The report examines the nature of multidisciplinary teams in identification, treatment, and prevention of child abuse and neglect. Reviewed is the operation of three types of multidisciplinary teams: hospital-based programs, interagency programs, and state mandated multidisciplinary teams. The bulk of the document is composed of appended material, including brief descriptions of approximately 50 child abuse and neglect programs using the multidisciplinary approach (arranged according to federal regions), and guidelines for the operation of the multidisciplinary team as formulated by the states of Virginia and Pennsylvania.
MULTIDISCIPLINARY TEAMS IN CHILD ABUSE AND NEGLECT PROGRAMS

A Special Report from the National Center on Child Abuse and Neglect

AUGUST 1978

National Center on Child Abuse and Neglect
U.S. Children’s Bureau
Administration for Children, Youth and Families
Office of Human Development Services
U.S. Department of Health, Education, and Welfare
Introduction

The emergence of the multidisciplinary approach in child abuse and neglect intervention and treatment has been described by DeFrancis as the result of a combination of the two other major models of child abuse and neglect -- the social service model and the medical model. The multidisciplinary approach is in part an attempt to enlarge the theoretical framework by which child abuse and neglect are understood. Just as the social service and the medical models imply approaches to intervention, so the multidisciplinary model implies a way of intervening in child abuse cases. This approach involves the combination of social service and medical personnel into a coordinated unit - the multidisciplinary team. Although there are a number of variations on this basic combination, most multidisciplinary teams directly involved in the treatment of child abuse and neglect include medical and social service personnel.

A multidisciplinary team, then, is a team of professionals (which may include paraprofessionals) from a variety of disciplines, often representing different agencies, working together for a well-defined purpose or purposes. These purposes have included coordination, diagnosis or identification, prevention, treatment, consultation, and education.

Why Multidisciplinary Teams?

Child abuse and child neglect are problems which do not lend themselves to a simple treatment approach. In many cases of abuse or neglect there are injuries or physical problems which require the services of a physician for diagnosis and treatment. The abusive or neglecting parent generally exhibits some degree of psychological impairment, though rarely as dramatic as psychosis, which requires the attention of a mental health or social work professional. It is likely that the abused or neglected child may also require psychological or psychiatric intervention. Because the abusive or neglectful family does not exist in a vacuum, it is necessary to consider and perhaps intervene in the family's interpersonal and social environment. This is traditionally the province of the social worker. Besides counseling on interpersonal relationships, the social worker is also concerned with problems involving family sustenance and shelter. Finally, there is a legal aspect of child abuse and neglect, in which the police, the public prosecutor, and the courts may figure.

If one considers other aspects of the problem besides treatment, such as identification and prevention, it becomes clear that other agencies and professions are, or should be, involved. Teachers and other school personnel can help by recognizing the signs of abuse or neglect and becoming familiar with reporting procedures; public health nurses may be able to identify abused or neglected children, or help to prevent abuse and neglect by encouraging healthy parenting.
Child abuse and neglect are problems whose effective amelioration must involve the coordinated efforts of professionals and community agencies. In an area in which resources are as chronically scarce as protective services, it is important that these resources be used in the most effective way. Lack of communication between agencies involved in the provision of services to families of abused or neglected children can lead to feelings of frustration and anger among those involved. Workers in one agency may have unrealistic expectations concerning the services available at another agency, or may be unaware of available services. An interagency multidisciplinary team can provide a forum for the exchange of services information, and for the development of better relationships among agencies. Moreover, if services are coordinated, the risk of duplication of effort or working at cross purposes is diminished.

Multidisciplinary teams within organizations such as hospitals can make use of existing resources within the hospital in a more effective way. Besides encouraging a sharing of expertise among professionals, the use of teams in case management brings to bear more perspectives on cases, and can relieve the social worker or pediatrician of the burden of having to make difficult case decisions alone. The concentration of expertise and responsibility for diagnosis or management in a hospital-based multidisciplinary team may lead to better recognition and handling of cases.

Types of Multidisciplinary Teams and How They Work

Child abuse multidisciplinary teams can be roughly categorized according to their organizational loci. Many multidisciplinary teams operate under the auspices of hospitals. According to Ray E. Helfer, M.D., a pioneer in the development of the multidisciplinary approach, any hospital which sees more than 25 cases of abuse or neglect per year should have a well-defined child abuse multidisciplinary team. Other multidisciplinary teams are not organizationally attached to any particular agency, but have members who represent different agencies.

Hospital-Based Programs

Although the treatment-oriented program at the University of Colorado Medical Center has provided a model for many other programs, including the Sinai Hospital program described below, most hospital multidisciplinary teams are not primarily organized for providing continuing direct treatment services. A 1973 survey of hospital programs dealing with child abuse and neglect showed that relatively few functioned as a treatment resource. Twenty-two of the 41 programs had a multidisciplinary team which engaged in evaluation, consultation, and crisis intervention; cases were referred to other agencies for long-term care. In many hospitals, the multidisciplinary team physician serves as the reporting physician for other doctors who use the hospital.
One program which illustrates the way in which a hospital multidisciplinary team can serve as a treatment resource, providing intensive evaluative, medical, and psychotherapeutic care for abusive families, is the Child Abuse Project at Sinai Hospital in Baltimore. The multidisciplinary team associated with this project is composed of two full-time paraprofessional community aides, a half-time nurse, a consulting pediatrician, a consulting psychiatrist, and a full-time social worker. An integral part of this team is the full-time secretary, who provides a variety of critically needed services and serves as a central point for all team communication and activity. The project is coordinated with the state’s child protective service agency so that referrals are accepted only from its local departments. The team social worker is the project coordinator, as well as the primary therapist for family members. The community aides function as listeners and behavioral models to the abusive parents; they work to ameliorate environmental stresses facing parents and act as parent advocates to overcome service gaps. The team pediatrician is available for medical evaluations and to provide ongoing medical care for the children and other family members. The nurse’s role complements that of the physician in seeing that family health needs will be met either within the scope of the program or by local community health resources. The psychiatrist provides ongoing consultation to the social worker, interviews each family, evaluates possible organic disorders which may contribute to parental violence, and is present at all weekly staff meetings. Evaluative data collected on the Sinai project demonstrate that families served by the program have benefitted substantially from the team’s intervention. One factor in the success of the program has been the careful selection of staff members who are willing to become intensively involved with their clients and stay involved throughout the course of treatment.

Because of the legal status of the mandated child protective services agency and reporting requirements in most states, some agreement between the child abuse team and the agency is desirable. The inclusion of a representative of the mandated agency on the team is invaluable in coordinating the efforts of the team and the agency.

The Boston Children’s Hospital Medical Center’s Trauma X Team, which is primarily oriented toward providing multidisciplinary case consultation, is an example of a hospital-based program which uses representatives from outside agencies. Four protective services agencies, including the state’s mandated agency, are represented on the Team. Nevertheless, it is the hospital administration, specifically the Department of Patient Services, which has responsibility for the conduct of the Team. Other Team members are a pediatrician, a psychiatrist, a hospital social worker, a child development specialist, a psychologist, a nurse, a case data coordinator, and an attorney. The Trauma X Team is a consultative group available to any professional at the hospital faced with the task of handling a vulnerable child and his family. Consultation may include any one or all of the following: support; information; and assistance in assessment, treatment planning, and followup. The mechanism through which the consultative input is
provided is decided by the individual requesting assistance. Consultation can take place in a number of ways, including by telephone, chart review, participation in the interviewing of parents, or through the Team's weekly clinical conference. There is at least one Trauma X Team consultant on call at all times. Child abuse cases are handled by management teams consisting of a physician, a nurse, and a social worker. The consultant on call at the time of a case referral becomes the Designated Consultant from the Trauma X Team to the case management team, acts as a link between the two teams, and participates in the evaluation and assessment of the case. Although all the Trauma X Team consultants are on call on a rotating basis, each has, in addition, special duties related to his or her profession. While Team members are not involved in the direct provision of treatment services, their input into the management of child abuse cases fosters sensitive and humane handling of these cases, and exposes the professionals directly providing family services to the elements of good clinical management of child abuse and neglect.

The Children's Protective Services Center in Honolulu illustrates a unique way of coordinating the hospital and social service agency. Under an agreement between the mandated agency, the Hawaii Department of Social Services and Housing; and the Kauikeolani Children's Hospital, the protective service unit is housed in the hospital. The protective service social work staff responds administratively to the public welfare agency and works cooperatively with the medical component at the hospital. The social work component continues to receive all referrals for protective services and is responsible for social service diagnosis and treatment. The medical component provides diagnosis and treatment in physical medicine for the child, and provides psychiatric and psychological diagnostic evaluations of child and family. All of the medical team members -- a pediatrician, a psychiatrist, and a psychologist -- serve as consultants to the social workers. These medical members, and the public welfare social work supervisor, meet weekly to provide diagnostic consultation on cases presented by social workers. The social worker has the final responsibility for deciding the course to follow in individual cases.

The child abuse program at the Presbyterian-University of Pennsylvania Medical Center in Philadelphia illustrates a very different relationship between a hospital multidisciplinary team and the mandated child protective services agency. The program, which includes the disciplines of social work, public health nursing, pediatrics, and psychiatry, developed in an atmosphere in which hospital staff felt that the mandated agency was not providing its legally mandated services. An agreement with the agency was reached which allowed the hospital project to provide services to families of abused and neglected children whom the hospital reported. The mandated agency agreed not to pursue further investigation in these cases as long as the hospital project regularly reported the status of each family to a designated supervisor at the agency.
Interagency Programs

Perhaps because of the extensive coverage given treatment-oriented, hospital-based multidisciplinary teams in the literature, there has been some confusion over what a multidisciplinary team is and can do. A multidisciplinary team does not have to be treatment-oriented, nor need it be based in a medical center. Different communities, having very different protective services needs and resources, evolve child abuse teams designed to meet the unique problems which face them. Many community programs have been developed for such specific purposes as better reporting and interagency coordination.

In Boston, a city with several teaching hospitals and a number of social service agencies, a multidisciplinary program evolved out of frustration caused by poor interagency coordination. With so many organizations involved in child abuse and neglect treatment and intervention, there was an acute need for communication and coordination, and clarification of roles. Children's Advocates, Inc. had its beginnings in informal meetings between a hospital and the mandated child protection services agency. It has grown to include representatives of 23 agencies, all involved in direct services to children and their families. The coordination made possible by Children's Advocates has been a boon in the identification of abused children. Because there is a tendency for abusive parents to go "hospital shopping" to avoid recognition, a network for sharing information on these cases can help considerably in identifying them. Such a network now exists in Boston. Besides sharing information and expertise, members work on committees to develop community resources. There is an education committee which has developed a speakers bureau to talk about reporting. A resource committee has arranged an information and referral telephone service for lay people and professionals, and has sponsored a Parents Anonymous group. Other committees have been formed to deal with public relations, legal issues, and membership. This program illustrates how much can be done toward effectively mobilizing the community to deal with child abuse and neglect, without any involvement in direct service provision and without major expenditure.

Some teams combine the function of interagency coordination with that of direct responsibility for case management and service delivery. The Ramsey County (Minnesota) Child Abuse Team is an example of this type of program. Here, team members who represent different agencies are involved directly in case management. Prior to the development of the Child Abuse Team, community intervention in child maltreatment was fragmented. Coordination among agencies was poor, and the Ramsey County Welfare Department, which is legally responsible for child protection, was ill-equipped to deal with the multiproblem families involved in child abuse and neglect.

In May, 1969, the Judge of the Juvenile Court urged that a program be developed to coordinate the work of medical, legal, and social agencies. This idea received the support of several area program directors and professionals. The St. Paul - Ramsey Mental Health
Center was chosen to organize the program. The Child Abuse Team includes representatives of all community agencies which are significantly involved in intervention and treatment of abusing parents and abused children. Agencies represented include the St. Paul Police Department; the Ramsey County Welfare Department; the Ramsey County Juvenile Court; the Departments of Pediatrics and Social Work at St. Paul - Ramsey Hospital; Children's Hospital; the Ramsey County Nursing Service; the Community Mental Health Center; and the Wilder Children's Placement Service.

Member agencies routinely utilize the team on all cases of confirmed abuse. Information on cases of abuse is shared by agencies and services are coordinated through the Team. Importantly, member agencies have not abrogated their respective roles and responsibilities: the police still investigate the circumstances of the abusive incident; the Welfare Department still provides investigation, assessment, and case management services; and the Mental Health Center is involved in psychological evaluations and therapy. The Team does not dictate the action of any professionals; it only discusses cases and makes recommendations. The team process consists of emergency staffings, which are called when a child appears to be in imminent danger; treatment planning staffings, held as soon as all the relevant information on a case is available; and implementation staffings, held at least quarterly by involved professionals when three or more agencies are involved in a case. Administrative policy commitments from all member agencies to involvement in the Team were found to be of crucial importance for its functioning. Equally important was the designation of a Team coordinator, the only funded position on the Team. Finally, it was found that role definitions of Team members had to be clear and mutually agreed upon. Because of the complexity of community coordination, the process requires significant ongoing efforts to run smoothly. Over seven years of operation, during which the Team has been involved in about 600 cases of child abuse and neglect, the benefits of Team operation have proved to be well worth the effort.

Multidisciplinary teams can be valuable in special applications as well as in community organization and coordination or treatment. For example, in the Adams County (Colorado) School District, a "minimalist" multidisciplinary team operates to coordinate abuse and neglect cases among the district's pupils. The team, which was recommended by a special task-force convened to develop solutions to poor reporting by school personnel and lack of coordination in handling cases, consists of a social worker and a nurse who have district-wide responsibility and act as a central clearinghouse for all incidents of abuse or neglect. The school principal and another school representative, usually the resident counselor, assist in the handling of cases in their school. Implementation of the program included panel presentations for school personnel. During the 1972-73 school year 24 cases were processed by the team. Most were handled without referral to other agencies. In several cases, seemingly insignificant incidents were reported that were matched later with similar occurrences involving a sibling in another school. Thus, the program's record
system provided data whose relevance might otherwise have been overlooked. Even when limited in scale and in scope, multidisciplinary teams can make a valuable contribution in the detection and handling of child abuse and neglect cases.10

State-Mandated Multidisciplinary Teams

Several states have either mandatory or permissive legislation for the establishment of multidisciplinary teams. The Colorado law encourages the creation of child protection teams in each county or contiguous group of counties. In counties in which 50 or more incidents of child abuse are reported in one year, the child protection teams must be established the following year. The teams, which are under the direction of the county welfare departments and include representatives of local law enforcement agencies and the juvenile court, review case materials, make recommendations to the county welfare department on individual cases, and make reports to the state central registry.

Michigan's law directs the state-mandated child protective service agency to provide "multidisciplinary services...through the establishment of regionally based or strategically located teams." The teams provide services "such as those of a pediatrician, psychologist, psychiatrist, public health nurse, social worker, or attorney." Missouri requires the use of multidisciplinary services "whenever possible," both in investigating cases and providing treatment services.13 California has authorized the establishment of pilot multidisciplinary teams in three counties, and Pennsylvania law requires that each child protective service agency in the state make a multidisciplinary team available.15 The Virginia law establishing multidisciplinary teams is explicit in spelling out the team composition and functions:

"The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multidisciplinary teams which shall include, where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children, coordinating medical, social, and legal services for the children and their families, helping to develop innovative programs for detection and prevention of child abuse, promoting community concern and action in the area of child abuse and neglect, and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court."
The codification of multidisciplinary teams in state law reflects the growing consensus in the child abuse and neglect literature on the necessity of a multidisciplinary approach to deal with abuse and neglect.

Child abuse multidisciplinary teams are now operating on many Federal military bases. Army regulations provide for the establishment of a Child Protection Committee (CPC) on every base; the Air Force has issued similar guidelines. The CPCs usually include pediatricians, social workers, psychiatrists, nurses, Red Cross workers, military family service or Army Community Service workers, chaplains, lawyers, military police, and unit commanders. Often, representatives from local civilian child protection agencies sit on the military committees in liaison, consulting, and support roles. The military has developed the team approach because there are no military welfare agencies similar to those in civilian communities, and because the legal base for child protective services in the military is limited.

Conclusions

Multidisciplinary teams represent a major step in the direction of more humane and effective child protection, and it appears that they will continue to proliferate. The multidisciplinary approach is consonant with the best thinking in the child protection literature. Eli Newberger, M.D., and others have noted that the multidisciplinary approach is better suited to the preservation of the family than earlier efforts. Different agencies and professionals working in relative isolation from one another can do more harm than good and break up the family. As Newberger points out:

"we now know that with the right kind of interdisciplinary cooperation, families can be kept together and made to be safer, more nurturant contexts in which children who have suffered abuse can grow. Professional energies will be invested more in the direction of making families stronger than in simply assuring that children's risk of reinjury is reduced."

Multidisciplinary teams can help eliminate, or at least reduce, many institutional and other barriers to effective action. Among the barriers noted in the literature are lack of understanding by the members of one profession of the objectives, standards, conceptual bases, and ethics of the others; lack of effective communication; confusion over roles and responsibilities; interagency competition; mutual distrust; and institutional relationships which limit interprofessional contact.

The results of systematic evaluation of multidisciplinary team efforts are encouraging. The Sinai Hospital team included a research component whose conclusion was that "the overall results of team intervention, which have been substantiated both by observable changes
in family functioning and by ongoing systematic research, have been gratifying. Evaluation of the handling of child abuse cases at Boston Children's Hospital Medical Center showed a reduction in the cost of medical services and in the risk of reinjury subsequent to diagnosis of child maltreatment after the institution of the Trauma X Team.

A recently conducted survey of 14 multidisciplinary teams revealed a number of problems and advantages in their operation. Two of the teams reported no problems, and six indicated that their problems were minor. On eight teams, intellectual conflict between members sometimes made a consensus difficult to reach. This problem, however, appears to diminish over time. Six teams identified the problem of territoriality or "turfism." Problems caused by personal conflicts were reported in six teams, but these were resolved in the group process. Four teams reported difficulty in developing treatment plans which realistically reflected the available resources, and four reported that confidentiality of client records was problematic. Problems related to scheduling team meetings and the geographic location of meetings were also reported.

The advantages of multidisciplinary operation, however, seemed to outweigh the disadvantages, which were generally characterized as minor. None of the teams reported that they had not met their objectives. Some team advantages have already been noted: the contribution of several different professional perspectives; the sharing of responsibility for difficult cases; the broadening of perspectives brought about by exposure to other disciplines; and the improvement in the quality of case management decisions. Interagency multidisciplinary teams studied tended to facilitate cooperation between potentially competitive service providers. Moreover, the cost efficiency of these teams was termed "impressive."

Besides providing a better and less expensive means of intervening in the cycle of child abuse and neglect, multidisciplinary teams offer several advantages accruing from their concentration of expertise. Multidisciplinary team members are well-suited to engage in community awareness activities such as speaking before groups, running workshops, and providing training for other involved personnel. They can become the focal point in the community for child advocacy, and for the development of additional resources.

Multidisciplinary teams may well represent a major part of the future of child protective services. Dr. Helfer maintains that "we can no longer afford the archaic system of maintaining county-governed child protection services and expect to make progress in the area of child abuse and neglect." He proposes the organization of child protective services on a regional basis, with state-administered multidisciplinary programs providing acute care, long-term therapeutic intervention, education, evaluation, and research.


19. Ibid.

20. Barnes, ibid.


BIBLIOGRAPHY


Children's Hospital Medical Center. Trauma X Guidelines. Boston: Children's Hospital Medical Center (Photocopied).


Appendix A

Child Abuse and Neglect Programs Which Use

A Multidisciplinary Approach

(Arranged by Federal Region)

The information for this Appendix comes from Child Abuse and Neglect Programs, The National Center on Child Abuse and Neglect (DHEW), March 1978. Available for purchase from:

The National Technical Information Service (NTIS)
5285 Port Royal Road
Springfield, VA 22161

Purchase Information:

PB-277 824 NTIS Price: $15.50
CHILD ABUSE AND NEGLECT PROGRAMS
REGION I

CP-00007
Boston Hospital for Women, Mass 27 Longwood Ave
Boston, MA 02115

Task for the Prevention of Family Breakdown
A Groves
Oct 74

Services: Part of this program is concerned with the prevention of child abuse and neglect. Social work counseling, health counseling, family planning, and medical care are offered directly to parents. Weekly follow-ups are conducted by social workers and nurses. Medical care is directly available to children. Other services are made available by referral, including homemaking services, day care, foster care, and welfare assistance. Daily to monthly follow-ups are made by social workers, visiting nurses, and visiting homemakers.

Clientele: Individual parents served by the program come from mixed-income, urban and inner-city areas. Twenty-four mothers were treated in the last fiscal year.

Staffing: All the staff, employed by the hospital and include primarily child welfare personnel, nurses, and psychiatric social workers. Psychiatrists, pediatricians, and homemakers also render services when needed.

Organization: The Boston Hospital for Women hospitil conducts the program on its own

Coordination: The team receives its cases from hospital staff. Care reports are made to social services authorities.

Funding: Program activities are supported financially by the hospital.

CP-00013
Children's Hospital Medical Center, Boston, Mass 300 Longwood Ave
Boston, MA 02115

Children's Hospital Trauma X Team.
M. Selvitenk and J. Hyde
Sep 70

Services: The Trauma Team, devoted entirely to child abuse and neglect problems, provides social work counseling, health counseling, family planning, and medical care for families. Parent Anonymous, various types of counseling and therapy, homemaking services, and medical care are provided directly to parents. Weekly follow-ups are conducted by social workers and nurses.

Clientele: Individual parents served by the program come from mixed-income, urban and inner-city areas. Twenty-four mothers were treated in the last fiscal year.

Staffing: All the staff are employed by the hospital and include primarily child welfare personnel, nurses, and psychiatric social workers. Psychiatrists, pediatricians, and homemakers also render services when needed.

Organization: The Boston Hospital for Women conducts the program on its own.

Coordination: The team receives its cases from hospital staff. Care reports are made to social services authorities.

Funding: Program activities are supported financially by the hospital.

CP-00048
New Hampshire State Div. of Welfare, Keene Keene District.
118 Main St
Keene, NH 03431

Child Abuse Project
S. M. Holden

Services: Lify therapy, social work counseling, pediatric care, home economics training, and psychological and psychiatric counseling are provided for families

Staffing: A social worker is on the project staff. A pediatrician, a psychologist, a psychiatrist, and a teacher volunteer the time.

Organization: The administering agency is a county office of the State Division of Welfare, which is part of the State Department of Health and Welfare.

Coordination: The mental health personnel serving the project come from Monadnock Area Mental Health, the pediatrician comes from Keene Clinic, and the teachers from Keene State College. The economics comes from Keene State College.

CP-00053
Family Service Society of Pawtucket, RI
33 Summer St
Pawtucket, RI 02860

Police Crisis Teams
J. Cari and M. Peirce
Jan 74

Services: Social work counseling, couples counseling, family counseling, individual therapy, and health counseling for parents are available directly. Individual therapy, group therapy, and family planning are offered through referrals. Individual therapy is available directly or through referrals. The training of police officers in other communities is contemplated in the upcoming year.

Clientele: The clients, who are primarily low-income, are drawn from suburban, urban, and inner-city areas. Individual children and families constitute 10 and 95 percent, respectively, of the total client profile.

Staffing: Family counselors, psychiatric social workers, and police officers comprise the program staff.

Organization: The program is operated by a private, nonprofit organization which is focused on mental health Supervision of the project is carried out by a board of directors. Major operational changes which have been made include the extension of services to 3 more communities.

Funding: Program income consists of 95 percent federal funds distributed through the state, 5 percent state funds, and 5 percent private foundation grants.

CP-01709
Boston Dept. of Health and Hospitals, Mass 818 Harrison Ave
Boston, MA 02118

Boston City Hospital Child Abuse Team.
A. McDonald
Sep 70

Services: The program is primarily concerned with child abuse and neglect. Social work counseling, health counseling, family planning, and medical care are provided for families. Social work counseling, group therapy, Parent Anonymous, couples counseling, family counseling, individual therapy, child management classes, welfare services, family planning assistance, and residential care are available through referrals. The children are provided with medical care, play therapy, individual therapy, and specialized therapy. Children are referred by day care, therapeutic day care, foster care, and residential care. Quarterly follow-up is maintained through return visits to the clinic and contacts with other community agencies involved with the families.

Clientele: The program serves low-income families from urban and inner-city areas.

Staffing: Team members include child welfare personnel, lawyers, nurses, pediatricians, social workers, and a data coordinator. The team members are employed by the Department of Health and Hospitals in other programs and are volunteers with the Child Abuse Team.

Organization: Evaluation is performed informally through peer review and interagency dialog.

Coordination: Clientele are referred from a wide variety of sources including some neighbor

hood health centers. Cases are reported to the judicial branch, juvenile services, and social welfare services.
CP-00082
Newark Police Department, N. J.
20 Pleasant Ave.
Newark, N. J. 07104
Youth Aid Bureau.
G. J. Hamer.

Services: Child abuse and neglect are a part of the program scope. The bureau directly provides social work counseling; referrals are made to the New Jersey Division of Youth and Family Services for family counseling and individual therapy for children. A police team approach in child abuse and neglect cases in conjunction with other agencies is anticipated.

Clientele: Individual children and individual parents served by the program mainly come from the inner city of Newark. There were 75 cases in the last fiscal year.

Staffing: Criminologists, family counselors, psychologists, and social workers staff the bureau.

Organization: The Police Department is directly supervised by the Newark City government.

Coordination: Referrals to the bureau come from social service agencies, schools, the police, relatives, and neighbors. Case reports are made to the central registry operated by the Division of Youth and Family Services and information is shared with the courts and the Essex County Prosecutor.

Funding: Approximately 95 percent of the program's financing came from the state and federal government. About 5 percent is from private sources.

REGION II

CP-00149
Long Island Jewish-Hillside Medical Center.
New Hyde Park, N. Y.
New Hyde Park, N. Y. 11040
Child Protection Program.
Dr. A. L. G. Diwan and P. L. Lipkonski, and N. B. Bogard.

Services: The program's primary focus is child abuse and neglect. Children are directly administered medical care, and specialized therapy. Parents receive family counseling, medical care, family planning assistance, health counseling, and individual therapy through a team. Follow-up is carried out by social workers monthly and by the Visiting Nurse Service weekly. A day care center is contemplated.

Clientele: Suburban and urban-dwelling children and their parents are treated individually by the team. Fifty percent of the clients are parents and 50 percent are children. In the last fiscal year, 56 parents were treated; 16 children were followed up. The average age of a physician was 42 years.

Staffing: The program is composed of a physician, a psychologist, a psychiatrist, and a social worker.

Organization: This is a private, nonprofit program.

Coordination: Clients are brought to the attention of county child protective workers, hospitals, and by clients themselves. All cases are reported to social welfare services and arrest authorities.

Funding: Approximately 40 percent of the program's financing was met by the government and 20 percent by the state. Fifty percent was obtained through referrals or on a contractual basis. Children receive day care and foster care services directly. A wide range of child care and health services furnished directly to parents, with a wide range of human, social, health, and welfare services furnished directly.

Services: Most of the program's scope encompasses child abuse and neglect. Social work counseling, couples counseling, medical care, residential care, and employment assistance are offered directly to parents. In addition, the bureau provides counseling for children through referrals or on a contractual basis. Children receive day care and foster care services directly. A wide range of child care and health services furnished directly to parents, with a wide range of human, social, health, and welfare services furnished directly.

Funding: Approximately 95 percent of the program's financing came from the state and federal government. About 5 percent is from private sources.

Services: The program's primary focus is child abuse and neglect. Children are directly administered medical care, and specialized therapy. Parents receive family counseling, medical care, family planning assistance, health counseling, and individual therapy through a team. Follow-up is carried out by social workers monthly and by the Visiting Nurse Service weekly. A day care center is contemplated.

Clientele: Suburban and urban-dwelling children and their parents are treated individually by the team. Fifty percent of the clients are parents and 50 percent are children. In the last fiscal year, 56 parents were treated; 16 children were followed up. The average age of a physician was 42 years.

Staffing: The program is composed of a physician, a psychologist, a psychiatrist, and a social worker.

Organization: This is a private, nonprofit program.

Coordination: Clients are brought to the attention of county child protective workers, hospitals, and by clients themselves. All cases are reported to social welfare services and arrest authorities.

Funding: Approximately 40 percent of the program's financing was met by the government and 20 percent by the state. Fifty percent was obtained through referrals or on a contractual basis. Children receive day care and foster care services directly. A wide range of child care and health services furnished directly to parents, with a wide range of human, social, health, and welfare services furnished directly.
CP-00217
Anne Arundel County Dept of Social Services, Annapolis, Md.
Calvert St.
Anne Arundel Center
Annapolis, MD 21404
Multidisciplinary Committee on Child and Sexual Abuse
A L Gezaway
Oct 73

Services: Part of the scope of this program is concerned with child abuse and neglect. The program offers social work counseling, family counseling, individual therapy, homemaking services, housing assistance, family planning assistance, medical care, and residential care directly to families. Services offered directly to children include day care, medical care, individual therapy, foster care, and residential care. Referral supplies lie therapy, group therapy, couples counseling, health counseling, child management classes, employment assistance, and several of the direct services for families and specialized therapy and residential care for children.

Clientele: Families from rural and inner-city, mixed-income areas are usually served by the program.

Staffing: The staff consists of social workers.

Organization: The organization is supervised by the State Department of Social Services. The program is evaluated by casework staff, administrative staff, and committee members.

Coordination: Sources of referrals are medical authorities, private social service agencies, schools, legal authorities, parents, other concerned individuals, and clients. Cases are reported by name to the police or the Judiciary, schools, legal authorities, parents, other concerned individuals, and clients. Cases are reported by name to legal authorities. Juvenile services, health departments, and to the state central registry maintained by the Maryland Social Service Administration.

Funding: In the last fiscal year, the program was supported by state funds, state-administered federal funds, and county funds.

CP-00240
Anne Arundel County Dept of Social Services, Annapolis, Md.
Calvert St.
Anne Arundel Center
Annapolis, MD 21404
Multidisciplinary Committee on Child and Sexual Abuse
A L Gezaway
Oct 73

Services: Part of the scope of this program is concerned with child abuse and neglect. The program offers social work counseling, family counseling, individual therapy, homemaking services, housing assistance, family planning assistance, medical care, and residential care directly to families. Services offered directly to children include day care, medical care, individual therapy, foster care, and residential care. Referral supplies lie therapy, group therapy, couples counseling, health counseling, child management classes, employment assistance, and several of the direct services for families and specialized therapy and residential care for children.

Clientele: Families from rural and inner-city, mixed-income areas are usually served by the program.

Staffing: The staff consists of social workers.

Organization: The organization is supervised by the State Department of Social Services. The program is evaluated by casework staff, administrative staff, and committee members.

Coordination: Sources of referrals are medical authorities, private social service agencies, schools, legal authorities, parents, other concerned individuals, and clients. Cases are reported by name to the police or the Judiciary, schools, legal authorities, parents, other concerned individuals, and clients. Cases are reported by name to legal authorities. Juvenile services, health departments, and to the state central registry maintained by the Maryland Social Service Administration.

Funding: In the last fiscal year, the program was supported by state funds, state-administered federal funds, and county funds.

CP-00227
Children's Hospital Medical Center, Philadelphia, Pa.
34th and Civic Center Blvd
Philadelphia, PA 19104

Suspected Child Abuse-Neglect Team
P. MacRae
Jun 73

Services: Part of the program deals with child abuse and neglect. The program encompasses the areas of identification, prevention, treatment, and follow-up. Parents receive social work counseling and medical care directly from the program, while parent aides and on-a contractual basis. Comprehensive special social health and specialized therapy are provided directly to children with comprehensive child care and child health services obtainable through referrals.

Clientele: Individual children, individual parents, and families account for 5 percent, 70 percent, and 25 percent of the total clientele respectively. Low-income urban and inner-city residents form the majority of clients served.

Staffing: The program utilizes lay therapists, pediatricians, psychiatrists, social workers, and training specialists.

Organization: The program is focused entirely on child abuse and neglect. The program is headquartered in Philadelphia and Philadelphia.

CP-00302
Philadelphia, PA 19133

Family Resource Center (National Demonstration Center for Child Abuse and Neglect, Philadelphia Area).

J Connolly, and O R Childress
Jan 75

Services: The program is focused entirely on child abuse and neglect. The program is headquartered in Philadelphia and Philadelphia.

CP-00304
Philadelphia, PA 19133

Family Resource Center (National Demonstration Center for Child Abuse and Neglect, Philadelphia Area).

J Connolly, and O R Childress
Jan 75

Services: The program is focused entirely on child abuse and neglect. The program is headquartered in Philadelphia and Philadelphia.

Services: The program is focused entirely on child abuse and neglect. The program is headquartered in Philadelphia and Philadelphia.

CP-00305
Philadelphia, PA 19104

The Children's Hospital is the major referral source. Cases are reported by name to the social services. Data is shared with the Suspected Child Abuse Center.

Funding: The program is entirely funded by the hospital.
Services: Most of the program scope focuses on child abuse and neglect. Direct services to parents include social work counseling, couples counseling, family counseling, individual therapy, family planning assistance, and medical care services. They are referred to other programs for group therapy, parent counseling, couples counseling, family counseling, individual therapy, homemaking, health counseling, housing assistance, and welfare assistance. Couples counseling, family counseling, individual therapy, and residential care services are purchased for parents from other programs. Children receive medical care services directly, and play therapy, specialized therapy, foster care, and residential care services are purchased for children from other programs. Follow-up is maintained through a quarterly review of medical records and through twice-monthly staff meetings. The addition of a parent aide service is anticipated.

Clientele: Military personnel and their families are served. Individual, children, individual parents, and families account for approximately 20, 60, and 20 percent of the total clientele, respectively. Clients are drawn from mixed-income rural, suburban, urban, and inner-city areas.

Staffing: The program staff consists of lawyers, nurses, pediatrics, psychiatric social workers, and social workers.

Organization: A case management summary on each established case of abuse or neglect is submitted to the Army Health Services Command at Ft. Sam Houston, Tex., for evaluation. Coordination: Hospitals, government social service agencies, schools, law enforcement agencies, parents, relatives outside the immediate family, and neighbors are the major referral sources. Cases are reported by name to the legal authorities, social services, U.S. Army Health Services Commands, and to a central referral agency. Statistical information is shared with the Child Welfare Information System, and Brooklyn Catholic Charities. Child Care Division. Case referrals come from social service agencies, courts, and siblings. Cases are reported by name to legal authorities and juvenile authorities, by name and code to social service authorities, and by gross numbers to health departments.

Funding: In the last fiscal year, 81 percent of the program's income came from city funds, 13 percent from county funds, and 8 percent from personal donations.
Services: Part of the program is focused on child abuse and neglect. The program provides social work counseling, group therapy, couples counseling, family counseling, individual therapy, child management classes, and psychological and psychiatric diagnostic evaluations for families. Homemaking services, health counseling, welfare services, family planning assistance, medical care, and residential care are provided through referrals. Play therapy and individual therapy are provided for children. Medical care, specialized therapy, foster care, and residential care are supplied for children through referral.

Clientele: In the last fiscal year, 50 children and 50 families from all income levels were treated. Clients are usually from rural or suburban areas.

Staffing: The program staff consists of program evaluators, psychiatric social workers, psychologists, and teachers.

Organization: The program is supervised by the Division of Mental Health of the Department of Human Resources.

Coordination: Case information is exchanged with the Clayton County Department of Family and Children Services, the Juvenile Court, and the Protective Services Team. A teacher-therapist is shared with the Clayton County Board of Education. Medical authorities, public social service agencies, schools, courts, clients, and other private individuals refer cases to the program. Cases are reported to social welfare services.

Funding: In the last fiscal year, 80 percent of program income was provided by the state, 10 percent through state-administered federal funds, and 60 percent through county funds.

REGION IV

CP-00475
Clayton County Protective Services Team, Jonesboro, Ga., Clayton Mental Health Center, Jonesboro, Ga.

Services: Part of the program is focused on child abuse and neglect. The program provides social work counseling, group therapy, couples counseling, family counseling, individual therapy, child management classes, and psychological and psychiatric diagnostic evaluations for families. Homemaking services, health counseling, welfare services, family planning assistance, medical care, and residential care are provided through referrals. Play therapy and individual therapy are provided for children. Medical care, specialized therapy, foster care, and residential care are supplied for children through referral.

Clientele: In the last fiscal year, 50 children and 50 families from all income levels were treated. Clients are usually from rural or suburban areas.

Staffing: The program staff consists of program evaluators, psychiatric social workers, psychologists, and teachers.

Organization: The program is supervised by the Division of Mental Health of the Department of Human Resources.

Coordination: Case information is exchanged with the Clayton County Department of Family and Children Services, the Juvenile Court, and the Protective Services Team. A teacher-therapist is shared with the Clayton County Board of Education. Medical authorities, public social service agencies, schools, courts, clients, and other private individuals refer cases to the program. Cases are reported to social welfare services.

Funding: In the last fiscal year, 80 percent of program income was provided by the state, 10 percent through state-administered federal funds, and 60 percent through county funds.
CP-00722
Child Advocate Association, Chicago, Ill.
19 S LaSalle St, Rm 401
Chicago, IL 60603
Child Advocate Association
T. Hanrahan
Feb 75

Services: Most of the program scope encompasses child abuse and neglect. Follow-up services are emphasized. The program provides legal intervention on behalf of children in relation to those services and institutions that impinge on their lives. Legal representation services are offered directly to children. The program aims to establish hospital-based interdisciplinary, interagency child abuse teams at key county hospitals, to develop a pool of volunteer attorneys to provide legal assistance to abused children, to provide legal and social work consultation to allied professions, to develop treatment resources for families who abuse their children and to encourage increased awareness and skill in handling child abuse on the part of professionals and the public. Follow-up is maintained through bi-monthly conferences and court reports.

Clientele: Program services focus on individual children. Clients are drawn from urban areas.

Coordination: Hospitals and social service agencies are the major referral source.

Funding: The first-year funding of the program was provided by the Illinois Law Enforcement Commission Additional income consisted of foundation grants and personal donations.

CP-0598
Jefferson County Children Services Board,
Steubenville, Ohio Department of Protective Service
240 John Scott Hwy
Steubenville, OH 43952
Protective Services for Children, W. Donetto and M. A. Curman
Feb 74

Services: The program scope is primarily focused on child abuse and neglect. Social work counseling, family counseling, parent aide groups, individual therapy, homemaking services, Parent's Anonymous, residential care, and foster care are available. Parent aide groups and individual therapy involving therapy and family counseling, child management classes, health counseling, medical care and specialized therapy, and child employment housing, welfare and family planning assistance are available through referrals. Day, residential, and foster care and individual therapy are offered to children directly. Medical care including physical therapy and specialized therapy are available through referrals. Follow-up by investigation and counseling is provided as needed.

Clientele: In the last fiscal year identification treatment and follow-up services were provided for 539 individual children and 430 families from low-, middle-, and upper-income levels and various locations.

Notes: Child welfare personnel, physicians, and caseworkers comprise the program staff. Development of a team approach to combat child abuse and neglect is anticipated. The team will consist of law officer, physician and staff member.

Organization: This is a county agency under the supervision of the Ohio Department of Public Welfare. The program is evaluated in-house.

Coordination: Medical authorities social service agencies, schools, law enforcement agencies, courts, abuse victims, and other concerned individuals refer cases to the program. Cases are reported by name to the police and juvenile courts. Protective services are given to abuse victims, health departments and a state central registry. Relevant information is shared with the Jefferson County Welfare Department. Funding: Monetary support is received from state, state-controlled federal, and city sources.

CP-00992
Miami-County Children Services Board, Troy, Ohio
201 W Main St
Troy OH 45373
Child Abuse Review Team
R. S. Painter
Sep 75

Services: The program focuses entirely on child abuse. Social work counseling, family counseling, and medical care are offered to parents directly. Couples counseling, individual therapy, and welfare and family planning assistance are available through referrals. For children, foster and residential care are offered directly.

Clientele: Families constitute the entire client profile. They come primarily from rural areas.

Organization: The program is a non-profit, child advocacy organization.

Coordination: The Association is a private, non-profit organization.

Organization: The Association is a private, non-profit organization.

Funding: Most of the program income will arise from voluntary agency funds.

CP-01817
Hamilton County Dept. of Welfare, Cincinnati, Ohio
628 Sycamore St.
Cincinnati, OH 45202
Group Home Program
S. Mattow, and D. Jazwinski.

Services: Part of the program scope is focused on abuse and neglect. Direct services to patients include social work counseling, group therapy, family counseling, individual therapy, and residential care. Most of the above services plus medical care are available through purchases; homemaking services, housing assistance, and welfare assistance are available through referrals. Individual therapy and residential care are available through purchases, and referrals may be used for some specialized therapy. Clientele: Individual children, children in groups, and families constitute 75, 20, and 5 percent of the clientele respectively. Clients are typically drawn from low-income urban and inner-city areas.

Services: Child welfare personnel, lay therapists, and social workers comprise the program staff. A coordinator is shared with other residential programs.

Organization: The program is supervised by the Hamilton County Commissioners. Evaluations are performed by in-house staff and also by a court review board.

Coordination: All cases handled by the program are the result of in-house referrals. Also, cases are reported to the parent social welfare agency. Follow-up of cases are conducted by the Protective Services division, as needed.

Funding: County funds support the program operations.
REGION VI

CP-01100
Louisiana State Div of Family Services. Baton Rouge
P.O Box 44065
Baton Rouge, LA 70804
Child Protection Services.
Rose Westerfield, and JL Fustrell
Jan 73

Services: The scope of the program covers, in part, the identification and treatment of abused and neglected children and their families. Services offered directly to families include social work counseling, couples counseling, family counseling, individual therapy, homemaker assistance, employment assistance, housing assistance, welfare assistance, and medical care. Residental care for families may be purchased and families are referred for group therapy and family planning. Children are provided directly with day care. Individual therapy, and foster care. Medical care and residential care may be purchased for children.

Clients: In the last complete fiscal year approximately 55 percent of those served were individual children and about 45 percent were families. Clients are from various locations and mixed-income levels.

Stafing: The staff is composed of child welfare personnel, homemaker specialists, psychiatrists, and a training specialist. The program plans to add attorneys and psychologists to the multidisciplinary team.

Organization: The administering organization is supervised by the Louisiana Health and Human Resources Administration. For evaluation, the Monitoring and Evaluation Unit reads samples of cases following a schedule designed for that purpose. Their report is sent to a Social Service Program Administrator who meets with the Protective Service Consultant to plan corrective action.

Coordination: Sources of referrals are medical authorities, social service agencies, schools, legal authorities, parents, other concerned individuals, and self-referrals. Adjudicated cases are reported by name to the state central registry maintained by the organization and to the District Attorney. Identifying codes are sent to the National Clearinghouse for Child Abuse and Neglect in Denver, Colorado. Information is also shared with regional mental health centers and parish health units. "Pediatric care is purchased through referrals and medical care furnished through referrals and follow-up is maintained by means of a questionnaire completed at the conclusion of treatment. A child management recall every 6 weeks and by medical recall every 4 to 6 weeks.

Clientele: Individual children and families from mixed-income, suburban, urban, and inner-city areas are served by the program.

Stafing: The program staff consists of dentists, nurses, pediatricians, psychiatrists, social workers, psychologists, social workers, psychologists, teachers, and educational diagnosticians.

Organization: The program is conducted by a private, nonprofit mental and physical health organization. Individual case records are evaluated quarterly by an interdisciplinary team of professionals. Results of management and degree of problem remediation are evaluated every 2 years by the Joint Commission on Accreditation of Community Agencies.

Coordination: Referring agencies include Child Welfare the Texas Youth Council various juvenile courts in Texas, child guidance clinics, school counselors, the military CHAMPUS program, parents, psychologists, doctors, psychiatrists, clients, and other concerned individuals. Cases are reported by name to the Department of Public Welfare and information is also shared with the Texas Rehabilitation Commission. The department works closely with the public schools where the students are enrolled.

Funding: In the last fiscal year, approximately 10 percent of the program's income was from private sources including personal donations and client fees.

REGION VI

CP-01171
Child Study Center Inc. -Fort Worth, Tex
1300 W Lancaster
Fort Worth, TX 76102
Psychiatric Services.
G. G. Maddox, and L. O. Eason
1966

Services: Part of the program scope encompasses child abuse and neglect. Services in the areas of prevention, treatment, and follow-up are available. Social work counseling group therapy, family counseling, and child management classes are offered directly to parents. Children receive day care, therapeutic day care, play therapy, individual therapy, and specialized therapy services. Medical services are furnished directly with referrals and follow-up is maintained by means of a questionnaire completed at the conclusion of treatment. A child management recall every 6 weeks and by medical recall every 4 to 6 weeks.

Clientele:Individual children and families from mixed-income, suburban, urban, and inner-city areas are served by the program.

Stafing: The program staff consists of dentists, nurses, pediatricians, psychiatrists, social workers, psychologists, social workers, psychologists, teachers, and educational diagnosticians.

Organization: The program is conducted by a private, nonprofit mental and physical health organization. Individual case records are evaluated quarterly by an interdisciplinary team of professionals. Results of management and degree of problem remediation are evaluated every 2 years by the Joint Commission on Accreditation of Community Agencies.

Coordination: Referring agencies include Child Welfare the Texas Youth Council various juvenile courts in Texas, child guidance clinics, school counselors, the military CHAMPUS program, parents, psychologists, doctors, psychiatrists, clients, and other concerned individuals. Cases are reported by name to the Department of Public Welfare and information is also shared with the Texas Rehabilitation Commission. The department works closely with the public schools where the students are enrolled.

Funding: In the last fiscal year, approximately 10 percent of the program's income was from private sources including personal donations and client fees.

REGION VI

CP-01204
Settlement Club, Austin, Tex
1800 Peyton Gin Rd
Austin, TX 78758
Aileen Millay
H Sco*in
Sep 87

Services: Part of the program encompasses abused and neglected adolescents and their families. Social work counseling, family counseling, and individual therapy are offered directly to families of residents. Children are directly provided with medical care, play therapy, individual therapy, residential care, recreational activities, and group therapy. Milieu therapy is emphasized. Many of these services are also available by purchase of referrals. Adolescents over 18 may be referred to Texas Vocational Rehabilitation for job training.

Clientele: Clients are adolescents between the ages of 13 and 18 and their families. They are primarily from suburban and urban, mixed-income areas.

Stafing: The staff consists of psychiatric social workers, psychologists, and psychiatrists.

Organization: The organization is governed by the Texas Department of Public Welfare. There are individual treatment evaluations at least every 3 months which involve the entire treatment team and are under the direction of the Director of Social Services.

Coordination: Referring agencies include Child Welfare the Texas Youth Council various juvenile courts in Texas, child guidance clinics, school counselors, the military CHAMPUS program, parents, psychologists, doctors, psychiatrists, clients, and other concerned individuals. Cases are reported by name to the Department of Public Welfare and information is also shared with the Texas Rehabilitation Commission. The department works closely with the public schools where the students are enrolled.

Funding: In the last fiscal year, approximately 10 percent of the program's income was from private sources including personal donations and client fees.
Services: The program is focused primarily on child abuse and neglect. Social work counseling, individual therapy, medical care are offered to parents. Meetings are called attention of concerned individuals to needs of previously hospitalized children and provide follow-up.

Clientele: Those served are individual children and parents. Meetings are called attention of concerned individuals to needs of previously hospitalized children and provide follow-up.

Organization: The program is conducted by a private, nonprofit organization.

Coordination: Medical professionals refer cases to the program. Information pertinent to the case of a hospitalized child is shared with the County Department of Social and Rehabilitation Services. A social worker is also shared with this agency.

Services: The program scope focuses primarily on child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, family counseling, individual therapy, mental health services, medical care, family planning assistance, employment assistance, and welfare assistance are offered directly to parents. Clients are drawn from mixed-income, rural, suburban, and urban areas.

Clientele: Individual children and parents are served. Clients are drawn from mixed-income, rural, and urban areas. The program staff consists of child welfare personnel, family counselors, lawyers, psychiatric social workers, psychologists, social workers, psychiatrists, and social workers.

Organization: The program is conducted by an interagency council made up of public and private agencies. The program is evaluated internally, using informal methods.

Coordination: Medical and legal authorities, social service agencies, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities, juvenile services, social services, and to a central registry maintained by the Wyoming Department of Public Assistance and Social Services. Cases are reported by gross numbers to the Council on Wilson. An interest in the area of child abuse and neglect is expressed.

Services: Most of the program scope encompasses child abuse and neglect. Services in these areas of identification, prevention, treatment, and follow-up are available. Social work counseling, family counseling, individual therapy, mental health services, medical care, family planning assistance, employment assistance, and welfare assistance are offered directly to parents. Cases are reported by name to the social services. Information is shared with the Utah Division of Family Services. A social worker is shared with the Utah Division of Family Services. Follow-up reports are also shared with the Utah Division of Family Services.

Clientele: Individual children and parents are served. Clients are drawn from mixed-income, rural, suburban, and urban areas. The program staff consists of child welfare personnel, family counselors, lawyers, psychiatric social workers, psychologists, social workers, psychiatrists, and social workers.

Organization: The administering organization is supervised by Intermountain Health Care, Inc.

Program evaluations involve the analysis of follow-up reports on clients to determine if they benefited from the services offered.

Coordination: Medical authorities and victims are the major referral sources. Cases are reported by name to the legal authorities. Information is shared with the Utah Division of Family Services. A social worker is shared with the Utah Division of Family Services. Follow-up reports are also shared with the Utah Division of Family Services.

Clientele: Individual children and parents are served. Clients are drawn from mixed-income, rural, suburban, and urban areas. The program staff consists of child welfare personnel doctors, family counselors, lawyers, psychiatric social workers, psychologists, social workers, psychiatrists, and social workers.

Organization: The administering organization is supervised by Intermountain Health Care, Inc.

Services: Most of the program scope encompasses child abuse and neglect. Services in these areas of identification, prevention, treatment, and follow-up are available. Social work counseling, family counseling, individual therapy, mental health services, medical care, family planning assistance, employment assistance, and welfare assistance are offered directly to parents. Cases are reported by name to the legal authorities. Information is shared with the Utah Division of Family Services. A social worker is shared with the Utah Division of Family Services. Follow-up reports are also shared with the Utah Division of Family Services.

Clientele: Individual children and parents are served. Clients are drawn from mixed-income, rural, suburban, and urban areas. The program staff consists of child welfare personnel doctors, family counselors, lawyers, psychiatric social workers, psychologists, social workers, psychiatrists, and social workers.

Organization: The administering organization is supervised by Intermountain Health Care, Inc.
REGION IX

CP-01522
Arizona Dept of Economy Security Phoenix
P O Box 80
Phoenix, AZ 85005
Child Protective Services
J Huebner and D W Burdue Aug 70

Services: The program focuses mainly on child abuse and neglect, social work counseling, group therapy, family counseling, individual therapy, home-making services, school counseling, planning assistance, psychiatric examination and psychological evaluation available through a network of doctors, psychiatrists, and psychologists. Referrals are available through personal visits, phone calls, and letters. The major referral sources are identified by name to the legal authorities and to the social services agencies. The program's income is shared with the community hospital school personnel, and with the Suicide Prevention Committee, with the client's permission.

Funding: In the last fiscal year, county, municipal, and private funds accounted for the majority of the program's income. Some of the program income was provided by the school district of Monterey, Pacific Grove, and Carmel counties.

REGION IX

CP-01523
YWCA Monterey, Calif
P O Box 1362
Monterey, CA 93940

Monterey Peninsula Child Abuse Prevention Council.
P. Fall and B. Fenney Apr 75

Services: Most of the program scope encompasses child abuse and neglect. Social work counseling, couples counseling, family counseling, individual therapy, child management, classes, employment assistance, welfare assistance, family planning assistance, and medical care services are offered to parents through referrals. Children receive day care and medical care, individual therapy, foster care, and residential care services through referrals. The program serves as a clearinghouse for information on child abuse. A list of community resources in this area will be prepared and efforts will be made to bring parent education into the curricula of all high schools. The establishment of a professional committee of physicians, lawyers, police officers, and social workers will meet periodically for the diagnosis and treatment of selected child abuse cases, and the establishment of a team to deal with long range treatment, education, research services, and follow-up for the program are anticipated.

Clientele: Clients are drawn from mixed-income, rural, suburban, and urban areas.

Staffing: The program staff consists of a program coordinator. The administration of the organization is governed by the Monterey County Board of Supervisors.

Coordination: Information is shared with the Monterey County Department of Social Services.

CP-01593
Monterey Peninsula Youth Project, Calif
467 Alvarado Monterey, CA 93940

Community Counseling Center
McPherson R Leep and J M Gallagher

Services: Part of the program scope focuses on child abuse and neglect. Social work counseling, couples counseling, family counseling, individual therapy, health counseling, and family planning assistance services are offered to parents through the program. Clients are drawn from mixed-income, rural, suburban, and urban areas.

Coordination: The program is conducted by the Monterey Peninsula Youth Project, a nonprofit mental health organization. The program is governed by the Monterey County Board of Supervisors.

CP-01628
Monterey County and Social Services
Salinas Calif
P O Box 299
Monterey, CA 93940

CP-0193
Salinas CA 93940
Crisis Intervention Cntnunum
E Cleary and J Phan

Services: Part of the program scope encompasses child abuse and neglect. Social work counseling, individual therapy, home-making services, school counseling, planning assistance, and welfare services are offered to parents through referrals. Children receive foster care services, and medical care services available through a network of doctors, psychiatrists, and psychologists. Referrals are available through personal visits, phone calls, and letters. The major referral sources are identified by name to the legal authorities and to the social services agencies. The program's income is shared with the community hospital school personnel, and with the Suicide Prevention Committee, with the client's permission.

Funding: In the last fiscal year, county, municipal, and private funds accounted for the majority of the program's income. Some of the program income was provided by the school district of Monterey, Pacific Grove, and Carmel counties.
Services: Part of the program focus is on child neglect. Social work counseling, group therapy, couples and family counseling, individual therapy, health counseling, child management classes, employment assistance, medical care, residential care, aftercare, and crisis day-care prevention are offered to parents. Day care, therapeutic day care, medical care, individual therapy, residential care, and group homes are offered to children. Follow-up is offered for 3 months after the return home on a trial basis, and aftercare is offered for 1 year.

Clientele: Children individually and in groups, parents and families from mixed-income suburban and urban areas are served by the program.

Staffing: Child welfare personnel, dentists, physicians, family counselors, lay therapists, nutritionists, pediatrists, psychiatric social workers, social workers, and teachers comprise the staff.

Organization: The program is governed by the Supervisory Council of the Good Shepherd. Missouri Program performance is evaluated in house by a team approach method.

Coordination: Private social service agencies, schools, law enforcement agencies, courts, prospective clients, and parents refer cases to the program. Cases are supported by a number of agencies and social service authorities. Information on the status of children and on program development is shared with the National Council of Juvenile Judges in Reno. Staff are shared with Nevada Mental Health and Vocational Rehabilitation programs.

Funding: Program support comes from state funds, personal donations, and client fees.

Services: The program focus is on child abuse and neglect. Social work counseling is offered to parents directly, social work counseling, group therapy, and foster care are available through referrals. For children, day care, therapeutic day care, medical care, individual therapy, and foster care are available through referrals. Changes in the program since its inception include provision for early intervention and treatment through case conferences involving involved professionals, development of a specific caseload involvement of the judicial component, and development of a secure center care. Future plans include increasing emphasis on public education, establishment of a family stress center, framing of professionals and paraprofessionals, expansion to a 24-hour reporting service on establishment of a multidisciplinary team and efforts toward sensitization of the legal system to a child advocacy role.

Clientele: Individual children (90 percent of the total clientele), individual parents (5 percent), and families (5 percent) from a wide variety of locales and income levels are provided identification and follow-up services. Staffing: The Coordinator also serves as administrator, training specialist, and data gatherer.

Organization: The program is governed by the Northern Nevada Task Force on Child Abuse and Trauma. It provides a non-punitive outlet for reporting. Other objectives are to improve communication between existing agencies and resources to design programs and to improve and educate the community. Program performance is evaluated from periodic reports to the District Health Officer and quarterly reports to the Mountain States Regional Medical Program (grantor).

Coordination: Medical authorities, government social service agencies, schools, law enforcement agencies, abuse victims, and other concerned individuals refer cases to the program. Cases are reported by name to the police and judiciary, and to social and welfare services. Health departments, day care centers, and hospitals are reported by gross numbers. Only a state central registry maintained by the Nevada State Welfare Designation Committee works with the Reno Police Department and Washoe County Sheriffs Department, Washoe State Division and Washoe County Welfare Department. The University of Nevada and the Washoe County School District, and Washoe Medical Center, and St. Mary's Hospital.

Funding: In the last fiscal year, program support came entirely from direct federal funds.
Services: The scope of the program is focused on child abuse and neglect. Day care therapeutic group counseling is provided to children. Services are provided directly to children through school counseling, lay therapy, group therapy, family counseling, individual therapy, and telephone assistance. Follow-up is conducted at weekly family counseling and weekly group therapy sessions.

Clientele: Parents and children from urban, low-income groups are served by the program.

Staffing: The staff consists of social workers, psychologists, pediatricians, lawyers, and medical specialists.

Organization: The program is supervised by its Board of Trustees.

Services: The program focuses on child abuse and neglect. Services in the areas of treatment and follow-up are offered directly to parents, group therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Funding: In the last fiscal year 95 percent of the program income was derived from county sources. 31 percent of the program income was derived from urban areas. Services: The program scope encompasses child abuse and neglect. Services in the areas of treatment and follow-up are offered directly to parents, group therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Clientele: Individual parents and parents in groups are served. During the last fiscal year, 68 percent of the program income was derived from county sources. 34 percent of the program income was derived from urban areas.

Staffing: The program staff consists of program evaluators, therapeutic specialists, social workers, outreach workers, and office managers. The social work supervisor supervises direct services.

Organization: The program is conducted by a private, nonprofit social service agency. The design of the program is expected to meet the needs of the community.

Services: The scope of the program focuses on child abuse and neglect. Services offered directly to families include social work counseling, day care, therapeutic group counseling, lay therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Funding: In the last fiscal year, 45 percent of the program income was derived from county sources. About 56 percent was contributed by voluntary agencies and personal donations. Social services are provided through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Clientele: Individual parents and parents in groups are served. During the last fiscal year, 68 percent of the program income was derived from county sources. 31 percent of the program income was derived from urban areas.

Staffing: The program staff consists of program evaluators, therapeutic specialists, social workers, outreach workers, and office managers. The social work supervisor supervises direct services.

Organization: The program is conducted by a private, nonprofit social service agency. The design of the program is expected to meet the needs of the community.

Services: The scope of the program focuses on child abuse and neglect. Services offered directly to families include social work counseling, day care, therapeutic group counseling, lay therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Funding: In the last fiscal year, 45 percent of the program income was derived from county sources. About 56 percent was contributed by voluntary agencies and personal donations. Social services are provided through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Clientele: Individual parents and parents in groups are served. During the last fiscal year, 68 percent of the program income was derived from county sources. 31 percent of the program income was derived from urban areas.

Staffing: The program staff consists of program evaluators, therapeutic specialists, social workers, outreach workers, and office managers. The social work supervisor supervises direct services.

Organization: The program is conducted by a private, nonprofit social service agency. The design of the program is expected to meet the needs of the community.

Services: The scope of the program focuses on child abuse and neglect. Services offered directly to families include social work counseling, day care, therapeutic group counseling, lay therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Funding: In the last fiscal year, 45 percent of the program income was derived from county sources. About 56 percent was contributed by voluntary agencies and personal donations. Social services are provided through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

Clientele: Individual parents and parents in groups are served. During the last fiscal year, 68 percent of the program income was derived from county sources. 31 percent of the program income was derived from urban areas.

Staffing: The program staff consists of program evaluators, therapeutic specialists, social workers, outreach workers, and office managers. The social work supervisor supervises direct services.

Organization: The program is conducted by a private, nonprofit social service agency. The design of the program is expected to meet the needs of the community.

Services: The scope of the program focuses on child abuse and neglect. Services offered directly to families include social work counseling, day care, therapeutic group counseling, lay therapy, couples counseling, child management classes, and medical care services. Services are offered through referrals. Follow-up counseling is conducted through a single home visit conducted at 30 to 90 days after case closure. Social work counseling is conducted through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving children with abuse and neglect. Coordination: Social service agencies, schools, relatives, and clients are served by the program. Social services are offered through referrals. A second goal of the program is to increase knowledge of abuse and neglect.

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Clientele: Individual parents and parents in groups are served. During the last fiscal year, 68 percent of the program income was derived from county sources. 31 percent of the program income was derived from urban areas.
Services: Most of the program scope encompasses child abuse and neglect. Services in the areas of identification, prevention, and follow-up are available. Parent aide services are offered directly to parents. Social worker counseling, couples counseling, family counseling, and child management classes are available to parents through referrals. Children receive day care, individual therapy, and foster care services through referrals.

Clientele: Individual children, individual parents, and families account for approximately 5, 5, 10, and 20 percent of the clientele, respectively. Clients are drawn from mixed-income, suburban and urban areas.

Staffing: The program staff consists of child welfare personnel, doctors, homemaker specialists, lay therapists, nurses, pediatricians, psychiatric social workers, psychologists, social workers, teachers, clergy, and a daycare coordinator. All are volunteers.

Organization: The Task Force is governed by the Division of Mental Health, the Division of Social Services, and Fairbanks Health Center.

Coordination: Medical authorities, government social service agencies, schools, parents, neighbors, and victims are the major referral sources. Cases are reported by name to the social services and health departments, and by group numbers to a state central registry.

Funding: During the last fiscal year, a service organization provided most of the program income.
Appendix B

Guidelines for Child Abuse and Neglect

Multidisciplinary Teams

The guidelines in this Appendix are reproduced with the permission and cooperation of the Virginia State Department of Welfare and the Pennsylvania State Department of Public Welfare. For additional copies of these publications, please contact:

Commonwealth of Virginia
Department of Welfare
8007 Discovery Drive
Richmond, Virginia 23288

Bureau of Public Education
Pennsylvania Department of Public Welfare
P.O. Box 2670
Harrisburg, Pennsylvania 17120

(Publication Number PWPE 28 12-77)
Recommended Guidelines for Community-Based Multidiscipline Teams for Child Protection

Commonwealth of Virginia Governor's Advisory Committee on Child Abuse and Neglect 1977
PREFACE

The General Assembly of Virginia in session during the winter of 1975 amended the Code of Virginia by adding in Title 63.1 a chapter numbered 12.1 containing sections numbered 63.1-248.1 through 63.1-248.17. The addition established the statute of the State regarding child abuse and neglect, defined certain pertinent terms, set the framework for reporting, and encouraged the fostering of multi-discipline community and hospital-based teams within each locality.

"The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multidiscipline teams which shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children, coordinating medical, social, and legal services for the children and their families, helping to develop innovative programs for detection and prevention of child abuse, promoting community concern and action in the area of child abuse and neglect, and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court."

(Chapter 12.1, Section of 63.1-248.6, E, Code of Virginia)

Although the local welfare departments were charged with "fostering" local teams, the same section suggests that public and private agencies as well as community groups and interested citizens be involved in the team.

Almost immediately, a need arose for some standards and guidelines to structure and give direction to the teams. Therefore, the Governor's Advisory Committee on Child Abuse and Neglect (also established by the aforementioned Code amendments) designated a subcommittee to perform such a function on behalf of the local teams.

Meanwhile, Region III of the Department of Health, Education, and Welfare signed a contract with the consulting firm Development Associates, Inc., to provide assistance to state groups as they began to structure programs for child abuse and neglect.

The material presented here is the result of the work of a subcommittee of the Governor's Advisory Committee on Child Abuse and Neglect consulting with representatives of Development Associates, Inc. Represented on the subcommittee were an established hospital-based team from the University of Virginia, the York County School Board, the Chesterfield-Colonial Heights Protective Services, the State Department of Corrections, the Orange County Welfare Department, a multidiscipline team in Virginia Beach, a mental health clinic in Martinsville, a health department in Abingdon, the Bureau of Child Protective Services and the general public.

Teams around the State provided advice and critical reaction as the subcommittee's work progressed.
The standards and guidelines presented here are based on the following model, which evolved from several currently in use about the State. This model seems effective for the broad range of situations existing throughout the State, but it should be considered eclectic, adaptable, and evolving.

In order for a multi-disciplinary child abuse and neglect team to meet the full spectrum of a community's needs, the team should consist of two general components or committees: a Case Consultation Committee and a Program Development Committee. Other committees may be developed, but it is conceived that they will either be components of these two general committees or they will be ancillary to them.

Development of the two committees is anticipated to be gradual. Either committee may be developed first—depending on the community's most pressing and immediate needs—with the second committee eventually evolving out of the first one.

The process will generally start with a small core group of highly interested and concerned citizens who see a need for case consultation on child abuse and neglect cases and/or the development of programs and services to provide community education, treatment and prevention, etc. The core group will coordinate efforts to form and develop one or both of these two committees in order to meet these needs.

Although the guidelines listed in this packet are only suggestions for developing a child abuse and neglect team, they may be considered basic requirements for developing a team that can adequately meet the community's need for prevention, identification and treatment of child abuse and neglect. When a system is developed for evaluating the quality of multi-disciplinary child abuse and neglect teams, these are the standards on which teams will be evaluated.
Guidelines for implementation may be considered flexible and subject to change from one community to another since each community can be expected to take into consideration its own unique resources.

Although it will undoubtedly take different communities different lengths of time to fully implement each standard, it is expected that all communities will eventually develop a fully functioning team incorporating each of them.

The responsibility for meeting these standards is the responsibility of the total community rather than any particular agency. However, it is expected that the impetus for forming the core group will come from the local welfare department.

The present subcommittee hopes to continue to function and to provide regional support services throughout the Commonwealth. It is foreseen that evaluative, educational, and training techniques can be provided by a permanent subcommittee on multi-discipline teams.

The committee welcomes your comments and criticisms. Send comments and suggestions to:

Chairperson, Sub-Committee on Multi-discipline Teams
c/o State Department of Welfare
Bureau of Child Protective Services
8007 Discovery Drive
Richmond, VA 23288

Persons responsible for writing these guidelines are:

Mrs. Elsie Elmore, Chairperson
Richmond, Virginia
Member of the Governor's Advisory Committee

Dr. Catherine Smith
Abingdon, Virginia
Member of the Governor's Advisory Committee

Mr. Ernest Mooney
York County School Board
Grafton, Virginia

Ms. Corinne Carr, ACSW
University of Virginia Medical Center
Charlottesville, Virginia

Dr. Joseph Leizer
Patrick Henry Mental Health Center
Martinsville, Virginia

Miss Suzanne Fleming
Department of Social Services
Chesterfield-Colonial Heights
Chesterfield, Virginia

Mrs. Margery L. Conme
Professional Task Force on Child Abuse and Neglect
Norfolk, Virginia

Mr. Austin C. Micklem, Jr.
Division of Youth Services
Richmond, Virginia

Mrs. Lee McAlpine
Department of Social Services
Virginia Beach, Virginia

Miss Pauline Minor
Department of Public Welfare
Orange, Virginia

Mr. Gary C. Koch
Office of Child Development
Region III, Health Education and Welfare
Philadelphia, Pennsylvania

Ms. Patricia A. Vasquez, Consultant
Development Associates, Inc.
Boothwyn, Pennsylvania
I. TEAM PURPOSE, FUNCTIONS, AND ORGANIZATIONAL ISSUES

A. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT CLEARLY IDENTIFYING ITS MISSION OR PURPOSE.

- This statement should include:
  1. measurable goals.
  2. priorities.
  3. specific objectives leading to the achievement of goals.
  4. action steps, members responsible and deadlines.

B. THE COMMUNITY BASED TEAM SHALL OBTAIN SANCTION AND SUPPORT FROM INFLUENTIAL GROUPS IN THE COMMUNITY.

- Sanctioning should be sought as early as possible in the team's development.
- The team should advise political leadership of its effort and submit periodic reports.
- Team members should seek sanction and support from their respective boards.
- The team should seek sanction and support from the local juvenile court and from the commonwealth's attorney, county attorney or city attorney.
- The team should develop alignments with other citizen groups and representatives of the private sector.

While the ultimate sanction for reducing the incidence of child abuse and neglect is based in law, the need for having everyone in the community understand and support the effort is obvious. Without this support, protective services and the community based team will be working in a vacuum. With the broadest community support that can be secured, everyone will become a part of the challenge, and the children will be the beneficiaries.

C. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT OF OPERATING PROCEDURES.

- This statement should include:
  1. a method of elected a chairperson.
  2. responsibilities of the chairperson and members.
  3. terms of service of the chairperson and members.
4. frequency of meetings.
5. convenient time and locations of meetings.
6. procedure for the conduct of meetings.

- Plans and mechanisms should be developed for continuous communication and coordination of efforts with sanctioning bodies and with other pertinent groups, public and private.

- The team may need to establish small, temporary subcommittees to undertake specific tasks.

D. THE COMMUNITY BASED TEAM SHALL BE PERMANENT SINCE EFFECTIVE SERVICE, PLANNING, AND COORDINATION ARE ENDURING PROCESSES. THE COMMUNITY BASED TEAM SHALL DEVELOP PROCEDURES TO INSURE COMMUNICATION AND COORDINATION AMONG ITS COMPONENTS.

- A firm link must exist between the Program Development Committee and the Case Consultation Committee through the core group.

- A member of the core group should serve as liaison between any temporary subcommittee and the team.

- The team members should understand how each organization represented on the team functions.

- Each member should be responsible for insuring that other members understand their professional "language."

II. COMMUNITY DEFINITIONS OF CHILD ABUSE AND NEGLECT AND STANDARDS OF CARE

A. THE COMMUNITY BASED TEAM SHALL RECOGNIZE THE COMMUNITY CONTEXT IN WHICH CHILD ABUSE AND NEGLECT OCCUR (COMMUNITY VALUES, INDIGENOUS PROBLEM SOLVING TECHNIQUES, CHILD-REARING TRADITIONS, RESOURCES AND LEADERSHIP) IN THE DEVELOPMENT OF PROGRAMS FOR TREATMENT AND PREVENTION OF CHILD ABUSE AND NEGLECT.

- The team should identify sources of leadership in both the public and private sector.

- The team should identify strengths in the community that help or could help in preventing child abuse and neglect.

- The team should identify social and economic problems and lifestyle patterns in the community that contribute to the problems of child abuse and neglect.

The definition should reflect community as well as professional standards and should be sufficiently broad for casework and preventive intervention. The definition should be reflective of the guidelines issued by the State Department of Welfare. The definition should consider the varying child-rearing practices in the community.

C. WITHIN THE FRAMEWORK OF EXISTING REGULATIONS, THE COMMUNITY BASED TEAM SHALL DEVELOP REALISTIC AND ATTAINABLE STANDARDS AND GUIDELINES FOR USE BY COOPERATING AGENCIES AND INDIVIDUAL PROFESSIONALS IN WORKING WITH CHILD ABUSE AND NEGLECT CASES.

The standards and guidelines should include:

1. joint diagnostic evaluation.
2. criteria for treatment plans.
3. criteria for format and timing of case review.
4. criteria for maximum caseload for team.
5. policies on follow-up of terminated or stabilized cases.
6. procedures for monitoring follow-up contacts.

Just as operational definitions can differ among communities, so also do the level of resources, leadership, decision-making processes, and cultural backgrounds. It is not possible, therefore, to develop standards and guidelines for service delivery that apply to every community situation. The team should bear in mind that if standards are set too low, they may be easily achieved but restrict progress. On the other hand, standards that are set too high may never be attainable in some communities, and frustration can be the result. By determining desirable patterns of services that are within the realm of reality and practicality, teams can measure needs by comparing existing patterns with the desirable ones. This process will provide the necessary groundwork for thorough program planning and development.

III. SIZE AND COMPOSITION OF COMMUNITY BASED TEAMS

A. THE SIZE AND COMPOSITION OF A COMMUNITY BASED TEAM WILL DEPEND ON THE TEAM'S FUNCTION AND PURPOSE WITHIN THE GEOGRAPHIC AREA.

The membership of the community based team should consist of a core group whose membership remains relatively permanent and a resource group whose membership varies according to the need of the team for consultation.

The core group should draw its membership from those who have given impetus to the formation and development of the community based team and who have shown regular attendance at the team's meetings. This should be a relatively stable group whose broad function is to act as a steering committee for the community based team. Specific functions of this group may include program planning and coordination as well as communication and liaison between the team's committees. It is recommended that membership of this group not exceed six.
The resource group should have an open-ended membership consisting of people who are invited to participate on the community-based team for varying lengths of time determined by the core group and who function as case or program consultants to the community-based team. The membership of this group need not be limited and should be comprised of people who agree to participate on the team for specific projects or tasks relevant to their areas of skill, knowledge, or community influence.

B. THE TEAM SHALL REFLECT THE RANGE OF PREVENTIVE AND TREATMENT RESOURCES AVAILABLE TO ABUSED AND NEGLECTED CHILDREN. IT SHALL INCLUDE PEOPLE INTERESTED AND WILLING TO PARTICIPATE ACTIVELY IN THE IDENTIFICATION, DEVELOPMENT AND EVALUATION OF PROGRAMS RELEVANT TO CHILD ABUSE AND NEGLECT.

• The membership of the community-based team (i.e., core and resource people) shall be divided into a Case Consultation Committee and/or a Program Development Committee. The community-based team may function in either one or both of these areas, depending on the continuing needs of the community in which the team is developed.

• The Case Consultation Committee should be restricted to community-based team members who have the professional expertise necessary to identify and plan for treatment of child abuse and neglect cases. Individuals with knowledge of a specific case to be staffed by the Case Consultation Committee may be invited to participate on the committee for whatever length of time required for their consultation. This committee may include both agency and privately employed professionals and should involve people with a broad range of treatment and management knowledge, such as physicians, ministers, school personnel, psychologists, psychiatrists, social workers, law enforcement officials and health professionals. The specific professions represented will vary with both availability as well as the demonstrated or expected contribution they may be expected to make to the committee. Where possible, these professionals should be drawn from local treatment agencies in order to provide a referral liaison between the committee and the agency. Agency professionals should have sufficient authority to accept referrals to their own agency as well as to represent their agencies’ policies and procedures.

• The Program Development Committee should include community-based team members who are agency as well as nonagency personnel. This committee should represent a cross-section community in demographic characteristics determined necessary by the Program Development Committee and may include representatives from civic groups, volunteer organizations, business and government. Members chosen for this committee should have skills, knowledge or influence necessary for contributing to program organization, coordination and evaluation as well as acquisition of funding. These members should also have demonstrated an interest and concern about child abuse and neglect in their community.

C. IF A MILITARY INSTALLATION EXISTS WITHIN THE AREA OF A COMMUNITY BASED TEAM, A REPRESENTATIVE FROM THE MILITARY SHALL BE INVITED TO BE ON THE TEAM.

IV. AREA AND COVERAGE OF COMMUNITY BASED TEAM

A. SUFFICIENT POPULATION SHALL BE ONE FACTOR IN DETERMINING THE AREA TO BE SERVED BY A COMMUNITY BASED TEAM AS WELL AS THE COVERAGE THAT CAN BE REASONABLY PROVIDED.
The population base might differ for the Case Consultation Committee and the Program Development Committee of the team. A Program Development Committee might take as its scope an area as comprehensive as an individual welfare region; however, a Case Consultation Committee should be limited to a single municipality or a section thereof and perhaps to one or more of its neighboring jurisdictions.

B. THE AREA CHOSE FOR COVERAGE SHALL NOT EXCEED PROSPECTS FOR ADEQUATE FUNDING TO ACHIEVE TEAM GOALS.

- Combined jurisdiction might guarantee a better financial base.
- Financial support for the team will come primarily from the budgets of participating agencies.
- Time and services may be donated by core and resource members of the team.
- There should be cooperative efforts between the public and private sectors in exploring the use of Title XX funds and other possible sources of funding.
- Supportive services may be provided by sponsoring organizations or groups. These can include such items as duplicating, clerical assistance, postage, etc.

C. COMMUNITY INTERESTS, LOCAL MORES, BUSINESS AND SOCIAL FACTORS AND TRANSPORTATION SYSTEMS ARE IMPORTANT CONSIDERATIONS OF AREA AND SCOPE OF COVERAGE.

- The team should determine whether the area has common problems amenable to solution through joint efforts.
- There should be a basic interpretation of community standards and values.
- Services should be accessible within a reasonable travel time.
- Existing transportation systems should be considered in developing services.

D. THE DISTANCE TO BE TRAVELLED BY ANY TEAM MEMBER TO ATTEND MEETINGS SHALL BE A LIMITING FACTOR ON AREA COVERAGE.

- A team member's travel time should not exceed two hours a day.

V. CITIZEN PARTICIPATION ON A COMMUNITY BASED TEAM

A. THE COMMUNITY BASED TEAM SHALL DEVELOP MECHANISMS FOR CITIZEN PARTICIPATION SO AS TO ASSURE AN ACCURATE VIEW OF AREA NEEDS, PATTERNS, AND TOTAL CITIZEN SUPPORT.

- The Community Based Team should encourage the participation of nonagency people. This will allow concerned citizens to share leadership and guidance in the planning and development of programs.
- Procedures for choosing nonagency members should reflect the community make-up, such as patterns of ethnic, racial, and economic levels. Other factors would include a willingness to serve and an interest and concern in the area of abuse and neglect.
The Community Based Team should develop relationships with volunteer and citizen groups.

The Community Based Team meetings dealing with community needs assessment, program planning and program evaluation should be open to the public.

The team should develop regular communications with all segments of the community.

VI. PROGRAM DEVELOPMENT COMMITTEE

A. THE COMMUNITY BASED TEAM SHALL STUDY THE EXISTING SERVICE DELIVERY SYSTEM FOR ABUSING AND NEGLECTING FAMILIES IN ORDER TO DETERMINE THE COMMUNITY'S PROBLEMS, SIGNIFICANT GAPS OR OVERLAPS, AND OBSTACLES TO DEVELOPMENT OF A COORDINATED PROGRAM.

- Elements of the system that should be studied include:
  1. identification and reporting.
  2. investigation.
  3. diagnosis and treatment planning.
  4. long- and short-term treatment and follow-up.
  5. training of professionals.
  6. community education.
  7. prevention.

- The study should include not only those organizations and individuals currently providing services, but also any others in the community that could provide preventive or treatment services.

- Recommendations should be sought from any existing case consultation committee(s) and human services planning groups in the community.

- Information on problems and needs should also be elicited from clients, e.g., Parents Anonymous groups or Client Involvement Committees.

- The study should examine procedures for coordination within and among agencies and organizations.

- Each organization represented on the team may wish to assess its internal service capability, administrative procedures, planning and funding resources and commitment to the team process before assuming responsibilities within the team's plan.

B. BASED ON THE FINDINGS AND CONCLUSIONS OF THE STUDY, A PLAN SHALL BE DEVELOPED TO SUPPORT A COMMUNITY SYSTEM FOR THE PREVENTION, IDENTIFICATION AND TREATMENT OF CHILD ABUSE AND NEGLECT.

- The plan should establish a framework for cooperative community structures to prevent and treat child abuse and neglect.
This plan should include:

1. Measurable goals (long-term, intermediate and short-term).

2. Priorities.

3. Operational objectives.

4. Specific action steps.

- The plan should consider adaptation of existing services as well as development of new ones.

- Recommendations for coordination at case consultation and program development levels should be included.

C. The Community Based Team Shall Assist the Community (including its political leadership), the Governor’s Advisory Committee, and the Legislators in Understanding Child Abuse and Neglect as well as in Formulating and Effecting Legislation and Realistic Appropriations for Services to Abusing and Neglecting Families.

- The team should inform the community and its leadership of the results of its needs assessment study.

- The team should seek support for its comprehensive plan among various public and private organizations as well as with political leaders.

D. The Community Based Team Shall Set the Direction for Social Action Through the Development of Public Policies That Strengthen Family Life, in Order to Alleviate the Economic and Social Conditions That Contribute to the Problem of Abuse and Neglect.

A thorough study must be undertaken before an effective plan can be developed. The study should consist of a compilation of relevant statistical information as well as opinions and the analysis of these to determine problems. It is crucial that real needs based on facts be identified. The problems that appear most obvious may be those for which a solution is already known and may not reflect the more critical problems underlying the service delivery system that should be addressed in the plan. The more directly each goal can be related to a specific part of the problem, the more successful planning efforts will be. It is difficult to develop realistic long-range goals because changes in conditions upon which they are based are not always predictable. It is important, however, that teams attempt long-range planning to set the over-all framework of their short-term goals and efforts. It is also essential that the team establish priorities among its goals to reduce confusion about which activity is more important and to provide direction on where scarce resources can most effectively be used. In doing this, the team should always keep in mind the interdependence of various activities.

Adaptation of existing resources as well as development of new resources should be considered. Existing day-care programs might, for example, reserve a number of slots for
abused or neglected children after securing training for program staff. Voluntary organizations and church groups also sponsor programs that might be adapted to the needs of abusing and neglecting families.

The plan should include a description of existing coordinating procedures, such as referrals, sharing of information, and terminating of cases, and should make recommendations for changes if needed.

VII. CASE CONSULTATION COMMITTEE

A. ANY MEMBER OF THE COMMITTEE OR HIS DESIGNEE MAY PRESENT A CASE TO THE CASE CONSULTATION COMMITTEE. THE LOCAL WELFARE AGENCY SHALL DETERMINE WHICH OF ITS CASES ARE IN NEED OF THE COMMITTEE’S ASSISTANCE. THE LOCAL WELFARE AGENCY MUST BE ULTIMATELY RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING SERVICE ON ITS CASES.

- Appropriate cases to be brought to the Case Consultation Committee should be situations where the specific treatment needs are not clear, where it is questionable whether the child can safely remain at home, where a permanent plan of foster care or adoption is to be considered, or where numerous community resources and treatment services must be coordinated.

B. THE CASE CONSULTATION COMMITTEE SHALL ASSIST THE LOCAL WELFARE AGENCY IN MAKING A COMPREHENSIVE DIAGNOSIS AND TREATMENT PLAN FOR EACH CASE PRESENTED TO THE COMMITTEE. THE COMMITTEE SHALL ASSIST IN MOBILIZING AND COORDINATING SERVICES TO MEET BOTH SHORT AND LONG TERM TREATMENT GOALS.

- The Case Consultation Committee shall assist by:

  1. collecting relevant information on the child and family members to validate a complaint or report; to the greatest extent possible, information should be collected directly from the family.

  2. providing a forum to integrate information and identify potential problems in service delivery.

  3. assessing needs, strengths and priority problems of the child and family members.

  4. recommending short- and long-range treatment plans and matching needs with appropriate resources.

  5. coordinating referrals to available resources.

  6. promoting development of needed resources.

  7. determining when a case is to be presented for another review.

  8. developing a recall system to assure that cases will be reviewed at predetermined intervals.
9. determining when a case can be safely terminated.

C. THE CASE CONSULTATION COMMITTEE SHALL INSURE THAT APPROPRIATE FEEDBACK IS PROVIDED TO INDIVIDUALS WHO REPORT SUSPECTED CHILD ABUSE OR NEGLECT SITUATIONS, WHERE THIS IS ALLOWED BY LAW.

- The State Department of Welfare, Social Service Manual outlines procedures for providing such feedback. In addition, the committee could determine other feedback methods; e.g., a reporting professional might attend diagnostic and/or treatment review conference.

D. THE CASE CONSULTATION COMMITTEE SHALL ENCOURAGE COORDINATED EFFORTS AMONG AGENCIES AND INDIVIDUALS WHO ARE RENDERING DIRECT SERVICES TO A FAMILY. WHEN SERIOUS PROBLEMS OF COORDINATION OR SERVICE DELIVERY OCCUR, THE CASE SHOULD BE REVIEWED BY THE COMMITTEE.

- Initially, service providers would convene to clarify their respective roles and set intervals for progress conferences. Each provider would accept responsibility for communicating with other providers whenever indicated, e.g., when a family crisis warrants concerted action. Providers will want to consider the advisability of involving family members in conferences when appropriate.

When a conflict between providers cannot be resolved, it would be in the family's best interest for the case to be reviewed by the Case Consultation Committee.

VIII. PARENTS' AND CHILDREN'S RIGHTS

A. THE CASE CONSULTATION COMMITTEE SHALL AT ALL TIMES REMAIN AWARE OF THE NEED TO PROTECT THE RIGHTS OF PARENTS AND CHILDREN IN THE PRESENTATION OF CASES BEFORE THE COMMITTEE.

- All committee members shall become familiar with State legislation and agency regulations regarding confidentiality in child abuse and neglect cases. Minimally, the Case Consultation Committee shall adhere to the Privacy Protection Act of 1976, Section 2.1-377 through 2.1-386 of the Code of Virginia.

- Any information shared concerning the child and his/her family shall safeguard to the greatest extent possible, the privacy rights of the individual involved.

B. DUE TO THE PRIVACY PROTECTION ACT, IT IS RECOMMENDED THAT TEAM MEMBERS SIGN A WRITTEN STATEMENT THAT GUARDS THE CONFIDENTIALITY OF ALL INFORMATION REVEALED DURING TEAM DISCUSSIONS.

IX. INTER AGENCY AGREEMENTS

A. THE TEAM SHALL OBTAIN WRITTEN AGREEMENTS OF COOPERATION FROM THE AGENCIES AND ORGANIZATIONS WITHIN THE COMMUNITY'S SERVICE DELIVERY SYSTEM.

- Local interagency agreements should reflect any agreements existing between State agencies.
Agreements should be based on the results of the study and comprehensive community plan developed by the team.

Agreements should include:

1. methods for formal and informal communication among staff.
2. referral procedures.
3. criteria for cases to be accepted by each.
4. the roles agencies will play in identifying and reporting cases, providing various types of treatment and day-to-day management of cases.
5. procedures for sharing information on diagnosis and progress of cases with which more than one agency is working.
6. mechanisms for resolving conflicts that might arise among staff working on a case.

B. THE AGREEMENTS SHALL RECOGNIZE THE LOCAL WELFARE AGENCY’S NEED FOR SUFFICIENT INVOLVEMENT IN CASES TO CARRY OUT ITS LEGAL MANDATE.

- The team should insure that the local welfare agency's authority and responsibilities are observed.

It is essential that the team insure that all agreements reflect the legal mandate of the local welfare agency; for example, the local welfare agency is given the authority to investigate all reported cases of suspected abuse and neglect.

C. THE TEAM SHOULD ENCOURAGE CONFERENCES AMONG COOPERATING AGENCIES ON A REGULAR BASIS TO DISCUSS PROBLEMS AND RECOMMEND CHANGES IN PROCEDURES AS NECESSARY.

- Administrators of cooperating agencies should meet quarterly to review progress in implementing the comprehensive community plan.

- Agreements should be reviewed and revised as necessary.

X. PROGRAM EVALUATION/RESEARCH

A. THE COMMUNITY BASED TEAM SHALL ENCOURAGE ALL AGENCIES TO MAINTAIN AND SHARE THE TYPES AND AMOUNT OF DATA NECESSARY FOR PLANNING AND EVALUATION OF PROGRAMS.

- This information should include:
  1. the number and sources of referrals.
  2. the number of valid cases.
3. the type of abuse and neglect.
4. the number of cases terminated and the reason.
5. the number of repeated cases.
6. the types of services provided by organization.
7. the number of organizations providing services.
8. the number of individuals providing services.
9. the number of case conferences held.
10. the number of joint treatment plans developed.
11. the number and types of training programs.
12. the number and types of public awareness programs.

B. THE COMMUNITY BASED TEAM SHALL REGULARLY PERFORM A REVIEW AND EVALUATION OF THE COMMUNITY'S OVER-ALL SERVICE DELIVERY SYSTEM WITH EMPHASIS ON THE EFFECTIVENESS, EFFICIENCY AND ACCEPTABILITY OF SERVICES FOR CHILD ABUSE AND NEGLECT CASES.

- Effective planning for child abuse and neglect services is based on regular evaluation of community programs and their effects on families.

C. THE COMMUNITY-BASED TEAM SHALL DEVELOP METHODS FOR REVIEWING AND EVALUATING THE EFFECTIVENESS WITH WHICH SERVICES ARE BEING COORDINATED AND UTILIZED.

- The team should designate persons skilled in evaluation methods to assist with this evaluation.
- The team should determine how a representative sample of cases is to be selected and assist with selection of cases for review.
- The team should spell out criteria for determining effective and noneffective use of services by clients; e.g., number of appointments made, kept, broken, accessibility of service, completeness of treatment plan, regularity with which treatment plan is reviewed and updated.
- The team should determine how often such reviews should be conducted.
- The team should be responsible for writing and distributing a report of findings and recommendations to improve service utilization and coordination.

D. THE COMMUNITY BASED TEAM SHALL COOPERATE WITH INDIVIDUALS AND GROUPS CONDUCTING BONA FIDE RESEARCH ON CHILD ABUSE AND NEGLECT BY PROVIDING APPROPRIATE INFORMATION.
• The teams should be assured that the purpose of research is valid.

• Only nonidentifying information should be released.

• The teams should insure that the researcher is following acceptable research standards such as those governing the protection of human subjects.

• Cooperation with appropriate research gatherers may result in valuable planning and evaluation assistance to the team.
Child Abuse Model Standards and Guidelines

FOR MULTIDISCIPLINARY TEAMS IN PENNSYLVANIA
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INTRODUCTION

This handbook is intended to assist county child welfare agency staffs and other interested parties to develop and improve Multidisciplinary Team services to abused and neglected children and their families.

On October 1, 1976, Frank S. Beal, Secretary of the Department of Public Welfare, requested top level staff assistance from various State Departments to join with the Department of Public Welfare to establish a State level Multidisciplinary Team.

The Team's major goal for 1976-77 was to develop a model with standards and guidelines for use by county child welfare agencies in establishing a county Multidisciplinary Team. This booklet represents the Team's efforts at pulling together all the general ideas on the Multidisciplinary Team concept and adapting them to Pennsylvania's law and particular needs.

The following individuals were assigned to represent their respective departments on this Statewide Team:

DEPARTMENT OF JUSTICE
Attorney General's Office
Mr. Paul Schilling, Deputy Attorney General

JUVENILE COURT JUDGES COMMISSION
Honorable Harvey N. Schmidt

DEPARTMENT OF EDUCATION
Ms. Frances DeWitt, Special Assistant, Deputy Secretary's Office
Mr. John Christopher, Director, Bureau of Instructional Support Services
Ms. Marian Lohr, Coordinator, School Health Services

DEPARTMENT OF HEALTH
Dr. Annette Lynch, Director, Bureau of Children's Services

PENNSYLVANIA STATE POLICE
Captain Salvador Rodriquez, Director, Community Relations Division
GOVERNOR'S COUNCIL ON DRUG & ALCOHOL ABUSE
Mr. Peter Pennington, Executive Assistant Director
Ms. Debbie Metz, Co-member**

DEPARTMENT OF PUBLIC WELFARE
Office of Mental Health:
   Dr. Alan Handford, Director, Children & Youth Services
   Dr. James Reisinger, Staff Assistant
Office of Mental Retardation:
   Ms. Carol Chalick, Chief, Division of Preventive Services
Office of Children and Youth:
   Mr. Joseph Spear, Child Welfare Specialist***
   Mr. Lee Miller, Administrator, ChildLine

FEDERAL REGION III
Mr. Gary Koch, Child Development Specialist, Department of Health,
   Education & Welfare

DEVELOPMENT ASSOCIATES
Ms. Patricia Vasquez, Project Director, Development Associates

I thank those Team Members who took time, including weekends,
from their busy schedules and contributed valuable information and assistance to us.

We hope the remaining pages of information are meaningful to you
and we welcome your comments.

Gordon Johnson, Team Coordinator
   Director, Bureau of Child Welfare

* Resigned from the Team
** New Member
*** Assistant Team Coordinator
PREFACE

The management of child abuse cases cuts across various professional disciplines and at one time or another may require the expertise of physicians, social workers, attorneys, psychologists, nurses, etc. With this in mind the concept of the Multidisciplinary Team was developed to prevent confusion to the child and parents and to allow the various professionals involved to work cooperatively for the betterment of all concerned. The treatment approach can be planned and implemented and services increased or decreased as the need arises. Through proper case management by the Team, the child can be maintained in his/her home environment with minimal risk and maximum treatment benefits.

The use of Multidisciplinary Teams also removes the awesome decisions and responsibilities from one person and distributes the responsibility among the various Team members. Since it does transcend one profession, it is appropriate that all professions involved in a particular case should meet to discuss the best approach to helping each particular family.

The use of Multidisciplinary Teams has the added advantage of minimizing the confusion to the client because it presents a systemized approach and coordinates the activities of all concerned and involved. This prevents a flood of helping persons from visiting the family and offering services which may be in direct contradiction to one another. It allows one person to take the leadership role with a particular family and to coordinate and arrange for other services as they are needed or indicated.

Multidisciplinary Teams can serve another valuable function for both the community in general and the child welfare agency administrator in particular by identifying gaps in service in the community and working to see that the necessary services are developed to fill this void. The Multidisciplinary Team can either develop these services directly or use their influence to convince the appropriate political structure that expansion or development of services is necessary.
Legal Mandate:

The Child Protective Services Law, Act of November 26, 1975, P.L. 438 (No. 124) mandates each county's child protective service to make available among its services for the prevention and treatment of child abuse the benefits of a Multidisciplinary Team. Attending departmental regulations, Chapter II, Section 23, stipulate that the Child Protective Service shall consult with and utilize the services of professional disciplines within their communities such as health, mental health, social services, education, law and law enforcement for the purposes of developing, reviewing, and implementing treatment plans for abused children and their families, and for receiving recommendations as to the improvement of overall service delivery by the Child Protective Service.

Acknowledgements:

In 1974 Congress enacted the Child Abuse Prevention and Treatment Act which made available for the first time monies to be used specifically for research and training in the area of child abuse and neglect. Part of this money was used to develop a contract with Development Associates, Inc., a Management and Governmental Consulting Firm located in Washington, D.C. The purpose of this contract was to conduct needs assessment surveys in all ten Federal Regions to ascertain what state and county agencies perceived as their greatest need in delivering services to abused and neglected children. The consensus of the various professions engaged in the planning and delivery of services to abused and neglected children in Region III was that there was a need for assistance in planning for and carrying out the roles of a Multidisciplinary Team as well as staff development assistance for the various state agencies involved in serving abusing, and neglecting families.

The Office of Child Development which is implementing this act awarded a second contract to Development Associates to assist the states in Region III in developing a state model for Multidisciplinary Teams based on the uniqueness of each state's law and administrative structure for delivering services to abused children and their parents. The first step in this process was to designate a Team composed of the various professions that carried program planning and development responsibilities for child abuse at the state level. One of the functions of this team was to develop the following model and guidelines for local communities to use in developing Multidisciplinary Teams. The Bureau of Child Welfare in the Department of Public Welfare was assigned primary responsibility to coordinate the activities of this Team.
Pennsylvania Model

Program Planning
- Assessment of community needs
- Development of comprehensive community plan

Program Coordination
- Implementation of comprehensive plan
- Negotiation of agreements
- Mediation and problem-solving
- Evaluation

Case Consultation

Crisis
- Investigation and determination
- Emergency protection
- Coordination of emergency services

Diagnosis/Service Planning
- Comprehensive diagnosis and treatment plan development
- Review of cases

Treatment
- Implementation of treatment plan
- Coordination of providers
- Assessment of progress
- Reinitiation of planning
- Termination and follow-up
DESCRIPTION OF THE PENNSYLVANIA MODEL: COMPONENTS OF SERVICE

The schematic on page five (5) is a functional model for community-based teams – that is, it outlines the essential, interdependent functions necessary to a coordinated community approach to child abuse. The organizational structure adopted by different communities, however, will differ with their characteristics and needs. One community might, for example, develop a single group to undertake these functions while another might develop a number of highly specialized subcommittees. A team might also be composed of permanent members who meet regularly and consulting members who undertake a specific task or who bring special knowledge or skills needed for an individual case consultation.

It is anticipated that the process of implementing the total model will be a gradual one, with each community determining which functions it will address first. Because of any number of variables, counties are in a continuum in establishing MDT’s. The Department of Public Welfare does not expect every county to implement MDT as described in this booklet. The purpose of the model, standards, and guidelines is to assist communities in establishing a MDT. Counties are not required to develop their MDT’s after the model described herein, but encouraged to take those parts or suggestions that would be of benefit to them.

This book should be considered as a beginning. Comments on its usefulness and suggested techniques would be appreciated.
I. Team Functioning/Organizational Issues

A. THE COMMUNITY-BASED TEAM SHALL HAVE A WRITTEN STATEMENT CLEARLY DELINEATING ITS MISSION OR PURPOSE AND MEASURABLE GOALS.

1. The team should establish priorities among its goals and objectives which should include the following:
   - review and assess community needs and resources
   - assist the child welfare agency in the development of its local plan
   - assist in developing needed resources
   - develop public awareness of the problem of child abuse
   - develop a component to provide consultation to the child welfare agency in specific cases
   - assist in the identification and development of interagency relationships
   - assist in educating organizations and individuals in identifying and reporting suspected child abuse
   - seek citizen participation (Sec. III, Citizen Participation)

2. Specific objectives leading to the achievement of each goal should be identified.

3. Specific action steps, members' responsibilities and deadlines should be outlined.

B. THE COMMUNITY-BASED TEAM SHALL HAVE A WRITTEN STATEMENT OF HOW IT WILL OPERATE (OR A CONSTITUTION AND BY-LAWS IF MORE FORMAL STRUCTURE IS REQUIRED).
The statement should include:

- a method of nominating and selecting officers
- responsibilities of officers and members
- term of service for officers and members
- frequency, times and locations of meetings
- whether meetings are open or closed to the public
- a set of ground rules for the conduct of meetings
- attendance at meetings
- use of subcommittees

C. THE COMMUNITY-BASED TEAM, NOT THE INDIVIDUAL MEMBERS, SHALL BE PERMANENT SINCE EFFECTIVE PLANNING AND COORDINATION ARE A COMPLEX AND DYNAMIC PROCESS.

D. THE COMMUNITY-BASED TEAM SHALL SEEK THE SUPPORT OR SANCTION OF GOVERNMENTAL GROUPS IN THE COMMUNITY.

1. The community-based team should advise the political leadership of its efforts and provide periodic reports on its progress.

2. Plans and mechanisms for coordination of efforts with other pertinent public and voluntary citizens' committees should be developed by the team.

3. Firm linkages should exist between program planning/coordination and case coordination.

4. The team should meet regularly with the administrators of cooperating programs to review progress being made in the development of a coordinated service delivery system.
The purpose of developing by-laws or statements of operation is to provide clarity in goals and objectives as well as a permanent structure for the team. Equally important is a clear understanding of how the team is to operate. Each member should understand his or her responsibilities as well as such ground rules as how decisions are to be made. The team can also begin to build a support base in the community by informing the political leadership, other significant public and voluntary citizens' committees or councils as well as the community at large of its goals and progress in achieving them.

II. Team Composition

A. THE COMPOSITION OF THE COMMUNITY-BASED TEAM SHALL REFLECT THE RANGE OF AMELIORATIVE AND TREATMENT RESOURCES AVAILABLE TO ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES.

1. Representatives from the fields of social service, health, mental health, education, law enforcement, legal profession, and elected governmental officials should be included.

2. In areas where military bases are located, a representative of this sector should be included.

3. There should be representatives from the community at large (non-agency members) selected on the basis of geographical distribution; community patterns of ethnic background, income levels, educational levels, and occupations, as well as willingness to serve, expertise, and concern.

B. QUALIFICATIONS OF TEAM MEMBERS SHALL INCLUDE THE ABILITY TO CONTRIBUTE TO THE SOLUTION OF PROBLEMS AND TO CARRY OUT THE RESPONSIBILITIES OF MEMBERSHIP THROUGH A WILLINGNESS TO SERVE ON A CONTINUING BASIS. MINIMALLY, MEMBERS SHALL HAVE DEMONSTRATED AN INTEREST IN AND CONCERN ABOUT CHILD ABUSE AND NEGLECT.
1. Members who represent agencies should be persons of sufficient stature that their actions reflect their agencies' policies. At the program coordination level, these members should be administrators; at the case level, supervisory and direct service staff. In either case, members should be able to make commitments on behalf of their individual organizations.

COMMENTS

The initial composition and size of a team will most often be determined by its purpose and goals as well as by the level of interest and commitment on the part of agencies and individuals. A team should strive to incorporate all organizations in the community which are or which could be providing ameliorative and treatment services. While a team should be large enough to be representative of the area it serves, caution must be taken so that it does not become unwieldy. A team might, for example, be composed of permanent and consulting members or might use mechanisms such as ad hoc committees.

If a community-based team is to become a realistic and effective joint planning and decision-making body, it is critical that members appointed by various organizations have the authority to represent their agencies' interests and points of view. Members should be able to stimulate implementation of plans by influencing the necessary political and administrative action and financing.
III. Citizen Participation

A. THE COMMUNITY-BASED TEAM SHALL DEVELOP MECHANISMS TO SEEK CITIZEN PARTICIPATION IN ORDER TO ENSURE AN ACCURATE VIEW OF AREA NEEDS AND PATTERNS AS WELL AS CITIZENS' SUPPORT OF PROGRAMS WITH THEIR IDEAS, LABOR, FUNDS, AND UTILIZATION OF THE SERVICES.

1. The team should identify sources of leadership in both the public and private sector.

2. The team should identify persons or groups in the community which do or could help in preventing child abuse and neglect.

3. The team should identify social and economic problems or patterns in the community which contribute to the problem of child abuse and neglect.

4. The team should make reports to the community detailing problems and needs, program plans and progress, and recommendations for changes needed to improve service effectiveness.

5. Team meetings dealing with community needs assessment, program planning, and program evaluation must be open to the public.

6. The team should develop linkages with voluntary organizations and citizens' groups.

7. The team should assist in the development of public awareness and education campaigns.
IV. Area/Coverage

A. THE CPS IN ALMOST ALL CASES FUNCTIONS ON A SINGLE COUNTY BASIS. HOWEVER, THE COMMUNITY-BASED TEAM MAY DEFINE ITS SERVICE AREA DIFFERENTLY, BASED ON SUCH FACTORS AS:

1. Sufficient population base;
2. Necessary financial resources;
3. Linkage through common business and social interests and transportation systems;
4. Political boundaries;
5. Existing service delivery boundaries or catchment areas.

COMMENTS

One of the first decisions which a team must make is the area which it will serve -- a single county; sections of a large city; or, particularly in some rural areas, all or part of several counties. Factors such as the type of team, size of the population requiring services, proximity of the people to the services, team staffing and budgetary constraints will all affect this decision. The team should also determine whether or not the area chosen has common problems which are amenable to solution through joint efforts.

V. Community Standards of Care

A. THE COMMUNITY-BASED TEAM SHALL WORK WITH THE CPS IN DEVELOPING REALISTIC AND ATTAINABLE STANDARDS AND GUIDELINES COMPATIBLE WITH EXISTING REGULATIONS--FOR USE BY COOPERATING AGENCIES AND INDIVIDUAL PROFESSIONS IN WORKING WITH CHILD ABUSE/NEGLECT CASES.
The standards and guidelines should include at least the following areas:

- criteria for treatment plans
- minimum frequency of contacts with families
- criteria for format and timing of case review
- criteria for maximum caseload size—fore team and type of staff
- criteria for determining timing and procedures for termination of stabilization of cases
- time between maximum progress and termination/stabilization
- policies re follow up of terminated/stabilized cases
- procedures for monitoring follow up contacts

COMMENTS

The team should bear in mind that if standards are set too low, they may be easily achieved but may restrict progress. On the other hand, standards that are set too high may not be attainable in some communities, and frustration can be the result. By determining desirable patterns of services that are within the realm of reality and practicality, teams can measure needs by comparing existing patterns with the desirable ones. This process will provide the necessary groundwork for thorough program planning and development.

VI. Program Planning/Development

A. THE COMMUNITY-BASED TEAM SHALL IDENTIFY, REVIEW AND ASSESS COMMUNITY PROGRAMS FOR ABUSING AND NEGLECTING FAMILIES, WITH A VIEW TOWARDS DESCRIBING THE EXISTING SERVICE DELIVERY SYSTEM. THE TEAM SHALL DEVELOP A REPORT OUTLINING ITS CONCLUSIONS AS TO THE COMMUNITY’S PROBLEMS, SIGNIFICANT GAPS OR OVERLAPS, AND OBSTACLES TO THE DEVELOPMENT OF A COORDINATED SERVICE DELIVERY SYSTEM.
THE DEVELOPMENT OF A COORDINATED SERVICE DELIVERY SYSTEM.

1. The elements of a coordinated system include:
   - identification and reporting
   - investigation
   - diagnosis and treatment planning
   - long and short term treatment and follow up
   - training of professionals
   - community education
   - prevention
   - program evaluation and monitoring

2. The review and assessment should include not only those organizations and individuals currently providing services but also others in the community which could provide ameliorative or treatment services.

3. Input should be sought from any human service agencies and/or planning groups in the community.

4. Information on problems and needs should be sought from clients of the service delivery system.

5. The team should review coordination procedures within and among agencies.

6. The report on conclusions should describe the procedures currently used to serve abusing and neglecting families, the types of services provided, and the agencies providing services. The assessment should consist of relevant statistical information as well as opinion, and the analysis of these to determine problems.
B. Based on the conclusions and findings of the review and assessment, a comprehensive community plan shall be developed to strengthen the service delivery system.

1. The plan should establish roles and responsibilities for cooperative community structures to prevent and treat child abuse and neglect.

2. The plan should recognize Child Welfare's mandate and legal responsibility to establish and maintain a MDT.

3. The plan should include:
   - measurable goals (short term, intermediate, and long term)
   - priorities
   - operational objectives
   - specific action steps to be undertaken by the team
   - mechanisms for ongoing evaluation

4. The plan should consider adaptation of existing services as well as development of new ones.

5. Recommendations for coordination needed at both the program or system level and case level should be included.

6. The broadest possible community participation should be sought in the development of the plan.

7. This plan should include recommendations to assist the agency director in developing the "Local Plan."
C. THE COMMUNITY-BASED TEAM SHALL ASSIST THE COMMUNITY, LOCAL CITY AND COUNTY GOVERNMENTAL OFFICIALS AND STATE LEGISLATORS IN UNDERSTANDING CHILD ABUSE AND NEGLECT AND IN THE FORMULATION OF LEGISLATION AND REALISTIC APPROPRIATIONS FOR SERVICES TO ABUSING AND NEGLECTFUL FAMILIES.

1. The team should inform the community and its political leadership of the results of its needs assessment.

2. The team should be an advocate for its comprehensive plan with public and private agencies and the political leaders.

3. The team should participate in the public hearings for the local plan.

D. THE COMMUNITY-BASED TEAM SHALL SET THE DIRECTION FOR SOCIAL ACTION TO IMPROVE THE ECONOMIC AND SOCIAL CONDITIONS WHICH CONTRIBUTE TO THE PROBLEM OF ABUSE AND NEGLECT THROUGH THE DEVELOPMENT OF PUBLIC POLICIES WHICH STRENGTHEN FAMILY LIFE.

E. THE TEAM SHALL OBTAIN WRITTEN AGREEMENTS FROM THE AGENCIES AND ORGANIZATIONS WITHIN THE COMMUNITY'S SERVICE DELIVERY SYSTEM SPECIFYING THEIR ROLE IN IMPLEMENTING THE COMPREHENSIVE COMMUNITY PLAN.

1. The agreements might include:

   - referral procedures
   - criteria for cases to be accepted by each
   - procedures for sharing information on the diagnosis and progress of cases involving more than one agency
   - mechanisms for regular review of agreements and revision as necessary
   - procedures for joint staff training
   - financial agreements
COMMENTS

A thorough needs assessment must be undertaken before an effective plan can be developed. It is crucial that real needs based on facts, not merely opinion be identified. The problems which appear most obvious may be those for which a solution is already known and may not reflect the more critical problems underlying the service delivery system which should be addressed in the plan.

The more directly that a goal can be related to a specific part of a problem, the more successful planning efforts will be. Although it is difficult to develop realistic long-range plans because changes in conditions upon which goals are based are not always predictable, it is important that community-based teams attempt long-range planning to set the overall framework of their shorter term goals and efforts. It is also essential that the team establish priorities among its goals to reduce confusion as to which activity is most important and to provide direction as to where scarce resources can best be used. In doing this, the team should always keep in mind the interdependence of various activities.

Using the service delivery standards, data from their needs assessment, and the comprehensive plan as a foundation, the team should seek appropriate agreements from all of the organizations in the service delivery system, specifying their roles and responsibilities and how they will interface with others. Most organizations have written policies and regulations which govern their actions and determine the area they serve, clients served, and kinds of services provided. The inter-agency agreements will serve as mechanisms for implementing the comprehensive community plan.
VII. Case Consultation

THE COMMUNITY-BASED TEAM SHALL OFFER THE SERVICES OF MULTIDISCIPLINARY CASE CONSULTATION GROUP(S) TO THE CHILD WELFARE AGENCY. WHEN THE AGENCY UTILIZES SUCH CONSULTATION, THE MULTIDISCIPLINARY GROUP BECOMES A PART OF THE CHILD PROTECTIVE SERVICES. AS SUCH THEY ARE BOUND BY THE SAME CONFIDENTIALITY STRICTURES AS THE CPS STAFF.

* Multidisciplinary consultation should be available during the three basic phases of the management of child abuse cases - crisis intervention, diagnosis/treatment planning, and treatment implementation.

* Depending on a county's characteristics and its needs, the community based team might develop a group which could coordinate services in each of the three phases; or it might develop a number of specialized groups.

* The multidisciplinary consultation group(s) should provide a forum for the sharing of appropriate information on diagnosis, treatment plans and progress among professionals involved with a child abuse case.

* The multidisciplinary group(s) should ensure that information on problems of coordination and needs for resources is shared with program planning and coordination components of the community based team.

THE LOCAL CHILD WELFARE AGENCY SHALL DETERMINE WHICH CASES ARE IN NEED OF A MULTIDISCIPLINARY CASE CONSULTATION GROUP'S ASSISTANCE.
Appropriate cases for referral to a multidisciplinary group should include those where it is questionable whether or not a child can safely remain in the home, where specific treatment needs are not clear, where it is questionable whether or not a child can be safely returned to the home, or where numerous community resources and treatment services must be coordinated.

MULTIDISCIPLINARY CONSULTATION GROUPS DEALING WITH CRISIS INTERVENTION SHALL INCLUDE THOSE PROFESSIONALS NECESSARY TO ASSIST CPS WITH ITS INVESTIGATION, PROVIDE IMMEDIATE PROTECTION TO THE CHILD, AND COORDINATE EMERGENCY SERVICES TO THE FAMILY.

* A crisis group should meet when child abuse is suspected and pool and evaluate available information in order to make two critical decisions – do the injuries seem to indicate child abuse and is the home safe for the immediate return of the child.

* The crisis group should coordinate the provision of emergency services to ensure that the family is served more efficiently in times of crisis by the various disciplines without long waits for services. Services might include short term counseling, medical assistance, emergency homemaker or child care, emergency financial assistance, family shelters, crisis nursery, emergency removal and placement of the child.

* The crisis group should ensure that duplicate investigations of a family do not occur, i.e., that information already collected is used where possible and allowable by law.

THE MULTIDISCIPLINARY GROUP PROVIDING CONSULTATION TO CPS ON DIAGNOSIS AND THE DEVELOPMENT OF TREATMENT PLANS FOR CHILD ABUSE CASES SHALL INCLUDE ONLY PROFESSIONALS WITH THE REQUIRED EXPERTISE TO FULFILL THE PURPOSE OF THE GROUP, I.E. ASSESSING MEDICAL, PSYCHOLOGICAL, LEGAL, AND SOCIAL ASPECTS OF COMPLEX CASES AND DEVELOPING A COMPREHENSIVE TREATMENT PLAN.
The group should include skilled representatives of the various disciplines who will meet regularly as a core group to provide consultation to CPS on cases as well as ad hoc consulting members who have knowledge or a special skill needed for a particular case. The specific professions represented on the core group will vary with availability as well as the contribution they may be expected to make to the team. Where possible, professionals should be drawn from local treatment agencies in order to provide a referral liaison between the team and agency.

This group should assist the CPS by developing a comprehensive diagnosis and treatment plan for each case referred to it. The plan should include:

a. a statement of the specific problems a family has and possible causes
b. an assessment of the needs and strengths of the family
c. treatment goals, short and long range objectives with dates
d. identification of resources to be used
e. a schedule for providing services, coordinating the needs of a family and those of the service providers
f. a schedule for reviewing treatment progress
g. designation of a case monitor to maintain frequent and supportive contact with the family and service providers.

This group should also assist in:

a. identifying and resolving potential problems in service delivery
b. developing a recall system to ensure that cases will be reviewed at predetermined intervals
c. reviewing a representative sample of cases to assess whether services are being utilized as planned and whether agencies are responsive to referrals of abusing families
d. ascertaining reasons for inadequate utilization of services
e. developing procedures for intervening when serious problems of coordination of service delivery occur.
COMMENTS

The county child welfare agency should assume the leadership role in establishing a MDT in the county. If there are two or more component groups, a member of the CPS does not necessarily have to be chairperson of each component. Because the CPS has the legal mandate to provide protective services, a member of the CPS should be directly responsible for the Case Management Component.

VIII. Parents'/Children's Rights

THE CASE MANAGEMENT TEAM SHALL ADHERE TO THE CPS LAW AND REGULATIONS CONCERNING THE RIGHTS OF PARENTS AND CHILDREN INCLUDING BUT NOT LIMITED TO THE FOLLOWING.

- Their rights to confidentiality of information.
- Their right to legal representation at any stage of the proceeding.
- Their right to receive all necessary treatment and social services to prevent future abuse and/or neglect if appropriate.
- Their right to court hearings for detention hearings, transfer of custody, etc.
- Their rights regarding amending, sealing, and expunging reports in which they are named.
- Children's right to admission to any public or private hospital for treatment
- Their right to a completed investigation within 30 days
- Children's right to protective custody
- Their right to appropriate and proper notification regarding receipt of the report status, changes, etc.
THE CASE MANAGEMENT TEAM SHALL ENDEAVOR TO INVOLVE THE PARENT(S) AND, IF APPROPRIATE, THE CHILD IN THE DIAGNOSIS AND TREATMENT PLANNING PROCESS AND DURING ONGOING REVIEWS.

* The team should invite the parent(s) and the child, if appropriate, to participate in meetings during which decisions are made about them.

* The case management team should develop procedures for assisting the family in understanding the results of meetings, decisions, and the status of the child.

* The team should endeavor to obtain the family's agreement to (or at least acknowledgement of) the treatment plan selected.

THE CASE MANAGEMENT TEAM SHALL DEVELOP A MECHANISM FOR CLIENT PARTICIPATION IN PROGRAM PLANNING AND EVALUATION.

COMMENTS

While the team must be guided by existing law and regulations regarding parents' and children's rights, it should give careful consideration to developing procedures for involving families in the decisions made about them in order to secure their cooperation in the treatment plan.

There has been increased legislative activity and litigation concerning the individual's right to privacy and freedom of information as well as parents' rights and professional malpractice. Case management teams should be aware of these trends in order to make fully informed decisions in regard to their own practices and procedures.
IX. Program Evaluation/Research

A. THE COMMUNITY-BASED TEAM SHALL ENCOURAGE ALL AGENCIES TO MAINTAIN THE TYPES AND AMOUNT OF DATA NECESSARY FOR PROGRAM PLANNING AND EVALUATION.

1. The team should have access to data such as:

- number of cases identified--by source
- number of cases investigated
- number of cases founded, indicated, unfounded
- classification of cases (type of abuse or neglect)
- amount of recidivism in founded and indicated cases
- number of organizations providing services--by organization
- services provided--by organization
- cost of services--by type and per client
- number of case conferences held
- number of joint treatment plans developed
- number of cases terminated
- number of professional training sessions--by source
- number and types of public awareness endeavors
- other information as might be necessary e.g., age, sex, and location of child.

B. THE COMMUNITY-BASED TEAM SHALL REVIEW AND EVALUATE THE COMMUNITY'S OVERALL SERVICE DELIVERY SYSTEM FOR CHILD ABUSE/NEGLECT CASES ON A REGULAR BASIS--THE EFFECTIVENESS AND EFFICIENCY AS WELL AS THE ACCEPTABILITY OF SERVICES.
1. The team should establish mechanisms which will assure a regular means of securing feedback from all cooperating agencies providing services and from service recipients.

2. The team should build measurable factors into all goal statements.

C. THE COMMUNITY-BASED TEAM SHALL COOPERATE WITH INDIVIDUALS AND GROUPS WHO ARE CONDUCTING BONA FIDE RESEARCH ON CHILD ABUSE AND NEGLECT BY PROVIDING APPROPRIATE INFORMATION.

1. The team should ensure the confidentiality of clients by providing only non-identifiable information.

2. The team should ensure that the researcher is adhering to acceptable research practices such as those governing the protection of human subjects.

COMMENTS

In order to do effective planning, the team must evaluate, on a regular basis, the total system's effectiveness and efficiency as well as its impact on individual families. An assessment which includes management policies and procedures as well as service practices will provide the team with the data necessary to inform policy makers and the community at large of needs for progressive changes in policies and procedures as well as the need for additional and/or different resources.