# THE SEXUAL ABUSE OF CHILDREN IN MASSACHUSETTS: A PRELIMINARY STUDY OF SYSTEM RESPONSE

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# PREFACE

This study was initially suggested by the juvenile specialists on the planning and program development staff of the Massachusetts Committee on Criminal Justice. It was their feeling that the sexual abuse of children in Massachusetts was an important issue about which little information was widely available. They believed that research in this area would aid the Committee in developing a deeper understanding of sexual abuse and in delineating its approach to the issue, and would also serve the more general purpose of providing agencies in the juvenile justice and social service areas with more thorough and objective information than is now available. As discussions about the project continued, it became clear that there were indeed many organizations with considerable interest in the information such a project would generate. It is our hope that this report addresses the needs of both of these audiences.

The author would like to thank the many individuals and organizations who gave freely of their time and expertise during the course of this study, especially to the Office of Social Services of the Department of Public Welfare, which provided statistical information on sexual abuse. Special thanks are due to Julie Fay, the Committee's Juvenile Justice Planning Specialist, and Greg Torres, Senior Juvenile Justice Specialist, for their support and criticism. Without their initiative, this study would not have been undertaken. We would also like to thank the following individuals who reviewed and commented on drafts of this report: Donald Main, Joseph Kelly and Flo

Trotman of the Committee on Criminal Justice; Beverly Weaver of the Sexual Trauma Team at Children's Hospital Medical Center; Estelle Raiffa of the Office for Children's Project Children at Risk; Susan Mann of the Office of Social Services of the Massachusetts Department of Public Welfare. The efforts of Barbara Reinhart in typing and preparing the manuscript of the report are greatly appreciated.

The findings presented in this report remain the opinions of the author and do not represent the official policy or position of the Massachusetts Committee on Criminal Justice.

# EXECUTIVE SUMMARY

The purpose of this study is to provide a preliminary analysis of the issues surrounding the response of Massachusetts' social service and criminal justice agencies to the sexual abuse of children. This report was prepared for the use of (a) members of the program development and planning staff of the Committee on Criminal Justice, who suggested the study, and (b) other agencies concerned with the sexual abuse issue. Our primary task is not to formulate specific programmatic recommendations but to delineate the nature of the issues involved and analyze the current institutional response. Because of the complexity of these issues and the short time period available for the study, our efforts must be viewed as exploratory. The areas examined in the study include:

1. The Prevalence of Abuse (Chapter II)
2. The Nature of Sexual Abuse (Chapter III)
3. Short-term Intervention (Chapter IV)
4. Long-term Services (Chapter V)
5. The Courts (Chapter VI)
6. Programmatic Implications (Chapter VII)

The study focuses on sexual abuse as one aspect of child abuse. For practical reasons, field work was limited to the Boston area. Interviews were conducted with 59 individuals from a broad range of social service and criminal justice agencies. Existing aggregate statistics and clinical research were also reviewed. Our primary findings are summarized below. For the most part, references and sources are not cited in this summary, but may be found in the text from which the summary is drawn.

## The Prevalence of Sexual Abuse[1.]

The Department of Public Welfare (DPW) is statutorily mandated to receive and investigate reports of suspected child abuse, including sexual abuse. Certain individuals, called "mandated reporters", are required by law to report suspected cases of abuse and neglect to DPW. Under the department's protective services procedures, reports which it receives are screened to determine if the alleged incident is reportable under the law. Emergency intervention, if necessary, should be provided in a matter of hours. Screening of non-emergency cases should be completed within several days. Cases "screened in" (i.e., in which a reportable condition exists) are then investigated to determine if ongoing protective services are necessary. This investigation, which should be completed within 45 days, is referred to by the department as an assessment and, like screening, is generally conducted at one of DPW's regional offices.[2] Cases "assessed in" (i.e., in which ongoing protective services are necessary) should be transferred to a local DPW office for treatment.

At the time our research was conducted, information on sexual abuse compiled by DPW on an ongoing basis was quite limited. The department has since implemented a new Child Information System which should provide ongoing data in a wide range of areas, including the number of reported cases,

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1. See Chapter II.

2. Cases can also be referred to a private agency, under contract, for assessment or treatment.

assessment outcomes, and services rendered. Since this system has only recenly become operational, no information from it was available to us during our study. All of our analyses are based on the most complete data available to us at the time of our investigation.

(1) At the time of our study the department did not have a completely accurate count of the number of sexual abuse cases known to it. Cases were classified by type of abuse only at initial intake when information may be limited. Cases which are reported as neglect or physical abuse and which are found to involve sexual abuse only after an investigation are not included in the statistics. The most recent data indicate that 282 cases of sexual abuse were reported to DPW during the last six months of 1978, or 4.1% of the total number of reports filed. Evidence from other agencies in the Boston area indicates that the number of cases known to or suspected by criminal justice or social service agencies is considerably larger than official DPW statistics would indicate. Further, practitioners believe that many, if not most, cases are never discovered.

(2) In 58% of the cases reported to DPW's Boston Region the perpetrator was a family member.[3] Many others involved adults known to the child. The experience of other agencies corroborates that about half of all known cases involve

[3] February - October 1978

incest. Many experts believe this to be the most common type of sexual abuse.

(3) Seventy-eight percent of all sexual abuse reports in the Boston Region [4] come from mandated reporters. Almost half came from hospitals. Many mandated reporters, however, do not report suspected cases to DPW. Mental health personnel, schools and private physicians have been particularly criticized. This failure is due to a number of factors, including the refusal to accept statutory responsibility and the lack of specialized diagnostic skills.

## The Nature of Abuse[5]

(1) DPW data indicate that the vast majority of victims of sexual abuse are female and that most incidents are heterosexual in nature. Victims average between ten and eleven years of age but wide variation exists. Many professionals agree that sexual abuse is not a problem confined to the poor, though the poor are more likely to be reported, but occurs widely in middle class families as well.

(2) Clinical experience indicates that sexual abuse (especially incest) is often not a single event but an ongoing process, that it often occurs within the context of a caring relationship, and that children seldom lie about such abuse. In many incest cases (involving father and daughter) the mother may

[4] February-October 1978

[5] Chapter III

be aware that the abuse is occurring.

(3) While the wide variation in types of cases makes generalization difficult, desirable intervention, especially in cases of incest, will often approximate the following guidelines.

a. It is essential to work with all family members.

b. Professionals must be able to deal with their own feelings about abuse before they can offer effective services.

c. Skilled initial intervention is critical to the subsequent handling of a case but may be more difficult than in many other abuse and neglect cases.

d. Long-term mental health services to family members, including family therapy, may often be advisable.

e. Court involvement may be necessary to insure family cooperation in long-term treatment.

f. Both specialized skills and effective interagency relationships are essential.

## System Response: Short-term Intervention[6]

A wide range of agencies is involved in short-term intervention in cases of sexual abuse. While substantial variations exist, the overall quality and level of services could use considerable improvement. Many victims and their families are not receiving adequate services.

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[6] Chapter IV.

- Personnel with expertise in handling sexual abuse cases are limited.
- Specialization is limited, allowing little opportunity for the development of a base of expertise.
- Professionals do not always deal with their personal feelings and reactions and this adversely influences management of some cases.
- There is a lack of interagency communication and cooperation. Many interagency disagreements are based not on service quality per se but on unarticulated institutional perspectives and priorities.
- Those with considerable experience with sexual abuse cases are generally more dissatisfied with available services than are other practitioners.

Awareness of the problems surrounding sexual abuse has clearly increased over the last several years, and some efforts at both improved skill development (on the part of DPW and other agencies) and increased interagency communication have been made. While these efforts are laudable, they fall far short of the improvements necessary to insure the provision of adequate services to cases of sexual abuse.

The following paragraphs relate to the nature and quality of services provided by specific agencies.

Department of Public Welfare. The vast majority of sexual abuse reports, 86% statewide, are screened in (i.e., in most cases DPW determines that a reportable condition does exist).[7]

[7] Refers to the period from July to December 1978

Only half (50.8%) of all sexual abuse reports are assessed in as protective service cases (i.e., DPW determines that ongoing protective services are necessary).[8] This figure is considerably lower than the estimates of validated reports made by other agencies in the Boston area. Among the likely reasons for this discrepancy are: (1) the lack of clear, widely accepted operational definitions of which specific behaviors constitute sexual abuse; (2) the failure of DPW workers to make adequate diagnoses in some cases; (3) the fact that DPW procedures are not always followed by local and regional personnel.

The investigation (screening and assessment) of the "average" sexual abuse case took 46 days. Many cases thus required substantially more than the 45 days specified by the department's procedures. Wide variations exist between regions. The screening and assessment of the average case (all types of abuse) in the Boston Region took 90 days. Sexual abuse cases do receive a priority response from DPW, after physical abuse but before neglect cases.

An emergency response was made in 19% of the assessed in sexual abuse cases. The child was removed from the home in 39% of the incidents. Home visits, observation of the child and the placing of phone calls to other agencies occurred in 68%, 74% and 87% of the assessed in cases respectively.

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[8] Refers to cases reported during May 1978 and subsequently assessed in. All other DPW data cited in this section also refer to this same group of cases. Because these data refer to only a one month time period and are now one year old, they must be viewed as only suggestive of current trends or conditions. This was the most complete information available at the time of our study.

The figures for cases assessed out are presumably lower. It appears likely that some cases are not receiving the attention that the satisfactory fulfillment of the assessment function would require.

Procedures specified by protective services regulations do not always reflect actual practices. The lines between screening, assessment and treatment are not always clear. Case conferences often do not occur when cases are transferred to the local level for ongoing treatment.

While the department's lack of expertise regarding sexual abuse is probably no worse than that of many other agencies, DPW's statutory responsibility for handling abuse cases makes its deficiencies worthy of particular attention. The high visibility of DPW, moreover, leaves it more open to criticism.

Hospitals. Hospitals provide only limited social services. Most hospitals, moreover, do not have trained personnel or established procedures for handling cases of sexual abuse. Exceptions are rare. A few institutions, notably Children's Hospital Medical Center and Boston City Hospital, have developed specialized multidisciplinary teams to provide a range of crisis intervention services.

Police Departments. Local police are probably better equipped for emergency response and outreach on a 24 hour basis than any other agencies. Police, however, have little expertise in the area of sexual abuse and social services generally. For the most part they understand and fulfill their responsibility to report cases to DPW, but conflicts with other agencies over the filing of criminal charges may sometimes occur.

The Department of Mental Health. DMH facilities do not appear to be actively involved in crisis intervention. Though they play a somewhat larger role in providing diagnostic services, other social service agencies claim that DMH is often uncooperative in reporting cases and accepting referrals. Though there are exceptions, most clinics have not actively sought to develop specialized skills with regard to sexual abuse.

Private Social Service Agencies. While little information is available on the quality of the services provided by private agencies, many professionals believe that they generally offer somewhat better overall services than DPW. These agencies do not have the legal mandate of DPW, however, and probably handle a higher proportion of cases which are reported by non-mandated reporters. Again, many do not have much experience or expertise in handling cases of sexual abuse.

## Long-Term Services[9]

(1) In theory, treatment services should be provided to all cases assessed in by DPW. A study recently completed by DPW indicated that department assessment workers recommended services to only 60% of the sexual abuse cases which were assessed in, a somewhat lower proportion than for neglect or physical abuse.[10] Counseling (52%) and foster placement (29%) were the most frequently recommended services. The extent to which these services were actually provided was unknown at the time of our investigation.

(2) DPW alone does not have the capacity to adequately render all necessary long-term services. Considerable assistance from private agencies, as well as DMH facilities, is essential.

(3) Viewing the overall performance of public and private agencies, we believe that effective long-term treatment (especially for families rather than individuals) does not occur in many cases. There are several reasons for this. (a) There is an insufficient number of qualified professionals available to provide services. Specialized knowledge of sexual abuse and skills in family therapy are lacking. Even where professionals with appropriate skills are available, priority may often be given to crisis intervention rather than long-term care. (b) There is a lack of incentives for families,

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[9] Chapter V

[10] Refers to cases reported during May 1978. This relatively low percentage may be due in part to deficiencies in the case records from which the data were derived.

especially father/offenders, to participate in long-term treatment. Many families are reluctant to admit the need for services past the crisis stage. The potential leverage of the courts is not used effectively. (c) The lack of inter-agency cooperation and coordination makes referrals and follow-up difficult. In particular, criticism has been aimed at the Department of Mental Health for its failure to provide services.

## The Courts[11]

(1) Court intervention does not occur in most known cases of sexual abuse. In most cases where such intervention does occur, Care and Protection proceedings are usually involved. Criminal charges are apparently filed less frequently.

(2) DPW has been criticized by other agencies for using Care and Protection petitions too hastily, especially to obtain temporary custody of a child before services have been offered. In cases were a C&P petition is vital, however, the department is better informed about the C&P process than many other agencies.

(3) Courts vary widely in their use of Care and Protection proceedings and in the level of evidence required to remove a child from the home. Although juvenile court personnel are generally better informed than are district court personnel regarding the statutes and procedures related to child abuse and neglect, most courts have little expertise in the area of sexual abuse.

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[11] Chapter VI

(4) While little is known about the use of criminal proceedings in sexual abuse cases, it is clear that the rules of criminal procedure can have a negative impact on child witnesses. This is exacerbated by the insensitivity and lack of knowledge and understanding of sexual abuse on the part of judges and attorneys.

(5) While sexual abuse treatment programs in other states have shown that court intervention can be used effectively to insure the delivery of social services, this does not generally occur in Massachusetts. The lack of adequate working relationships between social service agencies and the courts is widespread. The "coercive treatment" issue (that is, the pressuring of clients into accepting services) poses a particular dilemma for some mental health professionals, especially those with little experience in handling cases of sexual abuse.

## Programmatic Implications[12]

Practitioners interviewed during the course of the study indicated there were four types of activities which they felt would improve the quality and range of services available to victims of sexual abuse and their families.

(1) Education of a wide range of social service and criminal justice professionals in the basic clinical and service issues invovled.

(2) In-depth training to selected professionals in a variety of agencies who would specialize in offering direct services to victims of sexual abuse and their families.

[12] Chapter VII

(3) Establishment of a comprehensive sexual abuse treatment program.

(4) Development of mechanisms for increased inter-agency cooperation.

Although this study was not designed to produce specific policy recommendations, we have reached several conclusions which bear on future policy choices.

(1) The inadequacy of the system to handle sexual abuse cases should not be obscured by the relatively small proportion of agency caseloads these cases appear to comprise.

(2) General improvements in protective services will, of course, have some impact on sexual abuse, but more specific steps are necessary to address the lack of available expertise.

(3) An initial choice should be made between (a) encouraging the development of a relatively small number of specialized programs and (b) developing the specialized skills of a larger number of agencies on a more decentralized basis.

(4) The development of new services should be tied to the establishment of more adequate linkages between agencies, especially between service agencies and the courts.

(5) Specialized sexual abuse treatment programs in other states (several of which are described in Appendix B) vary in both their organizational placement and programmatic focus. If the development of such programs is contemplated in Massachusetts, the various models should be investigated to

determine their applicability to the conditions now prevailing in the Commonwealth.

(6) If future policy choices are to be made on an informed basis, more detailed and reliable sources of information on the number and treatment of known cases of sexual abuse are necessary. While DPW has recently implemented a new information system which should provide some of this data, information available from other agencies must also be improved.

## Additional Issues[13]

There are three issues in particular which this study did not adequately investigate:

1. Abuse Prevention. Many practitioners believe efforts at abuse prevention to be an important long-run activity.

2. Adolescent Services. The quality of services to adolescent victims of sexual abuse was particularly criticized by many professionals during the course of this study.

3. Private Social Agencies. Despite their important role, little is known about the quality of the services rendered by these agencies.

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13 Chapter VII.

# I. OBJECTIVES AND METHODOLOGY

## A. Objectives of the Research

Child abuse and neglect have become the subject of great interest in recent years, with considerable concern being expressed by social service and criminal justice agencies, as well as by the general public. Consequently, our understanding of this area has greatly increased and more effective strategies for action have begun to evolve. The sexual abuse of children, which is often subsumed under the child abuse umbrella, has emerged as a visible issue only much more recently. Much less is commonly known about its dynamics and incidence, about the need for intervention and about the form such intervention should take. Little has been done in Massachusetts to assess the overall response of the social service and criminal justice systems to the sexual abuse of children. It is the purpose of this report to further our knowledge in this area by outlining the major issues involved and presenting a preliminary analysis of those issues.

This report is aimed at two audiences. (1) The staff of the Massachusetts Committee on Criminal Justice (MCCJ), the state planning agency which plans for and administers federal Law Enforcement Assistance Administration (LEAA) funds in the state, initially suggested the study. Our objective is to provide MCCJ with sufficient information to aid it in formulating its role in the area of child sexual abuse. (2) We intend that the report also address some of

the information needs of other criminal justice and social service personnel concerned with the sexual abuse of children. The study can serve as a framework for further discussion, study and action.

It was not our intention to attempt a complete or exhaustive analysis of the many and complex issues surrounding sexual abuse. We could not hope to accomplish such a task with the resources at our disposal. Our intent is more modest: to identify the major parameters of the sexual abuse issue and to provide a preliminary analysis of what is known about the extent of sexual abuse in Massachusetts and the manner in which it is handled. The study was not designed to provide programmatic recommendations. The following specific issues were examined:

1. Extent of Abuse - How common is sexual abuse? How often is it reported to public and private agencies? What are the mechanisms for reporting? (Chapter II)

2. The Nature of Abuse - What are the characteristics of those involved in sexual abuse? What are the dynamics of the abuse itself? What type of response is desirable? (Chapter III).

3. Short-term Intervention - How are known cases of sexual abuse initially handled by social service and criminal justice agencies? (Chapter IV)

4. Long-term Intervention - To what extent are long-term treatment and other services provided? How adequate are these services? (Chapter V)

5. The Courts - What is the current role of the courts in reported cases of sexual abuse? (Chapter VI)

6. Programmatic Implications - Does the preceding analysis have any important implications for direct services or other related programs? What are the current needs in this area? (Chapter VII)

Our efforts must be viewed as exploratory. There are many complex issues involved and we were not able to study all of them in any depth. There are, moreover, conflicting opinions about the prevalence, nature and treatment of sexual abuse, and in recent years there has been some controversy in Massachusetts regarding the effectiveness of social service delivery in general. Because of these differing points of view, it is likely that many readers of this report will find something to disagree with. We believe, however, that our effort can form part of a framework within which informed discussion can take place. Some sections of the report will contain fairly lengthy descriptions of issues which may be well understood by those with extensive knowledge of sexual abuse or of the protective services system. We believe, however, that many users of this study will not have such a familiarity.

Although MCCJ is a criminal justice agency, we have taken a considerably broader perspective here, placing much emphasis on social service issues. Such an approach is essential if we are to obtain any real understanding of sexual abuse.

## B. Methodology

The exploratory nature of our work precluded any rigorous experimental or quantitative design. During the initial stages of the study the issues were not sufficiently defined for such an approach to be feasible. Accordingly much of our analysis is qualitative in nature.

One major constraint also played a major role in our methodological decisions - the work had to be accomplished by a single researcher within approximately a six month period. Two decisions followed directly from this. (1) The study would focus only on the Boston area. Only in this manner could any fairly thorough study be done in the time available. (2) The study would not analyze case records. Even if issues related to access and privacy could be resolved, any investigation which yielded a sample of cases large enough for reliable generalization would be too time consuming.

The study drew on four sources of information. (1) On-site interviews were conducted with personnel directly involved in the diagnosis, treatment and management of child abuse in the Boston area as well as with personnel in related administrative and service positions. A total of 43 interviews involving 59 individuals were conducted, as well as numerous informal meetings and discussions. Individuals were not selected randomly, but were chosen to insure that all important points in the social service and criminal justice systems were covered and that a wide variety of perspectives would be heard. These interviews included personnel from the following agencies and groups:

Department of Public Welfare
Department of Mental Health
Office for Children
District and Juvenile Court Probation Officers
District and Juvenile Court Judges
Local Police
District Attorneys' Offices
Department of Education
Hospitals
Private Social Service Providers
Legal Aid Programs

Interviews averaged over one hour in length. While this approach did not, and was not designed to, result in a statistically representative sample, it is quite adequate to provide the type of diagnostic and descriptive information required for our purposes. (2) Existing aggregate statistics were collected and analyzed. We drew heavily from information collected by the Department of Public Welfare, although more limited information was available from other agencies.

(3) Written policies and procedures were examined when available. (4) The existing clinical and statistical literature on sexual abuse and child abuse in general was reviewed. This was used extensively for background information in several sections of the report.

# II. THE PREVALENCE OF SEXUAL ABUSE

How prevalent are instances of sexual abuse of children? Through what mechanisms do we find out about them? How well do these mechanisms work? These are the issues we will discuss in the present chapter, placing particular emphasis on the reporting procedures established by the Department of Public Welfare (DPW).

## A. What is Sexual Abuse?

Let us first clarify the manner in which we are using the term "sexual abuse". "Sexual abuse", "sexual misuse", "child molesting", "sexual assault", "sex crimes" are all used to refer to various forms of adult-child sexual interaction which our society has defined as inappropriate. This would include incest, adolescent prostitution (both male and female), sexual assault by non-family members and other forms of deviant sexual interaction as well.

For purposes of this report, we will limit ourselves to sexual abuse as a form of child abuse - i.e., we will focus primarily on incest and other instances in which the adult is known to the child. As we will see shortly, the clinical and statistical evidence indicates that these make up the large majority of cases of adult-child sexual interaction. This way of approaching sexual abuse does not provide any clinical typology - many types of behavior are included.

Most states have chosen to treat child abuse as primarily a social service issue. In Massachusetts, the Department of Public Welfare (DPW) has the statutory authority and responsibility to receive reports, investigate cases and provide protective services. Many forms of sexual abuse, and physical abuse as well, are also a violation of criminal law, however, and these perspectives sometimes conflict.

There is no reliable estimate of the frequency with which sexual abuse occurs in Massachusetts. It is probably impossible to make any estimate that has a reasonable probability of being accurate. Many attempts have been made to estimate the incidence of sexual abuse (and child abuse in general) for other states, for the United States as a whole and for large urban areas.[1] These estimates vary widely depending on the methods employed and we believe that none should be used as the basis for any serious policy-related discussion. The methodologies used to arrive at these estimates generally suffer from one of two critical defects: (1) they are based on clinical samples that are either extremely small or selected in such a way as to make generalization inadvisable; or (2) they are based on large sets of aggregated data which are manipulated according to assumptions which for the most part are either unverifiable or inaccurate.

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[1] For examples of these see: Cohen and Sussman; DeFrancis; Gil; Nagi; Light.

We will make no attempt to address the question of incidence per se, but will instead focus on the number of cases which come to the attention of social service and law enforcement agencies. As we will see, even this figure is rather elusive. Many professionals believe that most cases of sexual abuse are never discovered. At this point, any estimate of whether the actual incidence is twice the number of reported cases or ten times that amount would be purely speculative.

## B. Procedures for Reporting Sexual Abuse

With the enactment of Chapter 1076 of the Acts of 1973, a completely new system for the handling of child abuse cases, including sexual abuse, was established in Massachusetts. Under Chapter 1076, the Department of Public Welfare (DPW)[2] is responsible for receiving all reports of abuse and neglect of children under 18 years of age, for investigating those reports, and for providing protective services if necessary.

[2]The provision of protective services is only a part of DPW's total responsibilities, most of which involve the provision of financial assistance such as Aid to Families with Dependent Children (AFDC) and Medicaid. A new Department of Social Services (DSS), which has been statutorily mandated and is now being implemented, will take over responsibility for social services, including protective services, currently provided by DPW. DPW, DMH (the Department of Mental Health) and DSS (once operational) are independent departments within the Executive Office of Human Services.

There are no special statutory requirements for sexual abuse cases. Certain individuals, called "mandated reporters" are required by law to report suspected cases of abuse and neglect to the Department of Public Welfare. This class of reporters includes physicians, nurses, teachers, family counselors, police officers, probation officers, social workers and several other occupations.[3] Any other individual may also report but is not required to do so. These reports are generally referred to as "51A's", after the form on which the report is made.

The protective services system currently used by DPW was initially implemented in March 1978. The investigatory process under this system occurs in two stages.[4] (1) After a report is received, it is screened to determine if a "reportable condition" exists, i.e., whether the alleged incident, if it were true, would constitute a condition reportable under the child abuse legislation. This step is not statutorily mandated and was instituted by the department. Home visits are

[3] The statute (Chapter 119, Section 51A) currently reads in part: "Any physician, medical intern, medical examiner, dentist, nurse, public or private school teacher, educational administrator, guidance or family counselor, probation officer, social worker, or policeman, who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering serious physical or emotional injury resulting from abuse inflicted upon him including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication".

[4] The following description refers to the theoretical operation of the system. As we will discuss in Chapter IV, actual practice may vary somewhat. For a more detailed explanation of DPW procedures, see Massachusetts Social Services Procedures Manual - Protective Services Procedures.

not made at this stage, though collateral sources (such as the agency making the report) are contacted by phone for further information. According to DPW regulations, departmental personnel must determine within one hour whether emergency intervention is required to alleviate immediate danger to the child. Such cases are then given an immediate (within four hours) response. In theory, all non-emergency cases are screened within one working day after the report is received. All reports received by DPW are screened at one of the department's six regional offices.

(2) If a report is "screened in" by DPW i.e., if the department judges that a "reportable condition" exists - an investigation is undertaken at the regional level.[5] These investigations, referred to by DPW as assessments, are performed by a regional social worker who should be involved with the case for a maximum of 45 days.[6] According to DPW regulations, the specific objectives of the assessment function are:

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[5] While most investigations (assessments) are conducted at the regional level, the regulations do specify certain exceptions for which investigations can be performed by a local DPW office. DPW also contracts with private agencies for the performance of assessments, as well the provision of treatment.

[6] Again, while this is the general rule, the regulations provide for specific exceptions which allow a longer time period.

i. to determine if the situation within the family requires ongoing protective services;

ii. to stabilize the situation in the family to the extent that the immediate risk of further harm to the child (children) is resolved; and

iii. to make an initial determination of the needs and strengths of a family that can be used for a basic service plan.[7]

Within the 45 day period, the assessment worker must develop a recommendation on whether a case requires ongoing protective services. If a worker judges that ongoing protective services are required, the case is referred to as "assessed in" and is transferred either to a DPW local office (Community Service Area or CSA) or to a private agency (under DPW contract) for the provision of those services. If a case does not require ongoing protective services, it is "assessed out", i.e., it is closed as a protective service case, although it may be referred to a DPW social work "generalist" for other social services.

DPW child abuse and neglect reporting forms and procedures have changed several times in the last few years and it is only fairly recently that the department has begun to develop a reasonably accurate count of the number of cases reported to it. Record-keeping procedures in effect at the

[7] Massachusetts Social Services Procedures Manual, page I-67

time of the study had several limitations which prevent us from obtaining a precise estimate of the number of sexual abuse cases known to the department. (1) The classification of cases by type of abuse (i.e., sexual abuse vs physical abuse vs neglect, etc.) is based on the 51A reports which are filed. The classification takes place at initial intake when information is fairly limited and the nature of the abuse may not be precisely known. (2) Further, there are no explicit and consistent guidelines for DPW intake workers to use in classifying reports with regard to sexual abuse. DPW regulations state only that sexual abuse includes "the commission of a sex offense against a child as defined in the criminal laws of Massachusetts". The criminal statutes provide only a broad definition and do not give specific guidance as to what forms of behavior are included. (3) Only the "presenting problem" as initially reported and interpreted by the intake worker is coded. Cases which are reported as neglect or physical abuse and which are found to involve sexual abuse only after an investigation is conducted are therefore not included in the sexual abuse statistics available to us.

DPW has recently implemented a new Child Information System (CIS) which is designed to provide more complete data on cases of abuse and neglect, including sexual abuse, than has been available in the past. This system will allow for an updating of the type of abuse and neglect at the assessment stage and will also provide data on assessment outcomes

and services rendered. The system was not yet operational when this study was conducted, and the analysis presented throughout this report is therefore based on information available at the time of our investigation. That information is far from adequate in many instances and the department's CIS should meet a very critical need.

## C. Data on Cases of Sexual Abuse Reported to DPW

### 1. THE NUMBER OF REPORTS

While many agencies receive initial reports of sexual abuse, the Department of Public Welfare's statutory role makes it the primary source of information. DPW data available at the time of the study afford us the following picture of sexual abuse reports.

There were 282 51A's filed during the last six months of 1978 which were classified as sexual abuse (Table 1). This was 4.1% of the total number of 51A's filed during that period.[8] The actual number of cases of sexual abuse known to the department is somewhat greater. Some cases involving sexual abuse may either be classified incorrectly as physical abuse or neglect, or may actually involve physical abuse and neglect as well as sexual abuse. Some DPW representatives estimate that sexual abuse probably occurs in from 10-15% of the abuse and neglect cases handled. This is similar to the most

[8] Table 1 indicates that in 19% of all reports, the type of abuse was not known. This does not indicate that DPW has not accounted for these cases, but that the forms from which these tabulations were made were not completed correctly. The number of reports and the number of children involved are not identical. DPW indicates that, on the average, about 1.6 children are involved per reported case of abuse or neglect.

TABLE 1

## REPORTED CASES OF SEXUAL ABUSE FOR SELECTED DPW REGIONS JULY THRU DECEMBER 1978

| | Reports | |
|---|---|---|
| Statewide | Number | Percent |
| Sexual Abuse | 282 | 4.1 |
| Other Abuse and Neglect | 5339 | 76.9 |
| Type Unknown | 1324 | 19.1 |
| Total | 6945 | 100.1 |
| Boston Region | | |
| Sexual Abuse | 50 | 4.6 |
| Other Abuse and Neglect | 854 | 78.3 |
| Type Unknown | 187 | 17.1 |
| Total | 1091 | 100.0 |
| Greater Boston Region | | |
| Sexual Abuse | 28 | 3.2 |
| Other Abuse and Neglect | 806 | 92.2 |
| Type Unknown | 40 | 4.6 |
| Total | 874 | 100.0 |

Source: DPW Office of Social Services

recent data (1976) from other states which indicate that sexual abuse cases comprise 12% of all validated abuse and neglect cases.[9]

The extent to which official DPW statistics on sexual abuse represent a gross underestimation of those cases which enter the social service system can be illustrated by examining data for the city of Boston. The Boston Region of DPW (covering the city of Boston) received 50 reports of sexual abuse during the last six months of 1978, or about 100 per year (Table 1).[10] The experience of several other agencies in Boston indicates the following:

- Children's Protective Services claims that its "active caseload" in Boston includes at least 32 known cases of sexual abuse.
- The combined estimates of the Suffolk County District Attorney's Office and three large Boston hospitals of the number of sexual abuse cases they handle yearly is approximately 350.
- The Boston Police Department received an estimated 118 reports of rapes of children under 16 in 1978.[11]

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[9] The validation issue will be discussed shortly. National data were derived from a study of 28 states conducted by the American Humane Association (National Analysis of Official Child Neglect and Abuse Reporting, page 30).

[10] Supplementary data from DPW's Boston Regional Office indicate that reports involving 88 children were filed during the period from February thru October, 1978

[11] Data compiled by the Boston Police Department Rape Investigation Unit indicated that 69 of the 235 (or 29.4%) rapes reported during the first seven months of 1978 were of children under 16. Prorated to a 12 month basis, this would be 118.

- One Boston program for runaways indicated that it believes a minimum of 5 to 10% of the 550 adolescents it served last year had been sexually abused by a member of their family. Some professionals working with runaways believe the proportion may be substantially higher.

The DPW Greater Boston Region, which includes a large portion of the Boston metropolitan area (excluding the city of Boston itself) received 28 reports during the last six months of 1978 which were classified as sexual abuse - or about 56 per year. One rape unit within a District Attorney's Office in the Boston area, however, indicated that it alone handled about 50 cases during 1978.

Some of these figures are rough estimates and must be interpreted cautiously, and there is undoubtably some overlap among them. Further, some cases may not actually be "sexual abuse" as we are using the term. Nonetheless, it is quite clear that the number of cases which are known to or suspected by social service or criminal justice agencies is considerably larger than official DPW statistics would indicate. Many of these cases are probably never reported to DPW.

2. INCEST

For the general public the image of the "child molester" is that of a stranger lurking in the shadows. Many professionals have long felt that this stereotype was not accurate - that children, especially younger ones, are most likely to be abused by those who have the greatest access to them, especially members of their families.

Cases of sexual abuse in which the victim and perpetrator are members of the same family are loosely referred to as "incest", although the precise meaning of this term is often not clear. Officially, the Department of Public Welfare uses the definition of incest specified in the General Laws of Massachusetts. Under the statute (Chapter 272, Section 17) incest refers to intercourse between individuals whose marriage is prohibited by law. With regard to sexual abuse, the term would include intercourse between a victim and her[12] father, grandfather, stepfather, brother or uncle (this includes relationships by both blood and marriage. Massachusetts General Laws, Chapter 207, Sections 1 and 2).

Practitioners (both in DPW and in other agencies) interviewed during this study used the term "incest" in many different ways, often more narrowly than the statutory definition (few social service practitioners appear to be aware of the specific provisions of the statute). Despite this ambiguity in usage, there is enough information currently available to indicate that incest is clearly a common phenomenon in Massachusetts. DPW data for the Boston Region indicate that from February to October 1978 58% of all reports of sexual abuse alleged that the abuser was a family member.[13]

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[12] Most known victims of sexual abuse in Massachusetts are female. This will be discussed in Chapter III. We might also point out at this point that the legal definition of intercourse is not very precise.

[13] Including stepparents, fosterparents, uncles and grandfathers. Source: DPW Boston Regional Office.

How many of the other cases involved adults known to the child is not known. A statewide DPW survey indicated that of those cases reported in May 1978 which were subsequently assessed in, 48% of the sexual abuse cases involved either a natural parent, stepparent, or boyfriend of the victim's mother.[14]

These figures are roughly comparable to estimates of Boston area service agencies, which indicate that about half of the sexual abuse cases known to them involve incest [15] and that most of the remainder involve adults whom the victim knows. Many practitioners believe, moreover, that cases of sexual abuse involving adults known to the child, and parents in particular, are less likely to be reported to an agency than incidents involving strangers. Many believe that in actuality incest is by far the most common type of adult-child sexual interaction. The most reliable aggregate information from other states indicates that 62.8% of all validated reports to protective service agencies involved natural parents and 26.8% involved other relatives or stepparents. Thus in a minimum of 89.6% of the cases, the adult and the child were not strangers.[16]

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[14] Rosen, Newsom and Boneh.

[15] Many of these estimates appear not to include family members such as uncles and grandparents.

[16] Based on 1976 statistics from 22 states (not including Massachusetts) compiled by the American Humane Association (AHA). This information was not included in the AHA's published report. The author would like to thank Patricia Schene, Project Director at AHA, for providing the computer runs from which this information was obtained. We should also note that the meaning of "validation" in this context is not clear. It does not necessarily correspond to either the screening or assessment stages of the Massachusetts DPW.

## D. Who Reports Sexual Abuse?

As we have described, there is a class of mandated reporters who are statutorily required to report suspected cases of abuse and neglect, including sexual abuse, to DPW. Their willingness to do so is, of course, critical for children at risk.

Reports of abuse and neglect come to DPW from a wide variety of sources (Table 2). During the last six months of 1978, about 61% of all reports statewide came from various mandated reporters,[17] and relatively few reports were self-referrals made by the victim or his/her parents.[18] 12.1% of the reports were made by relatives, neighbors or friends (non-mandated reporters) and 14.9% were made anonymously. There are many regional variations, however. In the Boston Region, for instance, almost 22% of all cases were reported by hospitals or clinics compared to 11% statewide. Conversely law enforcement and school personnel account for a lower proportion of Boston reports than in the state as a whole. In both the Boston and Greater Boston regions, the percentage of anonymous reports was slightly higher than statewide.

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[17] This figure for mandated reporters includes the following categories in Table 2: Private physicians, hospitals, police, courts, DPW, schools, other service providers. Since not all individuals in these categories may actually be mandated reporters, this figure is only a rough indicator.

[18] The relatively small proportion of reports by parents, neighbors, etc. may in part be an indication that when these individuals do report, they are more likely to contact another agency first, not DPW.

TABLE 2

SOURCE OF CHILD ABUSE AND NEGLECT REPORTS FOR SELECTED DPW REGIONS
JULY THRU DECEMBER 1978

| | STATEWIDE | | BOSTON REGION | | GREATER BOSTON REGION | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Child | 28 | .4 | 6 | .5 | 1 | .1 |
| Parent | 270 | 3.9 | 34 | 3.1 | 29 | 3.3 |
| Relative | 347 | 5.0 | 77 | 7.1 | 22 | 2.5 |
| Neighbor-Friend | 495 | 7.1 | 42 | 3.8 | 47 | 5.4 |
| Private Physician* | 115 | 1.7 | 6 | .5 | 6 | .7 |
| Hospital* | 783 | 11.3 | 238 | 21.8 | 105 | 12.0 |
| Police* | 459 | 6.6 | 32 | 2.9 | 74 | 8.5 |
| Courts* | 103 | 1.5 | 13 | 1.2 | 26 | 3.0 |
| DPW* | 975 | 14.0 | 125 | 11.5 | 133 | 15.2 |
| Other Service Providers * | 987 | 14.2 | 136 | 12.5 | 109 | 12.5 |
| School* | 838 | 12.1 | 88 | 8.1 | 109 | 12.5 |
| Anonymous | 1,032 | 14.9 | 190 | 17.4 | 157 | 18.0 |
| Other | 513 | 7.4 | 104 | 9.5 | 56 | 6.4 |
| TOTAL | 6,945 | 100.0 | 1,091 | 100.0 | 874 | 100.0 |
| Mandated Reporter | | 61.4 | | 58.5 | | 64.4 |

*Included in mandated reporter category.
Source: DPW Office of Social Services

The most reliable data at our disposal on the source of sexual abuse reports cover the Boston Region during the nine month period from February to October 1978 (Table 3). This information indicates that initial sexual abuse reports coming into DPW's Boston Regional Office are much more likely to come from mandatory reporters (78%, see Table 3) than are all abuse and neglect cases (59%, see Table 2).[19] Further, a considerably smaller proportion of sexual abuse reports are anonymous (9% compared to 17% for all abuse and neglect). We must emphasize that these data refer only to those cases initially classified as sexual abuse. As we have noted, this group constitutes only a portion of those sexual abuse cases known to DPW.

The only national data available (Table 4)[20] indicate quite a different situation from the Boston Region (Table 3). Only 57% of sexual abuse cases nationwide were reported by individuals who would be considered mandatory reporters in Massachusetts. A relatively high proportion of cases were reported by victims, family members, relatives and neighbors. Very few anonymous reports were made. This comparison should be interpreted cautiously, however, since reporting laws, definitions of mandatory reporters, record-keeping procedures and other factors which differ from state to state may have a marked impact on the statistics.

[19] Note: These two sets of data cover slightly different time periods.

[20] Source: Special tabulations covering 22 participating states provided by the American Humane Association.

TABLE 3

SOURCE OF SEXUAL ABUSE REPORTS

DPW BOSTON REGION

FEBRUARY - OCTOBER 1978

| | Number | Percentage |
|---|---|---|
| Victim | 1 | 1.1% |
| Parent | 3 | 3.4% |
| Relative | 0 | 0% |
| Neighbor | 2 | 2.3% |
| Private Physician* | 0 | 0% |
| Hospital/Clinic* | 41 | 46.6% |
| Police* | 5 | 5.7% |
| Court/District Attorney* | 1 | 1.1% |
| DPW* | 8 | 9.1% |
| Schools* | 3 | 3.4% |
| Other Service Provider* | 11 | 12.5% |
| Anonymous | 8 | 9.1% |
| Other | 5 | 5.7% |
| TOTAL | 88 | 100.0% |
| Mandated Reporter | | 78.4% |

* Included in mandated reporter category
Source: DPW Boston Regional Office

TABLE 4

## SOURCE OF SEXUAL ABUSE REPORTS FOR 22 STATES 1976

| | Number | Percent |
|---|---|---|
| Victim | 130 | 7.8% |
| Parent | 226 | 13.5% |
| Relative | 177 | 10.6% |
| Neighbor/Friend | 119 | 7.1% |
| Private Physician* | 37 | 2.2% |
| Hospital/Clinic* | 242 | 14.5% |
| Law Enforcement* | 296 | 17.7% |
| Court* | 57 | 3.4% |
| Public Social Agency* | 102 | 6.1% |
| Private Social Agency* | 31 | 1.9% |
| School* | 179 | 10.7% |
| Anonymous | 29 | 1.7% |
| Other | 48 | 2.9% |
| TOTAL | 1,673 | 100.1% |
| Mandated Reporter | 944 | 56.4% |

Note: Percentages may not add to 100.0 because of rounding

* Included in mandated reporter category

Source: Special tabulations on 22 states provided by the American Humane Association.

Although the vast majority of sexual abuse cases reported to DPW come from mandated reporters, individuals in this group vary widely in their willingness to report suspected cases to DPW. Some, by their own admission, do so only "selectively". In general, observers feel that private physicians, mental health personnel and schools often do not fulfill their reporting responsibilities. The available figures from the Boston Region (Table 3) lend credence to these perceptions. Of the 88 reported cases of sexual abuse (February through October 1978), only 3 cases were reported by schools, 1 by a facility affiliated with DMH[21], and none by private physicians. It is only fairly recently that many school districts have begun to develop guidelines for the reporting of child abuse. Procedures for the Boston schools, for instance, were only formalized in December 1978. In the past, teachers in many districts have been unaware of their responsibility to report, or unsure of reporting procedures. In some cases, administrative officials have either misinformed teachers, or have ordered them not to report. Even when they are informed, teachers do not necessarily report to DPW. Of 189 teachers and administrators in the Cambridge schools who responded to a questionnaire last year,[22] 130 said they had seen suspected cases of abuse or neglect, but only 72 (55%) said they reported it. Many

[21] This is included in the "other service provider" category in Table 3.

[22] "Concern", October 1978. About 1000 questionnaires were mailed.

observers feel that some professionals are reluctant to admit the existence of sexual abuse and that this is even more likely than other forms of abuse to go unreported.

Mental health clinics and private physicians have also been widely criticized for failing to report sexual abuse. Feelings about patient/client confidentiality probably play a major role here, as does the fear of civil or criminal liability, despite the fact that mandated reporters are protected from such liability by law.

In general, more is involved than simply the willingness to report and the recognition of statutory responsibility. Some professionals are still unwilling to accept that sexual abuse, especially incest, is not a rare occurrence, and that it is something they should be concerned with. Many also have little knowledge of what signs to look for and how to identify possible instances of sexual abuse. The importance of these factors should not be underestimated, as an example will illustrate. About 47% of all sexual abuse reports coming into the DPW Boston Regional Office came from hospitals (Table 3). Many hospitals, however, reported no cases. The majority of the hospital reports, in fact, originated from only two institutions - Children's Hospital Medical Center and Boston City Hosptial. These two have made conscious efforts to develop staff teams with skills in diagnosing sexual abuse and have attempted to sensitize other hospital personnel as well. They are thus not only more likely to report suspected cases

to DPW than many other institutions, but are also more likely to diagnose them in the first place. It is an obvious but critical fact that those who are unwilling to look for sexual abuse, or who do not have the skills to do so, will seldom find it.

Finally, we should point out that in some cases it is not clear exactly who is statutorily mandated to report. While DPW regulations provide some additional guidance - "public or private school teacher", for instance, has been defined to include teachers in day care centers[23] - many cloudy areas remain. Are mental workers included as "guidance or family counselors" under the law? Does "social worker" as stated in the legislation refer to individuals with that job title, or to anyone who performs a social-work function? Are hospital personnel who are not physicians, medical interns or nurses required to report? Are staff members of rape centers included in the statute? These ambiguities undoubtably have lead to confusion and disagreement about reporting responsibilities.

One important example of this involves Children's Protective Services and several other private agencies which handle abuse cases under DPW contract.[24] In addition to cases

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[23] See Mintzer p. 2

[24] Children's Protective Services of the Massachusetts Society for the Prevention of Cruelty to Children is the largest of these private agencies, maintaining a network of offices around the state.

assigned to them by DPW, these agencies also receive many reports directly from non-mandated reporters.[25] There has been some controversy over whether and in what form these agencies should report such cases to DPW. While DPW is often notified of these reports, 51A's are not generally filed on them. DPW ususally does not know what type of abuse or neglect is involved and these reports are not ususally included in DPW statistics (this varies to some extent from one region to another, depending upon the relationship between DPW regional offices and the local private agencies).

[25] Reports received by these private agencies from mandated reporters are reported to DPW, although DPW may sometimes refer them back to the agency for assessment and/or treatment.

# III. THE NATURE OF SEXUAL ABUSE

Most of our analysis focuses on the current institutional response to reported cases of sexual abuse. This response cannot be fully understood, however, without a better grasp of the nature of sexual abuse itself and the problems posed for those who intervene. In this chapter we address these issues from three perspectives: (a) an analysis of existing data on the characteristics of victims and perpetrators of cases of sexual abuse reported to DPW; (b) a discussion of some aspects of the dynamics of abuse, based upon existing clinical knowledge; (c) a discussion of the type of institutional response that would be desirable in cases of sexual abuse.

## A. Characteristics of Families and Victims

Detailed information on the types of families and individuals involved in cases of sexual abuse reported to DPW was not available at the time the study was conducted.[1] Nevertheless, existing information does enable us to make some informative comparisons. The data sources available were: (1) statewide data on the characteristics of all sexual abuse cases reported to DPW during May 1978 which

[1] This information should now be available through the department's recently implemented Child Information System.

were subsequently assessed in as protective service cases;[2] (2) characteristics of all sexual abuse cases reported in the Boston Region from February through October 1978. For the sake of simplicity we will refer to these sources as "state" and "Boston" respectively, but we must caution readers that we would not expect these two sets of information to be directly comparable.[3]

1. Sex of victim.. The vast majority of victims are female - 81% statewide, 76% in Boston (Table 5). This is consistent with national data.[4]

2. Sex of perpetrator. While there are no Massachusetts statistics available, national data indicate that 78% of perpetrators are male.

3. Heterosexual-homosexual orientation. In the Boston Region, 69% of all cases were heterosexual in nature (Table 5).[5] The vast majority (84%) of the homosexual cases involved males. All of the reported cases involving male victims were homosexual in nature.

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[2] These figures must be interpreted cautiously since they refer only to a one month period. Further, the data were drawn from case records and are thus only as reliable as those records. These issues are discussed in more detail in Chapter IV.

[3] Again we must note that these data refer only to those cases classified as sexual abuse at the time they were initially reported to the department.

[4] Many other service agencies in the Boston area indicate an even higher proportion of female victims.

[5] Other service agencies estimate a considerably lower proportion of homosexual reports than DPW appears to receive. Some observers feel that homosexual cases are more likely to be reported than heterosexual cases.

# TABLE 5

## CHARACTERISTICS OF SEXUAL ABUSE CASES

| | STATEWIDE[1] | | BOSTON[2] REGION | NATIONWIDE[3] |
|---|---|---|---|---|
| | Sexual Abuse | Other Abuse and Neglect | Sexual Abuse | Sexual Abuse |
| 1. Sex of Victim (% Female) | 81% | 48% | 76% | 85% |
| 2. Sex of Perpetrator (% Male) | X | X | X | 78% |
| 3. Percent Heterosexual | X | X | 69% | X |
| 4. Percent of Homosexual Incidents Involving Males | X | X | 84% | X |
| 5. Age of Victim (Mean Years) | 10.8 | 7.1 | 10.2 | 10.8 |
| 6. Natural Mother[4] In Home | 100% | 90% | X | X |
| 7. Both Male and Female Caretaker In Home 4 | 70% | 42% | X | X |
| 8. Race of Victim: | | | | |
| White | 90% | 77% | X | X |
| Black | 7% | 7% | X | X |
| Hispanic | 3% | 10% | X | X |
| Other | 0 | 6% | | |
| | N = 31 | N = 471 | N = 88 | |

1. Refers to cases reported during May 1978 and subsequently assessed in

2. Refers to all sexual abuse cases reported from February to October 1978

3. 1976 data from 22 states, compiled by the American Humane Association

4. Based on small number of cases-data may not be reliable.

Note: "X" denotes data not available.

4. Age of victim. The average age is about 10.8 statewide and 10.2 in Boston (Table 5). This is somewhat higher than the average age (statewide) for other abuse and neglect cases (7.1 years). Several things are worth noting. First, since in many cases sexual abuse has been going on for some time before it is reported,[6] the age at which the abuse began is somewhat younger than the 10-11 year average. Further, the average obscures the wide range of ages involved. In the Boston region, 24% of the reports involved children six years old or younger while 42% involved children 13 or older. In other words, few victims are "average".

5. Family type. The victim was living with her/his natural mother in all (100%) sexual abuse cases in the one month statewide sample. In 70% of the cases a male caretaker was also present in the home, although not necessarily the natural father.

6. Social factors. While in the past, some people have felt that child abuse (including sexual abuse) primarily occurred among the urban and rural poor, increasingly professionals are coming to believe that this is not the case, especially in the case of sexual abuse. Where sexual abuse occurs among poor and minority group members, it is probably more likely to be reported, since these groups are more likely to come into contact with public social service agencies. Any analysis using DPW data would probably reflect this bias. Little such data, however are even available. Statewide DPW information on the race of victims indicates that 90% of sexual abuse victims are white, compared to 77% of other abuse and neglect victims. DPW data also indicate that 10% of the sexual abuse victims have moved into the the state within the last three years, compared to 7% of physical abuse and 4% of neglect victims.

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[6] This will be discussed later in this chapter.

Some observers feel this indicates a more mobile middle class population. Though hard evidence does not exist, it is probably safe to say that sexual abuse is not confined to urban areas or to members of any particular socioeconomic class. The manner in which this abuse manifests itself and is dealt with by the system, however, may vary greatly depending upon the nature of the community.

7. Relation to other abuse and neglect. The statewide sample indicated that in 26% of the sexual abuse cases emotional neglect was present, while physical neglect was present in 19% of the cases.

## B. Dynamics of Sexual Abuse

The behavior labeled as sexual abuse is fairly complex and the interpersonal dynamics involved are not completely understood. This is especially true in the case of incest. In recent years, however, this understanding has increased as more research has been conducted and clinical knowledge has spread. In the following section, we will describe, in broad terms, some of the more important aspects of this phenomenon. While an analysis of these issues is not a major purpose of this research, some understanding of them will be important to the discussions which follow. It is not our intention to present an exhaustive discussion of the growing literature on sexual abuse, or an analysis of all the issues involved. Further, the many types of behavior which fall into the category of sexual abuse make generalization quite difficult. The descriptions which follow

will apply more directly to incest cases than to other types of sexual abuse.[7]

(1) Adult-child interactions labeled as sexual abuse include a wide variety of behaviors which must be understood as part of a continuum of physcial contact between adults and children. It is often difficult to draw the line between normal displays of parental affection and other types of contact not generally considered acceptable in our society.

(2) In general, sexual abuse does not occur only once, but is ongoing. It may start as a relatively "benign" form of behavior (e.g., looking, touching) and progress to intercourse or some other form of penetration. When a case comes to the attention of DPW or another agency, it is often quite likely that the incident being reported is not the first one which occurred. The process of intervention may begin at that point but the process of abuse may have been going on for some time.

(3) The abuse may often occur within the context of a loving relationship, unlike the situation which occurs in most rape cases. The adult may have very positive feelings toward the child. Likewise, the child (especially pre-adolescents) may, at least for some period of time, view the interaction as a positive one-not in terms of sexual

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[7] This discussion draws freely from the following written sources, as well as discussions with experienced clinicians: Burgess et al; DeFrancis; Geiser and Norberta; Poznanski and Blos; Schuchter; Sgroi; Summit and Kryso. Most of the discussion will focus on male perpetrators and female victims. It is this combination that we know the most about.

gratification but in terms of the affection and attention obtained. The notion that children provoke sexual incidents, however, is generally believed to be false. While there is no doubt that some children, particularly adolescents, can behave in a manner interpreted as provocative, parents must bear the responsibility for defining acceptable sexual behavior. Adults must ultimately be held responsible for their own sexual behavior and judgments regarding the appropriateness of sexual activity.

(4) Evidence of physical trauma or harm will not necessarily exist, even if penetration has occurred. Even in children who are relatively young such activity is quite possible without extensive physical trauma. The extent of physical injury will also depend on the motivation of the perpetrator and the relationship between mother and father (if the father is the perpetrator).

(5) Knowledge of the dynamics of family interaction is critical to grasping the nature of sexual abuse. The role of the mother, for instance, is an important factor in incest cases. In many cases the mother either knows or suspects that sexual activity is occurring but is unable or unwilling to take action to stop it. In some cases problems in the relationship between mother and father (or father substitutes) may have directly contributed to the abuse. Poor mother-daughter relationships are also often present. The mother may be more concerned with

preventing further disruption of the wife-husband relationship than with protecting the child. An understanding of the intra-family alliances that develop because of these factors is quite important in the initial stages of case intervention and in assessing the danger to the child.

(6) For the perpetrator of the abuse, the primary motivation may be non-sexual - the needs he seeks to satisfy may be for affection and companionship and may not involve sexual gratification per se.

(7) Once the abuse has begun there is great pressure on the victim not to tell anyone, especially outside the family. Secrecy is obviously critical if the abuse is not just a one-time event. For a variety of reasons, the child very often keeps the secret at least for a time: the perpetrator is often a person the child trusts; the child may have enjoyed the experience; physical rewards or threats may have been made.

(8) Many professionals are increasingly coming to believe that children seldom lie about sexual abuse. This contradicts a widespread myth, still believed by some professionals, that many of these encounters are fabricated by children. Most clinicians with extensive experience working with child victims now feel that when children make the initial allegation, particularly with regard to another family member, there is virtually always some degree

of truth to the claim. After the secret is revealed, the child may be placed under enormous pressure to change her story: direct pressure from family members, neighbors or others; indirect pressure because the child becomes upset with the family disruption that has occurred; fear or uncertainty about dealing with the courts or social service personnel. If a victim recants, this of course makes life more difficult for those handling the case, but more and more professionals are coming to realize that this should not necessarily be taken for a sign that the abuse did not occur.

(9) There is some disagreement about the extent to which families in which sexual abuse occurs have a relatively high incidence of other problems - alcoholism, neglect, "problem homes", etc. It is probably true that families coming to the attention of governmental agencies are somewhat more likely to have some of these problems than the average family. However many believe that it is these characteristics which make them more vulnerable to being reported, particularly in the case of the poor. Middle class families, with or without these problems, are probably less likely to be reported.

## C. Guidelines For Intervention

One further issue should be considered before we discuss the current institutional response to sexual abuse in Massachusetts. In simplified form, this issue is: what type of response is desirable? This is obviously not an easy question to answer. It is a question involving important value judgments and dependent upon the current state of professional knowledge. Much remains to be learned about intervention in cases of sexual abuse. Knowledge has grown rapidly in recent years, however. Some clinicians and other social service personnel have developed considerable expertise in this area and are in substantial agreement on a number of important issues. The following points represent our interpretation of this emerging consensus. There will, of course, always be cases to which some of these guidelines will not apply, but in general we believe they provide a good background for interpreting the remainder of this report.[8] As with previous discussions, it is not our intention to provide an exhaustive description of intervention techniques, but only to delineate some of the major issues involved. Nor is it our primary intention at this point to be prescriptive - to make specific programmatic recommendations.

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[8] This discussion draws freely on many sources, among them: Burgess et al; Schuchter; Berliner and Stevens; Brecher; Giaretto; Interagency Task Force; Summit; Sgroi; National Institute of Mental Health; Burgess and Holmstrom.

(1) Many professionals believe - and we share this belief - that the purpose of intervention should not only be to protect the child, but to strengthen the family and aid it in remaining together wherever possible. These goals cannot generally be attained by providing services to the child alone, or to only the offender. It is more often necessary to deal with all members of the family, often at both the diagnostic and treatment phases. This necessitates an understanding of family dynamics and interaction, and staffing adequate to allow personnel to put this knowledge to work. It is not always possible to both assure the safety of the child and keep the family intact, but it will seldom be possible except under these conditions.

How much interference in a family is justified? The dilemma with which we are faced has been characterized as "family autonomy vs coercive intervention", reflecting the conflict between the traditional autonomy of the family in raising children and the authority of the state to protect children from harm.[9] The legal and moral debate over the rights of parents versus the rights of children is a long one,[10] and it is not our intention to attempt to resolve this dilemma. Clearly, however, it is of great relevance to any discussion of intervention policies.

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[9] Newberger and Bourne

[10] See also Wald; Duncan; Bourne and Newberger; National Institute: A Comparative Analysis of Standards and State Practices, Volume VI.

(2) Sex in general and incest in particular can evoke strong emotional reactions in our society. This can be true of social service workers and criminal justice staff as well as anyone else. If professionals are to be able to offer effective services, it is critical that they recognize and control their own feelings about these issues. Workers must be able to talk about sex openly and refrain from imposing their own feelings on the situation. Certainly personal feelings cannot, and perhaps should not, be completely submerged, but neither can they be allowed to dictate the course of intervention or to interfere with the analysis of the situation. A team approach to intervention and adequate opportunity for consultation and feedback can be helpful in this regard.

(3) Sexual abuse may well be the most difficult of all types of abuse and neglect to investigate and diagnose. Clear physical evidence may often be lacking or may require more work to uncover. There is often tremendous denial on the part of the family. Talking directly to the child early in an investigation may often be more critical than for other cases, and more child-oriented skills are thus necessary. Considerable skill is required to intervene effectively given the wide variety of circumstances which may occur and the limited time often available.

(4) Especially in incest cases, skilled initial intervention is critical to the subsequent handling of the case, particularly if one objective is to maximize the chances of keeping the family together. The intervenor must be able to assess the intra-family alliances that have developed and to build effective relationships with family members. If the groundwork is not properly laid initially, the chances of intervening effectively later on are substantially diminished. Some feel that poor intervention can at times be worse than no intervention at all. Once the secret has been revealed and social service personnel have become involved, the child may sometimes be at greater risk if the issues are not resolved because she can be blamed for the family disruption which has occurred. Many professionals believe that a team approach is generally required, since it is difficult for a single person to pay sufficient attention to the various family members, who may have differing perspectives and needs.

(5) While much is still unknown about the effects of sexual abuse, the long-term (a year or more) involvement of professionals with mental health skills may often be necessary. Long-term psychological and emotional problems can result, especially in incest cases. Sexual abuse may result in the disruption of a child's school performance. Many mental health professionals working with adult women report seeing individuals with problems traceable in part

to childhood incest. In many cases it is incorrect to assume that the problems within a family are solved upon the separation of the child and the adult. Other family members may also need long-term mental health services, since many incest cases can be due in part to dysfunctional marriages and problems in husband-wife relationships. Family counseling, which has only been developed relatively recently, may often be quite useful, although the success of such therapy depends partially on the ability of the offender to participate meaningfully.

(6 ) Some form of court involvement, whether through the criminal or civil (C&P) process, may often be necessary to get families, especially fathers, to accept long-term therapeutic services. While this is not always the case (especially if a family member reported the abuse), many times families will not accept services voluntarily for any substantial length of time. Virtually all successful treatment programs in other states have developed a cooperative relationship with the courts. Many believe that criminal proceedings are more effective than civil proceedings such as the Care and Protection process (C&P), since C&P proceedings can only threaten removal of the child and cannot place direct pressure on the offender to accept services. While mental health professionals may be uncomfortable with the idea of "coercive treatment", many programs have found it an indispensable tool.

(7) Building interagency relationships and supportive services is essential - no single agency is likely to have all of the skills or resources to deal with all facets of sexual abuse. Some of the necessary services include: emergency response capability, diagnostic and investigative skills, availability of medical treatment, several modes of long-term mental health services, court advocacy, related services such as daycare, foster care, homemaker services. Many of these service needs are not unique to sexual abuse but also apply to other types of abuse and neglect.

(8) Some specialization is probably necessary for the delivery of high quality services. While all professionals (protective service, mental health, police, court, school, hospital) should be sensitized to the issues involved, it would be impossible to train all of them to do anything more than handle the most immediate aspects of a case. To the extent possible, those without specialized skills should not be required to deal with these cases. Since professional education focusing on sexual abuse is fairly limited, experience and in-service training become critical to the development of expertise. Some clinicians feel that, because of the emotional issues involved, only those protective service and mental health workers who specifically want to handle sexual abuse cases should be required to do so.

# IV. SYSTEM RESPONSE: SHORT-TERM INTERVENTION

Up to this point we have discussed the nature of sexual abuse, its prevalence, the mechanisms for reporting it, and some suggestions for the course intervention should take. The remainder of the report will focus on the manner in which the social service and criminal justice systems actually respond to reported cases of sexual abuse. These discussions must be considered preliminary in nature - in-depth evaluations of such complex issues as these cannot be developed based on studies as limited in scope as ours. We must again emphasize that our investigation was confined primarily to the Boston area.

The present chapter will focus on short-term intervention in known instances of sexual abuse. By this we mean (a) the initial investigatory and evaluative process which follows the reporting or uncovering of a suspected case of sexual abuse, in which the seriousness and validity of the allegations are assessed and the need for services determined, and (b) the emergency response, if one is necessary. Much of our analysis will focus on the Department of Public Welfare. While many other agencies are and must be involved, DPW's role is clearly a central one. More information is also available about DPW than about other agencies.

Before we proceed any further, there is one fairly obvious fact which should be stated: the response of the social service and criminal justice networks to sexual abuse must be viewed within the context of the overall functioning of those systems. We believe that there are a number of specific issues which should be kept in mind during the following discussions.

- Great publicity surrounds the entire child abuse issue at the present time. This publicity inevitably has some impact on the manner in which agencies approach these cases.

- The number of abuse and neglect cases reported to DPW has risen sharply over the past several years - from 3600 in 1976, to about 7,000 during the last half of 1978 alone. Protective service staffing levels have not increased proportionately and the department has been constantly adjusting to accommodate the increased caseloads.

- The delivery system for social services in general - and children's services in particular - has been widely criticized as too fragmented. This criticism was in part responsible for the legislation creating the new Department of Social Services.[1]

- There is considerable controversy about the quality and availability of services often necessary as back up in abuse cases, including foster care, day care, homemaker services and emergency shelters.[2]

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[1] cf Sheehan; Massachusetts Committee on Children and Youth.

[2] Regarding foster care, for instance, see Gruber.

While we will generally try to confine our analysis to sexual abuse, it will often be necessary to discuss factors which bear on protective and social services more generally.

## A. Overall Assessment

The bulk of this chapter will be devoted to an examination of the procedures and performance of specific agencies. First, however, we will state our overall assessment of the quality of services offered by all agencies, public and private. The response of these agencies varies widely. There are many inconsistencies from one agency to another, and even within agencies. There are wide variations in the specificity of procedures, the extent to which procedures are followed and the qualifications of the personnel involved. Though some highly qualified and motivated personnel do exist and some cases are handled quite adequately, it would be fair to state that, in general, the quality and level of services is not impressive. There is room for considerable improvement.

1. Personnel with expertise in handling sexual abuse cases are limited in number. All agencies have personnel with varying levels of skill. With few exceptions, however, most agencies do not have staff members with much experience or specialized knowledge in the area of sexual abuse, even though they may have the expertise to perform their other duties competently. Most agencies - of all types - simply do not have the knowledge to provide adequate services in many sexual abuse cases. Some training regarding sexual abuse

has occurred over the last several years. While this has been valuable in introducing people to the issues involved, it has often not dealt with those issues in depth or on an ongoing basis.

2. Specialization is limited. For the most part, sexual abuse cases are handled by the same personnel handling other cases in an agency's workload. In some instances this is due to a lack of awareness that a problem with specialized needs may exist. In other instances it is partially attributable to high caseloads. Since many individuals handle sexual abuse cases only occassionally, there is little opportunity to develop a base of experience. The quality of intervention may thus vary enormously, depending upon the worker who happens to be assigned to the case.

3. Sexual abuse cases often evoke emotional reactions on the part of professionals who work on them. Those reactions may adversely influence the management of a case. Many observers believe that this fact, plus the generally low level of specialized knowledge, often results in: (a) the problem being ignored or not recognized because it is too threatening, or (b) the child being removed from the home unnecessarily. Some have characterized the typical response as either "denial or overreaction". This is somewhat of an overstatement, but contains an important degree of truth.

4. Though there is some degree of interaction between agencies, there is a great lack of communication and a lack of knowledge even of those resources which are available. While some agencies are highly critical of the manner in which others handle sexual abuse cases - and of the way they function in general-relatively few really understand the way those other agencies operate or have made a consistent effort to develop personal ties. While some relationships between various public and private agencies are beginning to develop around the sexual abuse issue, many agencies remain outside of this network, and there exists considerable lack of knowledge about what other agencies are doing.

5. Some of the interagency disagreements are based not on the quality of services per se, though they are often stated in those terms, but on differences in institutional perspectives and priorities which are often not clearly articulated. Agencies have varying reasons for their involvement, different mandates, and different expectations. Both DPW and an agency reporting a case, for example, many agree on the need for services, but DPW workers assigned to the case may feel that since the reporting agency is involved and adequately handling the situation, DPW need not actively provide services. The agency, on the other hand, may have perceived itself as only holding the case until DPW could pick it up, and then being forced to keep it.

Agency priorities are also important. An agency may report what it believes is a serious case to DPW and expect immediate action. The department, however, may be handling a number of cases which in fact are more serious and a delay in response may result. Generally cases involving young children, for instance, receive higher priority from DPW than those involving adolescents because the department believes adolescents can better care for themselves and are not as likely to receive life - threatening injuries. A program that deals primarily with adolescents may view such a response as a refusal to co-operate.

6. Though there is wide agreement that many sexual abuse cases are difficult to respond to and evaluate, and that services could be improved, perceptions about the urgency of the situation vary. In general, those with the most experience with sexual abuse, especially clinical experience, are more likely to perceive an urgent problem and to believe that current skills and services need drastic improvement. Partially for this reason, as we will discuss later, criminal justice agencies are generally less likely to be alarmed by the present situation than are social service organizations.

## B. The Department of Public Welfare

As we have seen earlier, a wide variety of agencies may be involved in short-term intervention (including but not limited to emergency response) in situations in which sexual abuse is believed to have occurred. Indeed most cases known

to DPW are filed by mandatory reporters who may have intervened in various ways before reporting. Because of its statutory responsibility, however, the position of DPW is a pivotal one and we will discuss it first.

In Chapter II we described DPW's current protective service system - screening and assessment are handled at the regional level; cases assessed in for protective services are transferred to a local office for ongoing treatment.[3] In the following section we will discuss the operation of that system in more detail.

1. SCREENING

The function of screening is to determine if the condition alleged in the report is one which is covered by the statute. It is not surprising, therefore, that the vast majority of sexual abuse reports are screened in - 90% in the Boston Region, 96% in the Greater Boston Region and 86% statewide (Table 6). These proportions are not substantially different from other types of abuse and neglect.

2. ASSESSMENT

As we noted in Chapter II, DPW has recently implemented a new computerized Child Information System. This system should not only be able to provide an ongoing picture of the types of cases reported to the department, but also a picture of the status of those cases (whether they were screened in/out, assessed in/out) and the nature of the services they receive.

[3] As we have noted in Chapter II, DPW may also refer cases to contracted private agencies for assessment and treatment.

TABLE 6

SCREENING OUTCOMES FOR SELECTED DPW REGIONS
JULY THRU DECEMBER 1978

| Statewide | Number of Reports Filed | Number Screened In | Percent Screened In |
|---|---|---|---|
| Sexual Abuse | 282 | 243 | 86.2 |
| Other Abuse and Neglect | 5339 | 4477 | 83.9 |
| Type Unknown | 1324 | 878 | 66.3 |
| Total | 6945 | 5598 | 80.6 |
| **Boston Region** | | | |
| Sexual Abuse | 50 | 45 | 90.0 |
| Other Abuse and Neglect | 854 | 801 | 93.8 |
| Type Unknown | 187 | 156 | 83.4 |
| Total | 1091 | 1002 | 91.8 |
| **Greater Boston Region** | | | |
| Sexual Abuse | 28 | 27 | 96.4 |
| Other Abuse and Neglect | 806 | 738 | 91.6 |
| Type Unknown | 40 | 32 | 80.0 |
| Total | 874 | 797 | 91.2 |

Source: DPW Office of Social Services

Before the development of this system, DPW did not have a mechanism for compiling much of this information on an ongoing basis. At the time our investigation was conducted earlier this year, the CIS was not yet fully operational. Only limited data on assessment outcomes and departmental services to cases of sexual abuse were available. The primary source of such data was a study recently released by the department which analyzed all cases reported to DPW during May 1978.[4] Since all of the statistical information cited in the remainder of this chapter stems from that analysis, it is important to note its limitations.[5] (1) It is based on data for only a one month period and thus may not be representative. For example: there were nine sexual abuse cases reported in the Boston Region in May 1978. Yet there were wide monthly variations throughout the year, ranging from three in September to 20 in October. (2) The number of sexual abuse cases in the sample (all regions) is fairly small and should be used cautiously as a basis for generalization. (3) The period included in the study occurred only one month after the current protective service model was implemented. The results may thus not reflect current circumstances, now that DPW personnel have had more time to learn and adapt to the new procedures. (4) The data were not collected on an ongoing basis but were drawn, after the fact, from case files. The results can therefore be only as accurate

[4] Protective Service Reports in May 1978: A Preliminary Description by Rosen, Newsom and Boneh; March 1979

[5] The authors of the study were quite candid in stating these limitations.

as the files themselves. For these reasons, the results of the DPW study, especially as they apply to sexual abuse, must be viewed as only suggestive, not as proof of specific trends. These data nonetheless represent the best information available at the time.

a. Assessment Outcomes. The data indicate that about half (50.8%) of all sexual abuse reports were assessed in as needing protective services (Table 7)[6]. This is a somewhat higher proportion than for either neglect or physical abuse (45% and 35% respectively) but lower than for cases in which both neglect and physical abuse occurred (63% assessed in). If these figures are accurate, they indicate that in one half of the instances of sexual abuse reported, DPW workers determined that there was no need for the department's protective services.[7] The 50% figure is substantially below the estimates of validated reports made by other agencies in the Boston area that have encountered fairly substantial numbers of sexual abuse cases. These agencies generally indicate that, in their opinion, from 80 to 100% of the sexual abuse cases known to them are valid - i.e., the abuse did in fact occur.

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[6]This figure includes only those cases reported during May 1978.

[7]It should be noted that the figures are based on those cases for which an assessment decision had been made at the time the DPW study was conducted. As Table 7 indicates, the number of cases in which no assessment decision had been made is fairly sizeable.

TABLE 7

ASSESSMENT OUTCOMES FOR CASES REPORTED DURING MAY 1978
ALL DPW REGIONS

| Type of Incident | Number Reported | Number With No Assessment Decision*** | Number Assessed In | Percent Assessed In** |
|---|---|---|---|---|
| Neglect Only | 773 | 113 | 294 | 44.5% |
| Abuse Only | 302 | 68 | 82 | 35.0% |
| Neglect and Abuse | 202 | 51 | 95 | 65.9% |
| Sexual Abuse | 77 | 16 | 31 | 50.8% |
| Unclassified* | 105 | 5 | 11 | 11.0% |
| TOTAL | 1459 | 253 | 513 | 42.5% |

* Report filed with no clear description of symptoms

** Percentages based on number of cases in which assessment decision had been made

*** No assessment decision had been made on these cases at the time the DPW study was conducted.

Source: Rosen, Newsom and Boneh - Protective Service Reports in May 1979, Massachusetts Department of Public Welfare.

This discrepancy is important and merits some discussion. First of all, there is no operational definition of "sexual abuse" that is universally accepted by all social service agencies. Interpretations of which specific behaviors constitute sexual abuse vary to some degree from worker to worker and from one agency to another. DPW procedures state that protective services are needed and a case should be assessed in if "the child has been the victim of a sex offense as defined in the criminal laws of Massachusetts".[8] As we have pointed out in Chapter II, however, the criminal laws do not and were not intended to provide clear practial guidelines for social service personnel to use in their work.

(2) It is also possible that reported cases in which abuse has in fact occurred and in which protective services would be beneficial are being assessed out by the department. Since definitions are vague and the diagnosis, investigation and validation of sexual abuse can be extremely complex, some mistakes will inevitably be made under any circumstances. Many service personnel in other agencies who have fairly extensive interaction with DPW believe, however, that the margin of error in DPW assessments is probably greater than this. They advance two primary reasons: (a) a lack of specialized skills in the area of sexual abuse; (b) high case-loads which limit the amount of time available for home visits

[8] Social Services Procedures Manual: Protective Services Procedures p. I-70

and intensive intervention generally. Some DPW workers have verified that this is indeed sometimes a problem.

(3) Official DPW procedures are not always followed by regional and local workers. While departmental policy clearly indicates that a case should be assessed in if the assessment worker determines that the child has been sexually abused, some DPW personnel indicate that this does not always happen.

A few examples will illustrate circumstances in which this occurs.[9] (a) If a case of incest is reported to the department by another agency, the case may be assessed out, even if the DPW assessment determines that the abuse did occur, if the worker believes that the child is not in physical danger and feels that the reporting agency is adequately handling the case. (b) If a report alleges that the abuse was committed by someone not living with the child, to take another example, a critical issue for DPW is determining whether the parents were at fault and failed to adequately protect or supervise the child. If the assessment worker determines that parental neglect or problems with the home environment did not contribute to the abuse, the case may be assessed out even if there is a clear indication that the abuse did occur.

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[9] These practices do not necessarily occur in all DPW regions. Variations from stated policy do not necessarily have the approval of central office staff.

(4) It is also possible that the types of cases reported to DPW are somewhat different in nature than those handled by other agencies - that cases reported to DPW are less likely to be valid. While there is no comparative data available on this, it is clear that most sexual abuse cases known to DPW are also known to at least one mandated reporter.

b. Response Time. Protective services procedures indicate that screening should be completed within two days (except for emergencies, which should be responded to in a matter of hours) and assessment within 45 days. Available data indicate, however, that this often does not occur with cases of sexual abuse - or with abuse and neglect cases generally. The screening and assessment process for the "average" sexual abuse case which was assessed in took about 46 days (Table 8). Many cases took considerably longer. This is comparable to the time required for physical abuse cases and somewhat better than for neglect cases (about 68 days). Regional variations are enormous. Screening and assessment for the average abuse and neglect case (regional data on sexual abuse alone are not available) in the Boston Region took over 90 days, and in the Greater Boston Region took about 57 days (Table 9).

Table 8

RESPONSE TIME FOR CASES* ASSESSED IN ALL DPW REGIONS

| Average Number of Days Between** | Sexual Abuse | Neglect | Abuse | Abuse and Neglect |
|---|---|---|---|---|
| Report and Screening Decision | .5 (27) | .7 (243) | .5 (72) | .4 (88) |
| Screening Decision and Assignment to Assessment Worker | 4.1 (19) | 9.6 (143) | 2.2 (51) | 6.2 (62) |
| Assignment and Completion of Assessment | 41.0 (14) | 57.9 (91) | 43.5 (34) | 56.9 (40) |
| Assessment Completion and Transfer to CSA | 19.1 (9) | 9.9 (58) | 14.0 (28) | 9.7 (33) |

* Refers to cases reported during May 1978.

** Numbers of cases on which averages are based are in parentheses.

Source: Rosen, Newsom and Boneh, p. 34

# TABLE 9

## RESPONSE TIME FOR CASES*: REGIONAL COMPARISONS ALL ABUSE AND NEGLECT

| Average Number of Days Between ** | Boston | Greater Boston | All Regions |
|---|---|---|---|
| Report and Screening Decision | 1.2 (110) | 4.6 (189) | 1.4 (1256) |
| Screening Decision and Assignment to Assessment Worker | 32.3 (93) | 12.1 (129) | 11.7 (711) |
| Assignment and Completion of Assessment | 62.2 (32) | 40.7 (64) | 43.5 (456) |
| Assessment Completion and Transfer to CSA | 21.8 (6) | 1.4 (21) | 11.0 (144) |

* Refers to all cases reported during May 1978 for which data was available, regardless of assessment outcome.

** Number of cases on which averages are based are in parentheses.

Source: Rosen, Newsom and Boneh, p. 28, 37

While these are certainly not encouraging results, it is quite possible that the situation has improved since these figures were compiled a year ago. Further, the meaning of these figures is somewhat obscure without a discussion of the DPW assessment process itself. It is that task to which we now turn.

c. The Assessment Process. Generally, assessment workers in most regions are assigned to cover specific geographical areas. There is little specialization in the assignment of sexual abuse cases to assessment workers. Partially because of the high caseload, such assignments are most often done on the basis of staff availability. Departmental personnel indicate, however, that sexual abuse cases are usually given a fairly high priority - often below that of physical abuse, but usually above neglect cases. This is supported by the data on response time just discussed. The statistics available at the time of our study also indicate that an emergency response is made in 19% of all sexual abuse cases which are subsequently assessed in (Table 10).[10] This percentage is roughly comparable to physical abuse cases and considerably above neglect cases. DPW personnel indicate that an emergency response is most likely to be made in cases of sexual abuse if the initial report indicated the child had been physically

[10] All of the data presented in this section refer to assessed in cases. Unfortunately, little is known about the response to cases which are not assessed in. Once again, we must caution that these data refer to only a one month period and are now a year old.

TABLE 10

RESPONSE TO REPORTED INCIDENTS* FOR CASES ASSESSED IN: ALL DPW REGIONS

(Percent of cases receiving indicated response)

| | Sexual Abuse | Neglect | Abuse | Abuse and Neglect |
|---|---|---|---|---|
| Emergency Response Made | 19 | 10 | 21 | 12 |
| Child Removed From Home as a Result of Incident | 39 | 36 | 33 | 39 |
| Home Visit Made | 68 | 84 | 87 | 88 |
| Interview/Observation Of Child | 74 | 83 | 84 | 86 |
| Phone Call Made to Private Agencies | 87 | 63 | 61 | 77 |
| | N = 31 | N = 294 | N = 82 | N = 95 |

*Reported during May 1978

Note: Percentages refer to cases in which the indicated response was recorded in the case record. They must be considered minimums.

Source: Rosen, Newsom and Boneh, P. 34

injured or was in imminent danger, and if the perpetrator and the victim both still remained at home together. In 39% of the sexual abuse cases the child was removed from the home as a result of the reported incident.

Home visits were made in 68% of assessed in sexual abuse cases - somewhat below other cases of abuse and neglect (Table 10). Phone calls were placed to private agencies in 87% of assessed in sexual abuse cases - somewhat higher than other cases.[11] The victim was interviewed or observed in 74% of the cases. These are minimum figures - that is, they refer to the number of times these incidents were noted in the case record (the quality of these records is not uniform). Nonetheless, the figures would appear to indicate that a substantial number of cases may not be getting sufficient attention during this stage (which covers almost a month and a half, on the average).[12] Since the intent of assessment is not merely to determine the necessity for protective services but to determine the type of services required and to remove immediate risk to the child, it is quite possible that some of these cases are not getting the attention that the adequate fulfillment of these tasks would require. Departmental personnel indicate that a maximum of three or four home visits could normally be made to a family during the 45 day assessment period. Even

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[11] These differences may be due in part to the fact that a higher proportion of sexual abuse reports appear to be filed by mandated reporters than occurs with other cases of abuse or neglect.

[12] cf Table 8.

when that number of visits is made, all of them may not be productive. The family may, for instance, not be at home or may refuse to cooperate. Because of the large number of physical abuse cases needing attention, DPW may sometimes not be able to focus on "unproductive" cases in which the physical danger to the child is not immediately obvious. In these types of cases, the abuse may have occurred but may remain unverified.

Earlier in this chapter we noted that official departmental procedures are not always followed by local and regional workers. While the degree of variation from official procedures undoubtably varies from region to region and generally occurs without the approval of departmental leadership, there is no doubt that it does happen. Although investigating this issue is not a primary purpose of this study, there are several aspects of it which should be metioned.[13]

Clear lines between screening, assessment and treatment do not always exist in practice. Assessment workers sometimes become actively involved in service delivery. Since one of the objectives of assessment is "to stabilize the situation in the family to the extent that the immediate risk of further harm to the child is resolved",[14] this is obviously essential to some degree. Some DPW workers admit, however, that the involvement of assessment workers in treat-

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[13] Most of the following discussion applies to abuse and neglect cases in general.

[14] Social Services Procedures Manual: Protective Services Procedures p. I-67

ment may exceed this - that some regional assessment workers have difficulty ending their involvement with a case once it is assessed in and should be transferred to a local office. The data presented earlier (Table 8) suggest that transfers of assessed in cases to the local level may not always occur on a timely basis.

When the transfer occurs, DPW procedures require a case conference between the outgoing and incoming case workers, and the notification of the family that the transfer is being made. A survey released last summer by the Office for Children (OFC) indicates that this did not usually occur a year ago,[15] and according to more recent observations by OFC representatives and some DPW personnel, it still does not occur in many instances.

It also appears that communication and coordination between the various levels of the department (central office, regions, local offices) could be improved. Some departmental personnel interviewed during the course of this study have noted that this is the case and some of our own observations have confirmed this. For example: aggregated data on sexual abuse tabulated by the Boston Regional Office (some of which has been presented earlier in this report) had not been distributed to many supervisory and line personnel in the Region six months after it had been compiled.

[15] Survey of the Implementation of the New Protective Services Model, p. 6-7

## 3. AN EVALUATION OF THE DPW RESPONSE

DPW has come under considerable criticism from other social service organizations for a lack of trained personnel, inadequate supervision of social workers, poor response time and other related factors. That some of these problems have existed in the past has been clearly documented.[16] It is also quite clear that the department has taken significant steps over the last year or so to improve the situation. Newly hired personnel are more highly qualified and improved training programs (including training in the area of sexual abuse) have been implemented. While these accomplishments are notable and illustrate a committment by the department to improved service delivery, they should be viewed as only the initial stages of an ongoing process - much still needs to be done.

With regard to sexual abuse specifically, many departmental personnel lack adequate experience and expertise. It is probably true that many workers are "over-matched" in dealing with difficult cases, of which there are many. While DPW is not alone in its lack of expertise in this area, the department's statutory role regarding abuse and neglect make this particularly noteworthy.

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[16] The OFC survey previously cited indicated that as of May 1978 65% of protective service personnel had less than one year of protective service experience and only 1/3 had masters degrees.

## C. Other Agencies

While other public and private agencies do not have DPW's legal mandate to provide services to victims of sexual abuse and their families, they must nonetheless take an active role if this population is to be adequately served. The majority of cases which are reported to the department are filed by mandatory reporters, who may have intervened in some manner before notifying DPW. Further, not all cases of sexual abuse known to other social service agencies are reported to DPW. Knowledge of the procedures used by these agencies is therefore critical to understanding the overall response to sexual abuse. While a detailed study of the procedures used by the wide variety of agencies in the Boston area was well beyond the scope of this study, we can comment briefly on the situation.

For the most part, service agencies that have reported a case to DPW indicate that they do take some form of action - either before they file a 51A or soon afterwards. They do not necessarily wait for DPW to investigate the case. The specific action taken, however, depends very much on the type of agency involved and is in many instances quite limited. Hospitals, for example, are most likely to provide medical care and are unlikely to make home visits or provide other crisis intervention services. Private family service agencies are more likely to focus on crisis intervention. Virtually no agency can provide all necessary services.

1. Hospitals. Hospitals play a large role in sexual abuse cases and in child abuse cases generally. They are one of the first institutions families turn to and are available 24 hours a day, although they can generally provide only very limited outreach services. The vast majority of hospitals, however, do not have either established procedures or personnel trained to handle sexual abuse, and some are not well equipped to deal with child abuse in general. Since many potential sexual abuse cases come through the emergency room, often with vague complaint, it is important that emergency room staff know what symptoms to look for and that personnel with some expertise in sexual abuse be on call to offer crisis services. Even more basically, physicians and hospital personnel must accept the fact that their responsibility extends beyond simply treating physical symptoms, and that they must give some thought to the source of those problems. Unfortunately this often does not occur.

Some hospitals, however, have made a concerted effort to develop services for sexually abused children. Boston City Hospital (BCH) and Children's Hospital Medical Center (CHMC) in particular have taken important steps not only in attempting to educate medical personnel in the diagnosis of sexual abuse, but also in providing crisis intervention and victim counseling. The clinical services at Children's Hospital are considered by some to be the best short-term services available in the Boston area. Both BCH and CHMC sometimes provide consultation to DPW and other agencies, but many agencies seem unaware of

the BCH and CHMC efforts, and in any case their capacity is limited. We must point out again that these two facilities are exceptions - most hospitals have little to offer. Even if more hospitals were to develop specialized skills in the area of sexual abuse, they would still be inherently limited in the services they could provide. Few hospitals, regardless of their level of expertise, can afford to develop an extensive outreach capability or offer a wide variety of social services.

2. Police.[17] The role of the police in the initial stages of intervention is also quite important. Local police departments are perhaps better equipped than any other agencies to offer an emergency response capability around the clock. Intervention in domestic affairs has always been problematic for law enforcement agencies, however, and most police personnel have little knowledge regarding sexual abuse. Most departments appear to be aware of their responsibility to report abuse and neglect cases to DPW and in general they do so. But aside from making emergency calls and filing reports with DPW, police involvement is fairly minimal.

Conflicts sometimes occur, however, between police departments and social service agencies, particularly over the filing of criminal charges. Not surprisingly, law enforcement agencies are more often inclined to feel that charges should be

[17] Other criminal justice agencies - the courts and District Attorneys' Offices in particular - are not generally involved in the initial stages of intervention. They will be discussed in Chapter VI.

filed than are social service personnel. Some police officials also feel that DPW should notify them of all 51A reports, so that they can decide whether criminal charges are warranted. Social service workers, on the other hand, sometimes criticize the police for overreacting to situations about which they have little understanding. The typical police officer undoubtably encounters too few cases of sexual abuse to develop much expertise.[18] Increased training opportunities for police would undoubtedly increase the sensitivity with which they respond to sexual abuse cases. These opportunities have expanded to some degree in recent years, as the Massachusetts Criminal Justice Training Council has offered courses, taught by knowledgeable professionals, on both rape and child abuse.

3. The Department of Mental Health. The department has been widely criticized in recent years for its perceived failure to offer services to children.[19] In general this criticism is probably fairly accurate with regard to sexual abuse. Public mental health facilities are not much involved in the provision of emergency services, and certainly it can be argued that this is not their role. They can, however, make important contributions during the diagnostic stage which often follows emergency intervention. But many agencies report only limited success in obtaining what they consider

[18] A recently published national study indicated that the average patrol officer handled less than two rape cases per year. The number of cases involving children is substantially lower. National Institute of Law Enforcement and Criminal Justice: Forcible Rape-Final Project Report. p. 25,31. A few police departments - Los Angeles, for example, have specialized investigation units for child abuse cases.

[19] See, for instance, Sheehan. The Children's Puzzle.

satisfactory services from DMH affiliated institutions. They feel that DMH intake processes are too time consuming and cumbersome, and claim that many clinics will not take cases for short-term diagnosis. DMH institutions generally deny that this is the case.

What does seem clear is that few reports (to DPW) of sexual abuse originate from public mental health clinics. Few DMH facilities have taken an active role in providing services to individuals and families involved in sexual abuse cases or have specifically attempted to develop expertise in this area. Some exceptions do exist. The child service division of the Somerville Mental Health Center, for example, has revamped its intake procedures to screen for abuse, has developed guidelines, and has tried to develop staff expertise in this area. These are certainly encouraging developments. Nevertheless, there are limitations to what can be done within the traditional clinical environment. Emergency and outreach services are particular problems.

4. Private Social Service Agencies. A large number of private agencies are involved in the provision of services in the child abuse area, including sexual abuse. Few people outside of these agencies themselves, however, have any in-depth understanding of their operations. While we were unable to devote much time to investigating these agencies in the course of our study, we can make some general observations. It appears that, while most of these agencies do not have well

developed expertise in the area of sexual abuse, they may in some respects be in a better position than DPW to offer a wide range of services in a more efficient manner. The larger, more established agencies have better working conditions, lower staff turnover, and more direct access to clinical expertise. Further, while the overall caseload (the number of active cases assigned to each worker) may not be lower than DPW's, the number of incoming cases is probably lower. They can therefore probably afford to spend more time on active cases without interruptions to handle incoming reports. It is also likely, although we have no firm proof of this, that they handle a higher proportion of less troublesome cases. They are less likely to handle cases filed by mandatory reporters (often against a family's will) and more likely to handle cases reported by a member of the family. Such cases may be no easier to deal with in a clinical sense, but may make access easier and involve less imminent danger to the child. The Department of Public Welfare has contracts with Children's Protective Services (CPS) and a number of other agencies, and can refer cases to them for assessment and treatment. The capacity of DPW to actively monitor such referrals is unclear.

It is also critical to recognize that the intake and diagnostic criteria of private agencies may differ substantially in some respects from those used by DPW. Private protective agencies such as CPS and Catholic Charities, for example, do not have the statutory responsibilities of DPW. They are therefore not concerned with "reportable conditions" under the law

per se, but with whether or not they feel a family could benefit by the service they have to offer. Some public agencies, including DMH clinics, use similar criteria.

5. Other Agencies. Other agencies play a more limited role. Schools for instance, once they have reported a case (if they do) generally do not provide other services. As we have said, it is only recently that many local departments have have begun to draw up reporting guidelines. There are some exceptions to this, such as the Revere School Department which has a Community Health Education Center that has become more active in developing a follow-up and referral capacity.

## C. Concluding Comments

Despite the primarily negative tone of much of this chapter, there is some cause for optimism. Sexual abuse is still an emerging issue but the resources for addressing the situation are improving. Although awareness and knowledge about sexual abuse is still years behind that of child abuse generally, both sensitivity and expertise have increased to some degree over the last several years. Most critics of DPW feel that the department has improved during the last 12 months and that those improvements have been felt in the handling of sexual abuse cases. Training opportunities in particular have increased. As we have noted, there are a few other agencies which have actively sought to develop specialized expertise. Several workshops on sexual abuse have been sponsored by local agencies over the past year and other seminars, such as those on rape and child abuse offered by the Criminal Justice Training

Council, have included some materials on sexual abuse.

# V. SYSTEM RESPONSE: LONG-TERM SERVICES

In addition to services provided during the crisis and investigatory stages just discussed, a wide range of longer-term services may also be necessary in cases of sexual abuse. Day care, foster care, homemaker services, individual, group, and family counseling are among the services which may be required for a family.

This chapter will be considerably less detailed than was our prior discussion of the initial stages of intervention. There are two reasons for this: (1) we did not have sufficient time to study long-term services in any depth; (2) there is simply very little activity in the area of long-term services provided to families in which sexual abuse has occurred. Our discussion will focus almost entirely on the provision of various mental health services. While other services such as foster care and day care are of course important, counseling services are probably more likely to be prescribed than are others.

## A. DPW Services

As we have noted, cases assessed in by DPW at the regional level are then transferred to a local office for ongoing treatment (or to a private agency under DPW contract). Unfortunately at the time of our study there was no hard data on the nature or frequency of services provided to families in which sexual

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1 OF 2

abuse has occurred, or on who actually renders those services.[1] The only DPW data available to us came from the study described in the previous chapter which analyzed cases which were reported to DPW during May 1978 and subsequently assessed in.[2] This study provides information only on services recommended by DPW assessment workers, not on services rendered. The department is currently undertaking a follow-up study to determine which services were actually provided.

The data indicate that services are recommended to assessed in sexual abuse cases 60% of the time (Table 11).[3] This is a somewhat lower proportion than for neglect (78%) or physical abuse cases (82%). Counseling was recommended 52% of the time, foster placement in 29% of the sexual abuse cases, and day care and homemaker services were recommended infrequently. In 32% of the sexual abuse cases, some other service - the nature of which is generally unspecified - was recommended.

These figures certainly raise as many questions as they resolve - questions to which we do not, for the most part, have answers. (1) Why were no services recommended in 40% of the sexual abuse cases which were assessed in?[4] In theory, cases are assessed in because ongoing protective services are necessary. (2) To what extent were recommended services actually

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[1] DPW's new information system should now be able to provide those data.

[2] Protective Service Reports in May 1978: A Preliminary Description, by Rosen, Newsom and Boneh.

[3] The figures presented here must be regarded as minimum estimates. They reflect only what has been recorded in the case records.

[4] This may be partially the result of poor documentation in the case records used by the DPW study.

# TABLE II

## SERVICES RECOMMENDED TO "ASSESSED IN" CASES ALL DPW REGIONS*

(Percentage of cases for which specified service was recommended)

| Type of Service Recommended** | Sexually Abused (N=31) | Neglected (N=294) | Abused (N=82) | Abused and Neglected (N=95) |
|---|---|---|---|---|
| Any Service | 60% (21) | 78% (229) | 82% (67) | 83% (79) |
| Counseling | 52% (16) | 54% (159) | 60% (49) | 53% (50) |
| Foster Placement | 29% (9) | 27% (79) | 28% (23) | 24% (23) |
| Day Care | 6% (2) | 14% (42) | 20% (16) | 12% (11) |
| Homemaker | 3% (1) | 12% (34) | 2% (2) | 14% (13) |
| Other*** | 32% (7) | 19% (53) | 15% (13) | 23% (22) |

* Refers to cases reported during May 1978

** Number of cases on which percentages are based are in parentheses.

*** For the most part, the precise nature of these services is unknown.

Source: Rosen, Newsom, and Boneh, page 34.

provided? (3) For whom was counseling recommended - the victim, the victim's mother, or other family members? (4) While a lower overall proportion of sexual abuse cases had services recommended than did other abuse and neglect cases, the proportion recommended for specific individual services is not generally lower. This may indicate that sexual abuse cases are more likely to be recommended for multiple services.

## B. Long-Term Treatment - An Overall Assessment

As we have just seen, counseling is the service most often recommended by DPW for sexual abuse cases. This is probably even more true of other social service agencies. There are a wide range of mental health services that may be necessary, including individual, group and family counseling. Members of a single family may in fact require each of these types at some point in time.

Unfortunately, it appears that effective long-term treatment does not occur in many cases in which it would probably be beneficial. While there are, as we have noted, a few agencies which do have some specialization in the area of sexual abuse, they focus primarily on crisis intervention and diagnostic services. Aftercare has received considerably less attention. There are three primary reasons for this.

1. Lack of professionals willing or qualified to provide appropriate services. There are several interrelated aspects to this issue. (a) Specialized knowledge and skills regarding sexual abuse are simply not widespread. Many competent clinicians have not had extensive experience with these cases. Where some specialization does exist, the focus is most often on individual treatment (the traditional and most widespread mode of mental health services) and not on family therapy, which many experts believe to be essential to maximizing the chances of keeping families intact.

(b) Some agencies with a role in emergency response, such as hospitals and police departments, are not generally oriented toward long-term social services. Other agencies which do offer some long-term services must prioritize their activities. For many, including DPW, this often means that crisis intervention and emergency situations must take precedence over cases that are not in the crisis stage. The impact of this may be felt in staff deployment and in the capacity to follow up on referrals. This does not necessarily mean that DPW or other agencies are not concerned about the issue, but plans to provide long-term services may often be altered when unexpected crises occur.

(c) The lack of interagency cooperation and coordination inhibits the efficent use of those resources which are available. This is a critical issue and will be discussed momentarily.

2. Lack of incentives for families, especially father/offenders, to participate in long-term treatment. Particularly in cases which are not reported by a family member, families may be reluctant to admit they need services, especially after the initial crisis has passed. The complicated family dynamics often involved in incest cases play a major role in influencing families to refuse services. While the use of Care and Protection proceedings may be useful for assuring that the child is safe from further abuse, it is more difficult to utilize them as an incentive for families to accept mental health services. Criminal prosecution, or the threat thereof, is probably a more effective motivating force but is seldom used and has other drawbacks. Many social service professionals, especially in the mental health field, are unfamiliar and uncomfortable with clients who do not voluntarily request services (the "coercive treatment" issue). They do not have much experience with the courts generally, and both academic training and general institutional practices lead them to view forced treatment skeptically.[5]

One of the major results of this is that even in cases in which various family members may receive some services, families as a whole seldom do. This decreases the likelihood that separated families will be successfully reunited. Work with father/offenders is particularly limited.

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[5] This will be discussed further in the following chapter.

3. Lack of interagency communication and coordination. The impact of this on crisis intervention was noted in the previous chapter. Its effects on long-term services are similar. Referrals may be difficult to arrange and when they can be arranged there may be delays in the provision of services. Follow-up information either may not be requested or may not be obtained on a consistent basis. Services may often be fragmented, with different agencies serving different family members and inadequate attention paid to the family as a whole.

Many of the conflicts are due in large part to the differing priorities and professional philosophies of the agencies involved.[6] DMH, for instance, has no legislative mandate in the child abuse area and abuse cases may often be dealt with under the same procedures as other cases are. On the whole, the prevailing mental health philosophy gives preference to people who seek services voluntarily and with whom workers believe progress can be made. In many cases there are no real outreach efforts to bring in those who don't keep appointments. While such an approach may be adequate for the delivery of mental health services to more "traditional" clients, it is probably not appropriate for child abuse.

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[6] See Newberger.

The Department of Mental Health has the most extensive set of treatment skills of all public agencies, but most other agencies do not report great success in getting DMH to provide what they consider satisfactory services. While there certainly is variation among DMH clinics, and several have become active in the sexual abuse area, many agencies report that placements with DMH are difficult to make and that cases are sometimes refused. Others say that the quality of services, especially for juveniles, could be improved, and that intake procedures are often long and cumbersome. Hospital-based clinics are generally more severly criticized than community mental health centers. Private agencies offering counseling services are reported to be somewhat more cooperative. Many DMH clinics deny these allegations and charge that other agencies may try to "dump" their difficult cases on them.

DMH officials have recognized some of the problems with children's mental health services. Nine million dollars in the department's most recent budget request have been identified as being for children's services. Local clinics, however, retain a fairly substantial degree of autonomy in setting their service priorities.

No single agency, including the Department of Public Welfare, has the skills and resources to offer a full range of effective long-term services to families in which sexual abuse has occurred. This is a situation of which many DPW personnel are aware. Though DPW must be involved in long-term case management, it is imperative that DPW seek services

from other agencies that have the skills and resources to respond effectively to the specialized needs of sexual abuse cases. It is also imperative that other agencies, public and private, accept their responsibility to provide these services. We must emphasize that DPW cannot be held solely responsible for providing services in this area.

# VI. THE LEGAL SYSTEM

The legal system has an important role in the response to sexual abuse - and to child abuse generally. It is ultimately the authority of the court which is necessary to remove a child from the home or to impose sanctions on an offender. This chapter will discuss some of the major issues surrounding the use of both Care and Protection petitions and criminal proceedings in cases of sexual abuse, and will point out the major criticisms of the current system. As was the case with long-term services, we have been unable to study this area in as much detail as we would like.

Many reported cases of sexual abuse do not enter the criminal justice system, and many of those that do never get to court. As a result many court personnel are not as familiar with the issues involved as are social service agencies. Partially for this reason, they are less likely to perceive a problem with the way sexual abuse cases are managed and the level of services provided. As we have seen, few sexual abuse cases are reported to DPW by court personnel - by the time a case has been brought to court, at least one agency is already involved and the case presumably has already been reported by that agency.

DPW data on sexual abuse cases assessed in during May 1978 indicate that 42% had some form of court involvement, compared to 23% and 30% of other abuse and neglect cases

respectively.[1] Although there were no statistics available, either from DPW or the courts, those interviewed during the course of this study indicated that the vast majority of these were involved in Care and Protection proceedings and that the filing of criminal charges is relatively infrequent. The proportion of cases with some form of court involvement is probably somewhat lower for other agencies.

## A. Care and Protection Proceedings[2]

### 1. SERVICE AGENCIES

Although Care and Protection (C&P) proceedings are used in only a minority of cases, they are of great importance. The initiation of the C&P process is a serious step, often ultimately resulting in the separation of the family, at least temporarily. DPW personnel indicate that they file Care and Protection petitions under two general circumstances: (a) in the initial stages of an investigation DPW workers may seek a petition if the child is in clear danger of further injury, or if they feel danger is possible and the parents deny access to the child or refuse to cooperate in the investigation; (b) in later stages of a case, a petition may be sought as a "last resort" if the danger of serious injury increases or if

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[1] Source: DPW Office of Social Services.

[2] The Care and Protection process in general has come under some criticism and several proposals for reform of the statute have surfaced. It is not our intention to discuss this issue, but to focus more specifically on the use of the C&P process in sexual abuse cases.

parents refuse services that the department considers essential. DPW may sometimes use the C&P process as a lever, seeking legal custody of the child, but not necessarily physical custody.

Many professionals in other service agencies believe that DPW uses C&P's too frequently - that children are unnecessarily removed from the home and that department personnel are sometimes too interested in "covering themselves" even if the case may not warrant court action. The recent wave of publicity surrounding child abuse is believed to be partially responsible for this. There is particular criticism of the department's use of preliminary hearings to get emergency custody in cases where parents have refused to cooperate in an investigation. Some feel this is overused. There is no hard data to either confirm or deny these allegations, however.

Although it is fairly obvious, we should point out that judgments about the necessity of court action are not easy to make. The consequences of making an incorrect decision, moreover, can be serious ones, resulting either in the unnecessary removal of a child from his/her home, or in the continuance of unnecessary risk. Whatever DPW's possible shortcomings in this area, it is clear that the department's knowledge of C&P procedures and familiarity with the court process is greater than that of many other agencies. This is especially true in the case of mental health professionals, many of whom are wary of the legal system and unsure of how

to use it.

2. THE COURTS

Perhaps the most widespread characteristic of the courts themselves is their inconsistency. It is the feeling of many social service personnel that the courts vary widely in their conduct of C&P proceedings. They feel that some courts do not really understand the law and the procedures involved, though this problem is much more likely to occur in the district courts than in the juvenile courts.[3] Some judges, moreover, may require extensive evidence before removing a child from the home and may in fact virtually always refuse to do so. Others may require only very limited evidence. Many also believe that judges' decisions are often not made on the basis of all available information and that the reports of appointed court investigators are inconsistent in content, quality and extent of documentation.[4] The courts have also been criticized for unnecessary delays and continuances which result in hardships to victims and their families. Judges (and social workers) may change in the course of a case (from one continuance to another), resulting in a lack of continuity. Cases may sometimes be continued with no date set for review.

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[3] Of the 1372 Care and Protection petitions (for all types of abuse and neglect) filed during the fiscal year 1978, 964 (70%) were filed in the district courts, and 408 in the juvenile courts of the Commonwealth. (Source: Annual Report of the Office of the Chief Administrative Justice of the Trial Court, 1978. Published March, 1979)

[4] Also see Mintzer, p.5

Court personnel also vary widely in their knowledge of child development and family dynamics, and in their sensitivity to children. Although the juvenile courts are better in this regard than are district courts, many social service personnel believe that virtually all judges could benefit by increased training in these areas. Knowledge of sexual abuse is a particular problem. While most social service professionals lack much expertise and experience in dealing with sexual abuse, judges have even less knowledge and experience. Probation officers are generally more knowledgeable than judges about social service and child developement issues, but this also varies greatly from one court to another. It is clear from our investigation that many probation officers, even when they are aware of the available resources to deal with sexual abuse, have little knowledge of the quality of the services that are actually rendered.

## B. The Criminal Process

There is little information on the use of criminal proceedings in sexual abuse cases in Massachusetts.[5] It appears, however, that compared to C&P petitions criminal charges are seldom filed, especially in incest cases. Charges are most likely to be filed if the police had some initial involvement

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[5] The Research Division of the Office of the Commissioner of Probation is currently conducting a study of child abuse, including sexual abuse. When completed during the summer of 1979, this study will provide a wide range of statistics on criminal cases involving sexual abuse.

in the case. As we noted in a prior chapter, there have been disagreements between social service agencies and local police, with some police departments wanting notification of all abuse reports so they can decide if criminal charges are warranted. Conflict may be more likely, however, with District Attorneys' offices (DA). DPW personnel believe that some District Attorneys' offices are too eager to file charges without fully understanding a case and that they want to consider all reports of sexual abuse as potential criminal complaints which merit investigation.

The main reason social service agencies do not often seek to have criminal charges filed is perhaps an obvious one: they are oriented toward the provision of services and do not generally see involvement in the criminal process as consistent with that goal. Most experienced professionals agree that the criminal process itself can be very hard on the victim.[6] Establishing evidence to find a defendant guilty beyond a reasonable doubt may not be an easy task. Children, especially young ones, may not make "good" witnesses: their memories are not as long or explicit as adults', they can be easily confused by defense attorneys, and they may be awed, upset or bewildered by courtroom decorum and procedures. Trial delays also contribute to the problem and may result in charges being dropped.

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[6] See, for example, Berliner and Stevens; Burgess et al; National Institute of Law Enforcement and Criminal Justice, Forcible Rape: A Manual for Filing and Trial Prosecutors.

The difficulties caused by these legal and procedural issues may be exacerbated by the personal behavior of some judges and attorneys, as well as by societal norms which make it difficult for jurors to believe that "respectable" people would sexually abuse their children. A recently completed national study of rape, funded by LEAA, found that 92% of the prosecutors surveyed believed that victim credibility was a major problem in getting juries to convict.[7] The lack of expertise in child development in general, and sexual abuse in particular, is a much more severe problem in criminal cases than in Care and Protection proceedings. Another recent LEAA report documents that many prosecutors still hold to some of the myths surrounding rape.[8] This is supported by the experience of many in Massachusetts. Further, most District Attorneys' offices have no written procedures for filing rape cases, no special guidelines for interviewing victims, and few victim support services.[9]

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[7] National Institute of Law Enforcement and Criminal Justice, Forcible Rape: A National Survey of the Response by Prosecutors. p. 28.

[8] National Institute of Law Enforcement and Criminal Justice, Forcible Rape: A Manual for Filing and Trial Prosecutors. p. 1.

[9] Forcible Rape: A National Survey of the Response by Prosecutors. pp. 3, 10, 21, 23.

## C. The Courts and Social Services

The major impact of this is that social service agencies and the courts often do not work together effectively on sexual abuse cases. The two systems have differing philosophies and knowledge bases and often work at cross-purposes. It is clear from the experience of other states, however, that the criminal and C&P processes can be used more effectively.

The major issues involved are whether to keep families intact and how to provide long-term treatment services to victims and their families. It is probably not much of an exaggeration to say that the only ones who generally get these services now are those who either voluntarily request them or accept them readily if they are offered. In many cases, families are not quite so cooperative and the failure of social service agencies and criminal justice agencies to cooperate with each other often results in a failure to provide services, even in those instances where personnel are available to offer those services.

As we have stated several times earlier, the coercive treatment issue poses a dilemma for many social service practitioners. Though successful sexual abuse treatment programs in other states illustrate that the leverage of the court is often necessary, there is no unanimity on this issue in Massachusetts, especially among those who lack experience in dealing with sexual abuse. Mental health personnel with expertise in the area of sexual abuse are generally

aware that some form of leverage, whether explicit or implicit, is often necessary. The issue for them appears to be how that leverage should be brought about and the role they should play in the process. Should mental health professionals, for instance, take an active role in pressuring families into treatment, or should they leave this task to court personnel and the Department of Public Welfare?

Many programs in other states have found criminal proceedings to be more effective for these purposes than C&P type processes.[10] Criminal proceedings can bring direct pressure to bear on the father/offender. The intent of many of these programs is not necessarily to prosecute cases all the way but to use the threat of prosecution as an incentive for families to accept services. In many instances cases may be continued or counseling used as a condition of probation.

Cooperation between courts and social agencies in states where these programs operate has generally not occurred on a system-wide basis or primarily because of the enactment of new laws or procedures. Rather, the cooperation has often stemmed initially from the formation of mutual understanding on a more informal basis which then became institutionalized over time. For this to occur in Massachusetts, certainly more communication between social service and criminal justice

[10] Perhaps the best known program is the Child Sexual Abuse Treatment Program which operates out of the Juvenile Probation Department in Santa Clara County, California. See Appendix B for a brief description of this and other programs.

agencies and agreement on goals and strategies of intervention must occur. As we have seen, however, many social service agencies are not themselves in complete agreement on these matters.

# VII. PROGRAMMATIC IMPLICATIONS

This study was not designed to produce specific policy recommendations; such an effort would entail an investigation and comparison of alternative programs and policies which is well beyond our resources to conduct at the present time. We can, however, discuss those programmatic needs perceived by persons interviewed in the course of the study. Further, we can draw some general conclusions about certain factors which we believe have an important bearing on future policy choices.

## A. Areas For Further Investigation

Before beginning this discussion, we should mention several important topics which we were unable to address sufficiently in this report: (1) prevention, (2) adolescent services, (3) private sector agencies.

### 1. PREVENTION

While we did not study current abuse prevention efforts, many service personnel interviewed in the course of the study felt prevention to be of critical importance.[1] Some professionals take a fairly broad view of sexual abuse (and abuse in general) and view it as one sympton of family dysfunction. They believe that in the long run prevention efforts are essential to decreasing the incidence of abuse, and that such efforts should focus on family functioning in

[1] For some, this has been a long-standing concern. See, for instance, the 1973 report of the Massachusetts Committee on Children and Youth.

general and avoid excessive labeling of types of problems (e.g., "neglect", "sexual abuse").

Many also feel that prevention and effective treatment may be closely linked - that those who experienced some type of abuse as children and who have not come to terms with the resultant problems are more likely to abuse their own children. While there is some disagreement regarding the application of this to sexual abuse, it certainly merits investigation.

2. ADOLESCENT SERVICES

In recent years there has been much discussion in Massachusetts about the adequacy of services for juveniles and for adolescent girls in particular. The lack of facilities for adolescent victims of sexual abuse was a recurring theme in our interviews. 42% of the cases of sexual abuse (both male and female victims) reported in DPW's Boston Region[2] involved victims 13 years old and over. Many agencies working with runaways believe that sexual abuse is a major problem with this population.[3] The National Network of Runaway and Youth Services has in fact made services for adolescent victims of abuse one of its top priorities for the coming year. Many such cases, however, are not reported to the Department of Public Welfare and the actual incidence remains unknown.

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[2]During the period from February to October, 1978. See Chapter III.

[3]In 1976-1977 62% of all CHINS runaways in Massachusetts were female. See ABT Associates study, p. 37.

By its own admission DPW gives priority to abuse cases involving younger children whom it believes are generally more likely to sustain serious injury. Problems in finding foster care placements for adolescent victims of sexual abuse are particularly acute. Many of the criticisms of the Department of Mental Health focus specifically on its lack of attention to adolescent services. While this study has not been able to address the issues involved in adolescent services directly, many believe the problems in this area to be among the most urgent social service issues facing the Commonwealth.

### 3. PRIVATE SOCIAL AGENCIES

Private agencies comprise a major part of the protective services system. While we have discussed some aspects of the services offered by these organizations, these discussions have been fairly general. Many public agencies have limited contact with private agencies, and little knowledge of how they operate. Indeed the inability of state agencies (Department of Public Welfare, Department of Youth Services, Department of Mental Health, Department of Education) to monitor the services provided by private agencies with which they have contracts has been widely criticized.[4] Private agencies, moreover, provide many services which are not financed through government contracts, and even less is known about these services. The quality of

[4]DPW has recently established a Performance Evaluation Unit in order to upgrade its monitoring capabilities.

services provided by private physicians, psychiatrists and psychologists is virtually a mystery, although they are widely believed to be reluctant to report cases of sexual abuse and DPW data (See Chapter II) indicate that they in fact report few cases. This study has not been able to shed much light on the role of private sector organizations in intervention in cases of sexual abuse. Considerable work remains to be done before we attain an adequate picture of their services and practices in this area.

## B. Suggestions for Service Improvement

The interviews and discussions conducted during the course of this study suggest four types of activities which service professionals feel would improve the range and quality of services available to victims of sexual abuse and their families. Although unamimity does not exist with regard to these suggestions, agreement is fairly widespread. While all of these activities could indeed substantially improve services, we have not attempted to prioritize them or to formulate specific recommendations. The activities or general program types are the following:

(1) Education for a wide range of social service and criminal justice professionals regarding the nature of sexual abuse, basic intervention strategies, and the availability of resources. While not everyone can or should become an "expert", most professionals should become familiar with the basic issues.

(2) In-depth training to selected professionals in a variety of agencies who will specialize in offering direct services to families involved in sexual abuse. Mechanisms for ongoing feedback and access to clinical consultation should be important components.

(3) Establishment of a comprehensive sexual abuse program which would offer a wide range of services to all family members at all stages of intervention.[5]

(4) Development of mechanisms for increased inter-agency cooperation and communication. This has been a recurring need throughout all stages of our investigation.

## C. Conclusions

Although we are making no concrete programmatic recommendations, our research does, we believe, lead to a number of conclusions which have implications for programmatic choices. The following statements are not intended to be a summary of our findings (see Executive Summary) but a delineation of conclusions which flow from those findings.

(1) From some perspectives, the number of known cases of sexual abuse is not that large - that is, since there is little specialization in service delivery, such

[5] There is little agreement on where such a program should be located. This is a complicated issue and will be discussed in the following section.

cases comprise a relatively small portion of most agencies' caseloads.[6] To some extent this has allowed the lack of expertise and lack of adequate services to go unnoticed. There can be no doubt, however, that a problem does exist. This fact should not be obscurred by the fragmentation of service delivery or by deficiencies in agency records.

(2) Improvement of the entire protective services system would obviously bring about some improvement in the handling of sexual abuse cases. The delivery of adequate services to these cases, however, necessitates more than such general actions, however important they might be. Steps must be taken which directly address the lack of awareness and expertise regarding sexual abuse.[7] Any such steps should of course be considered within the context of current developments in the social services area (such as the implementation of the Department of Social Services, implementation of the Family Abuse Prevention Act, the Comprehensive Emergency Services programs being established in several areas of the state, etc).

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[6] It must also be considered that many if not most cases of sexual abuse never enter the protective services system.

[7] As we have discussed earlier some encouraging steps have been taken in the last year or so, among them the staff training in the area of sexual abuse now being provided by DPW.

(3) Perhaps the most basic policy choice to be made regarding specialized services for sexual abuse cases is the following: should a relatively small number of specialized programs or units be encouraged, or should the skills of a larger number of agencies be developed so that cases can receive services on a more decentralized basis? There are, of course, more than two alternatives here - these two options are really points on a continuum of choices.

(4) The development of any new direct service programs should be tied to the establishment of more direct linkages between agencies, especially between service agencies and the courts. The lack of these linkages is such a critical factor in preventing the efficient use of those skills and services which already are available, that the program development process should include the establishment of an adequate interagency base.

(5) While a number of comprehensive programs have been developed in other states, the organizational location and service focus of these projects varies. Programs have been established in the courts (e.g., the Child Sexual Abuse Treatment Program of the Santa Clara County (California) Juvenile Probation Department), in state child protection agencies (e.g., the Sexual Trauma Treatment Program of the Connecticut Department of Children and Youth Services) and in hospitals (e.g., the Sexual Assault Center of Harborview

Medical Center in Seattle, Washington).[8] It is not clear which of these (or other) models is best and it is quite possible that the appropriateness of each is dependent on prevailing circumstances. Each of the above projects, for instance, serves a somewhat different population, sees cases involving varying degrees of physical injury, and exists in a different community and service environment. If a comprehensive sexual abuse program is contemplated for Massachusetts, the strengths and weaknesses of existing models should be carefully examined in light of the conditions within which such a program would actually operate.

(6) More detailed and reliable sources of information on sexual abuse cases, including information on treatment outcomes, are needed on an ongoing basis. Otherwise, much of the present confusion will continue and it will be extremely difficult to make future policy decisions on an informed basis. Because of its central role, improved data from DPW is especially critical. The new Child Information System recently implemented by the department should represent a great improvement in the quality and timeliness of data available. Many other agencies, however, remain highly deficient in this area. Some now have no clear idea of the number of

[8] A brief description of these three programs may be found in Appendix B.

sexual abuse cases in their caseload. While it is always difficult to commit time and money to data procedures or systems when pressing needs exist for direct services, without some improvements our knowledge about sexual abuse will remain fairly limited.

# APPENDIX A

# INTERVIEW GUIDE

# INTERVIEW GUIDE

The following set of questions is indicative of the range of issues explored during the personal interviews conducted by the author during the course of this study. In some interviews additional questions were asked, in other cases some of the questions listed were inappropriate.

1. About how many cases of sexual abuse (per month or per year) does your program (department, office) handle?
2. How do you generally become aware of these cases?
3. When you are handling cases which ostensibly do not involve sexual abuse (e.g., emotional problems, truancy, physical abuse) do you ever attempt to discover if sexual abuse has also occurred?
4. Could you describe some of the characteristics of the children and adults involved in cases of sexual abuse, e.g., their sex and age?
5. What proportion of cases involve a perpetrator who is a member of the victim's immediate family?
6. In your opinion, what are the primary purposes of intervention?
7. What procedures do you follow if you discover a suspected case of sexual abuse (or if someone reports one to you)?
8. At what point in the process do you report instances of sexual abuse (or suspected abuse) to the Department of Public Welfare?
9. What proportion of the suspected cases that come to your attention are actually verified upon investigation?
10. What form of action do you take after you report a case to (DPW) protective services personnel?
11. In what proportion of the sexual abuse cases your agency handles is the child removed from the home?

12. What types of services are you able to offer to the victim or her family?

13. Who actually provides these services?

14. To whom are these services normally provided - the victim alone, family members (parents, siblings)?

15. Are there any special problems which occur or any special services which are necessary for cases in which the victim and the adult are members of the same immediate family?

16. Do DPW protective services personnel generally contact you when they investigate cases which you report? What role do you play in these investigations?

17. How long does it generally take DPW personnel to complete these investigations? Do you feel that this is a reasonable amount of time?

18. Do you generally agree with the conclusions of these investigations?

19. If protective services personnel complete an investigation and verify that services should be provided, what happens to your involvement in the case? (e.g., Does DPW take over responsibility for treatment? Does it ask you to provide treatment but manage the case itself? Does it ask you to manage the case)?

20. Does DPW ever refer sexual abuse cases to you for services? How often?

21. How are those cases managed - who determines the course of treatment?

22. Do you feel that you have sufficient resources to provide services for those cases of sexual abuse for which you are currently responsible? (scope of services, staff expertise).

23. Which agencies do you refer cases to for services?

24. What follow-up procedures do you use when you contract for services or refer cases to another agency?

25. What is your assessment of the ability of other agencies to render adequate services to those involved in sexual abuse cases, both in terms of the quality and type of services available? (DMH, DPW, schools, hospitals, courts, private agencies).

26. How often and under what circumstances do you file C&P petitions in cases of sexual abuse?

27. Overall, what is your assessment of the role of the courts in sexual abuse cases? Are they used too much/too little? Are judges, probation officers, attorneys, and police officers sensitive to the issues involved in cases of sexual abuse and aware of the impact of court proceedings on the child?

28. Why are C&P's usually filed and at what point in a case is the C&P process usually initiated?

29. About how often are criminal charges filed against the adult involved? Under what circumstances do you feel this is appropriate?

30. Are there any problems which occur when children are used as witnesses, for instance, with regard to a) the impact of court proceedings on the child; b) the child's credibility as a witness?

31. What are the major problems you encounter in dealing with cases of sexual abuse?

32. Viewing the system for handling sexual abuse cases in its entirety, which types of programs are most needed at the present time (public education, specialized treatment programs, crisis intervention, diagnostic services, legal advocacy, programs to improve inter-agency coordination, etc.)?

# APPENDIX B

# PROGRAM DESCRIPTIONS

I. SEXUAL TRAUMA TREATMENT PROGRAM
CONNECTICUT DEPARTMENT OF CHILDREN
AND YOUTH SERVICES

II. CHILD SEXUAL ABUSE TREATMENT PROGRAM
SANTA CLARA COUNTY, CALIFORNIA

III. SEXUAL ASSAULT CENTER
HARBORVIEW MEDICAL CENTER
SEATTLE, WASHINGTON

This appendix briefly describes three sexual abuse treatment programs currently in operation in other states. These descriptions are not all-inclusive and are intended only to illustrate the range of program models available.

## I. SEXUAL TRAUMA TREATMENT PROGRAM, CHILD ABUSE AND NEGLECT DEMONSTRATION CENTER, CONNECTICUT DEPARTMENT OF CHILDREN AND YOUTH SERVICES

The Connecticut program, funded partially by a grant from the U.S. Department of Health, Education and Welfare, is an example of a project located in a state child protection agency. Cases of sexual abuse handled by the program are those encountered by the Department of Children and Youth Services as part of its statutory responsibilties. The program provides a wide range of crisis and long-term services, including individual and group therapy and victim support services to those who are involved with the courts. The program focuses primarily on victims, their siblings and mothers (most perpetrators are male). Work with father/offenders is more limited. A team approach is used, with a minimum of two intervenors assigned to each incest case - one with primary responsibility for the victim, the second for the mother, a third for other family members if necessary.

The program has found the criminal process more effective for assuring treatment than juvenile court proceedings and has worked to develop working relationships with criminal justice personnel. A judge by judge, attorney by attorney approach was

necessary in order to begin to establish mutual understanding and expectations.

## II. CHILD SEXUAL ABUSE TREATMENT PROGRAM, JUVENILE PROBATION DEPARTMENT, SANTA CLARA COUNTY (SAN JOSE), CALIFORNIA

This program, which specializes in incest cases, is linked directly to the criminal justice system and accepts referrals primarily from criminal justice agencies in cases where criminal charges have been filed. Since initial intervention has already occurred in most cases, the primary focus of the program is on long-term rather than crisis services. Services are provided to victims and all family members including father/offenders. The criminal process provides the necessary leverage, with involvement in the program being imposed as a condition of probation or recommended at some other stage of the trial process.

The project utilizes many modes of counseling - individual, group and family - as they become appropriate for a particular family. Through a close relationship with Parents United, the project also maintains a self-help component which is a key part of its operations. The program probably serves a more middle class population than the other two projects discussed here. Perhaps the most distinctive feature of this program is the combination of criminal sanctions with a therapeutic approach. The program began slowly by enlisting the support of only a few judges and prosecutors. Support became more widespread after the program had proven its effectiveness. Although some particularly unusual or serious cases are screened out of the program, it reports an impressive success rate in reuniting families and preventing the reoccurance of abuse. The project has been

designated as a model by the California Legislature and several areas of the state have already implemented adaptations of the program.

## III. SEXUAL ASSAULT CENTER, HARBORVIEW MEDICAL CENTER, SEATTLE, WASHINGTON

Because of its hospital affiliation, many of the cases of sexual abuse served by this program come through the emergency room, although referrals from other sources are also taken. The program serves a somewhat different population than the San Jose project and sees a greater number of cases in which some physical injury to the victim has occurred. Medical services and crisis counseling are provided, as well as advocacy and support in those cases where there is court involvement. Long-term services are also offered, but this is not the primary focus of the program. While both victims and their families are treated, the program itself does not provide direct services to offenders on an on-going basis. Offenders are referred to other practitioners for treatment. Incest cases are reported to the state protective services agency. While the program does not have formal ties with the courts, program staff work closely with the sexual assault unit established by the King County (Washington) District Attorney.

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