PRACTICE

INTERDISCIPLINARY TEAMS: DO THEY HELP VICTIMS OF CHILD ABUSE?

—by Robert M. Reece

There are no good data to support the view that interdisciplinary teams have a positive impact on the prevention, treatment, or outcome of child abuse cases. Outcome measures relying on crude measures of success for clients are fraught with imprecision owing to the enormous complexities of such families, confounding variables, and effect modifiers. Case-control studies are lacking, leaving us with experience alone to assess the efficacy of particular models of service delivery.

Outcomes of interdisciplinary team functioning can and should be measured, to give us more accurate guidance on the value of such teams. They have strong advocates throughout the child protection world, however, because when such teams are functioning optimally, the positive effects experienced by both professionals and clients are numerous: better coordination of the diagnostic process, a stable working relationship promoting better communication among team members, richer case-specific information, a broader, deeper fund of knowledge because of the sharing of information across the disciplines, and the security of group support helping to prevent burnout.

How have interdisciplinary teams evolved? The interdisciplinary team model was utilized formally and informally in a variety of settings long before child protection teams began to make use of it. Within the health care field, interdisciplinary teams were used to organize services for the large numbers of multiply handicapped children resulting from the polio epidemics of the 1930's and '40's. This model was then used within hospitals to serve children handicapped from many other congenital and acquired diseases.

It was natural to follow this proven success within hospitals to deal with equally complex problems of child abuse. In 1958, C. Henry Kempe organized one of the first hospital-based child abuse teams, at the University of Colorado Hospital. Since then, such teams have been forged in cities, counties, regions, states, and on a national scale.

Within some smaller units of government—cities and towns—the interdisciplinary model has been organized with the legally mandated child protection service agency (Department of Social Service, Department of Human Services, etc.) as the convening body. The elements of these teams are usually the governmental social service agency, the prosecutor's office, law enforcement representatives, medical personnel, and members of the judiciary. Depending upon local conditions, mental health professionals, nurses, guardian-ad-litem groups, and victim witness advocates may also be members.

The functions of the team vary, with case review being the sole focus in some, while others see direct service delivery and case review as their goals. The commitment to education, research, and evaluation of outcome depends on the orientation, resources, and level of sophistication of the team.

The next level of evolutionary development of community-based interdisciplinary teams is best exemplified by the child advocacy center. In this model, the same agency representatives described above are participants, but the important difference is that the agency is governed by a non-profit advisory board whose members include leaders in the political and private sector and representatives from all the component agencies.

The Child Advocacy Centers's "one-stop shopping" streamlines the process for everyone, most importantly for the child and family. For child protection workers—who are generally undervalued, and get attention only when they make mistakes— cooperating in such a model enhances professional identity and self-esteem.

By lifting the mission of the child advocacy center above the vested interests of the individual components, no particular discipline dominates the group process, and all disciplines have equal status within the Center. Operating as a non-profit child protection agency in a child-friendly neutral facility, the CAC's goal is to deliver, under one roof, comprehensive interdisciplinary evaluation and treatment to the children and families involved in child abuse. One-way mirrors or closed circuit television allow all disciplines to cooperate simultaneously in forensic interviews with the child and family. Medical professionals can complete their examination during the same visit. Immediately following the evaluation, the child evaluators, case workers, attorneys, and law enforcement representatives sit down to make case management decisions.

The CAC's "one-stop shopping" streamlines the process for everyone, most importantly for the child and family. It promotes cohesion among the participating personnel, and expedites the initiation of therapy. For child protection workers—who are generally undervalued, and get attention only when they make mistakes— cooperating in such a model enhances professional identity and self-esteem.

The Children's Advocacy Center paradigm is a solution for a defined and circumscribed population, but it should be recognized as having limitations. The major limitation is that the service area is defined by the unit of government sponsoring it. For this reason, interdisciplinary services should be provided at a regional level. Newborn care services and poison control centers are successful examples of regionalization of specialized, universally-needed services. Similar centers of excellence could be developed to provide services to the ever-increasing numbers of families enmeshed in the child abuse epidemic sweeping the country. Such centers could, in fact, be more economical in both human and fiscal terms, by offering tertiary care interdisciplinary specialized child protective resource services for those complex cases not solved at the local level. Consultative "hot lines" in all of the relevant areas of psychosocial, legal, and medical domains could provide the most current information to community professionals working in the field.

This area of practice has made giant strides since Caffey and Kempe's pioneering work. But even the best service model can only reflect available knowledge; therefore, continuing relevant and creative interdisciplinary research must be supported and strengthened. New generations of highly motivated and well-educated professionals will be available only if we continue and expand educational initiatives in all disciplines. Educational programs that focus on interdisciplinary cooperation will smooth the transition from school to practice.

Those of us who have chosen this "road less travelled" may recall another line by Robert Frost: "But I have promises to keep, and miles to go before I sleep, And miles to go before I sleep." We have come far, but have much further to go to make interdisciplinary team cooperation function to the optimal benefit of children and families.

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SAVE THIS DATE

Monday, August 31, 1992, 5:30 p.m.
In conjunction with the ISPCAN Ninth International Congress on Child Abuse and Neglect, to be held in Chicago, APSAC will hold an International Networking and Social Hour. APSAC members and their colleagues worldwide will have an opportunity to meet and discuss the professional concerns that unite us across oceans. We hope to see you there!