their programs. True professionals, their concern was to help other communities build on their experiences.

At each site there was one person who assumed the responsibility of arranging interviews with relevant participants in the program, provided the introductions that allowed strangers to trust us, and shepherded us through our visit. We recall the following people with warm appreciation: Diane Erne, Alliance Coordination Services for Families at Risk in Syracuse, New York; Jan Frohman, National Children's Advocacy Center in Huntsville, Alabama; Kathleen Kennelly, The Sexual Assault Center, Harborview Medical Center, Seattle, Washington; Lieutenant Porter Richardson, Norfolk Family Sexual Trauma Team in Norfolk, Virginia; and Sue Whelan-Williams, Orlando Child Protection Team, Orlando, Florida.

We are greateful to Dr. Robert Goldberg who perceived the need for this guide and wrote the proposal that produced the funding for it.

And, finally, special thanks to Wanda Roberts for her patience and talent at the keyboard and to Sheila Bodner, whose editorial skills help many of us pass as writers.

INTRODUCTION

The development of a multidisciplinary approach to child sexual abuse represents an enormous challenge. Implementation of any new policy or program is always a major undertaking requiring careful planning, political strategizing, psychological insight, the finesse of a seasoned diplomat, and what may occasionally appear to be a magical mixture of pious patience and incandescent intolerance. This is true of many relatively simple changes attempted within individual organizations. The weight of this truth is multiplied when the change involves a number of different organizations, all of which are equally critical to the new program but not all of which necessarily share, at any given point in the implementation process, an equal commitment to the new idea. It is precisely these more complex conditions that characterize most efforts to bring about interagency cooperation in the handling of child sexual abuse cases. It is impressive, then, that a number of communities have accomplished this goal despite the apparent odds against success.

The National Center on Child Abuse and Neglect funded the Police Foundation to study five of these successful programs with the objective of drawing lessons from their experiences. Predictably, the five successful programs did not accomplish their goals without substantial effort, and most have had to grope their way through the implementation process, unguided by the experience of predecessors. They were pioneers who had no

choice but to cut new paths. By drawing on their experiences, other communities may be able to find a faster and smoother route to the same destination.

This implementation guide is intended, then, for other communities and agencies interested in establishing a similar program in their area. It is offered with all best wishes and congratulations to those communities setting about the hard but rewarding work of creating both a more humane and more effective way of dealing with one of the saddest problems in any society.

THE MULTIPLE NATURES OF MULTIDISCIPLINARY EFFORTS

In the most general sense, a multidisciplinary approach is an arrangement, loosely or tightly structured, among involved institutions for the purpose of handling child sexual abuse cases in a coordinated manner. Rather than each agency (e.g., police, child protective services, prosecutor's office, hospital, treatment agency,) having its own method for dealing with these types of cases, agencies share a set of mutually acceptable procedures for handling them.

Exemplary programs in five cities were studied for this report.[1] Each employs some type of multidisciplinary approach in response to child sexual abuse cases. However, not all of these approaches involve highly structured units or teams whose members work in close physical proximity on each case. In Norfolk, for example, police and social workers respond to cases together and so work directly as a team from beginning through termination of a case. When a problem arises, a supervisor from either agency can call a group meeting to resolve it. In Orlando, Seattle, and Syracuse, agencies handle cases using mutually agreed upon procedures, and representatives come together on only those cases that present particular problems. Additionally, they meet at times for oversight discussions or for in-service training. In Orlando, the program provides for case

---

[1]Alliance in Syracuse, New York; National Children's Advocacy Center, Huntsville, Alabama; Norfolk Family Sexual Trauma Team, Norfolk, Virginia; Orlando Child Protection Team, Orlando, Florida; Sexual Assault Center, Seattle, Washington.

coordinators who take charge of cases to make certain each participating agency receives the information needed from the others. The Huntsville program is coordinated through the use of weekly meetings, involving several agencies, during which every pending case is reviewed.

The Huntsville, Orlando, and Syracuse programs provide "neutral" meeting space for agency representatives; the Huntsville program is the only one that provides shared work space in which all the agency personnel may conduct and record their case work.

The five exemplary programs studied as the basis for this guide are described in greater detail in Appendix A. None of them is proposed as the ideal model of a multidisciplinary team. The five programs are all considered generally successful by professionals familiar with multidisciplinary efforts around the country, and these five represent a range of feasible arrangements that provide for integration of the efforts of agencies involved in handling child sexual abuse cases. What they have in common are philosophies and protocols that are shared among the locally interacting agencies in each community and ways of working together quickly and comfortably when problems arise on specific cases. Apart from this characteristic, there is not a "correct" program model for every community, county, or state; design of an appropriate system will depend on the resources and other conditions of each jurisdiction.

Regardless of the models they represent, the five exemplary programs have in common dramatic departures from non-integrated approaches to handling child sex abuse cases. Unlike the agencies discussed in this report, agencies that do not work within some type of integrated, multidisciplinary framework may employ different, and even conflicting, procedures and philosophical orientations toward cases. Police often assume, for example, that child protection workers are oriented to maintaining the family and are therefore reluctant to pursue an abusive situation as a criminal case. Social workers, on the other hand, may believe that police agencies and prosecutors will seek criminal charges in every case, regardless of the interests of the family unit.

A multidisciplinary approach can counteract some of the negative consequences of such inter-agency stereotypes and, ideally, increase the efficiency and effectiveness of community responses to child sex abuse cases. The result should be a less confusing and psychologically stressful experience for the victim and family and also for the professionals responding to the case.

THE IMPLEMENTATION PROCESS

Implementation, most simply defined, is the process of making planned change happen. This makes implementation sound synonymous with action. Yet, the first eight of the following thirteen implementation stages involve groundwork or planning rather than implementation activity. Emphasis is put on these

eight because the planning aspects of implementation are the ones most frequently overlooked in the enthusiasm to move directly from idea to action. Unfortunately, the history of too many programs suggest that any rush to action that ignores the essential role of planning is a probable rush to program failure.

STAGES OF IMPLEMENTATION[2]

1. Identification of Need
2. Development of a Work Group
   - a. Recruiting Participants
   - b. More Determined Efforts to Recruit Participants
   - c. "Nice" Is Not Always Effective
   - d. Leadership and Facilitation
   - e. Promoting Trust
   - f. Avoiding Turf Battles
3. Idea Formation
   - a. Articulation of Solutions
   - b. Secluded Planning
4. Specification
5. Assessment of Feasibility and Costs
6. Decision
7. Adjustment

---

[2] These 13 stages of implementation are the author's elaborations of those identified by Walter Williams in "Implementation Analysis and Assessment," Policy Analysis (Summer) 1975 and Rosabeth Moss Kanter in "The Middle Manager as Innovator," Harvard Business Review (July-August) 1982.

8. Implementation Planning
    a. Assignment of Task and Supervisory Responsibility to Individuals
    b. Timing of the Various Steps to be Taken
    c. Communication of Plans and Timetable to Relevant Actors
    d. Anticipating Resistance and Planning to Manage It
    e. Planning Ways to Demonstrate Commitment
    f. Setting up the Evaluation
9. Action
    a. Coalition Formation
    b. Doing the Work
    c. Reinforcing Team Bonds
10. Evaluation
11. Decision
12. Adjustment
13. Institutionalization
    a. Ongoing Supervision
    b. In-Service Training
    c. Retention of Trained Team Members
    d. Filling Vacancies
    e. Dealing with Burnout
    f. Rewarding Good Work

Each of these stages is discussed in turn.

1. Identification of Need

The idea that a problem must be perceived before a solution will be sought may seem too obvious to merit discussion, but

there is an important issue in whether the need is perceived and defined as local in nature. The need for a multidisciplinary approach was defined in terms of a pressing local condition in all five model programs.

In Huntsville, for example, the district attorney was aware of his own difficulty in handling child sexual abuse cases, and he assumed correctly that his problem was experienced throughout the system.

In Norfolk, a police lieutenant was disturbed by the incongruity of reports of the number of cases handled by the police department and by child protective services.

In Syracuse, a case that ended tragically drew dramatic attention to the limitations of the traditional system.

In Orlando, a child protective service supervisor grew tired of young victims and her staff members having to sit for hours in emergency rooms waiting for reluctant physicians to conduct examinations.

In Seattle, a social worker and a police officer realized they had common concerns about the frustrations and limitations each of their agencies experienced in trying to handle child sex abuse cases.

In each instance, the fact that the problems were local ones, identified by local people, and understandable in terms of local individuals and institutions, helped other professionals in the system accept the need for change. This sense that "we have a problem here" was the only way most of these five programs could have approached the development of a multidisciplinary

team, because when they began there was no national advocacy for such a strategy. Today, of course, there is; but, ironically, national advocacy of a strategy can be both an advantage and disadvantage. The community that develops a team may have to confront feelings on the part of some agency representatives that the local group advocating a team approach is responding primarily to external professional pressures. They may argue that "...just because some other community has had trouble handling child sexual abuse cases doesn't mean we have the problem here." There may be alliances formed to protect local agencies from being criticized and from being subjected to "unwarranted outside pressure."

This means that, while the initiating agency may have been motivated by professional literature or conferences to examine the issue, it should take care to demonstrate the need in terms of local cases and local statistics which other practitioners will recognize and with which they will be able to identify.

If outside consultants are to be employed, they can only be effective if local practitioners have acknowledged their own needs. If need acknowledgement has not yet occurred, attacking the outside consultant may be one means by which resistors can rally their forces. The initiating agency will need to gauge both general and professional community awareness and attitudes regarding child sexual abuse. Is there an awareness of the problem on the part of physicians, psychologists, district attorneys, law enforcement personnel, social service personnel,

judges, teachers, parents, and children? If not, education may be the first task of a work group.

2. Development of a Work Group

a. Recruiting participants

The purpose of a work group is to plan the multidisciplinary team. The initiating agency should seek one or more concerned, willing persons from each of the relevant professions to form the work group. The director of each agency to be involved in the proposed program should be invited to participate in the work group or to send a representative. If an agency is not represented, it should nonetheless be kept informed of the work group's progress through the mailing of minutes and work products. These steps will open and maintain lines of communication with professionals and organizations essential to the success of a multidisciplinary program and will prevent any agency from later feeling excluded from the planning process.

b. More determined efforts to recruit participants

Another strategy for encouraging support of the multidisciplinary process is sponsoring the attendance of a recalcitrant professional at a national conference or training session on the topic--preferably one sponsored by his or her professional organization. By attending training with colleagues, the person is able to discuss pros and cons with others who are working within similar constraints and for similar constituencies. An unresponsive judge might attend training

provided by the National Council of Juvenile and Family Court Judges or a district attorney might participate in a session conducted by the National District Attorneys Association.

Some communities have dealt with disinterested professionals by arranging for a community group to host a professional panel to discuss the problem of child sexual abuse. Having to prepare remarks and respond to questions about the problem has, in some cases, been enough to awaken a professional to the need to at least consider the team approach.

The initiating agency may want to seek allies if another agency continues to refuse to acknowledge a problem with the handling of child sexual abuse cases and will not join a planning group. In some of the programs studied, the initiator enlisted the aid of a distinguished, powerful, local person to help persuade others. This may have been a judge, district attorney, or prominent physician. By chairing discussion sessions, such persons can use their personal or political influence to convince others of the magnitude of the problem. When an alliance-for-persuasion strategy does not prove effective, allies may be put to more forceful use. When a police department on the east coast could not get the local child protective service agency to agree to joint handling of cases, the police presented the issue to a grand jury. The eventual result was a solid, cooperative arrangement.

c. "Nice" is not always effective

As this last case suggests, there can be a good deal of interagency and interpersonal acrimony involved at even the first stage of program development. It should be expected, and to some extent, even encouraged. Such advice would seem to run counter to the goal of developing a harmonious working relationship among agencies but, in fact, a premature commitment to harmony can constrain the ability to genuinely articulate and confront the issues.

The failure of agencies to cooperate has not been simply the result of formal organizational boundaries. Were that the case, it would be easy enough to develop organizational linkages. More often, the greater problem is attitudes that have developed among the members of diverse professions. Each agency may view the other as not being sufficiently concerned about the problem, as having employees who are untrained and incompetent, or as adhering to inappropriate philosophies. As suggested previously, social workers may assume the police will be interested only in developing cases for prosecution and will be insensitive to the need to protect the integrity of the families. Police, on the other hand, may believe that social workers will object to prosecution. Therapists for the child victim may counsel the protective parent against prosecution in the belief that the actions of police and attorneys will further traumatize the child. While some of these attitudes may result from the lack of interagency contact, there certainly may be real differences of philosophy, and these differences--whether imagined or real--

will have to be identified, confronted, and resolved before a working relationship can be created.

Exaggerated efforts by agency representatives to be pleasant and agreeable may only serve to camouflage beliefs and attitudes that should be aired. While interagency differences, both procedural and philosophical, need to be identified and examined, the task is not an easy one. Confrontation holds the potential for difficult, tense, and unpleasant meetings and the potential for disaster. At the same time, however, it offers an opportunity to explore differences with the goal of reaching a viable consensus on issues critical to the implementation process. The effort to create a successful interagency team may depend on commitment to temporary confrontation.

Since most people would rather avoid confrontation than embrace it, consideration should be given to recruiting an impartial and experienced group facilitator to expedite this process. The team-building process needs a leader with the ability--based on knowledge, and experience--to predict, explain, encourage, and manage confrontation. In some of the model projects, team advocates were initially startled by the breadth and depth of negative feelings among some professionals. The leaders feared they had unleashed feelings, the expression of which would cause irreparable harm. However, in the five study sites and in others that have shared their implementation experiences, it was possible to move beyond this stage. Individuals who greatly disliked the confrontation during the

early meetings came to regard it as an essential part of team development.

Given that confrontation is probable, the initiating agency or individuals should expect it and predict it for other participants. Expectation alone may take some of the sting out of the phenomenon. Additionally, there should be recognition of the need for a leader, who can feel at ease managing group tensions.

A key point to keep in mind is that there are two distinct aspects of any meeting; one is the information to be shared and the other is the process of sharing it. Information is the <u>what</u>, and the process of sharing is the <u>how</u> of the meeting. It is the how that is most often overlooked, resulting in confusion, poor decisions, hurt feelings, animosity, diminishing commitment, and, ultimately, the possible destruction of the entire team. From the beginning, the group needs the assistance of a facilitator, who is uninvolved in communicating the information and who can focus completely upon the process. Training one or more members of the group to perform this function at all meetings is one of the most important actions a group can take to ensure success as a team.

d. <u>Promoting trust</u>

Development of trust among participants is essential to the project. Participants meet as strangers, come from different organizational worlds, and may be suspicious of the motives of the initiating agency. They may wonder: is the advocacy of a

team a power play, political ploy, diversionary tactic? As people begin to interact in planning meetings, and later in the actual team operation, familiarity will resolve part of the problem. In the beginning, however, attention should be paid to structuring activities that will help erode personal and organizational barriers.

The setting for discussions should be informal and removed from the offices of any of the participating agencies. This helps avoid turf disputes. Arrangements might be made for refreshments or a meal to be served during the meeting. Informal gatherings after late afternoon meetings should be encouraged.

Another way to promote trust and strengthen group bonds is to create "exchange days" on which a member of one profession "walks in the shoes" of someone in another profession. For instance, a child protective service (CPS) worker could spend a day with a police officer or a state's attorney, and these people, in turn, could spend days accompanying the CPS worker. Points of view tend to be broadened substantially after such experiences. People get to know one another as individuals and gain insight into the constraints under which other professionals work.

If financially feasible, representatives of various professions should attend conferences or training programs together, or visit sites of established multidisciplinary teams to examine issues, collect ideas for their own program, and gain insights from professional peers already involved in such teams. Additionally, traveling together and being exposed to different

ideas and programs will serve to build trust and strengthen working relationships among individuals. Each of the five successful programs examined for this report was able to use shared travel to develop bonds among team members, and almost every person interviewed cited such experiences as important to project success. It was commonly noted that when team members had to struggle with difficult issues that could cause group strain, it helped to be able to recall shared trips and activities that had been amusing, interesting, or even exasperating.

e. Avoiding turf battles

Almost every effort to develop a multidisciplinary team has involved tensions that participants refer to as "turf battles." These struggles--overt or covert--can be over such issues as which agency assumes the leadership role; whose policies, procedures, and personnel are subjected to the most change, where the program is housed; and where meetings are held. It may be possible to reduce turf concerns if attention is given, during initial planning periods, to equal sharing among agencies of time, tasks, territory, and travel.

As suggested above, one way to avoid turf battles is to meet in space that does not belong to any of the agencies. Another is to have the meetings chaired by someone unassociated with any agency, or to have them chaired in turn by representatives of each participating agency. While the first proposal may seem inappropriate if one of the agencies has space

that is available and suitable for the meetings, it may nevertheless be desirable to trade convenience for neutrality. Years after the implementation of one successful program, some members of an agency still express irritation that they are always expected to meet in the office of the other organization. Because they have to give up work time for cross-town travel, they feel their time is viewed as less valuable by members of the host agency.

If meetings are not managed by a "neutral" party, the sharing of responsibility (power) for organizing and conducting meetings can help ease turf problems. Also, when public statements about the project are made or there are opportunities for team members to appear before the media, contributions of all the cooperating agencies should be credited.

While seemingly minor matters, turf issues are symbolically significant and well worth the trouble of avoiding whenever possible. Each participating agency, and particularly the initiating agency, should remain alert to the need of every partner agency to perceive itself and the others as sharing equally in all costs and benefits of the team relationship.

3. Idea Formation

a. <u>Articulation of solutions</u>

Assuming the solution to the problem of handling child sexual abuse cases is to create a multidisciplinary team, the planning group must decide what purpose the team will serve and what guidelines will direct its course. This is a time consuming

and tedious business but unless attention is given to the development of the internal structures (philosophy, policies, procedures, interagency working agreements), there will be no framework to hold the group together or direct its actions. With the variety of multidisciplinary teams now in existence, information about team guidelines is available for the asking. A planning group should obtain policies and procedures from several teams that might be adapted to local use.

If confrontation has not yet occurred, it might be expected when the group begins to develop the proposals for team structure and procedures. It is difficult to consider solutions without first identifying specific sources of the problem, and it may be tempting (and perhaps logical) for one agency to point a finger at another. Further, when solutions are proposed that impinge on the usual policies or procedures of an agency, strains will occur. However, it is critical that everyone expected to be involved in the eventual program be encouraged to submit ideas and express any concerns. Even if the initiating agency has a well-developed idea about what the program should be, that idea should not be aggressively promoted before exploring ideas of other members of the planning group. Not only might a better plan be devised, but full participation at this point is important to the ultimate sense of joint "ownership" by participants.

The initiating agency should not assume that advocacy of alternative ideas represents incipient opposition to the original proposal. Questions, lengthy discussion and idea exploration

should be treated as well-intentioned. Quick moves to squelch apparent opposition to the "right" idea can be self-defeating. Potentially valuable ideas may remain undeveloped and key professionals may become resistors when they feel shut out of idea formation.

Full discussion also guards against both the perception and possibility that an inappropriate solution will be imported from outside the community. This will be discussed further in the section on "Specification," but it should be noted that the development of multidisciplinary models (including those described in this report) presents the temptation to replicate a program that appears successful elsewhere. While the examination of other programs is encouraged and should shorten the idea formation phase, advantages of having models can be offset by disadvantages if an externally generated model is treated as applicable in toto to local conditions. The successful programs reported here had little in the way of models on which to draw. Although they might have wished for mentor programs, their success may be due in part to having had no alternative but to design programs around their local needs. Communities currently seeking to develop programs will have to work consciously to avoid over-reliance on existing models.

b. Secluded planning

Work at both the "problem identification" and "idea formation" stages is probably best done out of the public eye. As suggested previously, these are potentially volatile phases.

If the issues are explored in public, several undesirable conditions might arise: (1) pressure for premature closure on ideas might occur; (2) some participants might play for public support; and (3) media attention to the problem of child sex abuse might bring a greater flood of reported cases than the fledgling program can handle. This was the experience in Norfolk when the early decision was made to feature public education as a part of the total program.

Among the five sites, the ones that appear to have moved most smoothly through these stages were the ones in which the hard issues were hammered out behind closed doors, frequently in settings away from the normal work places. There were no audiences. There was no press. Those participants whose ideas or concerns were overridden by others did not have to be concerned about being publicly identified as "losers" in political or bureaucratic contests.

Although ultimately successful, the Huntsville effort experienced considerable tension in these first two phases because planning work was done publicly. Enough had been accomplished by key professionals--prosecutors, social service workers, and police--to allow for the establishment of joint multi-agency review (team review) of cases. However, after some months of team review, the participants decided that other groups, especially physicians and therapists, needed to be included on the team. In addition, they felt that community support could be important to the success of a broader program. Professionals and representatives of lay interest groups were

invited to a public forum that resulted in the creation of four subcommittees that met every two weeks for a period of eight months. Much of the potential benefit from this process was lost when some of the participants and agencies began to compete publicly for power and for publicity of their own agendas. Participants in the Huntsville program feel these meetings were useful for hearing the viewpoints of other professionals but also feel these attitudes might have been expressed sooner and more freely if meetings had not been public. There continue to be divisions in the broader community among individuals and institutions committed to the issue of child sex abuse.

Huntsville's effort at public coalition formation may have been less than successful because of its timing. Coalition formation might be more effective when reserved for the "action" phase, after problems have been defined and solutions clearly articulated. Other individuals and agencies will know better how to respond when they understand what it is they are responding to.

4. Specification

Specification involves providing details about the goals of the program, the means by which the program is to be implemented, and the way in which it will be evaluated. This should occur after a general program proposal has been developed and adopted. Because it is easier to agree on a general program concept than to concur on operational details, this is another point at which confrontation within the planning group may occur.

Given the probability of disagreement at this point, it may be advisable to withhold public announcement of the program until a later phase--preferably after the first "Adjustment" phase, if possible.

5. Assessment of Feasibility and Costs

It can be presumed that, by the time a program proposal has been subjected to the specification stage, there will be general agreement as to whether it meets the local need. The determination that it fits the need is <u>not</u> the same as the determination that it fits local resources. At the stage of feasibility assessment, the planning group must consider carefully what the program will cost in terms of money, political struggle, personnel, and the emotional costs of overcoming possibly substantial resistance. Basically the group has to ask:

What will it cost each agency to develop the program?

Do sufficient resources exist to do the job?

If "no," should additional resources be sought? From where?

6. Decision

If the answers to the second or third questions are positive, the decision to proceed essentially has been made.

However, the group may experience conflict if some participants see their agencies as having insufficient resources with which to support the proposed program. It may be necessary to negotiate differential distribution of costs across agencies, or to decide with the needy agency how the planning group might

lobby the agency's governing board for additional resources. This might be the time to start negotiating an externally-based coalition, perhaps of community service organizations, local businesses, and other potential backers or fund raisers, who will commit themselves to assist with resource development.

A Caution: Feasibility issues are tailor-made for persons or agencies with other reasons (political or philosophical) to defeat the team concept. At the same time, it is easy to interpret as resistance an agency's professed inability to supply the necessary resources. In fact, participating agencies each exist in different organizational contexts and the constraints on each will differ. Some will have greater resources and greater discretion in deciding how to allocate those resources. Part of the basic process of team building is the development of insight into the working contexts of other agencies. When an agency head indicates that it will be difficult for his or her agency to accomplish some aspect of the program, the appropriate response (voiced or unvoiced) is not "Surely you could do that if you really wanted to," but rather, "Tell us about that. What decisions would have to be made and by whom in order for you to be able to participate fully?"

Typically, the child protection unit of the state social service department is the most organizationally constrained among the groups involved in the planning process, but a representative of a hospital group, police agency, or school system also will have to contend with a relatively complex organizational environment. The more complex the environment, the more internal

negotiations the agency representative will have to conduct. The more negotiating the representative has to do, the longer it will take that person to make a commitment to the planning group and the more it will cost that person politically to participate in the planning process. Every approval or concession the person must seek from his or her own organization will cost a personal or political "credit." Depending on their status and power, this process will be more costly for some planning participants than for others. The district attorney's office, for example, may have the most discretion about resource commitment, and may be able to move more quickly than others toward a decision. Tensions among planning group members might be lessened if group members consider the organizational environments in which each of the other members work.

7. Adjustment

After a decision is made to proceed with team development, the timetable might require adjustment to allow one or another organization to recruit or transfer staff. It might become clear that use of a separate physical facility, if that was part of the plan, will need to be postponed until the funds to support it can be raised. If an adjustment phase is anticipated, modifications are likely to be seen as normal steps in the process rather than as setbacks.

8. Implementation Planning

Up to this point, the planning process has focused on the substance and structure of the program itself. Next comes the stage at which the group must plan the procedures for implementing the program. This is the step that so many planning groups fail to take; instead, they attempt to leap from program plan to program implementation, assuming that each actor or agency automatically will understand and perform the needed tasks. This happens partly because everyone is tired of planning and is eager to get on with the tasks; in part, because this can be a politically sensitive stage if one actor is perceived as telling others what to do; and, in part, because many people simply never have considered the importance of planning for implementation.

Everything can be lost here. Good ideas can fail to materialize for want of an implementation plan. When things don't happen, the team may break apart as one member accuses another of not living up to the contract. There will be claims and counter claims of "bad faith" when all that may be involved is lack of common understanding about steps to be taken, the timing for taking them, and a lack of supervision to ensure the job is being done.

The implementation planning stage can be viewed as including six steps.

a. <u>The assignment of task and supervisory responsibilities</u>

The sticky political issue here, of course, is who does the assigning and the supervising. One solution is to have the

agency representatives report what they see as their immediate tasks and what they have done to accomplish these. Supervision will be accomplished when the group next meets and reviews progress as compared to commitments made at the previous meeting. If group supervision is to be successful, the group must adhere to a regular review schedule.

b. Timing of the tasks

As implied in the previous stage, there should be an implementation schedule developed so that all members of the planning group share a common understanding as to what will be accomplished by an agreed upon date.

c. Planning an information campaign about the project

The group should develop a "script" or an information package to be used in describing the program plans and the planning process to members of their respective organizations, to the media, and to other community groups. Developing this mutually acceptable text will accomplish two things: (1) it will increase the public perception that the group is functioning as a team, and (2) it will provide another opportunity for planning group members to make sure they actually share a common understanding as to what they are trying to accomplish and how they are going to do it. (It is much too easy, at every stage, to take this shared perspective for granted. It is far better to design mechanisms for repeatedly checking than to attempt to

repair the damage that can result from an erroneous assumption of agreement.)

At this time, planning group members should decide when to release information to the media and who will be in charge of releasing it. As indicated earlier, it is important to make sure that everyone and every agency gets the public political credit that it thinks it deserves. All publicity releases should focus equally on every organization that has participated in the program. Credit can be seen both as a reward for past effort and as impetus for future cooperation.

Agency representatives should also discuss among themselves how and when to explain the program to other members of their own organizations. Any experienced administrator knows employees should be informed of new plans before they are announced publicly, but the sequence of information release is not always easy to control and should therefore be planned. Agency representatives will benefit from discussing with each other ideas for presenting the program to their organizations.

d. Anticipating and managing resistance

Planning announcements of the program can lead to contemplation of likely resistance, both from within the participating agencies and from external sources. The most splendid idea will have its detractors and it is better to expect resistance than to be surprised and offended by it. Perhaps the simplest way to deal with resistance is to encourage its expression on the ground that it is better to know where trouble

is likely to surface than to have it brewing unobserved. It will then be possible to target responses to resistors.

While opposition to good ideas may be politically motivated, or the product of general resistance to change, it is possible that there are also rational reasons for resistance. No matter how thorough the planning process, it is unlikely that planners will have anticipated every requirement and consequence of the new program. As the plan is exposed to more people, and especially to those who will have to implement it on a daily basis, limitations may become apparent. In the long run it can be beneficial if responses that might otherwise be viewed as stubborn resistance are treated initially as comments relevant to the program review process.

One way to preempt resistors is to draw them into the implementation planning process. The planning group representative should explain to resistors how important their role will be in the design and implementation of the program and then try to persuade them to accept a specific responsibility (e.g., helping design the training). If they agree to take on the task, a major step has been taken toward converting potential resistors into program owners.

If more general resistance is anticipated, the planning group should present the plan at an open forum of interested parties, inviting comment from all workers who would be affected by it. If evaluation is to be seen as an ongoing process, participant feedback will be important throughout the course of the program and should be regularly encouraged.

One advantage of using some established programs as role models is that participants in those programs may be able to help new program planners sell their ideas to potential resistors. By testifying about their own positive experiences, team advocates may be able to increase acceptance of the team approach by other members of their respective professions in different communities. Many established teams have indicated a willingness to perform this function for other communities.

e. Planning ways to demonstrate commitment

Members of participating agencies as well as members of the public must understand that the planners are determined to implement a new approach to handling cases. People who sense no firm intent behind the program will not bother to support it. The plan should be announced to agency members by the agency head and also by mid-managers and supervisors. The visible commitment of agency resources to the program and the announcement of special training for it are both ways of demonstrating seriousness of intent. The scheduling of regular review of program progress also signals "meaning it."

f. Setting up the evaluation

Another way to demonstrate commitment, and certainly the only way to know whether the new program is accomplishing its goals, is to design a program evaluation during the planning stage. The development of an evaluation also becomes a review of the planning process; if goals and tasks have been stated only

generally, it will be impossible to specify the data that will indicate program success or failure. Listing expected outcomes will ensure that panel members specify program details. It also will help the planners determine whether they do, indeed, share a common understanding of program goals; few things focus bureaucratic attention more sharply than a statement that "this is the measurement that will signal success and this is the one that will indicate failure."

A good evaluation comes in two forms: an outcome evaluation that is designed to measure whether the program is accomplishing its goals and a process evaluation that documents how the program is functioning. In the latter it is important to document who is doing what and when. Only if the process is documented will program reviewers know how to revise it should the outcome evaluation indicate the desired results have not been produced.

As with program planning, the evaluation should be designed, scheduled, and the responsibility for it assigned to a particular individual or group of individuals.

9. Action

Ironic though it sounds, many students of change consider the action phase, which is the essence of the endeavor, to be the easiest to accomplish. But this can be true only if the planning phases have been well conducted. As with all phases of the process, it would be possible to conceptualize several stages of action, but the principal elements can be addressed under three headings:

a. Coalition formation

b. Doing the work

c. Reinforcing team bonds.

a. Coalition formation

At this point the planning group should seek outside support for the program. Support may be sought from the press, the school system, parents' groups, corporate funders, the state legislature, or others. As suggested previously, attempts to involve too many outside groups before a plan is well developed may result in fragmentation of support among backers of various program ideas. While it is advisable to present a well-developed idea to these outside groups, it may be best--as with agency workers--to present the program as "preliminary," amenable to evaluation and change. The outside groups can be asked for their opinion and advice as well as their support. In this way, these individuals or groups are given the opportunity to feel a sense of program "ownership." Pride of authorship should not prevent the group that develops a new program from seeking ways of giving important groups and individuals outside the planning process a sense of sharing program ownership.

b. Doing the work

And so the newly designed work procedures are initiated. Several of the programs reviewed found it helpful during the early implementation stage to meet frequently to discuss program progress and individual experiences with it. The frequency of

meetings will vary depending on whether the team decides to review every case it handles. In Huntsville, where every case is reviewed, review of the cases becomes a simultaneous review of the process; if there are problems with the process, they become apparent when the team faces difficulties with a case.

The process of critique and adjustment may be slower and slightly more awkward when team members do not review cases routinely but meet only for regularly scheduled critiques or when especially complicated cases arise. When the critique process is based on an overview of case handling, rather than integrated with the handling of each case, team members have to be relied on to recall and document problems and bring them to the attention of other group members. If one or a few team members are inclined to be more analytic than others or are more willing to publicly call attention to problems, other team members may come to view the analytically inclined as chronic fault-finders. Such feelings will not contribute to a sense of team unity.

When the "doing of the work" is centered around routine review of specific cases, there may be less likelihood for problems to slip by unacknowledged and less likelihood that the review process will produce long term divisiveness among team members. Although case loads may be too heavy to permit review of every case, it would still be advisable to schedule regular reviews of a certain number of routine cases.

c. Reinforcing team bonds

Creation of team spirit does not guarantee its survival. A critical element of the action stage involves ongoing attention to maintenance of team bonds, especially in the face of personnel turnover. Long-term team members may not sense the extent to which new team members do not feel part of the group. The structure may appear, on the surface, to be accomplishing program goals, while underneath the essential element of trust may be eroding as new team members interact with "strangers" in the agencies.

Again, this seems less likely to occur in those programs that employ regular team review of cases. People get to know each other if repeatedly brought together to discuss cases. Group bonds can be further strengthened by meetings that include both business and social components. If regular team review of cases does not seem feasible, either because of the caseload or because of physical distances involved, it will be important to seek other means of reinforcing the group. All the programs reviewed have found it helpful for team members to travel together to conferences or workshops. Events that remove team members as a group from their respective agencies give people a chance to know each other as individuals, to break down organizational barriers, and to develop a basis for personal trust.

Working together to prepare in-service training or to present a program to community groups can also increase cohesion, as can team social activities. The problem with the latter, however, is that they are most likely to appeal to those people who already feel at home with the team; special efforts should be

made to attract persons who have the most to gain from informal interactions. This is why it is a good idea to append some social functions to working sessions--e.g., sharing food and drinks at the end of a Friday afternoon meeting.

One of the most effective ways to ensure continuity of the team is to guarantee that all team members benefit equally from participation. A truly multidisciplinary effort will make the job easier for each of the disciplines involved. The team will not exist simply to facilitate one of the functions involved in case handling (e.g., prosecution or treatment), but will serve to support decisions that each agency must make at each step of the case. Thus, child protective workers may receive advice from other team members about whether to remove a child from the home. Police officers may seek advice from social workers or therapists about how best to approach children experiencing various types of reactions to their situation. Prosecutors may solicit information from all the other team members that will help determine whether the child is prepared to be a witness in a court case. Doctors may need legal advice about how to prepare a medical case and how to testify in court. In the successful team, all participants will feel their job is made easier and their performance more effective as a result of their team membership.

However, new team members who have never worked in any context but that of the team, may not be bound to the team by this sense of benefit, precisely because they have no prior experience of how hard it is to work on child abuse cases in

isolated institutional settings. It is especially important to get these workers to participate in training programs for newly developing teams and to attend conferences where they can hear colleagues from non-team settings describe their problems. Also, it can be valuable for experienced team members to share with new personnel stories of what it was like "in the old days" to struggle through cases without the team.

10. Evaluation

This is the point--several months into the action phase of the project--at which the evaluation data are presented and discussed. This is another time when a skilled group facilitator can be an important asset to the team. If the evaluation data indicate anything but completely successful implementation (which is sure to be the case with any new team), tensions may develop when team members become tempted to focus on the shortcomings of particular individuals or agencies. Evaulation data alert team members to areas of the program that require adjustment or refinement and are a useful tool for team development.

11. Decision

Given the evaluation data, it will now be appropriate to decide whether to continue the program as currently being conducted or to modify it. This, too, can be a tense juncture in the process and the role of the facilitator will continue to be important. All programs will require modification on a continuing basis. It is the nature of a team, as a dynamic

structure, to change as new needs arise both within the team and in the community.

12. Adjustment

At this time, modifications recommended in the decision phase are implemented. Program modifications should be planned, introduced, and monitored as carefully as the original program plan.

The type and number of services to be provided frequently have to be adjusted after the initial action period. There is a tendency among newly formed teams to respond to every request for service or training and public presentations. This is appropriate at the first stage of team operation since team members need experience and the team needs exposure within the community. As the team and its services become widely recognized and accepted, members will find that they are under increasing pressure to manage requests for service. Reassessment and adjustment should be viewed as a <u>normal part</u> of organizational life, and teams should not get locked into their first definitions of service delivery. Rather than respond to every training request, for example, the team might develop an annual training calendar of the presentations it will provide. The calendar should be sent to appropriate agencies and organizations. Also, if the caseload becomes too large to be handled effectively by one team, other communities that contribute to the caseload could be helped to form their own teams.

In Syracuse, adjustments are made on a trial basis. If program workers see a need to change an approach or the service agenda, they explain to agency heads the solution they think appropriate and ask for time in which to try it out. After an evaluation period, they report to the agency heads and seek a policy change if the trial was successful. The Syracuse program is evidence that a healthy program constantly experiences analysis and adjustment to meet the ever-changing demands upon it.

13. Institutionalization

This is the process by which a new program becomes a part of the organizational structure, thus losing its special status. Until this is accomplished, it would be hard to consider a program successful, at least insofar as success is measured by survivability. Programs that are not incorporated into organizational routine run the risk of being abandoned. This can happen gradually, almost without notice, through the inertial tendency toward familiar routines--toward "business as usual." Or it can happen more obviously when the program's special patron moves on to another project, or when outside funding for the special effort is withdrawn. Program planning, then, should include planning for program institutionalization.

Institutionalization depends on six processes:

a. Ongoing supervision by agency heads to ensure that the program continues to be implemented as planned

b. In-service training that familiarizes all personnel with program procedures

c. Retention of trained team members

d. Filling vacancies with members who are aware of, and comfortable with, working in the team structure

e. Dealing with professional burnout

f. Rewarding good work.

a. Ongoing supervision

The need for ongoing supervision might be taken for granted, but it is not as common as one might hope. It is not unusual for a busy administrator to give concentrated attention to a new program for some period of time and then to re-direct that attention to other pressing issues. While understandable, the diversion of attention creates the opportunity for the program to slip away before it is fully institutionalized.

b. In-service training

Many professionals have been reluctant to get involved in team efforts because they feared the team setting would reveal how little they actually knew about handling child sexual abuse cases. Everyone should be assured that every other team member also is in need of training, and training should be an early and continuing priority for the team. A number of state and national conferences and seminars are now available, and notice of such training is included in professional journals, newsletters, and in flyers which are sent to local agencies. Each professional on

the team should scan journals and let other team members know about upcoming training. Many established teams also will provide training for new groups.

c. Retention of trained team members

Retention of experienced personnel has been a serious concern for some teams. Promotions and transfers of personnel within participating agencies pose the most common problem. During the planning process, consideration should be given to the need to maintain continuity on the team. Agencies should be encouraged to assign personnel who can be expected to stay in their current positions for extended periods of time and to make provision for a transition and training period when personnel must be transferred.

d. Filling vacancies

Agency heads should participate in discussions of the characteristics of personnel who will make good team members. It is best not to include any professionals who are brand new to their field. Recent graduates, whether physicians, attorneys, social workers, or psychologists, will have too many personal and professional issues to deal with to be effective team members. They must establish their professional confidence and their credibility within their own profession. Seasoned veterans will be essential to the team in its formative stages. Professionals with good standing among their colleagues can most effectively

spread the word about the team and elicit the cooperation and support of the professional community. A well-established team might accommodate a rookie, but a rookie will always require special, time-consuming attention.

e. Dealing with burnout

Burnout is a fact of life. It can occur in multidisciplinary teams, although many experienced team members feel the team itself provides protection against burnout. As further precaution, it may be helpful to allow team members to follow individual interests and to specialize in certain types of cases. They can then become experts in a specific area and earn recognition for their expertise.

Group therapy sessions for team members, conducted by a skilled therapist at regular intervals (e.g., two or three times a year), are an excellent means of controlling burnout and promoting group morale. Team members deal with exceptionally stressful and emotional cases, and it is impossible not to build up a residue of unresolved feelings about cases, colleagues, the "system," and one's own sense of effectiveness. An established means for venting these feelings in a positive, healthful manner is important for the continued well being of team members.

It should be remembered that this type of work can also take its toll on the personal life of the professional. While team members provide a logical and critical support system for each other, the team should not totally supplant the family as the professional's emotional ally. Because other team members

understand the problems so well--perhaps better than family members--it can become too easy to shut the family out of professional life. If this is ultimately destructive of the family relationship, both individuals and the team will suffer. An occasional team discussion about the stresses of child sex abuse work on the professional's family might be one way of easing tension between team and family.

f. Rewarding good work

Members on all the teams reviewed suggested that team membership was its own reward. Having supportive contact with other professionals who share the concern about child sexual abuse and being more effective as the result of team membership is rewarding. However, it is still important to consider ways that will help reinforce individual and institutional commitment to the team. The team itself might congratulate individual members who exert obvious extra effort on a particular case. This spirit of acknowledging good work is something that can be fostered intentionally by the team leader in early meetings; it is likely to become a habit that is perpetuated by the team.

In addition, the team should be self congratulatory of its own work. When the press covers the successful resolution of a high visibility case, the opportunity should be taken to point out that the work was the result of team effort and that the general ability to handle this type of case has improved since implementation of the team. Reading one's good reviews is always

reinforcing and, more importantly, such coverage can increase support for the team within the community.

A well established team may, over time, perceive less need to travel to training programs and conferences. However, travel should remain on the team's agenda for the purpose of keeping the team open to new ideas as well a means of rewarding productive team members. Additionally, strong team members should be promoted as speakers at local meetings and national conferences, thus giving them recognition for their performance.

A sense that the team has been successfully institutionalized doesn't end the need to think creatively about ways of repeatedly accomplishing each of the steps toward institutionalization. Maintenance of the team requires ongoing effort and attention to each of these six processes.

A FINAL NOTE

In the opening pages of this report we acknowledged the difficulty of implementing a multidisciplinary approach. We have, however, seen a number of successfully implemented programs and we have not yet met anyone involved in a team who did not consider the team worth the effort it took to create it. It is their conviction that has motivated us to support that effort with this guide.

In addition to this volume, the Police Foundation and the National Children's Advocacy Center have produced, with funding from the National Center on Child Abuse and Neglect, a 38-minute videotape describing Huntsville's approach to developing a team. Comments from individual team members and excerpts from two team staff meetings are included to illustrate how professionals from diverse fields can work together to manage each case as they deal effectively and efficiently with both legal issues and family needs. Also included on the videotape are discussions about the problems confronted by professionals during the development of their team and the strategies used to address these implementation problems.

Persons interested in renting or purchasing the videotape should contact either the:

POLICE FOUNDATION
1201 Connecticut Avenue, N.W.
Suite 200
Washington, D.C. 20036
(202) 833-1460
Fax: (202) 659-9149

or

National Children's Advocacy Center
106 Lincoln Street
Huntsville, Alabama 35801
(205)533-5437.

Other sources of technical assistance are listed in Appendix C and additional readings on child sexual abuse and multidisciplinary teams are listed in Appendix D.

Best wishes for the successful implementation of your program.

APPENDIX A

DESCRIPTIONS OF THE FIVE EXEMPLARY PROGRAMS

Alliance Coordination Services for Families at Risk
Onondaga County
Syracuse, New York

Alliance is, as its name indicates, a program for coordinating the handling of cases and the treatment and other services needed by families involved in cases of physical or sexual abuse of children. The Alliance agency is separate from any of the other agencies whose activities its coordinates. Its staff of four is housed in facilities provided by Catholic Charities and its funding comes from a variety of sources, including: United Way of Central New York, the City-County Youth Board, Onondaga County Department of Social Services, Catholic Charities, consultation and training fees, and grants from public and private sources.

As a coordinating body, Alliance itself is not a multidisciplinary team but rather is part of a multidisciplinary or community effort that also includes the following agencies and institutions: families, Children's Protective Services, Onondaga County Sheriff's Department, Syracuse Police Department, district attorney's office, state psychiatric hospital, Fairmount Children's Center, county treatment facility, Rape Crisis Center, therapists from the Sexual Abuse Study and Treatment Team, private therapists, teachers, physicians, a public health nurse, therapeutic groups, etc. Alliance might be thought of as the glue that holds them all together.

In addition to its coordination function, Alliance runs a program of parent aides, individuals who serve as role models and instructors for families in which parents need assistance in learning parenting skills.

A case might be initiated with a report to any of the agencies listed above. When the information is received by either Child Protective Services or a law enforcement agency, the other agency is informed and a case worker and investigator are assigned to it. The two decide how to proceed with the investigation. When they have established reason to believe that a violation has actually occurred, they contact Alliance personnel who then arrange a team meeting of representatives of the agencies, including therapists, to be involved in the case. The objective is to begin therapy and the delivery of other services to the family as soon as possible and to make a mutually informed decision about how to handle the case.

Alliance will call to the meeting a therapist who is a part of the Sexual Abuse Study and Treatment Team (SAST), a coalition of public and private therapists which has established a treatment philosophy that embraces the multidisciplinary approach. Persons wishing to be on the SAST list of therapists qualified to handle child sexual abuse cases must be screened and approved by SAST which accepts approved applicants for a training period before deciding whether to admit them to full membership. SAST thus serves both a screening and a training function for new members. It also provides training for established members who

meet periodically over lunch to share new knowledge about their practice.

In addition to its formal coordination function, Alliance also serves an informal oversight function. Members of all the agencies involved in a case know that Alliance staff, in the process of coordinating services to the family, will be regularly reviewing progress on the case and thus will be aware of the performance of the separate agencies. While Alliance has no formal sanction powers, no agency wants to be identified as the one that caused an unsuccessful outcome. There is no indication that this results in an aloof or adversarial relationship with the Alliance staff. Rather, representatives of participating agencies seem clearly to be expressing approval when they say they put effort into cases beyond what law and protocols might require because they know someone will be asking hard questions.

National Children's Advocacy Center
Madison County
Huntsville, Alabama

The National Children's Advocacy Center in Huntsville, Alabama is the home and coordinating organization for Madison County's multidisciplinary approach. Physically, the Center is an attractively renovated house in downtown Huntsville that contains interview rooms furnished for different age levels of children, a therapist's office, individual desk space in a common work room for workers from the agencies participating on the teams, a conference room and offices for the Center staff.

The Center was initiated and is managed by Madison County's District Attorney, but it is governed by a board of professionals and lay persons.

The Center is staffed by three full time employees who schedule the appointments at the Center, coordinate team activities on cases, and administer the variety of services--including training and consultation to other communities--provided by the Center. These people are supported in part by grants, the district attorney's budget, donations, and funds raised through training and consultation activities conducted by the Center. Additionally, a full time therapist is assigned to the Center. There are other Center staff who work for agencies participating in the multidisciplinary program (e.g, law enforcement, child protective services, district attorney's office, school system, county mental health) who, as part of their official functions, serve as the liaison between their agencies and the Center. They attend Center staff meetings and

coordinate the activities of people in their agencies working on child sexual abuse cases. In a somewhat less formal relationship with the medical community, the Center calls upon and involves physicians who have indicated an interest in participating in the program.

An effort is made to have all contacts with victims and their families occur at the Center. The exception is the medical examination which takes place at a hospital or physician's office. Thus the child and family are spared the confusion of large agencies such as the police department, child protective services, and district attorney's office. They have the reassurance of dealing with one individual who provides their introduction to personnel from the various agencies.

The procedural heart of Madison County's multidisciplinary approach is the team review meeting, held once a week at the Center. Personnel involved in pending cases meet to review and discuss each case and to consider steps to be taken. These meetings serve the function of guaranteeing a consistent approach to a case across agencies, of providing professionals information about their cases, providing advice and support to professionals having to make decisions about cases, and of facilitating cross-training among professionals who share knowledge as they discuss cases. The meetings assure case oversight; regular review is the safety net that prevents cases getting lost in temporal and procedural gaps. The meetings provide a regular opportunity for agencies to review and revise their procedures. Additionally,

these meetings constitute an ongoing source of socialization to the team approach for new professionals.

A team of professionals working on any particular case is likely to consist of people who are not assigned to the Center by their agency but who use the Center facilities when working on cases. Weekly team reviews include the regularly assigned staff members and other professionals involved in the cases to be discussed at a given meeting.

Norfolk Family Sexual Trauma Team
Norfolk, Virginia

The Norfolk Sexual Trauma Team represents a close working relationship among police investigators, child protective service workers, the deputy commonwealth attorney who handles abuse cases, family and circuit courts, the probation department, and therapists and support groups. The protocols that established the interrelations among these agencies were established in the context of a formally funded project, initiated by the police department in 1980, that provided for a team coordinator. The coordinator arranged meetings among the agency representatives, facilitated the development of protocols, monitored cases and collected data on case numbers and outcomes. At the end of the grant period, the team continued to function without the services of a coordinator. Its functioning is jointly overseen by the police lieutenant in charge of the youth division and the supervisor of the child protective unit that deals with incest and sexual abuse.

As formulated in 1980, the goals of the program are to:

1. Increase reporting to both child protective services and the police department,
2. Utilize a team approach to investigations,
3. Prosecute all offenders,
4. Remove the offender, rather than the child, from the home,
5. Eliminate, or reduce the probability of, the child testifying in court,

6. Provide therapeutic intervention for the child and other family members,
7. Stabilize and reunite family units,
8. Provide long-term follow-up (i.e., therapy and probation services) to prevent further sexual abuse.

Although a central objective of the program is the prosecution of offenders, incarceration is the ultimate goal only when the investigators, commonwealth attorney, and judge decide the offender is not a candidate for the diversionary program of therapy and rehabilitation.

The following discussion of diversion and treatment is taken from a grant progress report written in 1983 by the program coordinator.

> To be a candidate for diversion, to be in rehabilitative treatment as an alternative to incarceration, the offender is required to be cooperative to the fullest extent with all disciplines involved in the investigation, disposition, evaluation and treatment, prosecution and monitoring process. Cooperation constitutes:
>
> 1. admitting that a problem exists
> 2. admission of the offense
> 3. agreement to evaluation and treatment
> 4. adherence to conditions of bond
> 5. waiver of preliminary hearing
> 6. agreement to plead guilty as charged
> 7. full compliance with conditions of probation.

The team believes the child is best protected from the trauma of the judicial process by the securing from the offender a confession which will preclude the need for the child to testify. Additionally, the admission is considered psychologically essential to beginning the therapy process.

Therefore, the efforts of the child protective service and police investigators are directed at establishing the facts of the case and achieving the confession. On a case by case basis, the jointly trained members of the two organizations' special units decide among themselves how best to accomplish these objectives.

Whenever the evidence warrants it, the deputy commonwealth attorney charges these cases as felonies in circuit court. Since circuit court probation officers have arrest powers (family court probation officers do not), the circuit court poses a stronger threat to the offender who violates probation. Termination of therapy, further abuse of the victim, or violation of other conditions of the diversionary program could result in the incarceration of the offender.

Therapy includes formal psychiatric treatment and attendance at support group meetings. Support groups in the Norfolk program include Parents United, Daughters and Sons United, and Adults Molested as Children. Participation in therapy and support groups is mandatory for perpetrators and is monitored by the probation department.

Orlando Regional Medical Center
Child Protection Team
Orlando, Florida

The Orlando Child Protection Team is a formally structured group with offices in Orlando's Regional Medical Center. The team consists of 15 full-time members and another dozen individuals, termed "affiliated staff," who have an "on-call" relationship with the Team. Most of the latter are physicians or psychologists. The full-time staff includes a medical director, team coordinator, clinical supervisor, seven case coordinators, two prevention coordinators, two therapists and one therapist assistant. Some of the case coordinators have responsibilities not suggested by their title; one, for example, is the Team's computer consultant and another conducts or coordinates all training provided by the Team.

The function of the Team is to serve as a primary source of expertise and information for the other agencies involved in Orlando's multidisciplinary intervention and treatment program. It is the Team's responsibility to communicate to affiliated agencies the latest literature on child sexual abuse and to be familiar with the latest legal decisions affecting the handling of cases and the latest interviewing and medical examination techniques for detection of abuse.

Materials provided by the State's Office of Health and Rehabilitative Services detail the Team's duties.

> The specialized diagnostic, assessment, evaluation, coordination, consultation, and other supportive services that the teams shall be capable of providing include, but are not limited to, the following:
>
> 1. Medical diagnosis and evaluation services
> 2. Telephone consultation services
> 3. Psychological and psychiatric diagnosis, and evaluation services for the child, parents or care takers
> 4. Short-term psychological treatment up to six months duration
> 5. Expert medical, psychological, and related professional testimony in court cases
> 6. Case staffings to develop, implement, and monitor treatment plans for a child whose case has been referred to a child protection team by the Children, Youth and Family Program (of the Department of Health and Rehabilitative Services) or at the request of any other professional involved with a child, his parent or parents, guardian or guardians, or other care givers.
> 7. Such training services for program and other department employees as deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse and neglect cases.

None of the Team members is an employee of any of the public agencies (e.g., social service, police, prosecutor's office) that conduct the formal processing of cases. Members of these agencies work closely with the Team, but are independent of it. To a large extent, however, their interagency efforts are coordinated by the Team, especially when the case is non-routine. When a child is brought into the hospital emergency room, for example, the Team's case coordinator on duty is called to the

hospital where he or she will take photographs of any visible injuries, contact personnel from other agencies who need to know about the case, and make sure each agency receives copies of the appropriate reports.

Like all of the child protection teams in Florida, the Orlando Team ultimately is under the direction of the State's Department of Health and Rehabilitative Services. The Orlando Team members are employees of the Orlando Regional Medical Center, with which Health and Rehabilitative Services contracts for the delivery of the Team's services.

While the team contractor in Orlando is a hospital, in another community it might be a university or other non-profit organization. Each team's budget is provided by the state through the Children's Medical Services Program Office of the Department of Health and Rehabilitative Services. Every team has a medical director who is a qualified pediatrician and is responsible for the team's operation.

In 1986 the Orlando Child Protection Team was one of 18 such teams in the state. The plan is to increase the number of teams by three, annually, until each of Florida's 67 counties has its own team. Until that time, teams such as that in Orlando serve an area broader than a single county and have the responsibility for assisting surrounding counties in the development of their own teams.

Sexual Assault Center
King County
Seattle, Washington

The Sexual Assault Center of Seattle is a specialized medical and social service unit treating sexual abuse of both adults and children. Its staff provides medical service and psychological counseling to victims. When the Center becomes involved in a case, it assumes responsibility for coordinating work on the case with other involved agencies. The Center social worker assigned to the case tends to be the person with whom the victim and the victim's family have the most contact. The social worker informs the victim and family about the procedures of the other agencies and essentially serves as liaison between the victim and criminal justice personnel. In tracking the case for the purpose of keeping the client informed of its progress, the Center performs informal oversight of case handling by all agencies.

The Center staff also conducts quarterly training for agencies that handle sexual abuse cases (including agencies outside King County and the State), and contributes to the professional literature.

The Center is located at Harborview Medical Center, the teaching hospital of the University of Washington, where it has a collaborative relationship with the University's School of Social Work.

The Sexual Assault Center is a principal component of the Child Sexual Abuse Network of Seattle-King County. The Network is a cooperative relationship that includes all police agencies in

the county, Children's Protective Service, King County District Attorney's Office, King County Rape Relief, Seattle Rape Relief, and the Sexual Assault Center. Northwest Treatment Associates, which provides long term treatment for offenders and support for spouses, does not have a formalized relationship with the Network but cooperates with it and is viewed as an important part of the King County program.

The purpose of the Network is to increase the efficiency and success of prosecution of child sexual abuse cases and to reduce the number of interviews to which a child victim is subjected. Toward this end the participating agencies have coordinated their interviewing so that each asks the victim only the questions relevant to its own function while leaving the criminal evidentiary questions to the criminal justice system. For purposes of decision making about prosecution and for gathering evidence for prosecution, one interview is conducted in the prosecutor's office by the prosecutor, with the police officer and perhaps the child protective service worker and the Harborview therapist present.

Each of the major public agencies has a special unit that deals exclusively with child abuse cases. The prosecuting attorney's office includes a 12-prosecutor unit headed by a deputy prosecuting attorney that processes cases vertically, i.e., the same prosecutor handles the cases all the way through the system.

Both the Seattle Police Department and King County Department of Public Safety have child abuse investigative units.

Within the police department's Special Abuse Unit, a sergeant and five detectives handle only child sexual abuse cases. In the King County Department of Public Safety, a sergeant and seven investigators in the Juvenile Special Assault Unit investigate all cases in which a sexual assault victim is 18 years of age or younger.

Child Protective Services, King County, has a Sexual Assault Unit consisting of ten child protective service workers and their supervisor.

Participating agencies in the Network do not meet on a regular basis to routinely review cases. Individuals contact each other across agencies on an as-needed basis. Agency representatives meet bi-monthly to discuss procedures or to hear a presentation about a new concept or practice that has appeared in the literature. Agencies rotate the responsibility for setting the agenda and notifying members of these meetings.

Insofar as the Network can be seen has having a physical focus, it exists in the prosecuting attorney's office where the joint interviews occur and where the bi-monthly meetings take place. Otherwise, each agency handles its case work from its own facilities.

APPENDIX B

PROJECT METHODOLOGY

Programs were selected to represent a variety of types of agencies that either initiated or housed the program. These programs included medical centers, police agencies, social service agencies, prosecuting attorneys' offices, and treatment agencies. Since multidisciplinary programs might be associated with any of these types of agencies, an objective of the study was to determine whether there were implementation processes that were common to successful programs across types of agencies and also to attempt to determine whether there were experiences or conditions unique to a given type of agency.

Surveys were sent to 45 communities, asking whether there was in place an effort to increase interagency cooperation in child sexual abuse cases. Twenty-four questionnaires were returned, describing a variety of multidisciplinary approaches. Experts in the child sexual abuse field were questioned to determine which of the programs were recognized as being well implemented. The following five were selected for their repeated identification:

Alliance Coordination Services
for Families at Risk
Onondaga County
Syracuse, New York

The National Children's Advocacy Center
Madison County
Huntsville, Alabama

Norfolk Family Sexual Trauma Team
Norfolk, Virginia

Orlando Child Protection Team
Orlando Florida

The Sexual Assault Center
Seattle, Washington

Between October 1985 and May 1986 the project director visited four of these sites, spending 2-3 days at each, interviewing personnel in the agencies associated with the multidisciplinary effort. The numbers of people, identified by agency or community affiliation, interviewed at each site are indicated in Table 1. (The Alliance program in Syracuse was analyzed through its written reports and through telephone interviews with personnel in the key agencies.)

INTERVIEWS. Interviews typically lasted 45 minutes to an hour; all persons interviewed were asked to discuss:

1. The way in which the multidisciplinary program is structured and functions
2. Their role in the program
3. Strengths and weaknesses of the program
4. Advice they would give to other communities starting a similar program.

If the individual had been associated with the program since its inception, he or she additionally was asked:

5. To compare the handling of child sexual abuse cases before and after development of the multidisciplinary approach
6. The steps involved in creating the program
7. The most difficult problems to overcome in the implementation process
8. Objectives still to be accomplished.

All interviews were conducted by the project director.

TABLE 1

	SITE				
	Huntsville	Orlando	Syracuse	Norfolk	Seattle
AFFILIATION					
Program Administration	3	4	1	0	2
Childrens' Protective Services	2	3	1	2	1
Consultants	0	1	0	0	0
Courts	0	1	0	0	0
Police	2	1	1	4	3
Physicians	1	3	0	0	0
Prevention Personnel	0	1	0	1	0
Prosecutor's Office	3	2	0	1	1
Researchers	1	0	0	0	0
Treatment Personnel	1	4	0	0	6
Victim Assistants	1	1	0	0	0
Victims' Families	2	0	0	0	0
Volunteers, Other	1	1	0	0	0

DATA PROCESSING. Based on the interviews and a review of the literature on implementation processes, the project director wrote a draft of this document including descriptions of the programs and implementation processes at each site, the discussion of the general processes of implementation and the recommendations. Copies of the draft were forwarded to the contact person at each site for circulation among key personnel in the program. Additionally, it was reviewed by Dr. Robert Goldberg, by the project advisory committee, and by project participants from the American Bar Association and American Public Welfare Association. Comments and corrections were incorporated into the final draft.

APPENDIX C

TECHNICAL ASSISTANCE

There are a number of sources for information and assistance during the planning and implementation phases of a multi-disciplinary program. Chief among these is:

National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, D.C. 20013
202/245-2856

Clearinghouse on Child Abuse and Neglect
P.O. Box 1182
Washington, D.C. 20013
703/821-2086

Others include:

Alliance Coordination for Families at Risk
Onondaga County Social Services
1654 W. Onondaga Street
Syracuse, NY 13203
315/424-1880

American Humane Association
9725 E. Hampden Ave.
Denver, CO 80231
303/695-0811

Bureau of Justice Assistance
633 Indiana Ave., N.W.
Room 600D
Washington, D.C. 20531
202/272-4601

Children's Defense Fund
122 C Street, N.W.
Washington, D.C. 20036
202/628-8787

Henry Kempe Center for the Prevention and
Treatment of Child Abuse and Neglect
1205 Oneida Avenue
Denver, CO 80220
303/321-3963

National Center for Missing and Exploited Children
1835 K Street, N.W.
Suite 700
Washington, D.C. 20006
202/634-9821

National Center for the Prosecution of Child Abuse
1022 N. Fairfax Street
Suite 200
Alexandria, VA 22314
703/549-4253

National Child Abuse Coalition
1125 15th Street, N.W.
Suite 300
Washington, D.C. 20005
202/293-7550

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
205/533-5437

National Committee for the Prevention of Child Abuse
332 South Michigan Street
Suite 1250
Chicago, IL 60604
312/663-3520

National Institute of Justice
633 Indiana Ave., N.W.
Washington, D.C. 20531
202/724-7684

National Legal Resource Center for
Child Advocacy and Protection
1800 M Street, N.W.
Suite 200
Washington, D.C. 20036
202/331-2250

Norfolk Family Sexual Trauma Team
Norfolk Police Department
811 E. City Hall Avenue
Norfolk, VA 23510
804/441-2301

Office of Juvenile Justice and
Delinquency Prevention
633 Indiana Ave., N.W.
Room 1142
Washington, D.C. 20531
202/724-7751

Orlando Child Protection Team
Orlando Regional Medical Center
85 West Miller
Suite 304
Orlando, FL 32806
305/841-5111

Parents Anonymous
6733 S. Sepulveda Blvd.
Suite 270
Los Angeles, CA 90045
800/421-0353

Sexual Assault Center
Harborview Medical Center
325 Ninth Ave.
Seattle, WA 98104
206/223-3047

APPENDIX D

FURTHER READING*

Abel, Gene, Sexually Aggressive Behavior. JoAnne Roubeau and Jerry Cunningham, New York: Sexual Behavior Clinic.

Bennett, H. S. and French, J.H. (1980) "Elevated Intracranial Pressure in the Whiplash-shaken Infant Syndrome Detected with Normal Computerized Tomography," Clinical Pediatrics 19: 633.

Billmire, M. E., and Myers, P. A., (1985) "Serious Head Injury in Infants: Accident or Abuse?," Pediatrics, 72, No. 2 (February).

Braen, G. Richard, M.D., (1985) "Rape and the Rape Trauma Syndrome," Southern Medical Journal, 78, (10): 1230-1235.

Bross, Donald C., (1985) "Helping Prevent the Abused Child from Becoming a Grown-up Abuser (The role of the guardian ad litem)," The Judges Journal (Fall).

Bulkley, D., (Ed.) (1985) Papers from a National Policy Conference on Legal Reforms in Child Sexual Abuse Cases. Washington, D.C.: National Legal Resource Center on Child Advocacy and Protection.

Bulkley, J., (Ed.). (1985) Child Sexual Abuse and the Law. Washington, D.C.: American Bar Association National Legal Resource Center for Child Advocacy and Protection.

Bulkley, J., (Rep.) (1981) Recommendations for Improving Legal Intervention in Intrafamily Child Sexual Abuse Cases. Washington, D.C.: American Bar Association National Legal Resource Center for Child Advocacy and Protection.

Bulkley, J., (Editor) (1981) Innovations in the Prosecution of Child Sexual Abuse Cases. Washington, D.C.: American Bar Association National Legal Resource Center for Child Advocacy and Protection.

Burgess, Ann W., Groth, Nicholas and Holmstrom, Lynda Lytle (1978). Sexual Assault of Children and Adolescents. Lexington, Mass.: Lexington Books.

Canavan, W. (1981), "Sexual Child Abuse," in Ellerstein, N. (Ed.), Child Abuse and Neglect: A Medical Reference. New York: John Wiley and Sons.

*This list was prepared by Leigh Johnson of the National Children's Advocacy Center, Hunstville, Alabama.

Jones, B., Jenstrom, L., and MacFarlane, K., (Eds.), (1980), Sexual Abuse of Children: Selected Readings. Washington, D.C., National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services, Publication Number (HDS) 78-30161.

Jones, D.P.H., McQuistion, M. (1985), Interviewing the Sexually Abused Child. Denver: Kempe Center Series: Vol.6.

Kempe, C.H., Helfer, R.E., (1980), The Battered Child, 3rd ed. Chicago: University of Chicago Press.

Kempe, R. S., Kempe, C.H. (1984), The Common Secret: Sexual Abuse of Children and Adolescents. New York: W.H.Freeman and Co.

Kendrick, M.M., (1984), "What We've Learned From Community Response to Intrafamily Child Sexual Abuse: Perspectives on Child Maltreatment in the Mid-80s." Washington, D.C.: National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services.

Levine, L.J., (1973), "The Solution of a Battered Child Homicide by Dental Evidence: Report of a Case," Journal of the American Dental Association 87, 1234-1236.

Linedecker, Clifford L., (1981), Children in Chains. New York: Everest House.

Lloyd, D., (1982), The Corroboration of Sexual Victimization of Children: Child Sexual Abuse and the Law, National Resource Center for Child Advocacy and Protection, American Bar Association.

McClelland, C.Q., and Heiple, K.G., (1982), "Fractures in the First Year of Life: A Diagnostic Dilemma," American Journal of Diseases in Childhood 136:26.

McGrath, and Clemons, (1985), "The Child Victim as a Witness in Sexual Abuse Cases," Montana Law Review 46:229.

McNeese, Margaret C., and Hebeler, Joan R. (1977), "The Abused Child: A Clinical Approach to Identification and Management," CIBA Foundation Symposia 29:18-36.

Mayer, A., (1983), Incest: A Treatment Manual for Therapy With Victims, Spouses and Offenders. Holmes Beach, FL: Learning Publication.

Melton, G., (1984), Child Witnesses and the First Amendment: A Psychological Dilemma," Journal of Social Issues 40(2), (G. Goodman, ed.).

Cantwell, H. (1983), "Vaginal Inspection as it Relates to Child Sexual Abuse in Girls Under Thirteen," Child Abuse and Neglect 7:171-176.

Davidson, H.A. (undated), Child Sexual Exploitation: Background and Legal Analysis. A Monograph. Washington, D.C.: American Bar Association National Legal Resource Center for Child Advocacy and Child Protection.

Davies, A. (1986), "The Sexual Abuse of Children: Cases Submitted to a Police Laboratory and the Scientific Evidence," Medical Science Law 26:2.

Ellerstein, N.S., (Ed.), (1981), Child Abuse and Neglect: A Medical Reference. New York: John Wiley and Sons.

Falley, Kathleen Coulborn, Ph.D. (1984), "Is the Child Victim of Sexual Abuse Telling the Truth?," Child Abuse and Neglect, 8: 473-481.

Finklehor, D., (1985), Child Sexual Abuse: New Theory and Research. New York: Free Press.

Finkelhor, D., (1986), Source Book on Child Sexual Abuse, Beverly Hills: Sage Publications.

Goodman, G.S. and Helgenson, V.S. (1986), "Child Sexual Assault: Children's Memory and the Law," Papers from National Symposium on the Prosecution of Child Sexual Abuse in a Multidisciplinary Setting, April, 6-8.

Goodwin, J., (1981), Prior Incest in Mothers of Abused Children, Child Abuse and Neglect 5: 87-95.

Goodwin, J., (1982), Sexual Abuse: Incest Victims and Their Families. Boston: John Wright.

Helfer, R.E., Slovis, T.L., and Black, M., (1977), "Injuries Resulting When Small Children Fall Out of Bed, Pediatrics 60:533.

Hobbs, C.J., (1984), "Skull Fracture and the Diagnosis of Abuse," Archives of Disease in Childhood 59: 246-252.

Huffman, J.W., Dewhurst, C.J., Capraro, V.J., (1981), The Gynecology of Childhood and Adolescence. Philadelphia: W.B. Saunders Co.

Hunter, R.S., (1985), "Sexually Abused Children: Identifying Masked Presentations in a Medical Setting," Child Abuse and Neglect, 17-26, Kilstrom N. Loda, FA.

Jason, Janiane, (1984), "Child Homicide Spectrum", American Journal of Diseases in Childhood, 137: 577-581.

Melton, G., J. Bulkley and Wulkan, D. (1981), "Competency of Children as Witnesses," Child Sexual Abuse and the Law, 103, Washington, D.C.: American Bar Association J. Bulkley (ed.).

Miller, Gerald R., (1976), "The Effects of Videotaped Trial Materials on Juror Responses," in Gordon Bermant, Charles Nemeth and Neil Vidmar (eds.) Psychology and the Law. Lexington, MA: Lexington Books.

Mrazek, P., and Kempe, C.H., (1981), Sexually Abused Children and Their Families. Oxford: Pergamon Press.

Myers, John E.B., (1985), "The Legal Response to Child Abuse: In the Best Interest of Children?" Journal of Family Law.

Norvell, M. Benrubi, G., Thompson, R., (1984), "Investigation of Microtravra After Sexual Intercourse," Journal of Reproductive Medicine 29:4.

O'Brien, Shirley, (1983), Child Pornography. Dubuque, Iowa: Kendall Hunt Publishing Company.

Parker, Jacqueline Y., (1981), "Rights of Child Witnesses: Is the Court a Protector or Perpetrator?" New England Law Review 1981-1982:643-717.

Paul, D.M., (1986), "What Really Happened to Baby Jane? The Medical Aspects of the Investigations of Alleged Sexual Abuse of Children," Medical Science Law 26:2.

Pierron, "The New Kansas Law Regarding Admissibility of Child Victim Hearsay Statements," Journal of the Kansas Bar Association, 52.

Praeger, Irving, (1982), "Sexual Psychopathy and Child Molesters: The Experiment Fails," Journal of Juvenile Law, 6, (1).

Rush, Florence, (1980), The Best Kept Secret: Sexual Abuse of Children. New York: McGraw Hill.

Russell, A.B., and Trainor, C.M., (1984), Trends in Child Abuse and Neglect: A National Perspective. Denver: American Humane Association.

Seidel, J.S., (1986), "Presentation and Evaluation of Sexual Misuse in the Emergency Department," Pediatric Emergency Care 2:157-164.

Sgroi, S. (1982), "Kids with Clap: Gonorrhea as an Indicator of Child Sexual Assault," Victimology 2(2): 251-267.

Sgroi, S. (Ed.), (1982), Handbook of Clinical Intervention in Child Sexual Abuse. Lexington, MS: Lexington Books.

Skoler, (1984), "New Hearsay Exceptions for Child's Statement of Sexual Abuse," John Marshall Law Review 1.

Teixeira, W.R.G., (1981), "Hymenal Coloscopic Examination in Sexual Offenses," American Journal of Forensic Medicine and Pathology (September): 209-215.

University of Wisconsin Law School (1986), Punish the Offender, Protect the Victim, Treat the Family: A Guide for Communities Interested in Breaking the Cycle of Child Sexual Abuse. Madison, Wisconsin: University of Wisconsin.

Wagner, G. N., (1986), "Crime Scene Investigation in Child Abuse Cases," The American Journal of Forensic Medicine and Pathology 7:94-99.

Whitcomb, D., Sharpiro, E.R., Stellwagen, L.D. (1985), When the Victim is a Child: Issues for Judges and Prosecutors. Washington, D.C., U.S. Department of Justice.

Wooding,B. and Heger, A., (1986), "The Use of Coloscope in the Diagnosis of Sexual Abuse in the Pediatric Age Group," Child Abuse and Neglect 10:111-114.

Yates, A., (1982), "Children Eroticized by Incest," American Journal of Psychiatry 139:4.