DiBernardo Management Consultants DMC

FINAL REPORT

EVALUATION OF FAMILY CRISIS PROGRAM

Submitted to:

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EXECUTIVE SUMMARY

The Family Crisis Program in Nassau County, New York is a LEAA funded demonstration project which provides rehabilitative therapeutic services to families involved in violence. The project is under the fiscal and programmatic supervision of the Nassau County Criminal Justice Coordinating Council and the New York State Division of Criminal Justice Services. Major referral sources to the project include Child Protective Services, Coalition for Abused Women, Department of Probation, hospitals and Mental Health Clinics.

The Family Crisis Program is an outgrowth of the Child Abuse Community Centers Program, which operated under the same funding mechanism, from 1974 - 1977 to provide service to abused and neglected children and their families in Nassau County. The program provided intensive outreach services, traditional group and individual therapy and employed in addition, several innovative, non-traditional therapeutic modalities.

An evaluation of the Child Abuse Community Centers Program, conducted by DiBernardo Management Consultants, and completed in November, 1977, demonstrated that the intensive, specialized services of the project resulted in a significant decrease in the rate of recurrence of abuse/neglect, rate of Family Court Petitions and rate of Foster Care Placements for project cases in comparison to a control group. The control group consisted

of a random 10% sample of Child Protective Services cases not referred to the project.

The Family Crisis Program was designed to continue to serve the needs of the Child Protective Services population, and additionally to serve families involved in other forms of family violence. The decision to incorporate all forms of family violence in one treatment program was based on the theoretical premise that all forms of family violence are closely interrelated and that there exists a commonality of family problems and service needs for all these families. The expanded emphasis on family violence was also the direct result of DMC's evaluation of the Community Centers program which indicated that spouse abuse and other forms of family violence were frequently occurring problems among Child Protective Services families.

The Family Crisis Program is administered by the Department of Mental Health, while the Community Centers Program was under the administrative control of the Department of Social Services (Child Protective Services). The change in administrative locus, and the change in population served are the major initial differences between the two programs.

At present, there is an insufficient number of clients who have been engaged in services for a period of at least six months, to be able to conduct an outcome evaluation of the effectiveness of the Family Crisis Program's service delivery. The present

evaluative effort, therefore, addressed the following main issues:

- Comparison of problems and service needs between Child Protective Services clients and those involved in other forms of family violence.
- History of the projects, descriptions of operations and services, and illustrative case histories.
- Examination of the characteristics of cases referred to the Family Crisis Program by Child Protective Services in comparison to CPS cases referred to other community agencies, and those not referred for counseling.
- A follow-up examination of the long-term outcome of families served by the Community Centers Child Abuse Program.
- Analysis of the cost-effectiveness of specialized service delivery to Child Protective Services clients.
- Examination of the major problems arising during the first year of program operation including recommendations for addressing these problems.

Several major findings resulted from the evaluative endeavor:

- The major contributory problems and implied service needs of child abuse/neglect families are essentially the same as those of families involved in other forms of violence (spouse abuse, parent abuse). Child Protective Service clients, however, require more time and effort on the part of project staff in order to become actively involved in recommended services.
- Cases referred by CPS to the Family Crisis Program are more likely to be two-parent families than are those referred to other community agencies. FCP referrals are unlikely to involve court petitions or child removals, but the program is evidently seen as a major source of services for cases involving sexual abuse since 14% of referrals to the

projects involve sexual abuse, while only 3.5% of all CPS cases fall into this category. About 20% of the clients referred to the Family Crisis Program are diagnosed as having a severe psychiatric disorder (psychosis, or borderline personality disorder).

- A cost-effectiveness analysis based on the results of the Community Centers Program indicated that such programs, if institutionalized on a county wide basis, can prove to be a highly cost-effective endeavor. It would cost approximately one million dollars to implement the programs across the county to serve the needs of all families requiring such service. Approximately half this amount can be anticipated to be Medicaid reimbursable. Additionally, providing specialized services to all Child Protective Services clients requiring counseling would be anticipated to result in a potential savings of public funds amounting to $470,000 per year now being expended for such costly interventions as Foster Care and Family Court petitions.

- The major problem interfering with optimal utilization of project services, smooth administrative procedures, and mutual cooperation appears to be the lack of a well-developed mechanism for effective inter-agency communication. This situation has contributed to a lack of mutual understanding of agency orientation, pressures and problems; a lack of exploration of common goals and a lack of clarification regarding specific responsibilities.

1.0 REVIEW OF RELEVANT LITERATURE

Since Dr. Henry Kempe's presentation on the battered child syndrome, there has been an increased interest in providing rehabilitative services for the child abuse victim and his family.[1] Traditional approaches to child abuse have been modeled upon either a "punitive" model in which the parent is perceived as a perpetrator deserving of punishment, or a medical model based upon the perceived "pathology" of the patient.

If a punitive, authoritarian approach to the child abuse problem is accepted, the most common intervention is the removal of the child from the abusive home situation and placement of the child into foster care. Increasingly, however, child welfare workers have become aware of the destructive effects of long-term foster care on children.

There is general agreement among professionals in the field of child welfare, that the ambiguity and uncertainty which is inherent to the nature of a foster child's status in the family, limits the ability to form close, permanent, interpersonal relationships and denies the child the environment necessary for optimal personal development. Numerous studies have demonstrated

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1. Kempe, Henry and Helfer, Ray E. editors; Helping the Battered Child and His Family; Lippincott (Phelan) 1972.

the negative effect of long-term foster care on the emotional and psychological development of children.[2] In fact, the Commission on Children in Need of Parents has directly stated its finding that "a surer system for harming children and wasting money could hardly be invented than that which has grown up, like a pernicious weed, in the operation of foster care."

Recognition of the problems of the foster care system has led to an increased emphasis on the provision of "Preventive Services". The concept of Preventive Services is based upon the premise that the provision of intensive family services can alleviate family stresses and strengthen the family unit, thereby alleviating the necessity for child placement, or permitting the rapid return of placed children to the home.

If the etiology of the child abuse circumstances is assumed to lie in the psychopathology of the parent, the primary service required is psychotherapy. However, Child Protective Service workers have long been aware that referring abusive parents for therapy to a private practitioner or community mental health agency frequently does not have the desired outcome.

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2. Weinstein, E.A. Self Image of the Foster Child N.Y. Russell Sage Foundation, 1969 Thomas, C.B. The Resolution of Object Loss Following Foster Home Placement, Smith College Studies in Social Work, Vol. 37, June, 1967.

Psychotherapists, both in private practice and in a clinic setting, are accustomed to clients who voluntarily seek their services in order to find relief from emotional distress. The CPS client, however, generally does not feel the need for therapy and in fact is frequently highly resentful of the implication of emotional disturbance. Frequently, the abusive parent is completely unwilling or unable to follow through on the referral at all. If fear of losing their children propels the parents to engage in therapy, the therapist frequently finds that the client misses appointments, has little motivation for change, is hostile and resistant and drops out of treatment prematurely. Successful psychotherapy for the CPS client requires intensive efforts merely to engage the client in active participation in the therapeutic process. The average therapist has little experience in dealing with hostile, resentful clients and does not have the time required to perform intensive outreach. Typically, the CPS client manifests multiple problems: high rates of alcoholism, unemployment, financial problems, physical health problems and child-centered problems. Psychotherapy alone is frequently not sufficient to enable the client to cope with this multitude of problems. Assistance in dealing with community agencies, help with child care and other concrete services are also needed.

There have been many specialized programs which have been developed across the nation to respond to the needs of abused

and neglected children and their families. Such programs offer a wide range of theoretical approaches, and traditional, and innovative services directed toward parents, children or entire families. All such programs, however, have one goal: to provide for their clients an array of intensive services which can improve the ability of parents to adequately care for their children, thus maintaining the stability of the family unit and preventing unnecessary removal of children into foster care.

Some programs emphasize the mobilization of existing community resources to meet the needs of the multi-problem family. According to the Symposium on New and Innovative Treatment Approaches for Child Abuse and Neglect, those practitioners who see a family as psychologically distraught will emphasize therapy and counseling, while those whose vested expertise lies with socio-economic needs will emphasize the "provision of concrete services" to assist dysfunctional families.[3]

To illustrate the variety of programmatic approaches currently being employed in the provision of services to families at risk of child placement, this review will describe several projects, each utilizing a different approach.

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3. Klaus, Susan L. (prepared by) Symposium Report: Innovative Treatment Approaches for Child Abuse and Neglect: Current Issues and Directions for Future Research. DHEW #HEW-105-76-1136; June, 1977.

- Community Networking Approach to Preventive Services: Lower East Side Family Union
- Family Systems Approach: Peanut Butter and Jelly Therapeutic Pre-School, Infant and Family Center.
- Volunteer Services: Schenectady County Lay Therapy Program
- Group Therapy and Goal Attainment: Southwestern Institute for Group and Family Therapy
- Child-Focused Treatment: The Gilday Center

1.1 Lower East Side Family Union: A Community Networking Approach

The Lower East Side Family Union (LESFU) is a non-profit social welfare agency located on the lower east side of Manhattan in New York City. The stated goal of the Union is to help the most problem ridden families in a poor, multi-ethnic New York City neighborhood, deal with child rearing problems with the aim of reducing the frequency and duration of time with which children are placed away from their natural parents.

The Family Union has developed an innovative approach emphasizing community involvement. The direct-service staff is drawn from the same neighborhood as the families it services. Case-specific contracts are developed with each of the major organizations serving the area to provide support for the families with whom the Union works.

In a single year, some four hundred families come to the Family Union. Most of these families have already come to the

attention of a public child welfare agency. About half the families who come to the Union fall into the category of "high-risk"; that is, they have characteristics similar to those of families whose children are in foster care. These high-risk families are in desperate need of support; they lack the money to buy necessary services (homemaker, day care, baby-sitters, counseling) they also lack the ability to seek and use those services that are available to the poor.

The Family Union feels that the practices it has developed constitute a "new social invention". Included among these practices are the following:

- Contracts are developed between the Union and as many of the agencies servicing the community as possible. These organizations include settlement houses, Boys Clubs, hospitals, Special Services for Children (DSS), Educational Alliance, Department of Probation, etc. The contract specifies that the Union assumes the responsibility for coordination of agency services, service planning and service monitoring for cases involving both the Union and any of the contracted agencies.

- A case conference is held, subsequent to initial assessment of family problems, attended by the family and by representatives of various agencies that have worked with the family in the past or that might work with it in the future. The goal of the case conference is the development of a case-specific contract, which focuses on the needs of the particular family and on the actions that will be taken by the family and by the various participating agencies. The Union worker becomes the case manager, to insure that all participants in the conference deliver the services identified as needed.

- The development of four teams, each of which is responsible for a particular area. The team leader is a professional social worker, but the bulk of the team consists of workers and homemakers drawn from the neighborhood and trained on the job.

- The extensive use of homemakers to act as role models and teachers of parents in unstable home situations.

- The establishment of a system for evaluating the degree to which individual families attain the goals jointly developed by the family members, the local service providers and the Union staff. Obstacles to goal attainment, and the reason for these obstacles are identified in order to provide clues for future work with distressed families.

The Family Union believes that most of the people who need the services of health, education and welfare agencies do not have a single problem which can be dealt with outside the context of the individual family. The model developed by the Union is an innovative approach to mobilizing community resources for the provision of an integrated service package to meet the needs of families in stress.

1.2 The Peanut Butter and Jelly Therapeutic Pre-School, Infant and Family Center: A Family Systems Approach

Dr. Brian Grodner is the psychologist and Director of Training of the Peanut Butter and Jelly Therapeutic Pre-School, Infant and Family Center in Albuquerque, New Mexico. This program was established in 1972 in a low socio-economic community which is predominantly a Chicano population. The "Peanut Butter and Jelly School" is a comprehensive program for families whose infant or pre-school

child has been designated abused, neglected, autistic, developmentally delayed or emotionally disturbed. The parents in the program tend to be low on the economic scale, with unsociable parenting skills and exhibit signs of "severe stress" and emotional deficiency.

Dr. Grodner thinks that treatment approaches based on the parent's pathology and/or sociological-environmental circumstances, in effect inhibit the treatment of child abuse and neglect. Dr. Grodner employs the family systems concept approach to child abuse: "A family systems approach states that abuse is part of a pattern of relationships and reciprocal transactions between parent and child (and other family members) in which all parties play a part".[4] The family systems concept, however, does not preclude psychopathology nor social-environmental stress; this system recognizes the need to treat these problems as well as the family dysfunction, the interactions of child and caregiver, and the relationship between parental functioning and the child's temperament.

The Peanut Butter and Jelly Pre-School's initial step for dysfunctional families is an intake procedure. At this intake-meeting, the parents and child are seen together and interactions

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4. Grodner, Brian, Ph.D., "A Family Systems Approach to Treatment of Child Abuse: Etiology and Intervention", Journal of Clinical Child Psychology, 1. pp. 332; January, 1977.

of the parent and child are carefully observed. The child is then escorted into a classroom, where the teacher observes the child's interactions with staff and classroom materials. While the child is in the classroom, the parents remain in the conference room along with staff members to discuss topics more appropriately addressed without the child present.

The school's philosophy is to discuss parent involvement and family orientation as well as to receive an agreement of participation with the family. The staff also listens to the goals, expectations and problems of the parents. The parents' strengths, motivation, types and degrees of stress, possible pathology, influences of other family members and neighbors, and the parents' understanding of child development is assessed. In order to change the parent-child interactions, direct training, feedback and support are usually offered.

The main program components of the Peanut Butter and Jelly Program are:

- Therapeutic pre-school and outreach program for approximately 60 children and infants.
- A comprehensive program of parental training, counseling and involvement with emphasis on the parent's self-concept and parenting skills.
- Supplementary supportive and adjunct services are provided as needed.

The program components are highly flexible; each family is seen as a separate entity with a particular constellation of

problems. Therefore, individualized treatment plans are developed for each family. Some parents are involved in the classroom setting from one to five days per week. Some parents are predominantly involved with their own children. Parent-child activities are numerous: fixing snacks, cleaning the room, reading and discussing theories. In other words, the parents' involvement with their children outside of their home environment is a pertinent part of this program's objectives, although in-home services are provided as well.

There is plenty of emotional support. The staff helps the families deal with traumas such as "death in the family, to problems with food stamps, to scheduling a pediatric neurological examination." By the same token, friendliness, respect, informality and comfort and emphasized.

1.3 Schenectady County Lay Therapy Program: A Volunteer Program

The Schenectady County Lay Therapy Program is located in Schenectady, New York: similar volunteer programs are located in Arkansas, Pennsylvania, California, Missouri, and Colorado as well as other cities in the New York area. The model program was formed in 1969 in Denver, Colorado, under the auspices of the National Center for the Prevention of Child Abuse and Neglect as an experimental program. The Schenectady County Lay Therapy Program, originated with Nancy Trimpoli, Ginny Davidson and Sandy

Selby Spaulding, and is now operating with 20 volunteers, who participate in an intensive training program, one hour a week for five months. The training is geared around the pertinent mechanics of volunteer services. The best volunteers are described as people with high motivation, time, patience, and empathy with others. Ideally, they are reliable, even-tempered, and enjoy being with children.

The Schenectady County and related programs are grounded in the theory that abusive and neglectful parents can greatly benefit from the friendly presence of a non-threatening lay therapist. Previous research findings have indicated that such parents are:

- Under stress (poverty, crowded conditions, lonliness, extreme youth, alcoholism, etc.) and are unable to cope.
- In need of parenting skills. Frequently these parents were never properly parented themselves and so never learned the skills of parenting. Many, in fact, were themselves abused as children.
- Suspicious and distrustful of others, which leaves them friendless and isolated.
- Depressed, dependent and deprived and need care as much as their children do.

The referral source for all Schenectady County Lay Program clients is Child Protective Services. CPS conducts the initial assessment before reaching a verbal agreement with a client to utilize the services of the Schenectady Lay Therapist. After an agreement is reached, Sandy Spaulding, the supervisor of the program, does an in-depth analysis to match an appropriate volun-

teer with the referred client. For instance -- if the client is a young, single mother with small children, then the supervisor will seek a volunteer within the program who is also young, single and with small children. By the same token, if there is an intact family with both parents present, the supervisor will try to find both a male and female volunteer to talk and work with this family.

Prior to the meeting with the client, there is a series of conferences. Ms. Spaulding screens all clients before committing the program to response. After Ms. Spaulding has completed her conference with CPS and a volunteer is matched with the client, the CPS caseworker and the volunteer discuss the assessment. Helpful hints, suggestions, etc., are usually recommended by the caseworker. The lay therapist has the right to refuse any individual case.

The Schenectady Lay Therapy Program is staffed with a head supervisor who coordinates all services, volunteers and clients, as well as acting as liaison between the program and CPS. The Program also has two staff members acting as case supervisors. There are also additional professional staff who volunteer their services when needed by the program.

The Schenectady County Lay Therapy Program has a 15 week, two hours per week, training program for volunteers. This training session is held in the fall of every year. There is an

orientation night which centers around a general discussion of child abuse and neglect. Seven weeks are devoted to such topics as the characteristics of child abusers, how to recognize an abused or neglected child, why does child abuse occur, what are the symptoms of parents that abuse their child(ren). Other topics of discussion are: the role of a therapist in child abuse; the role of CPS, (usually this night is devoted to representatives from the Child Protective Services Department); the welfare system; family court; alcoholism; delinquency; experimental/role playing, etc. At the end of the training program there is a final examination.

This program has maintained its contributions to the community within an extremely low budget -- between $5,000 and $6,000 per year. The funds are from Title XX monies, The Division of Youth, and community donations.

Because of limited space, there is a minimum of services offered at Schenectady County Lay Therapy Program site location. Therefore, to compensate, the program offers two structured activities. Preceding the Christmas holiday, there is a cookie bake/luncheon in which the clients and their families, the professional staff as well as the volunteers and their families, meet. The same procedure is followed at an annual summer picnic.

The Schenectady County Lay Therapy Program strives to keep the family intact. The Program views removing a child from home

only as an immediate solution to an on-going problem. The volunteers must be prepared for the traumatic conflicts which may arise when the parent and child are separated. According to Dr. Arthur Green, a psychiatrist and director of the Brooklyn Family Center for the treatment of abused children and their families, separating families is in the long run usually more harmful than the actual physical abuse. "When you place the child in foster care", says the doctor, "the parents almost always get a replacement, by becoming pregnant or by choosing another child in the family for abuse, so rather than stopping abuse, you're escalating it."[5]

Every volunteer worker is assigned a family. The volunteer's commitment is high: each volunteer agrees to stay with a particular family for a full year, to make weekly visits, and to be available 24 hours a day by phone. The telephone has proved to be the most vital tool. The isolation, rejection and helplessness felt by most abusing parents makes the telephone literally a life line. These volunteers are trained to be non-judgmental, patient and empathetic. "They come because they want to...they have plenty of time...they accept and sooth...they suggest...they help."

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5. Kamien, Marcia, "They Dare to Care: Child Abuse Volunteers", Women's Day, November, 1978, pp. 188.

1.4 Southwestern Institute for Group and Family Therapy: Group Therapy and Goal Attainment

Dr. Blair Justice, Professor at the University of Texas Science Center and Dr. Rita Justice, Co-Director of the Southwestern Institute for Group and Family Therapy, located in Houston, Texas, have developed a novel approach to child abuse and neglect. Their approach features "group therapy with abusive parents and an innovative method of setting goals and measuring the effectiveness".[6]

This project has a maximum of five couples in a group at any one time who remain in therapy for an average of five to six months. All of the couples participating in this project are referred by local child welfare units in Houston. In at least 75 percent of the cases, there has been a court order for the removal of the child. This appears to be one of the few programs emphasizing service to families whose children have been removed. The project serves an initially resentful client population, but the staff have found that this phase of resentment lasts only from three to five weeks if support and understanding are provided.

Drs. Justice and Justice find group therapy to be more advantageous than individual therapy for this client population. Building upon their findings, the Justices' have trained caseworkers and child welfare supervisors to conduct group sessions.

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6. Justice, Blair; Justice, Rita, "Group Therapy Intervention Strategies for Abusing Parents and Evaluation of Results", Child Abuse and Neglect: Issues on Innovation and Implementation, Volume II, pg. 349; 1977.

As a result of this training technique, nine additional groups have been started since 1975.

The project is affiliated with the Texas Research Institute of Mental Sciences. The process involves an in-depth individual interview by the staff, as well as a separate interview with the chief of adult services, a psychiatrist, at the Institute before he client is accepted in group therapy.

The therapeutic framework of the Texas Research Institute of Mental Sciences chiefly relies upon transactional analysis, behavior therapy, hypnosis, RET (Rational Emotive Therapy), Child Management Techniques and information on the needs of children during specific development stages.

Figure 1 depicts a Goal Attainment Scaling (GAS) chart used by the project to determine whether methods are working and objectives are being achieved. The instrument serves as a therapeutic tool as well as a method of evaluation. The (GAS) measures the outcome, while couples are participating in group, as well as at six month interval follow-up evaluations.

The six basic problem areas are symbiosis, isolation, talking and sharing with mate, temper/impatience, child development and management, employment, other areas are added onto the GAS scale as soon as other problems are uncovered. The goal attainment levels are from -2 to +2 to be filled in for the client, depending on the success and change of the family.

FIGURE 1

FIGURE 1--GOAL ATTAINMENT FOLLOW-UP GUIDE

Level at Follow-up: Goal Attainment Score (Level at Follow-up)

SCALE ATTAINMENT LEVELS	SCALE 1: Symbiosis (weight$_1$ =)	SCALE 2: Isolation (weight$_2$ =)	SCALE 3: Talking and Sharing with Mate (weight$_3$ =)	SCALE 4: Temper/ Impatience (weight$_4$ =)	SCALE 5: Child Manage-ment (weight$_5$ =)	SCALE 6: Employment (weight$_6$ =)
most unfavorable outcome thought likely (-2)						
less than expected success (-1)						
expected level of success (0)						
more than expected success (+1)						
most favorable outcome thought likely (+2)						

One component of group therapy is the encouraging of couples to reach out in times of crisis. Therefore, the office as well as the staffs' home numbers are given to each couple and the couples are encouraged to call. The constant help-lines of staff members and the support of the group helps to ameliorate a common problem of abusive parents, low self-esteem. Within the group, experiences such as acceptance, gaining of friends, building of trust, expression of feelings, opinions and ideals all enhance the client's self-esteem of the client.

The chief objective of group therapy for abusive parents is to promote changes in the parents and in the family environment so that the safety of the child is assured upon return to his home. The necessary steps are:

1. Identifying the psychological and social dynamics of the spouses.
2. Determining the deficits in the couple's knowledge of child development and management.
3. Assessing the role played by the environment.

After the client has been given a notification to terminate their participation in group therapy, a recommendation to Child Welfare authorities is made, the authorities in turn present the recommendation to the court when evaluation of results shows that the criteria for termination have been met. Although termination notification has been forthcoming, "termination does not come before the child returns home." The parents remain in therapy

for an additional one month, after the child has been returned, to alleviate any unnecessary problems that may result in abuse and/or neglect.

1.5 The Gilday Center: Child Focused Treatment

The Gilday Center opened its doors on March 6, 1972 for children who are a part of families experiencing some form of crisis. The center is housed in a renovated parochial high school in the inner city of Boston, Massachusetts. The center serves 12 children, all below three years of age. The center was designed to provide a healthy environment in which children could develop trust in adults and peers, and also provide relief to parents so that they might better use available social services and increase their own self-esteem. It was conceived as providing social workers with a viable alternative to foster care for a child in need of protection.

Because of the original assistance and support, the center has access to a combination of public and private agencies, professional and volunteer services, and private and public funding. The initiators of the project include:

- Department of Health and Hospitals
- City of Boston Day Care Licensing Unit
- Inflicted Injury Unit of the Division of Family and Children's Services
- Assistant Commissioner for Social Services

- Department of Public Welfare
- Parents and Children's Services
- South End Community Health Center
- Rector of the Immaculate Conception Church

The Gilday Center is financed through a contract of service with the Department of Public Welfare. This contract was transferred from the Junior League to Parents and Children Services who assumed responsibility for the administration of the program in March of 1973.

The staff of the Gilday Center includes a director, who has a master's degree in education and two full-time child care workers. One of these is a licensed practical nurse. A part-time Spanish speaking child care worker was added to the staff in September; she received on-the-job training at the Center.

Volunteers are also an integral component of the Gilday Center. The volunteers work two shifts per day. Twenty volunteers are provided by the Junior League, and some volunteers come from such sources as colleges, secondary schools and community agencies. Some volunteers function as special "aunts" or acting "grandparents", while others are willing to help with housekeeping chores and the preparation of meals.

The Inflicted Injury Unit, which receives all reports of child abuse in the Greater Boston Area, provides the Gilday Center

"with a coordinating social worker who is responsible for on-going communication between social work and day care staff."

Transportation is another service of the Gilday Center. Two women who are employed by the center, drive their own individual station wagon. To alleviate any unavoidable consequences, each car has an additional adult whose duties include: going into the home, holding the infant while the car is in motion and maintaining order.

The Gilday Center originally maintained a period of three to six months as an average for each child who participated in the program. This rule had to be extended for longer periods of time because of the limited day care resources. The child is evaluated by an intake committee of the Gilday Center. The child is also seen by the Gilday Center's consulting pediatrician at the South End Community Health Center. The on-staff social worker arranges a visit to the center for parent and child.

After the initial medical examination, the South End Community Health Center provides on-going medical services for families who desire to have it. The Community Health Center is an important service component of the Gilday Center. Other available services include:

-- dental care
-- psychiatric examination
-- vision examination

-- hearing examination

-- any necessary lab work

If a child has not been immunized, he receives appropriate immunizations. The children are also tested for sickle cell anemia and lead poisoning. There is a weekly progress consultation with the pediatrician and the day care staff; such health problems as nutrition, head lice, sanitation and communicable diseases are discussed. All of the above services are financed through Medicaid.

1.6 Summary

There is, at present, a wide-spread recognition of the need for intensive service provision for families in crisis, and at risk of child removal. However, there have not been, as yet, any definitive comparative studies to demonstrate the appropriateness or success rate of one approach over another. It is difficult to assess whether or not the provision of a particular service reduces the likelihood of foster care placement. Differences in client populations, referral sources, referral criteria and relationships with Child Protective Services make such comparisons, in general, impracticable.

The Nassau County Family Crisis Program, described in the following sections of this report, incorporates in some form many of the specific approaches of the programs which have been described, with a primary focus on the family, and on the provision of therapy for family dysfunction.

2.0 HISTORY OF THE FAMILY CRISIS PROGRAM

This section of the report describes the events that led to the establishment of the original Child Abuse Community Centers program, and the evolution of that demonstration effort into the Family Crisis Program. The natural progression from servicing Child Protective clients to all victims and participants in family violence is highlighted.

2.1 Child Protective Services: Need for Services to Clients

The passage of the Federal Child Abuse and Neglect Treatment Act of 1974 and the concurrent development of reporting legislation within New York State radically changed the demands placed upon the one agency charged with the resolution of Child Abuse and Maltreatment, the Department of Social Services, Division of Child Protective Services (CPS). An expanded definition of abuse/neglect and the designation of specifically mandated reporting sources resulted in an in-flow of cases far exceeding the service delivery capacity of CPS.

The Nassau County Division of Child Protective Services, like similar public agencies across the nation, experienced major problems in serving their growing client population. Within Nassau County, Protective Service workers were carrying an average of 36 cases, severely limiting their capacity to provide direct rehabilitative services. Other problems encountered by CPS at this time included:

- The significant proportion of CPS workers' time allocated to investigatory activities. Since 50% of all cases investigated do not result in a finding of abuse/neglect, a major part of the responsibilities of CPS staff were of necessity devoted to cases never entering the service delivery area.

- The intensive therapeutic intervention required for successful rehabilitation of many abuse/neglect families. The necessity for specialized background training and skills not required of CPS workers became apparent.

- The dual authoritative/rehabilitative role of a CPS worker created major stress for both worker and client, and potentially undermined the formation of an effective rehabilitative relationship.

- The nature of the rehabilitative population to be served. As CPS clients are almost exclusively involuntary participants in the system, major problems in client engagement arose. The resistant client was the norm, and difficulties in engaging the client in recommended services became commonplace. The necessity for intensive outreach efforts was clear, but not possible within the limitations of the CPS worker's caseload demands.

- The need to utilize outside agencies to provide therapeutic counseling for 85% of those clients requiring such a service. The effective utilization of existing community resources was also affected by client resistance. Clients were frequently incapable of or unwilling to follow-up on referrals, and agencies unable to provide the intensive outreach efforts required. Resistive clients were frequently regarded as "unworkable" after cursory outreach efforts.

These problems, and the desire of Nassau County CPS to overcome these obstacles, resulted in the establishment of the Child Abuse Community Centers Program in 1975. This demonstration program was in operation for three years. When, at the close of

the demonstration funding period, no mechanism for securing additional funds was available, the Child Abuse Community Centers' project was discontinued in favor of a more comprehensive approach. The administrative locus of the projects shifted from the Department of Social Services to the Department of Mental Health. The new program attempted to address the special needs of all families in crisis, including referrals from agencies other than CPS. Two new project sites with completely different staff were established. A description of the Child Abuse Community Centers Program, and the transition to the implementation of the Family Crisis Program will be the focus of the following sections of this report.

2.2 Child Abuse Community Centers Program

In September of 1975, Child Protective Services established the Child Abuse Community Centers Program. Under the administration of the New York State Division of Criminal Justice Services and the Nassau County Criminal Justice Coordinating Council (NCCJCC) and funded by the Law Enforcement Assistance Administration, the Child Abuse Community Centers Program was designed to focus exclusively on rehabilitative services and to provide resources for crisis intervention directed at preserving and strengthening family life.

2.2.1 Program Overview

The Child Abuse Community Centers Program was located at two sites, each sponsored by a Community Agency. The Parent-Child Project, sponsored since its inception by the Family Services Association, was located in Levittown and serviced a catchment area comprised of four contiguous communities; Levittown, East Meadow, Bellmore and Merrick. The Family Center, sponsored for the first year of operation by Adelphi University and following October 1976 by the Long Beach School District, was located in Long Beach and services were directed primarily to the city of Long Beach, although the catchment area included adjacent communities.

Cases were referred to the demonstration projects following a CPS investigation of abuse/neglect allegations leading to a determination of "credible evidence" of abuse/neglect. The projects were not involved in the investigation, nor was there any contact with a case until a decision to "indicate" (determine the presence of credible evidence of abuse/neglect), a case had been made. After the decision to indicate a case, any active case or an individual family member within that case could be referred to the projects. The general criteria for establishing referral priorities were:

1. Severity of abuse/neglect conditions to which the child remained exposed; and

2. Poor prognosis for the client's engagement in necessary rehabilitative treatments elsewhere.

The project's mandate on all cases referred by CPS was to provide sustained, intensive outreach efforts to establish and maintain contact directed at engagement in an appropriate rehabilitative program. The methods and procedures to be applied in fulfilling this mandate were left to the discretion of the project staff. If after 30 days of intensive efforts to engage a client, no progress had been made, the project had the authority to request that its services be terminated. The final decision on project termination of a case, however, remained with Child Protective Services.

At the Child Abuse Community Centers Program, an assessment of problems and needs began with the first client contact and continued throughout the course of the first three to four months of service. In the majority of cases, the major problems contributing to abuse/neglect and the prescriptions for treatment were noted in the first discussion with the client. Thus, services planning began with the first successful client contact.

While the referring CPS worker maintained ultimate authority and responsibility for case management, the CPS worker's role following engagement was primarily supervisory. The case manager within the Community Center's project, appointed by the project director, assumed primary case management responsibility. As

problems and service needs were noted in the course of initial home and office visits, case responsibilities were assigned by the case manager to other staff members within the projects -- evolving over two to three months as a "service team" for each case. Regular "service team" meetings at each project served as a forum for joint assessment planning and decision-making on each case.

On the whole, the projects assumed primary rehabilitative functions for entire families. To insure the availability of intensive services, a ratio of one caseworker to about seven cases was maintained. Whereas the normal CPS ratio permitted only one hour per week per case for direct service, the project ratio permitted seven hours of direct service per week per case.

2.2.2 Service Provision

Both projects offered a core program of therapeutic services, which included the traditional services available at mental health clinics or from private practitioners: individual, marital and family counseling as well as group therapy sessions. Group therapy at the projects, however, was unique in comparison to group therapy offered by other agencies and professionals in that the groups consisted exclusively of abused/neglected children or their parents and were exclusively focused on intra and inter-personal problems contributing to abuse/neglect. Such groups included a mother's group, father's group, mixed latency-age groups, and a sibling group.

The Family Center was able to provide a unique therapeutic environment for younger children. A separate space was allocated within their mobile unit facility for a Children's Center, where the emotional, developmental and behavioral problems of children aged 12 months to 7 years were observed, diagnosed and treated. Children were left at the Center while parents participated in counseling or other services provided by the project. In addition, the Center was occasionally used as a drop-in center by mothers needing a few hours for themselves.

Both projects offered a "Mother-Child Home Program", which included a toy demonstration service, directed at building and fostering positive relationships between mothers and young children. Nearly half of the families active with the Family Center were participants in the program and at the Parent-Child Project, the program partially addressed the perceived gap in services to young children. The Family Center also operated an on-going Parent Effectiveness Training Program that met on a bi-monthly basis. The format included discussions of expectations of children of different developmental stages, appropriate means of discipline and other areas of parent-child relationships. Staff/client picnics and parties, a craft's group for mothers, debt management counseling and similar services not normally provided by mental health clinics were also offered. Typically, the services offered by local mental health clinics would be limited to diagnostic evaluation, and weekly individual, marital or group counseling sessions.

The overall framework for administration of the Child Abuse Community Centers Program established clear channels of communication and accountability between DSS and the two projects. Control and ultimate authority were centered within the Department of Social Services. Major case decisions, e.g., closings by the projects or CPS, filing of abuse/neglect petitions, and removal of children from the home were initiated by either the case manager or the CPS caseworker and were generally jointly discussed and agreed upon.

2.2.3 Research Findings

The results of the evaluation conducted by DiBernardo Management Consultants (DMC) showed that the Child Abuse Community Centers Program was clearly responsive to the needs of CPS and that the projects were able to affect significant and substantial improvements in service delivery in four major areas. The following gains were realized:

- an 8% reduction in the filing of petitions of abuse/neglect;
- a 13% reduction in the rate of child removals;
- a higher rate of successful engagement in rehabilitative/therapeutic services;
- a lower rate and severity of recurrences of abuse/neglect.

Although it was recognized that the Child Abuse Community Centers Program was providing a much needed service, there were

no means of institutionalizing the projects when the demonstration period ended. Funds were not available to enable the program to continue, and project staff were forced to find other jobs. It was necessary to close-out the entire project caseload. In short, the original projects were disbanded and there was a lapse of several months before implementation of the Family Crisis Program.

However, ten clients of the Long Beach Family Center were referred at this time to the Long Beach Mental Health Clinic at Long Beach Memorial Hospital. DMC staff conducted a follow-up on these cases, and learned that seven women are still actively engaged in group therapy. (Two families have since moved away from the area). In the opinion of staff at the former project, these clients would not have been able to successfully avail themselves of the services of the Mental Health Clinic without the previous intensive involvement at the projects. One goal of specialized projects such as the Community Centers Program and the present Family Crisis Program is to prepare the client to participate in services available through local community agencies.

2.3 Implementation of the Family Crisis Program

The original structure and focus of the Child Abuse Community Centers Program was expanded with the funding of the Family Crisis Program in January, 1979. The agency named to administer the current projects was the Nassau County Department of Mental Health.

It was agreed that 75% of Project referrals were to come from Child Protective Services. The projects were funded to provide services for all families in crisis, also receiving referrals from mental health clinics, the Coalition for Abused Women, and the Department of Probation, as well as Drug/Alcohol Rehabilitation Programs.

The new emphasis on the generic problem of family violence and related mental health issues was consistent with DMC's view of the Child Abuse Community Centers Project as an alternative to traditional mental health services. Furthermore, it was hypothesized that the various target groups to receive treatment services would have a commonality of needs such that the services of the project and the expertise of staff could be responsive to all clients.

The primary roles and functions to be provided directly by program staff for all referrals are, as outlined in the program proposal:

1. Diagnostic Evaluations
2. Services Planning
3. Direct Service Provision:
   - Family Therapy
   - Group Therapy
   - Children's Groups
   - Individual Therapy
   - Day Treatment (psycho-social rehabilitation, parent effectiveness training, vocational training, work activities, socialization skills training, competency and coping skills training)

4. Referral and follow-up for those service needs not directly provided by the project (i.e., drug treatment)

5. Outreach and home visits (to motivate clients to seek and remain engaged in the services program)

It was recognized that a number of presenting problems would give rise to the need to draw on these various functions of the project.

The programmatic elements of the Family Crisis Program were reflective of the previous effort. Components that continued to be emphasized in the initial plans of the Family Crisis Program included:

- Intensive outreach directed at motivating the client to engage in treatment
- Parent education directed at improved parenting skills
- Coordinated services planning, case management, concrete advocacy and therapeutic services
- Group forms of therapy for children and adults
- Family therapy

The Family Crisis Program benefitted from the experience of the previous demonstration effort. From the start of the current projects, it was understood that worker stress would be a factor that could potentially undermine programmatic success. Therefore, initial and on-going staff training was included as a component of the new projects.

Two project sites were named for this effort:

- North Shore University Hospital
- South Nassau Community Hospital Mental Health Clinic

There have been many difficulties associated with the start-up and implementation of the Family Crisis Project. These have included:

- Delays affecting the date at which the project sites became fully operational: North Shore; April 1979, South Nassau; August 1979.
- The extent and manner by which agreed upon referral criteria were operationalized by both DMH and CPS.
- The lower than anticipated number of referrals from agencies other than CPS, e.g., the Coalition for Abused Women was envisioned as a source of many referrals and in actuality provided only a small number of clients.
- The establishment of viable working relationships between CPS and the Department of Mental Health. It was necessary to transcend the issue of loss of administrative control by CPS in the previous project; realistically deal with the administrative role of DMH; and establish organizational procedures to facilitate and support cooperative monitoring, assessment and treatment of CPS clients by CPS and DMH staff.
- The South Nassau project's difficulties in finding a space to house their program. It was anticipated that the Woodward Center in Freeport, New York would serve as the program site, but this site proved to be unavailable. It was not until January 1980 that the South Nassau project had space sufficient for their programmatic needs.

These original difficulties have now been partially resolved, and at present both projects have been at least partially opera-

ational for one year. Project problems and recommendations for their resolution are discussed further in Section 9.0 of this report. It has become apparent that the evolution of the projects from the Child Abuse Community Centers program to a program focused on Family Crisis is an attempt to be responsive to the needs of a broad population of families involved in violence. The following section of this report presents a detailed explanation of the programmatic and treatment services of the Family Crisis Programs

3.0 DESCRIPTION OF FAMILY CRISIS PROGRAM: POLICIES AND PROCEDURES

The purpose of this section is to describe as completely as possible the theoretical orientations, staffing patterns and treatment capabilities of both the North Shore University Hospital and the South Nassau Communities Hospital Family Crisis Programs.

The Department of Mental Health has appointed a full-time Family Crisis Program Coordinator who is responsible for data collection and maintenance of statistics, acts as a liaison between the projects and Child Protective Services and represents the Department of Mental Health in its role as administrative agency for the program.

In addition, an Advisory Council has been organized, consisting of members of various community agencies in addition to representatives of Child Protective Services, Department of Mental Health and the projects themselves. The Advisory Council was formed to enhance community awareness, foster inter-agency cooperation and address problem areas.

The two demonstration programs themselves differ somewhat in basic approach; North Shore embodies a hospital-medical model for treatment while South Nassau employs a more traditional mental health approach to mitigating family dysfunction. The possible advantages and disadvantages of these two distinct approaches and the similarities and dissimilarities of the two projects are discussed below.

3.1 The North Shore University Hospital Family Crisis Program

The North Shore University Hospital Family Crisis Program is located on the main floor of a large suburban hospital. Consonant with the mental health needs of clients, the program is housed within the Division of Child and Adolescent Psychiatry. The program coordinator is a hospital staff child psychiatrist devoting ten hours per week to the Project. Core Project staff working full-time within the program include two social worker therapists, one bilingual para-professional and one secretary. Other treatment team members include a psychologist devoting approximately 40% of his time to the Project, a pediatrician and an additional psychiatrist who render part-time services. The staff is further enriched by the assistance of graduate students in psychology and social work who rotate through the program on an internship basis. Services at the project are available during both day and evening hours.

The program coordinator describes her staff as a highly specialized, sophisticated team for treating child abuse, spouse abuse and related family dysfunction. Operating within this framework, all clients accepted into the program during the first ten months of operation were involved in circumstances of either child maltreatment or spouse abuse. It was felt by Project staff that providing treatment for juvenile delinquents or other diverse client populations in the beginning phases of the program would interfere with staff becoming highly skilled and sophisticated in treating child or spouse abuse clients.

During the initial eight months of operating, forty-two families have been served by the project. These families include approximately 150 individuals, of whom 80 are children under the age of 18. Over three-quarters of these families have been referred to alleviate circumstances of child maltreatment, and the balance have received treatment for spouse abuse. Interviews with project staff indicate that clients are predominantly from middle and upper socio-economic levels, with less than 25% being eligible for Medicaid assistance. Tallies of clients by the project staff showed that the population served consists mainly of families with school age and adolescent children.

While the catchment area served by North Shore Hospital contains several "poverty pockets", the area in general consists of upper middle class suburban neighborhoods. Very young families frequently have not yet attained the income level required to maintain a residence in these neighborhoods. It is likely that the families served by the project reflect the distribution of the population in the catchment area of the hospital, rather than any specific referral policy of the referring agencies. This Project is serving a population often discounted in the available literature on child abuse and neglect, the middle class family.

3.1.1 Theoretical Basis

The theoretical basis for treatment at the North Shore Family Crisis Program (NSFCP) rests primarily upon the structural sys-

tems approach to family treatment proposed by Salvadore Minuchin. The basic premise of Minuchin's approach is that a family is a structural system, with each member of the family contributing to and maintaining the system which exists. The goal of therapeutic intervention, therefore, is to help the family as a whole to change a dysfunctional family system to a more functional and satisfactory one. Illustratively, the systems approach to a family involved in spouse abuse would involve the assumption that the "victim" is in fact as much a part of the system of violence as the perpetrator of the abuse, and bears an equivalent responsibility for changing the existing system.

The Project's major treatment modality is family therapy, and is based on the concept that child abuse, spouse abuse and family violence grow out of relationships and interchanges in which all family members play a part. The family itself is seen as the primary client.[7] This type of therapy is not generally used in treating cases of child abuse or maltreatment, but is well suited to the North Shore program as many of their families have latency age and adolescent children. In a different population this approach might not be as successful as it is difficult to involve children under age six or seven as active participants in family therapy.

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7. See also "A Family Systems Approach to Treatment of Child Abuse: Etiology and Intervention" Brian Grodner, Journal of Clinical Child Psychology, January, 1977.

The North Shore Project staff state that virtually all children in the families they serve need individual contact as well, and very probably most adults also have this need. Individual therapy is offered in addition to family treatment for many adults, especially in cases where the spouse denies any involvement in or contribution to their partner's problems. Individual therapy is also offered as additional support for many adults in time of crisis and for older children. The Child and Adolescent Psychiatry Unit within the hospital also receives referrals from the NSFCP and provides individual psychotherapy to children.

3.1.2 Diagnostic Evaluations

Individual client contact is also made during the diagnostic interviews conducted by the team psychologist and psychiatrist. These diagnostic interviews are conducted as soon as the family will give consent, usually within one month after the first contact has been made. In some instances this may be before the family has actually been seen at the project site, and the psychiatrist or psychologist will go to the client's home to conduct the interview. This practice of conducting diagnostic interviews in the client's home when necessary is a novel approach implemented by the North Shore Program.

Separate diagnostic evaluations are conducted for each parent and the indexed, or involved child. Testing batteries routinely

employed with children include the Wechsler Intelligence Scale for Children (WISC), the Remote Associates Test (RAT), the Bailey Infant Development Scale, and reading tests. These standard diagnostic tests are utilized to assess the cognitive, emotional and social development of children in addition to evaluating intellectual capacity. When professionally administered and evaluated, as at the North Shore Project site, these instruments are useful in the detection of mental and emotional disturbances of various kinds and degrees.

Complete psychological/psychiatric evaluations are not routinely given to siblings of involved children unless their behaviors seem abnormal or it is felt that their development may have suffered as a result of family dysfunction. A review of these diagnostic evaluations indicates that the Project is serving many children who evidence developmental delays and emotional difficulties, suggesting that children are affected in many ways by family crisis and/or that child-centered problems can precipitate or exacerbate crisis situations. Previous research also indicates that the developmental characteristics of a majority of abused and neglected children are "outside the normal range of intellectual, emotional, social and motor development parameters."[8] This program's strong medical/diagnostic orientation and the Mental Health emphasis of the Family Crisis Programs make the diagnostic evaluation an important component of North

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8. In, Peter A. & McDermott, John F., "The Treatment of Child Abuse," Journal of the American Academy of Child Psychiatry, 15(3) 430-440, Summer, 1976.

Shore's treatment plan. The formally written evaluation becomes a part of the case record and is used to validate and compare with caseworker impressions and informal diagnosis. When cases of retardation, learning disability, or hyperactivity are confirmed, the family and staff can deal with the concrete evidence of the child's problems and a treatment plan may then be developed.

3.1.3 Primary Therapist's Role

The role of the two primary therapists is to make initial contacts, engage and treat the clients through individual and/or family therapy and lead the family into health and satisfying relaitonships with one another. Their role is central in the rehabilitation of families, and can be best understood by a description of the client treatment process at the North Shore Family Crisis Program.

3.1.4 Intervention Process

The first step in intervention is an intake meeting between the referral source and the primary therapist who will be managing the case. Only the two primary therapists act as case managers, and cases are assigned to them on an alternating basis. When the referral source is Child Protective Services (CPS), usually both the CPS social worker and Supervisor meet with the North Shore Family Crisis Program's social worker and coordinator. It is common for CPS to discuss several referral cases at one meeting, but any emergency referrals are taken by telephone and attended

to immediately. If the referral source is within the hospital itself, the nurse and physician will meet directly with the Family Crisis Program social worker who will then contact the hospital's Department of Social Services for a conference. An in-house conference between the program coordinator, psychologist and primary worker will occur within one to two days and direct intervention will begin.

The outreach process is operationally defined by the NSFCP as beginning with a phone call to the family to make an appointment for a home visit. If the family does not have a telephone, a letter is sent to the family requesting permission for a home visit. If there is no response, a second letter is sent stating a date and time the primary therapist will make a home visit. The Family Crisis Program staff do not make unannounced home visits.

North Shore University Hospital regulations limit the completed contacts requesting permission for home visits to one per week to reduce possible client harrassment. However, once the client agrees to meet with Project staff, there are no limitations upon the number of home visits that may be made. Although the North Shore Program must abide by the hospital regulations which limit initial outreach efforts, they do not report any unusual difficulties in contacting clients to make the initial

home visit. The outreach process of trying to contact the family may continue for 8-10 weeks. If there has been no response on a CPS referral within four weeks, CPS is asked to call the family and pave the way for the Family Crisis worker's home visit. The program staff report that spouse abuse clients are nearly always receptive to services, and the CPS clients referred to the project are usually fairly receptive.

The assessment phase begins with the initial home visit made by the primary worker/para-professional team. At this visit, the FCP staff describe the services offered by the project, attempt to understand the family situation and try to reach some agreement on a course of treatment. Attempts are made to reach agreement for additional home visits, or to have the clients agree to come to the project site. At this time permission to conduct psychiatric/psychological evaluations may be granted, and Releases of Information are secured. These consent forms allow the NSCFP to release and receive information to and from physicians or other North Shore University Hospital personnel, as well as other physicians, psychologists or psychiatrists previously involved with the family, and the child's school. The primary worker will return to the home for as many visits as necessary over a two month period, but the initial goal is to have the family, or some family members, come to the Family Crisis Program for therapy sessions at the project site.

Engagement is operationally defined as the voluntary agreement of the client to arrange for and attend treatment sessions. While the engagement process is being completed, a family assessment is conducted. A unique aspect of the North Shore program is that all children are seen by a pediatrician and the involved child (subject of the abuse/neglect report) is seen by the psychologist. These pediatric examinations have disclosed the existence of many previously unsuspected health problems. Diagnostic evaluations of family functioning also occur during this phase. Concurrently, the para-professional works on mobilizing community resources to aid the family, and makes home visits to provide support and break through resistance to engagement in formal therapy.

When the psychiatric, pediatric and psychosocial evaluations have been completed, a formal treatment plan is developed. This usually occurs within four to six weeks after the initial contact with the family. Family therapy, individual adult, or individual child therapy or any combination of these may be called for in the treatment plan.

Therapeutic sessions at the NSFCP may draw upon one or more of the following treatment strategies to supplement the basic systems approach:

- modeling
- behavior modification
- parenting skills training

For the benefit of those readers who may not be familiar with the therapeutic modalities and techniques mentioned in this report, a brief description of each will be provided at first mention of each specific technique.

Behavior modification is a therapeutic approach based upon learning theory. The approach rests upon the basic theoretical premise that all behavior, both appropriate and inappropriate, is the result of learning. Following from this, inappropriate, non-productive behaviors can be "extinguished" (eliminated from an individual's repetoire of behaviors) and new, more productive behaviors can be learned. Learning, in accordance with the theory, is the result of reinforcement. That is, all behavior is learned and maintained by the reinforcements (rewards) with which the behavior is associated. Hence, the primary focus of the behavior modification intervention strategy is on the elimination of the reinforcements associated with inappropriate, non-productive behaviors, and the implementation of reinforcement schedules associated with the learning of new behaviors.

Behavior modification and the family systems approach have a commonality of focus, in that both intervention strategies place primary emphasis upon the present, in contrast to the traditional psychodynamic approach to therapy which places heavy emphasis on the development of "insight" into the relationship between present problems and early life experiences.

It has also been demonstrated by research in the field of learning theory that learning can occur by the observation of behaviors. The technique of "modeling" is based upon this premise, and therapy for families with young children often involves modeling techniques to encourage constructive interactions between parent and child. For example, the therapist, utilizing play equipment, may demonstrate for parents, methods of playing and talking with their child. In many families, parents may feel that they are unable to discipline their child without the use of excessive corporal punishment. In fact, the parents may simply not have learned other disciplinary techniques. If the therapist "models" for the parents more appropriate disciplinary strategies (perhaps by intervening in the child's behavior at a family session), more appropriate parenting behaviors can be learned through observation of the therapist's approach.

Adequate parenting involves the utilization of many skills. It is a common experience among caseworkers and therapists dealing with neglectful parents to discover that these parents have never developed any of these necessary skills. This lack of skills is frequently due to the fact that the individuals involved were themselves neglected children, and have never been exposed to adequate parenting. Providing these parents with training in specific required skills (which may include such areas as health practices, knowledge of expected child

behavior, communication skills, infant care, etc.) may enable them to function more adequately in fulfilling their parental responsibilities.

In some instances, young children may be present during family therapy but not included in the counseling session. These sessions allow treatment to focus on marital problems or individual difficulties and also provide the therapist an opportunity to observe parents' methods of controlling the child's behavior. Family therapy sessions in families with latency age and adolescent children include the active participation of the children.

Family therapy and individual therapy usually take place weekly. However, in many cases the family may be treated and an individual family member seen at different times during the same week.

Groups for children or adults have not yet gotten underway at the North Shore Family Crisis Program. An attempt was made in late November to bring parents together for a smorgasbord dinner and social evening. Letters of invitation were distributed* but response was low with many replying that they were too busy during the holiday season to attend another gathering. A second attempt will be made to get this group started in the near future. The group is envisioned as a social skills activity group where parents can make crafts items and socialize, and eventually lead up to a group therapy situation.

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* See Appendix

Program staff feel that clients were not "ready" for group participation before November. The ability to participate in a group is thus seen as an early goal of the treatment process. A Parent Education class will be offered during the winter season at the hospital and will be open to spouse abuse clients. An adolescent group is also being considered as a possible addition to the program.

3.1.5 The Role of the Para-Professional

The program has one Spanish speaking bilingual para-professional who adds another dimension to the comprehensive treatment approach. This worker has assisted mainly in cases of child abuse or neglect during the first nine months of the program. She has concentrated on building her expertise in working with these clients before going on to work with cases of spouse abuse or other family dysfunction. The role of the para-professional is to assist the primary therapist by making home visits to clients. The para-professional does not serve as a case manager but as an associate to the primary therapist. The para-professional helps to achieve the therapeutic goals by providing a warm, individual relationship with the family. As a non-threatening third party she will go to the home and talk with any family member, adult or child. An example of her work with children is her counseling with a slightly retarded teenage boy, trying to motivate him to find summer employment and seriously consider future job

possibilities. As a result of her contact, the boy is now attending a BOCES program learning a trade as a repairman. The para-professional's contact with adults takes many forms. She has accompanied a mother to a session with a guidance counselor at school, taught new cooking skills, gathered booklets on driver's education and assisted one parent in studying the manual to pass a driver's license examination.

The para-professional also provides assistance to clients by helping them sort through the array of social services and community resources. She has helped clients find day care centers that they can afford for their children, and made phone calls to get clients on a waiting list for subsidized housing. In many cases, the para-professional sees herself as an advocate for her clients, who frequently experience difficulties in the effort to obtain necessary services.

In addition to direct client contact, North Shore's para-professional does almost all of the community networking for the project. By making phone calls, following-up on leads and doing research, a card file and a folder of available community resources has been compiled. Although many brochures and resources sound inviting, the para-professional warns that not all programs offer the services they publicize. Additional contacts and screening of service offerings needs to take place before recommending a program to a client. Resources contacted in the com-

munity include churches, synagogues, social service agencies, adolescent after-school programs, and day care centers. These resources are then used to supplement the Family Crisis Program services.

The bilingual capability of the para-professional is extremely valuable. She has assisted in translating so that diagnostic interviews could be conducted. Since she is able to communicate with the client in his or her native language, many topics such as birth control methods are more easily discussed and understood.

3.1.6 Community Resources

Another valuable resource utilized by the NSFCP is the Nassau County Psychiatric Public Health Nurse. This resource of highly trained (Master of Arts proficiency level) nurses was contacted when the program coordinator recognized the great need for client outreach. These nurses serve five catchment areas and make home visits during the day, so they are able to complement the Family Crisis Program. The Public Health Nurses are of great assistance to North Shore's relatively small staff because they teach home-maker, housekeeping, health and parenting education skills to clients. They also help enrich client opportunities for socialization by contacting churches and other community resources. The nurses provide written descriptions of their initial home visit which become a part of the case record. Monthly meetings are

scheduled between NSFCP staff and the Public Health Nurses to discuss clients and associated problems. An outgrowth of their knowledge of the program has been their referrals of troubled families to the NSFCP for treatment.

3.1.7 Staff Development

Staff development and in-service training are used as methods to ward off worker burn-out at the NSFCP. Each of the primary social workers receive supervision from the program coordinator on a weekly basis and more than once a week when needed. The senior primary therapist provides weekly supervision for the team para-professional.

Hospital resources also provide for staff development, as in the use of the Chief Psychiatric Social Worker for training sessions in family therapy for the two NSFCP therapists. These sessions occur once every three weeks and are highly valued by the social workers as a forum to discuss management of difficult cases and a means of improving therapeutic skills. The hospital Departments of Education and Psychiatry have provided seminars in family therapy open to the graduate students assisting in the program and the team para-professional. Additionally, an extensive reading list was developed by the Program Coordinator to provide staff with a rich theoretical background.

An innovative approach to staff development involving self-instruction has been instituted by this project. Each professional team member has become an "expert" on one topic. For example,

one therapist read journal articles and literature on spouse abuse and presented the results of her study at a team staff meeting. This approach allows for staff members to enjoy the personal satisfaction of mastering a new topic and improving professional qualifications while benefiting the entire staff.

3.1.8 The Hospital-Based Approach

The NSFCP staff state that being located in a hospital is a definite asset. It is felt here that the many advantages of a hospital setting outweigh the few disadvantages. Perceived advantages of being located within the North Shore University Hospital include:

- the stigma-free atmosphere for receiving treatment.
- capability of immediate response to child abuse cases coming into the hospital emergency room.
- many treatment options for clients, such as an in-house alcoholism program, available pediatric ophthalmologic, gynecological examinations and psychiatric/psychological evaluations.
- the available resource of graduate students attracted to a teaching hospital.
- a pool of multi-lingual professionals who have volunteered their services as translators and interpreters.

The disadvantages of being located within the hospital include:

- the inability to use volunteers willing to work with program clients due to hospital regulations requiring volunteers to carry malpractice insurance. This malpractice insurance is practically impossible to obtain.

- hospital limitations on outreach.
- the lack of a casual place for clients to relax, chat and feel welcome on a drop-in basis.

The project coordinator and her staff have worked hard to establish the Family Crisis Program within the hospital. It has been necessary to schedule meetings with hospital administrators and explain the functions and goals of the program. FCP staff have publicized the program, explaining the dynamics of family crisis to hospital physicians and nurses, in an attempt to increase their awareness of the program's services.

The North Shore Family Crisis Program has successfully established itself as an entity within a large hospital. Drawing upon all resources available from within the hospital, and connecting with many treatment options outside their doors, the North Shore Family Crisis Program feels adequate to service difficult and disturbed clients. The Program enters their second formal year of operation ready to treat a full range of family problems.

3.2 The South Nassau Communities Hospital Family Crisis Program

The South Nassau Communities Hospital Family Crisis Program is a distinct, but integral, component of the South Nassau Communities Hospital Mental Health Clinic. The South Nassau Family Crisis Program (SNFCP) began seeing clients in January, 1979, but report that they were not fully operational until August, 1979. The program initially was housed adjacent to the hospital within the Mental Health Clinic. Overcrowding at this facility, however, forced staff to see clients at three different locations. Delays

in securing adequate space for the program caused consequent problems with record-keeping and staff morale during the initial months of program implementation. In January, 1980, the program moved to spacious accommodations in an office building on a main street in Oceanside, New York. The Family Crisis Program shares the new office space with staff from the Mental Health Clinic serving the Freeport, New York area. The two offices and three therapy rooms are located on the second floor of the building and it is anticipated that additional space in the building will soon become available. The new project site is centrally located within the community; it is accessible by bus to most clients and it is a short drive from the hospital.

By September 1, 1979 the program had provided services to a total of sixty families, including approximately 85 adults and 110 children.

The SNFCP treatment team is led by the program supervisor who is a full-time social worker and therapist. The treatment team includes one full-time Spanish bilingual para-professional, two part-time social work therapists, one per diem social worker serving 10 hours per week, two psychologists who together devote 20 hours per week to the program, and one psychiatrist who gives 8 hours of time each week to the program. In addition, the program has the support of one full-time statistician/bookkeeper, one receptionist/typist, and one undergraduate social work student.

The Director of the Mental Health Clinic maintains an active interest in this program. She assists the Program Supervisor in policy decisions and attends project staff meetings. This treatment team is able to offer services six days per week, including Saturdays and two evenings.

3.2.1 Therapeutic Approach

The major therapeutic approach of the South Nassau Family Crisis Program has been individual therapy, with a growing emphasis upon the family and family treatment. The project has developed a unique understanding of the mental health professional's role in treating child abuse and neglect clients. This understanding has led the South Nassau Family Crisis Program team to propose that in order to evaluate the progress of an abusive or neglectful family and vouch for the safety of involved children, the family must be seen in the home. Therefore, the staff are committed to making home visits to counsel clients. The primary therapist does more than provide counseling; she observes the patterns of family functioning in the home environment. This approach does not attempt to replace the monitoring role of the Child Protective Services worker, or place the mental health worker in the Child Protective role. Instead, the Family Crisis Program's responsibility toward the family and their well-being is recognized.

This Project has treated many facets of family violence. Referrals have been received from Child Protective Services, the

Coalition for Abused Women, Probation, and the South Nassau Mental Health Clinic. At first, many referrals of generic family crisis situations were transferred from the South Nassau Mental Health Clinic. Presently, however, the Project is working to build a sound relationship with Child Protective Services and is emphasizing referrals from this source. Approximately 60 families have been served at the South Nassau project at the time of final data collection (Setpember 1, 1979) and roughly 40% of these families are Medicaid eligible. The project at this site is serving a fairly large proportion of lower income families with a wide variety of presenting problems including child abuse and maltreatment, spouse abuse, other family violence and juvenile delinquency.

3.2.2 Intervention Process

Referrals from all sources are received at the Project by telephone, or via a direct conference between the referral source and the SNFC worker. The later case conference often occurs with referrals from Child Protective Services. The first action taken is for the social worker or para-professional to be available to make a home visit. This initial home visit begins the SNFCP intake/assessment process.

The intake/assessment period extends for approximately one month. During the assessment period three to four home visits are completed. During these visits, the South Nassau Family Crisis

Program present themselves and the program and gain a better insight of the family dynamics and problems. At this time, the staff try and obtain the client's consent to receive and release information from other therapists, physicians, teachers, etc., who may have been involved with the family, as well as their consent to participate in tests, examinations and psychological/psychiatric evaluations. If the family was referred to the program by Child Protective Services and there is difficulty in obtaining consent or release of information forms, CPS may be contacted and asked to talk to the family about this matter. The SNFCP is attempting to maintain an open, productive relationship with CPS throughout all phases of intervention. A diagnosis of family problems and service needs is the product of the assessment period. The primary therapist or psychologist formulates the diagnosis while the para-professional contributes insight and ideas to the case plan.

Any member of the treatment team, a social worker, para-professional, psychologist or psychiatrist may serve as a case manager. When a diagnosis has been reached, the case manager is assigned upon the basis of a match between presenting problems and staff capabilities. For example, the team psychologist devoting 15 hours per week to the project favors a "behaviorist" approach which the SNFCP believes to be very effective in cases of sexual abuse. The two specific areas with which behavior modification techniques have probably demonstrated the greatest

success have been in the treatment of phobias and sexual dysfunction. Therefore, cases of sexual abuse are generally assigned to this team member. The team's bilingual para-professional would be most likely to be assigned case management responsibilities for Spanish speaking clients.

After the diagnosis has been reached, a treatment plan will be developed for the family by the social work therapist, psychologist or psychiatrist. Although the para-professional may be responsible for the implementation of the treatment plan, the plan for therapeutic intervention will be developed by a team professional. For the first few months of the Project, many therapists might have been involved in providing treatment to a single family. For example, one social worker might have been counseling a neglectful mother and a second worker counseling the truant adolescent. Presently, the Project favors assigning one therapist per family. The new approach limits the confusion a family may feel in receiving counseling from separate therapists and centralizes case management. This change in orientation is one example of the South Nassau program's increases emphasis upon the family, and flexibility in responding to the needs of clients.

The treatment plan may be carried out either in the home or at the project site and may involve several contacts per week with the family. Every attempt is made to involve the family in treatment at the Project site, but if they will not agree to

this arrangement, treatment sessions take place in the home. The project will normally continue home visits for up to eight weeks. One family, however, has been counseled in their home for approximately 36 weeks. Counseling the family and/or its individual members may involve as many as three visits per week with one of the Family Crisis Program staff.

In addition to family and individual treatment, marital counseling and/or a Toy Intervention Program may be offered to clients. All of the modalities may involve the techniques of modeling, parenting skills education, communications skills and assertiveness training. The low self-esteem characteristic of Protective Services clients makes assertiveness training an appropriate intervention.

The Toy Intervention Program is an innovative approach to promoting interaction between a very young child, (usually over two years of age and developing language) and a parent. The Toy Intervention method is based upon the Verbal Interaction Project (VIP) developed in Freeport, New York. The Verbal Interaction Project is a widely recognized program for pre-school economically deprived children and their mothers. Program research has demonstrated significant increases in IQ scores for children in the VIP program in comparison to an equivalent control group.

The project is based upon the premise that children in economically deprived families frequently do not receive in the pre-

school years, the kind of stimulation which is necessary to prepare them adequately for successful school performance. Trained workers visit the home at regularly scheduled intervals, bringing with them selected books and playthings. The worker demonstrates for the mother methods for playing with, as well as reading to the child. The toys and books are left in the home, and the mother practices these techniques on a daily basis.

The Acting Supervisor of the South Nassau FCP has been trained in these techniques at the Verbal Interaction Project and has trained the para-professional staff member in using these techniques with project clients.

The SNFCP staff find this type of demonstration often fills a void in the mother's parenting skills. If a mother has never been read to, or played with as a child, she may not have any concept of parent/child interaction. Approximately 15 children (5 families) have participated in this non-threatening intervention strategy. The South Nassau Family Crisis Program hopes to use hospital volunteers and individuals from the hospital "PATH" program, which trains individuals over 50 years of age in various medical assistance techniques, to supplement their Toy Intervention Program in 1980.

The South Nassau Program has recently purchased a variety of play materials, clay, puzzles and toys to use in direct intervention with children. The Program Supervisor has trained the para-pro-

fessional in some of the techniques involved in utilizing creative play equipment to work with children. Although this work cannot be formally designated as play therapy, which requires extensive training, theoretical background and professional supervision, the underlying principles are similar. The child is allowed to "play out" his experiences and emotions with dolls representing family members, sand, water, clay, etc. Creative play materials allow the child to express inner thoughts and feelings and foster the child's emotional development. This medium of therapy will be used more frequently during the second year of operation.

Some staff members have been trained in Rational Emotive Therapy (RET), and this form of therapeutic intervention may be offered to individual clients. Rational Emotive Therapy is based upon the premise that "thinking" and "feeling" (emoting) are closely inter-related. Since human beings are uniquely "language creating" animals, both thinking and emoting tend to take the form of internalized sentences, which for all practical purposes, are synonymous with thoughts and emotions. The goal of the therapist, therefore, is to demonstrate to the client that these self-verbalizations have been and still are the primary source of the emotional disturbance. The therapist seeks to help the client by teaching him/her to organize and discipline thinking, eliminating irrational ideas and substituting rational, self-helpful ways of thinking.

Some of the major "illogical" ideas which, according to this view, lead to neurosis and self-defeat are:

- The idea that it is a necessity for an adult to be loved or approved by everyone for everything he does.
- The idea that unhappiness is externally caused and is forced on one by outside people and events.
- The idea that one should be thoroughly competent, adequate, intelligent and achieving in all possible respects.
- The idea that it is vitally important to our existence what other people do, and we should make efforts to change them in the direction we would like them to be.
- The idea that one has no control over emotions and cannot help feeling certain things.

It is the belief of the Rational Emotive therapist that such illogical ideas are the basic causes of most emotional disturbances. Therapy, therefore, focuses on uncovering and eliminating irrational thinking, and teaching the client to apply rational philosophies of living to the practical problems of everyday life.

Although specialized group therapy such as peer groups or crafts groups have not yet gotten underway, the Project foresees forming an Adolescent Group and a Mother's Group. These special activities groups will allow socialization opportunities and provide supportive interaction with peers. The new Project site affords the SNFCT sufficient space to offer such group activities.

3.2.3 Relationships with Child Protective Services

The SNFCP has instituted a convival means of discussing cases and fostering relationships with Child Protective Services workers. The project welcomes any CPS worker or Supervisor who may wish to come to an informal Friday luncheon. The CPS workers reportedly enjoy the opportunity to have a break from field work and are beginning to participate in these meetings. The Friday luncheons were instituted at the very beginning of the program but met with little CPS participation. As the relationship between these two agencies is strengthening, the Friday meetings are becoming more productive.

3.2.4 Staff Development

As the SNFCP has grown so has the program's awareness of the special training and support needed by the treatment team. The program has instituted a weekly staff meeting to be attended by the Director of the Mental Health Clinic and all treatment team members. As the South Nassau program draws upon part-time assistance from several individuals, these staff meetings serve the important function of bringing treatment team members together at one time. Case Management problems and project business are discussed at these meetings.

In addition, all Family Crisis Program staff attend the weekly meeting of Mental Health Clinic personnel. This two hour meeting is often used as an educational forum. For example, one

session was devoted to the special techniques involved in family therapy. The varied expertise of Mental Health clinic professionals may be "tapped" at these sessions. A challenging case may be presented and opinions on treatment and prognosis sought. The SNFCP benefits from the expertise of one Mental Health Clinic family therapist who serves as the "family therapy consultant" and is available to workers for case-specific consultation.

Weekly supervision is provided by the team psychiatrist to all social work therapists and the para-professional.

3.2.5 The Community Mental Health Center Approach

The South Nassau Family Crisis Program functions as one component of the associated Mental Health Clinic. The program staff cite advantages of being located within a mental health clinic including:

- the availability of trained mental health professionals for consultation and support; e.g., easy access to the Chief Psychiatrist for consultation
- the assistance of the Mental Health Clinic's secretaries/receptionists during evenings and weekends, enabling telephone coverage from 8:00 a.m. - 9:30 p.m., five days per week.

The program feels they are encountering many clients with severe psycho-pathologies. Additionally, many children seem to have anti-social, withdrawn or hyperactive tendencies. These mental health problems demand trained and informed treatment team

members. The community mental health center is able to supplement the skills of project staff through instruction, consultation and support.

The staff are pleased with the new Project site. As it is located within an ordinary office building, there is no stigma attached to attending treatment sessions at the program.

The South Nassau Family Crisis Program has evolved throughout the first year into a program with a new understanding of the needs of the difficult population they are serving. In addition, this demonstration project has made efforts to resolve the problems of inter-agency coordination and begins its second year with a strong commitment to working in concert with Child Protective Services.

3.3 Conclusion

The North Shore University Hospital Project and the South Nassau Communities Hospital Project provide somewhat different approaches toward providing comprehensive services for Family Crisis Program clients. In the absence of statistically reliable data on the effectiveness of the Projects (e.g., numbers of cases satisfactorily terminated, number of cases involving child removals, court petitions of abuse or neglect) it is not possible to recommend one approach over the other. There are, however, a few differences in the two projects that are worthy of further comment.

Three major differences stem from the North Shore Project's clearly delineated, hierarchial staffing pattern, as opposed to the South Nassau Project's less clearly defined structure. The first difference is that the North Shore staffing pattern rests upon well defined roles and job functions for the primary therapists, para-professional and program coordinator. There is clear definition of accountability for all casework problems and policy issues beginning with the para-professional and ending with the program coordinator. The structure for professional supervision emerges from well defined staffing patterns; the para-professional is supervised by the primary therapists, primary therapists are supervised by team psychiatrists and the program coordinator.

The second difference is that the more structured pattern adopted by the North Shore Project allows only the primary therapists to assume the position of case manager. At the South Nassau Project any staff member, including the para-professional, may be a case manager.

A third difference lies in the job functions of the team para-professional. At the South Nassau Program, the para-professional serves as an adjunct therapist, managing cases and providing treatment. At the North Shore Project, the role of the para-professional is to assist the primary therapists following the treatment goals developed by the professional staff. This para-professional is charged with the major responsibility for community

networking; uncovering and making contact with resources that may supplement the Project's efforts. Community networking is seen as a major element of providing servies to clients by the Family Crisis Program at North Shore Hospital. The South Nassau Project views their main purpose as the provision of Mental Health services and feels community networking is primarily the responsibility of the Child Protective Services worker who maintains responsibility for the case.

The final distinction between the two projects is the degree of emphasis placed upon diagnostic evaluations. The North Shore Project conducts separate, complete psychiatric/psychological evaluations for each parent and the involved child, and routinely provides pediatric examinations to all children in the family. The South Nassau Project is less structured in administering psychological evaluations, and due to the limited involvement with the hospital does not routinely administer pediatric examinations.

Similarities in the operations of the two demonstration projects include the emphasis on family therapy, and the recognition of the effects of family dysfunction upon children. At the North Shore site, family treatment was seen from the very beginning, as the primary treatment modality, and regular supervision in family treatment is provided for the staff. At South Nassau, a growing emphasis is being placed on family treatment, but a less formal structure exists. The family treatment specialist of the Mental Health clinic is available for consultation, but does not provide direct supervision to the staff.

While the North Shore Project is able to offer individual psychotherapy for children through the hospital Child and Adolescent Psychiatry Unit, the South Nassau Project is building the capability to provide informal therapy with play materials for a large number of children.

Neither project, in the first year of operation, had as yet implemented plans for group participation. The Community Centers Program placed major emphasis on group therapy of various kinds. Since it is not yet possible to conduct an outcome analysis of the Family Crisis Program, comparisons at this time of the two project sites and comparisons with the Community Centers Program are only possible on a descriptive, rather than evaluative basis.

4.0 TECHNICAL APPROACH

In this section of the report, the methodology of the evaluation effort will be described. Several alterations in technical approach were necessitated due to changes and delays in anticipated program implementation. The present report is primarily descriptive in nature, and does not address the essential question of the effectiveness of the services provided by the Family Crisis Program, or the comparative effectiveness of the two different project sites. It is recommended that a comparative outcome analysis be conducted when a sufficient number of clients have been served by the program to make such an analysis possible. A comparison of outcome between the two project sites may be able to provide a valuable contribution to the field of preventive services. Little research has been conducted comparing the effectiveness of different approaches to providing services to this client population.

4.1 Alterations in Evaluation Methodology

At the conclusion of the DMC evaluation of the Child Abuse Community Centers Program, Child Protective Services, nearing the end of the demonstration grant period, was endeavoring to secure additional funding to continue the existing programs.

In order to assist decision-makers in formulating plans for continuation and replication of the Community Centers Program, DiBernardo Management Consultants submitted a proposal for con-

tinued evaluation to focus on areas which were either not fully developed in the limited time span of the preceding evaluation, or which were identified as fruitful areas for futher study. The major issues which were addressed in this proposal are outlined below:

1. An intensive evaluation of referral criteria, procedures and engagement results directed at identifying those cases which might benefit most from the program. The results of this evaluative component would be employed to further refine referral criteria and procedures.

2. Intensive comparative analysis of project vs. other "outside serviced" cases directed at documenting and assessing differences in outreach procedures, services planning and services delivery which may significantly affect the success of service delivery from the perspective of the family as well as CPS objectives. It became clear in the course of the '76-'77 evaluation that the community projects placed considerable emphasis on non-traditional modes and formats of therapy, many specifically designed to address parent-child relationship problems. These modalities are not generally available at the mental health facilities normally employed as referral resources.

   These non-traditional modes and formats of treatment may account for the project's greater success with families in comparison to those referred to mental health clinics not offering specialized child protective programs.

3. The development of in-depth case studies highlighting case characteristics and specific approaches to treatment. The case studies were to be directed, on the one hand, at providing more clinical data on families served which would more clearly suggest services needs and service delivery problems; and on the other hand, at providing a rigorous documentation, analysis and assessment of specific

service modalities such as latency and cohort groups, parent-effectiveness training, and the mother's home program. It was felt that this would greatly enhance the understanding of the program's dynamics and provide guidance in replication and institutionalization.

4. Further development of the cost-effectiveness analysis to provide a more reliable basis for assessing the costs and benefits of treatment under the model program. The addition of medicaid costs associated with the treatment of non-project cases with similar emotional disorders as project cases will be a key focus of this expanded cost-effectiveness analysis.

5. Continued longitudinal analysis of cases referred to the projects since September 1, 1976 to expand the number and period of observations on which the evaluation of the program is based. It was projected that the larger sample will permit a comparative assessment of program effects by case type.

6. Application in all analytic procedures described above, of a typology of abuse/neglect cases developed by DMC on a statewide sample of 653 indicated cases of child maltreatment. The original research on this typology was conducted in conjunction with the evaluation of the Child Abuse Community Centers Program.

In November, 1978, when the decision had been made to discontinue the existing Community Centers Program in favor of a more comprehensive approach to families in crisis, and plans were underway for the implementation of the Family Crisis Program, DiBernardo Management Consultants submitted to the Nassau County Criminal Justice Coordinating Council an addendum to the existing proposal.

A review of the plans for the Family Crisis Program, staffing, organizational framework and projected caseflow indicated that there were two major changes in structure and emphasis between the Community Centers Program and the Family Crisis Program:

- The expansion of the client population to include not only Child Protective Services cases, but cases involving all forms of violence referred by a variety of community agencies.
- The change in administrative locus from the Department of Social Services to the Department of Mental Health.

While it was considered at this time that the major thrust of the evaluative design remained relevant to the revised program, it was mutually agreed by the DMC evaluation team and the concerned parties of the Department of Social Services and the Department of Mental Health that modifications in the design were necessary. There were three major modifications to the proposed evaluative effort.

- The expansion of the client population necessitated a comparison of client characteristics and service needs between CPS clients and those clients involved in other forms of family violence.
- The outcome analysis of Child Protective Services cases would be expanded to facilitate comparisons among three groups: Family Crisis Program cases, original Community Centers Program cases, and a control group of CPS cases referred for counseling to local community mental health agencies.
- Due to the changes in administrative control of the projects, it was now necessary to address the extent to which administrative and organizational procedures would facilitate and support a cooperative monitoring, assessment and treatment of CPS referrals between CPS and DMH staff.

A proposed twelve-month time frame was projected for the evaluative effort. It was anticipated by the Department of Mental Health at this time that by March, 1979 the project would be serving a total of 100 families.

Unanticipated delays in contract award, appointment of key staff, and referral procedures resulted in the fact that the projects were not under contract until January of 1979. Additionally, delays in the award of the contract for the evaluation necessitated a further revision in the evaluative workplan. The revised workplan condensed all efforts into a 6-month format to allow for completion of the evaluative effort by January, 1980. It was assumed at this time that since the projects would have completed the first year of their demonstration effort by this time, an outcome analysis would be possible.

However, a further change in the evaluation component was necessary. Although the Family Crisis Program was officially underway as of January 1, 1979, both project sites experienced major delays in becoming fully functional. The end result of these delays was that by the time of final data collection, most of the families served by the projects had been receiving services for only a month or so. In light of this finding, it was mutually agreed upon by the evaluation staff, and representatives of the Nassau County Criminal Justice Corrdinating Council and the New York State Division of Criminal Justice Services that it would not be feasible to conduct an outcome analysis.

It was decided at this time that the effects of a treatment program cannot be fairly evaluated until clients have had the benefit of treatment for a period of at least 6 months. On the basis of the findings of the evaluation of the Community Centers program, it is estimated that the Child Protective Services population is anticipated to require intensive therapeutic involvement for at least one year.

This Final Report, therefore, does not attempt to evaluate the effectiveness of the services provided by the Family Crisis Program. The evaluation effort focuses primarily on a descriptive "process study" of the Family Crisis Program in its first year of operation.

4.2 Hypotheses

The hypotheses to be examined in the context of the present effort are as follows:

- Hypothesis I

  There will be no difference found between the characteristics of those cases referred to the Family Crisis Program by Child Protective Services and those cases referred by other community agencies.

- Hypothesis II

  There will be no differences found between the characteristics of CPS cases referred to the North Shore site and those referred to the South Nassau site of the Family Crisis Program.

- Hypothesis III

  There will be no differences found between the characteristics of CPS cases referred to the Family Crisis Program and those in the control group.

If at any time in the future an outcome analysis of the Family Crisis Program is conducted, it will be necessary to have established the equivalence of the groups to be compared. Therefore, in the context of the present evaluation, a comparative examination of the characteristics of involved groups was conducted. This information is also of value in understanding the problems of families served by the projects, and the implied service needs associated with these family problems.

4.3 Methodology

Several interviews were held at each of the project sites in order to understand the theoretical approach of the projects, the nature of the services provided and the problems experienced by project staff. However, all data collection was conducted at the Nassau County CPS Central Register and the Nassau County Department of Mental Health in order to ensure a uniform data base for all cases.

The project sample consisted of all cases referred to the Family Crisis Program for which data was available at the Department of Mental Health by September 1, 1979, the date of final data collection. At this time, a total of 102 families had been referred to the Family Crisis Program. Child Protective Services referrals accounted for 57 of these cases. A random sample of 57 non-project cases was then drawn from the State Central Register computer listing of Nassau County cases indicated in 1979, to constitute the comparison sample.

An indicated case is one in which the investigation of an allegation of child abuse or neglect has resulted in a finding of "credible evidence". All cases in both comparison groups are "indicated" cases.

The original research design called for a comparison sample of CPS cases which had been referred for counseling to a community mental health facility. However, the nature of the file structure at the Nassau County Central Register is such that no information regarding referral for service is available centrally. Only the caseworkers' individual case records indicate if the case has been referred for counseling. In view of this finding, the decision was made to draw a random sample of 57 cases to constitute the control group, and conduct interviews with the caseworkers responsible for these cases regarding case problems, recommended services and referrals. The final comparison groups employed for analysis are as follows:

Family Crisis Program

	N=57
North Shore Hospital	N=28
South Nassau Hospital	N=29

Comparison Group

	N=57
Referred for Counseling	N=40
No Counseling referrals	N=17

The data collection forms utilized by the Department of Mental Health for Family Crisis Program cases were developed in a joint effort by the Family Crisis Program Coordinator and the evaluation team. As a result of this joint effort, all data for project cases which was required for the evaluation was available either in the Nassau County CPS Central Register (standardized forms mandated for all CPS cases in New York State) or in the Department of Mental Health. (DMH Family Crisis Project forms may be found in the Appendix to this report.)

However, the DMH data base was not available for the non-project cases in the control group. For this reason, detailed interviews were held with the caseworker responsible for each case in the control group to identify specific case problems, needed services and referrals for service. (The structured interview guides employed for these interviews may be found in the Appendix to this report). Coding formats were developed to insure uniformity of the data base and facilitate computer analyses. All data was then analyzed using the SPSS computer software package (Statistical Package for the Social Sciences).

Due to the small size of the samples employed, statistical tests of significance were not routinely employed. Results are reported in raw numbers and percentages in order to facilitate meaningful interpretation of the data. Chi-Square statistical test for significance is reported if meaningful to the data base employed.

Material for the development of case histories was compiled from case records of project staff and supplemented by interviews with project workers. The case histories were developed in order to provide for those readers unfamiliar with the problems of families involved in violence, a narrative description of family circumstances, project interventions and different types of problems encountered. Such narrative case histories are frequently able to provide a more meaningful understanding of these elements than are tables of frequencies or statistical tests of significance.

5.0 CHILD PROTECTIVE SERVICES CASES

An important question in the evaluation of demonstration projects such as the Family Crisis Program, is the degree of similarity which exists between those clients referred to the program and those in the control group. Cases are not referred to the projects on a random basis, but are selected for referral by the CPS worker on the basis of need for service, willingness to engage in counseling, etc. However, if an evaluation of long-term outcome is eventually conducted in order to evaluate the effectiveness of the program, it will be necessary to consider any differences which are found to exist between the comparison groups which might be anticipated to effect outcome. This section of the report discusses the similarities and differences which have been discovered between those cases referred by CPS to the Family Crisis Program, those cases referred for counseling to other community agencies and those cases which were not referred for counseling. The composition of the comparison groups employed for analysis is as follows:

Family Crisis Program	N=57
North Shore Hospital	N=28
South Nassau Hospital	N=29
CPS Control Group	N=57
Referred for Counseling (to community mental health facilities or private practitioners)	N=40
Not referred for counseling	N=17

5.1 Typology of Child Protective Services Cases

DiBernardo Management Consultants, in conjunction with the evaluation of the Nassau County Community Centers Program, and with the New York State CANTS Project, have developed and validated a typology of abuse/neglect cases. The results of this typology development demonstrated that the population of indicated abuse/neglect cases in New York State can be classified into four distinct groups, each of which is associated with specific case problems, implied service needs and anticipated case outcomes.

All variables employed in the classification process are available in the State Central Register as of the date of indication.

5.1.1 Characteristics of Case Types

Case Type 1A

- Constitutes approximately 20% of all indicated cases.
- Typically, there are substantiations of four or more different neglect allegations.
- Sixty-eight percent of type 1A cases are single-parent households.
- Forty-four percent of type 1A cases involve drug-alcohol dependence on the part of the caretaker; 51% involve psychiatric disorders, mental retardation and/or chronic illness.
- Spouse abuse is present in 20% of these cases (only 32% of this case type are two parent households).

- Additionally, these families have high rates of juvenile offenses (21%) and/or children's sexual activity (21%).

- In virtually all type 1A cases, children are removed into protective custody, and only 22% of removed children are returned to their homes within three years.

Case Type 2

- Constitutes approximately 30% of all indicated cases.

- Predominantly (65%) two-parent households.

- Substantiations typically involve excessive corporal punishment and "bruises, lacerations or welts."

- Common problems include "Unrealistic expectations of child" and "Inappropriate means of expressing anger."

- Child-centered problems such as "Hyperactivity" (17%), "Aggression/Hostility" (37%) and "Sexual Activity" (15%) are also common.

- In about 1/3 of type 2 cases, a child is removed into protective custody. Forty percent of these children are returned home within a three year period.

Case Type 3

- Constitutes about 6% of all indicated cases.

- Substantiations typically indicate serious physical abuse (fractures, burns, internal injuries).

- Common caretaker-centered problems include psychiatric disorders (35%) mental retardation (20%) and drug/alcohol dependence (40%).

- Children with health related problems are common in this case type: Chronic illnes (20%), congenital illness (10%), subnormal physical development (10%), premature birth (10%) and colicky infant (15%) all occur with greater frequency than in any other case type.

- Sixty percent of type 3 cases involve the removal of children from the home with 37% of these children returned within three years.

- Commonly recommended services include Homemakers (29%) and Day Care (24%) provided for those families in which children remain in the home.

Case Type 1B

- Constitutes approximately 45% of all indicated cases.

- Characterized by substantiations of neglect refering to one or two allegations.

- Typical case problems include: Misuse of existing Resources (44%), Unemployment (31%), and Sub-standard Housing (24%)..

- Only 6.6% of type 1B cases involve the removal of children from the home, and 55% of removed children are returned within three years.

A detailed description of the technical procedures involved in the typology development can be found in "Operational Typology of Abuse/Neglect: Technical Documentation", DiBernardo Management Consultants, 1979.

5.1.2 Typology Assignment of Comparison Groups

All cases in both samples (Family Crisis Program and CPS Comparison Group) were classified into the four existing case types according to the discriminant functions derived in the process of typology development. Table 5-1 shows that the distribution of case types referred to the Family Crisis Program is essentially the same as the distribution of CPS cases in the control group.

TABLE 5-1

Distribution of Case Types in Comparison Groups

Case Type	Family Crisis Program N = 57		Control Group N = 57	
1A	2	3.5%	5	8.8%
2	30	52.6%	27	47.4%
3	8	14.1%	7	12.3%
1B	17	29.8%	17	29.8%
TOTAL	57	100 %	57	100 %

It is interesting to note, however, that while a total of 70% of all cases in the CPS control group were referred for counseling to a community Mental Health Agency, (or private practitioner), this distribution was not proportional across case types. Table 5-2 portrays the distribution of case types among cases referred for counseling.

TABLE 5-2

Control Group: Distribution of Case Types

Case Type	% of Total Control Group		% Referred For Counseling	
1A	5	8.8%	3	60 %
2	27	47.4%	22	81.5%
3	7	12.3%	5	71.4%
1B	17	29.8%	9	52.9%
TOTAL	57	100 %	39	70 %

Counseling is clearly perceived by CPS workers as a major service need for the majority of their clients.

Type 1B cases are the least likely to be referred for counseling. This finding lends support to the general description of type 1B cases, which are characterized typically as child neglect in the context of environmental and circumstantial stresses, rather than as intra-psychic or inter-personal problems.

Case Type 2 is the most likely to be referred for counseling. Again, this finding supports the results of DMC's state-wide study (CANTS project). Type 2 cases are characteristically intact, middle income families and have been shown to be more likely than other case types to be willing to accept referral to a mental health clinic for counseling. That is, it is likely that the high rates

of referral for counseling do not reflect a greater need for counseling by this case type but rather a greater willingness to accept such counseling.

Table 5-3 indicates the distribution of case types in each of the projects. Although the percentages of case types differ somewhat, an examination of the actual number of cases indicates little difference in case type distribution between the two projects.

TABLE 5-3

Distribution of Case Types: Family Crisis Program

Case Type	North Shore N = 28	South Nassau N = 29	Total N = 57
1A	0	2 6.9%	2 3.5%
2	16 57.1%	14 48.3%	30 52.6%
3	3 10.7%	5 17.2%	8 14.1%
1B	9 32.2%	8 27.6%	17 29.8%

5.2 Family Composition

Table 5-4 illustrates the Family Composition of the comparison groups. Examination of this table indicates that cases referred to the Family Crisis Program are more likely to be two-parent households than cases in the CPS comparison groups. In the control

group, also, a higher percentage of two-parent households are in the "referred for counseling" category.

Eighty-six percent (86%) of North Shore Hospital Referrals are two-parent households, compared to 72% of South Nassau cases, 65% of cases referred for counseling to other agencies, and 53% of CPS cases not referred for counseling. North Shore cases were also least likely to be "single child" families, while 72% of South Nassau cases had more than four children in the family.

Single Parent Households comprise 48.3% of the New York State population of indicated child abuse/neglect cases. It appears, however, that Child Protective Service workers are more likely to refer the two-parent household for counseling. While the reasons for this are not readily apparent, several possibilities exist:

- Problems in the single-parent household may be perceived by the CPS worker as requiring concrete services more than mental health counseling. Economic and employment assistance, homemaker service and day care services may be considered as the primary service modality for the single-parent family.

- If severe caretaker-centered problems such as mental retardation, psychiatric disorders and/or drug/alcohol abuse are present in a single parent family the lack of another stable adult figure in the household is likely to result in high rates of child removals. Once children have been removed from an "at risk" situation, mental-health services are less likely to be provided for the parent or ordered by the court. This is particularly true in cases where it appears unlikely that the family situation can be improved sufficiently to allow the return of the involved children.

TABLE 5-4

FAMILY COMPOSITION

Family Crisis Program

	North Shore N = 28		South Nassau N = 29		Total N = 57	
Single Parent Household	4	(14.3%)	8	(27.4%)	12	(21 %)
Two-Parent Household	24	(85.7%)	21	(72.4%)	45	(78.9%)
Number of Children in Family						
1	4	(14.3%)	7	(24.1%)	11	(19.3%)
2 or 3	14	(50 %)	1	(3.4%)	15	(26.3%)
4 or More	10	(35.7%)	21	(72.4%)	31	(54.4%)

CPS Comparison Group

	Referred for Counseling N = 40		Not Referred N = 17		Total N = 57	
Single Parent Household	14	(35 %)	8	(47.1%)	22	(38.6%)
Two-Parent Household	26	(65 %)	9	(52.9%)	35	(61.4%)
Number of Children in Family						
1	9	(22.5%)	8	(47.1%)	17	(29.8%)
2 or 3	19	(47.5%)	5	(29.4%)	24	(42.1%)
4 or more	12	(30 %)	4	(23.5%)	16	(28.1%)

- Statewide, the most commonly reported problem for abuse/neglect cases is "marital discord". Two-parent families may, therefore, be more likely to be referred for marital/family counseling. The primary service modality of the Family Crisis Program is Family Treatment. The program, therefore, may be perceived by CPS workers as most appropriate for the intact family.

5.3 Nature of the Abuse/Neglect Circumstances

Cases in which a child is hospitalized as a result of the abuse/neglect circumstances are not likely to be referred to the Family Crisis Program. Approximately one quarter of the cases in the control group involved injuries serious enough to require hospitalization, and 64.3% of these cases (9) were referred for counseling, constituting 22.5% of the "referred for counseling" category. Only five (5) cases requiring hospitalization were referred to the Family Crisis Program (8.8% of referrals to the program). Table 5-5 illustrates these percentages.

TABLE 5-5

Child Hospitalized as Result of Abuse/Neglect

Family Crisis Program		CPS Comparison Group		
North Shore	4 (14.3%)	Referred for Counseling	9	(22.5%)
South Nassau	1 (3.4%)	Not Referred	5	(29.4%)
Total	5 (8.8%)	Total N = 57	14	(24.6%)

CONTINUED

1 OF 3

This finding appears to be related to the nature of CPS interventions. The Family Crisis Program is also relatively unlikely to be referred cases in which petitions of adjudication are pending in Family Court, or cases in which children have been removed from the home and not returned. These cases, however, are referred to other community agencies for counseling with greater frequency. Table 5-6 depicts CPS interventions for the comparison groups

TABLE 5-6

CPS Interventions

	Family Crisis Program						Comparison Group					
	North Shore		South Nassau		Total		Referred for Counseling		Not Referred		TOTAL	
Petitions Pending	3	(10.1%)	5	(17.2%)	8	(14 %)	14	(35%)	7	(41.2%)	21	(36.
Child Removed/ Not Returned		0	6	(20.7%)	6	(10.5%)	10	(25%)	5	(29.4%)	15	(26.
Child Removed/ Returned	4	(14.3%)	2	(6.9%)	6	(10.5%)	2	(5%)	1	(5.9%)	3	(5.

A case in which the child's injuries are serious enough to require hospitalization, is likely to be a case involving a court petition and frequently involves removal of the child into protective custody. While the reasons for not referring such cases to the Family Crisis Program are not entirely clear, CPS administrators have expressed the desire to avoid requiring court testimony by Project workers or the necessity to subpoena project case records. When such court appearances are anticipated, the case is unlikely to be referred to the project.

Presumably, if CPS cases are referred for counseling to local agencies, each individual community agency would have only a few such cases. If court testimony (and possible subpoena of records) is occasionally required, it would be unlikely that the same agency worker would be required to make court appearances with great frequency.

However, in the Family Crisis Program, the majority of cases served are CPS cases. If cases involving court petitions were referred to the program with regularity, FCP staff might be required to make frequent court appearances causing major interference with project functioning.

The issue of client confidentiality is also involved. The issue of confidentiality is always a sensitive area in terms of both testimony and subpoena of records. A successful therapist-client relationship involves intimacy and trust, difficult qualities to maintain when court appearances by the therapist are involved. Because of the sensitive nature of such court appearances, both CPS and project staff prefer to keep such cases to a minimum. The reluctance of CPS to refer to the project's cases in which court appearances are anticipated is an attempt at minimizing possible inter-agency conflict of interest and disruption of project routine.

North Shore Hospital staff have stated their desire to be referred clients who have been adjudicated with court-ordered

supervision and treatment. It is felt at this project site that only court-ordered treatment will impel unmotivated clients to become engaged in such critical services as treatment for alcohol abuse, a frequently occurring problem in this client population. However, such cases would have completed the adjudicatory process, and project involvement in the court procedures would not be required.

Child Protective Services, however, does not routinely refer to the project's cases which have been adjudicated. It is felt by CPS staff that such clients can be referred to local mental health agencies since treatment has been ordered by the court, and intensive outreach efforts are not necessary.

The Family Crisis Program is apparently seen by CPS workers as a primary source of services for sexual abuse cases. Fourteen percent of the referrals to the projects are indicated for sexual abuse, while only 3.5% of the comparison group are in this category. Table 5-7 indicates the nature of the substantiations for each group.

Minor physical abuse cases are referred to the projects at about the same rate as to other community agencies. Serious cases of physical abuse, however, involving injuries such as fractures, burns, subdural hematomal, etc., were referred to South Nassau Community Hospital at twice the rate of North Shore Hospital or other community agencies. About 10% of the comparison group, and

10% North Shore referrals involved serious physical injury, while 24% of South Nassau referral fall into this category.

It is likely that this observed difference is due to the population of the different catchment areas. Severe physical injuries are more likely to be perpetrated against young children who cannot protect themselves or run away. Adolescent children are less frequently severely injured. As previously stated, the North Shore project has a smaller client population of younger, more vulnerable children than does the South Nassau Site.

TABLE 5-7

NATURE OF SUBSTANTIATIONS

	Family Crisis Program			CPS Comparison Group		
	North Shore	South Nassau	TOTAL	Referred For Counseling	Not Referred	TOTAL
Serious Physical Injury (Fractures, Subdural hematoma, burns, malnutrition/failure to thrive, infant drug withdrawal)	3 (10.7%)	7 (24.1%)	10 (17.5%)	4 (10 %)	2 (11.8%)	6 (10.5%)
Less Serious Physical Abuse (Bruises, lacerations, welts, excessive corpral punishment, sexual abuse)	17 (60.7%)	12 (41.4%)	29 (50.9%)	22 (55 %)	5 (29.4%)	27 (47.4%)
a. Sexual Abuse	5 (17.9%)	3 (10.3%)	8 (14 %)	2 (5 %)	0	2 (3.5%)
Neglect (educational neglect; emotional neglect; medical neglect; lack of food, clothing, shelter; child's drug/alcohol abuse; lack of supervision; abandonment)	8 (28.6%)	10 (34.5%)	18 (31.6%)	14 (35 %)	10 (58 %)	24 (42.1%)

5.4 Associated Problems

DiBernardo Management Consultants, as part of a three year contract with the New York State Department of Social Services has developed and validated on a statewide basis, a list of thirty-five problems with demonstrated associations in Child Protective Services cases. This problem list includes child-centered, caretaker-centered and general family problems. Table 5-8 contains this problem list, and indicates the comparative rate of occurrence of each problem for the CPS cases referred to the Family Crisis Program and those in the control group. Information for Family Crisis Program cases was obtained from Department of Mental Health records (copies of forms may be found in the Appendix), while information for the control group was obtained from interviews with CPS caseworkers.

Examination of Table 5-8 indicates that many more family problems are reported for cases referred to the Family Crisis Program than for the control group. Family Crisis Program Referrals were reported to have an average of 3.02 associated problems per case, while the control group was reported to have an average of 1.14 problems per case. It cannot be assumed, however, that FCP referrals are necessarily a more problem-ridden client group. The intensive family involvement, and diagnostic/pediatric evaluations provided for clients in the Family Crisis Program undoubtedly allow for better understanding of clients' problems than is possible for the Child Protective Services caseworker. It is possible

that increased reporting of associated problems for project cases is merely the result of greater familiarity with family circumstances and needs.

The most commonly reported problems for FCP clients were marital conflict, lack of home management skills, unrealistic expectations of the child, psychiatric disorders, and alcohol dependence. The most frequently reported problems for the control group were alcohol dependence, juvenile offenses, spouse abuse and psychiatric disorders.

TABLE 5-8

Associated Family Problems: Family Crisis Program and CPS Control Group

	Problem	Family Crisis Program CPS Referrals N=57	CPS Control Group N = 57
	Child Centered Problems		
1	Congenital Illness	4 (7 %)	0
2	Chronic Illness	2 (3.5%)	0
3	Physical Handicap	0	0
4	Mental Retardation	0	0
5	Premature Birth	0	0
6	Colicky Infant	0	0
7	Delayed Physical Development	3 (5.3%)	0
8	Overly Active	4 (7 %)	0
9	Emotionally Withdrawn	4 (7 %)	1 (1.8%)
10	Aggression/Hostility	7 (12.3%)	0
11	Impaired Learning Skills	6 (10.5%)	2 (3.5%)
12	Juvenile Offenses	5 (8.8%)	7 (12.3%)
13	Sexual Activity	7 (12.3%)	1 (1.8%)
	Family Problems		
14	Marital Conflict	12 (21.1%)	5 (8.8%)
15	Phys. Abuse of Spouse	6 (10.5%)	6 (10.5%)
16	Dependency/Role Reversal	4 (7 %)	1 (1.8%)
17	Limited Financial Resources	5 (8.8%)	3 (5.3%)
18	Other Financial Problems	3 (5.3%)	2 (3.5%)
19	Unemployment	2 (3.5%)	2 (3.5%)
20	Substandard Housing	7 (12.3%)	1 (1.8%)
21	Cultural/Religious Background	3 (5.3%)	0
	Caretaker Problems		
22	Physical Handicap	5 (8.8%)	0
23	Chronic Illness	4 (7 %)	1 (1.8%)
24	Psychiatric Disorder	10 (17.6%)	6 (10.5%)
25	Mental Retardation	0	2 (3.5%)
26	Drug Dependence	2 (3.5%)	5 (8.8%)
27	Alcohol Dependence	9 (15.8%)	15 (26.3%)
28	Pregnancy	2 (3.5%)	0
29	Low Self-Esteem	7 (12.3%)	1 (1.8%)
30	Inappropriate Means of Expressing Anger	9 (15.8%)	1 (1.8%)
31	Unrealistic Expectation of Child	13 (22.8%)	1 (1.8%)
32	Unrealistic Perception of Child	0	0
33	Socialization Skills	7 (12.3%)	0
34	Social Isolation	3 (5.3%)	1 (1.8%)
35	Home Management Skills	17 (29.8%)	1 (1.8%)

5.5 Conclusions

Analysis of the characteristics of Child Protective Services cases referred to the Family Crisis Program in comparison to the control group indicates that some differences do exist between the two groups.

- Type 1A cases, frequently resulting in child removals, are somewhat less likely to be referred to the Family Crisis Program (3.5% of referrals); than occurring in the control group (8.8%).
- Cases referred to the Family Crisis Program are more likely to be two-parent families (78.9%) than cases in the control group (61.4%).
- Cases in which a child is hospitalized as a result of abuse/neglect; cases in which Family Court petitions are involved; and cases in which children are removed from the home are not generally referred to the Family Crisis Program.
- Sexual abuse cases are referred to the Family Crisis program at a higher rate (14%) than their occurrence in the control group (3.5%).
- Cases involving serious physical injury are also referred to the FCP at a higher rate (17.5%) than occurring in the control group (10.5%).
- More associated problems are reported for Family Crisis Program clients (2.96/case) than for the control group (1.14/case).

It is recommended by the evaluation team that if an outcome analysis is eventually conducted to assess the effectiveness of the Family Crisis Program, several constraints should be placed upon the comparison sample.

- Sexual abuse cases represent a specific category of Child Protective Services cases. Since sexual abuse cases are frequently referred to the Family Crisis Program, outcome for these cases should be compared to a sample of sexual abuse cases not referred to the program.

- The comparison sample should contain an equivalent number of cases involving serious physical injury, since the anticipated outcome for this group would be likely to involve higher rates of child removal if a recurrence of abuse should occur. The effectiveness of project impact, therefore, may be underestimated if the comparison sample is not adjusted to reflect an equivalent rate of serious substantiations.

- The selection of appropriate outcome measures should be carefully addressed. If cases in which court petitions are anticipated are not referred to the projects, then the effectiveness of the projects cannot be measured in terms of reduction in court involvement. Emphasis would then be more appropriately directed toward such outcome measures as the rate and seriousness of recurrences of abuse.

6.0 COMPARISON OF REFERRAL SOURCES: COMMONALITY OF SERVICE NEEDS

The Family Crisis Program is designed to serve families referred by Child Protective Services (indicated cases of child abuse or neglect) as well as cases involving other forms of family violence which are referred by other agencies. The theoretical basis for this programmatic model rests on the premise that there exists a commonality of service needs for all these families, and that while the presenting problem or reason for referral may differ (child abuse, spouse abuse, abuse of parent by child, etc.), the problems and needs of these families are essentially the same. Within this framework, therefore, the assumption is that the needs of clients referred from various sources, for various reasons, can be effectively addressed by a single model of service delivery.

One component of the present evaluation is designed to address this issue, and test the hypothesis that there will be no significant difference between cases referred to the Family Crisis Program from various referral sources, in respect to contributing problems, rate of engagement, and/or recommended services.

The data base employed for this analysis consisted of all cases referred to the Family Crisis Program as of October 1, 1979. Data were collected at the Nassau County Department of Mental Health and incorporated all information provided by the Coordinator of the Family Crisis Program.

Table 6-1 depicts the distribution of cases to each project by referral source.

TABLE 6-1

DISTRIBUTION OF CASES BY REFERRAL SOURCE

	North Shore Hospital		South Nassau Community Hospital		Total	
Referral Source		% of Project Total		% of Project Total		% of Total
CPS	32	76.2%	22	36.7%	54	52.9%
Coalition for Abused Women	2	4.8%	4	6.8%	6	5.9%
Hospital	5	11.8%	1	1.6%	6	5.9%
Public Health Nurse	1	2.4%	1	1.6%	2	2%
Non-CPS Source Unknown	2	4.8%	2	3.3%	6	3.9%
Probation	0		6	10 %	6	5.9%
South Nassau Mental Health Clinic	0		24	40 %	24	23.5%
TOTAL	42	100 %	60	100 %	102	100 %
Total non-CPS Referrals	10	23.8%	38	63.3%	48	47.1%

A total of 48 cases were referred to the Family Crisis Program by agencies other than CPS (47.1% of all Family Crisis Program referrals). Thirty-eight of these non-CPS cases (79.2%) were referred to the South Nassau Project. Fifty percent (50%) of all non-CPS referrals were "in-house" referrals, referred by the South Nassau Community Hospital Mental Health Clinic to the Family Crisis Program at the same site. Additionally, Department of Probation referrals were not made directly to the Family Crisis Program, but were referred to the South Nassau Mental Health Clinic which assigned the case to the Family Crisis Program.

The twenty-four cases referred to the Family Crisis Program by the South Nassau Mental Health Clinic include twelve cases categorized as self-referrals. In these cases, the client contacted the Mental Health Clinic seeking help for a problem which appeared to be most appropriately served in the Family Crisis Program. At the South Nassau Mental Health Clinic, the Family Crisis Program is one of the programs available for clients. A clinic case will be assigned to the program if, in the judgment of the clinic director, the client will be best served in this manner. The Family Crisis Program appears to be perceived here as a part of the comprehensive services provided by the clinic: a staff member may work part-time for the Family Crisis Program, and part-time for the clinic, and weekly staff conferences include both clinic staff and staff of the Family Crisis Program.

A total of only 18 referrals were received from other community agencies. The Coalition for Abused Women, anticipated to be a major referral source, has referred only six cases to the program. Section 10.0 of this report addresses the managerial issue of obtaining appropriate referrals from other community agencies.

Although the contractual agreement calls for a project caseload consisting of 75% referrals from Child Protective Services, as of October 11, only 36.7% of South Nassau FCP clients had been referred by CPS.

The administrator of the South Nassau FCP program has stated that a major future emphasis will be placed on Child Protective Services cases, with fewer referrals accepted from other sources.

6.1 Analysis of Non-CPS Referrals

The 48 cases representing all non-CPS referrals to the Family Crisis Program constitute the data base for examination. These cases were referred to the program for a variety of specific reasons. Table 6-2 indicates the predominant reason given for referring the case to the program.

TABLE 6-2

Reasons for Referral: Non-CPS cases

Reason for Referral	North Shore Hospital N=10	South Nassau Hospital N=38	Total N = 48
Spouse Abuse	10	10	20(41.7%)
Other Family Violence	0	7	7(14.6%)
Fear of Harming Others	0	6	6(12.5%)
History of Violence in Family of Client	0	4	4(8.3%)
Adolescent Acting-Out Behavior	0	2	2(4.2%)
Non-CPS Referral; History of Child Abuse/Neglect	0	8	8(16.7%)
Explosive Personality; Potential for Violence	0	1	1(2.1%)
	10	38	48(100%)

Twenty-seven cases (56.3%) were referred because of actual incidents of violence. Twenty of these involved spouse abuse, six involved abuse of a parent by a son or a daughter, and one abuse of a young girl by a "boyfriend".

Seven cases (14.6%) were referred for preventive reasons. In six cases, the client sought help for fear of harming others, and one was referred as an "explosive personality" with a potential for violent behavior.

The comparative rate of occurrence of associated family problems for Family Crisis Program CPS referrals and for non-CPS referrals to the program can be found in Table 6-3.

TABLE 6-3

Comparison of Case Problems: Child Protective Services and Non-CPS Referrals to the Family Crisis Program

	Problem	CPS Referrals N = 57	Non-CPS Referrals N = 48
	Child Centered Problems		
1	Congenital Illness	4 (7%)	1 (2.1%)
2	Chronic Illness	2 (3.5%)	0
3	Physical Handicap	0	0
4	Mental Retardation	0	0
5	Premature Birth	0	0
6	Colicky Infant	0	0
7	Physical Development	3 (5.3%)	0
8	Overly Active	4 (7%)	0
9	Emotionally Withdrawn	4 (7%)	1 (2.1%)
10	Aggression/Hostility	7 (12.3%)	0
11	Impaired Learning Skills	6 (10.5%)	0
12	Juvenile Offenses	5 (8.8%)	1 (2.1%)
13	Sexual Behavior	7 (12.3%)	1 (2.1%)
	Family Problems		
14	Marital Conflict	12 (21.1%)	23 (47.9%)
15	Physical Abuse of Spouse	6 (10.5%)	18 (37.5%)
16	Dependency/Role Reversal	4 (7%)	1 (2.1%)
17	Limited Financial Resources	5 (8.8%)	4 (8.3%)
18	Other Financial Problems	3 (5.3%)	0
19	Unemployment/Under Employment	2 (3.5%)	2 (4.2%)
20	Substandard Housing	7 (12.3%)	0
21	Cultural/Religious Background	3 (5.3%)	0
	Caretaker Problems		
22	Physical Handicap	5 (8.8%)	0
23	Chronic Illness	4 (7%)	2 (4.2%)
24	Psychiatric Disorder	10 (17.6%)	13 (27.1%)
25	Mental Retardation	0	1 (2.1%)
26	Drug Dependence	2 (3.5%)	0
27	Alcohol Dependence	9 (15.8%)	8 (16.7%)
28	Pregnancy	2 (3.5%)	1 (2.1%)
29	Low Self-Esteem	7 (12.3%)	8 (16.7%)

30	Inappropriate Means of Expressing Anger	9 (15.8%)	3 (6.2%)
31	Unrealistic Expectations of Child	13 (22.8%)	0
32	Unrealistic Perceptions of Child	0	0
33	Socialization Skills	7 (12.3%)	0
34	Social Isolation	3 (5.3%)	4 (8.3%)
35	Home Management Skills	17 (29.8%	2 (4.2%)

As can be seen in Table 6-3, CPS clients are reported to have more associated problems (an average of 3.02 problems per case) than the non=CPS client group (1.96 per case). In this case, the data may be interpreted as reflecting the actual differences between the two groups, since all data was obtained from the same source - Department of Mental Health records.

The most frequently occurring problems for the Child Protective Services clients are marital conflict, lack of home management skills, unrealistic expectations of the child, psychiatric disorders and alcohol dependence.

For the non-CPS client group, the most frequently mentioned problems were marital conflict, spouse abuse, psychiatric disorder, low self-esteem and alcohol dependence.

Child-centered problems were noted in only 4 cases (8.3%) in the non-CPS sample; while noted as common contributory problems for the CPS sample. This difference is undoubtedly due to the fact that by definition, all families in the CPS sample have children, while 14 (29.8%) of the cases in the non-CPS sample do not have

children under the age of 18 living in the home (4 cases did not have available data on family composition).

Marital Conflict is a frequently mentioned problem for both groups. Alcohol dependence was noted for 16.7% of non-CPS referrals and 15.8% of the CPS cases. Psychiatric disorders are also common problems for both, occurring in 18% of the CPS sample and 27% of the non-CPS sample.

In general, CPS clients appear to be a more problem-beset client group than non-CPS referrals. However, the major problems of both groups are essentially similar: marital conflict, alcohol dependence, psychiatric disorders are common in both groups. Lack of Home Management Skills is reported, however, as a major problem for only the CPS client group, as is also true for child-centered problems.

6.3 Recommended Services

The most frequently recommended services for the CPS referrals to the Family Crisis Program were Individual Therapy (45.6%), Marital/Family Therapy (52.6%) and Psychiatric Evaluation (35.1%). These services are consistent with the dominant problems associated with this group: problems primarily requiring counseling and therapy as remedies. Table 6-4 indicates the comparative frequency of recommended services between the CPS sample and the Family Crisis Program non-CPS cases.

As can be seen in this table, Individual and Marital/Family Therapy were the most frequently recommended services for both groups with non-CPS cases being somewhat more likely to be recommended for individual therapy and group therapy.

Parent Education training and training in Home Management skills are also seen by the Family Crisis Program as more necessary to the CPS client group.

TABLE 6-4

Comparison of Recommended Services:
Child Protective Services and
Non-CPS Referrals to the Family Crisis Program

	Recommended Services	CPS Referrals N = 57	Non-CPS Referrals N=48
1	Educational Testing	4 (7%)	1 (2.1%)
2	Psychiatric Evaluation	20 (35.1%)	5 (10.4%)
3	Health Screening	6 (10.5%)	0
4	Health Treatment	4 (7%)	2 (4.2%)
5	Homemaker or Public Health Nurse	5 (8.8%)	2 (4.2%)
6	Home Management	11 (19.3%)	1 (2.1%)
7	Day Care	2 (3.5%)	0
8	Crisis Nursery	0	0
9	Legal Services	0	1 (2.1%)
10	Housing Improvement	4 (7%)	0
11	Employment Related	0	1 (2.1%)
12	Debt/Budget Management	4 (7%)	1 (2.1%)
13	Parent Effectiveness Training	14 (24.6%)	0
14	Individual Therapy	26 (45.6%)	26 (54.2%)
15	Marital/Family Therapy	30 (52.6%)	19 (39.6%)
16	Other Group Therapy	0	7 (14.6%)
17	Play Therapy	1 (1.8%)	0
18	Day Treatment (Child)	0	0
19	Drug/Alcohol Treatment	7 (12.3%)	4 (8.3%)

6.4 Engagement Rates

DMC's evaluation of the Child Abuse Community Centers Program demonstrated that the intensive outreach efforts provided by the projects resulted in significant improvement in client engagement in therapeutic services compared to normal CPS service delivery.

Therapeutic intervention is seen by Child Protective Services workers as a primary service need for the vast majority (70%) of their clients. However, denial of the existence of emotional and relational problems is characteristic of this client population.

DiBernardo Management Consultants' analysis of 341 New York State Child Protective Services cases (CANTS project) resulted in the finding that only 13% of clients referred for marital/family therapy, and 22% of those referred for individual therapy ever completed the recommended service. Individual therapy was never even initiated by 36.6% of those referred; nor by 49.6% of those referred for marital/family treatment. The reasons for this poor rate of engagement and participation in these most frequently recommended services were almost exclusively client-centered. Denial of the existence of a problem, refusal of service and poor follow-through on referrals accounted for generally all of these cases. The CPS client is typically described as hostile, resistant and unmotivated, with client resistance creating a major barrier to effective service delivery.

The majority of clients referred to the Family Crisis Program by agencies other than CPS, however, have voluntarily sought help for their problems. (The six cases referred by the Department of Probation presumably are 'non-voluntary' referrals.) The DMC team examined differences in engagement for the Family Crisis Program CPS and non-CPS clients. Engagement in this context is operationally defined as client agreement and participation in recommended project services. Information obtained by the Department of Mental Health regarding the length of elapsed time between referral and engagement was employed as the data base. The length of elapsed time may be considered as an indicator of client resistance to engagement.

As can be seen by examination of Table 6-5, the mean number of elapsed days was 21.89 days for CPS referrals and 13.83 days for non-CPS referrals.

TABLE 6-5

Elapsed Time: Date of Referral to Date of Engagement
Family Crisis Program; CPS vs. Non-CPS Referrals

Length of Time Referral to Engagement	CPS Referrals	Non-CPS Referrals	Total
10 days or less	3 8.6%	22 62.9%	25 35.7%
11-20 days	13 37.1%	6 17.1%	19 27.1%
21-30 days	13 37.1%	5 14 3%	18 25.7%
More than 30 days	6 17.1%	4 11.4%	10 14.3%
	N=35	N=35	N=70
Missing Data	15	15	30
	$\bar{X}$ = 21.89 days	$\bar{X}$ = 13.83 days	

Sixty-three percent (22) of the non-CPS referrals to the program were engaged in recommended services in 10 days or less, while only 8.6% (3) of the CPS referrals had been engaged in that time.

The available data confirms the fact that CPS referrals can be expected to require more effort expended by staff in the attempt to engage the client in the recommended services. Both projects consider that home visits are a vital component of their services. Such home visits are a primary service need in the endeavor to actively engage a client in therapy, and this component of services delivery answers to the specific need of the CPS client population.

6.5 Diagnostic Evaluations

By the last quarter of the first year of operation, the staff of both the South Nassau Communities Hospital and the North Shore University Hospital Family Crisis Programs commented upon the high incidence of severe psychopathology they were observing in their client population.

As diagnostic evaluations are a component of the services offered by both projects it was possible to turn to current project records for diagnostic information to examine the nature of psychiatric disturbance among clients referred to the program. The projects provided the DMC team with diagnoses for both children and adults within the original sample chosen from their respective caseloads. Family Crisis Program staff told the DMC team that it often takes weeks or even months to gain a clients' permission to conduct psychological or psychiatric testing and to complete assessments.

The information discussed below was provided in February, 1980 and represents the most comprehensive and current diagnostic information available. Diagnostic evaluations were provided for 113 adults and 85 children enrolled in the Family Crisis Program. It is not possible to compare the diagnoses of FCP clients to the control group or original Community Centers clients, since such data was not routinely available for these groups.

A summary tabulation of diagnoses indicated that the incidence of psychiatric disorders of adults within the FCP is comparable to available estimates for the general CPS population. Tabulations for adult clients showed

- 22.5% of clients suffer from a severe psychiatric disturbance categorized as either Psychosis or Borderline Personality.
- 33.64% of clients have a Character/Personality Disorder.
- Non-CPS Referrals and CPS Referral clients present very comparable percentages of all categories of psychopathologies.

A questionnaire survey of New York State Child Protective Services caseworkers conducted by DiBernardo Management Consultants in 1978 indicated that in their judgement, 34% of all adult clients had Psychiatric Disorders. This estimate was not based on diagnostic evaluation, however, but on caseworkers' judgement and experience. Given this estimate of 34%, the 22.5% figure for psychosis/borderline personality in Family Crisis Program clients appears to fall within the parameters of the general CPS population. While caseworkers judgements and diagnostic tests are not comparable measures, the indications are that there is a fairly high level of psycho-

pathology within the CPS client population, and that mental health services are seen by CPS workers as a primary service need for the majority of clients.

It appears appropriate, therefore, that programs offering services to this client population place primary emphasis upon professional therapy/mental health counseling as is the case in the Family Crisis Program.

A summary tabulation of diagnoses for children served by the Family Crisis Program indicated:

- 8.34% have Developmental/Learning Disorders
- 7.06% have Depressive Neuroses/School Phobia
- 7.06% have Character/Personality Disorders
- 65.88% have Transient Situational Disorders/ Adjustment Reactions
- Children in families referred by Child Protective Services had a higher incidence of serious disturbance than did the Non-CPS referrals.

6.5.1 Diagnostic Classifications

The data have been tabulated to compare the Child Protective Services and Non-Child Protective Services referrals within each project, as well as to show the characteristics of the entire population served by the Family Crisis Program. Since some diagnostic classifications differ for adult and child populations separate classifications are presented.

For the purpose of this analysis, adult evaluation classifications include Psychosis, Borderline Personality Disorder, Neurosis, Character/Personality Disorder and Transient Situational Reaction.

A Psychosis is considered as the most severe disturbance and includes such chronic, incapacitating conditions as Manic-Depression and Schizophrenia. To illustrate the specific characteristics of the adult population the diagnosis of Borderline Personality is tabulated as a separate category. The presence of a diagnosis of either psychosis or borderline personality indicates a severe degree of psychopathology likely to require long-term, intensive therapeutic involvement.

The category of Neurosis in the adult tables is used in the traditional sense and includes evaluations such as Neurotic Depression, Obsessive/Compulsive, Phobia, etc. Character/Personality Disorders diagnosed included schizoid, hypomanic, inadequate, hysterical, explosive, anti-social, passive/aggressive and dependent personalities. The specific diagnosis of alcohol abuse occurred frequently.

The evaluation classifications for children are more numerous. In addition to the six classifications for adult psychopathologies the categories of Developmental/Learning Disorder, Hyperkinesis, Mental Retardation, and Behavioral Disturbances were noted. The classification of Neurosis is limited to the two specific diagnoses of depressive neurosis and school phobia.

6.5.2 Adult Population: Diagnostic Evaluation

Tables 6.6 and 6.7 illustrate the characteristics of the 113 adults diagnosed by the Family Crisis Program. These adults

represent 85 separate cases or families. A comparison of the diagnostic evaluations of the 63 adults referred from Child Protective Services and the 50 adults referred from agencies other than CPS shows the classification by category to be generally similar. Specifically:

- 9.52% CPS referrals have a diagnosis of Psychosis, as compared to 16.0% Non-CPS referrals
- 9.52% CPS referrals were classified as a Borderline Personality Disorder as compared to 10.0% Non- CPS referrals
- 23.81% CPS referrals presented with Neurosis and 24.0% Non-CPS referrals were classified as Neurotic
- 41.27% CPS referrals have a Character/Personality Disorder as compared to a 34.0% incidence in Non-CPS referrals.
- 15.88% CPS referrals were categorized as having Transient Situational Reactions as compared to 16.0% of the Non-CPS referrals.

TABLE 6.6

Diagnostic Evaluations of Adults
CPS Referrals Cases N = 46
Adult Individual N = 63

	South Nassau N = 29			North Shore N = 34			Family Crisis Program N = 63		
	M	F	TOTAL	M	F	TOTAL	M	F	TOTAL
Psychosis	1 10.0%	1 5.3%	2 7.0%		4* 19.0%	4 11.8%	1 4.3%	5 12.5%	6 9.5%
Borderline Personality Disorder	2 20.0%	3 15.8%	5 17.2%		1 4.8%	1 2.9%	2 8.7%	4 10.0%	4 9.5%
Neurosis	3 30.0%	2 10.5%	5 17.2%	3 23.1%	7 33.3%	10 29.4%	6 26.1%	9 22.5%	15 23.8%
Character/Personality Disorder	1 10.0%	8 42.1%	9 31.0%	9 69.2%	8 38.1%	17 50.0%	10 43.5%	16 40.0%	26 41.3%
Transient/Situational Reaction	3 30.0%	5 26.3%	8 27.6%	1 7.7%	1 4.8%	2 5.9%	4 17.4%	6 15.0%	10 15.9%
TOTAL	10	19	29	13	21	34	23	40	63

* One adult female classified as Manic-Depressive with Schizoid & Depressive features and Mental Retardation is included in this category.

TABLE 6.7

Diagnostic Evaluations of Adults
Non-CPS Referrals Cases N = 39
Adult Individual N = 50

	South Nassau N = 38			North Shore N = 12			Family Crisis Program N = 50		
	M	F	TOTAL	M	F	TOTAL	M	F	TOTAL
Psychosis	2 16.7%	4 15.4%	6 15.8%	1 20.0%	1 14.2%	2 16.7%	3 17.6%	5 15.2%	8 16.0%
Borderline Personality Disorder	1 8.3%	1 3.8%	2 5.3%		3 42.9%	3 25.0%	1 5.9%	4 12.1%	5 10.0%
Neurosis	2 16.7%	6 23.1%	8 21.0%	1 20.0%	3 42.9%	4 33.3%	3 17.6%	9 27.3%	12 24.0%
Character/Personality Disorder	7 58.3%	8 30.7%	15 39.5%	2 40.0%		2 16.7%	9 53.0%	8 24.2%	17 34.0%
Transient Situational Reaction		7 26.9%	7 18.4%	1 20.0%		1 8.3%	1 5.9%	7 21.2%	8 16.0%
TOTAL	12	26	38	5	7	12	17	33	50

It is interesting to note that when the categories of Psychosis and Borderline Personality are combined 26.0% of the Non-CPS referrals were categorized as "Severely Disturbed" as compared to 19.04% of the CPS referrals. The Non-CPS referrals in the North Shore project are exclusively battered spouses and their families. Diagnostic evaluations of these individuals account for 38.46% of the Psychotic evaluations on Non-CPS referrals, with females accounting for 30.77% of these evaluations. This information seems to suggest that spouses who are battered frequently suffer from severe disturbances, confirming the project's general theoretical approach. In the viewpoint of the family systems theorists, all members of a family contribute to maintaining family dysfunction and, hence, the victim of violence is as much a part of the pathological system as the aggressor, and equally likely to exhibit pathology.

Another interesting characteristic of the adult population is highlighted in the diagnosis of individuals classified as Neurotic. Neurotic depression was the diagnostic evaluation most frequently used and described 22.50% of all females in the Family Crisis Program CPS referral group and 24.24% of the females in the Non-CPS group. Approximately one quarter of the female referrals seen suffer from neurotic depression. The large number of women presenting with this problem could lend direction to planning specific treatment services for this group. In contrast only 2 men in the entire sample population were classified as having Neurotic depression.

Project staff have commented on the large number of adult clients who have the problem of alcohol abuse. These individuals are accounted for in the category of Character/Personality Disorders. To obtain a more exact count of the incidence of alcohol abuse separate tabulations were conducted for this category. These tabulations, showed that 23.07% of the males and 4.76% of the females diagnosed in the North Shore project CPS referrals presented with the problems of alcohol abuse. In the Non-CPS referral group 20% of the males and no females were diagnosed as alcoholics. This is in contrast to the individuals diagnosed at the South Nassau project where none of the GPS referrals, 25% of the male and 3.85% of the female non-CPS referrals were classified as alcoholic. The overall incidence of diagnosed alcoholism for the Family Crisis Program is 7.96%. This figure may not reflect the true incidence of alcoholism occurring in families served by the projects as it is expected that many

of the individuals with this problem will not even come to the program for treatment or consent to diagnostic testing.

Comparisons of the diagnosed psychopathology of the adult clients served by the two project sites show

- 14.71% of the North Shore CPS referrals were diagnosed as Psychosis or Borderline Disorder while 24.13% of the South Nassau CPS referrals received these diagnoses.
- 21.05% of the South Nassau and 41.66% of the North Shore clients referred by sources other than CPS were diagnosed as Psychotic/Borderline Personality.
- the largest proportion of adults in both referral groups from both project sites were diagnosed as having a Character/Personality disorder.

In summary, it appears that approximately 20% of the clients served by both projects may be diagnosed as severely disturbed, Character/Personality Disorders are displayed by 35.82% of the South Nassau adult population and 41.30% of the North Shore adult clients.

6.5.3 Child Population: Diagnostic Evaluations

The characteristics of the 85 children diagnosed by the Family Crisis Program appear in Tables 6.8 and 6.9. These children represent 48 cases or family groups. The tabulation of emotional disturbances of all children diagnosed shows:

- 9.41% as Psychotic or Neurotic
- 12.94% display either Behavioral or Developmental/Learning Disorders

TABLE 6.8

Diagnostic Evaluations of Children
CPS Referrals Case N = 34
Child N = 63

	South Nassau N = 30				North Shore N = 33				Family Crisis Program N = 63			
	M	F	NG	TOTAL	M	F	NG	TOTAL	M	F	NG	TOTAL
Psychosis	1 16.7%	-- --	-- --	1 3.3%	1 7.7%	-- --	-- --	1 3.0%	2 10.5%	-- --	-- --	2 3.2%
Depressive Neurosis/ School Phobic	-- --	1 9.1%	-- --	1 3.3%	2 15.4%	2 15.4%	-- --	4 12.1%	2 10.5%	3 11.1%	-- --	5 7.9%
Character/Personality Disorder	-- --	3 27.2%	-- --	3 10.0%	1 7.7%	-- --	1 14.3%	2 6.1%	1 5.3%	4 14.8%	-- --	5 7.9%
Transient Situational/Adjustment Reactions	5 83.3%	4 36.4%	11 84.6%	20 66.7%	5 38.4%	8 61.5%	6 85.7%	19 57.6%	10 52.6%	12 44.5%	17 100.0%	39 62.0%
Developmental/ Learning Disorder	-- --	2 18.2%	-- --	2 6.7%	1 7.7%	2 23.1%	-- --	4 12.1%	1 5.3%	5 18.5%	-- --	6 9.5%
Hyperkinesis	-- --	-- --	-- --	-- --	-- --	-- --	-- --	-- --	-- --	-- --	-- --	-- --
Mental Retardation	-- --	1 9.1%	-- --	1 3.3%	1 7.7%	-- --	-- --	1 3.0%	1 5.3%	1 3.7%	-- --	2 3.2%
Behavioral Disturbances	-- --	-- --	2 15.4%	2 6.7%	2 15.4%	-- --	-- --	2 6.1%	2 10.5%	2 7.4%	-- --	4 6.3%
TOTAL	6	11	13	30	13	13	7	33	19	27	17	63

TABLE 6.9

Diagnostic Evaluations of Children
NON-CPS Referrals Case N = 14
Child N = 22

	South Nassau N = 20				North Shore N = 2				Family Crisis Program N = 22			
	M	F	NG	TOTAL	M	F	NG	TOTAL	M	F	NG	TOTAL
Psychosis	--	--	--	--	--	--	--	--	--	--	--	--
	--	--	--	--	--	--	--	--	--	--	--	--
Depressive Neurosis/ School Phobic	--	--	--	--	--	1	--	1	--	1	--	1
	--	--	--	--	--	100.0%	--	50.0%	--	16.7%	--	4.5%
Character Personality/ Disorder	--	--	1	1	--	--	--	--	--	--	1	1
	--	--	25.0%	5.0%	--	--	--	--	--	--	20.0%	4.5%
Transient Situational/ Adjustment Reaction	9	5	3	17	--	--	--	--	9	5	3	17
	81.8%	100.0%	75.0%	85.0%	--	--	--	--	81.8%	83.3%	60.0%	77.4%
Developmental Disorder/Learning Disorder	--	--	--	--	--	--	1	1	--	--	1	1
	--	--	--	--	--	--	100.0%	50.0%	--	--	20.0%	4.5%
Hyperkinesis	2	--	--	2	--	--	--	--	2	--	--	2
	18.2%	--	--	10.0%	--	--	--	--	18.2%	--	--	9.1%
Mental Retardation	--	--	--	--	--	--	--	--	--	--	--	--
	--	--	--	--	--	--	--	--	--	--	--	--
Behavioral Distur/ bances	--	--	--	--	--	--	--	--	--	--	--	--
	--	--	--	--	--	--	--	--	--	--	--	--
TOTAL	11	5	4	20	--	1	1	2	11	6	5	22

- 2.35% were diagnosed as Mentally Retarded
- 2.35% to be Hyperkinetic

The most striking feature of the child evaluations is that the children referred by Child Protective Services have the larger portion of emotional disturbances. While the majority of the children in the CPS sample (68%), were diagnosed as evidencing either a Transient Situational/Adjustment reaction or a Behavioral Disturbance, a total of 18 children (29%) were reported as evidencing problems of a more serious nature (Psychosis, Neurosis, Character Disorder, or Developmental/Learning Disorder).

Although the non-CPS sample of children is considerably smaller, (N=22), the observation that only 3 children (13.6%) received similar "perious" diagnoses appears noteworthy.

The data, although inconclusive, suggests that children in families where child maltreatment is present suffer from more emotional/developmental disturbances than those in families involved in other forms of violence or crisis. The implication of this finding is that a real need exists for direct, therapeutic involvement with children of families referred by Child Protective Services. Traditionally, most programs serving CPS families have provided therapy for parents, rather than children.

6.5.4 Summary: Diagnostic Evaluations

The tabulations of diagnosis show that the largest proportion of adults serviced by the Family Crisis Program have Character/Personality Disorders and that many children seen in the projects suffer from acute emotional disturbances.

Programmatic implications of the data are that:

- Specific attention may be fruitful for the high percentage of women diagnosed as Neurotic Depressive.
- Treatment services for alcohol abuse is vital for many families. Outreach for alcoholic clients is a particular need. It may be possible to secure the cooperation of community agencies for alcohol abuse to provide these outreach services.
- Play therapy or psychotherapy are needed for many children served by the projects.

The severe psychopathology of many children and adults served by the Family Crisis Program cannot be overlooked. Seventy percent of the adults referred by CPS and diagnosed, suffered from either Psychosis, Neurosis or Character/Personality Disorders. Nineteen percent of the children referred by CPS have either a Psychotic, Neurotic or Character/Personality Disorder.

Many of these clients will require long-term rehabilitative efforts in order to achieve and maintain adequate family functioning. Supportive intervention of some kind may be required by many of these families for years. It is recommended that plans be made now for support services which these families can continue to receive after a period of one to two years of active involvement in the Family Crisis Program.

6.6 Summary and Conclusions

In order to examine the hypothesis that there are no real differences in contributing problems, rate of engagement and implied service needs, between CPS clients and clients referred by other agencies, an analysis was conducted of available data for 48 non-CPS referrals to the projects in comparison to 57 CPS referrals.

The results of these comparisons indicated that:

- The primary presenting problems for both groups are Marital Conflict, Psychiatric Disorders, and alcohol dependence.
- Child-centered problems, although occurring frequently for Child Protective Service cases, are not as common in cases referred by other agencies.
- The most frequently recorded reason for referral for non-CPS clients was Spouse Abuse which represented 37.5% of all referrals from other agencies.
- Individual Therapy and Marital/Family Therapy were the most frequently recommended services for both groups.
- Home Management Skills and Parent Education training are frequently recommended services for the CPS client group.
- Child Protective Services clients are reported to have more contributory problems than the non-CPS group.
- Among adult clients, CPS and non-CPS referrals present comparable rates of incidence of all categories of psychopathology.
- Children in families referred by CPS have a higher incidence of serious disturbances than do non-CPS referrals.

- The majority (62.9%) of non-CPS referrals required 10 days or less to become engaged in the required services, while only 8.6% of CPS clients were engaged in services in this time span.
- An average of 22 days elapsed between referral and engagement of CPS clients, while an average of 14 days was required to engage non-CPS clients.

The results of this analysis indicate that the major contributing problems and implied service needs are generally similar for all clients of the Family Crisis Program. However, CPS clients have some additional needs. They are more likely to exhibit child-centered problems, need training in home management and parenting skills and, additionally, require more time and effort on the part of project staff in order to become successfully engaged in therapeutic intervention programs.

Home visits are probably the primary initial service need of CPS clients in the effort to actively engage them in therapy. Therapeutic services for children are also needed for the CPS client population. In general, however, available data confirm the hypothesis that CPS clients and clients referred by other agencies are appropriately served within the same model of service delivery.

7.0 CASE STUDIES

In order to provide the reader with an understanding of the variety of problems and required services which the Family Crisis Program addresses, each project selected a sample of typical cases for which detailed case histories were prepared. One case from each project was selected as representative of each of the case types defined in the CPS typology (discussed in Section 5.1) and one case which is typical of a non-CPS referral. These case histories describe in narrative form the family situation and nature of project involvement as well as progress to date and future treatment plans.

7.1 North Shore University Hospital

7.1.1 Case Study 1-Type I: "Neglect"

Lynne is a young single parent who is overwhelmed by the responsibility of caring for her two school-age children. Her son is hyperactive and requires a strict regimen of medication, while her daughter's teacher reports that the girl has severe learning problems. Child Protective Services became involved when the school reported Lynne did not follow through on an eye examination for her daughter or supply appropriate medication for her son. In addition to these charges, the CPS worker's subsequent visit to the home revealed an apartment infested with vermin, and dirty enough to be a health hazard.

When the primary worker from NSFCP first visited Lynne, her apartment had been newly cleaned. The young mother was amenable to receiving help, agreeing to participate in home visits, pediatric examinations for her children, and a psychiatric evaluation for herself. Although Lynne was very cooperative in scheduling all treatment services, she has often arrived late and occasionally forgotten her appointment over the past seven months of engagement.

The Family Crisis Program's treatment plan for Lynne is two-fold; to encourage her to provide adequate medical care for her children; and, to be more realistic in expectations of herself and her family. These goals are being accomplished mainly through individual therapy with the primary worker.

The first treatment sessions with Lynne showed her to be an intelligent woman with impulsive, childlike behaviors and an underlying sense of depression. She fantasized about the exotic, romantic life that she could be leading and turned her fantasies into prose. This prose was used as a basis for reality testing in several therapy sessions. By centering on these writings the therapist and Lynne were able to explore the differences between fantasy and real possibilities for life. Lynne's feelings about her relationships with men and with her mother are also discussed. The NSFCP therapist has focused Lynne's attention on caring for herself, and even assisted in scheduling a gynecological examination.

Very structured, concrete assistance has been provided for Lynne in caring for her children. The local schools were contacted and asked to complete a Conner's Questionnaire[9] providing a profile of the children's behaviors and emotional growth, as well as to supply cumulative health and educational records. As a result, teachers are now involved in the treatment plan, informing NSFCP if Lynne's son does not have proper medication. Lynne was encouraged and supported in taking both of her children for medical and psychological testing. Parenting skills have been worked on by assisting this parent in setting limits for her children. The technique of providing a small reward for good behavior, such as allowing the children to ride their bicycles an extra half-hour when standards are upheld, was used successfully.

In a positive light, this young mother is consistently attending treatment sessions for the first time in her life. However, there are still many unresolved issues for Lynne to deal with, as well as the chance for her son to violently act out if not under medication. The Family Crisis Program staff feel that this family will need therapeutic intervention for many years.

7.1.2 Case Study 2-Type II: "Excessive Corporal Punishment"

The Q. Family are an intact middle class family with five

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9. Connor's Questionnaire is a behavioral checklist designed to be completed by schoolteachers, which provides a profile of children's behavior and developmental development.

teenage children. Mr. Q. holds a white collar position, and Mrs. Q. is a homemaker who states that she "loves kids". The family first came to the attention of Child Protective Services when the eldest child, a boy, was severely beaten by his father. The injured boy was found outside of the home and taken to the emergency room by the police. CPS contact documented an extremely rigid family who used the eldest son as a scapegoat for all family problems.

The Family Crisis Program's response was intervention by the primary worker, supplemented by home visits by the para-professional, and a complete psychological and psychiatric examination for the father, mother and abused son. Physicians, psychiatrists and the local school systems who were known to have been involved with the son was contacted for supportive documentation.

The first contact with the family was in the home, a spotlessly clean environment resembling "a picture from a magazine". In these surroundings the mother and father denied having any problems in their marriage, or in their relationship with their other children. This son was simply a "bad weed". The adolescent was openly ridiculed by his parents in the first sessions, but made no attempts to defend himself.

The ensuing psychiatric and psychological evaluations presented more information that contradicted the family's

presentation of themselves as the "All American" family. The parents were both categorized as "overdrawn stereotypes". The son who had long been diagnosed as hyperactive was shown to be mentally retarded, maladjusted, and to have a learning disorder as well. When confronted with these findings, the family denied their son's retardation, just as for years they had refused to acknowledge or treat his hyperactivity. The need to use this son as a scapegoat prevented them from recognizing his true problems.

Intense family therapy has focused on this family's need to show some support for their son. One treatment technique used was a "homework assignment", in which each family member was to say one positive thing to each other each day. As the deep-rooted inner conflict of the parents surfaced, their individual problems and marital troubles were discussed. In one session, as the mother was expressing distress and depression, her son interrupted, forcing the conversation to end and focus on him as a "troublemaker". An interesting dynamic was revealed; the son's need to fulfill his role and protect his mother.

Presently, the parents are refusing family therapy, as often happens when sessions become too revealing and anxiety levels increase. The goals of the NSFCP team are to keep the son engaged and prepare him for a trade or a job in a sheltered workshop. The NSFCP has succeeded in enrolling this adolescent in a BOCES program. No additional incidents of physical abuse

have occurred. However, verbal abuse has not abated, and project staff feel that the potential for the son to commit a violent act has increased. After nine months the family situation is still extremely volatile, and continued intensive therapeutic involvement is necessary.

7.1.3 Case Study 3-Type III: "Severe Physical Abuse"

The J. Family, a young Hispanic couple and their toddler children, was referred to the North Shore Family Crisis Program (NSFCP) by Child Protective Services. The family had first become known to CPS when their infant daughter, then the only child, was admitted to the hospital with a large, unexplained burn. Soon thereafter the infant was adjudicated neglected, but remained in the home under DSS supervision. During this period the parents gave birth to a son, whose arrival was welcomed, as the father had often expressed disappointment that his first child was a girl. When the case was referred to NSFCP the parents were sporadically attending court ordered treatment at another facility. They were reported as being highly resistant to therapy and not progressing.

At the Family Crisis Program, a three-pronged approach consisting of family therapy with the primary worker, extensive involvement of the bilingual para-professional, and diagnostic interviews, conducted by the program coordinator/psychiatrist was instituted. The daughter was shown to be of average mental development and alert, although initially wary of contact.

Both the young mother and father were found to be somewhat immature, withdrawn, and anxious. It was noted that the mother was working toward a higher standard of living and might have objectives and priorities about job and family that differed from her husband's. The para-professional attended the interview with the father and assisted in translating, a service necessitated by his low English ability.

The first family session revealed that the couple were troubled by environmental stresses. The father worked evenings, the mother worked days. The young mother, now caring for two children, felt robbed of her adolescence and isolated. Having a limited knowledge of child rearing and housekeeping skills, she fell back on the help of her mother-in-law, whom she resented deeply. At the onset of therapy the mother showed little enjoyment in, or interaction with her children.

Concrete assistance was given by the primary worker who contacted the young man's employer and achieved a change in his working hours. The NSFCP team felt that the language barrier and the man's lack of seniority prompted this direct supportive action. Additional assistance was offered by the para-professional, who directed the family to low-rent community housing, offered counseling about birth control, provided a drivers manual to assist Mrs. J. in learning to drive, and located a day care center for the children.

Family therapy has utilized modeling techniques and counseling to help the couple express feelings and concerns to one another. The modeling sessions, through the use of play equipment, have focused on increased parent-child interaction.

Child Protective Services requested and received an extension of court ordered supervision for an additional year. The NSFCP team feel that this young couple has come to understand some of their inadequacies and anger and will not purposefully abuse their children again. Different expectations about child rearing and a woman's role are currently being explored. The general prognosis calls for an increasingly stable family.

7.1.4 Case Study IV: "Spouse Abuse"

One evening Mr. H. became intoxicated, beat his wife, and then blacked out. This had happened before, but this time Mrs. H. called the police. Although Mrs. H.'s intention was to obtain an Order of Protection, the case went to criminal court. Mrs. H. found herself pressing criminal charges, something she never meant to do. The judge ordered the husband to attend treatment sessions at TASC (Treatment Alternatives to Street Crime) to control his violent behavior. Less than one month later, the Public Health Nurse who had been assisting the family in coping with their young son's chronic, life threatening medical condition, referred them to the Family Crisis Program.

At the initial home visit made by the NSFCP worker the family discussed their home circumstances and the instances of battering. The violent episodes reportedly occurred only when Mr. H. was intoxicated, the only times he could express his negative feelings. The couple has four young children, and Mr. H. works long hours and overtime to help defray the costs of medical care for their son. The initial impression of the primary worker has been validated over the seven months of treatment (this couple is in need of parenting).

The social summary prepared by the worker and the diagnostic interview conducted by the psychologist confirmed this impression. Mrs. H. did not receive supportive nurturing from her mother and left home as an adolescent. She scarcely knew her father. A history of substance abuse and destructive relationships with men was reported as well. This is Mrs. H.'s second marriage, she is depressed and has an inability to sustain close relationships. A diagnostic interview showed Mr. H. to be somewhat depressed and withdrawn, having little control over his environment and little ability to express his true feelings. The goals of the FCP are for Mr. H. to achieve complete abstinence from alcohol, and express himself verbally instead of physically. Goals for Mrs. H. are to take more responsibility for her actions and to improve her parenting skills.

Intense family therapy with the primary worker has been the main treatment modality. (The para-professional has not been involved in cases of spouse abuse when child abuse is not present). The couple is always seen with their children due to the medical needs of their son, and the children actively participate in some treatment sessions. Mrs. H.'s past history of leaving the family ("running away") and Mr. H.'s inability to verbally confront his wife with his anger and hurt over these incidents have been discussed. Mr. H. has begun, gradually, to express his need for support and nurturing.

7.2 South Nassau Community Hospital

7.2.1 Case Study 1-Type I: "Neglect"

Claire, a teenage mother of two, was referred to the South Nassau Family Crisis Program by Child Protective Services after her children were removed by a court order. Claire's father deserted her mother when Claire was very young. Her relationship with her mother was somewhat tense, but not excessively hostile. In her middle teens Claire was drugged and raped by a man in his mid-thirties. This was her first sexual experience. The outcome was Claire's pregnancy and subsequent birth of her twins. Claire remained at home with her mother during her pregnancy, and continued living at home after her children were born. During this time she entered into a relationship with Sam. After about a year of seeing Sam, Claire and the two children moved into Sam's three room apartment.

Child Protective Services received several complaints about Claire's care of her children while living with Sam. These complaints included such allegations as: The children being left alone in a car; a dirty and disorganized house; the children having diaper rash; and, Claire being suspected of using drugs. Finally, the children became very sick for the second time and had to be hospitalized for bronchitis and pneumonia. Doctors at the hospital stated that they felt the real cause of the children's illness was neglect.

The Social Worker from CPS made several visits to Claire and Sam's home and continually offered homemaker and day care services. Sam would not allow Claire to accept these services. Due to Claire's lack of receptivity to services and commitment to caring for her children, the court ordered the placement of the children in Foster Care. The Court also ordered Claire to move out of Sam's apartment as a condition for the return of her children.

Claire obtained her own apartment and visited her children in Foster Care several times. The Foster mother related that Claire did not seem interested in caring for her children. While in the Foster mother's home Claire would stand and watch as the Foster mother fed, bathed and clothed the children. Claire did not interact very often with the children.

Incorporated into the court order removing Claire's children were two conditions to which Claire had to adhere. One

was involvement with the Family Crisis Program; the other was attendance at the Parent and Child Training Program (PACT), which is part of the Family Service Association in Hempstead, New York. This program receives referrals from various segments of the community including self referrals, CPS, and the Family Crisis Program in South Nassau.

Claire's involvement with PACT began by attending group sessions once a week with other mothers whose children have been removed by a court order. These sessions focused on sharing of frustrations, discussions about parenting skills, and child development information. Claire continued her attendance at these group sessions after her children returned home. She took the children with her to group therapy. The program has a cooperative nursery; therefore, while Claire was in her group session, the children attended the nursery. In addition to group sessions and the cooperative nursery, the PACT workers also made home visits. For Claire these home visits included being transported to appointments and to complete errands, and help in running her household.

When Claire was first seen by the Family Crisis Program, her appearance was disheveled. During her initial interview Claire expressed a willingness to become involved in the therapy and a desire to have her children returned. A para-professional from the FCP went to Claire's home twice a week; these sessions focused on assertiveness training. She was also seen on a

weekly basis in her home by a Social Work Therapist and worked 10 hours a week at one of the county agencies.

Within a few months Claire's children were returned to her. She was able to maintain the house as well as care for the children and continue her employment. At the time the children were returned Claire was pregnant with Sam's child. Her FCP worker suggested homemaker service to Claire and Claire agreed to the services.

During her bi-weekly sessions with the para-professional, Claire expressed her fear of the homemaker and inability to express which areas she wanted help with. After several "role plays" with the worker, Claire was less intimidated by the homemaker and better able to express herself.

Claire's treatment program included attending the PACT program and seeing a social work therapist on a weekly basis, and receiving assistance from the homemaker three times a week. With this assistance Claire showed a great deal of improvement. She was working 10 hours per week, and her appearance was neat and clean. Her home was well kept and the children were fed complete meals regularly.

During a therapy session Claire mentioned that she had been assigned a new CPS worker and that she was afraid of the worker. Claire was afraid that the worker would come to her home unannounced, that her home would not meet the worker's

expectations, and that her children would be removed again. Claire also stated that when she visited her children in the Foster home she did not offer to bathe, feed or clothe them for fear that the Foster mother would disapprove of what she did. Claire was aware that her children had been removed because she was seen as neglectful and she was afraid that anything she did would contribute to that perception. By expressing her fears during therapy, Claire and her therapist were able to work out these fears and Claire developed a more positive self image.

As time passed, Claire mentioned that she was overwhelmed by the schedule of services she was receiving. After a case conference between the Family Crisis Program and Child Protective Services, an agreement was reached to reduce the levels of service to Claire. The homemaker hours were reduced and the para-professional hours were reduced to once a week. Claire stopped going to the PACT program, but continued in therapy once a week.

Claire gave birth to Sam's baby and they are planning to get married in a few years when Sam has a better job and can afford to support a family. Claire and Sam are being seen as a couple in therapy. Sam helps with the care of the children when he visits Claire. Claire has become less shy and more assertive. She has been seen by either a therapist or a para-professional for 38 home visits. Therapy continues and Claire is taking good care of her children.

7.2.2 Case Study 2-Type II: "Excessive Corporal Punishment"

Susan, a 17 year old, was referred to the South Nassau Family Crisis Program by Child Protective Services. She had contacted Child Protective Services requesting help after her father had beaten her on several occasions. CPS opened a service case for Susan and referred her to the Family Crisis Program.

Susan is the third child in a family of four; she has two older sisters and a younger brother. Her father is abusive to her mother, and he was also abusive to her older sisters who married at an early age in order to leave home.

Susan has a boyfriend who is eight or nine years older than she. They lived together for a few months until Susan returned home to live with her parents. Generally, Susan feels isolated, depressed, angry and insecure. Her grades in high school are "B" and "C", and she has continued her education despite her disruptive home life.

Family therapy was discussed with Susan, resulting in she and her mother attending one session together. However, Susan felt that individual therapy would be more helpful and, therefore, she was seen on a weekly basis for nine months (23 sessions). During the course of therapy it became clear that while Susan's parents were rigid and not terribly accepting of her, Susan also played a role in the family conflict.

Her depression stemmed from her expectation that she should be all loving and forgiving of her parents. When she expressed any "bad" feelings towards her parents she would become depressed. She also felt responsible for the family conflicts and needed to learn realistic expectations of her parents while simultaneously accepting her own anger with them.

By the time Susan terminated therapy she was about to graduate from high school and was planning to attend college. She had resolved her feelings of anger and hostility, had gained control of her own explosive behavior, had become more accepting of her parents limitations, and she had learned to control her provocative behavior. Her father's physical attacks had stopped and his verbal abuse of Susan had decreased substantially. Susan was feeling good about herself and optimistic about her future.

7.2.3 Case Study 3-Type III: "Severe Physical Abuse"

Miss W. and her common law husband Mr. L. were referred to the South Nassau Family Crisis program by Child Protective Services. At the time of referral one of the couple's two children had been removed by court order due to a finding of credible evidence of child abuse. The child was placed with Miss W.'s mother.

Miss W. and Mr. L. have known each other since childhood. Miss W. is approximately four years younger than Mr. L. Mr. L.

married another woman while he was in his late teens or early twenties, and has three children from that marriage. These children reside with Mr. L.'s estranged wife. Upon separating from his wife, Mr. L. returned to his childhood neighborhood and began dating Miss W. Subsequently, Miss W. became pregnant and the couple moved into their own apartment. They are now in their mid-forties.

They describe their first child, a girl, as frail, easily bruised and frequently injured during play. Their daughter exhibited some learning problems and needed to be placed in a special education class. At the same time, the young girl also began to fantasize and tell stories.

A neighbor living in the same building as Miss W. and Mr. L. reported to CPS that the girl had been thrown down a flight of stairs by her father. The CPS investigation revealed that several family pets had died; one of a broken back, that the mother beat her children with a hot spoon, and that the child had several bruises on her body. As a result of this investigation, the court ordered in-home supervision for their younger child, a boy, and removal of their daughter to her maternal grandmother's home. Initially, the couple agreed to placing their daughter with her grandmother.

When the couple was seen by the South Nassau Family Crisis Social Work Therapist they denied abusing their child and agreed

to therapy in order to have their child returned. Although they were willing to engage in therapy they were not willing to go to the FCP office. Family therapy took place in their home for several months on a weekly basis.

During these sessions Miss W. revealed that she was beaten by her mother as a child. She also related that she remembers seeing Mr. L.'s father chasing Mr. L. down the street with a baseball bat when they were children. The FCP Social Worker describes Miss W. as dependent and isolated. When this is discussed with Miss W. she denies her isolation and states that she is comfortable staying at home cooking and cleaning.

Mr. L. related that he was beaten as a child by his father. He works as a laborer, is seeking a second job, and also serves in the volunteer ambulance corps for his town. Although the neighborhood in which he lives has deteriorated, he does not want to move because he lives one block from the ambulance corps headquarters. He has legally changed his son's name to his own, while his daughter still retains Miss W.'s name. He has recently divorced his wife and states that he does not want to think about marriage to Miss W. until the situation with CPS is resolved. The therapist views Mr. L. as the dominant person in the couple's relationship. He discourages Miss W. from becoming independent, seems to have an explosive temper, and some hostility towards women.

Miss W. and Mr. L. questioned the care their daughter was receiving at her grandmother's home. They also stated that their daughter asks to come home during telephone conversations they have with her and that she cries when their CPS supervised visits end. They feel she is being spoiled, which creates problems for them during their visits with her. They find that their daughter is becoming difficult to control and that she does not obey them.

The CPS worker, however, reports that the child is pleased to see her parents during visits, but is not unhappy when the visits end. Recent tests administered by the Department of Forensic Psychology shows an improvement in the child's educational functioning. She has been placed in a regular class, and did so well in Math that she is in an advanced Math class.

The primary area of concern to Mr. L. and Miss W. during their nine months in therapy was the return of their daughter while continually denying any physical abuse of the child. They related that there were no conflicts in their relationship. During the course of therapy Miss W. and Mr. L. made overtures for a family reconciliation to Miss W.'s mother; these efforts were well received and the couple felt good about this.

Miss W. and Mr. L. have petitioned the Court for their daughter's return. However, the Court ordered continued placement of the child and continued in-home supervision for their son.

The FCP therapist is in the process of establishing a new therapeutic contract with Miss W. and Mr. L. To date, the couple have denied the abuse for fear that if they discuss it, they will never see their daughter. However, by not discussing the abuse and the feelings associated with it, they still do not have their daughter. Therefore, the therapist will approach them to make a commitment to therapy by coming to the office and beginning to talk about the abuse of their daughter.

7.2.4 Case Study 4: "Spouse Abuse"

Mrs. S. was referred to the South Nassau Family Crisis Program by the South Nassau Mental Health Clinic. During her initial interview Mrs. S. related that her husband drank a great deal and was physically abusive to both her and the children.

Mrs. S. is married for the second time. Her two children from her previous marriage are living with her former husband. However, Mr. S.'s children from his previous marriage are living with the S.'s. One of those children displays bizarre behavior, consequently, Mr. S. responds by striking the child. The S.'s. have separated once in their 7½ years of marriage. Divorce was seriously considered during this separation; however, the S.'s are now reconciled.

Mrs. S. presented herself as anxious and tense. She was receptive to therapy and was seen individually for 17 sessions. During this time she obtained a part-time job, left her husband, contacted a lawyer and filed for divorce. Within two weeks of leaving her husband they reconciled.

Mr. S. was also seen in individual therapy. He denied physically abusing his wife and stated they both drank. He has a history of several arrests, a long term problem with alcohol abuse, and was in a gang as a teenager. His therapist describes him as not having any guilt and having a somewhat impulsive personality. He projects the blame for any problems in the relationship on his wife and expects her to stop any of her behavior which may cause conflicts between them. Mr. S. was motivated to attend therapy because he did not want his wife to leave him.

After their reconciliation, the S.'s began marital therapy while Mrs. S. continued in individual therapy. The focus of this therapy has included alternative ways of communicating with their children. The S.'s have been exploring ways of tolerating feedback from their children. For example, when one parent criticizes one of the children, the child is encouraged to express his/her view as to whether the criticism was seen as aggressive or assertive. The parents are also using a cognitive approach to parenting. During feedback sessions

with the children they are employing such cognitive coping statements such as; "its O.K. to be wrong", "I can be imperfect", and "I'm only human", when referring to themselves.

Another area of focus in therapy for the S.'s is their relationship. The S.'s have diligently completed such therapeutic homework assignments as complimenting each other and keeping individual weekly records of the situations, environment, and circumstances under which they experienced negative feelings. They are also learning active listening, and how to lend support to each other.

At the present time the S.'s continue in therapy. They attend sessions regularly, complete their therapeutic homework assignments, and Mr. S. no longer abuses his wife. Future therapy will be family oriented. The S.'s and their children will be seen together. Work will continue to focus on reducing the frequency of negative verbal interactions among the family members.

8.0 ANALYSIS OF LONG-TERM OUTCOME FOR ORIGINAL COMPARISON GROUPS

Data collection for DMC's evaluation of the Child Abuse Community Centers Program was completed in August, 1977. The data base for the original evaluative comparison groups has been updated to provide a longitudinal view of long-range outcome measures. Table 8.1 depicts the significant CPS events which have occurred involving these cases since August, 1977.

As can be seen in Table 8.1, the original sample of project cases have had higher rates of reportable recurrences of abuse/neglect, case reopenings and children removed subsequent to August 1977 in comparison to the control group. While this unexpected and disappointing finding cannot be completely explained, several alternative possibilities exist.

- The specialized rehabilitative services offered by the projects, as demonstrated in DMC's original evaluation, were successful in reducing recurrences of abuse/neglect as well as consequent removals of children from the home. However, it is possible that such intervention strategies do not produce sufficient qualitative change in family functioning to ensure adequate parenting without the on-going support of rehabilitative intervention. That is, when project involvement ceases, family functioning may deteriorate to unacceptable levels if support services are not provided by other community agencies.

- An alternative possibility is that the cases selected for referral to the projects constituted specific sub-set of CPS cases, which by their nature, may require therapeutic intervention for many years. If this is so, the closing of the projects may have represented a premature termination of services for this client group.

TABLE 8.1

Update of Original Comparison Samples

Case Status	N = 97 Community Centers Project Samples	N = 87 Original CPS Comparison Sample
Closed	62 (63.9%)	63 (72.4%)
Continuing Open	9 (9.3%)	13 (14.9%)
Re-Opened	4 (4.1%)	0
Placement Monitoring	12 (12.4%)	2 (2.3%)
Other (transferred out of area or unknows)	5 (5.2%)	9 (10.3%)
Child Removals Subsequent to 8/77	8 (8.2%)	6 (6.9%)
Child Returns Subsequent to 8/77	6 (6.2%)	4 (4.16%)
Additional CPS Report Subsequent to 8/77	11 (11.3%)	3 (3.4%)

It has not been possible to secure complete information regarding the characteristics of those Community Centers Cases which have resulted in additional activity by CPS since the closing of the projects at the end of 1977.

However, an interview was arranged with the former Director and Chief Social Worker of the Long Beach Project in order to gain some insight into the problems of these families. At this interview, sixteen Family Center cases which were still active with CPS were discussed. Both staff members were familiar with each case mentioned and described for the evaluation team the circumstances surrounding each case. The results of this informal interview are described in the following chart:

Family Circumstances		
Severe psychiatric disturbance	4	(25 %)
Severe social malfunction (homicide, suicide, criminality, prostitution)	5	(32.2 %)
Drug/Alcohol Addiction	3	(18.75%)
Severely handicapped or emotionally disturbed child	4	(25 %)
Parents never actively engaged or dropped out prematurely	7	(43.7 %)

In five cases severe socially disturbed or criminal behavior was involved (suicide, homicide, imprisonment, prostitution). Four clients were described as having severe psychiatric disturb-

ances, while four cases involved children with severe emotional problems. Drug or alcohol abuse was present in three cases. In four cases, the family, despite intensive outreach efforts, had never become actively engaged in the program, and three clients dropped out of the program prematurely.

It appears that in almost half (44%) of the Long Beach cases with renewed CPS activity, the project was never able to help the client because of the client's refusal to participate.

In the remainder of the cases, there appears to be evidence of such extreme levels of dysfunction, that it does not appear likely that parenting abilities could be maintained at a satisfactory level without continued, long-term, intensive therapeutic and supportive involvement. One single case, for example, involved long-term drug abuse, a fatal muscle disease and homicide.

It appears likely, therefore, that the fact that the long-term outcome of some Community Centers cases was somewhat disappointing may be due to the fact that many of these cases were those which never became actively engaged in the program (or dropped out prematurely) while the remainder of the cases still active in Child Protective Services are characterized by indications of severe family pathology and could not realistically be expected to continue functioning in an adequate manner without long-term supportive services. This finding lends support to the statement of CPS staff that referrals to the Community Centers Program

constituted their "most difficult" cases. It also confirms the opinion of the evaluation team that the CPS client population can be anticipated to require long-term intervention, and that the majority of clients will require continued support from other community agencies after project intervention ceases. Hence, one of the functions of the projects should be to ensure "link-up" of a client with necessary agency services before project termination is finalized.

9.0 COST EFFECTIVENESS ANALYSIS

A major component of an evaluation of demonstration projects such as the Family Crisis Program is an analysis of their cost-effectiveness. Historically, Research and Demonstration funds have been made available to grantees for furthering the state of existing knowledge regarding concerns of national importance. Recent national social welfare priorities have included topics such as drug abuse, alcoholism, family violence and child abuse. Demonstration projects such as the Family Crisis Program have been funded with the hope that alternative, innovative methods for amelioriating social problems will be explored.

It is generally the intent of the funding source to incorporate into existing social service programs those demonstration projects which present viable alternatives for treatment and problem resolution. The New York State Division of Criminal Justice Services (DCJS) and the Nassau County Criminal Justice Coordinating Counsel have been the administrators of the grants funded by the Law Enforcement Assistance Administration (LEAA) for both the Child Abuse Community Centers Program and the present Family Crisis Programs. Since 1975, these demonstration projects have been aimed at providing effective, non-traditional services to clients of Child Protective Services (CPS).

Many of the elements of Child Protective Services are extremely costly. Family Court Petitions, subsequent court appearances, CPS

worker time over a case life and Foster Care placements represent sizeable expenditures of public funds, as well as disruption of family life and trauma to both children and parents. If the demonstration projects result in a reduction of public expenditures in these areas, the actual cost of implementing the projects can be considered as partially defrayed, in the context of maintaining family life and delivering needed services.

It is not yet possible to conduct an outcome analysis of the Family Crisis Program. Data are available for a total of only 57 CPS cases, some only recently referred to the program. However, the evaluation of the Child Abuse Community Centers Program did demonstrate that specialized service delivery to Child Protective Service families can result in reductions in filing of abuse/neglect petitions, Foster Care placements, and recurrences of abuse/neglect during the time span of project involvement. Table 9-1 shows outcome comparisons for the Community Centers Child Abuse Program.

TABLE 9-1

Community Centers Child Abuse Program
Comparison of CPS Outcome Measures

	Project Cases	CPS Comparison Group
Cases Involving Child Removals	25%	35 %
Petitions of Abuse/Neglect	17%	24 %
Recurrences of Abuse/Neglect	10%	26.9%
Engagement in Therapeutic Services	85%	65 %

This section of the report examines the potential cost-effectiveness of providing intensive services for families involved in child abuse and neglect and is based upon the results of the evaluation of the Child Abuse Community Centers Program. The appropriateness of employing the results of this analysis for assessing the cost-effectiveness of the Family Crisis Program will depend upon the ability of the FCP to demonstrate equivalent outcome effects.

A complete examination of cost-effectiveness involves two major components:

- Examination of the degree to which the actual budgetary costs of the program may be defrayed by the reduction of other public expenditures for these clients; e.g., decreasing Foster Care placements and a reduction in Family Court Costs.
- Exploration of funding mechanisms which can be employed to implement the eventual institutionalization of the programs.

Section 9.1 of this section provides the results of an intensive examination of the costs of petitions and adjudicatory procedures of abuse/neglect cases. Section 9.2 examines the costs of Foster Care and potential savings of public funds by the provision of intensive alternative treatment services. Section 9.3 discusses the availability of Title XX and Medicaid Funds to the current projects, and Section 9.4 examines the feasibility of funding additional such projects within Nassau County.

9.1 Abuse/Neglect Petitions

The decision to file an Abuse/Neglect petition[10] in Family Court usually represents a great deal of thought and effort on the part of the CPS worker. The disruptive impact of a court hearing and the activities which follow are not only traumatic for the family but represent a considerable public cost incurred by both the Social Services Department and the Nassau County Family Court.

In order to estimate the cost of filing Abuse/Neglect petitions, it is necessary to consider several distinct service delivery systems. DMC's initial task was to investigate the role of the various systems involved in the filing of petitions and subsequent court appearances. Some of these key systems include the Department of Social Services, the Family Court, Law Guardians, Legal Aid and County Attorneys.

Extensive data gathering efforts were made within each of these systems in an attempt to capture the actual cost of filing Abuse/Neglect petitions. Although the information was not readily available, data were obtained which can provide a foundation for further investigation. General estimates for the overall cost of filing an abuse/neglect petition are presented below.

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10. For definitional purposes, "petition" includes all necessary court appearances.

9.1.1 Limitations of the Data

In gathering the data for this cost analysis, several variables emerged which influence the accuracy of determining the cost of an Abuse/Neglect petition. Studies have been performed in the past in an attempt to capture cost/time data for Abuse/Neglect petitions and no single set of variables has been found that is present for every case.[11] The nature and complexity of each case has a direct impact on the effort, time and financial expenditure for that particular petition.

Some petitions may take only a few hours for all parties to prepare and present in court, others may take as long as twenty days for preparation and presentation. One case situation which may be cited as an example of the possible complexity of a CPS case, is a case which had been to court twenty-two times in one year. If one considers the amount of time and effort that went into preparing and presenting this case, the hours and cost become staggering. While this situation is an exception, it is indicative of the possible complexity of a CPS Family Court Case. All figures which follow are based on averages and may not represent a particular Abuse/Neglect petition. An undertaking of this magnitude lends itself to a separate and more in-depth investigation into existing information.

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11. Telephone interview State Office of Court Administration. November 29, 1979.

9.1.2 Overview of Abuse/Neglect Petition Proceeding

In some instances, it is in the child's best interest to be removed from his/her home immediately. In these situations, a preliminary proceeding takes place. Present at this proceeding are the County Attorney, a Law Guardian (representing the interests of the involved child(ren)), a DSS Social Worker, the Judge and all court personnel. As an outcome of this proceeding, the Judge may sign an order for an emergency removal, a petition is then filed and a first hearing is held.

If there has not been a preliminary proceeding, then it is at this first hearing or arraignment that a Law Guardian is assigned to the case. In either situation, it is at this first hearing that the parents of the child appear in court. The Judge advises the parents to obtain an attorney if they do not have one, and in those situations, where the parents cannot afford an attorney, the parents are referred to either Legal Aid, Nassau County Law Services, or receive a Court appointed attorney from the 18 B Panel.[12] In most instances, the county assumes the costs for the parents' attorney when the parent is unable to afford private counsel.

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12. Under the County Law, Article 18 B of the New York State Law, the responsibility for funding representation for indigent people accused of a crime or named in a petition of Child/Abuse belongs to the County.

All relevant information pertaining to the case is introduced at a second hearing, which is followed by a fact-finding hearing and finally a dispositional hearing. At the completion of the fact-finding hearing, the Judge will request a report from the Probation Department to be reviewed by the court at the time of the dispositional hearing.

There are times when psychological testing and/or psychiatric evaluations are court ordered for all members or individuals in a family. These test results are usually submitted to the court prior to the dispositional hearing.

The outcome of a dispositional hearing may be either dismissal of the case, removal of the child from his/her home by court order, or DSS supervision while the child remains in the home. The dispositional hearing usually involves one court appearance, while the other hearings may involve from one to ten days depending on the nature and complexity of the case.

9.1.3 Family Court

In 1978, the operating budget for the Nassau County Family Court was $2.3 million. This budget consists primarily of State funds, with the balance composed of county funds. As of April 1, 1980, Family Courts throughout the State of New York will be totally funded by the State.

In the same year 4% (N = 760) of the total volume of Family Court petitions were Abuse/Neglect petitions. Of this number, 723 were Abuse/Neglect and 37 were Permanent Neglect petitions.[13] The total operating budget for the Nassau County Family Court includes the salaries of the Judges, Chambers Staff (secretaries, law clerks), a Law Department, Court Reporters, Court Management, Court Operations, and Court Security. Four percent of this total operating budget for the Nassau County Family Court is $93,333. An average cost per Abuse/Neglect petition for 1978 was thus calculated to be $122.81 ($93,333/760 = $122.81).

The additional costs for Probation reports and diagnostic testing performed by the Department of Forensic Psychology are not included in this analysis. In order to obtain this information a case by case approach is necessary, as not all cases receive a court order for psychological or psychiatric testing. The cost for these tests are borne by the county, while the cost of the Probation Department is shared by the County and State (50% County, 50% State).

9.1.4 Parent's Attorney

Parents who cannot afford a private attorney can obtain an attorney through three sources: Legal Aid; Nassau County

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13. Permanent Neglect represents the severing of parental rights.

Law Services; or, an 18 B Panel Court appointed attorney. The cost for this legal representation is assumed by the county. In some counties in New York State there is a contract for this form of representation between the county government and Legal Aid. In Nassau County, however, parental representation is paid for through a voucher system.

The DMC staff experienced a great deal of difficulty in the effort to ascertain cost, number of cases and the percent of time spent with these case situations. It was possible, however, to obtain approximations on lawyers salaries, time spent preparing for a case, time spent in a fact finding hearing, and time spent for a dispositional hearing.

The average salary for a Legal Aid or Law Services attorney is estimated at $15,500.00 a year, based on the range of $13,500.00 - $20,000.00 for attorney salaries. (Salary range provided by Nassau County Law Services). Therefore, Legal Aid or Law Services attorneys receive an estimated $9.68 an hour for their services (based on an 8 hour work day, and 200 work days per annum). Based on this estimated hourly fee, calculations were performed concerning the cost of research/preparation, the fact finding hearing, and the dispositional hearing.

- Preparation

  DMC was advised that preparation time could take from 10 to 15 hours per case or as long as 30 or 40 hours per case.

The mid-point of the range of the distribution was estimated at 23.75 hours per case.

$$\frac{10 + 15}{2} + \left(\frac{\left(\frac{40 + 30}{2}\right) - \left(\frac{10 + 15}{2}\right)}{2}\right) = 23.75$$

Of course, there will always be those cases which require far more preparation time and the time commitment will depend on the complexity and nature of the individual case situation. Taking the 23.75 hour average of preparation time per case and multiplying it by $9.68 an hour, the average cost for case preparation is $229.90.

- Fact Finding Hearing

  It is estimated that a fact finding hearing can take from one to ten days maximum. Five days, or a total of 40 hours, are used as an estimated average per case for a fact finding hearing. The cost of fact finding would then be $387.20 (40 x $9.68 = $387.20).

- Dispositional Hearing

  Dispositional hearings were estimated from one to five days or longer. Three days or 24 hours was chosen as the average time involved for a dispositional hearing. The 24 hours were multiplied by $9.68 an hour, to yield an average amount for dispositional hearings, or $232.32.

The total estimated cost for a Legal Aid or Law Services attorney to represent parents in one Child Abuse/Neglect case is $849.42.

- 23.75 hours of preparation time x $9.68 an hour = $229.90 for Case Preparation.
- 40 hours fact finding x $9.68 an hour = $387.20 for Fact Finding Hearing.
- 24 hours dispositional hearing x $9.68 an hour = $232.32 for Dispositional Hearing.

TOTAL $849.42 per case for Legal Representation for parents of Abused/Neglected Children.

9.1.5 Law Guardian

The Law Guardian represents the child's best interests during Abuse/Neglect proceedings and is appointed by the court either at the preliminary hearing or at the first (arraignment) hearing.

Law Guardians are paid by a voucher system. Vouchers are approved by the Nassau County Family Court and forwarded to the Second Department, Judicial Office of Court Administration for payment by the State. The Judicial Office estimates that each voucher is for approximately $85.00. Two thousand vouchers were received in 1978 from the Nassau County Family Court. Four percent of the total volume of petitions were Child Abuse/Neglect petitions. Applying this same percentage, it is estimated that 80 vouchers were processed for Law Guardian representation in Abuse/Neglect petitions in 1978. The total of 80 vouchers seemed low in view of the estimate of 760 petitions filed. Consequently, the possible reasons for the difference in these numbers was explored.

What emerged from this investigation were two significant pieces of information.

- Each petition represents one child, while the Law Guardians represent entire families of children. Therefore, one Law Guardian voucher could actually be equivalent to six petitions.

- Some lawyers considered their function as a Law Guardian as part of their societal obligation and do not submit vouchers for the legal representation they provide.

Of interest is the fact that since the Law Guardians are paid $15.00 an hour, at a cost of $85.00 a voucher, approximately 5½ hours of effort are expended by the Law Guardian for each Abuse/Neglect case.

9.1.6 Department of Social Services

In a previous evaluation, DiBernardo Management Consultants estimated that Nassau County Department of Social Services costs assbciated with filing an Abuse/Neglect petition were $1,316[14] for the Fiscal Year 1976-77. Since that date, all public budgets have experienced an estimated 12% ($158.00) increase estimated (inflation rate). The estimated cost to the Department of Social Services for filing a petition in 1978-79 is, therefore, estimated at $1,474.00.

If the child(ren) remains in the home of the perpetrator, the court, in virtually every instance, will order supervision for a period of 18 months for adjudicated cases, and one year for adjournment in contemplation of dismissal (ACOD).

DiBernardo Management Consultants estimated the cost incurred by DSS for each case involving court ordered supervision at $2,980.00.[15] These figures were calculated for Fiscal Year

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14. Final Report on the Evaluation of the Child Abuse Community Centers (DCJS-2194). Submitted to Nassau County Criminal Justice Coordinating Council, December, 1977.

15. Ibid.

1976-77. For a more current figure, a 12% increase for inflation must be taken into consideration, bringing the cost estimated for ACOD's and court ordered supervision to $3,338.00 per case per year.

The estimates provided are focused solely on Social Worker time and do not take into consideration clerical, supervisory, or administrative overhead costs. These expenditures as well as those already cited for the Department of Social Services come primarily from Title XX funding. This funding represents 12½% cost to the County, 12½% cost to the State, and 75% Federal funds.

9.1.7 Summary and Conclusions

Based on the available data summarized in Table 9-2, the total cost of filing a petition, including subsequent hearings, is estimated to be $2,531.23. This estimate includes legal representation for parents who are unable to engage private counsel. The total cost in those situations where parents engage private counsel would be $1,681.81. Neither the figure of $2,531.23 nor $1,681.81 includes the cost of the County Attorney who represents the Department of Social Services in these cases. Unfortunately, cost data for the County Attorney was not available.

TABLE 9-2

COST ESTIMATE OF ABUSE NEGLECT PETITIONS PREPARATION/COURT APPEARANCES

COMPONENT	Cost with Parental Representation Provided by County	Cost without Parental Representation Provided by the County	FUNDING SOURCE COUNTY	STATE	
			10% (Approximate)	90% (Approximate)	
Family Court	$ 122.81 per case	$ 122.81 per case			----
Department of Social Services (Social Worker Time)	$1,474.00 per case	$1,474.00 per case	12½%	12½%	75%
Law Guardian (Child's Representation)	85.00 per case	85.00 per case	----	100%	----
Legal Representaion for Parent	849.42 per case	----	100%	----	----
County Attorney	Data Unavailable	Data Unvailable	100%	----	----
TOTAL ESTIMATED COST OF PETITION AND PROCEEDINGS	$2,531.23 per case	$1,681.81 per case			

Table 9-3 indicates that the total cost of Abuse/Neglect petitions including court hearings and a disposition of Court Ordered Supervision for one year is $5,869.23 per case. This estimate includes the cost of legal representation for parents. Without legal representation for parents, the costs would be $5,019.81 per case.

The evaluation of the Child Abuse Community Center Program indicated that the intervention of these programs reduced the rate of filing of Abuse/Neglect petitions by eight percent. If such effective services can be provided for all appropriate cases, the expected 8% reduction in the filing of petition would lead to a potential savings in State and County money of $154,405.00 on the basis of 61 less petitions/year (8% of 760 petitions/annum).

The reader must bear in mind the basic constraint of this information which is the method by which cases or petitions are counted. In fact, it is the definition of case or petition which is at the heart of the difficulty in data collection.

- Family Court counts petitions, therefore, a family with six children represent six petitions.
- Law Guardians count families; one voucher can represent six children or six petitions, but only one case.
- DSS counts children. However, in calculating the cost estimates for Social Worker time in preparing petitions and appearances in court, families were counted. Therefore, although six separate petitions may be prepared for the courts, usually the information on each petition represents one family and one family problem. The time estimated for a DSS social worker in the preparation of petitions and subsequent court appearances is actually estimated for families and not petitions.

TABLE 9-3

ESTIMATED TOTAL COST PER CASE BY DISPOSITION

	Disposition of Dismissal	Disposition of Supervision
Petition (Includes cost of parents attorney)	$2,531.23	$2,531.23
Disposition		$3,338.00
* TOTAL estimated cost per case by disposition	$2,531.23	$5,869.23

* NOTE: These estimations have included the $849.42 cost of Legal representation for parents, without legal representation for parents, a disposition of supervision would be $5,019.81 per case.

While the figure of $154,405.00 representing a potential savings of public expenditures is a very broad estimate, it can be considered conservative in light of the fact that cost estimates for the County Attorney and administrative DSS cost are not included.

This figure is considered a general estimate due to the manner of estimating the total cost of each petition. For example, Law Guardian services which were calculated at $85.00 per case, have been included in the cost of one petition. This $85.00 estimate may actually represent several petitions filed for one family. The same principle holds true for the DSS social worker. While the cost to DSS in preparing a petition is estimated at $1,474, this figure may well represent several petitions or one family. It is clear from the proceeding discussions that a major constraint in obtaining data for cost estimations per case is the manner in which case petitions are counted.

It is readily seen, however, that the costs of Family Court Petitions represent a sizeable expenditure of public funds. If the provision of intensive services to CPS families can result in reduced rates of court involvement, then the cost of providing such services will be partially defrayed.

9.2 Foster Care

An additional area of consideration in the determination of cost effectiveness is the cost of Foster Care placement. Foster

care placement can be operationally defined as providing a substitute family or living arrangements for a child who must be separated from his natural parents. This is a discrete service with essentially four goals:

- to prevent the permanent separation of a child from his family
- to assist natural parents in establishing a safe home environment so that the children who are removed may be returned home within prescribed time limits
- to provide a semi-permanent or permanent alternative placement through adoption or guardian arrangements when the return of a child to the natural home is inappropriate.
- to provide long term, stable living arrangements within an institution when adoption or guardianship are not possible

These goals are universally agreed upon by both public and private child welfare professionals.

The removal of an abused or neglected child into foster care, on either a short-term emergency basis or for long-term placement, is frequently necessary in order to ensure the safety and well-being of the child. It is important, therefore, that the placement of a child in foster care is not construed as a "failure" in service delivery on the part of either Child Protective Services or specialized projects such as the Family Crisis Program.

Despite the unavoidable necessity for removal of a child in some instances, the major efforts of Child Protective Services are

appropriately directed toward the goal of alleviating the abuse/neglect circumstances while keeping the family intact. Reasons for this goal are two-fold. One, the removal of a child from his/her home is a traumatic experience for all family members. Two, the nationwide shortage of "high-quality" foster homes dictates that many children must be placed in marginally satisfactory homes which do not provide a stable, rehabilitative environment for the child.

The Family Crisis Program is intended to provide rehabilitative services directed toward the preservation and strengthening of family life. It is clear that within the context of this primary focus of endeavor, one appropriate measure for evaluating the success of service delivery is any resultant reduction in the rate of foster care placements and/or reductions in the length of such placements when they do occur.

Foster care services are an extremely costly mode of intervention. If specialized service programs, such as the Family Crisis Program, succeed in lowering the rate and duration of placement in Foster Care, a sizeable savings in public expenditures will result, thus defraying a portion of the "true cost" of the program's services.

The results of the evaluation of the Community Centers Child Abuse Program demonstrated a 13% reduction in Foster Care placements in comparison to the control group. The reasons for this

reduction in placements are unclear, however, there are two possible explanations:

- the families served by the Program demonstrated significant improvement in functioning
- CPS workers judged children to be safe from harm in homes receiving intensive services and supervision.

In either case, the provision of intensive family rehabilitative services can be seen as a possible alternative to Foster Care for many families. It is proposed that specialized services provided by the Community Centers Child Abuse Program and the Family Crisis Program may help maintain the family unit, avoid the trauma of child removal as well as provide a far more cost effective method of intervention than placement of a child in Foster Care.

9.2.1 Characteristics and Statistics

Nationally, several interesting statistics have been developed concerning families known to Foster Care agencies.[16] Time spent in Foster Care varies, but the vast majority require long term service:

50% spend more than 2 years in placement
26% spend more than 5 years in placement
12% spend more than 10 years in placement

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16. Forgotten Children in Foster Care; Report of the National Commission of Children in Need of Parents; 1979.

The age of children in Foster Care also varies with half of Foster Care placements serving adolescents:

51% were 12 years of age and over
17% were between 9 and 11 years of age
25% were between 3 and 8 years of age
7% were under 2 years of age

The average age of natural parents in Foster Care is in the mid-thirties; they are maritally unstable, have several children, are poorly educated, and a highly transient population. Forty percent suffer from physical or mental illness, 33% are divorced, deserted or have drug problems, 17% have behavioral problems and 10% abuse or neglect their children. These parent characteristics, and the severity of family problems implied, help to explain the long term nature of most Foster Care placements. Without intensive services, it is unlikely that family functioning will improve to the degree that children will be able to return home.

9.2.2 Foster Care Laws, Payments and Services

There are six pieces of Federal legislation which support Foster Care with Income Maintenance payments and Social-Medical Health services. The following is a brief description of this legislation.

- Title IV A -- Social Security Act

  Provides Income Maintenance payments to children in Foster Care if the placement is court ordered and the client is eligible for Aid to Families with Dependent Children (AFDC). AFDC eligible children are needy and from single-parent homes.

- Title IV B -- Social Security Act

  Enables child welfare services and their maintenance by formula grants to States. Services might include counseling, adoption, day care, home assistance and child protection. There is no means test, all children in need of services are eligible. To date, Congress has not appropriated the full authorization of this Title which is approximately $226 million.

- Title V -- Social Security Act

  Provides maternal and child health medical care.

- Title XIX -- Social Security Act

  Section 1903 of this Title provides funds to States for medical services to eligible children and adults under a state plan, e.g., Medicaid. This includes children in foster homes receiving income maintenance payments.

- Title XX -- Social Security Act

  Provides Federal matching funds for social services and training for services providers and foster parents. Client eligibility is based upon income levels, for example, a client can not earn or hold assets of more than 115% of a State's median income. Title XX does not include maintenance payments.

- Supplemental Security Income -- SSI

  Provides medical services to disabled children.

9.2.3 Cost of Foster Care in Nassau County

New York State estimates that the yearly cost for a child in Foster Care facility is $8,000. This estimate includes children placed in Foster Care Institutions, group homes and Foster family homes. The cost itself reflects room, board, medicaid and

case management services. Funding for these placements are borne by the county, state and federal governments. It is estimated that each governmental agency bears approximately 1/3 of the cost for each placement. The foster child's education is carried jointly by the county and the state through a separate funding mechanism.

The Nassau County Department of Social Services reports that 380 children were placed in Foster Care during Fiscal Year (FY) 77-78. Of these, 80% or 304, were Child Protective cases. Assuming that all of these were court ordered placements (voluntary removals might account for a very small number of placements) an estimated $2,432,000.00 was expended in FY 77-78 for maintaining Nassau County children in Foster Care.

9.2.4 Potential Cost Savings

DMC's evaluation of the Child Abuse Community Center's Program indicated that these programs reduced child removals by 13% during the time of client involvement with the project. If such specialized services were available to all CPS clients in Nassau County, and the rate of removals could be decreased by 13% throughout the entire County, a potential savings of $316,000.00 in State and County funds could be realized.[17]

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17. A 13% reduction of 304 CPS Foster Care cases lessens placements by 31.5 cases. Each case saved yields an $8,000.00 savings; therefore, the total estimated cost reduction is $316,000.00 (39.5 cases x $8,000.00 = $316,000.00).

The DMC team is aware that these projected figures may be somewhat over-estimating the actual saving in public expenditure when consideration is given to the number of children from families receiving income maintenance payments (AFDC) who are placed in Foster Care. Since these children are already receiving public funds for their maintenance and medical expenses, their placement in a Foster home can be considered a transfer of public funds rather than an initial expenditure of public funding. Illustratively, the child whose family receives AFDC payments at a theoretical rate of $100 a month per child, receives $1,200 a year for maintenance. When that child is placed in Foster Care an additional $6,800 a year is expended for his maintenance rather than the full $8,000 for the child whose family has not been receiving AFDC.

The total potential cost savings figure of $316,000 given above represents only an estimated savings. In order to obtain more precise information, it would be necessary to gather data on the actual number of petitions which lead to Foster Care placements, as well as the number of children in placement receiving AFDC payments. For the purposes of this analysis, it is assumed that all CPS Foster Care placements were court ordered.

9.3 Title XX and Medicaid Funds

The two previous sections of this cost-effectiveness analysis have presented the potential savings the Family Crisis

Program could being to Nassau County by reducing abuse and neglect petitions and foster care placements. These reductions were estimated at $154,405.00 and $316,000.00 respectively. Therefore, if similar specialized intensive rehabilitative services can be provided to all CPS clients in Nassau County requiring such service, the resultant decrease in Family Court Petitions and Foster Care might be anticipated to result in a potential savings of public expenditures amounting to almost one-half million dollars annually.

Despite this potential savings in County, State and Federal expenditures, the difficult task remains of securing funds to meet the actual budgetary costs of continuing the present program when demonstration funds are no longer available. Additionally, if the Family Crisis Program proves effective, means of institutionalizing and expanding the program to accommodate the needs of all of Nassau County must be explored.

Two potential avenues of Federal funds could be available to the Family Crisis Program; Title XX and Title XIX. Title XX provides funds to states to help defray the costs of social services, and service provider training. Section 1903 of Title XIX provides funds to States for medical services to eligible children and adults under a state Medicaid plan. The potential use of these two resources will be considered.

9.3.1 Title XX

Background

The Federal government has provided funds to states for the provision of social services to welfare recipients since 1956. Title XX, a comprehensive, new social services bill became effective on October 1, 1975. This landmark legislation provides Federal matching funds to states for social services and training for service providers and foster parents. The Federal participation rate is 75%, with a non-Federal matching requirement of 25%. Funds are allotted the states according to the ratio of the state population to the nation as a whole. The only additional Federal requirement regarding service provision is that these services must be provided to Supplementary Security Income recipients; disabled children.

States are also free to establish their own eligibility categories. The only restriction is that at least 5% of Federal funds must be expended upon categorically related individuals and their families, e.g., welfare recipients. States are required to charge a fee for services to income eligibles who gross income falls between 80 and 115% of the state median income adjusted for family size. States have the option of charging fees for income eligibles with lower incomes.

New York State and Nassau County

New York State has mandated that the certain services be made available to the following categories of individuals:

- Services Mandated Without Regard to Income

  - Protective Services for Children
  - Protective Services for Adults
  - Information and Referral

- Services Mandated Up to State Eligibility Levels

  - Adoption Services for Children - 80% of State Median Income
  - Foster Care for Children - 80% of State Median Income
  - Foster Care for Adults - 62% of State Median Income
  - Unmarried Parent Services - 62% of State Median Income

Other services mandated in New York State include:

- Day Care - for employment purposes for AFDC recipients. In most instances, the cost of day care for this group is met through the cash grant under AFDC. In addition, local departments may choose to provide day care to other groups for employment purposes, e.g., seeking employment or for training purposes. Day care may be made available to the persons whose income does not exceed the state maximum level for appropriate family size or whatever groups the local district chooses, including recipients of financial assistance or Supplemental Security Income.

Title XX builds upon prior Federal social service legislation providing for social services to be delivered to low income individuals and families. At least 90% of the social service expenditure for which Federal funds may be applied must be for applicants for or recipients of public assistance.

The Federal regulations narrow the eligible population by limiting non-public assistance recipients to those with incomes no

higher than 150% of the State's AFDC payment standard, except for child care expenditures in which the maximum level is 233% of the AFDC payment standards. States are required to determine eligibility on an individual basis. A total of five services are exempt from the 90% requirements; child care and family planning, services to mentally retarded individuals, services to drug addicts and alcoholics undergoing treatment, and services to children in foster care.

Title XX funds are available to states who provide services directed toward specific goals set forth in the legislation.[18] Services offered must be directed toward one of the five goals of:

" I Achieving or maintaining economic self-support to prevent, reduce or eliminate dependency;

II Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

III Preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;

IV Preventing or reducing inappropriate institutional care by providing for community based care, or other forms of less intensive care;

V Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions."

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18. Section 2001, Social Security Act, as amended

- Family Planning - required for all applicants and recipients of public assistance and to be offered to all eligible persons upon request. Family Planning Services must be made available to all eligible persons in receipt of AFDC, HR and SSI, either under Title XIX or XX, and may be made available under Title XX to other groups with incomes up to 62% of the state median income.

Five services are mandated for recipients of SSI and may be made available to other groups including recipients of AFDC, HR and/or those with incomes up to 62% of the state income. These services are Home Management, Homemaker, Housekeeper/Chore, Housing Improvement, Health Related Services.[17]

Given the above eligibility and service requirements, it would seem that Title XX funds would be a fitting source of revenue to the Family Crisis Program. However, since the establishment of a ceiling on Federal Title XX monies, and New York State's shrinking share of these funds, Title XX is not an immediate funding option.

Expenditures of Title XX funds in Nassau County are currently at the maximum level. As more and more services are mandated by the State, the County has less and less money with which to fund new services or expand existing services. Over the past five years, the total staff of the Nassau County Department of Social Services has decreased, while the need for services continues to

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17. All service and eligibility requirements taken from the Comprehensive Annual Social Services Program for New York State, September, 1979.

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grow. In addition, the amount of Title XX funds available to Nassau County is declining due to the declining County population.

Therefore, the Nassau County Department of Social Services is, at present, unable to assume the cost of institutionalizing the Family Crisis Program or to purchase similar specialized services for CPS clients from private community agencies. While the possibility of utilizing Title XX funds for the provision of intensive rehabilitative services to CPS clients may exist for the future, this does not appear to be a feasible anticipation for 1982, the date at which LEAA demonstration funding ceases.

9.3.2 Medicaid

Background

Title XIX of the Social Security Act provides for a program of medical assistance for certain low income individuals and families. This program, known as Medicaid, became Federal law in 1965. Medicaid will account for some $19 billion Federal and State expenditures in Fiscal Year 1979 and is the primary source of health care coverage for the poor in America.

Medicaid is designed to provide medical assistance to those groups or categories of individuals who are eligible to receive case payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for

the aged, blind and disabled. In general, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. Exceptions to this general requirement surfaced in 1974 when welfare programs for the aged, blind and disabled were combined into the SSI program. States may now exclude some of these SSI cash assistance recipients from automatic Medicaid eligibility because the standards for the Federal program are more liberal than those previously generated by the State.

In addition, States may provide Medicaid to the "medically needy", that is, to people who fit intc one of the categories of people covered by the case welfare programs. The aged, blind, disabled individuals, members of families with dependent children when one parent is absent, incapacitated or unemployed, who have enough income to pay for their basic living expenses but not enough to pay for their medical care may be designated as medically needy.

It is important to note that Medicaid does not provide medical assistance to all of the poor. Low income is only one test of eligibility. Resources are also tested. And most importantly, one must belong to one of the groups designated for welfare eligibility to be covered.

Title XIX of the Social Security Act requires that certain basic services must be offered in any State Medical program: in-patient hospital services, out-patient hospital services,

laboratory and x-ray services, skilled nursing facility services for individuals 20 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, and early and periodic screening, diagnosis and treatment services for individuals under 21. In addition, states may provide a number of other services if they elect to do so, including prescriptions, eyeglasses, private duty nursing, intermediate care facility services, in-patient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

States determine the scope of services offered, for example, they may limit the days of hospital care or number of physicians' visits covered. States also determine the reimbursement rate for services, except for hospital care, where states are required to follow the Medicare reasonable cost payment system unless they have approval from the Secretary of Health, Education and Welfare to use an alternate payment system for hospital care. Since July 1, 1976, they have been required to reimburse for skilled nursing facility and intermediate care facility services on a reasonable cost-related basis.

Since states generally determine the eligibility level for the welfare programs (they set the AFDC level, and determine the amount of supplement, if any, to the basic Federal SSI payment), they exercise a great deal of control over the income eligibility levels for Medicaid. If they cover the medically needy, they may

establish the income level for eligibility at any point between the case assistance eligibility level for an AFDC family (adjusted for family size) and 133 1/3% of the payment to such an AFDC family. All of these variations in benefits offered in groups covered, income standards, and in levels of reimbursement for providers mean that Medicaid programs differ greatly from state to state.[20]

Medicaid is financed jointly with state and federal funds, with the current federal contribution to the cost of the program ranging from 50 to 75%. The program is basically administered by each state within broad federal requirements and guidelines.

New York State and Nassau County

The Medicaid services offered to Nassau County residents are the same as those offered throughout the state. New York State's Medicaid plan is quite liberal. In addition to paying for the basic medical services described in the preceding discussion New York's Medicaid also pays for optional necessary services provided by optometrists, dentists, and mental health professionals.

Medicaid eligibility in New York State is expanded beyond those people who are eligible for Aid to Families with Dependent Children and Supplemental Security Income, to include those who are

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20. Data on the Medicaid Program: Eligibility Services, Expenditures, 1979. Edition Revised Medicaid/Medicare Management Institute, U.S. Department of Health, Education and Welfare, Health Care Financing Administration, Baltimore, MD 21235.

medically needy and those who have been stricken with a catastrophic illness. The determination process for Medicaid eligibility is complicated and akin to the budget process used in determining a person's eligibility for public assistance. There are, however, some broad guidelines which set the parameters for Medicaid eligibility. For example, medically needy persons are those who are under 21 years of age, or 65 or over; people who are blind or disabled and members of families in which one or both parents are dead, absent from the home, or the father is unemployed. Included among those considered incapacitated are pregnant women from the fourth month of pregnancy until 12 weeks after delivery.

In conjunction with the previously stated guidelines, there are also income levels and family size which guide the determination of eligibility for Medicaid in New York State. The following table lists the amounts of earnings and allowable reserves, which includes the face value of life insurance, that determine Medicaid eligibility:

Number in Family	Annual Income	Allowable Reserves
1	$3,300	$2,150
2	4,800	3,400
3	4,900	3,950
4	5,000	4,500
5	5,800	4,900
6	6,500	5,250
7	7,400	5,700

For those households in New York State where the cost of shelter and heat as allowed in the Public Assistance Program are higher than the average for the states, the local social services agency is required to give consideration to those shelter and heating costs where it results in an amount higher than the Medical Assistance income level listed for that household.

Medicaid and the Family Crisis Program

Medicaid emerges as a very promising source of revenue for the Family Crisis Programs, when demonstration monies expire. Mental Health Services for Medicaid eligible individuals are available in New York State and Nassau County. These services are provided on an as needed basis for anyone enrolled in the Medicaid program. Medicaid payments are available for private therapy with a psychiatrist or psychologist, and reimbursement is also available to state licensed Mental Health Centers for eligible clients. The North Shore University and South Nassau Communities Hospital projects are eligible for reimbursement under the latter. Services provided by team psychiatrists, psychologists, and social workers are reimbursable by Medicaid, whereas services provided by para-professional team members are not covered. Home visits are reimbursable only when made by the team psychiatrist.

The reimbursement rates for Mental Health Services are established by the New York State Medicaid Administration. These rates are based on a weighted calculation for the cost of the service

provided by each facility. Therefore, there is a variation in allowable reimbursement rates for each mental health facility in the state. The North Shore Family Crisis Program receives a Medicaid payment of $52.00 per day, per client, while the South Nassau Family Crisis Program receives $30.55 per day, per client. This reimbursement rate covers all therapeutic engagements for an eligible individual during a given day. For example, a client may attend one hour of individual therapy and one hour of group therapy on the same day and Medicaid will only reimburse the mental health facility at the daily allowable rate.

At the North Shore Family Crisis Program, approximately 14% of the families receiving services are enrolled in the Medicaid program. A family receiving therapy once a week at the Medicaid rate of $52.00 represents $2,600.00 in potential revenues for one year. At present, the six medicaid eligible families served by the project represent $15,600.00 per year in potential revenues.[21]

The South Nassau Family Crisis Program, in contrast to the North Shore Program, serves a larger number of Medicaid eligible clients. Twenty-two families, or 40% of their client population are enrolled in the Medicaid program. If each of these families

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21. These calculations are based on a 50 week year. One family receiving weekly treatment services can be a source of $2600 yearly (50 weeks x $52 reimbursement rate = $2600). Therefore, six families represent a potential $15,600 yearly. (6 x $2600 = $15,600).

receive services once a week for one year, reimbursement of $33,605.00 could be anticipated.[20]

Additionally, Medicaid reimbursement may be obtained for each eligible family member receiving services. For example, if a client is seen once a week in individual therapy, with an adolescent child seen once a week for group therapy and the father, mother and child are seen in one family session, this would represent reimbursement for five sessions in that week. (Medicaid payments for group or family sessions are reimbursed at a lower rate than individual sessions).

Summary

In summary, Medicaid funds can be expected to defray approximately 20% of the yearly operating budgets for the Family Crisis Program in Nassau County. Current budgetary grants funds amount to $120,400 per year for each of the two project sites or a total of $240,800 needed to fund the Family Crisis Program for one year. The combined Medical payments received by the two projects amount to $49,205, or 20% of this total amount.

Medicaid reimbursement payments represent the largest source of revenue available to the projects. Other sources of revenue include third-party payments (insurance) and case payments received from clients able to pay for treatment services on a sliding scale

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20. One family receiving weekly treatment services could provide $1,527.50 to the project (50 weeks x $30.55 reimbursement rate = $1,527.50). Twenty-two families represent a potential $33,605 yearly (22 x $1527.50 = $33,605.)

fee structure. It is expected that many upper middle class clients would be willing and able to provide third-party payments for mental health services, which could be of benefit to the North Shore Project. On the other hand, an involuntary client population, such as those referred by Child Protective Services, cannot be expected to contribute a large amount of cash to pay for services they do not want. Additional research and calculations beyond the scope of this evaluation would be needed to estimate anticipated revenues from these two additional sources. However, third party payments and fee payments should not be discounted in budgetary planning.

9.4 Institutionalization of Family Crisis Programs in Nassau County

The previous sections of this cost-effectiveness analysis have documented:

- the projected savings that the Family Crisis Programs may be able to offer to Nassau County and New York State by reducing foster care placements and Family Court petitions
- the paucity of Title XX funds to provide financial support to projects when demonstration monies expire
- the availability of Medicaid funds to defray approximately 20% of the total yearly budgets for the Family Crisis Program
- the feasibility of using third-party and fee payments to supplement available Medicaid funds to support the continuation of the Family Crisis Program

The fact remains that although the Family Crisis Program may prove capable of saving considerable state and county monies, the actual cost of operating such specialized programs within Nassau County remains. The analysis has shown that approximately $191,595.00 per year in revenue will need to be appropriated if the present Family Crisis Programs are to continue after the expiration of LEAA funds.

This final section of the cost-effectiveness analysis attempts to estimate the number of project sites needed to provide services similar to the Family Crisis Program for all of Nassau County and the associated budgetary requirements.

9.4.1 Projected Number of Projected Sites

Preliminary figures from the Nassau County Department of Social Services reveal that approximately 700 indicated cases of child abuse or neglect are anticipated in the County during 1979.[21] To estimate the proportion of these clients who would be needing the specialized services of projects such as the Family Crisis Programs, DMC consulted the findings from a previous study conducted in 1978. As a part of the Child Abuse and Neglect Tracking System (CANTS) Project, DMC conducted a statewide survey of Child Protective Service caseworkers to determine which services were recommended for

21. An "indicated case" is that in which credible evidence of child abuse or neglect has been established. The estimate of 700 cases is based on computer generated figures for the first 9 months of 1979.

indicated CPS cases during 1975. County-by-county service recommendations were obtained. For Nassau County, 38.7% of the indicated cases were recommended for individual therapy, and 40.8% were recommended for Marital/Family Therapy.[22] The actual percentage of CPS clients recommended for mental health services was between 40 and 75% as some of the CPS cases were referred for both individual and marital/family therapy. If appropriate mental health services had been available in 1975, it is possible that an even greater number of clients would have been referred for counseling.

For the purposes of the cost analysis, DMC has assumed that 60% of all CPS clients are in need of counseling or mental health services. This figure may be considered conservative, as results from the analysis of the CPS control sample used in the current evaluation show that 33% of the cases were recommended for individual therapy, and 58% were recommended for marital and family therapy, with a total 70% of the families in the comparison sample being referred for some form of counseling. It is interesting to note that in the four years since DMC's first study of service recommendations, more clients are being referred for

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22. Report of Child Abuse and Neglect Tracking System Project (CANTS), Analysis of Treatment Package Questionnaires. Submitted to NYS/DSS. Albany, NY, July 1978.

counseling and an increasingly larger percentage of these being referred for marital and family therapy.

This esimate of 60% of all CPS clients in need of counseling can be applied to the 700 CPS indicated cases for 1979 to yield 420 cases, or families needing mental health services. The results of DMC's evaluation of the Community Centers Child Abuse Program showed the specialized mental health services offered by these projects to be the preferential mode of intervention for CPS clients. It would therefore be ideal if all of these 420 families per year could be serviced by projects such as the Family Crisis Program.

The North Shore University component of the Family Crisis Program is presently serving approximately 43 families, while the South Nassau Communities Hospital is serving approximately 55 families. Based upon an average of these two figures, it seems that specialized demonstration projects can be expected to service about 50 families at any one time. Each of the Family Crisis Program projects have contracted to service a client population composed of 75% CPS referrals. This would mean that each such project would be able to serve 38 Child Protective Service families at a given time. (.75 x 50 - 37.5 or 38)

It is generally agreed by staff at both project sites that the Child Protective Service client population is anticipated to require project intervention for at least one year. Once a

client has accepted project services, therefore, it would be expected that client turn-over will be low. A few clients, however, would be expected to drop-out of treatment, move away from the area or be successfully terminated before that time. It therefore appears reasonable to project that a total of 45-50 CPS families can be served by each project annually.

Assuming that 420 CPS clients would be referred for counseling each year, a total of eight to ten project sites would be needed in order to serve the entire CPS population requiring counseling. The remainder of this estimation of total costs will assume that a total of nine project sites in Nassau County would be able to serve the projected counseling needs of CPS families, each site serving between 40 and 50 families per year.

It is estimated that a substantial proportion of this cost can be assumed by Medicaid funds. The Nassau County Department of Social Services has reported that 59% of all CPS indicated cases are Medicaid eligible. Therefore, it can be expected that about 250 CPS families needing mental health services would be enrolled in the Medicaid program.[23]

If all of these families were referred to demonstration projects such as the Family Crisis Program, they would be receiving treatment services at a minimum basis of once a week. To calculate the anticipated revenue from these cases, it is neces-

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23. The number of families requiring service is estimated at 420 (60% of 700). 59% of these families (248) are anticipated to be Medicaid eligible.

sary to use an average Medicaid reimbursement rate. These rates are based on a weighted calculation for the cost of services provided and vary with each mental health facility. DMC therefore calculated the average of the South Nassau Communities and North Shore University Hospitals' reimbursement rates to obtain an average rate of $41.27 per person for each eligible individual. ($30.55 + 52.00/2 = $41.27). Multiplying this average figure by 50 weeks of the year yields an annual reimbursement rate of $2,063.50 per case that could be considered as potential revenue for the demonstration projects. For purposes of this analysis, it is assumed that one therapy session per family is held weekly.

However, in many cases, more than one reimbursable session may be held weekly. The entire family may be seen at one session with one member of the family seen individually and perhaps another member seen in a group setting. (Both current projects anticipate the initiation of Mothers' groups and/or adolescent groups.) Although family and group reimbursement rates are lower than rates for individual sessions, it seems reasonable to anticipate that 25% of the families referred would be reimbursed for two or more sessions weekly. Using this figure, it is estimated that a total reimbursement of $2,579 would be anticipated annually for each Medicaid eligible family.

It can be estimated that $644,750 would be received by the 9 proposed Nassau County projects from Medicaid payments.[24] How-

---

24. 250 Medicaid eligible cases, or families, seen in therapy for one year yields $644,750. (750 families x $2,579 average estimated annual reimbursement rate for one year of service.

ever, if the present Family Crisis Program is used as a guide for budgeting, $1,080,000 will be needed to fund nine Family Crisis Programs. The County will need to provide $435,250 to institutionalize the Family Crisis Program method of service delivery throughout Nassau County.

It will be recalled that it is considered possible that the provision of project services to all CPS clients requiring counseling would result in a potential savings of $470,000 in public funds now being expended for Family Court petitions and Foster Care placements.

That is, it would cost Nassau County approximately one-half million dollars annually to provide specialized, intensive rehabilitative services to all Nassau County clients requiring such services. However, such an expenditure would serve three important goals:

- the provision of sophisticated, highly skilled, specialized therapeutic intervention for a client population greatly in need of such services
- the ability, in many cases, to provide an alternative to the traumatic and destructive effects of Family Court intervention and child placement.
- the savings in other such costly public expenditures as Family Court petitions and Foster Care, which would account for virtually the entire cost of funding the program.

9.5 Summary and Conclusions

The information contained in the preceding analysis of costs must be interpreted in the light of several constraints.

- Data employed in estimating potential cost effectiveness are based upon the results of the evaluation of the Community Centers Program. Since no outcome analysis of the Family Crisis Paogram has yet been conducted, it is not appropriate to assume that the effects of the two programs on rates of child placement and court petitions will be equivalent.

- The incidence of court petitions may not be an appropriate outcome measure for the evaluation of the Family Crisis Program, since it has been stated by CPS administrators that an attempt is made not to refer to the projects those cases in which adjudicatory procedures are anticipated to be necessary. Project cases, therefore, would be expected to have lower rates of adjudication than a randomly selected control group which would include some cases in which court proceedings are planned.

- The analysis of long-term outcome conducted on the original sample of Community Centers cases indicated that recidivism rates for this group were higher than for the control group. The implications of this finding include the possibility that significant outcome effects may be sustained only for the duration of project involvement, and that savings in public costs may be short-term in nature.

However, it has been shown that if petitions of abuse/neglect can be reduced by only 8%, and placement of children by 13% through the provision of intensive preventive services, an estimated savings of $470,405 in public expenditures can be anticipated. Although this is not a reduction in the actual budgetary cost of operating such projects, the figure certainly represents a substantial savings to the County and State.

The Family Crisis Program is a demonstration project providing such intense services to families. A useful guideline for evaluating the effectiveness of the projects will be an

examination of rates of placements and petitions on project cases in comparison to a matched control group and to Community Centers cases.

If the Family Crisis Program proves to be an effective means of providing services to families, then attention must be given to institutionalizing the existing projects and implementing similar services throughout the county.

This analysis has shown thatMedicaid funds are the most available source of revenue for continuing these demonstration projects and offsetting the cost of additional project operations. Although securing the remainder of necessary funds will not be an easy task, it is hoped that if the projects can demonstrate the ability to be cost-effective, efforts to secure necessary funding will be facilitated.

10.0 PROBLEMS AND RECOMMENDATIONS

DiBernardo Management Consultants, in the course of the evaluation of the Family Crisis Program, held interviews with staff and administrators of the major involved agencies: Department of Social Services; Department of Mental Health; North Shore Hospital Project; and, South Nassau Hospital Project. In the course of these interviews, several problem areas emerged.

10.1 Inter-Agency Relationships

The major problem which exists, and which inhibits the maximally effective functioning of the Family Crisis Program, is the lack of productive, organized inter-agency communication.

As a federally funded demonstration program, the projects are responsible to both the Nassau County Criminal Justice Coordinating Council, and the New York State Division of Criminal Justice Services, for both programmatic and budgetary accountability.

The Department of Mental Health is the administrator of the program, and has appointed a full-time program coordinator. Each project site, the South Nassau Community Hospital Mental Health Clinic, and North Shore University Hospital, is autonomous in the areas of staff training, program design, service planning and service provision.

The Department of Social Services (Child Protective Services) is, by contract, the primary referral source to the projects. As contractually agreed, 75% of each project's caseload is to consist of CPS referrals. Child Protective Services, however, is, due to legal mandates, more than just a referral agency.

The Department of Social Services is, in New York State, the legally mandated agency bearing the responsibility for monitoring and ensuring the safety of abused and neglected children. This responsibility remains with the CPS caseworker assigned to the family throughout the open life of the case. That is, decisions regarding court petitions, removal or return of children, case closing, etc. are the responsibility of Child Protective Services whether or not the family is referred to the Family Crisis Program.

Each of the four major agencies (CPS, Department of Mental Health, South Nassau Hospital, North Shore Hospital) as well as the involved funding agencies, therefore, while functioning with a common goal, are operating within different areas of responsibility, accountability and orientation.

The DMC evaluation team, in the course of contacts with all involved agencies, became aware of two basic facts which affect all program operations:

- All agencies are, in fact, functioning with a common goal: the provision of therapeutic, rehabilitative services to families in crisis so that these families can remain intact and function in an adequate manner, ensuring the safety and well-being of the involved children.

- However, among the involved agencies, there exists very little mutual understanding of problems, respect for one another's knowledge and skills, or acceptance of differing orientations.

It is unfortunate that the original plans for a inter-agency team (which called for a weekly meeting to resolve both case specific problems and general issues) were never implemented. Although workers and supervisors of the different agencies do communicate informally regarding specific cases, the lack of an official mechanism for dialogue has, in the opinion of the evaluation team, greatly impeded effective inter-agency communication, and hence maximally effective service delivery.

Recommendation:

- Regular meetings between involved agencies are a necessity for productive inter-agency cooperation. Despite the heavy schedules of all staff, such meetings are a necessary forum for the resolution of differences, fostering mutual understanding and building necessary confidence in each other's skills.

  These meetings should be chaired by the Program Coordinator, and be attended by key representatives from both projects and Child Protective Services.

> The Program Coordinator should assume the primary responsibility for the identification of problem areas, ensuring that all necessary information is available, and encouraging productive discussion on critical issues.

There have been two major problem areas which have contributed to inter-agency disagreement: referral criteria; and, outreach procedures.

10.2 Referral Criteria

Demonstration projects, operating on limited budgets, cannot serve all clients. The issue of which clients should be referred to the program by CPS emerged early in the life of the projects as an area of disagreement.

Child Protective Services administrators have expressed the opinion that the clients in greatest need of project services are those for whom there exists insufficient evidence for adjudication. If a client can be brought to Family Court, the Court can order the client to obtain counseling, can remove children from an at-risk situation, or can order CPS supervision while the children remain at home.

"Credible evidence" of child abuse/neglect is not the same as a preponderance of evidence sufficient for adjudication. While "credible evidence" is sufficient to open a case to Child Protective Services and maintain information on the case in the State Central Register, if a client refuses services, such services cannot be compelled without the intervention of the court.

This is the client group which CPS administrators consider in urgent need of services. Insufficiently motivated to voluntarily seek counseling, and without the authority of the court to compel counseling, such cases are likely to be involved in additional reports of abuse/neglect, frequently of a more serious nature. Child Protective Services would like to refer these clients to the Family Crisis Program to receive intensive outreach services in an effort to engage the client in necessary counseling. (This kind of intensive outreach was provided by the Community Centers Child Abuse Program. In one case, the Long Beach Project engaged in client outreach for a year, until the client finally agreed to engage in therapy).

The North Shore Hospital site of the Family Crisis Program, however, feels that they can more productively serve clients who have been adjudicated with court-ordered counseling. They feel that the high proportion of clients who have the problem of alcohol abuse, and who are unmotivated to seek treatment, require court ordered treatment in order to become involved in a rehabilitative program.

Another point of view which might be taken, however , is that the most appropriate referrals might be those clients for whom sufficient evidence for adjudication exists, and for whom referral to the Family Crisis Program might serve as an alternative

to court involvement. Child Protective Services does not generally refer these cases, however, since they feel that there is a high likelihood that court involvement may be necessary despite referral, necessitating the appearance in court by project staff and possible subpoena of project records.

It is obvious from this brief discussion that different viewpoints exist on the characteristics of CPS cases most appropriately referred for project services. In addition, North Shore Family Crisis Program staff feel that they are receiving the most difficult cases to serve, and would prefer a random assignment to the project so that some more highly motivated clients would be referred.

CPS staff, however, do not agree that the "most difficult" cases are being referred. In their judgement, cases which would have been referred to the Community Center Program are not suitable for referral to the Family Crisis Program and that "more difficult" cases were referred to the original projects. Both FCP sites require client's signatures on "release information" forms, and CPS staff state that they refer only those clients expressing some willingness to attend the program and to sign the required forms. This implies that the most hostile, resistant clients are not referred to the Family Crisis Program.

The unresolved issue of appropriate referral criteria is one which should have been defined and clearly understood by all involved parties before the start-up of the projects. The lack of resolution of this issue prior to project implementation is a contributory factor to the observed lack of mutual inter-agency agreement on many basic issues.

Recommendation:

- Specific clarification of the criteria or client referral is, even at this late date, a recommendation which may prove productive. Perhaps some agreement may be reached in which a specific number of CPS referrals are designated to be cases with insufficient evidence for adjudication, others have been adjudicated with court-ordered services, and still others are referred as a possible alternative to court involvement.

10.3 Outreach Activities

Another major problem area has been the lack of definition of appropriate outreach activities.

Child Protective Services, since the beginning of the Family Crisis Program, has stated that the projects are not providing the intensive outreach services required by their client population.

Intensive client outreach was one of the primary service modalities of the Community Centers Program, and it was anticipated by CPS that the Family Crisis Program would exert

similar efforts to engage the unmotivated client. CPS caseworkers interviewed by DMC staff repeatedly expressed their dissatisfaction with the outreach efforts of the projects.

The projects, however, feel that they are engaging in appropriate outreach activities. In the opinion of project staff, they have no authority to compel the client to accept the services they offer, and are unwilling to "harass" the client who refuses services. Hospital regulations also limit the number of contacts which staff can make if the client does not agree to services.

Again, it is unfortunate that specific criteria for outreach activities were not clearly defined at the initial stages of project implementation. This lack of clarity has contributed greatly to the existing lack of cooperation and understanding between CPS, DMH, and the projects.

10.4 Referrals from Other Agencies

It was originally anticipated that community agencies, in particular the Coalition for Abused Women, would be major referral sources to the Family Crisis Program. Very few such referrals were actually received.

The major referral sources for non-CPS clients have been primarily "in-house" referrals: North Shore Hospital itself; and, the South Nassau Mental Health Clinic.

Again, it appears that the lack of appropriate inter-agency communication prior to project start-up is primarily responsible for this finding. Staff at the two project sites have been actively involved in disseminating information about the program, and accepting appropriate referrals from the sources most readily available to them - the hospital and Mental Health Clinic with which they are affiliated.

If the Department of Mental Health, as originally proposed, planned to utilize major community agencies as referral sources for the program, specific planning with each such agency prior to project start-up would have greatly facilitated the implementation of these plans.

Informing each such agency of the specific services offered by the Program, requesting information from the agencies regarding the needs of the clients they serve, incorporating agency suggestions into program planning, scheduling regular conferences with each referral agency, and securing written commitments on the number of referrals agreed upon would have been a worthwhile initial activity.

10.5 Implementation of Proposed Services

One of the primary service modalities of the Community Centers Program was group treatment of various kinds for both adults and children. As outlined in the program proposal for

the Family Crisis Program, group therapy and children's groups were seen as an important part of the program.

However, by the end of the first contract year, neither project had as yet implemented any group activities for clients. The South Nassau project, throughout the first year, did not have suitable physical facilities available for groups. At North Shore, the staff report that the clients they serve are not ready to participate in group activity until they have been involved with the program for some time.

Both projects, however, do state that they plan to implement group programs in the near future.

In many ways, despite the fact that the projects are in the second year of operation, the Family Crisis has not yet achieved full implementation of the activities and services outlined in the proposal. In the judgement of the evaluation team, another year of operation should be completed before an outcome analysis of project effectiveness is conducted, in order to allow the projects to provide a full range of services for a long enough period of time to assess full impact.

10.6 Conclusions

Most of the problems experienced by the Family Crisis Program in its initial year of operations are due to poor inter-agency relationships. In the judgement of the evaluation team, a valuable lesson has been learned regarding multi-agency efforts.

When several agencies must function cooperatively, it is absolutely essential that mutual understanding and respect be fostered through a structured, regular context for inter-agency communication.

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APPENDICES

APPENDIX 1

NORTH SHORE HOSPITAL:
LETTER OF INVITATION

NORTH SHORE
UNIVERSITY HOSPITAL
A TEACHING CENTER OF
CORNELL UNIVERSITY MEDICAL COLLEGE

Family Crisis Program,
Division of Child and Adolescent Psychiatry

(516) 562-4990
562-4740

November 21, 1979

Dear [redacted]

We would like to do something for YOU!

Because of the fast pace of everyday life, parents don't often take out the time they need for relaxation and enjoyment, which is very important to help refresh ourselves in today's busy world.

On Thursday evening, December 6th, 1979, our program will sponsor a Smorgasbord Dinner for Parents. (You may also bring a relative or friend.) We expect this to be the first of a series of opportunities for you to enjoy an evening of relaxation and fun! Of course, we would like your ideas and participation in planning these evenings which will take place every two weeks--beginning December 6th through May.

We plan to offer a variety of activities ranging from musical entertainment to cooking demonstrations, and sampling of course! Perhaps you would enjoy the opportunity to learn various crafts, such as making pottery, seasonal decorations, leather goods, etc.--or a chance to make some last minute gifts just before Christmas.

If transportation is a problem for you, please call and let us know so that we may try to make arrangements for you. We would also like to know the number of people who will be coming to our first get-together on December 6th, and whether you plan to bring a relative or friend.

May we hear from you by November 29th.

Sincerely,

Team Member,
Family Crisis Program

APPENDIX 2

DATA COLLECTION FORMS: DEPARTMENT OF MENTAL HEALTH

FRANCIS T. PURCELL
COUNTY EXECUTIVE

ISIDORE SHAPIRO, ACSW
COMMISSIONER

FORM # 1

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3355

FAMILY CRISIS PROGRAM

REFERRAL FORM

Date: _____

Agency Referred to: Family Crisis Program - South Nassau Communities Hospital

Referred From: _____

Address: _____

Contact Person: _____

Telephone Number: _____

Sex: Male ( ) Female ( )

For N.C.D.M.H. use ONLY: F.C.P. Case Number: V _____

Client _____

Address: _____

Telephone Number: _____

Members living in household:

Father _____ Age _____

Mother _____ Age _____

Siblings _____ Age _____ (M) ____ (F) ____

_____ _____ (M) ____ (F) ____

_____ _____ (M) ____ (F) ____

_____ _____ (M) ____ (F) ____

Others living in household:

Name _____ Relationship _____ Age _____

_____ _____ _____

_____ _____ _____

ADC: Yes _____ No _____

Weekly Income: _____ Ethnic Group _____

(over)

Last Prior Contact with Other Agencies:

Agency Name _____ Date _____

_____ _____

_____ _____

_____ _____

Additional Information: (History of service by referring agency)

Reasons for Referral:

Recommendations for treatment planning:

FORM # 2

FRANCIS T. PURCELL
COUNTY EXECUTIVE

ISIDORE SHAPIRO, ACSW
COMMISSIONER

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3355

INTAKE CONFERENCE SUMMARY

Case Name: _____

F.C.P. Case #: _____

Conference Date: _____

Attendance:

NAME	AGENCY

Location of Meeting:

___ Protective Service
___ S.N.C.H.- F.C.P.
___ N.S.U.H. - F.C.P.
___ Other _____

Summary of Meeting:

Problem Areas	Recommendations

(over)

FRANCIS T. PURCELL
COUNTY EXECUTIVE

FORM # 2

ISIDORE SHAPIRO, ACSW
COMMISSIONER

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3350

INTAKE CONFERENCE SUMMARY

Case Name: _____

F.C.P. Case #: _____

Conference Date: _____

Attendance: NAME AGENCY

_____

_____

_____

_____

Location of Meeting:

___ Protective Service

___ S.N.C.H.- F.C.P.

___ N.S.U.H. - F.C.P.

___ Other _____

Summary of Meeting:

Problem Areas	Recommendations

(over)

II. Data Requested for Transmission:

Family Member	* Data	Date Requested

* Data
Code: 1) Medical Records 2) Psychological 3) School Reports 4) Other (Specify) ____

I. CASE ASSESSMENT

a.

Attitude Toward Intervention	Positive	-Inconsistent/ Reticent	Negative
Recognition of problem	6	7	8
Follow through on referrals			
Attitude toward therapy			
Attitude toward project			

b.

Prognosis if no improvement	Not Indicated	Uncertain	Indicated
Petition for adjudication	1	2	3
Removal of child: friends/rel			
foster care			
permanent			
Removal parent: psychiatric			
other			
Recurrence of abuse/neglect			

BK:jds
2/2/79

FRANCIS T. PURCELL
COUNTY EXECUTIVE

ISIDORE SHAPIRO, ACSW
COMMISSIONER

FORM # 3

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3355

FAMILY CRISIS PROGRAM

ONE MONTH INITIAL EVALUATION

Agency _____ Date _____

Case Worker _____

F.C.P. Case Number _____ Date Referred _____

I. Outreach

Date of First Contact _____ # Tel. Contacts _____ # Home Contacts _____

Problem Encountered in Outreach:

II. Engagement: Actively accepting treatment (if not engaged, list reasons or problem areas).

Date Engaged: _____

Progress to date:

III. Date of first office visit _____

Number of office visits by client (to date) _____

(over)

IV. Evaluation/Diagnosis (include tests administered and results):

V. Treatment Planning Meeting:

ATTENDANCE

NAME	AGENCY

VI. Short Term Goals:

PROBLEM	GOAL

VII. Long Term Goals:

PROBLEM	GOAL

VIII. Referrals:

Client	Age	Agency	Problem

jds
/79

FRANCIS T. PURCELL
COUNTY EXECUTIVE

ISIDORE SHAPIRO, ACSW
COMMISSIONER

FORM # 4

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3355

FAMILY CRISIS PROGRAM

FIRST CONTACT - SUMMARY SHEET

Date _____

Agency _____

Agency Contact Name _____ Telephone No. _____

Client Name _____

Address _____

Telephone No. _____

1) Date and time of initial meeting; description of any prior attempts to schedule meeting and problems encountered (not home, refused to see social worker, etc.):

2) Description of family members seen and general response to project social worker; description of home environment emphasizing observations related to abuse/neglect substantiation:

(over)

3) Concerns expressed by client:

4) Assessment of client understanding or problem, attitudes toward therapy, barriers to engagement, if any:

5) Agreement reached with client (further home visits, meetings with other family members, referrals, etc.):

HK:jds

FRANCIS T. PURCELL
COUNTY EXECUTIVE

ISIDORE SHAPIRO, ACSW
COMMISSIONER

FORM # 5

NASSAU COUNTY
DEPARTMENT OF MENTAL HEALTH

240 OLD COUNTRY ROAD
MINEOLA, N. Y. 11501
516 535-3355

FAMILY CRISIS PROGRAM

MONTHLY - CLIENT PROGRESS REPORT

Date _____

Family Crisis Program Case No. _____

Agency _____

Agency Contact Person _____ Telephone No. _____

Date Referred _____

Referral Agency _____

Client Name _____

Address _____

Telephone No. _____

PROGRESS REPORT NARRATIVE:

(Refer to Short Term and Long Term Goals)

GOAL	ACTION TAKEN

(over)

Goal	Action taken

STATUS OF CPS ISSUES

CPS Issues	1 Significant Improvement	2 Somewhat Improved	3 No Change	4 Somewhat Deteriorated	5 Signific Deteri
1					
2					
3					
4					
5					
6					

SOUTH NASSAU COMMUNITIES HOSPITAL MENTAL HEALTH CLINIC
FAMILY CRISIS PROGRAM

SUPPLEMENT TO THE MONTHLY TREATMENT PLAN

MONTH _____ YEAR _____

1. CASE NAME BY INDIVIDUAL _____ or CASE # _____

2. # of sessions this month 5 cumulative to date 15

3. # of weeks in treatment from first day of treatment 12

4. List below any change in id data (address, birthdate etc) of pt:

5. Any change this month in major complaints or symptoms now focused on? list below if any:

6. List below any significant new information about past history of physical, mental ills:

8. CHANGES IN MENTAL STATUS: list below

9. CURRENT DIAGNOSTIC ASSESSMENT _____

Is this a change? _____

APPENDIX 3

INTERVIEW GUIDES: CPS WORKERS

INTERVIEW GUIDE
CASE WORKERS

CASE SPECIFIC INFORMATION

Central Registry Number:_____

Is client on Public Assistance?_____

Is client Medicaid eligible?_____

I. Court Petitions:

a. Is there sufficient evidence in this case for a court appearance?_____

b. Has the case been adjudicated? _____

How?_____

c. Is a court appearance planned?_____

d. Are all the children in the home?_____

e. If not, have children been removed to foster care, relatives or other?_____

II. Referral:

a. Has case been referred to Family Crisis Program?

Name of Project_____

b. Has case been referred to Mental Health Clinic?

Name of Clinic_____

c. Was case served by old projects?_____

Name of Project_____

*If Yes, go on to Question VII

III. Case Problems:

_____

_____

_____

(Show problem to worker; list above the numbers of relevant problems.)

IV. Case Goal (return home, adoption, reduce neglect in Family)

_____

_____

_____

V. Service Plan:

(obtain a statement of a service components included in the service plan. Ex. day care, homemaker counseling)

_____

_____

_____

VI. How would you describe this case?

(Extremely difficult, hostile, cooperative, psychotic, etc.)

_____

_____

_____

VII. Old Project Cases:

a. Is the case still open? ___ yes ___ no

IF YES:

b. Nature of the case which is still open:

___ abuse ___ neglect

c. Reason for case remaining open:

_____

_____

_____

d. Has the case been reopened? ___ yes ___ no

e. Reason for reopening the case (Client requested service, a new referral about the family was received by the agency)

_____

_____

f. What services are currently being provided? (Counseling, Day Care, Homemaker, etc.)

_____

_____

g. How would the worker characterize this case? (Extremely difficult, hostile, chronic, etc.)

_____

_____

INTERVIEW GUIDE
CPS WORKERS

GENERAL PROJECT INFORMATION

If the worker has a case in the new projects ask the following question.

A. Is the worker satisfied with the services being provided by the project.
YES_____ NO_____

B. Is there a particular service, feature or aspect of the project which the worker would like to comment on.

If the worker has a case in each project

C. Ask if the workers sees any differences in service provision.

If the worker has a case in the new project and a case in a mental health center

D. Ask if the worker sees any difference in service provision.

E. If the worker referred cases to the old projects, was the worker satisfied with the services provided?

F. Does the worker have specific comments regarding the old projects?

G. Does the worker see any differences in service provision between the old and new projects?

APPENDIX 4

DATA CODING FORMATS

CODING FORMAT

Central Register Data
CPS Control Group
CPS Project Cases

CARD 1

Column			
1		Card # 1	
2--7		CR #	
8		Single Parent Female Household	YES=1
9		Single Parent Male Household	YES=1
10		Two Parent Household	YES=1
11		Hospitalized	YES=1
12			
13	Blank		
14			
15		Petitions:	NO ACTION=1
16		Petition Pending in Family Court	=1
17		Substantiation Code A (1)	YES=1
18		B	YES=1
19		C	"
20		D	"
21		E	"
22		F	"
23		G	"
24		H	"
25		I	"
26		J	"
27		K	"
28		L	"
29		M	"
30		N	"
31		O	"
32		P	"
33		Q	"
		Code only 1 of 3 columns below: whichever category is most serious	
34		Least Serious Substantiation (G,I,L,M,N,O,P,Q)	YES=1
35		Moderately Serious Substantiations (D,F,K)	YES=1
36		Most Serious Substantiations (A,B,C,E,H,J)	YES=1
37		Child Never Removed	=1
38		Child Removed and Returned	=1
39		Child Removed and Not Returned	=1
40		Number of Prior Indications	
41		Project Code Control Group	=6

CODING FORMAT CON'T

CARD 2

1--6	CR Number	
7	Perpetrator Mother Only	= 1
8	Perpetrator Father Only	= 1
9	Both Parents	= 1
10-11	Number of Abuse Children	
12-13	Number of Children in Family	

OLD PROJECT CASES UPDATE
CODING FORMAT

COLUMN		
1--2	DMC # (Leave Blank for now)	
3--8	CR Number	
9	Case Status	1=Still Open; 2=Closed 3=Placement Monitoring 4=Reopened 9=Unknown
10-13	Date of Closing if Closed	Month (10,11), Year (12,13)
14-17	Date of Reopening if re-opened	Month (14,15), Year (16,17)
18	Any children ever removed?	1=YES 0=NO 9=MISSING
19	# of children ever removed	
20	Any Children removed and returned	1=YES 0=NO 9=MISSING
21	Number of children returned	
22	Any removals after 8/77	1=YES 0=NO 9=MISSING
23-26	Date of removal (most recent)	Month (23,24), Year (25,26)
27	Number of Children removed after 8/77	
28	Any children returned after 8/77	1=YES 0=NO 9=MISSING
29-32	Date of return (most recent)	Month (29,30), Year (31,32)
33	Number of Children returned after 8/77	
34	Second report after 8/77?	1=YES 0=NO 9=MISSING
35-38	Date of Above	Month (35,36) Year (37,38)
39-55	Substantiation	1=YES
56	Court petition after 8/77?	1=YES
57-60	Date of Above	Month (57,58), Year (59,60)
80	Project Code	1=Long Beach Family Center 2=Parent Child-Levittown 3=CPS Control Group

CODING FORMAT
DMH DATA

CARD #1

Referral Form (Non-CPS Cases) Form #1 or Intake Conference Summary (CPS cases) Form # 2

Column	Variable	Code
1	Card Number	1
2--10	Sondex #	Start in column 2
11-16	Central Registry #	Leave blank at present
17	Project Code	North Shore =4 South Nassau =5
18	Referral Source	1=Coalition for Abused Women 2=Department of Probation 3=South Nassau Mental Health Clinic 4=CPS 5 6 7
19	Household Composition	Single Parent Female =1 Single Parent Male =2 Two Parent Household =3 Other =4
20-21	Number of Children in Family	
22	ADC	YES=1 MISSING=9
23	Weekly Income	1=Under $100.00 2=$101.00-$200.00 3=$201.00-$300.00 4=$301.00-$400.00 5=More than $400.00 9=MISSING
24	Ethnic Group	1=White 2=Black 3=Hispanic 9=MISSING 4=Oriental 5=Other
25	Reason for Referral	1=Child Abuse/Neglect 2=Spouse Abuse 3= 4= 5=

GO TO COLUMN 61 FOR NON-CPS CASE

Column	Variable	Code
26-60	Problem Areas	Problem List 1=YES
26	Congenital Illness	
27	Chronic Illness	
28	Physical Handicap	
29	Diagnosed Mental Retardation	
30	Premature Birth	
31	Colicky Infant	
32	Physical Development	
33	Overly Active	Involved Children
34	Emotionally Withdrawn	
35	Aggression/Hostility	
36	Learning Skills/Poor School Performance	
37	Juvenile Offenses/Adolenscent Acting Out	
38	Sexual Behavior	
39	Marital Conflict/Non-Support. Spouse	
40	Physical Abuse or Spouse	
41	Dependency Role Reversal	
42	Limited Financial Resources	
43	Financial Problems	
44	Unemployment/Underemployment	Family Problems
45	Substandard Housing	
46	Cultural/Religious Background	
47	Physical Handicap	
48	Chronic Illness	
49	Psychiatric Disorder	
50	Mental Retardation	
51	Drug Dependence/Addiction	
52	Alcohol Dependence/Addiction	Caretaker Problems
53	Pregnancy	
54	Low Self-Esteem	
55	Inappropriate Means of Expressing Anger	
56	Unrealistic Expectations of Child	
57	Unrealistic Perception of Child	
58	Socialization Skills	
59	Social Isolation	
60	Home Management Skills	

Column	Variable	Code
61-80	Recommendations	Service List 1=YES

61	Educational Testing
62	Psychiatric/Psychological Evaluation
63	Health Screening (Physical)
64	Health Treatment (Physical)
65	Homemaker
66	Home Management
67	Day Care (Child)
68	Crisis Nursery (Child)
69	Legal Services
70	Housing Improvement
71	Employment Related
72	Debt and Budget Management
73	Parent Effectiveness Training
74	Individual Therapy
75	Marital or Family Therapy
76	Other Group Therapy
77	Play Therapy (Child)
78	Day Treatment (Child)
79	Drug or Alcohol Treatment
80	No Services Required

CARD #2

Form #2 (Intake Conference Summary)

Column	Variable	Code
1	Card #	2
2--10	Sondex #	
11-16	Central Registry Number	
	Case Assessment	
	Attitude	
17	Recognition of Problem	
18	Follow through on Referrals	1=Positive
19	Attitude toward therapy	2=Inconsistent/Reticent
20	Attitude toward project	3=Negative
	Prognosis	
21	Petition for Adjudication	
22	Removal of child/Friends or Relatives	
23	Removal of child/Foster Care	1=Not Indicated
24	Removal of child/Permanent	2=Uncertain
25	Removal of Parent/Psychiatric	3=Indicated
26	Removal of Parent/Other	
27	Recurrence of abuse/neglect	

Form #3 One Month Initial Evaluation

28-31	Date Referred	Month (28,29), Date (30,31)
32-35	Date of First Contact	Month (32,33), Date (34,35)
36-37	Number of days between referral and first contact	
38	Number of telephone Contacts	
39	Number of home Contacts	
40-41	Outreach Problems	01=Financial 02=Unavailibility of Client 03= 04= 05= 06= 07=
42-45	Date of Engagement	9999=Not Engaged
46-47	Number of days between first contact & engagement	

Column	Variable	Code
48	Problems of Engagement	1=No Problem 2=Not Keeping Appointment 3= 4= 5= 6= 7=
49-52	Date of First Office Visit	
53-54	Number of Days between Engagement and Office Visit	
55	Diagnosis, if any	01= 02= 03= 04= 05= 06= 07= 08= 09= 10=
56-57	Short Term Problem 1	01=Parent/Child Relationship 02=Alcohol 03=Child(ren) Learning 04=Child(ren) Emotional Needs 05=Child(ren) Physical Problems 06=Child at Risk 07= 08= 09= 10=
58-59	Short Term Goal 1	01=On-going Assessment 02=Referral to Alcohol Treatment 03=Outreach 04=Counseling 05=Monitor Visitation 06=Child Treatment 07=Parenting Skills 08=Family Relationships 09=Individual Emotional Assistance 10=Socialization Skills
60-61	Short term Problem 2	(Code as Problem 1)
62-63	Short term Goal 2	(Code as Goal 1)
64-65	Short term Problem 3	
66-67	Short Term Goal 3	

Column	Variable	Code
68-69	Long term Problem 1	01=Denial 02=Custody 03= 04= 05= 06= 07= 08= 09= 10=
70-71	Long term Goal 1	01=Awareness 02= 03= 04= 05= 06= 07= 08= 09= 10=
72-73	Long term Problem 2	(Code as Long Term Problem 1)
74-75	Long term Goal 2	(Code as Long Term Goal 2)
76-77	Long term Problem 3	
78-79	Long term Goal 3	

END