# Evaluating Multidisciplinary Child Abuse and Neglect Teams: A Research Agenda

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A review of child welfare research literature reveals that although multidisciplinary teams are increasingly used to investigate and intervene in child abuse and neglect cases, the field does not know enough about their structural variations, implementation processes, or effectiveness. Moreover, although articles advocating multidisciplinary teams enumerate their apparent strengths, they lack attention to the teams' possible weaknesses. The article discusses implications for future evaluation studies.

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Over the past two decades, the increasing prevalence of child abuse and neglect (Kolbo & Strong, 1997; National Committee to Prevent Child Abuse, 1999) has increased pressure on child welfare professionals to act promptly, yet professionally, in reported or substantiated cases (Ells, 2000). Because this problem is complex and multicausal, no single profession or state agency has the ability to respond adequately. Instead, child abuse requires the involvement of multiple professions and community resources. Health care, law enforcement, mental health, and social services, among other agencies, frequently must investigate allegations and provide protection and rehabilitation for the child and family once a caseworker has substantiated child abuse or neglect (Kaminer, Crowe, & Budde-Giltner, 1988).

In response, agencies are using multidisciplinary teams (MDTs) in an effort to be more effective and out of concern that uncoordinated efforts to protect children may cause additional harm to victims. In other words, harm to children can occur not only as a result of maltreatment itself but also because of insensitive procedures used to address maltreatment. Such systemic effects on children may be the result of redundant interviews, intrusive medical examinations, separation from support systems, intimidating courtroom procedures and tactics, and communication breakdowns (Jones, 1991, as cited in Kolbo & Strong, 1997).

The literature advocating MDTs presumes them to be more effective and efficient in achieving their intended outcomes, and more benign in their processes. Researchers claim MDTs result in more accurate assessment and prediction of risk, more adequate intervention (Goldstein & Griffin, 1993; Pence & Wilson, 1994), decreased fragmentation in the delivery process, less role confusion among different disciplines, reduced duplication of services among agencies (Pence & Wilson, 1994; Skaff, 1988), enhanced quality of evidence for lawsuits or criminal prosecutions (Dinsmore, 1992–1993, as cited in Kolbo & Strong, 1997), and improved quality of services (Cohn, 1982; Hochstadt & Harwicke,

1985). In addition, researchers theorize that MDTs reduce traumatization of children and contamination of evidence gathered during the investigative and judicial processes (Saywitz & Goodman, 1996, as cited in Kolbo & Strong, 1997). Finally, some believe MDTs provide mutual support for professionals engaged in emotionally stressful work (Kolbo & Strong, 1997).

MDTs have been popular for decades, however, relatively few studies have systematically evaluated them. Although fragmentation of services to children and their families can be a serious problem in abuse cases (Hochstadt & Harwicke, 1985; Kaminer et al., 1988), no empirical evidence exists that MDTs decrease fragmentation (Straus & Girodet, 1977, as cited in Hochstadt & Harwicke, 1985). More generally, researchers have performed few follow-up studies of MDTs' effects on service delivery and outcomes (Hochstadt & Harwicke, 1985).

This article critically reviews the MDT research literature and summarizes the evidence concerning MDT benefits. The authors pose unanswered questions concerning variations in MDT design and effectiveness. Finally, the article suggests an MDT evaluation agenda for future research.

## Team Practice in Child Protection: A Historical Overview

Hospitals have been using MDTs for nearly 40 years (Ells, 2000). In the 1950s, child protection teams originated in urban, hospital-based settings in Pittsburgh, Los Angeles, and Denver. Initiated by physicians encountering emergency-room presentations of child abuse (Jacobson, 2002; Kaminer et al., 1988), these teams employed a medical model in the management of medical care treatment and child protection. A few years later, community-based MDTs emerged under the umbrella of public child protection services (Jacobson, 2002).

Since the 1950s, child-protection MDTs have become an integral part of child welfare services (Jacobson, 2002). Both hospi-

tal-based and community-based teams have expanded their membership to include psychiatrists, psychologists, police officers, lawyers, and teachers in addition to the original disciplines of medicine, nursing, and social work (Kaminer et al., 1988).

Researchers identified the need for MDTs decades ago, and the Children's Justice Act of 1986 first offered federal funds to states for establishing multidisciplinary taskforces to review and evaluate the management of child abuse cases (Sheppard & Zangrillo, 1996). Currently, agencies and the government promote interagency coordination by state statutes and case law, written guidelines for developing a shared investigative process, descriptive accounts of collaborative team efforts, and training in team building (U.S. Department of Justice, 1993). By now, most states have adopted the MDT approach; many have formalized its use through legislative mandate (Jacobson, 2001).

## Definitions of MDTs

According to Bell (2001), MDTs are intended "to provide a holistic view of the maltreated child so that his or her legal, social, therapeutic, and medical needs could be addressed" (p. 77). More specifically, Ells (2000) described a multidisciplinary child abuse team as

> A group of professionals who work together in a coordinated and collaborative manner to ensure an effective response to reports of child abuse and neglect. Members of the team represent the government agencies and private practitioners responsible for investigating crimes against children and protecting and treating children in a particular community. An MDT may focus on investigations; policy issues; treatment of victims, their families, and perpetrators; or a combination of these functions (p. 5).

Whatever the definition, MDTs assume that a coordinated effort among diverse professional groups is a more effective

method of investigating child sexual abuse than single-agency, uncoordinated strategies (Steele, 1992, as cited in Jensen, Jacobson, Unrau, & Robinson, 1996).

## Team Models and Compositions

Agencies can create and manage MDTs in multiple ways. A survey by Kolbo and Strong (1997) described teams that varied in configuration, legislation, function, composition, and training. Although the child welfare literature describes several MDT models, Kaminer et al. (1988) placed them in four main categories:

1. **Treatment Team.** A group of treatment experts who collaborate on the diagnosis and treatment of the child or family. This group of service providers shares responsibility with CPS workers for case assessment, diagnosis, treatment plan development, referral to treatment resources, and case follow-up.
2. **Case Consultation Team.** A group of experts who collectively provide opinions and advice regarding child protection cases. The team reviews cases in terms of case management and diagnosis, and serves in an advisory capacity to primary caseworkers regarding treatment planning and critical decisions. The team also provides technical assistance and support to service providers.
3. **Resource Development or Community Action Team.** A group of service agency representatives, professional service providers, child advocates, and citizens who collectively work with local problems associated with child abuse and neglect. They address ongoing planning, coordination of services, community needs, community education and awareness, and so forth.
4. **Mixed Model Team.** The combination of two or more of the team functions by a single team, or two or more teams with different functions working in a central coordination mechanism (Pettiford, 1981, as cited in Kaminer et al., 1988).

Program descriptions of child welfare MDTs suggest that in practice, the most common type is the mixed model, which employs multiple functions. Among the possible subcategories of MDTs responding to child maltreatment are:

- **Multidisciplinary Interview Centers.** These coordinate management of child sexual abuse cases. In this subtype, police detectives, CPS investigators, and assistant district attorneys meet to interview child victims and develop pre- and postinterview strategies (Sheppard & Zangrillo, 1996).
- **Traditional Hospital-Based and Community-Based Child Abuse Teams.** These review all types of maltreatment in a specific hospital or a local community (Bross, Ballo, & Korfmacher, 2000).
- **Child Advocacy Centers.** These are independent, multidisciplinary programs that facilitate joint investigations of reported child abuse, reduce the trauma of repeated victim interviews, and provide child-friendly environments and therapy for victims. Professionals are co-located in a facility of their own, either of the participating agencies or an independent nonprofit organization administers the team (Sheppard & Zangrillo, 1996).

In Kolbo and Strong's (1997) national survey of 45 expert informants on MDT composition in their states, team members were most likely to represent (in descending order of involvement): CPS, law enforcement, and the legal system. The professions of medicine, education, mental health, public health, and juvenile corrections were the next most commonly represented professions. Finally, psychologists or psychiatrists, guardians ad litem, juvenile corrections officers, family support and child care agency workers, and court-appointed special advocates were least frequently represented (Kolbo & Strong, 1997).

Teams also vary according to setting, function, composition, sponsorship, and other factors. Each community or agency using an MDT tends to develop its own model based on community

needs and resources (Kaminer et al., 1988). Table 1 classifies the examples of various teams and team members.

## MDT Effectiveness

Although many theoretical justifications exist for using MDTs, the evidence for their effectiveness remains scarce. Furthermore, the vast majority of published MDT evaluations focus only on the benefits of the team approach. Very few describe the possible disadvantages, problems, and challenges. Table 2 summarizes these studies.

Hochstadt and Harwicke (1985), for example, combined clinical data mining (Epstein, 2001) of available case records with follow-up interviews to determine the effectiveness of an MDT practice in Chicago. They measured effectiveness by the number of MDT recommendations or services followed. One year after discharge, a community worker reviewed the MDT's recommendations. The worker contacted CPS workers, the birthparents, or the foster parents to ascertain whether the family had received the services recommended. The sample included 180 children who had been suspected of being abused or neglected.

Recommended services obtained one-year postdischarge included: returning home (100%), foster care (92%), visiting nurse (76%), and additional medical assessment (66%). Cases did not follow the outpatient psychological service recommendations as frequently as other services. For example, families obtained family psychotherapy in 44% of the recommended cases, individual psychotherapy for a child 35% of the time, and additional psychological or psychiatric assessments only 29% of the time. Type of abuse or neglect did not influence the number of services obtained, but it did influence the type of service recommended, especially for failure-to-thrive cases.

Although Hochstadt and Harwicke's (1985) study indicated that MDTs may have a positive effect on the delivery of services,

**TABLE 1**
**Team Composition**

| *Study* | *Team Type* | *Core Disciplines* |
|---|---|---|
| Bander et al. (1982) | Child sexual abuse treatment team | Medicine, psychology, art therapy, criminology, law, and research |
| Bell (2001) | Child protection team | MH, LE, assistant DA, psychology, SW, nurse, doctor, and victim witness |
| Bross et al. (2000) | Consultation team on crimes against children | Pediatric, law, psychology, and SW |
| Durfee & Gellert (1992) | Child death review team | Coroner-medical examiner's office, LE, prosecuting attorneys, CPS, pediatric, and health |
| Faller & Henry (2000) | Child sexual abuse investigative team | CPS, LE, and the prosecutor's office |
| Goldstein & Griffin (1993) | Hospital-based child abuse treatment team | Physician and SW |
| Hochstadt & Harwicke (1985) | Child abuse and neglect treatment team | CPS, medicine, psychology, psychosocial, educational, and developmental professionals |
| Jacobson (2001) | Child sexual abuse investigative and treatment team | LE, law, probation and parole, MH, CPS, health, schools, and child advocacy |
| Jensen et al. (1996) | Child advocacy model/child sexual abuse investigative and treatment team | CPS, LE, and the legal system |
| NYS Dept. of Social Services (1995) | Child sexual abuse investigative team | CPS, DA's office, LE, and MH |
| Onyskiw et al. (1999) | Child advocacy model/community-based child abuse treatment and prevention | Community nurses, SW, CPS, MH, LE, and child abuse detectives |
| Skaff (1988) | Child maltreatment coordinating committees | CPS, health, LE, MH, attorneys, private agencies, court personnel, and parent or child groups |

Note: MH = mental health; LE = law enforcement; DA = district attorney; SW = social work; CPS = child protective services.

it assumed causality. Clearly, a quasiexperimental study using a comparison group of concurrent cases not reviewed by an MDT would have strengthened the study. Alternatively, by creating an experimental analog (Sainz & Epstein, 2001), the researcher could make comparisons with cases investigated prior to the MDT program with other comparable attributes. Either of these would enhance the ability to infer that it was the MDT that influenced service delivery.

In addition, although the study demonstrated that not all cases received all recommended services, it did not explain why. Whatever the reasons for the relatively low level of psychological services received, the presence of an MDT does not ensure the delivery of recommended services.

A national survey of 301 caseworkers in 33 American states studied the relationship between worker satisfaction and MDT availability (Fryer, Poland, Bross, & Krugman, 1988). Factors considered included the caseworkers' attitudes toward colleagues and clients and access to consultative services. Half of those who answered the questionnaires reported membership in or access to an MDT. Access was associated with positive attitudes toward continuing work in the field of child protection; better relationships with clients, supervisors, peers, and other professions; and reduced need for additional consultation.

More specifically, MDT-affiliated caseworkers were less likely to report feeling restless in visits to disadvantaged communities, delaying seeking clients, having intolerant feelings toward clients, and having difficulty in concentrating on client problems. Team participants expressed particular satisfaction with regard to access to and support from lawyers. Fryer et al.'s (1988) study indicated that MDT access was associated with a more positive view of working conditions, decreased stress, better client relations, and better overall attitudes to work; it did little, however, to confirm the connection between worker satisfaction and effective service delivery.

**TABLE 2**
**Team Effectiveness**

| *Study* | *Study Type and Data Source* | *How Effectiveness Is Measured* | *Outcomes/ Findings* |
|---|---|---|---|
| Faller & Henry (2000) | Review of records; 323 criminal court files (closed cases over 10 years) | CPS and LE involvement, videotaping of child interviews, medical exams, child disclosure of abuse, child placement, suspect confessions, confession and plea rate, trials, child testimony, sentences received by offenders | Outcomes were a consequence of the collaborative efforts of LE, CPS, and the prosecutor's office, which resulted in a high confession and plea rate. |
| Goldstein & Griffin (1993) | Evaluation of hospital-based center's experience over five years | Stability in the team, communication, trust and respect, sharing of goals and values | More accurate conclusions, earlier and more effective therapeutic intervention, less trauma for a child, decrease in the rate of burnout. |
| Hochstadt & Harwicke (1985) | Retrospective review of records; child's CPS worker and parents (180 children) | Service delivery: the number of recommendations that were followed/obtained by the child's CPS worker one year after discharge | Increased probability of service acquisition such as reducing fragmentation and duplication of efforts and providing case coordination. |
| Jaudes & Martone (1992) | Retrospective chart review; children's cases, and sexual abuse assessments 1985–1986 (38) classified as pre-VSIP and compared with VSIP evaluations 1987–1988 (226) | Service provision and delivery aspects | Interdisciplinary evaluations decreased the number of interviews a child must undergo and increased the likelihood of indicated cases, identification of the perpetrator, and charges being pressed. |

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| Jensen et al. (1996) | Evaluation; official data, interviews, and program tracking records; team members, children (294), and their parents | Efficiency of investigation process, professional communication, child trauma, availability of information about the case, therapeutic service delivery for clients, duplication of services, and protection of the victim | 87% of the children felt "very good" to "a little good." Team members were satisfied with efficiency and effectiveness of CACs' services. Parents' satisfaction with services was high at intake but decreased by the three-month follow-up. |
| Onyskiw et al. (1999) | Qualitative evaluation; in-person interviews; review of all client records; clients (17); team members (10) | Service delivery: less fragmentation, duplication, and more responsiveness to client needs, better coordination and communication between providers | Ability to seek services when needed, immediacy of the response time and availability of support during stressful times, and informal support received from team members were found beneficial by clients. Team members found access to services easier for clients. |
| Skaff (1988) | Interviews and site visits; 188 committees reviewed; 24 coordinating groups used to test the hypothesis | Committee participation and member collaboration | Greater collaboration; equal member power and neutral committee setting both increased the likelihood of collaboration. Opportunity to communicate directly and gain new services, increasing community awareness were benefits. |

Note: CPS = child protective services; LE = law enforcement; VSIP = victim sensitive interviewing program; CAC = child advocacy center.

In a much smaller study based on 18 interviews, Bross et al. (2000) examined the role of a consulting forensic team approach to criminal child abuse cases. Created in 1985, this MDT was intended to improve criminal prosecutions and provide additional expertise to child abuse caseworkers. In this study, in contrast with most others, those who had referred cases for consultative services evaluated the service rather than the service providers.

All respondents agreed that the team provided missing expertise. A large majority (83%) agreed that the team alleviated ambiguities in cases, made resolutions possible that might otherwise have remain unresolved (67%), and reduced delays in the processing of cases (55%). The general consensus among respondents was that the team was quite helpful, provided moral support, and improved confidence that the case was being managed correctly. Not all results, however, were as positive as the authors concluded. MDT could not eliminate ambiguities in several cases and did not have the capacity to resolve disputes in even more. Nor did the study describe how MDT did what it did so successfully.

In the most recently published national effort to assess MDT effectiveness, two-thirds of Kolbo and Strong's (1997) 50 survey respondents (each representing a state) reported at least one benefit. The following benefits were enumerated without regard to MDT type:

- increased coordination and collaboration between agencies,
- a broader range of viewpoints considered,
- more collaborative decisionmaking,
- otherwise unknown resources identified, and
- better quality assessments and treatment services.

Other benefits reported were: more cases reviewed, fewer cases missed, and more cases resolved successfully. Secondary benefits reported were a greater sense of accomplishment and improved interagency relationships.

Respondents suggested ,however, that MDT involvement presented challenges as well. Many indicated that collaboration was not always easy. Initially, some individuals and agencies were hesitant or resisted participation. Although respondents perceived MDTs as helping lessen the burden on CPS workers, some were confused about leadership roles, questioned ownership of the case, and felt uncomfortable about additional scrutiny of their work. Others commented that, at least at first, interdisciplinary decisionmaking was more time-consuming than traditional approaches.

Unfortunately, Kolbo and Strong (1997) did not enumerate the percentage of respondents reporting each of these outcomes. Moreover, they made no differentiation regarding type of MDT. They generally compared results of the study with previous national surveys, although they acknowledged changes in MDT designs. They concluded that investigation and treatment planning have surpassed advising and consulting as the primary functions undertaken by MDTs. In addition, community education and monitoring the resolution of cases has become more important of late. In other words, contemporary MDTs focus on more direct and active participation of different disciplines in addressing cases. Kolbo and Strong (1997) hypothesized that this shift of MDT attention to treatment planning and monitoring of case resolution in MDTs is likely to reverse the increasing percentage of confirmed cases that do not receive services; however, they presented no evidence to support this hypothesis.

A more ambitious and historical study by Faller and Henry (2000) examined processes and outcomes for 323 criminal court cases during a 10-year period in a relatively small Midwestern community. Starting in 1985, local MDTs developed case management plans with the following special components, among others: coordinating between CPS and law enforcement, videotaping child interviews and interrogation of suspects whenever possible, and offering polygraphs to nonconfessing suspects.

Over the 10-year study period (1988–1998), the percentage of cases with CPS involvement declined dramatically. The explanation, Faller and Henry (2000) suggested, was increasing caseloads and a consequent limitation on CPS involvement in noncaregiver cases. Overall, the MDT videotaped 73% of child interviews and polygraphed 38% of offenders, with the polygrapher diagnosing deception in 63% of the polygraphs and the offender confessing in 9% of polygraphs. Sixty-four percent of offenders confessed during the investigation, and 76% pleaded to some form of criminal sexual conduct in the target case or another. The agency charged 69% of cases, with the most common reason for not charging being passing the polygraph. Only 15 cases (5%) went to trial, with six convictions. Seventy-six percent of offenders received some sort of sentence. Less than 10% of children had to be placed outside the home.

Faller and Henry (2000) reported that although imperfect, the rates of charging, confession, plea, and child placement compared favorably to the charging rate reported in Cross, Whitcomb, and De Vos's (1994, as cited in Faller & Henry, 2000) research, who studied criminal prosecution in four jurisdictions, and to MacMurray's (as cited in Faller & Henry, 2000) findings. MacMurray examined case outcomes for 87 Massachusetts cases (Faller & Henry, 2000). Discussing their outcomes with community professionals, Faller and Henry concluded that the relative effectiveness of MDTs they studied could be attributed to interagency collaboration. Because they presented no data concerning the character or extent of collaboration and its relationship to various measures of effectiveness, however, it would have been more prudent for the authors to treat this conclusion as a hypothesis for future testing.

In a more process-oriented qualitative study, Goldstein and Griffin (1993) provided a historical account of five years' experience developing and implementing a physician–social worker team for evidentiary evaluation of child sexual abuse. Located in

San Diego County, CA, this MDT substantiated abuse via a videotaped social work interview and a physical examination with the social worker and physician functioning as a collaborative unit.

Goldstein and Griffin (1993) identified three benefits of the team process. First was the continuing reminder that the child's history and physical examination were linked and provided more information when considered together than separately. Second, although focusing on evidentiary evaluation, MDT was able to reinforce healing by providing gradual transitions for children. Hence, the team enhanced the family's security by providing a comprehensive and therapeutic evaluation. Finally, MDT provided an avenue for dialogue and support for the team members.

Goldstein and Griffin (1993) concluded that an effective MDT is built on good communication and partnership among team members. Although these elements are probably necessary for effective team functioning, one wonders whether they are sufficient to ensure desired case outcomes. These conclusions would be more convincing if the researchers presented service delivery and outcomes data. In other words, did families and children receive the psychotherapeutic interventions recommended? And if received, did the interventions achieve their intended treatment outcomes?

Focusing on redundancy and coordination issues, a pre-/post-MDT study by Jaudes and Martone (1992) evaluated the effectiveness of a Victim Sensitive Interviewing Program (VSIP) designed to decrease the number of interviews children who were alleged to have been sexually abused endured. In this MDT variant, VSIP provided a coordinated investigative interview, medical examination, and follow-up medical and counseling services to alleged child sexual abuse victims.

In this data-mining study, Jaudes and Martone (1992) conducted retrospective chart reviews on all suspected abuse cases

seen at a hospital-based center in Chicago between January 1984 and June 1988. They extracted data on demographics of victim and perpetrator, identification of the perpetrator, number of interviews, number of interviewers, and so forth. They classified sexual abuse assessments before and through 1986 ($n$ = 38) as "pre-VSIP" and compared them with VSIP evaluations conducted from 1987 through 1988 ($n$ = 226). A number of significant differences emerged from this comparison:

- 24% of pre-VSIP versus 88% of VSIP youth were interviewed by only one interviewer,
- 68% of pre-VSIP versus 88% of VSIP cases were indicated cases of sexual abuse,
- 71% of pre-VSIP versus 85% of VSIP youth identified the perpetrator, and
- 33% of pre-VSIP versus 60% of VSIP youth pressed charges if the agency identified the perpetrator.

Despite the advantage of including historical comparisons in this study, it is clear that differences in effectiveness were highly contingent on the measures chosen. Moreover, cases screened at a hospital-based center are likely to have a higher index of suspicion than cases referred, for example, by neighbors or teachers. Hence, one needs to keep in mind context-specific differences before generalizations about MDT effectiveness can be comfortably made. Disregarding these contextual differences, Jaudes and Martone (1992) strongly recommended that agencies form interdisciplinary teams to assess allegations of child sexual abuse.

In a study of three children's justice centers (CJCs) in Utah, Jensen et al. (1996) evaluated a form of MDT that most closely approximates the child advocacy center model for investigating child sexual abuse. These CJCs offered a "homelike" environment for children, used MDTs in interviews, and conducted weekly multidisciplinary case reviews. Participants were children and parents referred to three CJCs between August 1993 and September 1994. The researchers aggregated data across CJCs on 294

cases. They analyzed abuse-related variables, children's and parents' satisfaction with their experiences, team members' satisfaction with services provided, and legal case outcomes. In addition, they conducted a brief pretest-posttest assessment of children's behaviors and emotions at intake and at a three-month follow-up with 87 of the participants.

Findings revealed that child problem behaviors had significantly decreased at the three-month posttest. Moreover, 87% of the children felt "very good" to "a little good" about the interview, with only 12% of children reporting that they felt "bad" or "very bad." Team members consistently registered their satisfaction with the efficiency and effectiveness of the CJCs' services across all sites. On the other hand, parents' satisfaction with the CJCs' services was high at intake but decreased markedly in the three-month follow-up. By that time, they were less satisfied with the extent to which they believed their caseworker had listened to their problems and with the help they had received.

The reasons for a decrease in parental satisfaction were unclear. Jensen et al. (1996) hypothesized that parents received more limited services than they had been led to expect or felt they needed. Also, Jensen et al. speculated that parents may have experienced confusion about the roles of CJC staff and other MDT members.

Although comparisons among CJCs and with non-CJC cases might have increased the interpretability of the findings, the reduction in parental satisfaction at the three-month follow-up underscores the importance not assuming that MDTs ensure comprehensive and effective service delivery to children and families.

Focusing on a collaborative, community-based, child abuse prevention–oriented team approach, Onyskiw, Harrison, Spady, and McConnan (1999) examined program efforts and the opinions of 17 clients and 10 team members about the changes that MDT had made. Prior to its inception, different agencies with

different organizational missions and structures offered prevention, detection, investigation, and treatment of child abuse and neglect. This resulted in a lack of coordination among service providers, fragmentation of services, and ineffective outcomes. Other reported inadequacies included client access to multiple services because these were offered at different and distant locations. The new MDT model brought services together in one convenient location.

Both clients and staff expressed greater satisfaction with the new program and the more convenient, personalized, and responsive services that it provided. Participants viewed improved access to an MDT of providers, more rapid response time following referral, and the reduced fragmentation of a range of services positively. At face value, it would be hard to contest their conclusion; however, the client portion of the evaluation was based on a very small, nonrepresentative sample of families in which child abuse and neglect are problems. Moreover, because the MDT model Onyskiw et al. (1999) evaluated was defined as a prevention program, it is likely that it served at-risk families who received a rich array of services relatively early in their abuse and neglect histories.

Similarly, prevention-oriented MDT staff members function in what we might presume to be a resource-rich environment with relatively high staff-to-client ratios and less severe family and child pathology than staff in more ameliorative MDT programs. Hence, in addition to the problems evaluating the long-term effectiveness of MDT services and the complex issues associated with measuring the efficacy of prevention programs, one wonders how generalizable this particular MDT program model is.

In a more rigorous study of multiple MDTs, Skaff (1988) conducted a national study of factors associated with the effectiveness of multidisciplinary coordinating committees. In contrast with all of the previously described studies, this one tested two very specific sets of hypotheses. First was that committee partici-

pation would be greater when members were allowed equal power in group decisions or when members perceived the committee to be effective by potential group members. Second was that committee collaboration would be greater if one of the following exists: perceived equality of power among members, a sharable group goal, the committee operates in a neutral setting, or the community supports the committee. Key dependent variables in the study were committee participation and member collaboration.

Skaff (1988) used a stratified random sampling procedure. Skaff reviewed 188 committees and strategically selected 24 coordinating committees to test the stated hypotheses. Of all the independent variables tested, only perceived committee effectiveness was significantly associated with committee participation. On the other hand, member collaboration was significantly related to several factors. For example, when communities emphasized communitywide goals versus individual agency concerns, collaboration was greater. Equal member power and a neutral committee setting increased the likelihood of collaboration as well.

Skaff (1988) concluded that the most essential benefit of coordinating committees was the opportunity for members to communicate directly with one another, to exchange information, to share their distinct perspectives, to learn about new services, and to increase community awareness regarding child abuse and neglect. According to Skaff, effective committees were able to sustain prevention and treatment programs that would otherwise have been eliminated.

Nonetheless, Skaff (1988) identified a variety of issues as problems in establishing these groups. Among these were arriving at shared goals and objectives, securing financing for committee operation, resolving turf disputes, and overcoming community denial of the existence of the problem. Repeatedly, participants mentioned agency territorialism as the primary barrier to committee effectiveness. They often mentioned how to increase agency

willingness to cooperate as an unanswered question.

Finally, the authors consider a study by Tjaden and Anhalt (1994) comparing process and outcome of child abuse investigations in five communities that varied in the degree of collaboration between police and CPS investigators. Across the communities, Tjaden and Anhalt found that the term *joint investigation* was so loosely defined that they operationalized it as involving at least one contact between the two agency investigators during the CPS investigation or one conjoint interview sometime during the investigation process. Despite this minimal measure of collaboration, Tjaden and Anhalt found that joint investigations were more likely to occur with sexual abuse, more serious physical abuse, and multiple forms of abuse. Moreover, they were more likely to happen when law enforcement was the first agency officially reporting the abuse and when emergency medical treatment was necessary.

Compared with independent investigations, joint investigations had shorter caseworker response times, lengthier investigations, more contacts during the investigations, more frequent use of face-to-face interviews, more custody removals, more perpetrator departures from the home, more perpetrator confessions, more frequent victim corroboration, more substantiated reports, more dependency filings, more criminal prosecutions, and more guilty pleas. Joint investigations did not have more repeat interviews than independent investigations.

Without further study, however, the possible explanation for this impressive list of differences between joint and independent investigations is difficult to surmise. Possibly these differences might be explained entirely by differences in the seriousness of abuse. In other words, it is possible that cases in which agencies decided to intervene more intensely were those assigned to be jointly investigated. If this were true, joint investigation would be more properly considered a consequence of professional resolve rather than a cause of MDT effectiveness.

Predictably, Tjaden and Anhalt (1994) did not statistically control for these possible "confounds," nor did they address them in their discussion. A more rigorous comparison of communities that differed on degree of joint versus independent investigations would require a multivariate analysis that controlled for the effect of seriousness of abuse in testing the effect of collaboration.

## Summary of Findings

As the foregoing review has shown, MDTs in child welfare have obvious strengths. On the other hand, a critique of prior evaluation studies opens a whole new set of problems and questions. By and large, referral sources, team members, and service recipients saw the multidisciplinary approach as advantageous. Generally ascribed benefits included increased coordination and collaboration between agencies (Kolbo & Strong, 1997). Particularly, researchers said teamwork integrated a broader range of viewpoints (Kolbo & Strong, 1997; Skaff, 1988), reduced need for additional consultation (Fryer et al., 1988), increased information exchange (Skaff, 1988), and enhanced communication and access to other professionals (Fryer et al., 1988; Skaff, 1988; Tjaden & Anhalt, 1994).

As a result, agencies reviewed more suspected cases, missed fewer cases, and resolved more cases successfully (Hochstadt & Harwicke, 1985; Kolbo & Strong, 1997), and they reduced fragmentation and duplication (Hochstadt & Harwicke, 1985; Onyskiw et al., 1999). In addition, team members reported the MDT approach helped bring a more positive view of working conditions, decreased stress, and improved client relations (Fryer et al., 1988), and it provided moral support and confidence (Bross et al., 2000). Clients found services more accessible and less fragmented (Onyskiw et al., 1999).

Although these functions are undeniably positive, MDT problems can occur as well. Effective teamwork is contingent on ne-

gotiations between different professionals with agency missions, professional perspectives, and information priorities. A dysfunction to one team member may be an objective of another. Accordingly, listed among the most common barriers to team effectiveness were defining shared goals and objectives (Fargason, Barnes, Schneider, & Galloway, 1994; Skaff, 1988); conflicting theories and ideologies about child abuse and neglect, lack of consensus (Mouzakitis & Goldstein, 1985); turf disputes, agency territorialism, and power struggles (Skaff, 1988); confusion about leadership roles and the ownership of the case; feelings of excessive case scrutiny; and that interdisciplinary decisionmaking is more time consuming than traditional approaches (Kolbo & Strong, 1997).

Furthermore, although the MDT approach is based on the notion that a group of professionals can effectively and efficiently make recommendations in the best interest of the child or family, it can also diffuse responsibility by adding additional players to the situation. This aspect may decrease stress but increase coordination and collaboration problems (Winton & Mara, 2001).

The consequences of poor cooperation can be profound. For example, the inability to effectively coordinate the activities of law enforcement agencies, the courts, and CPS agencies has proven disastrous when dealing with children who are victims of sexual and physical abuse (Doss & Idleman, 1994). Doss and Idleman (1994) remarked that "[all] too often, media accounts of tragedies against children are exacerbated by one agency not having a clear grasp of another agency's involvement in a particular abuse case" (p. 676).

## Evaluation Agenda for Future Research

Although the information contained in this literature review may be the most comprehensive synthesis of MDT evaluations to date, clearly, many remaining evaluative issues demand further attention. Needed are:

- more consistent operational definitions of short- and long-term MDT outcomes;
- more descriptive quantitative studies of variations in MDT designs and structures;
- more qualitative studies of MDT collaborative processes;
- more comparative quasiexperimental studies of MDT effectiveness;
- more multivariate studies of MDTs that control for the effects of confounds such as differential case assignment, variations in MDT structures, and professional composition, and so forth; and
- more ethnographic, context-specific studies that take into account variations in organizational and community cultural environments.

From a research design standpoint, sufficient evidence (or at least consensual agreement) exists that MDTs are beneficial and benign, such that it would be difficult to justify prospective, randomized, controlled experiments to evaluate their effectiveness. Such "gold standard" studies would gratify researchers but raise serious ethical issues for professionals and political issues for community groups. Comparative experiments involving random assignment to different MDT models, however, might be feasible. Alternatively, as Sainz and Epstein (2001) have shown and some of the previously discussed studies have intimated, available information from case records might be used to create analogs to MDT experiments. These would increase researchers' ability to make causal inferences without intruding into program operations or raising ethical concerns.

Further research based on original data should provide a comprehensive analysis of an MDT by collecting information from all available sources—team members, clients, records, and so forth—to capture the whole picture of team practice. Views from those outside the team are no less important than those inside the team. Evaluation of the team by victims, their families, outside agencies, members of the general community, and agency

managers or supervisors are critical to evaluation as well as to proper team development (Ells, 2000).

From the standpoint of program operations, future research needs to examine which aspects of MDTs (a) encourage appropriate reporting, (b) generate legally acceptable evidence, (c) resolve cases in a timely manner and in the best interests of the child victim, and (d) respond to the needs of child victims and the potential victims of future maltreatment (Kolbo & Strong, 1997).

Ultimately, this critical review of MDT evaluation studies returns to the questions that prompted it in the first place. Given the increasing popularity of MDTs, are they more effective than traditional modes of child abuse and neglect service provision? Do they minimize the iatrogenic effects of investigation of children and families? Do they maximize the treatment potential for victims and the rehabilitative potential for perpetrators? Do they provide a more supportive and informative working environment for professional participants? What unanticipated problems do they introduce and how can these problems be resolved?

A final set of questions that this review has raised is, How do different MDT structures differ in their capacity to serve abused and neglected children and their families? Under what conditions and toward what ends do different MDT arrangements work best? Only through a more rigorous and integrated MDT evaluation agenda can these questions be answered.◆

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