Chapter 3
Working with the Multidisciplinary Team

Kristen J. MacLeod

Vignette

R is a 10-year-old boy who has disclosed sexualabuse by his father. His father has been arrested and is currently in jail. R is seen for a sexual assault exam, referred by local police. The victim advocate comes to the exam to support R's mother and make sure she has access to the resources necessary to access help for her and her family. Neither Child Protective Services (CPS) nor law enforcement is present for the exam. The clinician does not have access to the forensic interview and does not even know that it has occurred. The clinician performing the exam recommends mental health services for the child as soon as possible and social services for the mother, as the child has indicated that there is often nothing in their refrigerator. The mother requests a cab voucher to get home from the exam. The results of the exam are faxed to the law enforcement and local child protective services. Two days later, the clinician receives a call from the pediatric hospitalist, requesting a consult for an 8-year-old girl who was admitted to the hospital 7 days ago for psychiatric reasons. She has been making inappropriate sexual gestures, using profane sexual language and propositioning aides. She has been placed in the pediatric Intensive Care Unit because she requires 1:1 nursing for safety. Psychiatry has been consulted, but won't see her for 2 more days, because it is a weekend. The Child Abuse clinician arrives at the hospital and the nurse caring for the child says that CPS has been involved with the case for several weeks. She believes this child's sibling, R, was recently seen for a sexual assault exam at the sexual assault facility. The clinician is upset that she had not been made aware that R's sibling was inpatient at the hospital with concerns of sexualized behavior, sexual abuse, and other mental health issues.

K.J. MacLeod, M.D. (✉)
Washoe County Child Abuse Response and Evaluation Team, Reno, NV 89519, USA
e-mail: kj_macleod@sbcglobal.net

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The nurse practitioner at CPS is upset that she was not made aware that R had made a disclosure and had been referred for a sexual assault exam. No report was made to law enforcement about the sibling in the hospital.

This case vignette illustrates several of the negative consequences that occur when the multidisciplinary approach to these cases of suspected childabuse fails. Not only do the professionals involved experience frustration in delivery care, but more importantly, a family and children are failing to receive essential services in a timely, coordinated manner. Evidence can be lost and investigations impeded without full involvement from the members of a multidisciplinary team. This exposes the children and non-offending caregiver to repeated trauma and prevents the child victim from receiving the highest quality of care available to him or her in the community.

Introduction

At its core, the care of abused children has always been a multidisciplinary field. The universal need for close collaboration between multiple professional disciplines in caring for suspected victims of child abuse makes the field of child abuse unique. Kempe's landmark article in 1962, "The Battered Child Syndrome" published in The Journal of the American Medical Association was the first in medical field to clearly state the need for the physician to have liaisons to professionals in social work, law enforcement, and mental health (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). The article recognized the reticence of some medical professionals to become involved in the legal aspects of such cases. However, the protection of abused and neglect children in our communities evolved neither out of the clinical fields of medicine or mental health nor even the field of law enforcement. Almost unbelievably, Kaplan points out in his 2011 textbook, it arose out of the entirely unrelated Society for the Prevention of Cruelty to Animals and the plight of Mary Ellen Wilson, a horribly physically abused 9-year-old (American Humane Association, 2013; Kaplan, Adams, Starling, & Giardino, 2011). In 1874 in New York City, Henry Bergh, the founder of the American Society for the Prevention of Cruelty to Animals (ASPCA) acted through the urging of concerned private citizens and used his connections to send a NYSPCA investigator to Mary Ellen's home. An ASPCA attorney provided the petition for her removal from the abusive home, initially making her a ward of the court. Mr. Bergh's willingness to act on his principles of humane treatment for all living things, likely saved Mary Ellen's life and provided a ground swell for the establishment of our modern day child protective services, as well as the need for legal involvement in these cases (Watkins, 1990).

This concept of using a multidisciplinary approach in the complex care of children who may have been abused has become well accepted over the last 25 years (Hochstadt & Harwicke, 1985; Jones, Cross, Walsh, & Simone, 2005; Kempe et al., 1962; Lashley, 2002; U.S. Department of Justice & Office of Juvenile Justice and Delinquency Prevention, 2000; Watkins, 1990). All 50 states and the federal

government mandate various versions of multidisciplinary collaboration in child protection investigation (Child Welfare Information Gateway, 2013; U.S. Department of Health et al., 2002). The main goals of the multidisciplinary team are to facilitate timely, thorough, and successful investigations, while improving the welfare of the children and non-offending caretakers (Fontana & Robison, 1976; U.S. Department of Justice & Office of Juvenile Justice and Delinquency Prevention, 2000). Two critical pieces to improving this welfare involve the reduction of stress and trauma for the child victim and increasing the reliability of child disclosures through reducing the number of child interviews (Bruck, Ceci, & Hembrooke, 1998; Jaudes & Martone, 1992). Multiple barriers, such as competing professional mandates and the unpopularity of child abuse cases must be overcome in each professional discipline involved in order to achieve these goals. Cases of child sexual assault are considered difficult, unpopular, and anxiety-provoking. Physicians, who might routinely perform below-the-knee amputations or care for dying cancer patients, shrink away at the thought of child sexual assault evaluations. Law enforcement professionals who deal routinely with gang warfare can find cases of child sexual assault less desirable to investigate than other crimes (Newman, Dannenfelser, & Pendleton, 2005). By virtue of such challenges, this field has advanced the concept of multidisciplinary care to a level which surpasses most other case collaborations (Kaplan et al., 2011). The composition of the team, approach to collaboration, measures of effectives and development of best practice standards remain in progress. This chapter will take a look at the development of the multidisciplinary Team (MDT), the roles of the various members, the variations in approach to its implementation across the nation and the development of best practice standards for MDT's. The rising presence of Children's Advocacy Centers (now more than 800 operating), as the means by which to provide multidisciplinary care has reemphasized a child-focused approach to these difficult cases (National Children's Advocacy Center, 2014a).

Roles of the MDT Members

Perhaps one of the greatest and most unique challenges to smooth functioning of the multidisciplinary team is the need for each professional to completely fulfill both his individual professional mandate and the collaborative goals set out by the MDT. Core members of the MDT include professionals from law enforcement, child protective services, the prosecutor's office, mental health, medicine and victim advocate programs (often through law enforcement agencies). Additional contributing members include those from the juvenile justice program, public health, domestic violence programs, and the school truancy board. A thorough understanding of the professional parameters and mandates of each member of the team is critical to effective collaboration between the members and has been shown to be directly related to the effectiveness of the team (Lashley, 2002; Lalayants, Epstein, & Adamy, 2011).

Child Protective Services

Over the century and a half following the case of Mary Ellen and the birth of the New York Society for the Prevention of Cruelty to Children, our present day Child Protective Services (CPS) has grown into the primary agency responsible for investigating and intervening in cases of suspected childabuse and neglect where the perpetrator is a caregiver. CPS serves both an investigative and therapeutic role, as the professionals charged with securing the safety and welfare of children within the families in which they live. CPS has primary responsibility for determining the residency or placement of the child in a safe environment. They are the only agency that remains intimately involved with the child and family from the initial investigative phase through the court system and into the therapeutic phase. CPS procures the family services necessary to improve the functional well-being of the family and the environment in which the child lives. The concept of the child-centered social worker may even include providing direct clinical therapy to the child (Anderson, Weston, Doueck, & Krause, 2002). CPS must function within the family court on the civil side of the law to ensure safe residence for the child. This residence may be in the home with support provided by external services or it may require removal from the home for out of home placement. They must work within the constraints of the family court system, while remaining accountable to federal, state, and county guidelines. In their investigative role, CPS may conduct minimal fact interviews, forensic interviews, and scene investigations. The collection of collaborative reports and documents such as school, childcare, and healthcare records routinely falls to the child protective service worker in assessing the safety of the child's environments. CPS routinely refers their cases to the jurisdictionally appropriate law enforcement agency. Law enforcement, not CPS, will then determine the need for criminal investigations and charges.

Law Enforcement

As the agency responsible for investigating crimes and securing the safety of citizens in its community, law enforcement's role in cases of childabuse and neglect is closely related to both the prosecutor's office and Child Protective Services (CPS). In fact many states require co-investigation with CPS and law enforcement (LE) in suspected cases of abuse and neglect (Cross, Finkelhor, & Ormrod, 2005; Cross, Walsh, Simone, & Jones, 2003). Their primary responsibility in cases of CAN is to gather evidence and determine if a crime has been committed against a child, with subsequent arrest of the suspect and preparation of charges for the criminal court. As the first responders, they often have exclusive access to the initial scene. The responsibility for collecting evidence at the scene of the suspected abuse falls primarily to LE. Each law enforcement agency has its own professional and legal framework within which it must operate. LE must ultimately answer to the office of the district attorney or the attorney general, for agencies such as, the Bureau of

Indian Affairs and the Department of Public Safety. In each of these agencies, successful criminal prosecution depends on LE's approach to investigation and knowledge of the legal intricacies of their jurisdiction. This can at times put them at odds with the other members of the MDT whose professional obligations are centered solely on the needs of the child and family. This includes demands from professionals such as medical and mental health providers and child protective service workers. It bears remembering that LE often physically assists CPS in the removal of children from an imminently dangerous situation and may even perform the removal without CPS present if necessary. Given the variety of roles, both investigatory and protective that LE plays in these cases, there will be a large variability in training and experience with child abuse cases (Portwood, Grady, & Dutton, 2000). A patrol officer will generally have far more limited knowledge of the intricacies of CPS investigations than will a detective in the child crimes unit. The LE personnel in a rural district will have less opportunity for specific training in CAN cases given the great distance they have to cover and the small budgets. By virtue of their rural designation they will have a lower volume of cases and may be working with prosecutors who have little experience in bringing these cases before the court. Despite disparate settings and variations in agency training and investigatory practice, the ability to recognize child maltreatment and a basic knowledge of child development have been cited as key common areas for improvement in law enforcement training (Portwood et al., 2000). The multidisciplinary team and the emergence of CAC provide routine contact with multiple child abuse professionals who can provide knowledge in these areas (Newman et al., 2005).

Much has been written and studied about the often successful, though at times contentious collaboration between law enforcement agencies and child protective services. (Cross et al., 2005; Faller & Henry, 2000; Jordan, Yampolskaya, Gustafson, & Armstrong, 2011; Newman et al., 2005; Pence & Wilson, 1994; Tjaden & Anhalt, 1994). Child sexualabuse cases in particular require interaction between the two agencies, as these charges rise to the level of criminal rather than civil prosecution in most cases. The two systems collide most frequently due to different professional mandates and different timeline requirements in investigation (Newman et al., 2005). CPS workers have a strict timeframe in which they must meet requirements for removal of a child. Law enforcement does not have the same constraints. Law enforcement may want to wait and gather more evidence before interviewing potential suspects and victims, so as not to jeopardize the criminal charges. CPS needs to perform interviews to gather their information and determine imminent risk often within just a few days. The early investigations by CPS workers can interfere with evidence collection from the point of view of criminal prosecution. These early interviews can tip off perpetrators the quality of law enforcement investigations (Newman et al., 2005).

The 1974 federal Child Abuse Prevention and Treatment Act and subsequent mandated reporting laws led to a massive increase in reports and enormous investigatory burden on CPS over the next decade (Reece & Jenny, 2005). In the late 1990s concerns arose that the investigatory burden on CPS was becoming too great and hindered their ability to provide services to these high risk families (Center for the

Study of Social Policy, 2000). Inadequate investigation and inadequate services can have deadly consequences. Two states, FL and AK therefore experimented with moving the investigatory responsibility for childabuse cases under the jurisdiction of law enforcement agencies, essentially creating a separate unit within LE to conduct the investigative aspect of these cases (Kinnevy, Huang, Dichter, & Gelles, 2003, 2005). There is limited data demonstrating the effect of this shift in roles. The follow-up study by Jordan and colleagues in 2011 looking at the consequences of this change in Florida shows higher rates of substantiated cases in areas where law enforcement was responsible for child protection investigation compared to the areas where the child welfare agency assumed this responsibility (Jordan et al., 2011). Unfortunately, the results also show an increase in the odds of experiencing recurrent maltreatment, especially for younger children, in areas where law enforcement assumed the role of child protection investigations (Jordan et al., 2011). The explosion of Children's Advocacy Centers (CACs) seems to have replaced models such as those in AK and FL in an attempt to improve outcomes in terms of both substantiation and recurrence of maltreatment.

Court System

The criminal courts and civil child protection or family courts both play a large role in cases of child abuse and neglect. Understanding the major differences between these two courts and the constraints they place upon agencies involved in the investigation of these cases greatly enhances the understanding of the often problematic differences in various MDT members' approaches to the investigation. Law enforcement is guided by the legal standards and statutes of the criminal court. CPS answers to the statutes and timetables of the civil family court. Criminal prosecutor's offices spearheaded several early multidisciplinary teams across the country. The model for our current CACs grew out of such a team. Efforts by former district attorney and Congressman Robert E. "Bud" Cramer of Alabama led to the formation of the first CAC in 1985, now a national model and training center (National Children's Advocacy Center, 2014a). The participation of the court system is critical to the success of the multidisciplinary team.

The criminal court and civil court vary in their impacts on the child and family, their processes for hearing evidence and the burden of evidence required for judgments in these cases. The family court most often directly impacts the child's life by determining abuse or neglect by caregiver or guardians (Kaplan et al., 2011), while the higher profile criminal court seeks justice in those child abuse offenses that have reached the level of a major crime. The civil side of the court system works closely with child protection and child welfare agencies in every case to determine residency, or placement of the child. Two important factors further distinguish it from the criminal court. In the civil court evidentiary proceedings are most often heard in front of a judge instead of a jury. This may make it easier for experts such as medical or mental health professionals to give evidence, as they can directly address the

judge who presumably has a higher level of education than the average juror and a significant amount of experience in these cases (Kaplan et al., 2011). Experts giving testimony in criminal court must be able to explain complicated scientific concepts to the jury. With the gravity of the charges and the severity of the potential sentences experts may find it difficult to testify due to interruptions from lawyers on both sides. Perhaps the most significant difference between the civil child protection court and the criminal court, however, concerns the burden of proof required to win a case. The civil courts hold to a standard called "preponderance of evidence," while the criminal court must meet the standard for evidence "beyond a reasonable doubt" in order to make a conviction. This means that in cases of child abuse and neglect, safe placement of a child, including removal from his or her family can be achieved without meeting the hefty criminal court burden of "beyond a reasonable doubt." Members of the multidisciplinary team may be able to affect safe placement of the child in many cases where the prosecutor's office is unable to seek justice in the criminal courts.

Victim Advocates

Victim Advocates play a critical role in linking the victim, the MDT process and community services together to minimize trauma to the victim and facilitate healing (Campbell, 2006). Victim services and the role of the advocate has been strengthened greatly by the federal Violence Against Women's Act of 1994 (Violence Against Women's Act. Title IV & sec. 40001–40703 of the Violent Crime Control and Law Enforcement Act of 1994) which initially granted 1.6 billion dollars over 5 years to improve services to victims, increase criminal penalties, and broaden resources for investigators in the field.

Financial analyses of net social costs of the program indicate that the services provided through VAWA funding have saved almost $15 billion dollars in averted social costs (Clark, Biddle, & Martin, 2002). Victim advocates act as a liaison to community services for the victims and families (Long, Willkinson, & Kays, 2011). They help the families access funding and guide them through the investigatory and courtroom process. Victim advocate support becomes critical as the child and family prepare for criminal trial. Some advocates work out of grant funded community programs. Others are provided by local law enforcement agencies or the prosecutor's office.

As a truly victim-centered member of the MDT, advocates are ethically and legally bound by rules of confidentiality. Communications between victim and advocate are considered confidential and fall under the protection of VAWA's RCW 5.60.060 (U.S. Department of Justice & Office of Juvenile Justice and Delinquency Prevention, 2000) *Privileged Communications* requirement. Advocates may not disclose any information or conversation with the victim without consent from the victim. They cannot be subject to questioning by police as to information provided to them in privileged conversations with the victim. This requirement, while crucial to

fulfilling their role, may limit the information they can contribute in multidisciplinary settings. Even when the advocates cannot disclose specific information about a victim, they may guide the team in addressing system-based concerns that can improve the overall outcome of the case (Micheel, 2011).

Mental Health Providers

The mental health providers involved in childabuse cases assist the members of the MDT in both investigation and substantiation. Their role encompasses evaluation of disclosures and behavioral concerns. They are also called upon to provide therapeutic assessment and intervention for the child and often even family members (American Psychological Association [APA], 2013; Kaplan et al., 2011). Given this broad range of roles, there may be more than one mental health provider participating in the MDT. In accordance with current American Psychological Association Guidelines and Ethics Code, a clinician directly treating the child or family member involved in the allegations should not be primarily responsible for assessing the validity of allegations (American Psychological Association, 2013). Therefore there may be psychologists, as well as clinical social workers assisting in child protection cases. All cases require the mental health provider to employ evidence-based standards in decision making and treatment whenever possible (American Psychological Association, 2013; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005; Herman, 2005).

Mental health providers routinely provide guidance to the team when the child in the case exhibits concerning behavior. Quite commonly this behavior is sexualized in nature. These cases are particularly challenging for the investigative members of the team, as over 90 % of child sexualabuse cases will have normal physical exams and no retrievable DNA evidence (Adams, Harper, Knudson, & Revilla, 1994; Heger, Ticson, Velasquez, & Bernier, 2002; Kellogg, Menard, & Santos, 2004; Thackeray, Hornor, Benziger, & Scribano, 2011). The mental health provider must have the relevant skills and knowledge to help the team interpret these behaviors as developmentally appropriate or concerning, given the child's age and cultural milieu. This may include use of tools such as the Child Sexual Behavior Inventory, developed by Dr. Friedrich and colleagues (Friedrich et al., 2001; Friedrich, Fisher, Broughton, Houston, & Shafran, 1998), as well as specific cultural knowledge and understanding of any disabilities the child may have.

Traditionally, mental health professionals have been asked to interpret not only concerning behaviors, but also the validity of disclosures or even lack of disclosure. In communities where the MDT does not utilize a dedicated, trained forensic interviewer, mental health providers may be asked to review interviews from various team members, traditionally LE and CPS, to determine credibility of the disclosures or reasons for lack of disclosure. Guidelines for conducting such an evaluation delineate special competencies required by the APA Ethics code, such as use of evidence-based knowledge, experience and training in cases of childabuse and

declination of cases in which the provider has a preestablished therapeutic role with the child, suspect or family member which will threaten objectivity and impartiality (American Psychological Association, 2013; Herman, 2005). This presents particular challenges for many geographic areas, in particular rural areas with a shortage of mental health providers.

Finally, the mental health providers engaged in an MDT are uniquely poised to guide the team in securing mental health treatment for both the victim and non-offending family members. In this role the providers must be equally insistent on procuring evidence-based therapy whenever possible and when necessary, referring to medical providers for medication. In this sense mental health providers are responsible for both the efficacy and the timeliness of therapy in these cases. Trauma Focused Cognitive Behavioral Therapy has emerged as a promising evidence-based form of therapy for victims of childabuse who are suffering from symptoms of post-traumatic stress (Cohen et al., 2004, 2005). The mental health provider can educate MDT members, such as social workers and medical providers on how these symptoms may manifest in children, as well as adult family members. In the course of therapy more disclosures may occur and issues regarding validity of disclosure may become apparent to the therapist. This again underscores the necessity of avoiding crossover between the therapeutic role of treatment provider and the role of consultant regarding validity of disclosures.

Medical Providers

Caffey's, 1946 landmark article on long bone fractures and subdural hematomas in infants was the first published peer-reviewed article declaring the medical community's responsibility to recognize childabuse as a distinct medical disorder (Caffey, 1946). Kempe's 1962 article was the first to call for collaboration between medical providers and professionals in the community to ensure the proper care and safety of these young victims (Kempe et al., 1962). The presence and active participation of specialty trained child abuse clinicians provides both clinical and educational expertise to members of the MDT. Participants often include forensically trained nurses, both RNs and APNs, and pediatricians or emergency room physicians with training in child abuse and neglect. Each of these providers must comply with mandates from the state board governing his or her practice, such as the state medical board and the state nursing board. Above all else, they must adhere to their code of healthcare ethics in delivering compassionate and competent expert medical care to the child victim. Highly trained clinician members of the MDT ultimately deliver top quality forensically defensible healthcare.

There is a longstanding tradition of specialty trained sexual assault nurses performing evidence collection in adult cases. For many decades they have worked closely with law enforcement agencies. Nursing participation has grown rapidly in the field of child and adolescent sexual assault with the introduction of the SANE-P certification through the International Association of Forensic Nurses (IAFN).

The IAFN is the most well recognized and clinically advanced subspecialty accrediting body for forensic nurses, setting forth specific requirements for obtaining Sexual Assault Nurse Examiner certification for both adult and pediatric victims. Forensic nurses are now recognized as extremely valuable and technically competent in collecting forensic evidence and guiding initial care in acute cases of child and adolescent sexual assault (Bechtel, Ryan, & Gallagher, 2008; Hornor, Scribano, & Hayes, 2006; Hornor, Thackeray, Scribano, Curran, & Benzinger, 2012). Nurse practitioners, considered mid-level providers, can provide diagnoses and may be involved in more ongoing treatment of a child and referral to other medical or mental health specialists. As with all clinicians in this field, training must include a thorough understanding of court room proceedings and communication, as well as guidance in assessing current scientific literature.

The role of physicians in cases of childabuse and neglect is even more wide-ranging than that of their nursing colleagues. The American Board of Pediatrics, subspecialty board certification in Child Abuse and Neglect represents the most comprehensive medical child abuse certification available. It requires more than 2 years of additional subspecialty training above and beyond general pediatric residency training.

Pediatricians with subspecialty board certification in childabuse and neglect are uniquely poised to provide both education to their child abuse colleagues in other professions and clinical intervention for the child abuse victim. They must have a comprehensive understanding of the psychosocial dynamics of the family (Reece & Jenny, 2005), competency in identifying and documenting injuries or medical conditions related to child abuse or neglect and up to date knowledge of factors involved in transmission, treatment, and diagnosis of sexually transmitted infection. Child Abuse Pediatricians are required to have training in courtroom communication and experience with complex scientific testimony (Kaplan et al., 2011). Pediatricians are often called upon to educate law enforcement or CPS colleagues on normal child development and how this may reflect on the plausibility of a given injury mechanism for a child of a given age (Reece & Jenny, 2005).

Developmentally normal childsexual behaviors often raise questions in suspected cases of child sexual assault. Both the pediatric and mental health providers may be asked to interpret the developmental appropriateness of such behaviors (Friedrich et al., 1998, 2001; Kellogg, Committee on Child Abuse and Neglect, & American Academy of Pediatrics, 2009). In cases of child sexual abuse DNA evidence and physical evidence of injury are rare (Adams et al., 1994; Heger et al., 2002; Kellogg et al., 2004; Thackeray et al., 2011). The clinician will be asked to educate the judge or jury as to how a lack of physical evidence does *not* mean that the child was *not* assaulted. In children who do suffer injuries from inflicted sexual trauma, pediatricians may be asked to estimate the impacts of such injuries and the risk for future disability, as this will impact both social welfare decisions and decisions surrounding criminal charges.

One important current issue facing the medical providers in cases of childabuse and neglect is the impact of the Supreme Court decision in *Crawford v Washington* (2004). The precedent set by the decision in this case has challenged the medical

provider's exception to hearsay in cases of child abuse and neglect. In the past, medical testimony regarding conversations with the patient in a therapeutic setting qualified for exception to hearsay. *Crawford v. Washington* challenged that exception, asserting that aside from excited utterance, testimony from medical providers in cases of child abuse and neglect may be considered testimonial unless the information was being gathered for the purposes of medical diagnosis and treatment. *Crawford v Washington* asserts that the medical provider places himself in a potentially investigatory role when asking detailed historical questions that stray beyond those necessary for medical diagnosis and treatment. In this sense, that history would become "testimonial" and would count as hearsay testimony against the defendant. Additionally, there is no current scientific evidence base to instruct child abuse professionals on how the medical history taking may impact the case if the medical history differs from the information obtained in the forensic interview. For these reasons, medical clinicians providing initial care and evaluation to potential victims of child abuse and neglect must conduct their history solely for the purposes of medical diagnosis and treatment. The clinician must document that historical details being gathered are meant to specifically guide diagnosis and treatment. Additional details will be obtained in investigatory and forensic interviews. The active participation of the medical provider in the MDT will ensure that he or she receives access to more extensive information surrounding the case as it becomes available.

Assessing Effectives and Developing Best Practices

Despite the now accepted MDT model as the standard for handling suspected cases of childabuse and neglect, the evidence base for effectiveness and best practices in implementation remains incomplete. One of the barriers to adequate research is what Reece calls the "patchwork quilt of services" developed to address the needs of agencies and communities in child protection cases (Reece & Jenny, 2005). The variations in MDT implementation, composition, provision of services and measures of accountability remain enormous. Some teams are very well-coordinated, with routine case review, a physical location that allows daily contact between members and easy access to medical and mental health services. In other communities, the collaboration is less formal and contains no structured method for quality assurance. Without consistent, universally accepted definitions and standardized approaches, outcomes are difficult to measure and high quality, prospective research is difficult to perform. Interestingly, this is the same issue that impedes large-scale meaningful studies in other areas of Child Abuse and Neglect.

The relevant research available to date indicates preliminary success in attaining a few important goals. An MDT can assist in the avoidance of repetitive child victim interviews (Jaudes & Martone, 1992; Jones et al., 2005) and thereby reduction in stress for the child, as well as reduction in the risk for inaccurate recall or false memories (Bruck et al., 1998). Improvement in case outcomes may include higher substantiation rates and higher rates of successful prosecution (Faller & Henry, 2000;

Jaudes & Martone, 1992; Tjaden & Anhalt, 1994). A functional team allows for better collaboration between agencies to avoid interference in case investigation (Hammond, Lanning, Promisel, Shepherd, & Walsh, 2001; Pence & Wilson, 1994). Complete and timely access to services for the victim and family can also be facilitated by the MDT approach (Walsh, Jones, & Cross, 2003). Identified areas of continued weakness in multidisciplinary team functioning may include cross agency case tracking (Sedlak et al., 2006) and access to mental health services. Two studies (Lalayant et al., 2011; Lashley, 2002) have looked at the approach to implementation of MDT's and identified common themes to healthy functioning. Elements such as communication in day-to-day tasks outside the MDT meetings and a thorough understanding of the roles and cultures of collaborating agencies can be attained through the commitment of the individuals participating in the team. Other factors such as adequate resources and structural supports depend on the systems in which the agencies function and may be harder to achieve. It is exactly this type of barrier to implementation of desirable MDT quality indicators that makes it so difficult to study outcomes. Ultimately, a well-functioning MDT needs to support members of the team in fulfilling their individual professional mandates while contributing to the future health and safety of the victim and other vulnerable populations within the community.

Two of the most controversial areas surrounding the forensic interview of the child include identifying which professionals should interview the child and what the optimal timing is for the interview. Can the medical exam take place before the interview? What happens to the accuracy and validity of the subsequent forensic interview when CPS or LE has already conducted minimal facts interviews to determine the safety and disposition of the child?[1] Unfortunately, there is no good evidence base to answer either of these questions. They remain a source of much debate on many multidisciplinary teams. It is generally accepted that interviewers should be trained in a protocol for forensic interviewing, but there is little consensus and no good evidence base for which protocol(s) is most valid and effective. It is generally accepted that the interview should be conducted in a neutral, child-friendly facility and as soon as possible, but there is no evidence base to indicate exactly how the time frame will affect accuracy and validity of the interview. As soon as the child discloses, he or she begins to see the consequences of that disclosure. How does this influence the accuracy and validity of the forensic interview? The vast majority of child sexualabuse cases involve a delayed disclosure, obviating the need for emergent medical examination and forensic evidence collection. In these cases, the forensic interview should be scheduled prior to the exam. If DNA or injury evidence needs to be obtained, or if there is a suspected medical condition that needs treatment, the medical exam can precede the forensic interview. In these cases the clinician will be especially rigorous in obtaining his or her history for the purposes

[1] Minimal facts interviews are often conducted by LE or CPS when they need information to determine the placement of the child, the safety of the child and the potential need for forensic evidence collection. These often have to take place at the scene or prior to the scheduled forensic interview.

of medical diagnosis and treatment only. As is the case with minimal facts interviews, there is no good evidence base to inform our practice as to the influence of the medical history taking on the subsequent forensic interview.

Fortunately, the rising popularity of Child Advocacy Centers (CACs) as the child-friendly centralized location for MDTs and the services they provide (Walsh et al., 2003) has the potential to create a forum for standardizing approaches to collaborative child-centered care and core outcome measures in cases of suspected child abuse. Data from the National Children's Alliance indicates that 286,457 children were served through CAC in 2012 (National Children's Advocacy Center [NCA], 2014a). The NCA delineates ten core components for accreditation (NCA, 2014b). Although many CACs function without accreditation, these core components serve as a common frame around which communities can build their programs. The single MDTforensic interview in a child-friendly setting is one of these core components. The research is not yet clear on whether or not CACs are consistently effective at achieving this goal (Cross et al., 2008). Preliminary research seems to indicate that suspected child abuse cases handled in a CAC setting more often include collaboration with law enforcement (Cross et al., 2008; Smith, Witte, & Fricker-Elhai, 2006) and are more likely to receive medical examinations and mental health referrals (Cross et al., 2008; Smith et al., 2006; Walsh, Cross, Jones, Simone, & Kolko, 2007). These CAC cases may also lead to higher rates of substantiation and more frequent referral for prosecution (Smith et al., 2006; Wolfteich & Loggins, 2007; Miller & Rubin 2009). There is a clear trend among researchers in the field toward larger scale studies to examine the efficacy of the MDT model within the CAC setting in order to guide more concrete best practice guidelines for the future.

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