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16. Abstracts
This report presents an analysis framework for studying the impacts of eleven demonstration child abuse and neglect projects on their local child abuse and neglect service systems. In the context of this framework, the impact of individual projects on their community systems and a comparative analysis of impact are discussed. Central to the analysis are factors associated with improvement in the following areas: community coordination mechanisms; interdisciplinary input at all treatment stages; a centralized and responsible reporting system; availability of a comprehensive set of services; the quality of case management throughout the system and the level of community education and public awareness.

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PREFACE

In May of 1974, the Office of Child Development and Social and Rehabilitation Services of the Department of Health, Education and Welfare jointly funded eleven three-year child abuse and neglect service projects to develop strategies for treating abusive and neglectful parents and their children and for coordination of community-wide child abuse and neglect systems. In order to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, the Division of Health Services Evaluation of the National Center for Health Services Research, Health Resources Administration of the Department of Health, Education and Welfare awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report is one of a series presenting the findings from that evaluation effort.

This evaluation effort was the first such national study in the child abuse and neglect field. As such, the work must be regarded as exploratory and suggestive, not conclusive. Many aspects of the design were pioneered for this study. Healthy debate exists about whether or not the methods used were the most appropriate. The evaluation focused on a demonstration program of eleven projects selected prior to the funding of the evaluation. The projects were established because of the range of treatment approaches they proposed to demonstrate, not because they were representative of child abuse programs in general. The evaluation was limited to these eleven projects; no control groups were utilized. It was felt that the ethics of providing, denying or randomly assigning services was not an issue for the evaluation to be burdened with. All findings must be interpreted with these factors in mind.

Given the number of different federal agencies and local projects involved in the evaluation, coordination and cooperation was critical. We wish to thank the many people who helped us: the federal personnel responsible for the demonstration projects, the project directors, the staff members of the projects, representatives from various agencies in the projects' communities. Ron Starr, Shirley Langlois, Helen Davis and Don Perlgut are all to be commended for their excellence in processing the data collected. And in particular we wish to thank our own project officers from the National Center for Health Services Research--Arne Anderson, Feather Hair Davis and Gerald Sparer--for their support and input, and we wish to acknowledge that they very much helped to ensure that this was a cooperative venture.

Given the magnitude of the study effort, and the number and length of final reports, typographical and other such errors are inevitable. Berkeley Planning Associates and the National Center for Health Services Research would appreciate notification of such errors, if detected.

LIST OF CONTENTS

LIST OF CONTENTS (Cont.)

SUMMARY

Introduction

In May of 1974, prior to the first expenditures of funds appropriated under the Child Abuse and Neglect Prevention and Treatment Act, P.L. 93-247, the Office of Child Development and Social and Rehabilitation Services of DHEW jointly funded eleven three-year demonstration child abuse and neglect projects to develop and test alternative strategies of treating abusive and neglectful parents and their children, and alternative models for coordinating community-wide child abuse and neglect systems.

The projects, located around the country and in Puerto Rico, differed in size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. In order to document the context of the different service interventions being tested and to determine their relative effectiveness and cost effectiveness, the Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the demonstration effort. This Community System Impact Report presents the findings from that evaluation related to the changes which have occurred in each of the demonstration communities' child abuse and neglect systems, the extent to which those community systems now approach the "ideal", and the demonstration projects' contributions to the observed changes.

Methodology

A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resource committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. Then people were re-interviewed at yearly intervals to collect information about the changes which had or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit of the contract staff from project personnel, Project Advisory Board members, and knowledgable individuals in the community. The data were hand tabulated and analyzed by BPA staff. The focus of the analysis was to study changes that had occurred in the community system during the demonstration period; and in the process to determine whether knowledge and theories about community service systems in general are applicable to the child abuse and neglect field. The findings of this effort are, of course, limited, because of the absence of control communities.

Community System Impacts

Attempts to better coordinate the respective efforts of all community agencies who have occasion to deal with child abuse and neglect cases invariably took the form of organizing community-wide multi-agency coordinating groups (councils or boards) and developing formal coordinative agreements with various agencies around the handling of specific case-management functions such as reporting cases, service planning, and case referral. In each community that did not have a multi-agency coordinating body prior to the demonstration project's implementation, except St. Louis, such councils or boards were subsequently developed by the projects, often as Project Advisory Boards. Several of these, during the course of the three years, became autonomous from project sponsorship and developed into community-wide bodies.

The factors which appear to have facilitated effective coordinating council operations were (1) the existence of strong, committed leadership; (2) the development of council sub-committees focused on particular issues or tasks; and (3) expansion of the council's mandate beyond community coordinating concerns to include efforts such as amending legislation, providing community education or securing funds for specific programs.

Although there was no relationship between the project's sponsorship (e.g., public agency or independent) and success in developing these coordinating bodies, there was definitely a relationship between sponsorship and a given project's ability to stimulate formal coordinating agreements between agencies on a system-wide basis. Thus, those projects that were protective service agency-affiliated developed more coordinative agreements between themselves and other agencies than independent projects, and the communities in which these public agency projects were housed also evidenced an increase in coordination agreements among more non-project agencies than did the communities in which the demonstration project was an independent program.

The development of multi-disciplinary teams, either community-wide or agency specific (project or hospital teams), was the primary method of securing interdisciplinary input for case review and management, although several projects also hired staff or consultants of various disciplines to extend the primary social work orientation of most community systems. All project communities had multidisciplinary teams, although in only six communities were these teams available to review cases on a community-wide basis.

Although setting up the teams was, logistically, relatively easy, problems related to developing operational guidelines for the team (how often to meet, how many cases to review, how cases were to be presented, who was to attend meetings) were prevalent. Staff were often ill-equipped to appropriately use the teams; they were not trained to present cases effectively or to make the best use of the individual team members' expertise. Finally, these teams were generally able to review only a small proportion of the

total cases in any community. For these reasons, several teams have undergone numerous modifications in attempts to increase their usefulness.

Centralized reporting systems and 24-hour coverage for the receipt of reports appear to have been solved satisfactorily in each of the demonstration communities except one. Although in only seven communities has reporting been centralized in the local protective service agency, the remaining three communities with dual systems have developed arrangements whereby the sharing of reports or referral of cases between agencies occurs smoothly. Twenty-four-hour coverage exists in nine communities; in eight of these, the after-hours systems were developed subsequent to demonstration projects implementation and most often the projects were heavily involved in the system's development. State legislation was clearly the major input to development of a centralized reporting system, and most often to the development of 24-hour coverage as well.

Although, in general, all types of child abuse and neglect cases are provided some services in each community, there appears to still be a definite difference in both the numbers of different types of cases accepted for service and the quality of service provision. Although substantiated cases of both abuse and neglect are handled by child protective services in each community, abuse cases are afforded a priority in most cases, being dealt with more quickly and thoroughly and receiving more intensive service; neglect cases are less carefully monitored, receiving mere "maintenance" services in many cases. Likewise, although reported sexual abuse cases always receive services, in only two communities have any steps been taken to provide special services tailored to the needs of this client group. Finally, high risk or potential cases of both abuse and neglect are sometimes handled by the protective service agencies, and sometimes not, depending primarily on how large the caseloads are and whether there is any provision for this type of case covered by state statute.

Each of the demonstration projects increased substantially the amount and type of services that were available in their communities for dealing with child abuse and neglect cases, but were generally unable to effect the provision of additional services by other community agencies. All projects provided individual counseling and advocacy services to their clients and group therapy or counseling was the new service most consistently provided by the projects, in addition to more concrete supportive services such as transportation and homemaking.

Many of the projects also added relatively innovative services such as self-help programs, counseling hot-lines, or educational services. Since these services were generally available to only project clients, however, unless the projects were affiliated with the local protective service agency, the services were provided to only a small proportion of the community's cases.

Services for children and preventive services were generally inadequate in the communities and only a few projects addressed these problems in any meaningful way; two projects provided extensive therapeutic services for children, but to a small caseload, and one project developed a program of visiting parents of newborns to acquaint them with the community services available. There was little recognition on the part of either project or other agency staff that these might be important areas to pursue.

There was little proliferation of services by community agencies other than the projects. The problems with developing such service increases appear to be both a lack of resources and commitment on the part of other agencies, and a pervasive attitude that with the development of the demonstration project the problem of inadequate service was no longer a "system" problem, but was a "project" responsibility.

The utilization of community resources besides the demonstration projects and protective service agencies was generally poor. Many more agencies and groups, both public and private, existed in each community than were tapped to provide services for cases of abuse and neglect.

Except for communities where the demonstration projects were housed in, or affiliated with, the local protective service agency, little change in the quality of case management, system-wide, was observed. The timing of responses to reports by the legally mandated agencies was generally good, with most reports responded to in two days or less. Several projects affiliated with CPS agencies developed special Intake Units which appeared to facilitate adequate response to reports. The adequacy of case assigment, service planning and case monitoring, system-wide, remained much the same as it was prior to project's implementation, except in those few cases where multidisciplinary teams were instituted for case review and service planning. Each of the projects generally handled these functions more adequately than is usual in a protective service agency, but any carry-over to the remainder of the system was evident only in communities where the projects had an affiliation with the protective service agency. The termination and follow-up procedures of both community agencies and the demonstration projects were generally poor, and little change was observed during the demonstration period.

All of the projects provided extensive education and training to both professional and community residents. This education and training, although mostly focused on professionals, reached a wide audience; between 3,000 and 28,000 people in each community were educated during the course of the demonstration.

In summary, although the projects did have significant success in correcting many of the deficiencies in the community systems, especially problems of coordination and expansion of services under the projects' auspices, several problems consistently remain in the project communities at the end of the demonstration period. Coordination among both public and private agencies is inadequate; interdisciplinary input, while provided for in some cases, is not afforded the majority of the communities' cases; existing community resources have not been fully utilized in the provision of services; child

neglect and high risk cases are provided minimal services; preventive services and therapeutic services for children are inadequate; and the case management function, particularly with respect to adherence to appropriate termination procedures and the provision of follow-up, is generally less than optimally carried out.

INTRODUCTION

History of the Demonstration Effort

During the fall of 1974, prior to the passage of the Child Abuse Prevention and Treatment Act, Public Law 93-247, the secretary's office of the federal Department of Health, Education and Welfare (DHEW) allocated four million dollars to child abuse and neglect research and demonstration projects. A substantial portion of that allotment, approximately three million dollars, was to be spent jointly by the Office of Child Development's (OCD) Children's Bureau, and Social and Rehabilitation Services (SRS) on a set of demonstration treatment programs. On May 1, 1974, after review of over 100 applications, OCD and SRS jointly selected and funded eleven projects for a period of three years.[1] The projects, located across the country, differ by size, the types of agencies in which they are located, the kinds of staff they employ, and the variety of services they offer to clients and their local communities. However, as a group, the projects embrace the federal goals for this demonstration effort, which include:

(1) to develop and test alternative strategies for treating abusive and neglectful parents and their children;

(2) to develop and test alternative models for coordination of community-wide systems providing preventive, detection and treatment services to deal with child abuse and neglect;

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[1]The projects include: The Family Center: Adams County, Colorado; Pro-Child: Arlington, Virginia; The Child Protection Center: Baton Rouge, Louisiana; The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico; The Arkansas Child Abuse and Neglect Program (SCAN): Little Rock, Arkansas; The Family Care Center: Los Angeles, California; The Child Development Center: Neah Bay, Washington; The Family Resource Center: St. Louis, Missouri; The Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida; The Panel for Family Living: Tacoma, Washington; and the Union County Protective Services Demonstration Project: Union County, New Jersey.

(3) to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness.

In order to accomplish this third goal, as part of DHEW's strategy to make this demonstration program an interagency effort, the Division of Health Services Evaluation, National Center for Health Services Research of the Health Resources Administration (HRA) awarded an evaluation contract to Berkeley Planning Associates (BPA) in June 1974, to monitor the demonstration projects over their three years of federal funding and document the effectiveness of their effort.

Overview of the Demonstration Evaluation

The overall purpose of the evaluation was to provide guidance to the federal government and local communities on ways of developing community-wide programs to deal with problems of child abuse and neglect in a systematic and coordinated fashion. The study, which combined both formative (or descriptive) and summative (or outcome/impact related) evaluation concerns, documented the content of the different service interventions tested by the projects and determined the relative effectiveness and cost-effectiveness of these strategies. Specific questions, addressed through analysis of quantitative and qualitative data gathered through a variety of collecting techniques, notably quarterly five-day site visits, special topic site visits and information systems maintained by the projects for the evaluators, include:

- What are the problems inherent in and the possibilities for establishing and operating child abuse and neglect programs?
- What were the goals of each of the projects and how successful were they in accomplishing them?
- What are the costs of different child abuse and neglect services and the costs of different mixes of services, particularly in relation to their effectiveness?

- What are the elements and standards for quality case management and what are their relationships to client outcome?

- How do project management processes and organizational structures influence project performance and, most importantly, worker burnout?

- What are the essential elements of a well-functioning child abuse and neglect system and which project activities are most effective in influencing the development of these essential elements?

- What problems do abused and neglected children possess and how amenable are such problems to resolution through treatment?

- And finally, what is the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors?

During the summer of 1974, the projects began the lengthy process of hiring staff, securing space and generally implementing their planned programs. Concomitantly, BPA collected baseline data on each of the projects' community child abuse and neglect systems and completed design plans for the study. By January 1975, all but one of the projects was fully operational and all major data collection systems for the evaluation were in place. Through quarterly site visits to the projects and other data collection techniques, BPA monitored all of the projects' activities through April 1977, at which time the projects were in the process of shifting from a demonstration status to that of an ongoing service program. Throughout this period, numerous documents describing project activities and preliminary findings were prepared by the evaluators.[1]

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[1] See Appendix A for a listing of other major evaluation reports and papers.

Project Profiles

As a group, the projects demonstrated numerous strategies for community-wide responses to the problems of abuse and neglect. The projects each provided a wide variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and paraprofessionals in the provision of these services; they each utilized different coordinative and educational strategies for working with their communities; and they were housed in different kinds of agencies and communities. While not an exhaustive set of alternatives, the rich variety among the projects has provided the field with an opportunity to systematically study the relative merits of different methods for dealing with the child abuse and neglect problem.

Each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado

The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred on to the central child protective services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia

Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a multidisciplinary diagnostic review team. as well as to provide consultation to individual workers.

The Child Protection Center: Baton Rouge, Louisiana

The Child Protection Center, a protective services-based agency, tested a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all CPC cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment program, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases.

The Arkansas Child Abuse and Neglect Program: Arkansas

In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource poor state, like Arkansas, could expand its protective service capability by using lay therapists, supervised by SCAN staff, to provide services to child abuse cases.

The Family Care Center: Los Angeles, California

The concept behind the Family Care Center, a hospital-based program, was the demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington

This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally-based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri

A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida

Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as parent education classes, which others could then adopt.

The Panel for Family Living: Tacoma, Washington

The Panel, a volunteer-based private organization, demonstrated the ability of a broadly-based multidisciplinary, and largely

volunteer, program to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey

This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private service agencies in the county.

The Community Systems Analysis

A central aspect of the Evaluation of Joint OCD/SRS Demonstration Projects in Child Abuse and Neglect has been the assessment of the extent to which delivery systems for child abuse and neglect in communities with demonstration projects have undergone positive changes during the period of federal funding.

The importance of contributing to the development of a more effective community-wide service delivery system has been reiterated in both the goals identified as top priority for the national demonstration program and the goals clarified by each of the individual projects. As indicated earlier, one of the three goals of the overall demonstration program was:

> To develop and test replicable models of community-wide systems providing preventive, detection, and treatment services to deal with child abuse.

Each of the individual projects identified increased coordination of services and the development of more effective service delivery systems in their communities as a goal either in its grant proposal, or in the goal clarification exercise undertaken as part of this evaluation.

There were several purposes in undertaking this community systems evaluation. These included:

(1) To confirm what the most essential elements of a well-coordinated, well-functioning community child abuse and neglect system are;

(2) To monitor the changes in the child abuse/neglect system in the demonstration communities and to assess the extent to which positive changes (in terms of an "ideal" system) in these communities have occurred during the demonstration period;

(3) To determine the relative influence of specific factors in each community system (including effects of the demonstration project efforts) which have facilitated improved system coordination and functioning;

(4) To highlight and analyze factors which have impeded development of adequate community systems and, where possible, provide recommendations for solving these problems in other communities;

(5) To provide information on the probable longevity of the changes in these community systems subsequent to the end of federal demonstration funding.

The overall purpose, then, was not to compare the demonstration projects against each other, in terms of which projects worked "best" in changing their community systems, but to assess the general effectiveness of the projects, and other community agencies, in upgrading their own child abuse and neglect systems, and to confirm what specific factors either facilitate or inhibit communities from developing adequate systems for providing prevention, detection, and treatment services to abusive and neglectful parents and their children.[1] Much is known already about how to enhance the functioning of social service systems in general. The study serves to assess the applicability of such generalized knowledge to the specific problems of child abuse and neglect service delivery. This report presents the findings from the Community Systems Analysis. The interpretation of findings must be undertaken with care. No data on control communities were collected, and the projects studied do not necessarily represent child abuse and neglect programs in general.

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[1] Only ten projects are included in this study. The Los Angeles project, a residential facility, provided services to too few families (ten at any given time) to have realistically modified the Los Angeles community's general system for child abuse and neglect. Also, implementation and operational problems precluded any community endeavors from being undertaken by project staff until the final months of the project's operation.

SECTION I: METHODOLOGY

Development of the methodology for assessing changes in the demonstration communities' systems for child abuse and neglect and the projects' contributions to such changes took place during the first six months of the three-year evaluation period. The original intention was to provide an assessment of community system change by (a) analyzing service statistics both before the demonstration projects' implementation and after several years of operation, (b) analyzing documented projects' efforts to enhance community system operation and (c) conducting periodic structured interviews with representatives of key community agencies to elicit their perceptions of improved community system operation.[1] As more was learned about the communities during this early stage of the evaluation, these plans were modified significantly to reflect the actual situations as found in the ten communities. In essence, a descriptive case study approach replaced more structured survey and data analysis plans, due to a lack of availability of case statistics as well as an inability to control for a myriad of factors (both from within and outside the community) that may have influenced the community system. Data for this assessment were collected in the following ways:

A. Data Collection

1. Community Agency Representative Interviews. During our first site visits to the projects in the fall of 1974, with the help of the project directors, an inventory of all key agencies in each of the eleven communities was made based on our knowledge of child abuse/neglect systems. Interviews were conducted with representatives of the key agencies in order to gather baseline information on the services available, the way services were coordinated, the degree of awareness of both professionals and citizens about child abuse and neglect, and the existence of any gaps, duplications or other problems in the system.[2] These interviews were carried out using structured

[1] See Community Systems Report on Analytical Design and Baseline Data by Berkeley Planning Associates, March 1975.

[2] The focus of the data collection was on the way community systems operated prior to the funding of the demonstration projects.

interview guides developed specifically for this purpose (see Appendix B).

The key agencies in every community included, at a minimum: the protective service agency, the Juvenile Court or other court with responsibility for child abuse cases (e.g., Family Court), the Police Department, the Sheriff's Office, the school district office, one or more hospitals which provided care to a large number of infants and children, and the foster care agency of the community. In addition to these agencies/programs, various others were identified as particularly important in certain communities. These included: private counseling or social service agencies, mental health centers, public health nursing departments, community hotline agencies, children's treatment programs, and centralized record keeping sources such as state central registries. Where an agency was considered key to the community's child abuse and neglect system, they were included in this round of interviews. The descriptive baseline information received from these key agency representatives was judged to be highly accurate (based on the evaluators' observations and consistency between those interviewed) with respect to categorizing the operation in the community systems, including the identification of strengths and weaknesses in these systems prior to the demonstration's implementation; these observations thereby provided the basis for describing the changes later observed which are included in this report.

A second and third round of interviews with community agency representatives, using similar but more detailed questionnaires, was conducted in January 1976 and January 1977 in order to provide comparative information at several points in time. In addition to determining the changes which had occurred in the way these communities handled child abuse and neglect problems, respondents were also asked to provide information on the role played by the demonstration project in enhancing the community system's operation.

The major portion of the descriptive information in this report is a result of these community interviews.

2. Statistical Record Keeping. In addition to the information collected through community interviews, the design of this component relied heavily on analysis of service and caseload statistics from the various community agencies within the child abuse/neglect service system. The original plan was to compare the changes in these statistics from the baseline period (one year prior to the project's implementation) through termination, a period of four years. However, the first round of interviews with community agency representatives pointed out numerous constraints relative to the availability and quality of the numerical or statistical baseline data which were necessary for the analysis. Thus, for example, few communities had what would be considered community-wide statistics of unduplicated numbers of cases in the service system, proportions of abuse versus neglect cases, the sources of reports of cases, or final data on the disposition of cases (e.g., foster care placements, problems satisfactorily resolved, permanent placements, etc.). In the few cases when communities did have adequate data, it was often found that owing to the differences in record keeping procedures, philosophies, and definitional problems, these data were not comparable across communities. And, finally, in several agencies, there was reluctance to undertake the necessary collection of ongoing service data for the next three years which would be necessary for comparative analysis among projects.

In response to these constraints, we limited the number of agencies in each community for this record keeping to the two which appeared most central to child abuse and neglect, the protective service agency and the juvenile (or comparable) court. These agencies were requested to maintain ongoing data on various aspects of reporting and service delivery (see Appendix B for instrumentation). Even with this reduction, however, not all of these agencies could provide adequate data in the format required. Protective service statistics tended to be complete, but not always comparable across communities, while data from the courts are less consistent for each community. When the data were judged reliable, they have been used in the report as supporting evidence for the more descriptive analysis of community system changes.

3. Project Record Keeping. The two areas in which the demonstration projects were most consistently directing their community efforts were the improved coordination among agencies and professionals, and the increased education of professionals and community citizens. In order to gauge the amount of effort expended in these areas which could later be compared with the effectiveness of those efforts, projects kept data on the number and type of coordination and education activities undertaken, the focus of those activities, and the observable results (see Appendix B for instrumentation).

In addition to these structured data collection mechanisms, other information relative to the operation of the community systems and changes which were occurring, was gathered informally from demonstration project directors during each site visit, by means of written materials supplied by the projects, and often through attendance at community or project Advisory Board meetings.

All of the information collected was checked by the evaluators for accuracy, hand tabulated, and analyzed.

B. Data Analysis

All of the collected data, both quantitative and qualitative, relative to changes which each community system has undergone and information about the demonstration projects' community activities has been integrated to analyze the impact of the projects on their respective community systems and to identify effective approaches to the implementation of coordinated and effective community-wide service delivery systems. Intra-community analyses and across-community analyses have been undertaken to portray a broad picture of both the individual project's successes and the achievement of the overall demonstration program relative to community impact.

1. Intra-Community Analysis

In the intra-community analysis, we were concerned with assessing each community "on its own terms" or in terms of its own baseline condition prior to the demonstration period. This is particularly important due to the diversity of the communities along parameters such as geographic setting, state child abuse legislation and administrative policies, the extent to which communities were "child abuse aware," and the amount of previous efforts to achieve greater coordination and more effective service delivery prior to the demonstration period.

The analysis of the communities depended upon a comparison of each system from the baseline period (1972-1973) through the three-year demonstration period, in this case roughly through January 1977. The analysis was focused on five specific issues within each community:

a. System Operation: the functional roles and interrelationships among the key agencies in the service delivery system;

b. Caseload Size and Case Outcomes: the magnitude of the reported abuse and neglect problem in each community and the dispositions made of cases entering the system;

c. Legislative and Resource Base: the legislative foundation and level of resource commitment to abuse and neglect in each community;

d. System Coordination: the nature and extent of collaborative arrangements among key agencies in the system;

e. Community Knowledge and Awareness: the amount of education provided to professionals and citizens and the level of knowledge and awareness of the dynamics of abuse and neglect and the community resources available for its treatment.

These five areas were chosen because they represent the most salient features of a community's system for dealing with abused and neglected children, and also because they are the primary areas in which the demonstration projects, to a greater or lesser extent, had planned to focus their non-direct service delivery efforts.

A detailed discussion of this intra-community analysis framework and the findings for each community appear in Appendix C.

2. Across-Community Analysis

In addition to assessing the changes in individual community systems, and the extent to which the demonstration projects affected the communities in which they were located, we were particularly interested in carrying out comparisons across communities (1) to determine the commonalities and dissimilarities in their respective efforts and achievements, (2) to identify, to the extent possible, those factors which facilitated or hindered the adequate functioning of community systems in different localities under varying conditions, and (3) to more fully describe different aspects of communities that were particularly noteworthy and which might constitute replicable models for other programs.

A slightly different, but complementary, approach from the assessment of individual community systems was taken for the across-community analysis portion of this report.

The communities in which these eleven demonstration projects operated differed in many respects at the time of federal funding. Some were urban, central city, while others were primarily suburban or rural. The populations ranged from primarily middle class (Arlington, Virginia) to very low income (Puerto Rico and St. Louis). Some communities had extensive services for abused and neglected children and their parents; others could claim little beyond the maintenance services of a protective services agency and foster care placement. Some communities were, in general, very well educated about abuse and neglect and relatively sophisticated in their understanding of the dynamics of the problem and potential solutions, while others were almost exactly the opposite. And in some communities there were networks of coordination mechanisms which operated as successful integrative forces to reduce gaps and duplications, while in others little or no coordination existed between service providers. In order to analyze the demonstration projects as a group and develop conclusions about the success of their activities in developing more effective community systems for dealing with child abuse and neglect, it was necessary to construct a framework that (a) would accomodate the variety of types of information available, (b) would allow for comparisons across communities, and (c) was also

capable of accommodating the major differences among communities. It was particularly important that the framework not depend on a single perspective of the "only" or "best" way of organizing and maintaining an adequate community system, but that the framework be focused on general concepts whose inclusion in any community were considered central, but the specifics of which could be implemented in different ways according to the community's unique situation or context.

After three years experience with the eleven demonstration communities and others around the country, it has become clear that concepts that are generally subscribed to as essential elements of any social service delivery system are equally applicable to child abuse and neglect systems. A listing of such concepts, refined to reflect child abuse and neglect systems more specifically, became the tool in analyzing changes in each of the demonstration communities. This listing of "essential elements of a well functioning child abuse and neglect system," which has general applicability to any community, includes:

a. Community Coordinating Mechanisms: including, at a minimum, the availability of a multi-agency coordinating or advisory body whose function is to monitor the overall operation of the community system and plan for needed changes, and the existence of well-articulated, formal coordination agreements between key agencies;

b. Interdisciplinary Input: provision is made for obtaining input from various disciplines (e.g., social work, medical, legal, psychological) at all stages of the service decision-making process, including but not limited to the existence of a multidisciplinary review team;

c. Centralized Reporting System: a 24-hour centralized reporting and response system is available and known to all community residents (this may or may not include a state central reporting system);

d. Service Availability: provision is made for handling the full range of child abuse and neglect cases (emotional as well as physical abuse and neglect and sexual abuse) and a wide variety of treatment and preventive services are available for both parents and children, including therapeutic, supportive, advocacy, and educational services, crisis and long-term services, and residential as well as day services;

e. Quality Case Management: minimum standards of case management, including prompt investigation of reported cases, appropriate assignment of clients to service providers, planful treatment provision, ongoing case review, coordination with other service providers, and referral to other services as necessary, timely termination, and follow-up of closed cases are adhered to by all service providers;

f. Community Education and Public Awareness: all community residents, both professional and lay, are provided with education to heighten their awareness of the problem of child abuse and reduce the stigma attached to the problem and are instructed as to their reporting responsibilities and the procedures to follow in identifying and reporting suspected cases.

These six elements, then, represent the factors and concepts which are present in well-functioning, effective community systems for dealing with problems of child abuse and neglect. Although there are certainly other important factors, these can be regarded as the necessary minimum; they represent the criteria by which we have judged the overall effectiveness of the demonstration projects' efforts toward improving their own community systems' operation. We have assessed the extent to which the project communities, individually and as a group, embody each concept, the unique ways some communities have dealt with problems around implementation of the concepts, the problems which still remain in some communities, the factors which appear, in general, to facilitate or hinder positive achievements, and the relative effectiveness of the demonstration projects' efforts to implement these functional elements. As such, we have taken some concepts, generally accepted as important in social service delivery, and assessed their applicability to the problem of child maltreatment.

Section II presents brief summaries of the changes in each demonstration community relative to these six elements. Section III presents the findings from the across-community analysis and overall conclusions

As indicated earlier, this study was carried out on projects selected because of the new and different service strategies they proposed to demonstrate, and not because they were representative of child abuse and neglect programs across the country. The findings represent the collective experiences of these demonstration projects and the communities in which they are located, and do not necessarily reflect child abuse and

neglect service systems in general. For this reason, care must be used in generalizing from the findings. In addition, because no control communities, without demonstration projects, were studied during this three-year time period -- a period which saw a proliferation of child abuse and neglect activities across the country -- no firm conclusions can be drawn about the impact of the projects per se on their communities; any discussion of such impact must be seen as suggestive, not conclusive.

SECTION II: SUMMARIES OF INDIVIDUAL COMMUNITY ANALYSES

A. The Family Center: Adams County, Colorado

1. Community Coordinating Mechanisms

The county's multidisciplinary review team (MDT), which reviews all intakes entering the system through the Department of Social Services or this project, also serves as the primary coordinating body in the community. Because of the team's broad-based professional membership, it is able to maintain close contact with the respective agencies and monitor the care responsibilities delegated to each. In addition, formal coordinative agreements exist among almost all key agencies which have contact with child abuse cases. The project, by staffing the MDT and by promoting formalized interagency agreements for case handling, has had a major influence on the high degree of coordination that exists.

2. Interdisciplinary Input

As stated above, the MDT is the primary mechanism for obtaining community-wide interdisciplinary input for the child abuse system. The team, which has membership from most relevant agencies and institutions (hospitals have not been included, to date) began almost six months prior to the project's funding. The project has furthered interdisciplinary input into case handling by means of its staff nurse who attends to the medical needs of the abused children and by means of a range of consultants who are called in as needed. The high degree of cooperation among the key service agencies is indicative of the community's commitment to the value of inter-agency and interdisciplinary input into the process of working with abuse cases.

3. Centralized Reporting System

The Adams County system does not have a centralized reporting system, as either the Department of Social Services or law enforcement agencies may legally receive reports. In 1975, the new law added Social Services to law enforcement as a mandated agency to which people reported. Most reports in the county did and still do come to Social Services, which delegated some of its responsibilities to the project after it was implemented. The county has 24-hour intake capacity with a paid crisis team to handle after-hour and weekend reports. Because the county is relatively small and tightly knit, and because a recent agreement between law enforcement and Social Services (including the project) divided investigative duties, reporting is well coordinated throughout the system.

4. Service Availability

All reports of child abuse and neglect, including high risk potential cases are accepted for services by the Department of Social Services, whereas the project only provided intake and treatment of abuse cases. There is a difference in emphasis between abuse and neglect cases, due primarily to the fact that, pre-1975, child neglect was not a reportable offense in Colorado and, therefore, these cases have historically received less intense and less coordinated services. While theoretically all services available to child abusers and their children are also available to neglecters and neglected children, in fact neglect cases receive mostly maintenance services, whereas abuse cases receive a wide range of treatment services. The community, including Social Services and Mental Health Center, have in the past offered individual and group services to abuse and neglect cases, but with the advent of the project, several new services aimed specifically at abuse cases were introduced. These new services included education services for parents and a range of individual and group services for abused children.

5. Quality of Case Management

The system has a quick response to reports, with most abuse cases investigated soon after the report. Neglect cases have usually taken longer for a response to be made. The abuse cases coming to the Department of Social Services have traditionally been handled by a separate intake unit. The project also provided specialized intake for abuse cases. After review by the multidisciplinary review team at intake, many cases are then referred to other community agencies for services, in addition to remaining as open cases in either the project or protective services. While there are defined procedures for assessing cases for termination, most often decisions on termination are made somewhat arbitrarily. The project's primary influence on quality of case management within the community has been to develop a thorough and interdisciplinary approach to the intake process.

6. Community Education and Public Awareness

Staff of the demonstration project have spent significant amounts of time presenting child abuse and neglect education and training to community groups and professionals. Over 180 presentations to professionals and 80 presentations to community groups were made during each of the three years, reaching an estimated 25,000 during the course of the demonstration period. Through the School Referral Program, personnel at all levels of the school system have received by far the largest amount of education, having been the target group for over 30% of all education provided. Personnel in other community agencies, student and hospital staffs received the next largest proportion of all professional education.

In addition to the education provided by the project, other community agencies including the protective service agency, hospitals, health department and schools have increased the amount of education they provide to their own and other agency staff.

B. Pro-Child: Arlington, Virginia

1. Community Coordinating Mechanisms

The Pro-Child project in Arlington subsumed the existing Protective Services Agency and was thus in an excellent position to effect coordination of the entire Arlington child abuse and neglect system. A Project Advisory Board, composed of representatives from the court, police, hospitals, schools, and the local hotline agency was established. This board functioned as a community coordinating council as well as a project advisory board, and, early in the third year, became autonomous from the project in order to exert more influence in the community as an independent community council. In addition to this council, the project also developed formal agreements between themselves and the Court, hospital, police and foster care agencies regarding the referral and case management of child abuse and neglect cases with which these agencies came into contact.

2. Interdisciplinary Input

The project developed a multidisciplinary team, composed of a psychiatrist, psychologist, pediatrician, lawyer, and a representative from the schools to provide input into the diagnosis and service planning decision-making of particularly complex cases. Four to six cases were reviewed each month, a small percentage of the agency's caseload. Staff did not always find this arrangement helpful in making decisions about their individual cases and in the third year, the team was reconstituted and now meets only once a month.

The multidisciplinary team members were also available to staff on an individual basis when needed for specific case consultation, and

both a Public Health Nurse and Homemaker were members of the project staff during the grant period, thus providing additional interdisciplinary input for the majority of the child abuse cases identified in Arlington.

3. Centralized Reporting System

In 1976, a new Virginia state law mandated the development of a 24-hour system to receive reports of child abuse and neglect, and designated the local protective service agencies as the only agencies to receive reports. The protective service agency in Arlington (also the project) had begun to set up this type of system even before the new law was passed. The 24-hour reporting system includes both a statewide number and a local number which have been well publicized and can be used by anyone to report cases. Pro-Child contracted with a local 24-hour hotline to receive the phone calls, which are then forwarded immediately to an "on-call" staff member for investigation. The system has worked extremely well and, in general, all cases of child abuse identified in Arlington are very rapidly referred to Pro-Child. Coordination among agencies in this regard is excellent.

4. Service Availability

Pro-Child accepts all types of child abuse and neglect referred to them, including physical, emotional and sexual abuse, physical and emotional neglect and potential or high risk cases. There are no specific types of services or programs dealing with these different problems, and most clients receive essentially the same services irrespective of the type of abuse/neglect problems they are confronting.

Because the Pro-Child project is the local protective service agency, an array of new services were made available to a majority of the community's child abuse and neglect clients. These included group services, homemaking, medical care and residential facilities (short-term), for parents, and group services, residential facilities (short-term) and day care for children. No other community agencies offered any new services for abuse and neglect clients during the grant period.

Services for children, especially therapeutic care, are sorely lacking in Arlington, and there is no self-help group, educational program for parents, or real preventive programs currently in operation.

5. Quality of Case Management

The project was instrumental in improving the overall case management for abuse and neglect cases in Arlington. Now that all reports are referred directly to the project, they are responded to very promptly -- immediately in emergencies and within two days for other cases. A central Intake Unit was established, and night and weekend coverage is handled on rotation by the staff.

Few cases receive the benefit of multidisciplinary team review for diagnosis and service planning, but the team members are available on an as-needed basis for individual cases. The project has a nurse and homemaker as staff members to provide additional interdisciplinary input, and, in general, service planning is conducted in a comprehensive manner.

There are few treatment options available in the community besides the project, and the project developed very few coordination linkages with those that do exist; one children's group program was co-led by Mental Health Center staff.

The termination and follow-up processes of the project received little attention during the grant period. Cases tend not to be terminated in any planful manner and there was virtually no follow-up of closed cases unless the client sought assistance or there was a subsequent report filed.

6. Community Education and Public Awareness

Staff of the Pro-Child project spent significant amounts of time providing both professional and community education. More than 70 professional and close to 30 general community presentations were made each year, reaching over 3,000 people during the three year demonstration period. Students, school personnel and other Arlington agency staff were the primary recipients of the professional education. The

project was the primary source of all child abuse and neglect education in Arlington; no other agencies or groups increased their educational efforts during the grant period.

C. The Child Protection Center: Baton Rouge, Louisiana

1. Community Coordinating Mechanisms

The project's Advisory Board, with broad-range professional and lay membership, served as the community's multi-agency coordinating group. The core membership of the Board had organized prior to the demonstration effort to lobby for a state-wide abuse and neglect service network and to apply for federal money for the Baton Rouge Center. Formal coordination agreements existed between the project and the key public and private agencies which might refer or serve abuse/neglect clients. Most of these agencies also had other case-handling agreements with their primary referral sources. The project staff, especially in the first year, effectively promoted inter-agency agreements by actively participating in community-wide coordinative efforts.

2. Interdisciplinary Input

There is no community-wide multidisciplinary review team for abuse/neglect cases operating in Baton Rouge, but the project did use such a team for a limited number of its own cases. The team, which was made up of the staff physician and two consultants (a lawyer and a psychologist) reviewed about two cases per week. Other relevant professionals working with a case under review were invited to participate in the review. The half-time pediatrician and full-time homemaker also give evidence to the project's awareness of the need for

a range of disciplines to assist in working with abuse and neglect clients.

3. Centralized Reporting System

The Louisiana law does not provide for centralized reporting but, in fact, during the course of the demonstration the project had managed to effect a clear division of responsibilities for receiving reports. Whereas at first the request and expectation was that all abuse and neglect reports would come through the project, by the beginning of the second demonstration year, protective services took over responsibility for neglect cases and the project handled abuse cases. At the end of the three-year demonstration, the community, including law enforcement, was aware of the dual reporting system and was cooperating by referring all reports. Protective services and the project also refer inappropriate reports to each other with little difficulty. The project set up and maintains a 24-hour on-call service, both for new reports and for client counseling. The project staff have borne this unmandated responsibility since the beginning of the demonstration.

4. Service Availability

The Baton Rouge system provides services to both abuse and neglect referrals, with the project handling abuse cases and protective services taking care of neglect cases. Potential cases are not theoretically excluded from services, but due to the large volume of actual cases, they are most often referred to maintenance units. The demonstration project did not really add any lasting new treatment services for abuse clients, but did provide more intense individual and supportive services to its clients. Also, the project and its Board effectively managed to establish, under other auspices, emergency shelter care for children, a service not previously available. The system still has inadequate therapeutic treatment services for both adults and children.

5. Quality of Case Management

Over the three-year demonstration period the timing and quality of response to reports has varied considerably, due to the staffing capacity changes of the respective agencies. The sheriff's department lost its child abuse team, but the protective services unit almost doubled in size, and for a period the project had a severe staff shortage. This meant that, while there were times when response was excellent, overall it can only be termed as adequate. There was no special intake unit, so the worker on rotation for the day investigated the incoming reports and usually then followed through as primary case manager. As needed, the multidisciplinary review team provided recommendations for service planning. Termination procedures are limited in practice, meaning that most cases are closed when the client moves or during periodic "housecleaning" by workers. All terminated clients of the project are told that they can contact workers any time a crisis arises, leaving follow-up to the initiation of the clients.

6. Education and Public Awareness

The Child Protection Center staff included a full-time public education specialist whose task was to coordinate the dissemination of information to the public. The project provided over 75 professional presentations and close to 50 community presentations during each of the three years, reaching an estimated 8000 people over the demonstration period. Community agencies, schools and law enforcement groups were the primary recipients of the professional education. Students received approximately 25% of all educational presentations. Other community agencies have also slightly increased the amount of education they provide in the community, but most agency representatives attribute the major portion of the educational increase to the demonstration project.

D. Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

1. Community Coordinating Mechanisms

An Interagency Committee, with representatives from most key agencies, was begun by the project in 1975 to begin to coordinate the community system for dealing with child abuse and neglect cases. One service of the committee was the development of a common reporting form to be used by all agencies for reporting cases to the local social service office who then refers substantiated case to the project, a special unit within social services. There was generally very little other coordination between community agencies either before or during the demonstration period, except for the development of a Health Board whose function was to plan for needed children's health care, a pressing problem of abused and neglected children in Bayamon.

2. Interdisciplinary Input

The demonstration project offered the only interdisciplinary input for case management that was available for child abuse and neglect cases in Bayamon. A multidisciplinary team met once a month and the project had the part-time availability of a psychiatrist, psychologist and pediatrician for its clients (all substantiated child abuse cases in Bayamon). The Interagency Committee formed by the project offered interdisciplinary input into solving the child abuse and neglect problems community-wide, but not on a case by case basis, and the local social service agency had no interdisciplinary input available.

3. Centralized Reporting System

In 1974, just prior to the project's implementation, a new Puerto Rico law mandated reporting of all child abuse and neglect cases to the local social service agency, although few people knew of the law's passage. There was no provision for 24-hour coverage and all reports made after hours still are referred to the police. No change in the reporting system was made during the demonstration period. More reports of child abuse and neglect are being made to social services since passage of the law, although certain problems

are so widespread, such as neglect, that it is clear not all cases of this problem are ever reported; other agencies, such as the schools, also handle abuse and neglect cases without referring them to social services.

4. Service Availability

The demonstration project offered numerous new services to its 60 clients including multidisciplinary review, psychological and psychiatric testing, pediatric examinations and health care, individual therapy and counseling, group therapy and assistance with transportation, housing, day care and drug/alcoholism treatment. A few other agencies, including the local social service agency and schools were offering slightly expanded treatment services at the end of the demonstration period, but, in general, most service expansion was a result of the project's direct efforts. Therapeutic services for children, and preventive services remain virtually non-existent.

5. Quality Case Management

The quality of case management in Bayamon was greatly enhanced during the demonstration period. Cases reported to the local social service agency were responded to much more quickly, and a more thorough record-keeping system had been developed. Although use of other community resources was still minimal, service provision, in general, was more comprehensive. Once cases were referred from the local social service agency to the project, the case management function at the project was carried out very well. In particular, the termination process was greatly improved, focusing now on the actual risk to the child and the potential benefit of further treatment. No follow-up of terminated cases occurs system-wide, however.

6. Community Education and Public Awareness

The project's health educator provided over 50 educational sessions to professionals in Bayamon each year, and although the exact number of community presentations is not known, over 6,000 people were educated in Bayamon during the course of the three year demonstration period. Principal among the professional groups receiving education were the schools, local social service agency offices, and health and housing programs.

The project was the only agency providing any specific education or training about child abuse in Bayamon during the demonstration period.

E. Arkansas Child Abuse and Neglect Project: Arkansas

1. Community Coordinating Mechanism

Each of the three counties comprising the demonstration project had community task forces which began before the project's (SCAN) implementation. All relevant professional and interested citizens were members of these groups, whose initial function was to plan the SCAN program and coordinate service provision. Late in the grant period, however, they became almost solely fund-raising groups. Effective coordinating agreements between the SCAN units, which handle only abuse cases involving children under 12, and the local protective services agency which handles neglect cases and abuse cases involving older children, were developed for referral and assignment of cases, and for case supervision. Hospital Diagnostic Teams were also developed to coordinate service provision for cases identified in the hospitals. All of the coordination mechanisms developed were at the initiation of the demonstration project.

2. Interdisciplinary Input

Consultants of various disciplines, including physicians, nurses, lawyers, teachers, counselors and public officials, are available on an as-needed basis to attend the scheduled SCAN staffing of cases for diagnosis, case assignment and progress assessments. The Hospital Diagnostic Teams also have interdisciplinary input from physicians, nurses, public health nurses and staff of both SCAN and the local protective service agency. These were all implemented during the demonstration period. In general, cases of neglect, or cases involving older

children which are referred directly to protective services and are managed solely by that agency, do not have access to consultants of different disciplines.

3. Centralized Reporting System

In July 1975, a new Arkansas law centralized reporting within the Department of Social Services (the local protective service agency). The legislation also required the development of a 24-hour statewide reporting number. Previous to this, 24-hour coverage was already available in the demonstration communities via a 24-hour answering service implemented by the project. Although the local protective service agency is mandated to receive reports, they have passed that mandate on to the local SCAN units in each county where the project is operational, since most people were reporting to SCAN anyway. All reports made in this way to SCAN are then immediately also forwarded to protective services for their records; likewise any reports made to protective services are shared with the SCAN units. This system works very efficiently, in part because of the coordination between the two groups, but also because most people in the counties have positive feelings about the SCAN project.

4. Service Availability

Numerous services for parents are available in the demonstration communities, some of which existed previously, and some of which were developed as part of the project. Individual and couples counseling is available at protective services, the project and the mental health clinic, and individual and group therapy is provided by the mental health clinic. The project-sponsored services include lay therapy, a Parents Anonymous group, crisis services, advocacy services, and parenting classes. Although no new services were developed during the demonstration period by agencies other than the project, it was always assumed the local SCAN units would remain in existence since the contract service with the Division of Social Services is written into the State Plan, and thus, continuation of their services was assured. Beyond the parenting classes and a 24-hour crisis line, there are no real preventive services available, and therapeutic services for children are notably lacking.

5. Quality of Case Management

The way in which cases are managed in the demonstration communities has improved markedly since the project's implementation. Reports are investigated promptly -- immediately in emergency cases and within two days for all others. Thorough diagnosis and service planning is provided with input from a variety of disciplines. Clients rarely participate in the case planning process. A variety of services are available, and well-used, in the community, and the small number of cases (3 at a maximum) that each Lay Therapist handles is conducive to intensive service provision. Follow-ups are conducted routinely at 6-month intervals on all terminated cases. Most of the changes in case management, community-wide, were a direct result of the project's efforts, although the local protective service offices have also improved their management of cases in several areas.

6. Community Education and Public Awareness

The demonstration project staff have provided significant amounts of professional and community education during the three year demonstration period. Over 50 educational presentations to professional groups and over 150 community presentations were made each year, reaching an estimated 14,000 people during the three years. Staff of the hospitals, schools, protective service agencies and other community agencies were the primary recipients of the professional education and all requests from various community groups for education were filled as well. Although the local SCAN staff provided the major portion of all education from 1974-1977, some education was also provided by the statewide SCAN staff and the social services coordinators and the task forces in each demonstration county.

Among the results attributed to this education have been requests for additional educational presentations and interagency coordination improvements.

F. The Child Development Center: Neah Bay, Washington

1. Community Coordinating Mechanism

A Child Development Council, with representatives from every social service or other relevant agency on the reservation, was developed by the project to coordinate all services and programs for abuse and neglect cases in Neah Bay; in 1976 the Council stopped meeting formally. With the exception of the Tribal Council, there is currently no community coordinating body meeting regularly. Because of the extremely small size of the reservation, and the few number of abuse or neglect cases reported each year (less than ten), coordination of all functions is easily achieved. The project is responsible for investigating all cases and coordinating needed services with other agencies; this has developed during the demonstration period primarily through weekly multidisciplinary team meetings held at the Indian Health Clinic, but there are no other coordinative mechanisms between the other agencies operating on the reservation.

2. Interdisciplinary Input

The use of a variety of disciplines in the diagnostic, service planning, and monitoring phases of the case management process evolved as common practice by the second year of the demonstration. Weekly multidisciplinary team meetings, attended by project staff, mental health workers, a physician, public health nurse and school psychologist, were conducted to provide guidance in the overall management of child abuse and neglect cases. This is the only mechanism for interdisciplinary input for social service cases in Neah Bay, as the other community agencies operate relatively autonomously.

3. Centralized Reporting System

Legally, the protective service agency in Port Angeles is the central repository of child abuse and neglect reports, but in 1976 a new Tribal law designated the demonstration project as the recipient of all reports on the reservation. The Washington state law is very vague about reporting neglect cases, so although both abuse and neglect cases are reported to

the project, only abuse cases are then also formally reported to protective services in Port Angeles.

There is no legal provision for 24-hour coverage, but, in fact, project staff, and staff of the court or community health representatives are available at any time to receive reports. There are so few reports on the reservation (5 in 1976) that the system, in reality, operates quite efficiently and effectively.

4. Service Availability

Prior to development of the demonstration project, services for abuse and neglect cases were confined to the counseling provided by the Health Center, as the protective service worker from Port Angeles assigned to the reservation rarely visited. The project developed peer counseling services (for marital, child development, financial and emotional problems), homemaking services and parent education classes, but there is still a lack of group services, self-help groups or any services for children beyond Head Start. Therapeutic and behavioral services, although available, are somewhat limited. The new services developed by the project will continue after the grant period under the auspices of a state-funded child and family services center.

5. Quality of Case Management

The case management and service provision function was not assumed by the demonstration project until the third year of the grant period. Previous to this, project staff acted as a liaison between other service providers. In general, the management of cases by the project is of high quality; there is excellent multidisciplinary case planning and review, adequate service provision, in view of the limited reservation resources, and consistent follow-up on terminated cases. There is some delay in the initial response to reports, since the staff desires to meet with the multidisciplinary team before beginning initial investigations, but no cases are ever "lost" due to this procedure. The quality of case management has thus improved substantially, and the project's efforts were the primary impetus for these changes.

6. Community Education and Public Awareness

Project staff in Neah Bay have provided both professionals and community residents with education and training focused particularly on increasing people's awareness of child development patterns and improving their knowledge of the resources available to deal with parent/child problems. Approximately 15 professional presentations and five community group sessions were held each year monthly parent education classes and a monthly newsletter. A major child development seminar, attended by over 140 people, provided education in such areas as child development, child welfare legislation, foster care, and adoption. There has also been a slight increase in the education provided by other reservation program personnel, including school staffs and the Community Health Representatives.

G. Family Resource Center: St. Louis, Missouri

1. Community Coordinating Mechanisms

There is no community coordinating council or board in St. Louis, and coordination remains a general problem of the community system. A written coordination agreement between the local protective service agency and the project was established during the demonstration period, but no other agreements are in operation between other community agencies except for the reporting of cases to protective services as mandated by law. The project's attempts at coordination were directed primarily at establishing two way coordination between itself and individual agencies community-wide coordination, in general, did not improve significantly during the three years, except for the change to a centralized reporting system occurring in 1975.

2. Interdisciplinary Input

There is no community-wide multidisciplinary team operating in St. Louis, but the two major hospitals developed interdisciplinary Child Abuse

Management Teams during the demonstration period for cases of abuse and neglect which were identified in the hospital. The project provided multidisciplinary consultants for its cases, but these cases represented a very small proportion of all child abuse and neglect cases in St. Louis (approximately 40-50 abuse cases per year). There was little increased awareness among staff of the protective service agency, police or court of the importance of seeking advice from a variety of professionals when diagnosing or planning services for child abuse and neglect cases, and the demonstration project did not appear to have the increased use of a variety of disciplines system-wide as a goal.

3. Centralized Reporting System

In 1975, a new law was passed in Missouri centralizing the receipt of child abuse and neglect reports. All reports were to be made to the local protective service office, replacing the previous dual system where both protective services and the courts received reports. The new law also provided for 24-hour coverage via a statewide toll-free number with referrals made then to the local protective service agency intake unit. The new system was implemented quickly and appears to be working well, with at least the majority of all cases being reported to the correct agency and 24-hour response provided for most cases.

4. Service Availability

All cases of child abuse and neglect, including physical and emotional abuse and neglect, sexual abuse, and high risk as well as substantiated cases are accepted for services by the protective service agency, but there are no specific services for different types of problems. A Sexual Abuse Committee was formed during the demonstration period to plan for a special program for this particular problem. The services available through the protective service agency in St. Louis are confined to individual counseling, some homemaking services and very limited day care, and there was no change in them during the demonstration period. The project offered a full complement of services to its small caseload, including individual, group, marital and family counseling, child development classes, behavior management classes,

play therapy, parent counseling services and comprehensive case management. No other community agencies increased their services to abusive or neglectful families, and, in general, the services available in the community for the majority of the cases are very limited, particularly preventive services and therapeutic services for children.

5. Quality of Case Management

The initial investigation of reports is excellent in St. Louis, with all reports investigated within 2 days. However, except in crisis cases, close to a month may elapse before any real services are provided. There is no interdisciplinary input into diagnosis or case planning within the protective services agency, and few referrals to other community agencies for services except the project. In general, no follow-up of terminated cases occurs. The project offers comprehensive case management services, including interdisciplinary input, thorough monitoring of cases, intensive service provisions and adequate follow-up of cases, but this has not been expanded to the remainder of the community system. With the exception of 24-hour coverage and a quicker response to reports which grew out of the new legislation, the quality of case management in St. Louis has not changed markedly during the demonstration period.

6. Community Education and Public Awareness

There has been a significant increase in the amount of education and training provided by, and to, many community agencies in St. Louis during the previous three years. The demonstration project provided an average of 60 educational presentations to professionals and 100 sessions to community groups each year, reaching an estimated 9,000 people. In addition, provision was made for a state child abuse and neglect training specialist and nine local trainers after the passage of the new law, all of whom have provided extensive education to a variety of professional and community groups since 1975. Each of the other key agencies in St. Louis, except the schools, also provides both professional and community education when requested. Hospitals, schools, students and general community agencies are the focus of the project educational efforts, while hospital staff,

additionally, receive the major portion of the education/training from other groups.

H. Parent and Child Effective Relations Project (PACER): St. Petersburg Florida

1. Community Coordinating Mechanisms

The PACER project in St. Petersburg was housed in the Juvenile Welfare Board, a totally independent program of the county, with few ties to the established child abuse and neglect system. The community system in St. Petersburg is not a well-coordinated one, except for the centralization of reporting to the local protective service agency (HRS). Late in the grant period, the project developed a community coordinating committee with wide representation, whose purpose was to develop a coordinated approach among social service agencies in the prevention of abuse and neglect. Because of its late development, little evidence of success is yet apparent.

Although project staff developed numerous coordinating agreements between themselves and other agencies (CPS, schools, etc.) the local protective services agency remained isolated from the remainder of the community system, developing only one coordinating agreement with the police to provide assistance in after-hours investigations. The project staff made efforts to remedy some of the coordination problems in the system, but, due to the project's lack of public agency affiliations and major administrative problems in the protective services agency, few of these were successful.

2. Interdisciplinary Input

The project helped spearhead the development of a Family Consultation Team (similar to a multidisciplinary team) in a local hospital with medical and social service input. To date the team has received relatively few cases, since staff of protective services, who were to refer cases to the team, were originally reluctant to make use of the team's expertise. PACER also developed, and supported, an agreement with the State Attorney's office to provide legal assistance to protective service workers bringing cases into the Court system. Beyond these two project innovations, there is virtually no interdisciplinary input for the majority of the child abuse and neglect cases in the community, and, in fact, little recognition that this might be an important addition to the community system.

3. Centralized Reporting

Centralized reporting, with all reports made to protective services either at the local or state level has been mandated in Florida since 1971. The extensive publicity which accompanied the development of this new system was responsible for major increases in reports at all levels, which has caused severe bottlenecks at both the state and local levels that have yet to be resolved. There were no changes in the reporting system during the demonstration period, and almost all identified cases are being referred to protective services as required by law.

4. Service Availability

The local protective service agency provides services to all types of substantiated abuse and neglect cases, but does not have the capacity to handle high risk cases. Through the use of Parent Aides, the project was able to provide service to a small number (10 at a time, average of 16 over time) of high risk cases, but the majority of these cases in St. Petersburg are unsupervised.

The services available for abuse and neglect clients from protective services are minimal, consisting primarily of monitoring, some individual counseling and removal of the child if required. Few clients are referred to other community agencies for services, although some are referred for food stamps or welfare assistance to other programs within the umbrella agency

of which CPS is a part. The demonstration project helped provide additional services through the development of a Parent Aide program which provided a small number of families with transportation, lay therapy, and assistance in securing day care and medical care. A series of child management classes reaching over 300 people was also begun by the project, as was the program of securing legal assistance from the State Attorney's office mentioned previously. The project also supported two Parents Anonymous groups and developed an extremely innovative system of visiting new parents in the community and providing information about the availability of community services. During this visit, high risk parents were identified and encouraged to make use of the available services. No other agencies increased their services for abused and neglect clients, and services remain inadequate for most cases.

5. Quality of Case Management

In general, the case management of most child abuse and neglect cases in St. Petersburg is inadequate. Bottlenecks in the reporting system at the state level have created 3-4 month delays in transmittal of reports to the local level, and even when finally received at the local protective service agency, staff shortages create further delays before investigations commence. During 1975, in a reorganization of the umbrella agency of which protective services is a part, a central intake unit for dependency, juvenile offenders and child abuse and neglect cases was created which further diluted the effectiveness of the system by combining several types of cases into one supervision unit.

Few cases in St. Petersburg received the benefit of adequate service planning, case management or referral to other agencies for services. The only well handled cases appear to be those few receiving services from the Parents Aides of the project. There is little interdisciplinary input and minimal coordination between service providers. The project was only able to effect small changes in the case management function community-wide, primarily through the use of Parent Aides and the provision of legal assistance for cases requiring court intervention.

6. Community Education and Public Awareness

Extensive education of both professionals and citizens community-wide was provided by the PACER project, which had a full-time educator on the staff. Almost 200 educational sessions for professionals and over 150 community citizen presentations were made each year, reaching an estimated 28,000 people over the three years. The professional education presentations were directed primarily toward medical personnel, schools, law enforcement agencies and social service providers, with school personnel at all levels receiving the most education over the demonstration period. All community agency representatives agreed that the project's educational efforts, particularly the major community conferences sponsored each year, had been extremely successful in increasing both professionals' and citizens' knowledge and awareness of child abuse and neglect problems.

I. Panel for Family Living: Tacoma, Washington

1. Community Coordinating Mechanism

The Panel for Family Living functions as a very successful community coordinating body for child abuse and neglect, as it did prior to federal funding. Representatives from essentially all public and private child and family service agencies in the community participate in Panel activities. Through this informal network, and through formal efforts by protective services and the Panel itself, coordination, including several formal, written agreements between agencies, increased during the demonstration period.

2. Interdisciplinary Input

Although the Panel established a multidisciplinary review team that was available, not just to review Panel cases, but to those of other agencies in the community as well, the team actually met rather infrequently and

reviewed very few cases. A moderate increase in interdisciplinary input in case handling is seen, however, through the use of consultants from a variety of disciplines.

3. Centralized Reporting System

Changes in the Washington State law early in the demonstration period helped to more clearly strengthen the already centralized reporting system, which requires that all abuse and neglect reports be made to the local protective service agency. A 24-hour response system exists in the community but not as a legislative mandate. Panel members have been instrumental in implementing this 24-hour response system, but the demonstration project itself played no role in this.

4. Service Availability

All cases of child abuse and neglect, including physical and emotional abuse and neglect and high risk as well as substantiated cases are accepted for services by protective services. A Sexual Abuse Committee was formed during the demonstration period, clearly as a direct result of the Panel's concern about this problem; protective services and other agencies are now paying more careful attention to this particular client group. A relatively complete set of services is available in the community, definitely enhanced by those services offered by the Panel -- notably parent education classes, group therapy and lay therapy. With the end of federal funding, the Panel closed its services and it is not clear that other agencies will begin providing these services.

5. Quality of Case Management

The quality of case management in the community did improve during the demonstration period. In part through changes in the state law and in part through increased communication due to the Panel, duplicative investigations by CPS and the police and CPS and the courts were reduced. CPS established an intake unit, not necessarily as a direct result of Panel activities, which improved the response time to reports, the diagnosis of cases and the referral on to the most appropriate service

provider. The intake unit freed up other CPS treatment workers to offer more comprehensive and thorough case management services.

6. Community Education and Public Awareness

Staff of the Panel of Family Living's demonstration project provided extensive education and training to professionals and community members during the three-year demonstration period. Over 100 presentation to professionals and close to 70 community presentations were made each year, reaching an estimated 25,000 people during the three years. Students, staff of other community agencies, school personnel and staff of the protective service agency were the primary professionals receiving this education. The Speakers Bureau of the Panel has provided much of the community education, while the paid staff of the Panel (the project) have been responsible for organizing the provision of training and education, and for training the professionals of various agencies. In addition to the education provided by the Panel, other groups and agencies, including Parents Anonymous,have also increased the amount of education they are providing to residents of Tacoma. All agency representatives agree that significantly more education/training has been provided in Tacoma during the past three years, and that professionals and citizens alike are much more knowledgeable about problems of child abuse and neglect than they were before the demonstration project's implementation.

J. Protective Services Demonstration Project: Union County, New Jersey

1. Community Coordinating Mechanisms

The Union County demonstration project's Advisory Board, which had been operational for most of the project's history, disbanded during 1976 and was reconstituted as an independent, community-wide coordinating council. The Council, with wide representation of the relevant community agencies, now deals with broader community problems relative to child abuse and neglect cases than the previous Advisory Board, because of its project affiliation, was able to do.

The other primary coordination mechanism in Union County is the contract relationship between the project and several community service agencies; each agency is under contract to provide specific services to a specified number of abuse and neglect clients per month. Beyond this, most coordination among community agencies is of an informal nature, depending on individual staff initiative and knowledge of resources.

2. Interdisciplinary Input

A multidisciplinary team consisting of a psychiatrist, psychologist, pediatricians, visiting nurse and project staff members, was developed by the project to provide input into the diagnostic and service planning phases of the case management process for complex or serious cases. This team proved ineffectual for a variety of reasons, and, during the third project year, a smaller team, including the psychologist, public health nurse, case work supervisor, unit supervisor and the individual worker handling the case, was formed. This team now reviews all cases at intake and other priority cases during treatment and is functioning more effectively than the larger team did. Other than the variety of disciplines represented on these teams, there is no other interdisciplinary input in the Union County child abuse and neglect system.

3. Centralized Reporting System

A 1974 New Jersey state law required all cases of child abuse and neglect to be reported to the local protective services agency; a 24-hour coverage system for report receipt was also mandated. During the day, a central intake unit from the Department of Youth and Family Services screens all reports and refers appropriate cases to the project. (functioning as the local protective service agency). After hours, a Response Unit, developed and funded by the project, receives reports, conducts investigations if necessary, and refers cases to the project the following day.

In actuality, both the police and protective services still receive reports of abuse and neglect in Union County, but the police now refer all reports they receive to protective services. During the third

project year, a new policy of reporting all cases to the Prosecutor's Office was instituted because several cases were allegedly mishandled. The system works fairly well, and eventually all cases are reported to the legally mandated agency.

4. Service Availability

The demonstration project provides services to abuse cases, while the Division of Youth and Family Services handles neglect cases. High risk or preventive cases are provided minimal services. Although sexual abuse cases have always received services from the project, these services were significantly improved during the third year after special training in the treatment of sexual abuse was provided to the staff.

Through contracts with community agencies, the project was able to substantially increase the amount and types of services available for child abuse cases. In addition to the individual and couples counseling provided by staff members, these agencies are providing group counseling, lay therapy, marital counseling, homemaking services, day care, and medical care for a specified number of clients. Cases of neglect, which are not handled by the project receive only those services previously available through the Division of Youth and Family Services (primarily individual counseling and supervision). A new Parent Line, developed by the project during its third year, is the only preventive service available, and, with the exception of day care provided some children, services for children, particularly therapeutic, are very inadequate.

5. Quality of Case Management

In general, the timing of response to reports has improved, although there are still some delays, particularly between the Screening Unit at DYFS and the Response Unit at the project; cases are not always referred as quickly as they might be. Although service planning now has the advantage of interdisciplinary input, coordination between the project and the contract agencies could be improved to provide smoother referral of cases. In general, once a plan is decided upon and implemented, clients or the project receive a wide variety of services, although this is not

necessarily true of neglect cases not handled by the project. Little or no follow-up on terminated cases is carried out.

6. Community Education and Public Awareness

A Citizens' Committee in New Jersey began five years ago to educate the community about problems of child abuse and neglect. The project expanded the education provided by this group during its three-year operation. Close to 50 educational presentations to professionals and 20 presentations to community groups were made each year, reaching an estimated 13,000 people. The groups receiving the most education from the project included school personnel, hospital staff, police, and staff of other community agencies. Both the police and hospitals in Union County have also expanded the amount of education/training they provide, primarily to their own staff, but the police also make school and civic presentations.

SECTION III: ACROSS-COMMUNITY ANALYSES

A. Community Coordination Mechanisms

A first step in creating a well-functioning community-wide system is the establishment of a mechanism by which different agencies concerned with child abuse can meet and work together around both system problems and individual case concerns. This community-wide coordinating body generally takes the responsibility for eliminating the fragmentation, isolation, duplication and inefficiency that often characterize a community's child abuse/neglect services. It also provides a forum for communication and, eventually, service planning. Many different versions of such coordinating bodies exist, from totally volunteer-based to a group of select political appointees, and each has its advantages and disadvantages. Perhaps the most important characteristic of such a coordinating or advisory body is that it does have representation from all those agencies in the community that are or should be concerned with child abuse and neglect. Minimally this includes: protective services, the police and/or sheriff's department, the juvenile court (or court handling juvenile cases), the schools, the local hospital(s) treating children, private service agencies and community representatives.

Another key to the well-functioning system, in which different agencies work together, sharing resources, sharing expertise, communicating with each other and solving problems to everyone's mutual satisfaction, is the existence of specific coordinating agreements. It is important that the police and protective services, the schools and the courts, the medical center and the mental health center all be willing to remain open to new ways of solving problems while retaining their agency responsibilities for various aspects of service provision. Agreed-upon relationships between any two agencies for reporting or referring cases, for service provision or for input into case decisions, need to be known and understood by more than high ranking officials in those two agencies; line workers need to understand how they can relate to or depend upon another agency. Other agencies in the community need to know about existing interagency agreements. Thus, the formalization of agreements, usually by putting them into writing, can help, as it forces careful articulation of what is being agreed to and can serve as a record as workers leave and are replaced.

1. Project Achievements

Given the multiplicity of agencies and individuals involved in the prevention, identification, and treatment of child abuse and neglect -- some under legislative mandate, others out of a long history of "helping" families and children -- one of the major problems in every community studied was the adequate coordination of these resources to promote expansion of the communities' capabilities and reduce gaps and duplications in functions and service provision. Although each project listed "coordination" of the community system as one of its goals, the impact that the projects actually had was uneven across communities.

Table 1 outlines the differences among the communities relative to the existence of multidisciplinary coordinating or advisory councils or boards and their main features. Multi-agency coordinating bodies are operational in nine of the ten demonstration communities. In five of these, the coordinating bodies were developed subsequent to the implementation of the demonstration projects, and in each case the impetus for the council or board was the demonstration project itself.

The composition of the councils varied both in numbers of members (from eight in Arlington to over 80 in Tacoma) and in comprehensiveness of representation. In general, all of the bodies developed have adequate representation of community professionals; almost always including representatives of the key agencies (CPS, Court, law enforcement, schools, hospitals) and usually also including representatives of other private and public agencies (e.g., Mental Health, public health nurses, private counseling agencies). One relatively new addition to several councils or boards is consumer or citizen membership, which appears particularly important in cases when these groups are planning for needed expansion of services or contemplating changes in procedures.

With the exception of the multidisciplinary team in Adams County, the County Task Forces in Arkansas, and the Inter-Agency Committee in Bayamon, all of the groups have as a primary purpose the coordination and planning/monitoring of the overall community system dealing with child abuse and neglect. The Multidisciplinary Team in Adams County fulfills these functions, but also acts as the review team for specific diagnosis and service

TABLE 1: Comparison of the Availability and Characteristics of Multi-Agency Coordinating Groups

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Existence of a Multi-Agency Coordinating Group	yes	yes	yes	yes	yes	yes	no	yes	yes	yes
Pre- or Post-Demonstration Implementation	Pre-Demonstration	Post-Demonstration	Pre-Demonstration	Post-Demonstration	Pre-Demonstration	Post-Demonstration		Post-Demonstration	Pre-Demonstration	Post-Demonstration
Type and Composition of Council/Board	MDT; extensive professional and consumer membership	Community Advisory Board; moderate professional membership	Community Council; extensive professional and citizen membership	Interagency Committee; moderate professional membership	County Task Force; moderate professional and consumer membership	Community Council; extensive professional membership		Community Committee; moderate professional membership	Community "Panel"; very extensive professional and consumer membership	Community Council; extensive professional membership
Functions Served	Case review and community coordination	Community and Project coordination and planning	Community and Project coordination and planning	Professional training; legal research, record-keeping development	Fund-raising	Community and project coordination		Coordination and planning	Coordination and planning	Community and project coordination and planning
Project Responsibility for Development of Council/Board	none	primary	none	primary	none	primary		primary	none	primary
Project Influence or Effectiveness of Council/Board	major	major	moderate	major	minimal	major		major	minimal	major

planning for individual cases of child abuse and neglect active in the community system. The County Task Forces in Arkansas function primarily in a fund-raising capacity, although conceivably might become involved in wider system problems at different points in time. The Inter-Agency Committee in Bayamon has worked extensively in three specific areas: (1) the training of professionals, (2) a review of the laws affecting minors, and (3) the development of reporting forms for child abuse/neglect referrals.

In the six communities in which no multi-agency coordinating body existed prior to the demonstration period, all but St. Louis have subsequently developed such a council or board. In each of the five communities (Arlington, Bayamon, Neah Bay, St. Petersburg and Union County), staff of the demonstration project, either alone or in concert with other agencies, were responsible for the implementation of their coordinating bodies, and also played a major role in enhancing the effectiveness of the councils or boards. The Adams County project, although not responsible for development of the Coordinating Council (it was developed, in part, to secure federal demonstration funds) was nonetheless an important factor in ensuring the effectiveness of the council.

In general, the councils or boards have been most successful in attempting to coordinate the existing resources in their communities, and less successful in carrying out their implicit planning and monitoring function. The most obvious reason for this is the multiplicity of agencies represented, each with its specific legal or administrative mandates and procedures, which would possibly be disrupted if major changes in service provision or the overall operation of the system were contemplated. Without clear guidelines in the form of a legal mandate or at the least a state-level administrative agreement between major service providers, it is unlikely that any major revamping of community systems with respect to child abuse and neglect cases could occur.

In this regard, it is interesting to note that four of the coordinating groups (Arlington, Baton Rouge, St. Petersburg, Union County) began as Demonstration Project Advisory Committees, but later, recognizing a need for more leverage and a clearer mandate for assuming community-directed

coordination functions, these were disbanded and reconstituted as actual community councils. Although project staff are still members of these cou - cils (and are probably still responsible for much of the council/board activities) the groups have chairpersons from outside the project.

There does not seem to be any relationship between the type or size of the demonstration projects, or the agencies in which they are housed, and the effective implementation of a community coordinating body. Thus, independent projects (Neah Bay and St. Petersburg) were as likely to develop adequate councils as were the larger, protective service agency affiliates (Arlington, Bayamon, Union County). The one factor which could be isolated as definitely contributing to the development and continued effective operation of these councils was the initiative taken by a single individual or agency to orchestrate the overall effort and retain an ongoing responsibility for coordinating the council's activities and maintaining interest in the council. In the case of the five councils developed during the demonstration period, this responsibility fell to the Project Directors, all of whom viewed these councils as important community additions and spent extensive amounts of time working with them.

In addition to the existence of multi-agency coordinating bodies, another aspect of system coordination is the existence of formal agreements between agencies for dealing with child abuse and neglect problems. The following table (Table 2) illustrates the ways in which agreements about case handling procedures and general coordination of the community systems operate, and the coordination mechanisms established between the demonstration projects and other community agencies.

Four communities, Adams County, Arlington, Baton Rouge and Tacoma, have numerous agreements operational between the protective service agency and other key agencies. In each case, the demonstration projects in those communities also developed extensive agreements between themselves and other community agencies, as did the project in Neah Bay. Only Adams County and Baton Rouge have formalized case handling agreements between community agencies other than those involving either the protective service agency or the demonstration project.

TABLE 2: Community Inter-Agency Coordinative Agreements and Demonstration Project Contributions

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Formalized case-handling agreements between CPS[1] and...	Project, D.A.'s office, mental health, law enforcement, hospital	Court, hospital, law enforcement, foster care	Project, hospital, mental health, court	Project	Project	NA	Project, schools	Project	Project, law enforcement, military hospital	Contract agencies
Formalized case-handling agreements between demonstration project and...	CPS, court, schools, law enforcement, hospital, mental health, health department, D.A.'s office	Court, hospital, foster care, law enforcement	CPS, hospital, court, sheriff, schools, mental health, private counseling agencies	CPS	CPS	Informal agreements with all appropriate reservation agencies	CPS	CPS	CPS, hospital	Contract agencies
Other formalized case-handling agreements between...	hospital & health department, hospital & schools, health department & mental health		court & schools, court & sheriff, court & hospital, mental health & schools			Informal agreements via MDT				
Mechanism for general community coordination other than formal agreements	MDT with all relevant agency participation	Project advisory board	Project advisory board	Inter-agency Committee from July '75 to Nov '76, Health Board		Tribal Council, MDT		MDT & Coordinating Committee	Panel meetings (host agency of project)	Child Protection Council (county-wide)
Project contributions to general system agreement(s) development	High	High	High	Low	Low	High	Low	Low	Low	Low
Project effectiveness regarding agreements between project and other agencies	High	High	High	Low	Low	High	Low	Moderate	Moderate	Low

[1]Note: for ease of comparability, agencies have been designated as CPS when they are the agency providing protective services to children, even though the name of the agency may be different in different localities (e.g., Division of Family Services, Division of Social Services, etc.).

One key to the development of actual formal agreements between agencies was the commitment of a single agency or group with either a legal mandate regarding child abuse and neglect or the endorsement of a variety of agencies, to take on coordination of the entire system as a priority area of its program. In cases where this was successful, it was usually done by CPS, often with the impetus or at least strong support coming from the demonstration project. Of the four projects with the largest number of coordinative agreements (Adams County, Arlington, Baton Rouge, and Tacoma), it is important to note that three of these were affiliated with the local CPS, clearly giving the project leverage within the community system. In those communities where the demonstration project was not formally affiliated with a key community agency (Neah Bay, St. Louis, St. Petersburg and Tacoma), only Tacoma evidenced a multiplicity of coordination agreements between agencies, a result of the Panel for Family Living (the project's host group) having an historical emphasis on coordination via the Panel's monthly meetings which were attended by literally every child serving agency in the community, public and private. Although completely informal, there is an understanding between key agencies on the Makah reservation about appropriate case handling procedures for child abuse and neglect; these are workable, nonetheless, given the reservation's small size, the relative scarcity of resources, and the very small number of child abuse and neglect cases reported (five in 1976). In Union County, formal agreements between CPS (encompassing the demonstration project) and other agencies are limited to agreements with contract agencies providing supplemental services to CPS cases. The size of the Union County system, and the historical lack of coordination among service providers, appear to be the main factors inhibiting coordination.

2. Barriers to Implementation

There appeared to be few problems among the demonstration projects with respect to the development of multi-agency coordinating bodies. However, one of the problems evidenced in some of the councils and boards was the tendency to begin very actively, with a large and enthusiastic representation, but to then experience difficulty maintaining adequate attendance

at meetings and the commitment to spend significant amounts of time working through difficult problems. In those communities which have successfully maintained an active multi-agency coordinating body, three things seem to contribute to this success.

The first factor is the existence of strong and committed leadership, usually a single person, who retains the responsibility for attending to the logistics of scheduling meetings, developing the agenda, notifying all representatives and adhering to a relatively structured meeting format.

The second factor which has benefited many councils is the development of sub-committees from within the larger body with specific responsibilities (e.g., training, legislation, foster care). In this way, individuals are able to work on those issue areas in which they are particularly interested or skilled, which is key to maintaining a high interest level. The Baton Rouge Council has successfully maintained six subcommittees on (1) Policy Advisory, (2) Emergency Shelter Care, (3) Legislation, (4) Public Awareness, (5) Resources, and (6) Comprehensive Emergency Services, which have greatly enhanced the Council's effectiveness.

Finally, broadening the work of these councils beyond community concerns, and maintaining a diversity in the projects undertaken by the councils has served to increase the overall effectiveness of these bodies. Thus, developing or working on new state legislation, applying for federal/state funds for service projects, and providing professional and community education are all areas beyond the usual scope of a "coordinating council" but all serve to increase both the visibility and the effectiveness of these councils.

An example of how these factors converge can be seen in Tacoma, which has the most effective community council among the ten studied. This group, the Panel for Family Living, was begun in 1972, and has maintained the active participation of an extremely wide variety of professional and community representatives (currently there are over 80 members) through the use of monthly breakfast meetings and by focusing on major and substantive areas on which the Panel can impact.

Thus, the Panel maintains primary responsibility for all professional and community education through its Speakers Bureau and was the impetus behind the demonstration project which is a component of the Panel.

Several factors appear to have operated in opposition to the development of adequate community-wide coordinating agreements. The most obvious, in terms of the demonstration project effectiveness, was the project's affiliation. Although several independent projects (Neah Bay, St. Petersburg and Tacoma) were at least moderately successful in developing coordination arrangements between themselves and other community agencies, only those projects with some protective service agency affiliation (Adams County, Arlington, Baton Rouge), were also successful in stimulating such agreements between and among other community agencies. Neah Bay was successful in both activities due to the extremely small number of reservation agencies, and because the project, in fact, functions as the proxy protective service agency on the reservation.

St. Louis and Union County were the least successful of the projects with regard to adequate coordination agreement development; although Union County did implement service provision arrangements with local agencies on a contract basis, these were solely for purchase of services rather than other coordinative agreements. The size of these communities, the large number of service providers, an historical lack of coordination among community agencies, and the relative lack of emphasis of the demonstration project's management on these endeavors appear to account most heavily for the lack of success.

There are several other problems related to the nature of the coordinative agreements in most of these communities. The areas in which agreements have tended to be made are (1) reporting procedures, (2) joint investigations, (3) initial multidisciplinary diagnostic review of cases, and (4) referral procedures. Union County also developed "purchase of service agreements" with several agencies. Other important areas where coordinative agreements could have been developed but were not, include: initial assignment of cases to appropriate agencies, ongoing review of cases, and follow-up of terminated cases, but these have not been tested in any large-scale way in the demonstration communities.

Another drawback in the current arrangements is the lack of any formal agreements in nine of the ten communities between the local foster care agency(ies) and other child abuse/neglect service agencies. Given the current controversies surrounding such issues as appropriate placement criteria, length of stay limits, and particularly visitation rights of natural parents vs. foster parents' rights, it would seem incumbent on any community system to have clear guidelines about foster care procedures and coordinative agreements to ensure a harmonious interface between treatment and placement agencies which promote achievement of each agency's goals for parents and children.

Finally, and perhaps most obvious in these communities, is the lack of formal, or even informal, agreements between public agencies and private social service agencies (again, Union County did have purchase of service agreements with private agencies). This is regrettable in the case of adult-serving private agencies, given the high caseloads of adult clients in the public agencies, but is an even more serious omission in the case of children since none of the communities had what could be considered adequate public treatment services for children. Adequate community system functioning requires that all resources, public and private, be optimally utilized and coordinated in the pursuit of high quality services for all cases of child abuse and neglect; this interface between public and private agencies is missing in most communities.

3. Summary

Each of the demonstration communities have some type of multi-agency coordinating body operational. In five of these communities (Arlington, Bayamon, Neah Bay, St. Petersburg and Union County), the coordinating councils or boards were developed subsequent to the demonstration project's implementation, and in each case the project was primarily responsible for its development and subsequent functioning. In four of the communities, these multi-agency groups began as Advisory Boards to the demonstration project, but were later reconstituted as autonomous community councils/boards in order to increase their

visibility and leverage within the community system.

Each council has adequate to extensive professional membership, including key agency representatives as well as other community agency and/or consumer representatives in some cases. Most of the groups have the planning and coordination of the community child abuse and neglect system as their goal, but in a few cases, their mandate is much more narrow (e.g., fund raising).

Coordination in the demonstration communities was also accomplished via formal or informal coordinating agreements established between and among the demonstration projects and other key community agencies around issues such as referrals and general management. In each case, the demonstration projects established such agreements at the least with the local protective services agency, but in several communities (Adams County, Arlington, Baton Rouge, Neah Bay) agreements were reached with a variety of other community agencies as well. In four of the communities (Adams County, Arlington, Baton Rouge and Tacoma) the local protective service agency also established numerous coordinating agreements with other agencies besides the project, but in three of these the projects were affiliated with child protective services, thus influencing the development of these agreements. Only Adams County and Baton Rouge saw the establishment of extensive coordinative agreements between agencies other than the project or local child protective services.

Few problems with the development of multi-agency coordinating bodies were experienced, but it was often difficult for these groups to sustain the momentum they had when first becoming active groups. Strong and committed leadership, the development of sub-committees, and extending the work of the councils/boards beyond local issues are factors which appear to have helped some communities maintain an active council or board.

The demonstration projects that were affiliated with the local protective service agency were the most successful in developing coordinating agreements system-wide, but even in these communities some deficiencies in the developed agreements were noted; the agreements

do not cover the range of functions for which agency coordination would be an asset; there are few agreements between treatment agencies and placement (foster care) agencies; and there is only one community (Union County) which has attempted to include the private service providers among those agencies with which coordination has been formally established.

B. Interdisciplinary Input

> Because child abuse and neglect are multi-faceted, multi-dimensional problems, a well-functioning system provides input from many different perspectives throughout the treatment process, from intake, initial investigation and diagnosis through treatment and termination. Solving problems of child abuse and neglect involves skills in diagnosis, counseling, therapy, advocacy, jurisprudence and child care. Protective service workers should have access to legal consultation when preparing a petition for court; a school social worker should have psychiatric consultation when determining a therapeutic treatment plan for abused children; an emergency room physician should have social work consultation when deciding if a case is indeed child abuse. The method of obtaining the interdisciplinary input can include: supplementing social workers in treatment agencies with staff from different disciplines; hiring outside consultants; developing formal or informal working arrangements with professionals of different disciplines; and initiating multidisciplinary review teams. These teams, typically composed of social workers, pediatricians, psychiatrists and/or psychologists, lawyers, teachers, police and/or court workers, meet periodically to discuss individual cases in detail and develop treatment recommendations. Such team reviews are sometimes provided for every case referred to protective services, while other teams review only a small proportion of all cases in a community system.

1. Project Achievements

With the exception of the St. Louis project, all of the demonstration projects focused some attention on the development of an interdisciplinary approach to child abuse and neglect in their communities, through the development or use of multidisciplinary teams, the hiring of interdisciplinary project staff and/or consultants, or by providing education to community professionals about the advantages of an interdisciplinary approach. In St. Louis, the project used consultants of different disciplines for case management in the project, but did not

focus on developing an interdisciplinary philosophy in the community at large.

Table 3 provides a comparison of the extent to which an interdisciplinary approach has been operationalized in each of the ten communities and the demonstration projects' contributions to fostering positive changes in this regard. Six communities have community-wide multidisciplinary teams, defined as teams available to review most cases in the community system. These teams are usually affiliated with (although not necessarily housed in) the local CPS agency. In the remaining four communities without community-wide multidisciplinary teams, each community has a more limited team; three of these (Baton Rouge, Bayamon, Arkansas) are project-sponsored teams available to review primarily project cases and two communities (Arkansas and St. Louis) have hospital-based teams to deal with child abuse/neglect cases identified in hospitals. Although theoretically available to to provide input into individual case decision-making at all stages of the process, the large number of cases in every community system have forced most teams to function primarily as initial diagnostic teams, and rarely are they able to review cases on an ongoing basis. In response to this overburdened situation, the full multidisciplinary team in Adams County now only reviews serious or complex cases while a subcommittee of the team reviews other intake cases. This may be one solution that could be replicated in other communities facing the problem of too many cases for review. With the exception of Adams County, where state law mandates multidisciplinary review of all cases, the teams in other communities, such as Arlington, Baton Rouge, St. Petersburg, Tacoma and Union County, review only a fraction of the open cases in the community, usually the most complex.

Most of the teams that are community-wide or demonstration project-specific have very good representation of relevant disciplines, including social work, pediatrics, general medicine, psychiatry, psychology, law, and other health and school-related disciplines. The hospital teams, with the exception of the one in St. Petersburg, tend to focus more exclusively on medical and social work personnel.

TABLE 3: Comparison of Mechanisms for Obtaining Community-Wide Interdisciplinary Input

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Existence of Community-Wide Multidisciplinary Team	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes
Existence of "Other Agency" Multidisciplinary Team	No	Yes, single community and project team	Yes, project team	Yes, project team	Yes, hospital diagnostic team and project team	No	Yes, two hospitals have multidisciplinary child abuse/neglect teams	Single community team housed in a hospital	Yes, single community and project team	No
Provision for Inter-Disciplinary Input, Community-Wide	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes
Interdisciplinary Mechanisms of Demonstration Projects	Project use of MDT and interdisciplinary consultants	Interdisciplinary staff (homemaker, nurse, etc) and use of MDT	Use of MDT (limited representation)	Psychologist, psychiatrist, pediatrician consultants	hospital personnel, public health nurse, lawyer, public officials, teachers & ministers are MDT members	Mental health staff, physician, public health nurse, psychologist and judge consultants	Use of interdisciplinary consultants	Use of MDT and interdisciplinary consultants	Extensive use of all disciplines in entire project	Psychologist, public health nurse, and other agency staff consultants
Project Contribution to Fostering Community Use of Diverse Disciplines	Major	Major	Moderate	Moderate	Major	Major	Minor	Major	Moderate	Major

Some of the demonstration projects, notably Adams County, Arlington, Baton Rouge, Neah Bay, St. Louis, St. Petersburg and Tacoma, have expanded the interdisciplinary focus beyond the use of multidisciplinary teams for case review to include the use of different disciplines as project staff or hiring consultants in various fields. These staff and consultants are available on an as-needed basis to assist the projects in all facets of case management, not just diagnosis, and have the added advantage of being asked to apply their special skills only to particularly relevant problem areas. Thus, through an agreement with the State Attorney's office, the St. Petersburg project has secured legal assistance for cases requiring court intervention; the Adams County and Arlington projects have public health nurses on staff to assist in medical diagnosis and management of client health problems; and the Neah Bay project has developed very close working relationships with all other agency staff of reservation programs and uses their input extensively for specific cases.

2. Barriers to Implementation

Although with the exception of St. Louis all communities had either a community-wide or a demonstration project-affiliated multidisciplinary team, the maintenance of these teams was not without problems. In cases of community-wide teams, the potential number of cases to be reviewed is extremely large, and the teams have been forced to become very selective in which cases receive reviews, limiting them primarily to the most complex or difficult ones, and almost always conducting the reviews only during the initial case planning phase. There is little provision for multiple, ongoing reviews of cases by these teams, which raises the question of whether the majority of the community's child abuse cases, many of which are open for more than a year, are receiving the benefit of interdisciplinary input. Most multidisciplinary teams, however, have very adequate representation of different disciplines.

Many staff have had little experience or education in the appropriate use of these teams; they experience problems deciding whether their cases are "good" ones for the team to review; they are unclear about how best to present relevant case information in a concise manner, and they are hesitant to ask for specific recommendations from individual team members.

Due to the above mentioned problems, the multidisciplinary teams in Arlington, Tacoma, and Union County have been dropped or changed (in terms of membership, frequency of meeting, or criteria for reviews) during the latter half of the demonstration period, in the hopes of developing other, more efficient mechanisms for ensuring the necessary interdisciplinary input into case decision-making.

In general, the projects have used interdisciplinary input successfully in their own programs, often through the use of a wide variety of project consultants of different disciplines in addition to what is available through the MDTs. In four of the communities, however (Baton Rouge, Bayamon, Arkansas, St. Louis), there has not been a subsequent use of different disciplines in the remainder of the community system. In part, the lack of resources in community agencies is a factor; the demonstration projects had funds to cover consultants, most agencies do not. But in part, also, it appears to be related to a difference in philosophy. Historically child abuse was a social service problem, and social workers were responsibile for dealing with it; it is only relatively recently that the need for cooperation among different disciplines has become an issue. And, finally, creating the atmosphere and developing the mechanism for eliciting input from different disciplines is a time-consuming and often frustrating endeavor, due to a historical lack of cooperation among disciplines, ambiguity surrounding the appropriate roles and responsibilities of different professionals in dealing with child abuse cases and problems knowing how to use the skills of each discipline to its greatest

advantage. The experience of the demonstration projects suggests that a concerted effort by all disciplines involved, a strong commitment from some "lead" agency or individual, and the flexibility to test several mechanisms, rejecting those that don't work well, is the only way of developing, and maintaining, the requisite interdisciplinary input in community systems.

3. Summary

In general, the projects have been successful in the implementation of an interdisciplinary focus for their specific projects through various mechanisms, primarily the use of a variety of project consultants, or the development of project multidisciplinary teams, if community-wide MDTs did not exist. Several have also been effective in encouraging the remainder of the community system to take steps toward integrating other disciplines into their programs, but this was not evident for all projects.

The high cost of multidisciplinary team reviews (monetary costs if team members are paid, or in "time lost" from other work if members are voluntary), suggests that other mechanisms for ensuring interdisciplinary input for many of a community's cases need to be available.

Perhaps the demonstration projects' main contribution in each of their own communities has been focusing on the issue of the importance of interdisciplinary input, and testing various approaches, even if the most effective community-wide mechanisms are not yet in place.

C. Centralized Reporting System

The well-functioning child abuse system has the capacity to intervene in family situations, on the child's behalf, at any time, with appropriate investigation procedures and service provision. Many state laws already require that some mechanism exist for 24-hour reporting of cases. A critical ingredient of a 24-hour reporting and response system is access, at any time, to a place to call; but such a repository of calls is not sufficient, particularly if it is statewide. There is also a need for an immediate local response to these calls to determine if there is current danger to a child, and if so, for appropriate action to follow.

However a 24-hour reporting and response system is organized (statewide/local level shared responsibility, local "beeper" systems, etc.), it is important for community residents and professionals to know that the system can respond quickly to emergencies and that knowledgeable personnel are providing immediate intervention.

Numerous problems currently besetting communities, including "lost" cases, duplication of functions, and case "tracking" (i.e., reporting a case to one agency results in a certain set of actions, perhaps strictly criminal, and reporting the same case to another agency results in different actions, perhaps strictly therapeutic), could be reduced or eliminated through a centralization of reporting, where only one agency is designated to receive reports and both professionals and community citizens know which that is. However, even if state laws designate two agencies to receive reports, the problems can be minimized by requiring tnat copies of all reports received by one agency be forwarded to the other agency for information purposes. It is then incumbent upon both agencies to coordinate the investigative and treatment planning activities pursued for individual cases so that duplications are eliminated.

1. Project Achievements

A 24-hour reporting and response capability exists in nine of the ten projects. In all but one of the nine communities (Tacoma), this capability was developed subsequent to the federal funding of the demonstration projects. The following table (Table 4) outlines the provisions of these reporting

TABLE 4: Comparison of Community Reporting and Response Systems

Features of Reporting and Response System	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
24-Hour Receipt of Reports	Yes	Yes	Yes	No	Yes	Yes, informally[1]	Yes	Yes	Yes	Yes
Date of 24-hour coverage implementation	1975	1976	1974	--	1975	1974	1975	State--1972 local--1976	1972	1974
Legislative mandate for 24-hour coverage	Yes	Yes	No	No	Yes	No	Yes	Yes	No	Yes
Mechanism for report receipts	CPS "Crisis Team" coverage	Statewide number & local intake unit	Local answering service & beeper system	Must report to police after 5 p.m.	Statewide number & local SCAN unit		Statewide number & local intake unit	Statewide number & local intake unit	Intake unit at CPS	Special response unit
Centralization of reports	No, CPS or law	Yes, CPS (Project)	No, Project, CPS, Court, law	Yes, CPS	Yes, CPS with agreement for SCAN referral	Yes, Child Development Center	Yes, CPS	Yes, CPS	No, CPS & law	Yes, CPS (Project)
Level of coordination between agencies around receipt of reports	Moderate--some problem between DSS & law	High	High	High	High	High	High	Low, cases delayed between state and local level	High	High
Level of project responsibility for development/ maintenance of system	Partial	Partial	Complete	--	Partial	Complete	None	None	None	Partial

[1] An informal system of responding to all reports exists through the Child Development Center (the demonstration project), but due to the small number of abuse/neglect reports (five in 1976) it is rarely needed.

systems and the extent to which implementation and/or modifications in these systems was a demonstration project-related occurrence.

Although it is evident that in only two communities (Baton Rouge and Neah Bay) was the demonstration project primarily responsible for development of the 24-hour reporting capacity, the projects did make substantial contributions in this regard. In some cases, for example Arlington, the project was developing such a capability when passage of new state laws mandated their existence, and in others, the project acted as a catalyst by bringing people together to focus on the issue of 24-hour coverage. It is interesting to note that in all cases where the projects were primarily or partially responsible for the development of this 24-hour reporting capability (Adams County, Arlington, Arkansas, Union County), the project was affiliated with, or was, the local child protective services agency designated to receive child abuse/neglect reports in the community. It is unlikely that any agency not mandated legislatively to receive reports could develop or maintain such a system efficiently or effectively; this accounts for the low level of project involvement in the St. Louis, St. Petersburg and Tacoma projects, all of which are independent projects.

In addition to the demonstration projects' efforts, the passage of state legislation was the primary impetus behind development of the 24-hour reporting and response systems in six of the nine communities (Adams County, Arlington, Arkansas, St. Louis, St. Petersburg, and Union County), and in four of these, the legislation provided for the existence of a toll-free state-wide number for 24-hour reporting of cases in addition to the local system.

The process for report receipt (and subsequent response) has been centralized, in all cases legislatively, in seven of the ten projects (Arlington, Bayamon, Arkansas, Neah Bay, St. Louis, St. Petersburg, Union County). In Adams County and Tacoma, two of the three project communities where reports may be made to more than one agency, coordinative linkages have been worked out so that all reports are shared between agencies. In Baton Rouge, although reports can be made to the local CPS agency, the Court or law enforcement agencies, in practice all abuse reports are handled by the demonstration project and all neglect reports are handled by CPS.

2. Barriers to Implementation

Existing state child abuse and neglect legislation, rather than any efforts of community agencies, including the demonstration projects, appears to be the factor most associated with the development of 24-hour centralized reporting systems. In all of the communities in which a centralized reporting-system exists, it has been legislatively mandated, and in six of the nine communities having 24-hour coverage of report receipts, this round-the-clock coverage was also legislatively mandated. Although at least two communities were developing a 24-hour coverage mechanism prior to the passage of state laws requiring it, numerous problems were encountered until there was a legal mandate. It appears that only CPS agencies, or agencies legally mandated to receive reports, would be in a position to implement such a system effectively, and, in fact, in the cases where the demonstration projects played either a primary or partial role in the implementation or maintenance of these 24-hour coverage systems, all, with the exception of Neah Bay, were adjuncts of, or were, the local CPS agency (through informal agreement, the demonstration project in Neah Bay functions

Once development of a 24-hour reporting system was decided upon, there were few real implementation problems. The amount of compensatory time to be paid for "on duty" coverage was a point of contention between local CPS administrators and staff in Arlington and Baton Rouge, but compromises were subsequently reached. In Tacoma and Union County, the use of regular CPS staff to provide after-hours coverage proved unsatisfactory and in both cases additional staff were hired specifically to carry out the intake/response function. The statewide, 24-hour reporting system in Florida has experienced the most major difficulties in the maintenance of their response system, stemming primarily from a tremendous increase in reports in the year following the passage of new state legislation without the necessary increase in CPS staff at either the local or state level to handle the increase. The result has been intolerable delays (up to several months) in transferring reports of cases from the state to the local level, and shorter but still significant delays in the local CPS units' response to reports.

Minimal problems were evident in any of the communities with respect to the actual operations of their reporting systems, whether centralized or not. In the seven communities in which the local CPS agency is the only agency designated to receive reports, almost all reports are channeled to those agencies and, where necessary, coordination mechanisms have been established with other agencies for transferral of any reports received by them. In the three agencies without a centralized reporting system (Adams County, Tacoma, Baton Rouge), likewise, administrative arrangements have been developed between agencies to provide for the efficient operation of each community system, and few, if any, problems with the arrangements were noted by community agency representatives.

3. Summary

In summary, the majority of demonstration communities have moved ahead during the demonstration period to implement a 24-hour reporting and response capability. Six of the demonstration projects were primarily or partially responsible for the maintenance of these systems since they were the local agency mandated to receive reports, although new state legislation requiring 24-hour coverage was clearly the impetus for development of after-hours coverage in four communities.

Likewise, new state legislation has created a centralization of reporting systems in seven of the ten communities, identifying the local CPS agency as the sole agency to receive reports. In cases where two or more agencies are identified to receive reports, provisions have been made either to specify a division of reports going to each agency (e.g., abuse vs. neglect reports) or to share all reports between the agencies involved. In four communities, a statewide reporting number has been established for 24-hour reporting in addition to a local reporting system. While there is insufficient evidence of serious problems due to either a dual reporting system or a non-centralized system, the increased possibility of such problems developing still appears to point to the advisability of developing centralized 24-hour local reporting systems in those communities where it is at all feasible.

D. Service Availability

Although one form of maltreatment, physical abuse, is perhaps most well recognized and engenders the most immediate response, there is ample evidence to suggest that other forms of maltreatment, including physical neglect, emotional abuse and neglect or sexual abuse, are equally threatening to children's well-being and, in fact, may be more prevalent problems. It is important for communities to provide treatment options for all types of child maltreatment and not be limited to narrow definitions of the problem.

Because problems of child abuse and neglect are interactive between parents and children, and because the predisposing family problems triggering the maltreatment are different for different families, a variety of treatment options for both parents and children need to be made available for optimum effectiveness.

A full complement of treatment services would include: individual and group services; supportive and advocacy services as well as therapeutic and educational ones; crisis or emergency and long-term treatment; day services as well as residential care; and professionally provided services as well as self-help endeavors.

It is becoming clear that preventive efforts are as important in child abuse and neglect systems as are treatment services. Primary prevention might be defined as those activities which are aimed at eliminating the situations and behaviors often cited as responsible for child maltreatment before they become realities. These include adequate curriculum for school age children about the responsibilities of adulthood, sensible and early sex education, and family life and parenting education including introductions to problems of child abuse.

Secondary preventive services are those activities which intervene at the point in a family's situation when abuse or neglect are imminent, but maltreatment has not occurred. These activities are usually of two types. The first are those in which professionals can identify situations or behavior that might be called high risk, and can encourage families to seek assistance. Examples of these services are prenatal or hospital screening programs. The second type of secondary preventive activities are those which are sought by parents themselves. These activities are often crisis oriented, such as 24-hour counseling hotlines, but may be more planned and long-term, such as parenting classes for families encountering difficulties and frustrations with their children.

1. Project Accomplishments

Each of the ten communities, under legislative mandate, are required to provide services to both physically abused and neglected children, including children sexually abused. There is no requirement in most communities to report or consequently provide services in cases of emotional abuse or neglect, or for potential cases of these problems (which is true nationally as well). However, despite the lack of specific mandate in cases of emotional and/or potential abuse and neglect, the demonstration communities generally do provide services to these reported cases, but on a smaller scale, with some important differences.

Each community provides services for cases of both abuse and neglect, but there appears to be no differentiation, in most cases, in the services received, despite the often commented-upon differences in the etiology of the two problems. In those cases where there are differences in service provision (e.g., Adams County and Arkansas), it appears that neglect cases receive less intensive, less well coordinated services, often bordering on mere "maintenance" services.

Likewise, there are only two communities in which services for sexually abused children and their parents have been a specific issue. In St. Louis, a Committee on Sexual Abuse has been developed to study the problem and provide for increased education and training in this area, and in Tacoma a conference on sexual abuse sponsored, in part, by the project was the impetus for developing a special sexual abuse program which, although still small, is gaining in stature. Several elements may be responsible for this lack of specific attention to sexual abuse, including inadequate training and preparation of social workers in this area, a lack, until recently, of any model programs for sexual abuse, a generally inadequate theoretical base about the causes and treatment of sexual abusers and abused, and a still-pervasive discomfort among workers when dealing with this problem. Whatever the cause, few of the communities studied have, as yet, developed any adequate solutions.

Variation was also found in the extent to which the demonstration projects and their community systems provide for potential or high risk cases of abuse or neglect. While no service system specifically excludes these cases, the CPS agency in some communities, such as Baton Rouge, Bayamon, St. Petersburg and Union County, have such high caseloads of actual cases that potential cases are not dealt with at all, are transferred to other "maintenance" units and lost track of, or are provided only minimal services. This difference between actual and potential case handling is clearly a practical, rather than philosophical, disparity and, without the addition of new workers, does not appear solvable.

In only two cases did the demonstration projects have any real impact on expansion of the categories of abuse and neglect cases provided services. As noted before, the Tacoma project provided the impetus for developing a sexual abuse program, and the St. Petersburg project developed a program of preventive services for parents who were considered "high risk." In all other cases, the projects supplemented the services available to the same client groups as had been served previously.

Each community in the demonstration group witnessed an increase in the volume and type of services made available during the three-year demonstration period; in some communities the new services drastically altered the previous system, while in others the new services were merely supplemental to the existing services, increasing only the numbers of clients served, or providing new types of services to only a few client families.

Table 5 illustrates the range of services, both treatment and preventive, which were available to parents and children in each community during the demonstration period. With the exception of the Arlington and Union County projects, both of which are housed within Protective Service agencies, and thus provided some of the listed services prior to federal funding, all services provided or sponsored by the demonstration projects were new services in the community developed after the projects became operational.

TABLE 5: Availability of Project-Sponsored and Other Agency-Sponsored Services

	Adams County		Arlington		Baton Rouge		Bayamon		Arkansas		Neah Bay		St. Louis		St. Petersburg		Tacoma		Union County	
	PS*	OAS*	PS	OAS	PS	OAS	PS	OAS	PS	OAS	PS	OAS	PS	OAS	PS	OAS	PS	OAS	PS	OAS
Treatment Services for Parents																				
Individual therapeutic services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Group services	✓	✓	✓				✓		✓	✓			✓				✓	✓	✓	
Supportive/advocacy services	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Educational services									✓		✓		✓		✓			✓	✓	
Crisis or counseling hotline		✓				✓				✓				✓		✓		✓		✓
Residential services			✓																	
Self-help programs	✓	✓							✓				✓		✓		✓			
Treatment Services for Children																				
Crisis care	✓		✓			✓														
Individual services	✓												✓							
Group services	✓		✓										✓							
Residential programs																				✓
Foster care	✓	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
Day care	✓		✓							✓		✓	✓	✓					✓	✓
Preventive Programs																				
Identification program											✓	✓			✓					
Treatment program															✓					
Primary prevention (e.g., school education program)	✓		✓		✓			✓	✓		✓								✓	

*PS = Project Sponsored; OAS = Other Agency Sponsored.

A review of the table points out both similarities and some striking differences between communities, and also between projects, with regard to service availability. All communities and all projects provide some form of individual counseling or therapy to parents, and for most communities and projects these remain the major mode of service provision, irrespective of target population or problem (e.g., abuse or neglect). In addition, most of the communities (Adams County, Arlington, Bayamon, Arkansas, St. Louis, Tacoma, Union County) have group services available, and in four of these, group work was a new addition with the advent of the demonstration project. Supportive or advocacy services, including assistance with welfare, financial, legal or housing problems, homemaking services, or transportation are provided by most communities and projects. In general, the projects were responsible for providing more concrete supportive services such as homemaking or transportation, than was usually available through protective services, which normally concentrated on providing referrals to needed supportive/advocacy services or assisted in reducing the red tape associated with service provision in other agencies.

Beyond individual, group and supportive services for parents and foster care for children, which have historically been available, although often inadequately, in every community, there is wide disparity in service availability between the communities and projects. Crisis or counseling hotlines (not always solely for child abuse or neglect problems) are available in seven communities, but only in Baton Rouge was this development a direct result of project activities. Only Arlington has residential care for parents available and this is limited to a single home available to care for a parent and child for limited time periods. Although self-help programs such as Parents Anonymous have been widely advocated, only half of the communities (Adams County, Arkansas, St. Louis, St. Petersburg and Tacoma) have established such programs; in each case the demonstration project played a key role in the development of the program.

Services for children in every community were limited almost entirely to day care prior to the demonstration period, and even though technically available, geographic, financial and practical (e.g., long waiting lists accessibility) severely limits day care use for abuse and neglect clients. In all communities, this still remains the case. Only two of the demonstration projects (Adams County and St. Louis) focused major attention on the development of treatment or crisis services for children.[1] In these projects, the services developed included crisis care (a crisis nursery in Adams County), individual therapy (usually play therapy), and group socialization and therapy programs focusing on emotional and developmental problems of children. The Arlington project also provided a small day care program, crisis shelter and, for a time, art therapy for children, but only served a few children.

None of the community systems and only one of the demonstration projects focused significant attention on preventive services. The most common preventive services provided were parenting classes, offered in four projects, and education to school-aged children about both general parenting problems and skills and problems of child abuse and neglect, which more than half of the projects (Adams County, Arlington, Baton Rouge, Bayamon, Arkansas, Neah Bay and Union County) offered. The St. Petersburg project made the most significant progress toward integrating preventive services into the community system. Numerous parent education classes, all well attended, were provided through the school's extension program. A screening program for parents of newborns was conducted to identify high risk individuals, who were then made aware of the variety of supportive services available in the community. Follow-ups were conducted to determine how many parents then voluntarily availed themselves of services.

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[1]The Los Angeles project provided residential services, including therapy and socialization groups to ten children at a time, but it is not included in this report.

Beyond the increase in community resources stemming directly from the new services provided by the demonstration projects, the projects had little success in promoting other-agency sponsored service expansion. It appears that most communities have a variety of services available which are appropriate for child abuse and neglect clients (e.g., therapeutic counseling, Mental Health services, children's services, homemaking services), but few, if any, of the communities have developed adequate arrangements to tap these resources. Thus, the primary service providers typically remained the protective service agencies (and the demonstration projects for the previous three years). Both the Arlington and Arkansas projects co-sponsored group services with their community's Mental Health Center. In Union County, the project developed "contracts" with local agencies (Visiting Homemakers, Public Health Nurses, Family Counseling Agencies) to provide services to abuse and neglect clients, but these, again, must be considered project-sponsored activities. The Panel for Family Living also encouraged the expanded use of existing services for abuse and neglect clients and the local protective services agency is now providing group therapy and parent education classes.

2. Barriers to Implementation

As mentioned previously, most communities provide services to substantiated cases of emotional and physical child abuse and neglect, and most CPS agencies will handle sexual abuse cases when called upon to do so. Large caseloads in most protective service agencies and the fear of physical danger to a child, however, have resulted, in many cases, in what amounts to a priority ranking for services, so that serious cases of physical abuse receive the most intense services, with cases of emotional abuse or neglect receiving much less attention. Few communities have developed alternative service "packages" for different types of child abuse or neglect; the problem appears to be both lack of resources and lack of theoretical knowledge about the treatment requirements of different types of problems. Only Tacoma provides special services for sexual abuse cases through a program developed by the demonstration project. In the remainder

of the communities, the same lack of resources is a problem compounded by the dearth of adequately tested program models of sexual abuse, and, conceivably, by the discomfort of service agency staffs.

Inadequate service capability, stemming both from availability and accessibility problems, are prevalent in most communities. Several factors appear to contribute to this problem. As with the inability to adequately handle all types of cases, the inability to provide what could be considered a broad range of treatment services stems primarily from inadequate resources. Protective Service agencies have been historically understaffed, and despite new federal legislation, the situation is not improving. Simply providing individual counseling (available in all of the communities) to their caseload consumes the major portion of the staff's available time.

A second problem, however, is a general lack of initiative among service agencies to move away from traditional "social work" services (i.e., individual counseling) into more innovative areas such as group work, lay therapy, self-help programs. These agencies' lack of implementation of widely tested service models is in large part due to the intractability of the bureaucracy, but may also be due to a lack of knowledge about new treatment models and/or their effectiveness.[1]

The final problem evidenced in the communities that saw no growth in resources except for the demonstration project-provided services, concerns accessibility rather than availability of services. Most communities, in fact, have many more services available through public and private agencies than were typically provided by CPS agencies; they were simply not used to their full potential for child abuse and neglect clients. Thus, with the exception of Union County (which developed contracts with other community agencies) and Arkansas, few communities or demonstration projects developed agreements with other agencies for service provision. Several factors, including different eligibility criteria used in different agencies, cumbersome record-keeping in cases of client referral (many clients would be eligible for most available services under Title XX, but the provider/vendor payment scheme is extremely complex), inadequate knowledge of existing community resources, long waiting lists at some agencies (e.g., Mental Health), and simple lack of initiative are probably the most common reasons for the under-utilization of existing resources.

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[1]Demonstration projects housed within protective services are clearly an exception to this.

The lack of services for children throughout these communities, even after the demonstration projects' development, is a critical gap which, according to current literature, is nationwide in scope. Given the multiplicity of problems exhibited by the few children who have received therapeutic services through the demonstration projects,[1] the immediate development of community children's programs is a critical issue which should be addressed as a priority in every community. It is interesting to note that few of the agency representatives interviewed as part of this evaluation spontaneously cited the lack of services for children as a major problem area in their community, pointing up, perhaps, the usual lag between theory or philosophy (services to children has become an issue in the field only during the past few years) and actual practice.

Several reasons for the inadequacy of preventive services are evident. The first is the lack of appropriate screening/treatment models for high risk parents which do not violate parental rights and which are non-stigmatizing. Attempts to remedy this gap in the field are currently being undertaken through the development and testing of appropriate models, which when completed may spark replication in other communities. The second problem, which is endemic in the field of child abuse and has been a factor in every community studied, is the lack of adequate resources to provide everything that is believed helpful in combating the problem. With current CPS caseloads at unmanageable levels, and services for treatment of parents and children sorely lacking in many communities, it is not surprising that little attention is being directed toward prevention.

3. Summary

All of the communities provided services to the whole range of child abuse cases (physical and emotional abuse and neglect as well as sexual abuse), but not all cases were dealt with adequately. Thus, in the large

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[1] See Final Children's Report, Berkeley Planning Associates, October 1977.

CPS agencies, neglect cases received less intensive services than abuse cases, more attention was focused on physical abuse and neglect than emotional maltreatment and, in general, there was so little differentiation in the services provided to all types of cases as to suggest an erroneous perception that the etiology of all child abuse and neglect problems was similar. Cases of sexual abuse tended, likewise, to receive whatever services were available, and only the Tacoma and St. Louis projects moved ahead in the development of special sexual abuse programs.

In general, although the demonstration projects were instrumental in the development of additional services for parents to supplement existing CPS services, these tended to be more focused on traditional counseling, both individual and group, and supportive services. Other new or innovative services for parents were provided by only 4-6 of the projects. Services to children, lacking in all communities, were not noticeably impacted by the demonstration projects except in St. Louis and Adams County. Secondary prevention services, in the form of education for parents and children, were offered by half of the projects, but to a limited audience. Only the St. Petersburg project provided extensive primary preventive services. Beyond the services offered directly by the demonstration projects, little progress was made in expanding the services available through other community agencies, which poses a major problem to the long-term impact of these projects in their communities, if the services they offered are not incorporated into other agency programs at the end of the demonstration period.

E. Quality Case Management

The ways in which each case of child abuse and neglect in a community is handled by individual service providers, from identification through case planning, service provision, termination and follow-up, may well be the largest single determinant of the overall community system's effectiveness. Although definitive standards for the quality management of cases are difficult to specify, and even more difficult to reach professional consensus about, there are numerous practices, procedures and methods of carrying out the case management function which would be considered by most to be "good practice." It is, likewise, possible to identify areas in which serious problems with case management are occurring.

Adherence to minimum standards of case management would, then, ensure that there was prompt response to all reports; decisions concerning service provision were reached in a planful manner, preferably with interdisciplinary input; clients were initially assigned to the most appropriate agency and staff member within agencies; clients received the appropriate services at the required level of intensity according to their needs; referrals to other service providers were made, when necessary, and followed-up by the primary case manager; clients were terminated according to established criteria; and all terminated clients received follow-up services. (1)

1. Project Achievements

The demonstration projects have made some contributions toward improvements in the way their community systems handle the majority of child abuse and neglect cases. Table 6 outlines the significant aspects of the case management practices in each community and the projects' contributions to improving these systems.

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[1] For an expanded discussion of the Quality of Case Management within the demonstration projects themselves, see "Assessing the Quality of Case Management in Child Abuse and Neglect Programs," Berkeley Planning Associates; October 1977.

Table 6: Comparison of Community Case Management Adequacy

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Timing of Response to Reports	Good	Good	Adequate	Adequate	Good	Adequate	Poor	Poor	Good	Poor
Existence of Specialized Intake Unit at Primary Report-Receiving Agency	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes
Criteria for Case Assignment	Client needs	Staff skills & caseload size	Staff rotation	Client needs; emergency/ non-emergency status of case	Client needs; staff skills	Client needs	Emergency/ non-emergency status of case	Random assignment	Random assignment	Client needs; staff skills
Multidisciplinary Input Into Service Planning	Yes	Yes (for some cases	Yes	No	Yes	Yes	No	Yes (for some cases	No	No
Use of Community Resources for Service Provision	Moderate	Moderate	Moderate	Minimal	Moderate	Extensive	Minimal	Minimal	Extensive	Extensive
Adequacy of Termination Procedures	Poor	Poor	Poor	Poor	Good	NA	Poor	Poor	Good	Poor
Adequacy of Follow-Up on Terminated Clients	Adequate	Poor	Adequate	Poor	Good	Good	Poor	Poor	Poor	Poor
Project Contribution to Improved Community Case Management	Major	Major	Moderate	Moderate	Major	Major	Minimal	Minimal	Minimal	Major

In all but St. Louis and St. Petersburg, the timing of response to reports was considered at least adequate, and in Adams County, Arlington and Arkansas, all reports are responded to extremely promptly; usually the dame day, but always within two days. In St. Louis and St. Petersburg, delays of over one month often occurred before reports were investigated or services provided (crisis or emergency reports were probably responded to more quickly).

The initial assignment of child abuse and neglect cases to the most appropriate agency, and individual staff within agencies, has a critical impact on the eventual successful treatment of clients' primary problems. Slowly, many of the primary agencies for receiving reports in the ten communities have become aware of the need for more than random assignment of cases, but most communities face constraints in implementing what could be called adequate sorting or "triage" systems.

In six of the communities, central intake units are available within the CPS agency for initial investigation and case assignment. This system has some advantages over the more traditional "rotational" system where each worker carries out the intake function at different times. It provides workers with the experience to develop the skills necessary to quickly diagnose the clients' primary problems and also allows the intake workers to become more familiar with the resources available in the community and the special skills of individual staff both inside and outside their own agencies.[1]

Despite the expressed criteria for case assigment (i.e., both agency assignment and individual staff assignment) within these communities, high caseloads in CPS agencies, limited community resources and the lack of cooperative agreements among service providers have contributed to situations where the majority of all cases of child abuse and neglect are maintained by CPS or are referred to the demonstration projects, and receive primarily only those services available within these two agencies. Within these agencies, also, despite a desire that it were otherwise, the pattern appears to be somewhat random assignment of cases to staff members, based more on

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[1]One of the many disadvantages associated with intake units, however, is the rapidity with which workers burn out.

caseload size than on the needs of the clients. Several of the communities, notably Adams County, Neah Bay, Tacoma and Union County, are beginning to make extensive use of other community resources, for example mental health centers, homemaker agencies, and private counseling agencies. In Union County, particularly, the demonstration project (CPS) has greatly capitalized on the skills and resources available in other community agencies by developing contractual arrangements with these agencies for service provision to abuse/neglect clients. Thus, one would expect a more appropriate initial assignment of cases to various agencies/staffs in this community.

Beyond this use of formal arrangements with other community service providers, the existence of multidisciplinary input during the diagnosis and service planning phases (available in Adams County, Arlington, Arkansas, Neah Bay and St. Petersburg), has greatly increased the probability that clients are initially referred to the appropriate agency/staff and receive the most beneficial services.

In three of the communities (Neah Bay, Tacoma, and Union County) the local CPS agency has developed agreements with numerous service providers in the communities that can be called upon for additional services for clients. In Neah Bay and Tacoma this has occurred through informal arrangements between service providers, but in Union County, the demonstration project (part of CPS) developed contractual agreements with numerous community agencies to provide special services to child abuse and neglect clients. In Bayamon, St. Louis and St. Petersburg, the local CPS agencies make minimal use of community resources for service provision; their clients usually receive only those services available from the agency itself.

Although more adequate use of community treatment providers (besides CPS) was made in Arlington, Baton Rouge and Arkansas, as the discussion in Chapters V and VIII noted, there are still numerous community agencies, particularly private ones, that have been totally excluded from the child abuse and neglect service delivery system in all ten of the communities.

The two areas of case management that were most consistently inadequate were the adherence to appropriate termination procedures and the conduct of follow-up on terminated cases. Only two communities, Arkansas and Tacoma, are routinely adhering to criteria which reflect a planned approach to terminating clients. In these projects, cases are assessed by staff (an interdisciplinary group in the case of Arkansas) and are terminated when their needs can no longer be met by the service providers. In contrast, the remainder of the community CPS agencies (and in some cases the demonstration projects) tend to keep their cases open indefinitely, even though services to these clients may have been drastically decreased or discontinued altogether. In these communities, clients tend to be terminated in "batches," when a staff member's caseload approaches unmanageable proportions. In none of the communities were the procedures for termination nearly as comprehensive as those for intake.

Likewise, seven of the communities offer very inadequate or no follow-up to terminated clients. In the three communities which do provide some follow-up, only the procedures of Arkansas and Neah Bay were considered of actual high quality. In Arkansas, all clients of the project are routinely followed-up at six month intervals, a system that is particularly feasible there since the lay therapists (primary service providers for all abuse cases) carry a maximum of three cases at a time. In Neah Bay, due primarily to the small size of the community, terminated clients remain highly visible to the staff. In Baton Rouge, clients are instructed that they may use the 24-hour "on-call" system to discuss any problems they experience after termination, so that all follow-up is at the initiative of the client.

2. Barriers to Implementation

As the preceding table showed, there are no generalizations about how well, or poorly, community agencies in the demonstration group carry out their overall case management function; rather, the observed strengths and weaknesses appear to be related to individual components of the case management process.

The primary factors associated with inadequate case management in these communities include very large caseloads at most CPS agencies; lack of adequate linkages with other community agencies for appropriate client assignment and subsequent service provision; heavy record keeping and administrative procedural requirements in the larger agencies; and a lack of importance attached to the termination and follow-up processes. These constraints, to a greater or lesser extent, were prevalent in most of the communities studied; they are, furthermore, the hallmarks of many child abuse and neglect systems in the country.

The large caseloads and heavy record keeping and administrative/procedural requirements are characteristics of large agencies that are likely to remain constant for some time to come. Although it may not be possible to eliminate them, more attention paid to terminating clients at appropriate times (thus eliminating "maintenance" cases from individual workers' caseloads) and concerted efforts focused on reducing the amount of duplicative or unnecessary record keeping would help to free workers to spend more time directly with clients, assessing their needs, delivering and/or referring them for required services, and providing the necessary follow-up on terminated cases.

The remaining three constraints to quality case management, inadequate linkages between community service providers, inappropriate terminations and lack of follow-up, are clearly problems for which solutions are available. Providing the necessary interface between service providers is a time-consuming process, but efforts expended in that activity reduce the need for <u>all</u> clients to receive <u>all</u> services from the local CPS agency, thus freeing staff to provide more intensive services of an appropriate nature to those clients who can most benefit from them. The lack of emphasis on termination and follow-up is an historical one in social service agencies, perhaps because many social service cases have always been "long-term maintenance" cases, perhaps because social workers are loathe to close cases in which less than optimum success has been achieved. This is particularly true in child abuse and neglect cases, if there is any possibility of future damage to the child. In any case, major efforts need to

be directed toward developing adequate termination criteria, training staff in the use of those criteria, and providing both supervision and outside consultation in the often-times difficult termination decision-making process.

It is interesting to note that so few communities provide any follow-up services to terminated clients, even though re-abuse is clearly within the realm of possibility for many of these families. A greater emphasis on this phase of the service process needs to be made by social service agency heads, so that follow-up of terminated cases at specified intervals can become standard procedure in child abuse and neglect programs.

3. Summary

The demonstration projects had mixed success impacting on the quality of case management within the overall community system. In general, local CPS agencies' (or other legally mandated report receiving agencies) response to reports occurs in a timely fashion (within several days) even though only five agencies have specific Intake Units to handle this function. In Adams County, Arlington and Union County, the demonstration projects were responsible for the development of these Intake Units. Although specific criteria for assigning cases to the appropriate service providers exist in seven communities, it was generally observed that the actual assignment of cases is more often than not a random one, or is based on the individual worker's caseload size.

Half of the communities have made provision for securing interdisciplinary input into service planning, but in only three communities (Neah Bay, Tacoma and Union County) are the community's resources (beside CPS and the demonstration project) being extensively used for service delivery.

There was a marked inadequacy in both the temination and follow-up procedures in most communities. Cases tend to be kept open beyond the point when services have ceased to be effective, and often workers simply terminate a group of cases all at once in order to make room

in their caseloads for new cases. Although several of the demonstration projects provided excellent follow-up to their own clients, the follow-up occurring for the majority of clients in each community was usually non-existent.

Those projects which were most able to make major contributions to improving the case management practices in their communities (Adams County, Arlington, Arkansas, Neah Bay and Union County) were, in most cases, an adjunct to or part of the local CPS agency; independent projects had less overall impact on their communities' case management practices.

F. Community Education and Public Awareness

The more informed professional staffs of all agencies are in a community about the dynamics of abuse and neglect and the way their community system functions, the better the care abused and neglected children and their families receive. Lack of knowledge leads to prejudicial and often injurious treatment of both parents and children. Because of the high turnover rates in many of the professions dealing with abuse and neglect and because knowledge about maltreatment is continually being advanced, it is important for training to be an ongoing process of dissemination, sharing and discussion of information. And, it is important for such training to reach all relevant professional groups and classes of workers who are involved in the detection, treatment or legal aspects of child abuse.

An integral component of an adequate child abuse and neglect system, also, is the education of all community citizens so that they understand the dynamics of child abuse and neglect, and the system which is in operation for receiving reports and providing treatment for parents and children. The development of an adequate, well-functioning system in the community will be of little value if the people most often in a position to detect child maltreatment are not aware of their reporting obligations or of the proper agency(ies) to contact. Providing community education is the responsibility of all agencies involved with child abuse and neglect, not just protective service agencies or demonstration projects. Each agency should have at least one person, but preferably several, capable of providing educational presentations to community and civic groups when requested. Agency staff should also encourage the provision of education sessions to various groups who might not have thought to request such training.

In response, no doubt, to national attention focused on the need for expanded training and education of professionals and lay citizens alike, and also in response to the perceived lack of such activities in their own communities, the demonstration projects directed a major portion of their non-service delivery efforts to providing training and education in the dynamics of abuse and neglect, the appropriate procedures for reporting suspected cases, and on the availability of community treatment resources.

1. Project Comparisons

Table 7 depicts the overall educational effort of the demonstration projects during the three-year period. Although, as can be seen, a very large number of educational presentations were made to both professional and citizen audiences, with the exception of Arkansas and St. Louis, most projects concentrated their efforts more heavily on providing information, education or training to select professionals in the community.

While education was clearly a goal of each demonstration project, the three projects that consistently reached more professionals (Adams County, St. Petersburg, Tacoma) placed a special emphasis on this activity and developed particularly successful methods for accomplishing it.

In Adams County, a School Referral Program was established, which included providing carefully planned and systematically executed educational programs to each school district in the county; these presentations were often repeated during the course of the demonstration period. The Center's social workers and nurses were each assigned a district and met regularly with the teachers and principals in the schools, thus providing a continuity to the education.

The PACER project in St. Petersburg undertook the primary responsibility for providing education and training in Pinellas County, reaching a diverse population including the local medical society, schools, law enforcement agencies, social service providers and civic groups. One full-time position within the project was allocated to education/training which allowed a more fully planned and comprehensive education program to be developed. This staff member, with other PACER staff, also undertook the development of specific educational "packages" for different groups, including the screening and selection of appropriate materials, and spent considerable time acquainting Pinellas County professionals and civic groups with PACER's resources, and "encouraging" the scheduling of educational presentations. Secondly, the project was the co-sponsor, with the medical society, of a major conference (200-300 attendees) each year which increased the visibility of the project's educational program and sparked additional interest for training/education among those previously uninterested. Two features of these conferences are worth noting. The first is the use of the "co-sponsor" strategy to encourage medical personnel participation, a stated

TABLE 7: Project-Sponsored Community Educational Activities

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Average Yearly Professional Education Presentations	182	77	76	56	50[c]	15[c]	62	194	115	47
Focal Agencies (in order of proportional amount of education	Schools, other agencies, students, hospitals	Students, other agency, CPS, schools	Students, other agency, schools, law enforcement	Schools, Health Center, Department of Health, Department of Housing	CPS, other agency, hospitals, schools	School, day care, Head Start, Alcoholism Program	Students, other agency, hospitals, schools	Schools, medical, other agency, law enforcement	Students, other agencies, schools, CPS	Schools, other agency, hospitals, police
Average Yearly Community Education Presentations[a]	83	28	46	NA	165[c]	5[c]	100	154	68	20
Focus of Training/ Education	Increased knowledge of project; Increased knowledge of reporting laws; Etiology of abuse/ neglect	Increased knowledge of project; Increased knowledge of reporting laws; Etiology of abuse/ neglect	Increased knowledge of project; Etiology of abuse/ neglect; Increased knowledge of reporting laws	NA	Etiology of abuse/ neglect; Increased knowledge of project; Increased knowledge of reporting laws	Increased knowledge of child development; Increased knowledge of project	Increased knowledge of project; Etiology of abuse/ neglect; Increased knowledge of reporting laws	Increased knowledge of project; Etiology of abuse/ neglect; Increased knowledge of reporting laws	Etiology of abuse/ neglect; Increased knowledge of project; Increased knowledge of reporting laws	Increased knowledge of project; Etiology of abuse/ neglect; Increased knowledge of reporting laws
Approximate Three-Year Attendance at Education Presentations[b]	25,000	3,000	8.000	6,000	14,000	NA	9,000	28,000	25,000	13.000

[a] Includes general community presentations and media coverage (newspapers, magazine articles, TV/radio spots).

[b] Figures extrapolated from one year (1976) of information; does not include media coverage. Rounded to nearest 1000.

[c] Figures extrapolated from one year (1976) of information, thus may not be completely representative of the total demonstration period.

goal of the project, and one which was very successful. The second innovation which encouraged broad participation was working out arrangements with state or local boards to provide continuing education "accreditation" units for participation for various groups of professionals (teachers, physicians, law enforcement personnel).

The Speakers Bureau of Tacoma's Panel for Family Living, which was operational before the receipt of federal demonstration monies, quickly became the focus for all child abuse and neglect training and education in Pierce County. Through use of both paid staff and volunteers, the Speakers Bureau was able both to respond to all requests for education and presentations and to encourage specific professional and civic groups to take advantage of this resource. The Panel was also responsible for involving an increased number of individuals from different agencies and groups in providing education and training themselves to others, and is viewed by the community as the primary education "coordinating point" in the system.

Analysis of the target groups to which most of the projects' educational efforts were addressed depicts both similarities and differences in emphasis among the communities. The schools were included among the four main target groups or agencies receiving the most education in every community. Several factors most likely account for this emphasis. Other than immediate family members, school personnel, including teachers, principals, guidance counselors, and school nurses, are in the best position to identify potential child abuse and neglect cases among the school-age population due to their daily interactions with these children. Increasing these professionals' detection skills would thus have important implications for expanded case identification. Secondly, there has historically been confusion about the appropriate role of school social workers and guidance counselors vis-a-vis child abuse cases, with many of these staff handling abuse and neglect in much the same way they would other child/family/school problems, without referral to CPS or other legally mandated agencies and many times without the benefit of intensive, specific services to parents. Education focused on the importance of reporting all suspected child abuse cases to the legally mandated agency would be important to promote increased resource coordination between the schools and other agencies and to ensure adequate

therapeutic intervention and case monitoring.

Other community agencies (mental health, social service agencies, etc.), students and hospitals were the next most common target groups in the communities for professional education. No doubt the emphasis on other agencies and hospitals arose because these groups are both in a unique situation to come into contact with cases of child abuse due to their proximity to children and adults and the nature of their work, and because, historically, they have received little education about child abuse and neglect in the past. The education of students, on the other hand, served a dual purpose. In the first case, that of education to college-age classes, it was predominantly directed at students of social welfare, in order to expand their knowledge about the types of cases they will be confronting in their professional work. In the second case, education of grade-school and high school students, the purpose was primarily a preventive one; to promote adequate parenting skills, develop an awareness of child rearing problems, particularly those of child abuse, and identify the community resources available to help treat child abuse and other parenting/familial problems.

The remainder of the groups/agencies in each community which received the most education from the demonstration projects (day care agencies, law enforcement, health agencies, etc.) were chosen according to the perceived educational needs of each community, either because they were particularly key agencies (i.e., saw many cases of child abuse and neglect) or because they had received little child abuse education in the past.

It is interesting to note from Table 7 that, in all cases, the focus of the training and education in each community has been in three areas: the etiology (dynamics) of the child abuse and neglect problem; the increased knowledge of state reporting laws; and an increased understanding of the demonstration projects' role and resources. Each of these areas is viewed as key to confronting many of the problems which communities face in expanding and increasing the effectiveness of their child abuse and neglect systems. A thorough understanding of the dynamics of child abuse with a lessening of any "stigma" and the encouragement of a therapeutic rather than punitive approach can lead to more prompt identification of appropriate cases, increased self-referrals, the use of "crisis" intervention services

before serious maltreatment occurs, and the adoption of the perspective that child abuse is both a preventable and a treatable problem. Increased knowledge of state child abuse and neglect laws both encourages reporting (in many cases great leverage is gained from citing "the law") and provides increased efficiency within the system by channeling reports to the appropriate agencies at the outset. Although increasing the community's understanding of the demonstration projects was obviously in their own self interest, it was nonetheless probably an effective mechanism for increasing reporting, as it provided both professionals and citizens alike with a confidence that intensive, therapeutic and supportive service provision, rather than punishment or "labeling" without any follow-up is the likely result of reporting. This appears to be particularly important when encouraging reporting from traditionally non-reporting groups, such as the medical profession.

There appears to be some relationship between the size of the community in which the demonstration project is housed and the amount of education provided or numbers of people reached, although it is not consistent for each community. For example, in the communities with the largest populations (St. Louis, St. Petersburg, Tacoma and Union County each have 400,000+ populations), St. Petersburg and Tacoma reached extensive numbers of people with numerous presentations, while St. Louis and Union County could be classified as having provided a moderate level of education. In the average-sized communities (Adams County, Arlington, Baton Rouge and Bayamon each have 100,000 to 300,000 populations) the trend is less clear, with only Adams County reaching a very large number of people in proportion to population. The two smallest projects, Washington County, Arkansas with a population of 77,000 and Neah Bay with a population of 1,400, have made admirable efforts to provide very extensive educational coverage of their entire communities.

2. Project Accomplishments

It is difficult to assess project accomplishments or impacts in the context of community and professional education activities. If one assumes that education per se is a beneficial activity, then each of the projects has made important contributions to its community. The amount of education in each community was greatly expanded during the demonstration period. Certainly in each community, based on interviews with a wide range of community representatives, perceptions are that professionals and the general public alike are much more aware of the problem, its causes, who to report to and what services exist in the community. Whether the increased awareness has or will result in systems changes must remain a question open to conjecture. It is our observation, however, that many of the other changes in the community systems, described in this report, were in part enabled because of the projects' extensive educational efforts.

3. Barriers to Implementation

The demonstration projects were more consistently successful, as a group, in the provision of professional and community education and training about child abuse and neglect than in other community activities undertaken. With the exception of several projects, however, two problems still remain in most communities.

The first problem is that the education/training that occurred was not carefully planned or focused on specific target groups. Although most key agency professionals received some training, it was a rare project that carefully mapped out an education strategy ensuring adequate coverage of <u>all</u> professionals with specifically designed education/training "packages." In most cases, all agencies and professionals received essentially the same education in training sessions or workships, often developed at the convenience of the agency head rather than that of the staff to be trained, and often without a clear indication from these supervisors that attendance was a priority. Thus, not only were all key agencies not always provided education, but not all staff within agencies had the benefit of training; repeat educa-

tional presentations within agencies were the exception, it appears, rather than the rule.

Community education was even less well-planned than professional training/education. With the exception of some media presentations, most educational activities undertaken in the community were in response to requests from civic groups (e.g., PTA, Junior League, Chamber of Commerce) to make presentations, rather than at the initiative of the project. Thus, there was less systematic coverage of community citizens, and less education of these groups in general than of professionals.

What may turn out to be a second problem with the education undertaken by the demonstration projects emanates directly from their success as trainers and educators. Because most projects have assumed the role of education in the community, few other groups have made any attempts to increase their own educational efforts, presuming this to be a project function. Thus, many of the educational resources of the community (e.g., staff of protective service agencies or the schools and voluntary efforts of civic groups) remain under-utilized while the projects carry the entire education load, sometimes at the expense of direct service provision. This may become a particular problem during the next year, when most projects will undergo dramatic reductions in staff, often disappearing altogether after federal funding ceases, and communities will be forced to pick up the education and training functions that the projects formerly assumed. In the long run, it would have been perhaps more profitable if the projects had encouraged a more diversified approach to education; training professional staff and community groups to conduct educational presentations, and acting as a coordinating point rather than the delivery mechanism for education. In some communities, notably Adams County, St. Louis and Tacoma, this has begun to happen on a limited scale (although these projects remain heavily involved in the actual "doing" rather than the "coordinating"), but in the others, there will no doubt be a significant gap in education when the projects are phased out.

4. Summary

Overall, the demonstration projects were successful in greatly expanding the educational efforts in the communities. Except in Arkansas and St. Louis, significantly more attention was focused to the training and education of professionals than to the communities, although both groups were the target of major efforts. Each project provided at least 50 professional education sessions per year during the three-year demonstration period, with some, notably Adams County and St. Petersburg, providing close to 200 such sessions per year. School personnel received more training than other groups in each community, but students, hospitals and other community agencies were specific target agencies in many communities. The subject areas for the training and education were remarkably similar in each community, namely, the etiology of child abuse and neglect, increased knowledge of state reporting laws, and increased knowledge of the projects' resources. The approximate three-year attendance at both professional and community group educational presentations ranged from 3,000 in Arlington to 28,000 in St. Petersburg.

Although it is difficult to assess with confidence the impact of this education due to lack of data and the inability to control for such factors as increased national publicity and changes in state laws, positive effects are evident. All key agency representatives interviewed perceived that the projects had done an exemplary job of providing this education/training, and perceived that knowledge of both professionals and citizens had been considerably broadened through these efforts. Most perceived that the focus of their community's educational efforts had, indeed, become the demonstration project.

Two problems with regard to education were found in most communities. The first was a lack of planful and focused education to ensure that all relevant professionals and citizens were systematically and continuously provided appropriate education; in most communities education was provided in response to requests rather than at the initiation of the project, particularly community education endeavors. Secondly, few agencies in the communities increased their own educational efforts, but rather, relied on the efforts of the project. This leaves the continuity of the current

educational efforts in these communities in question after the demonstration projects phase out. In view of the overall success of the projects' education and training activities, however, these problems cannot be construed as major constraints.

G. CONCLUSIONS

In summary, although the projects had marked success in modifying certain aspects of their community systems, such as increasing the knowledge and awareness of both professional and community residents and developing multi-agency coordinating bodies, they had mixed success, as a group, in other areas. The only project characteristic which appears to be associated with overall community impact is project affiliation, and then only for certain aspects of community impact. Thus, projects that were affiliated with the local protective service agency were more likely to be able to influence the development of coordinating agreements between agencies, provide new or innovative services to the majority of the community's child abuse and neglect cases, and improve the overall case-management function within the community than were independent projects. On the other hand, project affiliation had little to do with the development of coordinating councils or boards, the provision of interdisciplinary input into case decision-making or the provision of education and training on a community-wide basis. The development of a centralized 24-hour reporting system was almost totally dependent on state legislation and, except for efforts to properly implement the legislation, was rarely impacted by the projects.

Although the projects did have significant success in correcting many of the deficiencies in the community systems, several problems consistently remain in the project communities at the end of the demonstration period: coordination among both public and private agencies is inadequate; interdisciplinary input, while provided for in some cases, is not afforded the majority of the communities' cases; existing community resources have not been fully utilized in the provision of services; child neglect and high risk cases are provided minimal services; preventive services and

therapeutic services for children are inadequate; and the case management function, particularly with respect to adherence to appropriate termination procedures and the provision of follow-up, is generally less than optimally carried out.

APPENDIX

Listing of Major Evaluation Reports and Papers

Reports

(1) A Comparative Description of the Eleven Joint OCD/SRS Child Abuse and Neglect Demonstration Projects; December 1977.

(2) Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977; December 1977.

(3) Cost Report; December 1977.

(4) Community Systems Impact Report; December 1977.

(5) Adult Client Impact Report; December 1977.

(6) Child Impact Report; December 1977.

(7) Quality of the Case Management Process Report; December 1977.

(8) Project Management and Worker Burnout Report; December 1977.

(9) Methodology for Evaluating Child Abuse and Neglect Service Programs; December 1977.

(10) Guide for Planning and Implementing Child Abuse and Neglect Programs; December 1977.

(11) Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings; December 1977.

Papers

"Evaluating New Modes of Treatment for Child Abusers and Neglectors: The Experience of Federally Funded Demonstration Projects in the USA," presented by Anne Cohn and Mary Kay Miller, First International Conference on Child Abuse and Neglect, Geneva, Switzerland; September 1976 (published in International Journal on Child Abuse and Neglect, Winter 1977).

"Assessing the Cost-Effectiveness of Child Abuse and Neglect Preventive Service Programs," presented by Mary Kay Miller, American Public Health Association Annual Meeting, Miami, Florida; October 1976 (written with Anne Cohn).

"Developing an Interdisciplinary System for Treatment of Abuse and Neglect: What Works and What Doesn't?", presented by Anne Cohn, Statewide Governor's Conference on Child Abuse and Neglect, Jefferson City, Missouri; March 1977 (published in conference proceedings).

"Future Planning for Child Abuse and Neglect Programs: What Have We Learned from Federal Demonstrations?", presented by Anne Cohn and Mary Kay Miller, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"What Kinds of Alternative Delivery Systems Do We Need?", presented by Anne Cohn, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"How Can We Avoid Burnout?", presented by Katherine Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Evaluation Case Management", presented by Beverly DeGraaf, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Quality Assurance in Social Services: Catching up with the Medical Field", presented by Beverly DeGraaf, National Conference on Social Welfare, Chicago, Illinois; May 1977.

APPENDIX B

COMMUNITY SYSTEM EVALUATION INSTRUMENTS

I. Protective Services Questionnaire: this questionnaire, and five similar ones developed for Hospitals, Courts, Schools, Police and Foster Care, were administered to agency representatives yearly during the demonstration period. A similar questionnaire, without the references to "changes in the system" was used to collect the baseline data at the beginning of the study.

II. Protective Services Data Tabulation Form and Definitions: these forms, and five others like it for the agencies listed above, were maintained by the community agencies during the three year demonstration period (Note: not all agencies in every community agreed to tabulate this data).

III. Log of Abuse/Neglect Complaints/Referrals Not Provided Ongoing Project Services: these forms were maintained by each project for the duration of the demonstration period.

IV. Log of Community Education/Coordination Activities: these forms were also maintained by the projects' staffs for the three-year demonstration period.

COMMUNITY SYSTEM INFORMATION

PROTECTIVE SERVICES

Agency Name _____

Respondent's Name _____

Title _____

Address _____

_____

Telephone _____

Interviewer _____

Date _____

Briefly re-introduce BPA and the Evaluation.

We are interested in reviewing with you again how this agency handles cases of abuse/neglect and your perceptions about the child abuse and neglect system in (community) . Basically we want to determine what changes, if any, have occurred since the fall of 1974. After you answer each question, therefore, will you also tell me whether the current situation you are describing is different from the situation 1-1/2 years ago.

1) Now, could we talk about what happens to clients in your agency. First, which agencies or individuals generally refer cases to you?

Changes?

2) Approximately how many cases are reported to you each month (year)?

_____ abuse cases/month _____/year

_____ neglect cases/month _____/year

Changes?

3) If the number of reports has increased or decreased, ask "Do you have any ideas about what caused this increase/decrease?"

4) Do you know which agencies are mandated by law to receive reports of abuse/neglect? Which are they?

Changes?

If there are changes, ask "Would you say this change will significantly improve the community system?"

5) Do you send copies of reports you receive to any other agency? Which one(s)?

Changes?

Investigation

6) What happens when a case is reported/referred to you -- do you usually do some kind of investigation? If yes, who on your staff does this?

Changes?

7) How long after a report is received does your staff begin this investigation?

Changes?

8) What does this investigation procedure consist of?

Changes?

9) Do you usually make a home visit in conjunction with your investigation? If yes, elaborate.

Changes?

10) Do you ever make an investigation in conjunction with other agencies? Which agencies?

Changes?

11) How often do you do these joint investigations?

Changes?

12) Do you contact other agencies about a case during an investigation? Which agencies?

Changes?

13) About how long does the investigation take?

Changes?

14) What criteria do you use in deciding that a case is or is not an abuse/neglect case?

Changes?

15) After the case is investigated, about what proportion of cases are substantiated as abuse or neglect?

Changes?

16) After an investigation has been made, do you ever send a case to court? If yes, what is your agency's function in relation to those cases sent to court?

Changes?

Services

Could we now talk first about those clients to whom you give services, and then we'll talk about cases you refer elsewhere.

17) If your agency doesn't bring all cases of abuse/neglect into its caseload, how do you decide which cases to accept and which to drop or refer elsewhere?

Changes?

18) Do you provide services only to cases where abuse/neglect has been substantiated? If not, do you also provide services to clients who are suspected of abuse/neglect or who may have a potential for abuse/neglect?

Changes?

19) About how long is it between completion of investigation and the time the client begins receiving services?

Changes?

20) What services do you provide to these clients?

Changes?

21) Do you ever purchase services from other agencies for clients? If yes, what services do you purchase? From which agencies?

Changes?

22) Do you ever provide a lump sum of money to other agencies/programs (e.g., to hold a day care "slot" whether or not a child uses it)?

Changes?

23) Which services do most of your clients receive?

Changes?

24) How long do you usually continue to work with a case? What percent of your cases would you say "drop out" before the services are completed?

Changes?

25) What criteria do you use in deciding to terminate a case? Do you ever follow-up on cases after they have been terminated? What type of follow-up do you do?

Changes?

Staffing

26) Are any of your staff specifically assigned to work with abuse/neglect cases? How many people?

27) About what proportion of their time would you say they spend?

_____ Less than 10% _____ Close to 25% _____ Close to 50%

_____ Close to 75% _____ Close to 100%

28) How many of your staff ever work with abuse/neglect cases?

29) About what proportion of their time would you say they spend?

_____ Less than 10% _____ Close to 25% _____ Close to 50%

_____ Close to 75% _____ Close to 100%

30) Have any of your staff received specific training dealing with abuse/neglect cases since the fall of 1974? If yes, from whom was the training received?

Changes in staffing?

Referrals

Now let's talk about the ways in which you refer cases to other agencies.

31) Where do you most often refer cases? (If these agencies are unfamiliar ask for the agency director's name -- we will follow these up by phone.)

Changes?

32) About what proportion of your cases are referred to other agencies?

Changes?

33) Once you've referred a case, what follow-up procedures are carried out by this agency? Do you tell the client to go to the other agency? Do you make an appointment for them? Do you call the agency to ask whether the client kept the appointment? Do you check with the client to see if they kept the appointment or went to the agency? Do you take the client to the appointment?

Changes?

34) Once you refer a case elsewhere, do you consider that case closed? (If not) when do you terminate a case? How do you decide this?

Changes?

35) Do you consult with the agency to whom you've referred a case before you terminate that case?

Changes?

Other Functions

36) Do you have any specific coordination procedures with other agencies for dealing with abuse/neglect cases? Would you explain these to me. For example, do you: share staff, have joint funding, have verbal or written agreements, arrange purchase of services, consult with other agencies in service planning for a client, or have joint staff training?

37) Have any of these coordination/referral procedures been implemented since the fall of 1974? If yes, how did they come about?

38) Is there a Community Child Abuse/Neglect Task Force or Committee in the community? Do you participate on this Task Force/Committee?

39) (If yes to above) when was the Task Force begun? What was the impetus for developing the Task Force?

40) Is your agency involved in any community education endeavors, that is, do you give talks, presentations, workshops related to child abuse/neglect? Would you explain these.

Is this agency doing more or less community education than in the fall of 1974?

Would you say there has been more education about abuse/neglect in the community than in the fall of 1974? (If yes) which agencies/programs seem to be most involved in this?

Data

41) Have any of your record keeping procedures or forms changed during the past 1-1/2 years? If yes, please explain. (Pick up copies of new forms)

Project Assessment

42) Has your agency had any contact with (project) ? If yes, please explain the nature of these contacts.

43) Have any coordination agreements or arrangements been established between your agency and the project? If so, please describe them.

44) What do you see as the role of (project) in the community child abuse and neglect system here?

45) What, in your opinion, have been the most positive aspects of (project) since it began? (Probe with: What successful things have they accomplished?)

46) What, in your opinion, have been the problems associated with the project?

47) Do you foresee any other problems for the project in attempting to implement its program during the next year?

48) We are interested in knowing whether you feel that the services provided to clients by (project) are effective in helping them to overcome their problems. Would you say that the services are: _____ very effective;

_____ effective; _____ somewhat effective; _____ not effective;

_____ very ineffective.

49) Because it is sometimes difficult to determine whether services are actually helping people, we are also interested in knowing whether you think the project generally offers high quality services. Would you say that project services are of: _____ very high quality;

_____ high quality; _____ average quality; _____ low quality;

_____ very low quality.

50) What were the characteristics of the project's services that you had in mind when making this judgment?

51) Are you basing your judgments about the effectiveness and quality of the services the project offers on information their clients have shared with you, your own contacts with the project, discussions with other people in the community, or what?

52) What would you think other people in the community would say about the quality and effectiveness of the services which the project offers?

53) What is your overall reaction to the project?

54) Considering all of the agencies in the community handling child abuse/neglect cases, would you say the system for dealing with abuse/neglect in (community) is: _____ very effective; _____ moderately effective; _____ not effective; _____ very ineffective?

55) What do you see as the major problems, if any, which inhibit the efficient operation of the child abuse/neglect system here?

56) What would need to change in order to solve these problems?

57) Who do you think should have the responsibility for effecting these changes?

Name of Unit _____

PROTECTIVE SERVICES 1976 II(a).

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
A. ABUSE REPORTS													
1. No. New Reports Received													
2. No. Repeat Reports Received													
3. No. Reports Investigated													
4. No. Reports Substantiated													
B. NEGLECT REPORTS													
5. No. New Reports Received													
6. No. Repeat Reports Received													
7. No. Reports Investigated													
8. No. Reports Substantiated													
C. TOTAL ABUSE AND NEGLECT REPORTS													
9. Source of Reports:													
a. Protective Services													
b. Physician													
c. Hospital													
d. Law Enforcement Agency													
e. School													
f. Court													
g. Other Agency													
h. Spouse													
i. Sibling													
j. Relative													
k. Acquaintance, Neighbor													
l. Anonymous													
m. Unknown													
n. Self-Referral													
10. No. of Reports (Cases) Accepted for On-Going Services													
11. No. of Reports Referred to Court													
12. No. of Reports Referred to Other Treatment Agency													
13. No. of Reports Referred for Foster Care/Placement													
14. No. Reports Forwarded to Central Registry													
15. No. Reports Forwarded to Court													

PROTECTIVE SERVICES

DEFINITIONS FOR COMMUNITY DATA FORM:

1,5. No. New Reports Received: Reports of cases which are new to this agency, i.e., the agency has not received any reports on them previously, and has not had them as a case.

2,6. No. Repeat Reports Received: Reports of cases on which this agency has previously received reports, or has previously had as a case.

3,7. No. Reports Investigated: Of the reports received (#1,2,5 & 6), the number for which an investigation was performed. Investigation refers to whatever activities this agency specifies as constituting an investigation, e.g. home visits, telephone contacts, contacting other agencies, etc.

4,8. No. Reports Substantiated: Of the reports received, the number which are substantiated cases of abuse or neglect, according to this agency's standards for case substantiation.

9. Source of Reports: Source of the report to this agency.

9a. Protective Services: Cases identified within this agency, either by the Protective Services Unit or by another unit of the agency.

10. No. of Reports Accepted for Ongoing Services: Of the reports received, the number which have been accepted for provision of ongoing services by this agency. Excludes cases which have been opened for an initial investigation or evaluation only. Refers only to cases which will remain open for some ongoing service provision.

11. No. of Reports Referred to Court: Of the reports received, the number which have been referred to the Court for investigation, hearings, or some other court action. These may be cases which will remain with your agency, or will be terminated from your agency upon referral to Court.

12. No. of Reports Referred to Other Treatment Agency: Of the reports received, the number which have been referred to another agency for treatment, either in addition to the services they will be receiving from this agency or as an alternative to services from this agency.

13. No. of Reports Referred for Foster Care/Placement: Of the reports received, the number which are referred for placement or foster care--this may be to a foster care unit in this agency, to another foster care agency, to the Court, or whatever is the appropriate mechanism for foster care or placement referral. Placement includes, in addition to foster care, institutional placement, placement with other individuals (including relatives) and adoption.

14. No. Reports Forwarded to Central Registry: Of the reports received, the number on whom reports were forwarded to the Central Registry.

15. No. Reports Forwarded to Court: Of the reports received, the number on whom reports were forwarded to the Court for its information. This is to be distinguished from item 11, which involves actual referral to the Court for services, hearing, etc., although, of necessity, a referral to the court implies that a report is simultaneously forwarded. Therefore, all referrals should be counted as reports also. "Reports forwarded" means simply that the Court has been informed, for its records, of the case.

PROJECT NAME_____

LOG OF ABUSE/NEGLECT COMPLAINTS/REFERRALS NOT PROVIDED ON-GOING PROJECT SERVICES

N-C19A
BERKELEY PLANNING ASSOCIATES

DATE	FAMILY NAME	ADDRESS	SOURCE OF REFERRAL	REPEAT REPORT Yes/No	ABUSE OR NEGLECT	ASSESSMENT/ EVALUATION (No/Yes/Type; e.g., home visit, telephone contact	SUBSTANTIATED Yes/No	TO WHOM REFERRED: Court, Foster care/ placement, other (specify)	REPORT SENT TO:		REASON FOR NOT PROVIDING ON-GOING SERVICES
									COURT	CENTRAL REGISTRY	

Project Name _____

Please check (or write in) the appropriate boxes

LOG OF COMMUNITY EDUCATION/
COORDINATION ACTIVITIES

N-C110B
Berkeley Planning Associates

Date (write in)	Focal Agency/Organization												Type				Description										Attendance (write in)	No. staff involved (write in)	Purpose/Subject Area										Results										Comments
	Schools	Police	Hospitals	Protective Services	Court	Day Care	Nurses	Other Agency	Students	General Community	TV/Radio	Newspaper/Magazine	Professional Educn.	Community Education	Inter-Agency Coord.	Intra-Agency Coord.	Other	Speech	Seminar/Workshop	Conference	Meeting	Pamphlet/Poster Distribution	Other Written Documentation	Other			Etiology of abuse/ neglect	Increased knowledge of reporting laws	Increased knowledge of project	I.D. of cases	Child Development	Research	Coordination of Existing Services	Development of New Services	Legislative Action	Other	Request for Add'l. Education	Volunteers Recruited	Formal Procedures Implemented	New Services Developed	New Legislation Adopted	Increased Referrals to Project	Informal Results	Other	

B.18

IV.

APPENDIX C

INTRA COMMUNITY ANALYSIS FRAMEWORK AND INDIVIDUAL COMMUNITY ANALYSES

Section 1: Analysis Framework

As mentioned earlier, the framework for the analysis of changes in each community system, and the demonstration projects' efforts to affect these changes, was developed around five critical aspects of those systems: System Operation; Caseload Size and Case Outcome; Legislative and Resource Base; System Coordination; and Community Knowledge and Awareness. This section describes what is meant by these five components of a community system and presents the major issues which were addressed under each component when analyzing the changes in each of the ten demonstration communities.

System Operation

System Operation includes the roles and inter-relationships of the key agencies in the child abuse and neglect service delivery system. The issues concern the availability of services, gaps and duplication in service provision, points of bottleneck in the system, and problems of case loss and case tracking.

A model child abuse and neglect service delivery system would ensure quality performance of each of the essential service delivery functions for all families flowing through the system. There are at least eleven such major functions in the model service delivery system: outreach; prevention; identification; investigation; initial disposition; treatment planning; treatment; placement; termination; and follow-up.

The analysis of system operation in each community used such a model system as the framework for identifying current functioning problems in a community system and monitoring changes in the system over time.

Issues

- *Are there functional gaps in the service delivery system, with one or more of the key functions not performed in the community?*
- *Is there functional duplication in the community, with one or more of the key functions performed by several agencies without provision for avoiding overlap?*
- *Is the system centralized, with one particular agency serving as the "funnel" through which all cases are channeled?*
- *Is there a single focal agency or multiple, each serving as the focal point for a particular function in the service delivery system?*
- *Are there subsystems or tracks in the community's service delivery system? For example, is there a separate legal track and social service track, such that cases are tracked into one subsystem depending upon the agency initially identifying the case?*
- *Are these subsystems segregated, or mutually exclusive, so that once a case enters a particular track, it cannot "cross-over" into another?*
- *Is there a mechanism for initially evaluating cases to ensure that the entire range of system resources are considered in development of a treatment strategy, rather than limiting the approaches and resources considered to those available in the evaluating agency?*
- *Are there functional bottlenecks in the system? For example, are so many cases reported that a bottleneck is created at the point of investigation, precluding all cases from being investigated?*
- *Are there points of premature exit in the system where clients drop out or are "lost" prior to completion of service delivery? For example, are some clients who are identified by a given agency, such as law enforcement, never referred to service providers?*

Caseload Size and Case Outcome

Caseload Size and Case Outcome includes analyses of the total volume of abuse and neglect cases in the community and the outcomes of disposition of those cases. The key issues in this component are changes

in the reported incidence of abuse and neglect, the individuals identifying cases, and the number of families receiving services.

Another important concern is change in the proportion of families who are separated while services are being provided, the length of that separation, and the number of children who are eventually returned to their homes.

Thus, this component deals primarily with the amount of activity occurring in the community system, while the System Operation component is concerned with the adequacy and effectiveness of the community's activities relative to child abuse and neglect cases.

Issues

- *Is the reported incidence of child abuse and neglect in the community changing?*
- *Are the patterns of reporting sources in the community changing, and specifically, is there an increase in reports from typically non-reporting sources?*
- *Is the proportion of reports which are substantiated upon investigation changing?*
- *Does the community system have the capacity to effectively deal with an increased number of reports and substantiated cases of abuse/neglect?*
- *How many substantiated cases of abuse and neglect receive some service from community agencies?*
- *How are critical decisions in the service delivery system made by various agencies? Are there explicit criteria for deciding to place a client in treatment services, remove a child from the home, reunite a family, etc?*
- *What is the overall disposition, both interim and final, of cases in the community? Is there an emphasis on keeping families together while solving their problems, or is removal of the child(ren) routine?*
- *Is there a wide variation in case disposition that is dependent on which "track" or subsystem (e.g., legal, social service) a client enters?*

Legislative and Resource Base

This component, Legislative and Resource Base, concerns two major inputs to the community system: (1) the state reporting laws, which constitute the legislative framework of the system, and (2) the staff, service and financial resources which have been allocated to abuse and neglect cases in the community. The key concerns of this component include an evaluation of the comprehensiveness and specificity of the state legislation during the demonstration period, and the identification of changes in the resource allocation of key agencies in the community, including changes in the number and kinds of services provided to families, especially those services believed to be most effective in dealing with abusive or neglectful parents and their children.

Legislation and financial resources are the basic underpinnings of the community system. Although they clearly are not the only important inputs into these systems, it can be expected that changes in the adequacy of these two variables will influence the effectiveness and efficiency of the system.

Issues

- *How inclusive is the specification of persons who must report suspected abuse or neglect cases?*
- *How inclusive is the definition of reportable situations? How clear are the definitions?*
- *Is the reporting system specified in the legislation centralized (one agency receives all reports), or are there provisions for sharing information and/or centralizing information from reports if more than one agency is designated to receive reports?*
- *Does the legislation include legal penalties for non-reporting?*
- *Does the legislation provide any immunities to individuals making reports in good faith?*
- *Are services mandated to be provided in abuse and neglect cases?*
- *What level of resources (both labor and financial) have been allocated to abuse and neglect in the community?*

- *Is there an expected correlation between changes in resources and changes in system volume, where the former influences the latter, or does a reverse correlation exist, e.g., increases in system volume influence resource commitments?*

- *What is the range of services available for abusive and neglectful parents and their children?*

- *Which of the "essential" services for abuse and neglect clients are available in the community?*

System Coordination

The System Coordination component of the intra-community analysis involves an assessment of collaborative arrangements among agencies in the service delivery system. Collaborative arrangements could involve the sharing of financial or staff resources between two agencies, transfer of information between agencies, specification of respective goals of two agencies, development of procedural guidelines for working together, or a range of other inter-organizational relationships between agencies. In a social service system, this coordination could be based on a series of "horizontal" collaborative arrangements between individual pairs of agencies in the system, or could be "vertically" based, with one focal agency having coordinative relationships with several other agencies which do not have direct interaction with each other.

This type of interactive or inter-organizational analysis serves primarily to describe the nature and extent of established coordinative procedures and agreements among agencies in the system, whether formal or informal, written or verbal.

Issues

- *Have agencies in the system established mechanisms for coordinating their respective responsibilities?*

- *Are collaborative arrangements formalized or informal?*

- *Are collaborative arrangements statutorily mandated or initiated by agencies themselves?*

- *Do agencies in the system share financial and other resources?*

- *Is coordination primarily horizontal or primarily vertical?*

- *Is interagency collaboration a characteristic of the whole community system, or is it limited to a few agencies?*

- *What is the nature of collaborative arrangements: are they designed to achieve coordination of information and activities on individual cases, or are they designed to develop mechanisms for working jointly on specific functions (for example, to develop a joint investigation or joint diagnosis arrangement), or are they designed to delineate specialized functional roles (for example, agreements for each agency to specialize in particular functional areas)?*

- *Is there a community-wide task force or committee for abuse and neglect?*

- *Is there a central record-keeping system with all key agencies participating?*

- *Is there routine feedback to agencies of data from the central record keeping system?*

Community Education and Awareness

One of the key elements of an effective abuse and neglect service delivery system is Community Education and Awareness, or the extent to which community residents, both professionals and the general public, are knowledgeable about the problems of abuse and neglect, their reporting responsibilities, and the resources available to deal with the problem. Because of the difficulty in accurately diagnosing abuse and neglect cases and the hesitancy to become involved in this problem, it is important that community residents and professionals who are in a position to detect suspected cases be given accurate and appropriate information which will enable them to deal effectively with the problems they encounter.

It is not possible, without extensive survey research, to accurately determine the actual level of knowledge or awareness of the community. Thus, this component focused on the nature and extent of education and training which various professionals and other individuals have received from the demonstration project and key agencies, as an indicator of awareness and knowledge.

Issues

- *What is the general level of awareness among community residents of the etiology of abuse and neglect, the state reporting requirements, and the resources available to deal with the problem?*

- *Are relevant professionals in the community aware of the state laws, their provisions, and the requirements for reporting suspected cases of abuse and neglect?*

- *Do professionals know of the resources in the community which are available abusive and neglectful parents and their children?*

- *Is the amount of professional and community education/training increasing?*

- *Are more agencies or groups involved in the provision of child abuse education and training?*

- *Are there differences in the level of education and training received by professionals, based on the type of agency in which they work or by their roles in the system, e.g., do social work agency staff have more or less training than legal agency staff; do medical professionals have more or less than others?*

Although each of these components was comprehensively evaluated for this report, it should be noted that, due to the variability in both quantitative and qualitative data available for each community, not all issues raised under these five components could be assessed at the same level of detail for every community. Thus, the following individual community reports do not contain totally similar data, but rather, present the most important information for assessing a given community system based on what the major problems were at the time of demonstration funding and what the most positive achievements have been during the three-year demonstration period.

Section 2: Individual Community Analyses

The Family Center: Adams County, Colorado

Summary

Some of the significant changes that took place in the Adams County abuse system since the funding of the demonstration project were: (1) a large increase in the number of services available to abuse clients, both children and parents; (2) bringing the schools into the abuse service system, primarily in identifying cases, but more and more as collaborators in providing services to abused children in the school setting; (3) developing new procedural agreements between agencies; (4) a more thorough intake process; and (5) greater knowledge and awareness on the part of the health community.

Despite the many positive steps forward in the three demonstration years, some problems identified by key actors in the community must still be resolved. The project and ACDSS' protective services unit still did not effect a smooth, efficient transfer of those clients that have been through the intake process at the Center and were then transferred to a worker at protective services for ongoing services. Further, it has been difficult on occasion to persuade protective service workers to refer their clients to the full array of services offered by the project. Also, some professionals in the community see a need to improve the working relationship between law enforcement agencies and ACDSS and the Center; philosophical differences on the need for out-of-home placement seemed to be a source of tension. And finally, the process of handling neglect cases requires modification in light of the 1975 law. There have been complaints that the definition of reportable neglect is too vague and that service follow-through to date on the part of ACDSS has been irregular.

Community System Operations

Prior to federal funding of the Family Center, the child abuse and neglect service system in the county was already quite centralized, with ACDSS serving as the focal agency through which most cases were channeled. Although prior to 1975, the Colorado reporting law required that all reports of abuse be made to a law enforcement agency, in Adams County ACDSS traditionally received more initial reports than the Sheriff's Department and all police departments combined. ACDSS was, in addition, the primary service provider to abuse and neglect families. Other community agencies, such as the Health Department (Tri-County Health Department), and the Mental Health Center, also had demonstrated concern about the problem and were identifying and providing services to these families.

The Juvenile Court in Adams County was and still is integrally part of the primary service system. Until the mid-1960's, when ACDSS expanded its protective services unit, the Court was the primary agency to investigate abuse and neglect cases. After ACDSS demonstrated its ability to adequately intervene, the Court stopped investigation of such cases and now refers all incoming reports to ACDSS. The Court's current

role is to act on petitions for removal of the child(ren) from dangerous environments and for supervision of Center families.

The county's primary public hospital resource is Colorado General Hospital, a state-supported hospital located in Denver. The Hospital, which houses the nationally reknowned National Center for the Prevention and Treatment of Child Abuse and Neglect, was also part of the county's service system even before the demonstration project was a reality. Most cases needing medical attention were brought to Colorado General, and the child abuse identification and treatment program at the hospital involved ACDSS on all cases originating in Adams County.

Other agencies and institutions which potentially could have been part of the service system for families of abuse and neglect were isolated from the mainstream. The school districts had a self-contained method for dealing with suspected abuse and neglect. Most school personnel would not or could not identify child abuse in the classroom and, if they did, were reluctant to report it because of fear of parent retaliation and/or past negative experience with ACDSS' response to their reports. Except for the most extreme cases, schools attempted to intervene on their own. Private hospitals and private medical personnel in the county were also segregated from the abuse/neglect service system. Again, the reason seemed to be a lack of familiarity with the symptoms and dynamics of abuse and neglect, as well as a hesitance to report.

Although most agencies reported to ACDSS, law enforcement agencies received a significant number of child abuse reports from the community at large. However, the various police departments and the Sheriff's Department in the county were separate from the rest of the service systems, primarily because of a difference of opinion about appropriate intervention strategies. Law enforcement agencies believed that removal of the child and strong legal penalties were required in these cases, and ACDSS believed that therapeutic services to the families would be more fruitful. The law enforcement agencies in general conducted their own investigation on all reports received and, if warranted, pursued criminal investigations.

Colorado has had a Central Registry for all child abuse cases since 1967. The purpose of the Registry is to maintain statistical records for program planning and to provide a central listing of families with past histories of child abuse so that the Departments of Social Services around the state can better plan their services. Also, the registry is used to check on those applying for day care and foster care licenses. Any person who identified a suspected abuse (or neglect case after 1975) case is requested to complete the reporting form and copies are sent to the local Department of Social Services, the appropriate law enforcement agency and to the Central Registry.

The service system as a whole had several gaps in mid-1974 when the demonstration project was funded.

- In addition to the lack of identification of cases by several reporting sources, there was little outreach into the community to identify abusive or neglectful families.
- Prevention services in the way of education or identification of high-risk families were not provided in the county (although ACDSS had set a precedent of readily accepting potential abuse cases, which can be defined as a preventative measure).
- Services for children were the most notable deficiency in the treatment service delivery system, and there were only limited treatment services available for parents as well.
- Only Colorado General Hospital provided follow-up on terminated cases.
- Because child neglect was not a reportable offense, procedures for the community's handling of neglect cases were not clear; those who might report were not sure of what should be reported and response to these reports was definitely more fragmented than for abuse cases.

The most obvious duplication of services prior to 1974 was in the area of investigation of suspected cases, particularly those in which both ACDSS and law enforcement were involved. Because the two agencies were approaching the case from divergent perspectives, it was felt necessary by both parties to carry out separate assessments of the case, thereby making the family undergo similar (and uncomfortable) questionings. The Health Department and other agencies or institutions that identified abuse or neglect cases would also conduct investigations on their own before deciding to refer a case to ACDSS, which in turn would conduct its own evaluation of the case.

The direct impacts of organizing the Center and its subsequent operation were quite dramatic. First of all, the multidisciplinary spirit that fostered the project carried over to an ongoing multi-disciplinary review team which began meeting before any word on project funding was heard. The team managed to keep the participating agencies working together in a joint effort, and effectively enhanced consideration of the alternatives available in handling and treating child abuse cases. The social workers of both the project and ACDSS developed a more thorough intake process, primarily a result of multidisciplinary review team requirements for assessment of intakes.

Few changes in functioning occurred in those agencies which already had been cooperating together before project funding. The primary changes were in law enforcement agencies and in the school districts. In 1975 the Sheriff's Department hired a new investigator who was assigned to handle abuse cases and, also in late 1975, the

various law enforcement agencies began working with the Family Center and ACDSS to coordinate investigation of abuse cases. Partly due to the new reporting law, but also in part due to efforts on the part of the project staff, it was agreed that the law enforcement agencies would be called in for a joint investigation of severe physical abuse (burns and broken bones) as well as sexual abuse; all other referrals would usually be handled solely by Center or ACDSS workers.

A procedure for identification and referral of abuse cases was worked out in all school districts in the county. Because of early positive relations between schools and the Family Center, principals and other school personnel no longer felt the need to carry out their own preliminary investigation of suspected cases, but were willing to refer suspected cases to ACDSS or the project immediately.

Tri-County Health Department and the Mental Health Center continue to be the predominant agencies accepting referrals for ongoing services. While neither had treatment services only for abuse cases, their respective staffs became more sensitive to the special needs of these clients through the in-service training provided by the project and other training resources.

Caseload Size and Case Outcomes

Table 1 illustrates the changes in county-wide reports received between 1973 and 1976. The reports to ACDSS, including the project, have increased by 170% since 1973. Colorado General's reports, on the other hand, have decreased somewhat since the project began, a finding in keeping with the Center's effort at encouraging Adams County hospitals and medical personnel to treat local abuse cases.

Table 1

Abuse Reports: Adams County, 1973-1976

Agency	1973		1974		1975		1976	
	All Rpts.	Valid Rpts.	All Rpts.	Valid Rpts.	All Rpts.	Valid Rpts.	All Rpts.	Valid Rpts.
ACDSS (including the Family Center beginning 11/1/74)[a]	206	170	UA[b]	267[c]	404	319	554	456
Colorado General Hospital (Adams County cases only)	UA	15	UA	39	34	31	57	24
Sheriff's Department -	UA	UA	UA	UA	UA	83	UA	74

[a]Involving children 12 years old and younger only.

[b]UA = data unavailable.

[c]Figure from actual Family Center data plus extrapolation of ACDSS data collected between February 15 and December 30, 1974.

Table 2 shows the changes in referral sources from 1973 to 1976. Over the four year period reports have increased significantly from almost all sources. With the outstanding exception of private physicians, the professional and community education of the project appears to have paid off in terms of identification of possible new cases.

Table 2

Source of Abuse Reports to ACDSS (including the Family Center after 11/1/74): Children Birth-12 Years, 1973-1976

Source of Reports	1973	1974[a]	1975[b]	1976[c]
ACDSS	5	--	48	21
Physician	5	--	--[d]	2
Hospital	44	--	30	69
Law enforcement	28	--	24	51
School	13	--	60	113
Court	5	--	0	0
Other agency	36	--	98	96
Relative	18	--	--[d]	50
Acquaintance/neighbor	29	--	128[d]	108
Anonymous	1	--	--[d]	0
Self-referral	5	--	16	37
Other	17	--	0	7
Total	206	--	404	554

[a]Data unavailable

[b]Based on actual collected data from the Family Center and estimation based on ACDSS data tabulated for November 1974-October 1975.

[c]Estimated from percentage distribution of referral sources for children birth-18 years.

[d]Referrals from physicians, relatives, anonymous persons and acquaintance/neighbors were collapsed under one category in 1975.

At an early stage of the intake process a decision was made on whether the report was valid (i.e., whether the case was either actual or potential abuse). ACDSS together with the project took in a large percentage of potential abuse cases. In 1973, 40% of all valid cases were identified as potential abuse; in 1976, 54% of all new cases were potential abuse.

Also, usually during intake, a decision was made on whether to involve the Court and/or recommend foster care placement. These two actions are not necessarily synonymous since children can be placed voluntarily and the Court need not be party to this decision. The Court saw a steady increase in the number of petitions filed on abuse and neglect cases, from 131 in 1973, 186 in 1974, 219 in 1975 to 252 in 1976 (petitions involving abuse rose from 77 in 1975 to 100 in 1976). Also, foster care placements increased, as seen in Table 3. Further, the average length of stay of these children placed during each of the years increased from about eight weeks to 13 weeks. Both of these increases are substantial, indicating perhaps one of four possibilities: an increase in available foster homes in the county; an increase in the number of foster care workers to handle the demand; a change in policy towards encouragement of more placement; or, an increase in more serious cases (it is suspected that this last possibility is not the case, however).

Table 3

Foster Care Placements for Abused and Neglected Children: Adams County, 1975 and 1976

	1975	1976
Number of abused and neglected children placed in foster care	264[a]	352
Average length of stay of children placed in foster care	7.7 weeks	13.3 weeks

[a]Extrapolated from data tabulated for February-December 1975.

Legislation

In mid-1975 Colorado passed new legislation to expand the existing reporting law. The major changes in the new law were:

- Child neglect was added to child abuse as a reportable offense.
- The list of professionals required to report was expanded from five to 15 (others may report).
- County Departments of Social Services were indicated (in addition to law enforcement agencies) as agencies mandated to receive reports.
- A misdemeanor-level charge and a fine up to $200 were levied as a penalty for non-reporting; previously there was no penalty.
- Patient/physician and husband/wife communication is no longer considered privileged with regard to abuse and neglect.
- Departments of Social Services are now required to be available to receive reports 24 hours a day and to coordinate all investigation on reports, in addition to providing social services.
- The Central Registry must now expunge all unsubstantiated reports from records.
- Multidisciplinary child protection teams must be organized in all counties with 50 or more reports per year, in order to review new cases.

The project played a role in guiding the development of the current law. The project director provided review and comment on all drafts of the bill and testified at legislative hearings, encouraging the expansion of reportable offenses to include child neglect and the centralization of reporting and investigation within the Department of Social Services. The positive experience with the multidisciplinary review team in Adams County served as a model for the mandated inclusion of such teams throughout the state.

The new statute had little effect in Adams County as of the end of the federal demonstration period because the county already had many of the new requirements in operation. However, the multidisciplinary review team was expanded to include new members as required in the law, and the Family Center, ACDSS and law enforcement staffs held meetings in order to effect an efficient division of responsibilities for investigating abuse and neglect reports. The impact of the requirement to report neglect cases was not felt at ACDSS, at least through mid-1977. In 1975 an estimated 348[1] substantiated cases of neglect were opened, and in 1976 there was actually a decrease to about 288[2] new cases opened.

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[1] Extrapolated from data tabulated for May-December 1975.

[2] Extrapolated from data tabulated for February-December 1976.

Community Resources

In the past three years, since the project's inception, significant staff additions were made in two key agencies which are part of the abuse system. The Sheriff's Department added a special officer to serve as the child abuse expert and liaison on these cases, and ACDSS added a new protective services unit (four workers plus supervisor) in the fall of 1976, mostly in response to the tremendous increase in cases since 1974.

The number of abuse and neglect services available in the community also increased substantially. Most of the new services were either provided directly by the project or through its coordinative efforts. In mid-1974 the only services available from ACDSS staff specifically for children were foster care, day care and very limited residential treatment. Colorado General Hospital, through its special abuse program, delivered medical evaluation and care for some children from Adams County. The Mental Health Center's Child Advocacy Team provided counseling to a few school-aged children with special needs, some of whom were abused. Tri-County Health Department delivered medical follow-up by public health nurses to abused and neglected children in their caseload. The project, however, set up several new treatment services for abused children. The Family Center staff directly provided medical evaluation of suspected abused children, as well as play therapy, individual and group therapy, family therapy, crisis nursery care, therapeutic day care and therapeutic foster care. The project, through the University of Denver, arranged for speech and hearing evaluation and therapy for all children from abuse situations. In addition, some school personnel, through the efforts of the project staff, were brought into the service picture by providing monitoring and specialized attention to children identified as abused.

Besides new children's services, services for parents were added. Before project funding ACDSS, for the most part, offered case management, individual counseling and advocacy services to abusive and neglectful parents. The Mental Health Center also had made available individual and group therapy. In addition to expanding these services just mentioned, an infusion of new services included group therapy, parent education classes, and lay therapy under the auspices of the Family Center; three Parents Anonymous chapters organized around the county; and provision of parenting and child development instruction to potential and actual abuse and neglect cases in their caseload by Tri-County Health Department public health nurses.

Community System Coordination

As mentioned earlier, part of the abuse system was already well coordinated before the demonstration project began; ACDSS, the Court, the Mental Health Center and Tri-County Health had informal and formal arrangements for referral procedures, and one of the multidisciplinary review team's purposes was to ensure that the appropriate agencies were cooperating in the handling of abuse cases. To some extent, coordination also was supported by the Central Registry which requests that all people actually witnessing a suspected case complete the reporting form; the form,

in turn, is forwarded to both law enforcement and ACDSS.

Since its inception the Family Center spent a great deal of time in further coordinating the entire abuse service system. Most coordination-related meetings attended by project staff were with ACDSS, but a large number of these meetings were with various schools and other county service agencies, including the Mental Health Center and Tri-County Health Department. Less time for coordination efforts went into working with law enforcement and hospitals. By far, most coordination meetings (about 80%) were aimed at further coordinating existing services (this was seen in the very high number of meetings between ACDSS and the project, a large majority of which were to continuously monitor working relations between the two staffs). A somewhat smaller amount of the coordination activity of the project was directed at developing new resources, and the remainder of the time for community coordination was spent on coordinating research and influencing legislation. One of the primary focuses of coordination on the part of the Center was contributions of time to the Metropolitan Child Protection Council, a group of Denver-area lay persons and professionals who are attempting to promote area-wide cooperation and expansion of services.

As a result of its coordination effort, the Center was able to effect collaborative agreements with several of the agencies in the service system. In addition, while not directly attributable to the work of the Center, other agencies in the county also worked out both formal and informal working arrangements. Table 4 outlines the formal collaborative agreements worked out between the project and other key agencies.

Education and Public Awareness

Through the School Referral Program, school personnel by far were the largest target of the Center's educational presentations, having been the audience more than 30% of the time over the three demonstration years. The Speakers Bureau also reached many others, including notably, all relevant community agencies, students, and charitable, civic and religious groups. Table 2 showed that these targets of the project's education efforts indeed increased their reporting substantially since the project's inception.

The various abuse agencies in the Adams County project's service area all perceived a general increase in the level of educational activity around child abuse, both from child abuse professionals and in the newspaper and on television. Personnel in these other agencies themselves contributed a great deal to heightened public awareness by participating in efforts on the subject of child abuse. ACDSS workers made several community presentations; the local judge who handled juvenile cases was often called upon to give talks (however, these were mostly out of county); Colorado General Hospital child abuse staff were continually participating in presentations as part of the Denver National Center Training Work; the local Health Department's nurses made presentations in classrooms on parenting; and the various school districts began to incorporate more parenting

and child development information into some classes for junior high, high school and adult education students.

Table 4

Family Center Formal Collaborative Agreements

Agency	Content of Agreement
ACDSS	--Representation on multidisciplinary review team (MRT) --Agreement on definition of intake responsibilities and case referral procedures
Juvenile Court	--Representation on MRT
School districts	--Procedures for referrals on suspected abuse cases --Representation on MRT
Law enforcement agencies	--Division of investigative responsibilities for abuse reports --Representation on MRT (one police department only)
Colorado General Hospital	--Procedures for referral to Hospital
Mental Health Center	--Representation on MRT --Case referral arrangements
Tri-County Health Department	--Representation on MRT --Referral procedures, joint staffing of cases --Supervision by Center nurse on Health Department's abuse cases
District Attorney's Office	--Representation on MRT --Guidelines for District Attorney involvement in abuse cases

Pro-Child: Arlington, Virginia

Summary

The system for dealing with child abuse and neglect has undergone many positive changes since implementation of the demonstration project in May 1974. Centralization of the system, with Pro-Child (protective services) as the sole agency mandated to receive reports, forward case data to the Central Registry, undertake treatment planning, and coordinate service provision with other community agencies has been enhanced both by Pro-Child's educational and informal coordination efforts and by implementation of a new state law. Most agencies report that cases identified by their staff are now being referred to protective services, although it is probably the case that some cases are in fact being handled by the court and schools without referral to Pro-Child. In general, however, the system is functioning at a much more efficient and effective level. All new cases reported to Pro-Child are also reported to the Central Registry.

An increase in the total number of cases reported to protective services has occurred between fiscal year 1974 and fiscal year 1977. This increase can be correlated with the increased staff capacity at the project (from 7 to 12 people) that has allowed more education and coordination to be undertaken. No other community agencies have increased the resources they commit to the child abuse and neglect problem, either in terms of staff, or in terms of the kinds or amounts of services they provide to their clients.

There have been only a few changes in the sources of reports to protective services, with the percentage of reports from the local welfare department (DHR) increasing slightly, while reports from schools, relatives and neighbors have increased dramatically. The project's educational focus on these groups has certainly contributed to this increase, although national publicity has no doubt played some part.

In general, implementation of the demonstration project and the new state law have contributed most substantially to changes in the community system in Arlington, and there is some evidence to suggest that the project has played the major role in the community changes. The two areas in which the project has been most successful in the community are in the development of numerous new service components (e.g., group counseling, day care, children's therapy), and in the formal and informal education and coordination provided to professionals and community residents. The latter efforts have contributed to developing a core group of people committed to increasing the effectiveness of the overall system, and have laid the groundwork for a system that deals more carefully and consistently with people who have problems in the area of child abuse and neglect.

Community System Operations

The primary service delivery system for clients with child abuse and neglect problems prior to implementation of the demonstration project in

May of 1974 consisted of several agencies working relatively independently of each other. The Protective Services Unit of the Department of Human Resources had the responsibility of providing services to substantiated and potential child abuse/neglect cases, but was not legally mandated to receive reports, although they did receive them from some agencies and individuals. The police and Juvenile Domestic Relations Court, the legally mandated agencies to receive reports, worked inconsistently with each other and with the protective services agency. Thus, cases were reported to any of three agencies and in some cases a single case was reported to more than one agency. Duplicate investigations were occasionally carried out by these agencies.

The criteria for "substantiating" reports varied; the police and the courts maintained a strict legal definition, while protective services used broader criteria, including "potential" as well as actual abuse/neglect cases. None of the community agencies reported cases to the state Central Registry, although required by law to do so.

The disposition of cases and the services received by clients depended, in part, on the agency which received the report, with each agency prescribing primarily those services available or known to it.

Several gaps in the community system existed. There was virtually no outreach into the community. Preventive services were provided only to clients referred to protective services as "potential" abuse and neglect cases, although some other community agencies, e.g., mental health services, Northern Virginia Family Services, etc., were no doubt providing some preventive counseling services without labeling clients as potential abuse cases as such. Because there was no provision for 24-hour services in the community, reports of abuse and neglect received after hours (often the most serious cases) went to the police and were handled in much the same way as any criminal complaint.

Few other community agencies perceived a role for themselves with respect to abuse and neglect cases. Except for severe cases, the schools, hospitals, and public and private social service agencies handled abuse and neglect cases in the same ways in which they would handle all "social service" problems.

In 1974 the demonstration project, Pro-Child, became part of the existing protective services agency, almost doubling the resources available to that agency. Because this was already the agency most capable of providing treatment services, one goal of the project from the outset was to have protective services become the central Arlington agency for both the receipt of reports, service planning and treatment, making referrals to other agencies as appropriate. Through intensive education and coordination endeavors, this had practically been accomplished by project staff when a change in the state law mandated that protective service agencies across the state become the only agencies legally designated to receive reports. Thus, Pro-Child has become the central focus for the child abuse and neglect system, ensuring that reported cases are handled consistently,

and providing the link with other community agencies (the courts, police, schools, hospitals and community treatment agencies) to promote coordination of the system.

Criteria for accepting clients based on the type and severity of abuse and neglect, and definitions of what should be considered abuse and neglect have been developed and distributed to all community agencies by the project. Procedures for referring cases for treatment have been established, but the primary treatment source remains the project. A 24-hour reporting system has been developed by the project to provide off-hours coverage. The Advisory Committee to the project includes representatives of most key agencies in the community and serves as another focus of coordination for dealing with both policy and programmatic issues of the child abuse and neglect system.

Caseload Size and Case Outcomes

During the baseline period (FY74) 279 cases were reported to protective services. In fiscal year 1975 this had risen to 341 cases, an increase of 20%. In fiscal year 1976, 367 reports were received, and in fiscal year 1977, the projected number of reports is 432. This figure represents a 65% increase in reporting over the baseline period. This increase, however, may be due to the recent centralization of the reporting system, with many reports which used to be received by the courts and police now being forwarded to protective services. However, data from the Juvenile Court also shows an increase in the reports received, from 30 reports during calendar year 1974 to 70 reports during calendar year 1975. Staff from the police department maintain that all cases identified by them are immediately reported to protective services, so an increase in reports cannot be validated from that source. From the data of the court and protective services, it appears that the reported incidence is in fact increasing at a fairly substantial rate.

Of the 279 reports received by protective services in fiscal year 1974 (baseline period), 70% were substantiated, but during fiscal year 1975, 84% of the 341 reports received were substantiated. Although not a dramatic increase, this change is perhaps indicative of a heightened awareness on the part of both agency personnel and the community of the kinds of cases which are appropriate for referral to Pro-Child.

There have been several changes in the source of reports to protective services during the demonstration project period. One significant change is the reduction in the proportion of cases reported by the Department of Human Resources from 29% in fiscal year 1974 to 19% in fiscal year 1976. This perhaps indicates that a broader range of cases across the community are being identified, rather than primarily those cases previously known to the social services or "welfare" system. Two other changes are readily evident. The proportion of reports from schools has increased from 2% to 19% and the proportion of reports from relatives and neighbors has increased from 19% during the baseline year to 32% in fiscal year 1976. It is likely that the project's educational efforts, which were focused on both the general community and school system during the first year, con-

tributed to these changes, by clearly defining to school personnel and community residents the kinds of cases which should be reported and to wh m they should be reported.

Although data on the final disposition of all cases in the Arlington system, particularly cases that were referred to the court, are not currently available, the following table illustrates changes in the foster care placements of abused and neglected children during the project period.

Foster Care Placement and Returns, FY74, 75, 76, 77

	FY74[1]		FY75[2]		FY76		FY77	
	No.	%	No.	%	No.	%	No.	%
Total children in project caseload	995	100	1205	100	1329	100	1462[3]	100
Children placed in foster care	57	5.7	86	5.0	40	2.9	44[3]	3.0[3]
Children returned home in same fiscal year	7	12	52	60	22	55	NA	
Average length of stay	NA		3.2 months		3.1 months		NA	

[1]Data from previous Pro-Child director's statistics.

[2]Data from Pro-Child's re-funding application, February 1976.

[3]Projected on basis of first five months data.

Although the project has served an increasing number of children every year, the percentage of children placed in foster care has decreased by almost 50% since federal funding. Additionally, the proportion of children placed who are returned home in the same year has increased dramatically. Many factors are probably contributing to this, including Pro-Child's emphasis on providing alternatives to foster care, and the staff's desire to have children returned as soon as the home situation can be considered safe, while providing continuing supportive services to parents.

Legislation

New state legislation was passed in March of 1975 which considerably broadened the definition of child abuse/neglect, and also provided a more centralized organizational structure for handling reports and providing services to these clients.

The most important changes in the legislation include: designation of the local social services agency (protective services) as the sole agency to receive reports; provision for development of a state-wide 24-hour reporting system; establishment of a Central Registry; and inclusion of penalities for non-reporting.

By means of its educational program, Pro-Child is continuing to alert both community agencies and residents to the provisions of the law and providing them with information relative to reporting suspected cases. Staff of all community agencies interviewed felt that the new law would increase the effectiveness of the system for dealing with abuse/neglect cases and understood their responsibilities under the new law.

Community Resources

With the exception of the demonstration project (protective services), no agencies in Arlington have staff specifically committed to dealing with child abuse and neglect problems. Rather, staff of these other agencies, including probation officers of the court, the juvenile division staff at the police department, school social workers, foster care workers, hospital social service staff, public health department staff, hotline referral staff and staff in several counseling agencies, provide services to abuse/neglect clients in much the same way as they would to other clients. Because of the problems defining abuse/neglect cases, most of these agencies do not have data on the actual number of cases to which they provide services, and therefore, cannot estimate the percentage of staff time committed to abuse and neglect.

With receipt of the demonstration grant, protective services was able to increase its staff from seven to 12 workers, and additionally to acquire the consultation services of a psychiatrist, a psychologist and a lawyer. The services available through protective services include: case management; multidisciplinary team review; individual therapy and counseling; group counseling; psychological testing; couples and family counseling; day care; art therapy for children; homemaking services; babysitting and child care; and ancillary services including transportation and emergency funds. All but case management, individual therapy and counseling, and ancillary services are new services developed subsequent to federal funding.

Services available through other community agencies are limited primarily to counseling and therapy and to some advocacy and support services. There is little in the way of outreach or preventive services available anywhere in the community, and follow-up of cases terminated from protective services or other agencies is seldom carried out. Volunteers have not been used to any great extent in the Arlington system.

The project has made some gains in their attempts to expand and coordinate the services available in Arlington, but the primary service expansion to date has been from the federal demonstration grant, which leaves it unclear whether many of the services currently provided by protective services will be continued after termination of the grant if additional money is not forthcoming.

Community System Coordination

The coordination of the community system dealing with child abuse and neglect in Arlington has changed in several areas since the implementation of the Pro-Child project. The Advisory Committee to the project includes representatives from the schools, police, court, hospital, Public Health Department, and several private and public social service and referral agencies. These representatives are the coordinative link between protective services and all other agencies, and the monthly meetings of the Committee serve as the vehicle for jointly establishing many of the procedures under which the system operates. The primary coordination efforts to date among all these participants have been in the areas of reporting, investigation and feedback to complainants, and the procedures developed are closely adhered to by most agencies. Forms for reporting cases have been developed by Pro-Child and distributed to all relevant agencies, and the use of the Pro-Child phone number and after-hours number have been carefully explained. Procedures for conducting investigations, particularly during off-hours (when police assistance may be necessary) have been developed. Forms for providing feedback to complainants (both agency staff and community residents) have been developed, although these are not always used.

Coordination on individual cases is achieved primarily when a protective services staff member initiates contact with other agencies about specific cases. Approximately 10 coordinating contacts have been made by project staff each month.

Changes in the state law have also contributed to better coordination of the Arlington system. Centralization of reporting within protective services and a clearer definition of reportable incidents has led to more focused identification, investigation and treatment provision, all of which are done primarily by protective services, but which are also coordinated with other agencies as necessary. The state record keeping system which went into effect in June 1975 covers all child abuse and neglect reports in Virginia. This aids in coordination between contiguous counties (e.g., Arlington and Fairfax counties) which is important since so many in this population are very mobile. The information in the Central Registry will also provide basic data on reported cases which, if made available to all community agencies, should increase their awareness of the problems in the system and help spur further coordination between agencies.

Education and Public Awareness

The level of education and training on child abuse and neglect has increased substantially since the baseline period (FY74). Prior to implementation of the project, few community agency personnel except

protective services staff had received any education or training about the etiology of abuse and neglect, criteria for identifying cases, or the resources available in Arlington to deal with the problem. Since that time, staff of Pro-Child have provided education and training sessions to staff of most key community agencies including schools, court, police, and hospitals. Many other agency staff, such as public health nurses, foster care workers, day care staff, and staff of other counseling agencies have also received education since implementation of the project.

Efforts to educate residents of the Arlington community have included speaking engagements with community groups, television and radio appearances, and contributing to newspaper and magazine articles. In terms of educational effort, less priority has been placed on general community education than on professional education. Pro-Child staff have provided approximately eight educational sessions per month to professionals and community residents. The primary results of this education have been increased requests for additional education, and to some extent, an increase in referrals to the project.

Representatives of all key agencies interviewed agreed that the amount of education/information provided to prefessionals and community residents has increased markedly since fiscal year 1974. They also agreed that, in addition to the proliferation of newspaper and magazine articles which is generally occurring around the country, protective services has been the primary agency in Arlington providing education about abuse and neglect. None of the agencies interviewed have increased their own educational efforts nor do they perceive this as an appropriate role for their staff, which raises some questions about the continuity of educational efforts if the project cannot carry them out due to lack of money after federal funds run out.

The Child Protection Center: Baton Rouge, Louisiana

Summary

Many positive changes have taken place in the Baton Rouge child abuse and neglect service system since the project began. Three of these changes, however, are most noteworthy. First, there is a new level of awareness about the magnitude of the abuse and neglect problem, which has led to increased coordination among personnel of the various agencies and to the doubling of the staff in the local protective services unit. Second, the provision of 24-hour crisis intervention by the demonstration project staff has provided the general public and certain reporting agencies (hospitals and law enforcement, primarily) immediate access to assistance by trained social workers. The extensive use of the 24-hour call system (25 to 35 calls per month) proves that the service is meeting a tremendous need. And finally, the project's affiliation with Earl K. Long Hospital has helped ensure that medical care is provided to many children who otherwise would not receive it.

Some community-wide problems still need to be resolved before the service system can become fully effective. Some of the most important are the following: the private medical community has not met its responsibilities in reporting suspected cases; the project needs on-going support from the state office of the Division of Family Services for maintaining adequate staff capacity; and the mental health centers and the private counseling agency which accept project referrals have not yet worked out an adequate treatment approach for working with abuse and neglect clients.

Community System Operations

A spirit of informal cooperation among the key agencies characterized the community abuse/neglect services in Baton Rouge prior to the federal funding of the Child Protection Center. The system was not centralized around a single agency, but instead some of the key agencies and institutions had evolved a division of responsibilities. Prior to the passage of the 1972 reporting law, the Probation Department of the City-Parish Family Court had the responsibility for handling abuse and neglect cases. In the late 1950's already the Court had worked out an agreement to have the Sheriff's Department conduct the initial investigation on severe cases. With the implementation of the 1972 state reporting law, the Court divided responsibility for abuse and neglect cases with the Division of Family Services; the Court handled those families that did not qualify for public assistance and the Division of Family Services, Protective Services Unit, handled those who were public assistance recipients. The Family Court was also responsible for filing petitions regarding removal of children from the home. Most petition requests originating from outside the Probation Department came from the Division of Family Services.

In addition to homemaker services, the Protective Services Unit of the parish office Division of Family Services provided traditional

protective services: investigation, counseling and advocacy services. This unit was very short-staffed for the volume of cases received and, therefore, following the delivery of services during a family's crisis period, the case was then transferred for maintenance to the regular welfare services staff. Foster care was and still is under the jurisdiction of the Division of Family Services. All cases that require placement of the child(ren) when a willing relative or friend cannot be found, are automatically transferred to the Foster Care Unit for ongoing case management and services.

Law enforcement agencies are one of the mandated agencies to which the public can report suspected abuse and neglect, and before the inception of the project, the East Baton Rouge Sheriff's Department was the agency receiving most initial reports in the community. Publicity efforts had encouraged the public as well as other police departments to make referrals to the Sheriff's Department and its Child Abuse Team. Their policy was to conduct immediate investigations, but then to call in either the Division of Family Services or the Family Court workers. In 1973- the Sheriff's Department set up a Child Abuse Team in its Juvenile Division and this team developed a reputation for effective handling of suspected cases.

The city's private hospitals and physicians were very uninvolved in the abuse/neglect services system. However, Earl K. Long Hospital, the local charity hospital, became a leader in the community in providing services. The Chief of the Pediatrics Department at the Hospital was primarily responsible for bringing the problem of child abuse and neglect to the attention of the state leadership. He aided in the upgrading of the local service system by developing and urging implementation of the shared responsibility services model which was in effect prior to the Child Protection Center. Evidence of the Hospital's commitment to abuse and neglect services is total house staff participation in in-service training on recognition of child abuse and neglect, and a bi-weekly Pediatric Family Clinic which provides regular follow-up to all hospital-identified abuse and neglect cases. Further, the Hospital has a policy of providing temporary shelter for children until alternate placement can be found. Often this means that children are admitted even though there is no medical necessity, or that once admitted, they may be kept beyond the time medically necessary until other arrangements can be made.

School personnel were isolated from the abuse/neglect services network. Visiting Teachers, a special unit handling truancy, were responsible for dealing with abuse and neglect cases discovered in the Baton Rouge schools, although most were not aware of the scope of the problem. These teachers worked with school nurses and social workers in deciding how to proceed in alleviating any situation that arose. If it was decided that the child was seriously endangered, a referral was made to either law enforcement, protective services, or the court.

Other community service agencies were also removed from the main delivery system. The two mental health centers and the East Baton Rouge Health Unit (the parish public health department), with resources to accommodate individual case referrals from the Court or protective services, were not knowledgeable about the dimensions of the abuse and neglect situation. These agencies had no special programs for abuse and neglect, and with minor exceptions, were not a source of reports of suspected cases.

The state has a Central Registry which began keeping abuse and neglect reports in March of 1973. The Registry uses the American Humane Association's reporting form and was originally set up to enable protective services workers to track repeat abusers who were moving around the state. However, little use has been made of it for disposition of individual cases; instead, the Registry data serve primarily as a program planning tool for the Division of Family Services.

Over its three years of operation the project has become the focal community agency for the handling of abuse cases. Originally, it was planned that the Center would provide parish-wide intake and short-term (three to six months) services for both abuse and neglect cases, but this proved impossible given the ever-increasing volume of reports and the limited staff. Therefore, in exchange for increased state funding to fill three more protective service slots, the parish office of the Division of Family Services agreed to take all reports and deliver ongoing services to child neglecting clients while the Center would provide those services for child abusing clients. There are, thus, separate entry points into the system, depending on whether the case is one of abuse or neglect. The other abuse/neglect service agencies have been alerted to this shared role, and for the most part refer appropriately; the general public is still given only the Center's phone number for reporting purposes, but the Center staff then refer all neglect reports on to the Division office. Both the protective services unit and the project use the same resources for referral of clients for additional services: day care, the mental health centers, special school-based learning programs, and charitable organizations, such as the Salvation Army and churches.

The major change in Earl K. Long Hospital's service since the Center began has been a reduction in the length of stay (from 3-4 weeks to less than one week) for abused and neglected children admitted without a medical diagnosis for lack of outside placement possibilities. This has been due to the development of two emergency shelter care homes, a few more foster care homes, the concerted efforts on the part of the project staff to find relative placements as soon as possible, and the reduction of the number of available beds at the Hospital.

With the project's inception, the Family Court's Probation Department no longer received reports or provided services for any abuse and neglect cases. Instead, the Court now acts only in the capacity of holding hearings on cases which require Court involvement, that is,

change of custody cases or cases which the social workers believe should have court supervision. Other court-related changes in the abuse/neglect system have been an increase in the number of private or legal aid attorneys in court cases (the project itself contracts for an attorney to regularly consult with its social workers on all court-involved cases); a requirement that only the District Attorney's office (and not the Probation Department) can now file a petition on abuse cases; and the development of a procedure whereby judges set specific follow-up dates for review of progress on cases.

After the project began, the Sheriff's Department Child Abuse Team continued to be the key child abuse/neglect investigator among the parish law enforcement agencies. The Center and protective services almost always called in the Child Abuse Team to accompany them in dangerous situations or when a child had to be removed. The Sheriff's Department also came to rely on the project to a great extent for joint intervention in abuse reports. It is felt that the local police departments, which sometimes must respond to calls, are still not as sensitized to the handling of abuse cases as the Sheriff's Department. The Child Abuse Team was dissolved in late 1975, but one of the deputies continues to function as the liaison on abuse calls.

The provision of in-service education to several schools by the project staff has brought school personnel in more contact with the abuse/neglect system. The School Board as a whole has adopted a policy to facilitate the handling of abuse and neglect by ensuring that the appropriate Visiting Teacher is called in on all suspected cases; he or she must then report to either the Center or protective services.

Caseload Size and Case Outcomes

Table 1 illustrates reporting changes in four agencies which are part of the abuse/neglect system. By extrapolating the Center's five-month experience in 1974 to a full year (66 to 158), it is clear that the volume of reports to the project jumped considerably from 1974 to 1975. The effects of the project's extensive public education were felt. Some of the drop in reports to the Center in 1976 might be explained by the increase in reporting to protective services during that year (for part of 1975, the project accepted neglect cases). Another possible explanation is that with the severe staff shortage in early 1976, the project was not able to maintain its high intensity public education efforts and community awareness of child abuse and reporting responsibilities diminished. The increase in reports from 1974 to 1975 to Earl K. Long Hospital is most likely due to its affiliation and working relationship with the project; the project social workers bring all cases of abuse or neglect needing medical examination to the Hospital, whereas before reports were received from Hospital personnel identifying cases in the emergency room or in clinics. The slight decline between 1975 and 1976 is probably the result of the project's decrease in incoming referrals.

There are two possible reasons for the sharp drop in Sheriff's Department reports. First, the project, through its publicity efforts over the course of three years, spread the word that people should report to it rather than the customary sources, either the court or law enforcement. Secondly, the Child Abuse Team in the Sheriff's Department, which was alert to abuse and neglect situations, was disbanded in late 1975, which might have meant a decrease in awareness of the problem among the juvenile officers, so that fewer cases were being identified as either abuse or neglect.

Table 1

Volume of Reports: East Baton Rouge Parish

Agency	Number of Reports								
	Abuse			Neglect			Total		
	1974	1975	1976	1974	1975	1976	1974	1975	1976
Child Protection Center	25[a]	187	171	41[a]	61	9	66	248	180
Protective Services	26[b]	4	0	60[b]	100	168	86	104	168
Earl K. Long Hospital	44	100	127	19	65	15	63	165	142
Sheriff's Department	53[b]	42	22	110[b]	37	26	163	79	48

[a]Data since Center opened, August-December 1974.

[b]Figure extrapolated based on actual data for January-October 1974.

Table 2, illustrating referral sources of abuse and neglect reports to the project, protective services and the Sheriff's Department, shows the variation in reports by source for 1974, 1975 and 1976. While there were 126 more abuse and neglect reports community-wide in 1975 and a drop of 35 in 1976, the sources of reports remain quite consistent. Some minor changes include an increase in reports from law enforcement agencies, more cases identified from within the Division of Family Services, and a moderate decline in relative reporting.

Table 2

Source of Child Abuse/Neglect Reports: East Baton Rouge Parish

Source of Reports	Agency Reported to:									Total to the Three Agencies:					
	Child Protection Center			Protective Services			Sheriff's Department			1974		1975		1976	
	1974[a]	1975	1976	1974[b]	1975	1976	1974[b]	1975	1976	Number	%	Number	%	Number	%
Division of Family Services	13	15	8	14	14	29	0	1	14	27	9	30	7	51	13
Physicians	1	4	3	3	0	0	7	0	0	11	3	4	1	3	1
Hospitals	8	35	25	8	5	13	7	4	0	23	7	45	10	38	9
Law enforcement	7	26	17	3	5	16	2	2	2	12	4	33	8	35	9
Schools	12	32	35	6	5	10	11	7	1	29	9	44	10	46	12
Court	3	6	1	1	1	1	5	0	0	9	3	7	2	2	.5
Other agency	0	0	0	0	3	4	3	3	0	6	2	7	2	1	0
Spouse	3	19	21	3	5	19	31	11	5	37	12	35	8	45	11
Sibling	0	1	0	0	3	0	0	3	0	0	0	7	2	0	0
Relative	13	44	27	20	29	34	44	11	5	77	24	84	20	66	17
Acquaintance/neighbor	3	38	23	9	13	20	38	14	17	50	16	65	15	60	15
Anonymous	2	13	9	5	16	19	15	19	3	22	7	38	9	31	8
Self-referral	0	9	2	10	0	0	0	0	0	10	3	9	2	2	.5
Other	1	5	9	0	4	6	0	0	1	1	.5	9	2	16	4
Unknown	0	0	0	1	0	0	0	14	0	1	.5	14	3	0	0
Total	66	248	180	86	104	168	163	79	48	315	100	431	100	396	100

[a]Center opened, August 1974.

[b]Referral source figures extrapolated from actual data collected for January-October 1974.

Cases reported to either protective services or to the project can be handled with or without court involvement. Data on cases that are brought to the Family Court show that 43 abuse or neglect hearings were held during 1975 and 42 such hearings were held in 1976. While there are no data for 1974 or before, against which to make comparisons, personnel at the court believe that since the project's inception there are more formal hearings called, rather than the previous method of informal hearings in the judges' chambers.

For out-of-home placements to foster care -- cases which the Court must act upon (it can be handled without a formal hearing, however, if all parties agree) -- the figures as seen in Table 3 show little difference in the number of children placed between 1974 and 1975, but a dramatic increase in placements in 1976. Given that the total number of abuse and neglect reports to the project and protective services, the agencies which recommend placement, stayed almost the same between 1975 and 1976 (352 and 348, respectively), it appears that an explanation of this phenomenon is two-fold. More foster care and emergency shelter slots are now available in the community and, therefore, children who need out-of-home placement can now be accommodated, whereas before they could not. Further, there seems to be an emphasis on the part of the project staff to advocate out-of-home placements as a solution of choice rather than other modes of intervention.

Table 3

Foster Care Placement: East Baton Rouge Parish

	1974	1975	1976
Number of abused/neglected children placed in foster care	63	69	138
Number of abused/neglected children placed since beginning of year who are returned home	40	25	77
Percentage of abused/neglected children placed since beginning of year who are returned home	63%	36%	56%

Legislation

The project's primary legislative effort has been in the area of revising the state's termination of parental rights law. A subcommittee of the Center Advisory Board, headed by the consulting attorney who is under contract to the project, worked diligently in attempting to loosen up the very restrictive law, which made it almost impossible to terminate parental rights. In mid-1975 the state legislature passed such a new law which outlines specific steps and time limits for moving toward terminating rights of those natural parents who show no interest in their children.

Community Resources

Overall, since the project's inception, there has been a general decrease in the number of staff in other key abuse and neglect agencies. Prior to federal funding of the Center, Earl. K. Long Hospital had a Child Trauma Team which handled the assessment and disposition of hospital-based abuse and neglect cases. In addition, the hospital social workers provided social work counseling to identified abuse/neglect cases in inpatient and outpatient treatment. With the advent of the project, a new staff pediatrician was hired jointly with the Center, to spend half time directly on abuse and neglect cases. With the development of a successful working relationship with the project and the Hospital, the Trauma Team was disbanded since it duplicated the Center's work.

The Family Court had 17 probation officers spending approximately 10% of their time managing and providing services to abuse and neglect cases prior to the implementation of the project. When the Center began and the probation department ended its involvement in handling these types of cases, the number of staff actually working with abuse and neglect cases, in addition to the judges and their staff, was reduced to three intake workers who prepared neglect petitions. In 1976 it was decided that these intake workers could no longer legally prepare neglect petitions and today no probation officers work directly on abuse and neglect cases.

Prior to the project's development, the Sheriff Department's Juvenile Division had implemented a Child Abuse Team to coordinate all abuse and neglect investigations. For both internal political reasons and because the members of the team were either transferred or on leave, the team stopped functioning in the fall of 1975.

Two major exceptions in the general reduction of agency staff time for abuse/neglect cases are, first, protective services, where the staff has almost doubled -- from three workers plus a supervisor in 1974 to six workers plus a supervisor in the spring of 1975. This staff increase was due directly to pressure from the project to divide intake and case management responsibilities with protective services after it was discovered that there was too great a workload for the Center staff alone. Second, the District Attorney's office now has a special

abuse/neglect section. One attorney has been designated to handle these cases, including the preparation of all petitions.

The noticeable additional abuse and neglect services available in the Baton Rouge community have been those either implemented or supported by the project. A full-time homemaker is on the Center staff and 24-hour crisis intervention is provided to suspected abuse and neglect cases and to clients receiving ongoing services; medical care is delivered to all reported abused and neglected children requiring it; and project staff and the Advisory Board lobbied successfully for two emergency shelter care facilities to accommodate children over two years of age who have to be removed immediately from their dangerous home environments.

Community System Coordination

Of all the coordination-related meetings attended by project staff in the course of the project's three years, over 65% were with a variety of agencies in the community which also identify or provide services to abuse and neglect families, such as schools, law enforcement agencies, hospitals, the Family Court, the District Attorney's office, and 4-C's. Almost 20% of all coordination meetings were held with the Division of Family Services, either with the state office or with the local protective services unit. The remaining staff time on coordination activities was spent with legislators or with community-wide resource planning groups.

Another focus of the Center's coordination activity is its Advisory Board. The Board members have put in many hours attending meetings and lobbying for community awareness regarding the needs of abused and neglected children and their parents.

Prior to the project's beginning in mid-1974, the East Baton Rouge Parish agencies which were part of the abuse/neglect system had made some formal collaborative agreements among themselves for greater efficiency in handling cases. The Division of Family Services had made referral arrangements with both Earl K. Long Hospital and the mental health centers and developed a division of abuse and neglect intake and service responsibilities with the Family Court. The Court had also developed procedural agreements with the Baton Rouge School Board, the Sheriff's Department and Earl K. Long Hospital, and the mental health centers had worked out a referral mechanism with the School Board.

However, the project's efforts have succeeded in further coordinating the service delivery system in Baton Rouge by means of new collaborative arrangements with a variety of agencies. Table 4 illustrates the formal ties established to date.

Table 4

Child Protection Center Formal Collaborative Agreements

with Division of Family Services, protective services unit	--Division of abuse and neglect casework responsibilities
with Earl K. Long Hospital	--Sharing a staff position (project's pediatrician half-time at the Hospital)
	--Procedures for referral to Hospital emergency room
	--Arrangements for project staff to handle all social work on hospitalized abuse cases
with Family Court	--Procedures regarding hold orders
with Sheriff's Department	--Joint investigation procedures
with Schools	--Referral and case feedback procedures
with Mental Health Centers	--Referral and case feedback procedures
with Family Counseling Services	--Purchase of services

Education and Public Awareness

Personnel in the parish abuse/neglect service agencies all believe that both the professional and lay community are more aware today of the child abuse and neglect problem and what is being done about it than was the case before the Center began its work. Other agencies' staff members have contributed in some degree to this overall increase in knowledge about child abuse and neglect. However, most of the increase in community awareness can be attributed to the concerted effort of the project staff itself. The project has a full-time public education specialist whose task it has been to coordinate the dissemination of information to the general public. This has been accomplished through the use of all aspects of the mass media, and by talks and audio-visual presentations. Other Center staff, primarily the director, also make presentations on abuse and neglect and the project's role in the system. During this past year a team made up of the project pediatrician, the project director, a social worker, the public education specialist and a legal consultant have visited several schools.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

Summary

The major change in the Bayamon community was an increased awareness by professionals and the general public of the special problems of child abuse and neglect, and an increased commitment to finding ways of combating the problem. This change appeared to have resulted in a small increase in the services applied by the various agencies to preventing or treating individuals who abuse or neglect their children. This was most true in the city of Bayamon office. Also, other agency staff appeared to have focused more on the special problems of abusive and neglectful parents and their children. In particular, the schools appeared to be more sensitive to the problem and relied more heavily on DSS and the project staff. The Interagency Committee made it possible for the first time for administrators and key workers in the various agencies to discuss the problems of child abuse and neglect in Bayamon, and to jointly develop solutions.

The health educators reached a large audience of professionals. Their specially developed materials and stimulating presentations appeared to have inspired other health educators to undertake similar education efforts. There are more referrals being made by professionals to DSS than before the project started. Professionals in the community are more aware of the availability of resources in Bayamon for helping their clients.

Nonetheless, the system for dealing with child abuse and neglect in Bayamon has gaps and deficiencies. Outreach and prevention were virtually non-existent. Identification of abuse continued to be poor, but some improvement has been made. The community system still lacked a hotline for 24-hour reporting and for parents on the verge of hurting their children to obtain help. The shortage of adequate housing and jobs compounded the problems that DSS workers and project staff were helping their clients overcome.

Community System Operations

Prior to the implementation of the demonstration project in May of 1974, the organization receiving most of the reports of abuse or neglect in Bayamon was the local office of the Department of Social Services (DSS). Other agencies such as the schools referred cases only when they were unable to provide the necessary services themselves. If a child had been physically or sexually abused, other agencies like the Municipal Health Center would immediately refer the case to the police. The police would usually investigate the charge and, if substantiated, would refer it to the District Court as a felony case. Since DSS did not have sufficient coverage for reporting, the only agency that could be contacted after the hours of work was the police.

Another type of case that would not necessarily be reported to DSS before May of 1974 was the failure of parents to provide adequate shelter, clothing or food for their children, a situation termed abandonment in Puerto Rico. Frequently, one of the parents or a relative would request the District Court to take legal action against the parent. Since public resources are scarce and other social problems appear more serious, many agencies did not bother to report cases of mild or moderate neglect. Those neglect cases reported to the local DSS office were usually complaints from neighbors and relatives, or requests by other agencies for assistance. The courts sometimes called on DSS when the custody of a child was an issue, since DSS had the legal responsibility to supervise and provide foster care homes and institutions for special children.

In September of 1974, the staff in key agencies other than DSS appeared to have little consciousness of the etiology of child abuse or of the underlying pathologies associated with neglect.

During the period preceding the project's initiation, the other agencies in the community worked together sporadically. Investigations were conducted separately. Referrals were made haphazardly. A number of gaps existed in the community system. There was no outreach into the community to identify parents who were abusing, much less neglecting, their children. Prevention efforts were minimal, consisting primarily of classes on child development for parents and teachers of first graders in the Northern Bayamon public school district, and pre-natal, well-baby and family planning clinics operated by the Municipal Health Center. The home economics and health classes taught in the public schools occasionally touched on such subjects as child development or management. Follow-up was virtually non-existent with the possible exception of the school system whose social workers occasionally re-investigated cases if a child continued to exhibit problems.

None of the agencies had received any special training on child abuse or neglect, or on the responsibilities of the various community agencies. The police appeared to have no awareness of the phenomenon of child abuse and looked upon the matter simply as taking legal against the parent(s) if a child were hurt. Frequently, the anti-social actions of older children were interpreted by the police as matters of juvenile delinquency even though the child's behavior was a direct result of parental negligence or their willful encouragement. The courts generally treated child abuse as a felonious matter. The courts usually handled abuse and neglect in one of three ways: (1) the administrator referred the case to the Juvenile Chamber of the Superior Court because it involved the custody of a child or juvenile delinquent; (2) the administrator or the District Court judge mandated the case to the Adult Chamber of the Superior Court because it involved assault and battery or incest; (3) the case was handled in the District Court because it involved misdemeanor charges against the parent(s) for failing to provide child support. There was no system in the courts for recording the number and disposition of cases of child abuse and neglect that were heard.

In July of 1974, the long-standing practice of referring dependency cases to DSS was codified by Law 191. Beginning in September of that year all those who had knowledge of a child being abused, particularly those holding professional jobs such as teachers, doctors, pharmacists, etc. were required to notify DSS within 48 hours.

Very few agencies were aware of the passage of the law when the demonstration project started to function in September of 1974. Although DSS had established a Central Registry in January of 1974, DSS was virtually the only agency filling out the forms and even their response rate was low.

Caseload Size and Case Outcomes

The reported incidence of child abuse and neglect has increased since the project's implementation. During the baseline period of 1974, there were approximately 71 protection cases from the city of Bayamon that were referred to DSS. However, although many of these cases involved incidents of child abuse and neglect, DSS did not differentiate among the types of protection cases. Hence, there is no way to know exactly the number of cases received by DSS during the baseline period.

As part of the evaluation, the local DSS staff recorded on special forms the reports of child abuse, neglect, and abandonment for 1975. There were 83 reports of child abuse, neglect and abandonment, of which five were repeat reports on the same situations (see Table 1). Of these 83 reports, 44% were substantiated. In 1976 there were 105 reports, 56% were substantiated.

Table 1

DSS Caseload and Reporting Statistics: 1974, 1975 and 1976

Caseloads		1974[1]	1975[2]	1976[2]
Reports by Type:	Abuse	NA	31	57
	Abandonment	NA	32	19
	Neglect	NA	20	29
	Total	71	83	105

[1]Departomento de Servicios Sociales, Oficina Local de Bayamon, Programa de Servicios a Familias con Ninos-Movimiento de Solicitudes (1974). Note: This statistic refers to all protection cases. Figure adjusted due to unavailable data for May 1974.

[2]Source: BPA form filled out by DSS local office.

As far as the source of reports was concerned, in 1975 and 1976 reports were divided approximately equally between agency and non-agency sources (see Table 2). The schools were responsible for almost one-fifth of the reports. The hospital increased its percentage of reports from 2% in 1975 to 10% in 1976. The courts were responsible for a few percent. The police made only one report during 1976. According to the local Bayamon DSS office, both the schools and hospitals were making more referrals, but also many of these referrals were unsubstantiated. This situation was particularly true for the hospitals.

In mid-1976, to keep better record on the child abuse and neglect situation in Puerto Rico, the central DSS office improved the monthly reporting form for all local offices by adding the following categories: abuse, neglect, abuse as a result of alcoholism or drugs, mental retardation, and abandonment.

Table 2

Referral Sources to DSS[1]

Source of Reports	1975		1976	
	Number	Percent	Number	Percent
DSS	8	10	13	12
Hospitals	2	2	10	9
Police	2	2	1	1
Schools	15	18	18	17
Court	6	7	4	4
Other agencies	7	9	10	10
Spouse	17	21	10	10
Family member	9	11	22	21
Neighbors	11	13	15	14
Self referrals	4	5	2	2
Anonymous	1	1	0	0
Unknown	1	1	0	0
Total	83	100	105	100

[1]Source: BPA form filled out by the local DSS office.

Legislation

Working with the Interagency Committee, formed in July of 1975, the project began in the latter part of that year to consider revisions in Law 191, the Puerto Rican reporting law. Work began on formulating specific recommendations to the Legislature for revision of the law. DSS established a special task force to make recommendations to the Legislature.

Law 191 broadly specified who was required to report to DSS including such professionals as teachers, doctors and nurses. Reportable situations were those causing a physical or mental deterioration in a child as a result of abuse. No definition of abuse or "maltrato" was given. Neglect was not explicitly made one of the reportable situations. The law provided a fine of $100 to $500 and a charge of misdemeanor for failure to report, although this provision of the law was not enforced. All informants were granted both civil and criminal immunity and all information was to be kept confidential. The law did not mandate that any services be provided for abuse cases. The law was amended by Law #104, June 2, 1976.

Community Resources

During the period from May 1974 to April 1977, the project and the local DSS office were the only two agencies in Bayamon whose primary purpose was to deal specifically with child abuse and neglect problems. The other agencies frequently served their clients without considering whether they had abused or neglected their children. Since these other agencies did not keep any statistics on abuse or neglect, they could not estimate the percentage of their staff time committed to providing service to abuse or neglect cases.

The staff resources provided by the project include four masters degree level social workers and the part-time services of a psychiatrist, psychologist, and pediatrician. The project has offered the following services to its 60 clients: case management, multidisciplinary review, psychological and psychiatric testing, pediatric examinations and and health care, individual therapy and counseling, group therapy, and ancillary services such as transportation and emergency funds. The social workers engaged in obtaining supportive services such as housing, day care, temporary foster care, medical assistance, and drug and alcoholism treatment. The project also offered positive behavior reinforcement activities such as summer camps, outings, and parties for client families.

In January of 1977 the local DSS office for Families with Children had a staff of two masters level social workers, one of whom was the director, and eight bachelor's degree social workers (called technicians). One technician carried out the intake function for all cases referred to the Families with Children office and the remainder of the staff functioned as social workers. The director estimated that the one master's level social worker and the two technicians who carried the most abuse cases spent about 100% of their time dealing with those clients, while the other six technicians spent less than 10% of their time on abuse cases.

As a group the director estimated that the workers spent approximately one-third of their time dealing with abuse. In 1974 the office had eight workers, two of which had master's degrees in social work. The services available from DSS included: case management, social work counseling, psychiatric evaluations, homemaking services, day care, adoption services, foster care, and placement in institutions for the developmentally disabled.

The local DSS office was providing more immediate service in January 1977 than in the fall of 1974. Whereas in 1974 it was common for protective service cases to go unattended for several weeks or more, in 1977 if a case appeared to be an emergency, a social worker would visit the home immediately. In situations which appeared undangerous, the staff were seeing the cases within three or four days. The staff were using a goal-oriented case record keeping system which was reviewed every six months. They appeared to be more thoroughly diagnosing child abuse cases and had a clearer concept of when it was appropriate to terminate cases.

The services available through other community agencies were more limited, primarily consisting of counseling and some advocacy and support services. The school social workers provided counseling and assistance to parents in obtaining the needed services. The school districts offered some group sessions as well. In the northern school district of the city of Bayamon, there were nine social workers assigned to the elementary through senior high schools. According to their supervisor, they spent approximately 50% of their time on child abuse and neglect situations. In school year 1974-1975 the social workers had 940 cases.* In the first semester of school year 1976-1977 these workers had 1200 cases.

In January 1977, the Municipal Health Center had an entirely new administration. The one social worker who had been providing assistance to families and patients and making referrals to DSS had left the hospital when CETA funds which paid her salary were no longer available.

Considering support services, there continued to be a critical shortage of low-cost housing. Since a change of housing was frequently necessary in order to stabilize a family situation, the lack of housing meant that some approaches to treatment were not as effective as they might have been.

Essential services for children were provided through the Head Start programs, day care and the schools. Play therapy and therapeutic day care, however, were not available. Medical care for children was available through the Municipal Health Center for those who could not afford private care. However, the long waiting lines and the deterior-

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* Note: since the district did not classify cases, these figures represent all kinds of situations, not only child abuse and neglect.

ating physical conditions of the facilities make medical care difficult to obtain. The new director of the Center plans to establish community clinics, remodel the Center, and improve its services. The addition of a new subregional hospital, however, improved the quality of secondary care. Nonetheless, preventive health programs in the Bayamon area continued to be very limited. In summary, during the period from May 1974 to January 1977, there had been a small increase in the quantity and quality of community resources available for treatment of child abuse and neglect beyond what the project was offering to its clients.

Community System Coordination

The project was the principal means of facilitating coordination among the agencies in Bayamon. None of the other agencies appeared to have made any formal agreements for coordinating their services to abuse or neglect cases except for an informal working relationship between the schools and the local DSS office.

The Interagency Committee, convened under the auspices of the project, represented the first time that most of the key community agencies had assembled to discuss the special community problems relating to child abuse and neglect. Agencies that were involved included the Head Start programs run by the city of Bayamon and the Evangelic Council, the Department of Services Against Drug Addiction, Police Department, Alcoholism Program, Department of Instruction, Local Health Center, Department of Housing and Urban Renewal, and several of the larger hospitals that serve the region and the island. During the fall of 1975, the committee developed a form to be used by all agencies to refer cases to DSS and the Unit. In 1976, these forms were circulated to all key community agencies. A Health Board composed of representatives of the various community health agencies met during 1975 to develop programs to meet Bayamon's most serious health problems, particularly those pertaining to children.

During the period from May 1974 to January 1977, according to records maintained for the national evaluation, the project spent approximately 8% of its total budget on coordinating with other agencies, primarily on educational and administrative matters. The bulk of these coordinative efforts were to arrange meetings or to accumulate educational material for meetings. Some of these efforts were spent coordinating for administrative purposes or treatment to clients. Time spent on attempting to develop a more effective community system for identifying, referring or treating parents who abuse their children represented several percent of the project's budget. These figures do not include many of the project's activities which had the indirect effect of improving the community system but which were accounted for under other headings in the project's record keeping system.

Education and Public Awareness

The staff of the various community agencies became more aware of the

problems of child abuse, and to some extent neglect, in Bayamon, and more knowledgeable about where to refer cases. Almost all of the training that the agency staff received was a result of the project's health educators' efforts.

According to statistics collected by the project, approximately 270 professionals were educated by the project in Bayamon during the period from May 1975 to January 1976. Almost three-quarters of those trained were teachers. Others included staff of Head Start, Municipal Health Center, Department of Health, and Department of Housing and Urban Renewal. The project made presentations before several professional conventions.

In the period from January 1976 to December 1976, over 400 professionals were educated. Principal among these were the local offices of DSS. Other agencies included the schools, alcoholism program, and Bayamon CRUV. The local Bayamon DSS office staff appeared to have made significant gains in improving their skills and awareness as a result of the project's educational activities. Similarly, the schools were enthusiastic about the project's training and appeared more capable of identifying and referring cases of child abuse and neglect.

The health educators made presentations before the parents of Head Start and public shcool students, community groups at the community centers in the housing projects, and mothers attending the well-baby clinic at the Municipal Health Center. In total, the project educated over 2100 people from May 1975 to January 1976. From January 1976 to December 1976, the project educated over 4100 people. In addition, the project participated in a dozen radio and television programs acquainting the public with child management, child development, social workers, child abuse and neglect, the project, and the reporting law. Several of the major daily newspapers ran articles on child abuse and neglect and the project.

The Child Abuse and Neglect Demonstration Project: Arkansas

Summary

The coordination and integration of the existing community system, as well as the development of new components within it, have improved considerably over the funding period of the demonstration project. In addition to centralizing reporting to the Division of Social Services (either directly or indirectly through SCAN), the case management function was centralized in SCAN, a private agency under contract to Social Services to deliver treatment services in child abuse cases involving children under the age of 12. To supplement the services commonly provided by Social Services, the project has developed additional resources, including hospital diagnostic teams, multidisciplinary consultation teams, lay therapy, and Parents Anonymous. The diagnostic and consultation teams provide a professional arena for the integration of the key referring and service-providing agencies in the community, while lay therapy and Parents Anonymous integrate the extensive informal network of self-help and support services. Responsibility for coordinating these two systems rests in the ability of the county project directors to function effectively in both professional and non-professional environments.

To complement the expansion of the resource base, an aggressive education and public awareness effort has been pursued by the project. While initially the staff sought out forums for community and professional education, they are now sought by these groups in an active schedule of approximately 90 presentations annually for each project county. The resulting impact of these efforts on reporting statistics is apparent, with a total increase of reports for abuse/neglect of 163% during the three years of the demonstration. Since substantiations have only increased 29% over this same period, however, the appropriateness of the increased reporting is somewhat in question.

With a few exceptions (notably increased reports from physicians and hospitals and decreased reports from law enforcement agencies, the courts and acquaintances and neighbors), the proportion each source represents of the total reports has remained fairly constant. Within these proportions, however, the actual number of referrals has, in some cases, doubled, tripled, even quadrupled in the three-year period under consideration. The declines in referrals from the reprisal agencies in the system would seem to corroborate the finding that cases are being identified by other agencies in the system before they require legal intervention.

Recognizing the three fundamental gaps identified in the service delivery system (i.e., insufficient day care facilities, insufficient treatment facilities for abused children, and insufficient treatment programs for parents of/and abused children over 12), the coordination and functioning of the community system for abuse/neglect in ACAN counties has made sig-

nificant progress during the demonstration period. All of the gains made should be interpreted as permanent or at least the new baseline to which future improvement will accrue, since the SCAN/Social Service model has been adopted into the State Plan and additional counties throughout the state plan to develop similar systems.

Community System Operations

The ACAN (Arkansas Child Abuse and Neglect) demonstration project was funded in three counties in Arkansas. In two of those counties the SCAN/Social Services model was already in place when the grants were awarded. Since that time, the model has been replicated in six additional counties for a total of nine SCAN counties including the original project in Little Rock. The community system for dealing with cases of child abuse and neglect is similar in all the SCAN counties, with a few minor exceptions. Before SCAN, some cases that were discovered by citizens in the community were reported to several different agencies, and cases discovered by members of the agencies were reported at least to social services and sometimes to another agency. Many cases were simply not reported. The main community agencies that provided services for families in which child abuse or neglect had taken place were Social Services and the Juvenile Probation Department of the court. For cases that were not referred to juvenile court, the services mostly amounted to crisis intervention, temporary shelter for the child, if indicated, and some casework and advocacy by caseworkers in Social Services.

While each of the demonstration counties experienced some unique situations in the development of their system, for the purposes of this report, the experience of the Washington County project will be used to illustrate the community system, its functioning and related dimensions. Washington County is the second most populous county in Arkansas after Pulaski County (Little Rock) with a population of 77,370 in 1970. It is also the fastest growing county in the state. Most of the people live in Fayetteville and Springdale, two low-density towns. The median family income in 1970, at $6825, is one of the highest in the state; nearly 10% had incomes of $15,000 or more annually. The low median age (25.3) for the county reflects the student population from the University of Arkansas.

Prior to the demonstration project, the primary service delivery system for identifying, diagnosing and providing treatment for abuse and neglect clients consisted of two main agencies (Washington County Social Services and Ozark Guidance Center), with several other agencies referring cases to them (juvenile court, the police department, the school districts, the public health department, and the hospitals). At that time, the state reporting law mandated the welfare department and the police department to receive reports. There was no cross reporting requirement, although the agencies involved did not hesitate to refer cases to each other. In addition to the absence of centralized reporting, the basic gap in the system was the insufficient treatment program which responded directly to the needs of abusive parents.

The two service providers in the community delivered the standard complement of services to abuse/neglect cases as well as to other appropriate cases. The Division of Social Services conducted immediate investigations of reports, provided immediate protection and court action as required by the case, provided foster care and permanent placement arrangements when necessary, and offered social work counseling and support services to the families. The Ozark Guidance Center offered individual and family therapy, marriage counseling, play therapy, a mothers' group in home and child management, and an in-patient unit.

With the institution of SCAN, which operates via contract through the Division of Social Services, a centralized case management function was developed, which in turn tapped the already operating resources in the community as well as developing additional resources. A hospital-based Child Protection Team, a multidisciplinary consultation team, Parents Anonymous, and lay therapy through SCAN volunteers constitute the major new resources for which the demonstration project is responsible. Other efforts to muster service providers have coordinated such resources as emergency funds, transportation, medical care, and babysitting into a centralized resource directory to which the project can refer. A very recent service developed in a coordinated effort by SCAN and Head Start is the Parent Education Program which draws from the expertise of many community agencies in delivering child development and management classes.

During the course of the first year of project operations, changes in the state law centralized reporting in the Division of Social Services and expanded the list of agencies and individuals mandated to report. While Social Services has extended the mandate to SCAN, the Division remains the single agency ultimately responsible in the county for receiving reports and forwarding them to the Central Registry in Little Rock. While there is evidence that some agencies, and particularly private citizens, feel more comfortable reporting to SCAN, all agencies interviewed realize that Social Services is the final, authorized recipient of those reports.

While little has been attempted formally in the outreach and prevention functions of a model system, the main service providers who come in contact with a wide range of clients are sensitive to the dynamics and their implications for potential abuse. The schools, Head Start, and the public health department, in particular, try to alert SCAN of potential cases.

The identification function in the system has expanded tremendously since the inception of the project. This has been the result of extensive community and professional education. There is some indication from the comparison of the substantiated reports to total

report volume that the criteria for abuse and neglect have not been adequately communicated, since the gap in the ratio widens each year, rather than closing.

Investigation of reports was always a highly responsive function in the system although it was susceptible to duplication by various agencies. While joint investigations between the project and agencies like the court and the police have not increased, there is an operating awareness of the need for immediate investigation and referral of cases appropriate for SCAN and Social Services. The project, in turn, attempts to evaluate each report within a day or two of receipt and makes the initial disposition based on their findings: opened as a SCAN case if abuse or severe neglect of children under 12; opened by Social Services if neglect or involving children over 12; or unopened if unsubstantiated during evaluation.

Prior to the project's development of the Child Protection Teams in the hospitals, and the multidisciplinary consultation team, the decisions involving treatment planning, referral, placement and termination were done pretty much in isolation by the Division of Social Services taking responsibility for the case. Now, these decisions enjoy the multiple perspectives of the members of the teams, who review case needs and progress at all critical junctures in service delivery.

The most profound change has undoubtedly been in the focused treatment program of lay therapy offered by the project. The philosophy of "reparenting the parent", which underpins the complex treatment modality delivered by trained volunteers to abusive parents, was not offered by any other service provider in the community. Much of its credibility as a valuable and valued service in treating abusive parents comes from the other agencies in the service delivery system, most impressively from the mental health services.

The major service delivery gap, observed in interviews with nearly every community agency, is the absence of sufficient day care facilities, which most service providers view as a critical support service to the parent during treatment and as a therapeutic service to the child. Increasingly, as the project and other agencies have worked with these cases, the desirability of treatment services for the children involved has gained priority in their assessment of additional service needs. There is also a concern that abused children over 12 become the target solely of legal intervention without the necessary complement of treatment services which both parent and child require.

Caseload Size and Case Outcomes

In each of the counties in which a SCAN unit has been formed, the volume of reports and referrals has increased. To illustrate the dimensions of this increase, the following discussion is based on information

collected in Washington County. Comparing data collected by the Division of Social Services from 1973 through 1976 on Table 1 reveals a pattern of continued increase in reports. Total reports for abuse/neglect increased 163% in three years from 112 in 1973 to 295 in 1976, with the bulk of the increase occurring in the first year. The pattern is highly differentiated, however, for abuse and neglect. Reports of abuse increased nearly 500% over the data collection period, with the major proportion of this increase experienced between 1973-1974. Neglect reports, on the other hand, did not show such a dramatic increase overall (i.e., 64% for 1973 through 1976), and despite relatively steady increases annually between 1973 and 1975, neglect reports decreased during the last reporting period by 25%.

Table 1

Division of Social Services Volume of Reports: 1973-1976

Washington County, Arkansas

Reports	1973[1]	1974	1975	1976
Abuse				
Number of reports	26	87	94	154
Number valid	18	57	44	55
Percent reports substantiated	69%	66%	47%	36%
Neglect				
Number of reports	86	128	185	141
Number valid	48	71	45	30
Percent reports substantiated	56%	56%	24%	21%
Total				
Number of reports	112	215	279	295
Number valid	66	128	89	85
Percent reports substantiated	59%	60%	32%	29%

[1]Data for 1973 extrapolated on basis of information collected for July 1973 through December 1973.

While the reporting has increased, substantiations of those reports have undergone very different patterns. Overall, the number of valid reports of abuse/neglect increased from 66 in 1973 to 85 in 1976, for an increase of only 29%. However, within that time period substantiations peaked in 1974 at 128 valid reports, or nearly double the baseline figure; subsequently, the 1975 and 1976 figures represent continued declines from the preceding year. The proportion of reports being substantiated has also declined from 60% in 1973 and 1974 to about 30% in 1975 and 1976. These trends, in varying degrees, occurred in each of the two categories.

The widening gap between the volume of reports and the proportion of those reports which are substantiated suggests two hypothetical explanations. It is possible that education efforts have over-sensitized the community to the problem, or perhaps failed to convey the definitions of abuse and neglect that are operating in the agencies. It is also possible that, in the absence of a full complement of social services, reports of families in need of other services are being channeled into the very responsive abuse/neglect system.

Displayed in Table 2 are data on origination of reports to the Division of Social Services in Washington County. Since the baseline period (1973), reports have increased substantially from every source except law enforcement and the court. This may be explicable by the perceptions of those agencies, as well as of the project, that cases are being reported prior to the point of necessitating legal intervention. Reports from other agencies (e.g., social service, physicians, hospitals, schools) have doubled, tripled and even quadrupled their volume, although their proportions of the total have not shifted significantly. The exception to this observation is reports from Social Services (which includes SCAN), which in 1973 accounted for 0% of the total and in 1976 represented 11%. Public education efforts appear to have paid off as well with each of the individual source categories increasing reporting many-fold.

Table 2

Division of Social Services Source of Reports/Referrals: 1973-1976

Source of Reports	1973[1] #	1973[1] %	1974 #	1974 %	1975 #	1975 %	1976 #	1976 %
Social Services	0	0	1	--	8	3	37	11
Physician	8	7	9	4	33	12	23	7
Hospital	2	2	9	4	15	5	19	6
Law enforcement	8	7	12	6	9	3	13	4
Court	10	9	9	4	6	2	10	3
School	12	11	21	10	29	10	28	8
Other agency	14	13	32	15	36	13	22	7
Spouse	0	0	0	0	1	--	7	2
Relative	18	16	40	19	43	15	35	10
Sibling	0	0	0	0	2	1	0	0
Acquaintance/neighbor	38	34	77	36	68	24	104	31
Anonymous	2	2	0	0	13	5	16	5
Self-referral	0	0	7	3	8	3	16	5
Unknown	0	0	0	0	8	3	6	2
Total	112	100[2]	215	100[2]	215	100[2]	336	100[2]

[1]Data for 1973 extrapolated on the basis of information collected for July 1973 through December 1973.

[2]Columns may not sum to 100% due to rounding.

The incidence of new and repeated possible abuse which required hospital attention in Washington County declined 40% from 17 cases in 1975 to 10 in 1976, while new possible neglect cases increased 80% from 11 to 20 during the same period. One plausible interpretation for this reversal is that the provision of a new service (SCAN) to abuse cases has had the effect of reducing cases requiring hospital intervention. Yet, while the neglect cases are benefiting from the same public education campaign and are consequently more visible, the service delivery system has not expanded to accommodate and treat these cases. Additional support to this interpretation is the increase of referrals to SCAN in the face of declining abuse cases as contrasted with decreased referrals to Social Services despite a significant increase in neglect cases. The following table illustrates these observations with selected data from the major hospital facility in Washington County.

Table 3

Washington Regional Medical Center, 1975-1976

	1975	1976
Number new cases identified as possible abuse	15	9
Number repeat cases identified as possible abuse	2	1
Number cases evaluated by Child Protection Team*	28	14
Number new cases identified as possible neglect	11	20
Number repeat cases identified as possible neglect	2	0
Number cases evaluated by Child Protection Team*	22	27
Number children retained in hospital overnight	17	21
Number cases referred to Protective Services	22	17
Number cases referred to SCAN	6	10
Number cases referred to court	1	4

*New and review

Table 4 illustrates the disposition of those cases in Washington County requiring legal intervention. During the study period (1973-1976), an 82% increase occurred in the number of court hearings involving abuse/neglect cases. Although double counting due to multiple disposition of a case occurs in 1974 and 1975, trends can be observed. While removal of the child has increased absolutely during the project period, it has decreased in proportion to the total dispositions of the court. More of the removals are court ordered temporary placements than voluntary temporary or court ordered permanent placements. Both of these latter categories experienced an upsurge during the first two years of the project with a subsequent return to the previous rate in 1976. By the end of the project period, a substantial proportion of the cases were dismissed for insufficient evidence, which indicates either that a large number of inappropriate cases are being brought to the attention of the courts or that the court and reporting agencies (normally, social services) do not share common criteria in defining child abuse and neglect.

Table 4

Selected Juvenile Court Case Dispositions: 1973-1976

Washington County, Arkansas

	1973	1974	1975	1976
No. court petitions involving abuse/neglect cases[1]	--	--	--	--
No. court hearings involving abuse/neglect cases	38	54	54	69
Disposition of Cases:				
Case dismissed: insufficient evidence	4	7	13	17
Child at home under supervision	14	17	16	15
Court ordered temporary removal of child	12	8	17	23
Voluntary temporary placement of child	1	8	10	3
Court ordered permanent removal of child	5	10	8	4
Consent to adoption	2	9	1	3
Action deferred; case pending	--	--	4	4
Total	38	59[2]	69[2]	69

[1]Washington County Juvenile Court does not accept initial reports of abuse and neglect.

[2]"Total disposition" larger than "total hearings" due to multiple or overlapping disposition for some cases.

Legislation

New state legislation was passed in July of 1975 which significantly refined the definitions of cases to be considered child abuse or neglect and provided for a more centralized organizational structure for handling reports. The most important changes contained in the legislation include: expansion of individuals mandated to report suspected abuse and neglect; clearer articulation of the definitions of abuse and neglect; designation of the Division of Social Services of the Department of Social and Rehabilitative Services as the sole agency mandated to receive reports, rather than the police and welfare departments; reduction of legal penalties for non-reporting; procedural requirements to be undertaken upon receipt of a report; the establishment of a single statewide telephone number for reporting cases of suspected abuse and neglect; and the appointment by the court, in every case filed under the Act, of a Guardian ad Litem for the child. The Guardian ad Litem is charged in general with the representation of the child's best interests, and in many cases SCAN is appointed in this role. There is, however, some question that this may constitute a conflict of interest, since SCAN is co-jointly involved in bringing these cases to court.

Both SCAN and the Division of Social Services contributed considerable momentum to the efforts to amend the previous law. By means of letters, lobbying and testimony, staff members lent their support to the new bill. The staff of the project and community agencies interviewed in Fayetteville uniformly expressed confidence in the new law, its comprehensiveness and expected effectiveness in dealing with abuse and neglect cases. Although not all community agencies interviewed were fully aware of their responsibilities under the new law, the project's educational program continues to provide clarifying information on the provisions and implications of the law.

Community Resources

With the exception of the demonstration project (SCAN and the Division of Social Services), there are no agencies in Washington County with staff assigned exclusively to child abuse and neglect problems. The providers in other agencies (e.g., probation officers in the court, criminal investigative officers in the police department, school social workers, foster care workers, hospital social service staff and emergency room personnel, public health department staff, and staff in two counseling agencies) deliver services to abuse/neglect clients in much the same way as they would to other clients. In the absence of differentiation among clients, none of these agencies can estimate accurately either the actual number of abuse/neglect cases to which they provide services, or the percentage of staff time committed to the problem.

While the demonstration grant in Washington County resulted in the identification of a Coordinator role within Social Services for coordinating between SCAN and the division, it did not increase the number of staff positions assigned to casework on abuse/neglect cases. Neither did it affect the investigation, counseling, and advocacy services already provided by that agency. Expansion of the resource base did occur, however, in the form of the SCAN unit (four staff members and ten lay therapists) and with the development of the consultation services of the hospital-based Child Protection Team and the Multidisciplinary Consultation Team. The services available through SCAN include: case management; multidisciplinary team review; hospital diagnostic team review; lay therapy; individual counseling; sponsorship of a Parents Anonymous group; sponsorship of parent education classes; ancillary support services, such as transportation, emergency funds, and occasional babysitting; and advocacy services.

In each of the demonstration grant counties in Arkansas, the SCAN units have developed Resource Directories containing written agreements with public and private agencies who have agreed to supplement the services provided by SCAN. In addition to individual and group counseling and therapy, legal aid, and placement services, the agencies provide a wide range of support services, including emergency medical care, shelter, babysitting, financial assistance, food, clothing, and transportation. While there has not been consistent need to resort to these available services, they have responded to requests. In Washington County, signed agreements have been secured from approximately 65 public and private agencies and individuals. The single critical gap in the resource base is perceived by all to be the absence of continuous day care facilities. With reductions in the level of state funding, which resulted in a cessation of state day care in December 1975, the projects have made efforts to raise funds locally to match federal funding for day care.

The project has made substantial gains in coordinating the services available in Washington County, with the major resource expansion effort being the development of lay therapy as an additional service in the community. Since future funding of the SCAN units is anticipated through the combined public and private sources, it would appear that the existing service provision and coordination is likely to continue after termination of the grant.

Community System Coordination

Several system changes in Arkansas have resulted in better coordination of the key agencies in handling abuse and neglect cases. At the statewide level, a legislative change centralized reporting to the Division of Social and Rehabilitation Services of the Department of Social Services. In turn, Social Services, through a formalized

state agreement, has granted SCAN the status of the receiving agency in counties with SCAN units. Those reports made directly to SCAN are forwarded immediately to the local division of Social Services, and subsequently forwarded to the Central Registry in Little Rock.

At the county level, the most critical coordinating function is represented by the relationship between Social Services and SCAN, in which constant communication is maintained in order to deliver services to each agency's specific case focus. SCAN cases include those abuse and gross neglect cases involving children under the age of 12; Social Services, on the other hand, serves all other neglect cases, and cases involving children over 12. These criteria for service provision are not, of course, screened by the referral source, and entail close coordination between the two agencies in order to respond quickly and appropriately to reports.

Other changes which have improved the interagency coordination at the county level include the formation of the two consultation teams; the Child Protection Team, and the Multidisciplinary Consultation team. The former is based at the community hospital (in Washington County, Child Protection Teams have been staffed for each of the two major hospitals), and meets on an as-needed basis. Team members include representatives from pediatrics, psychiatry, social work, hospital administration, SCAN, Social Services, Public Health, pediatric nursing, and the director of nursing. For non-hospital based cases, the Multidisciplinary Consultation Team members attend SCAN staffings to review cases when requested. This team consists of representatives from Social Services, SCAN, the community mental health center, university departments of Social Welfare and Counselor Education, school counselors and psychological examiners, and church-related social service agencies. With the exception of law enforcement representation, the major agencies in the community system are intimately involved in the management of abuse/neglect cases.

In addition to the consultation teams which have set up regular procedures for interacting and coordinating their functions, the SCAN units maintain a Resource Directory of additional public and private agencies who have submitted written agreements to provide supplementary services to SCAN clients. Responsibility for initiating activities on individual cases with these groups is incumbent upon SCAN. Within the juvenile court, a staff position, Community Resources Specialist, was recently formed to coordinate existing and develop new resources within the community for cases requiring court intervention. Additionally, this person is assigned the role of active liaison with SCAN for the juvenile court.

While procedures for referral, investigation and feedback have been developed, they operate at an informal and cooperative level rather than through formalized and statutorily mandated channels. Key to understanding these informal collaborative arrangements is consideration of the size of the catchment area which each SCAN unit is serving and recognition of the close operating relationships among the few agencies in the communities.

Education and Public Awareness

Since the baseline period, substantial increases in the level of education and training specifically related to child abuse and neglect have occurred in each of the project counties. Prior to implementation of the project, only the staff of the Division of Social Services had been familiarized with the etiology of abuse and neglect, reporting laws, means of identifying the dynamics, and the resources available in the communities for dealing with the problem. Since that time, however, the staff of the local SCAN units have provided an active educational program to train staff of most of the key community agencies and to alert the community at large to the problem and its solutions. In addition to three or four lay therapy training workshops held annually in Little Rock, which average 100 attendees including current staff, new volunteers, and interested professionals and lay people, each county unit presents about 50 sessions each year at various levels of information complexity within their communities.

In Washington County alone, approximately 1200 individuals attended presentations in 1975. Most of the key agencies (schools, hospitals, police, court, mental health, day care, and public health) received at least two presentations, with a total cumulative attendance of 275 professionals. Fourteen speeches to various classes at the university (Social Welfare, Home Economics, Child Development, Secondary Education and the Legal Clinic) exposed more than 400 students to the SCAN program. Twelve presentations to community groups (PTA, Kiwanis, Hospital Women's Auxiliary, and the like) reached another 400 lay people. And an inestimable proportion of the community was reached through the distribution of 5000 pamphlets and the various media coverage (radio spots, seven newspaper articles, and a local television feature interview).

Representatives of the key agencies perceived the increase in education and information dissemination efforts proliferating from the SCAN unit at both the professional and community levels. Several of the agencies (notably the hospital and juvenile court) include references to SCAN in all their public appearances and routinely call

on the project to train new staff members. Among the results attributed to these efforts have been requests for additional information and presentations, interagency coordination improvements, donor money, volunteers, and in general, a better understanding of the problem of abuse and neglect and the procedures within the community for confronting it.

The Child Development Center: Neah Bay, Washington

Summary

The Child Development Center has changed the framework and manner in which social services are provided to Neah Bay families. In contrast to the pre-grant period when social welfare services were provided by the state from a distant office and the few service providers on the reservation were uncoordinated and under-staffed, the community has developed its own informal social service system with the Child Development Center as the catalyst for many of the activities that improve families' ability to care for their children. In the development of new resources and the centralization of authority in child welfare concerns, the project has closely cooperated with existing education and service providers so that organizational affiliation has not hindered the delivery of services or the monitoring of family situations.

Until the last year of the project, there was no formal case management in Neah Bay, although the project staff served a similar function by closely monitoring families. However, during the final year of the grant, this situation changed dramatically. While not creating formalized social service intake forms and case progress documentation, the caseload of the Child Development Center climbed to 45, with 20 considered active by the staff and 25 in a "stabilized but monitoring" status. Treatment planning is carried out in the context of staffings, held jointly with the project's consulting psychiatrist, and in the multidisciplinary team reviews held at the Indian Health Clinic. During these meetings, the needs of particular families and the appropriate services and providers are discussed. The major unfilled service needs continue to be the absence of recreational activities for the adults in the community and the lack of trained therapists located at Neah Bay on a full-time basis.

The community's awareness of the needs of parents and children appears to have increased during the time the project has been operating. Before May 1974 the Head Start program was probably the only activity alerting people to the needs of children. The project has increased this awareness by making the community conscious of the special needs of its parents and children and the need to educate prospective parents.

Change comes slowly to a community as steeped in tradition and as small as Neah Bay. Many of the changes are difficult for outsiders to observe. In addition to the lack of adequate jobs, the conflicts in values between the outside culture and the Makahs and the isolation of Neah Bay make it difficult to improve conditions quickly for those parents having difficulties fulfilling their own and their children's needs. Nonetheless, it would appear that Neah

Bay has developed a system for helping those parents in need and protecting the welfare of its children. The Child Development Center has played a critical role in this change.

The project was the largest single agency, in terms of staff size, addressing the problems in the social service delivery system, and it quite naturally became the core of the system. A significant additional factor, which helped to focus the system, was the fact that the entire staff was Makah, and consequently had access to families in the community that non-Makah service providers could not reach. Many of the forward strides in developing a cohesive community system for dealing with child welfare problems can be expected to continue, following the end of the grant period, since the Child Development Center will be subsumed under an umbrella agency, the Child and Family Center.

Community System Operations

Prior to the implementation of the project in May of 1974, the responsibility for dealing with child neglect or the rare case of child abuse in the small community of Neah Bay was not assumed by any agency. Those who came in contact with a family where a child's welfare was in jeopardy provided whatever minimal services were within their resources.

School teachers might refer the situation to the principal or the attendance counselor. If parents were refusing to send their children to school, the principal might refer the matter to the Tribal Judges. If the family were on welfare, the principal might call the Child Protective Services unit in the Washington State Department of Social and Health Services (DSHS) in Port Angeles.

The Head Start program, which served approximately 60 children, had been in operation for several years. Through the program, the teachers had a chance to observe most of Neah Bay's three and four year olds. Almost all the children were examined by a physician during their first month in the program. Where there was an emotional problem, the case was referred to the Mental Health Representative at the Indian Health Clinic or to the program's consulting psychiatrist who visited for one day each month. The Head Start staff felt they had no place to refer cases requiring more thorough investigation and ongoing help. On a few occasions when a family was on welfare, the Head Start Director might call DSHS to provide assistance to the family or to protect a child.

The most common type of call to the Tribal Police was for abandonment of a child at home when there was no one to care for him/her. If the Tribal Police were called, they usually would remove the child temporarily until the parents returned home and would notify the Tribal Judges.

The Indian Health Clinic occasionally encountered cases of neglect, but the nurses and doctors, as non-Makahs, were reluctant to report the situation. In some instances they might advise the Mental Health Representative at the Clinic of the situation, or in the case of gross negligence they might notify the Tribal Police. Another resource, used on occasion, was the Community Health Representatives (CHR) who worked out of offices at the clinic and were responsible for various community activities. The nurse or doctor might ask the CHR to check on the family when she was making home visits in the community.

The tribe did not have any legal jurisdiction over dependency matters. Nonetheless, the two Tribal Judges, who are Makahs and employed by the Bureau of Indian Affairs (BIA), might ask the police to investigate or they might hold a hearing to see if the matter could be settled without involving the Juvenile Division of the Clallam County Superior Court (which legally has jurisdiction over dependency cases). Strong sentiment has developed against the practice of having non-Indians living off the reservation adopting Makah children. The Tribal Judges, feeling they had no resource to deal with the problems of persistent neglect, might ask the parents to voluntarily accept a decision on placement of their children or to receive counseling from the probation and parole officers.

DSHS, the agency charged under the state reporting law of 1971 * to investigate cases of neglect or abuse, is located in Port Angeles. In earlier years, DSHS sent a case worker to Neah Bay once a month. In 1974 a case worker was visiting Neah Bay for half a day each week. Once a report was made to Port Angeles it took up to five days before the case worker might be able to investigate. In emergencies DSHS could ask the Tribal Police to investigate and take some action such as removing the child. Because of the remoteness of Neah Bay, the treatment services that DSHS could offer to Neah Bay residents were few, consisting primarily of counseling by the Child Protective Services case worker. Foster care was often the only solution for a family situation that did not improve quickly.

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*Note: Under the State Law, the law enforcement agency is designated as another responsible agency for receiving reports, but since for Neah Bay it was not appropriate to involve the Port Angeles Police, which are the nearest law enforcement group (ten miles away), this part of the law was not operationalized.

In Neah Bay, prior to May 1974, there was no outreach to identify families that were having difficulty adequately caring for their children. Preventive activities were limited to the physical examinations of the Head Start children, the WIC (Women and Infant Children food program), and the monthly well-baby clinic run by the Indian Health Clinic. The high school offered no classes on child rearing or child development. None of the agencies followed up on cases once the original problem that had led to their involvement was resolved.

During the period from May 1974 to January 1977, the Child Development Center became the center of the community system for conducting investigations, assisting in the initial dispositions, and coordinating the delivery of services including provision of counseling by the staff and individual therapy by the project's consulting psychiatrist. Because of the trust that the Child Protective Services supervisor and caseworker had in the project staff, DSHS relied on the project to identify and investigate cases. The Port Angeles unit only took action on requests from the project, and closely coordinated with the project its contacts with Neah Bay welfare recipients who were having difficulty caring for their children. At the same time, the project gained the confidence of other service and education providers at Neah Bay (school, police, judges, Indian Health Clinic, Community Health Representatives, Head Start/day care) who felt able to report their concerns to the project and work out a way of jointly helping parents and children in need. The project's advisory board, the Child Development Council, composed of representatives of all the service and education agencies on the reservation and DSHS and BIA, facilitated the coordination of services. Much of the treatment planning and case monitoring took place in the Indian Health Clinic meetings which were attended by representatives of the school, the court, the health and mental health clinics, and all of the Child Development Center staff.

Most of the community agencies referred cases of neglect directly to the project. Except for the referrals between the project and Child Protective Services, the number of reports from community agencies to DSHS has decreased to practically zero. The Port Angeles Juvenile Court has developed open communication with the Tribal Court during the time since the project was initiated.

With increased availability of foster homes on the reservation, the tribal court, supported by the investigative services of the Child Development Center, has assumed responsibility for temporary placements. They jointly conducted the first child custody investigation and decision to be made by an Indian tribe's court system.

The project did not develop any criteria for determining which families would receive service since it viewed itself as serving all Neah Bay families, whatever the need. Initially, the project did not consider its role to be that of case manager; rather, it functioned for two years more as a monitor of families that were known to be having problems. During the last year of the grant, however, as the staff skills increased and the magnitude of the child welfare problems became known, the project workers have assumed the full range of case management responsibilities from investigation, diagnosis and referral to treatment planning, service delivery, and coordination.

In addition to counseling by the staff, the project provided some parents with individual therapy sessions and couples counseling by its consulting psychiatrist once a month. Although the parents receiving these services were not always the ones most in need of service, the skills developed by these couples probably were transferred to other parents in the community and helped to create an atmosphere that made therapy more acceptable.

A new resource in the community was the satellite DSHS office at the Tribal Government Center which opened in the fall of 1975. Although no Child Protective Services staff were involved, the full-time homemaker has provided many of those receiving public assistance, including some 30 families with dependent children, with a much-needed service as well as providing outreach services for the Child Development Center. The project coordinated closely with the homemaker when families were in crisis and required someone to remain in the home and care for the children. The financial aid worker at the satellite office also made it possible for more Makahs to receive prompt service.

In the fall of 1974 the Makah Indian Center for Alternatives to Substance Abuse (hereafter called the Alcoholism Treatment Center) started to provide drop-in service, counseling, and Alcoholics Anonymous groups to Neah Bay residents. Since alcoholism affects a large number of Makahs, the initiation of this program filled one of the biggest social service needs at Neah Bay.

The project has provided Neah Bay with its first outreach services. Working closely with the CHR for WIC, the staff have sought out families where help was required and provided the necessary services. In the last year outreach efforts were significantly augmented by the addition of a full-time homemaker aid to the project staff.

The project has made a contribution to the community in the area of prevention by helping organize dances and movies, fostering the development of recreational activities for parents, especially those

who are socially isolated, sponsoring monthly parent education classes, putting on workshops on child growth and development, running an emergency clothing and food bank, and distributing surplus furniture to needy families.

Caseload Size and Case Outcomes

The available data does not portray the dimensions of child neglect in Neah Bay or the manner in which cases are handled or disposed. The reasons for this ambiguous situation are several-fold. Neglect at Neah Bay is generally of the mild variety. Frequently, it means leaving children unattended over night, failing to provide adequate meals, or not providing proper clothing for the children. Since this kind of neglect is usually a chronic phenomenon, many reports are repeats. Because Neah Bay is such a small community, the Child Development Center may have knowledge of a situation long before any report is made. In many cases there will be nothing that could be called a formal report, but rather, someone may casually mention to one of the staff that a family is having trouble.

The project responds to 5 or 6 informal referrals a week, some of which they appropriately redirect but others of which enter their own caseload, after initial investigation, for treatment planning and services. Referrals have come from most agencies in similar proportions to the formal reports demonstrated in the following table.

Table 1

Reports to Child Development Center, 1975-1976

	1975	1976
Number reports: abuse	4	2
Number reports: neglect	11	3
Source of reports:		
Protective services	1	1
Indian Health Clinic	1	1
School, Head Start/day care	5	0
Juvenile judges	0	0
Sibling	1	0
Relative	6	3
Neighbor	1	0

The increased referrals and subsequent need for case management is seen by most as testimony to the acceptance of and confidence in the services being made available, rather than a reflection of new or developing problems in child welfare on the reservation.

The number of reports to the Port Angeles Child Protective Services unit from non-project sources declined from five in 1974 to zero in 1976, as demonstrated in the following table.

Table 2

Reports of Abuse/Neglect to Children Protective Services,

Department of Social and Health Statistics

	1973	1974	1975	1976
Child Development Center			5	2
Relative	2	2	1	
Acquaintance/neighbor		1		
Anonymous		1		
Unknown		1	1	
Total Reports	2	5	7	2

With regard to the disposition of cases, only one case was referred to the Juvenile Court in 1975 and one in 1976, and the project staff were closely involved in the decision to remove the children. In the first case the child was subsequently returned home; in the second the placement was permanent. During 1975, four children were placed in foster homes, three of which were on the reservation. In 1976, six children were placed in foster homes, all of which were on the reservation. The project assisted in helping children that were in foster homes during the grant years to return to their families. In addition, the project arranged for four children to be placed temporarily in a foster home until the parents were ready to resume care of their children.

Legislation

Since Indians have special legal status in the United States, it is not always clear which of the various laws--federal, state or tribal--are applicable in different situations. For reporting child abuse or neglect, the Makahs are subject to the Washington State law which makes the reporting of non-accidentally inflicted death, physical injury, physical neglect or sexual abuse mandatory for certain professional persons, i.e., teachers, physicians, social workers, clergymen, DSHS employees, etc. However, the law is virtually meaningless for Neah Bay, since there are rarely any cases of child abuse or severe physical neglect. Because the community is not anxious to publicize its problems to outsiders, or to alienate members of the community by making reports, the law is ignored. So long as the reporting law does not affect them, the project and the community have not been concerned about changing it.

The project and other community professionals have wanted to change Washington State law so that the Makahs would have jurisdiction in dependency matters. Under Public Law 280 passed by Congress in 1972, the states have legal authority in certain areas if they reserve that right. Washington State passed legislation which gives the State jurisdiction over adoptions, foster care placements, and juvenile delinquency.

The project staff and other Makahs have worked with the Affiliated Tribes of the Northwest, and other Indian nations, to revise federal and state laws regarding dependency. The community also revised the Tribe's Law and Order Code, which governs legal matters on the reservation, to include dependency issues. It will be several years at least before the necessary legal changes can be made; in the meantime, since many of the professionals in the community, as well as the project's staff, would like to assert tribal authority as much as possible, the staff have been acting informally on a number of dependency cases with the tacit approval of Child Protective Services and the Juvenile Court. The landmark child custody case, occurring during the last year of the project, was a powerful declaration of the Indian nation's right to self-determination.

Community Resources

The Child Development Center increased the resources available in Neah Bay for identifying, investigating, and treating cases of child neglect, and for arranging supportive service providers. The project's staff, comprised of the director, two community workers and one homemaker aide, was the catalyst for many of the activities that took place in the community relating to families and children. In addition to counseling and homemaking services by the staff, the project offered, through its consultant, three hours of individual therapy per month, and one hour of parent education per month.

Elsewhere at Neah Bay, the following people are available to provide counseling and therapy: one community health representative, one public school counselor, one public school attendance counselor, three alcoholism

and drug abuse counselors, two probation and parole officers, one Mental Health worker at the Indian Health Clinic, and the consultants to Head Start, the schools, and the Indian Health Clinic.

There has been one other homemaker available to people at Neah Bay; however, her caseload is restricted to public assistance recipients. Transportation for medical purposes has been available through the Indian Health Clinic. Day care for families in which both parents were working or studying has been available through the Day Care Center. The project ran an emergency clothing and food bank, as well as assuming responsibility for surplus furniture distribution. Authority to license foster homes was granted to the DSHS homemaker, which eased the demand for Indian homes for foster placements. Although the Child Development Council has discussed the development of a group foster home facility, the idea is unpopular for a variety of reasons, including the concern that Makah children be brought up with Makah families.

The staff's personal growth as counselors has meant that one of the gaps in the community's service system has gradually closed. Neah Bay could benefit from the presence of a full-time therapist. However, for a therapist to be effective, he or she would have to be an Indian and most likely a Makah. Since there are currently no people with those qualifications, the second most feasible solution is to train people such as the project staff or the Mental Health Representative to become therapists. In addition, the cost of having a full-time therapist is probably beyond the financial means of a community as small as Neah Bay.

The resources, in terms of developed skills, expertise and community and professional acceptance, will remain in the community following the termination of the grant; with the security of state funding assured, the Child Development Center can be expected to continue as a cohesive force in the community.

Community System Coordination

Prior to implementation of the project, there was little discussion of matters pertaining to child and family welfare among agencies. Many agencies did not know where to turn for assistance. The goal of coordinating services has taken some time to develop. The Child Development Council has been one forum for service and education agencies to exchange information on their programs. The staff have regularly attended meetings of other agencies such as the Law and Order Committee and the Indian Health Clinic. They also published a monthly newsletter on social service programs and developments for all Neah Bay residents. In the project's early days, the most common way of coordinating services was through the informal and almost daily contact between the project staff and the workers in the various agencies. However, during the last year weekly multidisciplinary team meetings held at the Indian Health Clinic helped to regularize the system. Although no formal contracts have been written, the staff have established informal understandings related to contacting each other about family situations that might be of concern to the project.

The confidence that the Port Angeles DSHS has had in the Center's staff has made it possible for both the State and Makah interests to be served. DSHS has relied heavily on the judgment of the project's staff and tried to provide whatever services were at its disposal as requested by the project. The increased authority granted the satellite DSHS office in Neah Bay reflects this close working relationship.

There is no central record keeping system, nor is there a likelihood that any such system will be established. The smallness of the community and the political problems that might be created by such a system appear to outweigh the few benefits that might be realized.

Education and Public Awareness

The amount of education of professionals and the general community in Neah Bay on subjects relevant to child abuse and neglect has increased as a direct result of the project's activities. The primary focus of the project's educational activities has been on increasing the knowledge of professionals and community residents about child development patterns and the resources available from the project to deal with parent-child problems. Annually, the project averages 15 presentations to professionals, including day care/Head Start, the schools, the Alcoholism Treatment Center, and the Indian Health Clinic. In addition to the monthly parent education classes, educational activities for the general community average five per year.

One of the most successful attempts to educate the general community was the child development seminar, originally envisioned as an annual event. Attended by approximately 140 people, two-thirds of whom were Neah Bay residents, the seminar covered such topics as child development and management, child welfare legislation, and foster care and adoption. Another vehicle was the monthly newsletter published by the project for all Neah Bay residents. Increasingly successful in reaching Makah parents has been the project's monthly parent education classes.

There has been a slight increase in the amount of education provided by other programs. The school sponsored a program during the summer of 1975 in which the early childhood specialist at the elementary school visited Neah Bay homes and talked to parents about the creative use of toys. The project made a presentation to high school students in the fall on child development, but the school has not developed any special education programs on child development. As the Community Health Representative gained more knowledge of child development, she was able, through her informal contact with WIC participants, to share information with parents on child care.

The Family Resource Center: St. Louis, Missouri

Summary

Reported incidence of abuse and neglect is up substantially in St. Louis. Some move within major agencies to assigning staff specifically to abuse and neglect cases can be seen. Increased education of professionals and the general community has occurred. Finally, a 24-hour statewide reporting hotline has been implemented.

The new state child abuse and neglect law appears to have brought about the most significant changes in the community system in St. Louis. The impetus for the new law cannot be attributed to any one cause, but included the need to be responsive to federal requirements, recognition on the part of most persons in the community of the deficiencies of the original law, and efforts of key people, including members of the demonstration project staff, to remedy the gaps of the old legislation.

The demonstration project also had some significant effects on the community system, chiefly the injection into the system of some new services; widespread education efforts; and the beginnings of coordination between agencies. The project is working to achieve stable continuing funding, but the prospects are uncertain at this time, and thus the longevity of the effects is also uncertain.

Some of the changes inspired by the project's example and community education efforts (e.g., Cardinal Glennon's assignment of a single hospital worker to handle abuse, which they directly attribute to observing the success of SLCH-FRC's similar approach) should remain, however.

The major remaining problems include lack of real coordination among agencies and the lack of intensive treatment services except for those families in the caseload of the demonstration project.

Community System Operations

Prior to 1974, and until new legislation was passed in Missouri in June 1975, two agencies had primary responsibility for responding to reports of abuse and neglect: the Division of Family Services (DFS) or the Juvenile Court. The law further stated that reports "may" be made to the appropriate law enforcement authority.

In practice, major referral sources, such as hospitals, schools, and other agencies and individuals, chose between the two agencies sometimes on a philosophical basis, sometimes on the basis of which could be expected to respond most quickly and thoroughly. The two major children's hospitals reported to DFS, and only when pressed to the Court. The schools sometimes reported to DFS and sometimes to the Court, when they reported. The police reported to the Court, on cases which they reported at all. In fact, the police department believed that it was the primary agency to which reports should be made and was disturbed that it was not receiving more reports. Both DFS and the Court received self-referrals, and reports

from relatives, neighbors and other individuals.

The law did provide for coordination between the Court and DFS, by requiring that each forward copies of every abuse and neglect report to the other. Both agencies carried out this requirement, at least for the most part, but each suspected the other of not forwarding all reports.

The law passed in mid-1975 changed the system radically. All reports are now to be made to DFS, through a central toll-free hotline number. The Court is not to receive initial reports, although DFS is required to forward information on all substantiated cases to the Court.

Duplication of effort was an obvious problem under the original system. Both the Court and DFS investigated each case, whether initially reported to them or reported by the other agency. In addition, hospital social workers and medical staff did their own investigations on cases which they identified; school social workers investigated school-identified cases; and the police investigated cases reported to them. The focus and purpose of the investigations done by these different agencies varied of course; nevertheless, much of the material overlapped and was needlessly repeated by each agency. Duplication of investigative procedures is reduced, although not eliminated, under the new system.

Caseload Size and Case Outcomes

Reported incidence in the city of St. Louis is up strikingly for DFS and somewhat for other agencies. Table 1 shows the number of reports to DFS through the hotline in the 4½ month period after implementation of the new law (mid-August to December 1975) was 598. This compared to just over 620 reports for the entire year in each of the preceding years of 1973 and 1974. For 1976, the first full year following the new law, over 2000 reports came in. Abuse reports to the Court were stable between 1973 and 1975 at about 75 reports in each of the three years, with a slight increase during 1976 to 91 reports. Neglect reports showed a slight increase over the three year period and a major jump in the fourth year. Only abuse statistics are available for the two remaining agencies tabulating data for BPA: St. Louis Children's Hospital showed almost a 25% increase between 1973 and 1974 in the number of cases identified, with a leveling off between 1974 and 1976; the schools reported a doubling of the number of abuse cases identified there between 1974 and 1975 although the total number is small and no statistics are available for 1976. No statistics are available from the police, although interviews with police personnel indicate that the number of cases of abuse reported to them is down since the new law. However, the number of abuse cases seen by the police was small even prior to the new law, according to those interviewed.

Table 1

Reports of Abuse and Neglect

Agency	1973			1974			1975			1976		
	Abuse	Neglect	Total	Abuse	Neglect	Total	Abuse	Neglect	Total	Abuse	Neglect	Total
DFS	--	--	623	--	--	623	--	--	598*	--	--	2012
Juvenile Court	71	180	251	75	215	290	75	218	293	91	300	391
St. Louis Children's Hospital	101	--	--	124	--	--	132	--	--	128	--	--
Schools	--	--	--	6	--	--	14	--	--	--	--	--

*August-December, 4½ month period only.

One question that always arises when major increases in abuse and neglect reports occur is whether the increase in reported cases reflects large numbers of inappropriate reports, because members of the community are "overreacting" and reporting situations which do not involve abuse or neglect. There is an indication that the proportion of reports to DFS in St. Louis which can be substantiated has remained stable, or even slightly increased, since the new hotline was implemented and the number of reports increased. Substantiation rates ranged from about 58% in 1973 and 1974 to an average of about 65% in the months immediately following implementation of the new law. Partial data available from the Juvenile Court on substantiation of abuse and neglect reports indicates no clear trend in substantiation rates, with the proportion of cases substantiated remaining about 10 to 15 percent.

A second issue of interest is whether any change has occurred in the sources of reports--are agencies or individuals now making reports who did not do so in the past? Interviews with DFS personnel indicate that more reports are being received from schools and hospitals, as well as from physicians. The increase in reporting from physicians is attributed to a change in the director of the city hospital and increased education of hospital physicians by social workers.

Reports to the Court from hospitals and schools and law enforcement

agencies are down, both in numbers and as a proportion of the total, probably because many of these agencies began reporting to DFS instead of the Court after the law change in 1975.

All cases identified in the St. Louis system, with the exception of some reported to the police and possibly the Juvenile Court, do get into the social service network. However, not all receive the same type or intensity of services, since some clients receive these services through the hospitals, some through the schools, some through FRC (the demonstration project), and some through DFS. It is difficult to determine whether any real change has occurred in the type and intensity of services provided to families in this community. One is tempted, then, to conclude that there has been no significant change, with the notable exception that those families who are served by FRC receive intensive services. These families, however, are a select number, since the agency only carries a caseload of about 25-40 families. Some additional discussion of the type of services available in the community is presented in the following section.

The ultimate disposition of cases is, of course, the most important question: what happens to these families? Comparable data on case disposition have not been available for the four years spanning the demonstration project implementation. A satisfactory answer to the question of what happens to these families would require a thorough study, with records maintained on the outcome of all cases entering the system.

Legislation

As is evident from the earlier discussion, a major legislative change occurred in Missouri during 1975. The specification of persons required to report abuse and neglect was expanded. The definition of abuse and neglect was specified in greater detail, and the age of children for whom such occurrences are reportable was increased from under 17 to under 18. The major system change, which has been discussed above, was the focus on Division of Family Services as the single agency to receive all initial reports. Other changes included legislative language encouraging the use of multidisciplinary services; permitting temporary custody in certain situations; requiring DFS to provide continuing education on abuse and neglect; and requiring a Guardian ad Litem for all children involved in court hearings.

Community Resources

While agencies in St. Louis are not able to provide estimates of the dollar resources devoted to service in the area of child abuse and neglect, changes in staff resources, usually the major resource in any service agency, are determinable. With DFS as the one exception, no real change occurred between 1973-1974 and 1976 in this area. In 1973-1974, 30 full-time equivalent workers within DFS provided service for abuse cases.

Not all abuse and neglect cases were served by specialized workers, however. By 1976, DFS had 69 full-time equivalent protective service workers, including supervisors, doing intake or specializing in treatment of abuse and neglect cases. This was a major change from the decentralized system of earlier years, where each office handled protective cases as they saw fit, often without using specialized workers. The Juvenile Court has a special Neglect Unit to handle all abuse and neglect reports, as well as other cases not involving delinquency. The size of this unit has grown from five to eight full-time workers over recent years. During the past year, the Unit has moved toward even more specialization, with three of the eight workers now specializing in abuse and neglect, spending 50% of their time on these, rather than other cases. For the two hospitals, Cardinal Glennon has a diagnostic team and six social workers, devoting part-time to abuse and neglect cases, and have had this set-up for several years. In early 1977, they assigned one of these workers to handle all abuse cases. St. Louis Children's Hospital, the sponsor of the demonstration project, originally had seven to eight social workers devoting part-time to abuse and neglect cases and a child abuse team. In 1975, they reorganized to have one full-time abuse worker (funded through demonstration project monies), a diagnostic team, and eight workers handling neglect cases, which required perhaps 10% of their time. The police and schools made no real change in staff resources for abuse and neglect cases, with their existing staff of about 70 juvenile officers and 55-60 school social workers, respectively, devoting a small proportion of their time to abuse and neglect. The demonstration project added an average of about ten full-time staff and up to 70 volunteer part-time personnel to the resources for treating abuse in St. Louis. It is unclear, however, at what level the project will continue after May 1977. Staff of other agencies dealing with abuse should remain stable.

There have been some noteworthy changes in service resources in the St. Louis community. Prior to the time when the demonstration project was initiated, the community had several service gaps; there was no 24-hour reporting, and there were limited treatment resources -- no lay therapy/parent aides, no group treatment, no Parents Anonymous, child management, therapeutic day care or crisis nursery for abuse and neglect cases. The new law and the provisions for reporting abuse and neglect have implemented a 24-hour reporting and response system. As an adjunct to the demonstration project, a Parents Anonymous group was begun. Several other services were added by the project, although only for its own limited caseload -- parent aides, therapeutic day care, child management and group therapy. Again, the longevity of the services offered by the demonstration project is somewhat in question.

Community System Coordination

The two major agencies with responsibility for abuse and neglect cases have always had coordination mechanisms, as required by the law, for sharing reports with each other. Coordination beyond this has been problematic, Court staff often feeling that DFS does not provide the type of information needed by the Court, and DFS often unsatisfied by the Court's follow-through on cases. The new law has changed the basic coordination process somewhat, with DFS now receiving initial reports on all cases, though it must share reports on all cases of injury or disability from abuse or neglect. No definite change has yet been observed in other coordination problem areas.

A written coordination agreement was established in 1974 between DFS and FRC. This was a major accomplishment for both agencies, since it established clear ground rules for their cooperation on cases, and since written agreements for coordination between agencies were not used in the past by any St. Louis agencies. The agreement outlines procedures by which FRC will have major responsibility for certain cases, while still ensuring that DFS will follow the case sufficiently to carry out its legal mandate. Procedures for worker coordination, such as for joint case staffings and other case coordination practices, are spelled out. The agreement was renewed for a second year.

Coordination other than that outlined above has always been, and remains, a problem in this community. Neither the schools, the police, nor the foster care agency have any specific coordination arrangements, other than following legal reporting and referral procedures. The two children's hospitals, during 1973-1974, shared card files on abuse and neglect cases to guard against "hospital hopping" and held joint CAM (Child Abuse Management) meetings. As of 1975, however, these joint meetings had been abandoned, and the card file was no longer reciprocally maintained.

At the end of its first year of operation, FRC jointly sponsored with DFS a community-wide child abuse workshop. Participation was good by all key agencies, as well as others, and certainly continuation of such joint endeavors can enhance cooperation and coordination. The project has also devoted significant effort to establishing coordination, either formal or informal, with a wide range of agencies in St. Louis and has arranged referral procedures with a number of them.

In summary, the coordination system in St. Louis' service delivery

system for abuse and neglect still leaves much to be desired. There is no community-wide committee, task force or other mechanism to provide communication and coordination. The major coordination arrangement is the legally mandated centralization of reports. This is an advance over the dual, uncoordinated system of the previous legislation, but there remain real misunderstandings about reporting requirements, which can probably only be remedied by increased communication and cooperation among currently isolated agencies. The Central Registry, further, centralizes all reports in one place, but in the past no routine feedback of this information has been returned to major reporting agencies, other than gross counts on a city and county basis. The demonstration project has devoted significant effort to coordination, and has some notable achievements, but its efforts have been primarily directed toward establishing two-way coordination between itself and individual agencies, and community-wide coordination is still a major problem.

Education and Public Awareness

Special training about abuse and neglect has been limited in most of the key agencies, and, except at DFS and the demonstration project, has shown no real change over the past few years. Court and police training in these areas rests primarily on the initiative of the individual, who can attend local seminars and workshops, as available. Both agencies do, however, encourage this, and try to provide funds for the training. In-service training is also provided to the neglect unit staff of the Court by its supervisor. Training in the schools focuses on the reporting law. Both hospitals provide in-service training, and utilize the materials developed by the demonstration project for their in-house training. SLCH, with the advent of the project, uses its full-time abuse worker to provide comprehensive training to nurses, emergency room staff, new medical staff and others on a routine basis.

The most significant change in staff training on abuse and neglect has been at DFS. In 1973-1974, training was minimal, and the two staff trainers who provided this resource were not really used. With the new law and some reorganization, there is now a state training specialist and nine local training specialists, a 100% improvement in the estimation of key DFS personnel.

All five of the key agencies interviewed, with the exception of the police, indicated an increase in general professional and community education between 1973-1974 and 1976. Most attributed this increase to the effect of the new law, the publicity and education surrounding the 24-hour hotline, and the education carried out by the demonstration project. Over this time period, DFS progressed from accomplishing little or no outside education, to having its statewide abuse specialist-trainer canvas the state conducting education sessions, and locally, being joined by top DFS staff to educate a range of groups. She works now with a Task Force, including the abuse worker from SLCH, formerly a member of the project staff. Each of the other agencies, with the exception of the schools, conduct community and professional education on request. The primary recipients of this training seem to be hospitals, with a variety of other groups receiv-

ing education on occasion. The schools, additionally, provide high school courses on family life and parenting, including treatment of abuse and neglect.

The demonstration project, during each full year of operation, made over 100 community education presentations, including talks with community organizations and student groups as well as media spots and discussion programs. The staff also made large numbers of professional education presentations, reaching social service professionals, school and day care personnel, nurses and physicians.

PACER: St. Petersburg, Florida

Summary

Protective Services in Florida is relatively new. It was approximately six years ago that the state legislature authorized its existence. Prior to that, the Juvenile Welfare Board had established a protective service program in Pinellas County which functioned very well. When the state system began, many of the skilled, experienced social workers in Pinellas County were transferred throughout the state to assist in implementing the new system. Many of the problems evidenced in the current Florida system and Pinellas County in particular are also due to recent system disruptions and innovations. The Central Registry and the mandated reporting requirements of this state system placed a great strain on an agency learning to fulfill its task. To further aggravate the system, in 1975 the state legislature, in an effort to improve the inadequacies perceived in the state bureaucracy, mandated a state-wide reorganization of all social and health services into one umbrella agency called Health and Rehabilitative Services (HRS). The intent of this reorganization was to minimize existing fragmentation of service delivery, a problem in most state departments of social service, and to begin treating the family's problems as a unit. As a result, all child services, abuse, neglect and dependency, were channeled through a central intake, and assigned to case managers who would be responsible for serving the whole family's needs. Workers who had been child abuse specialists in protective service were now generalists working with dependency, abuse, and the myriad of multi-problems families presented. Their past experience had not prepared them for this demanding, diverse set of family complaints. Staff were transferred, promoted, and/or fired. These changes have gone on for two years and staff morale is very low. Because this reorganization happened to occur at a time when Florida was having its worst year financially, and the county was suffering serious financial limitations, it was implemented with fewer manpower resources than had been originally planned and without the time for training and orientation necessary to smooth out many rough spots. Needless to say, service delivery was chaotic.

Into this turbulent environment enters the newly funded project, PACER, whose intention is to improve the coordination and functioning of the community system and to start preventive programs for abuse/neglect. The most natural agency to share in this endeavor and who would most benefit from PACER's expertise and promise of training and education was HRS. This was not to be the case. HRS could not or did not invite PACER to provide training and assistance to their workers. In fact, throughout most of PACER's existence, HRS was to be the weak link in developing a community system.

Because the Pinellas County system had so many needs, the contributions of the PACER project have been to provide an educational training milieu which would create a climate for the growth and development of a community child abuse system. In addition to setting a climate of awareness and information, they have directly and often indirectly, spearhead-

ed the establishment of preventive programs, realizing that a system unable to handle the total number of reports must give high risk people programs that can prevent crisis abuse/neglect situations. Now the community has two Parents Anonymous groups, parent education classes and parent aides who can give clients the individualized attention they require. Also, because of PACER's legal intern program, the State Attorney's office is now defending HRS workers with court cases. A multidisciplinary team, housed in All Children's Hospital, has provided assistance to HRS workers in treatment planning for their clients.

Due to these project activities, PACER has made tentative inroads into HRS, and has been invited to assist them in training their workers. HRS has become much more active and cooperative on the Family Consultation Team. As a result of the legal intern program, they have improved their court case presentations. Further, PACER is now negotiating with HRS to assume ongoing supervision of the parent aide program when the project terminates.

Concomitant to these activities, PACER pursued the development of a coordinated approach among social service agencies in the prevention and treatment of abuse and neglect. In the third year, they have successfully implemented PACER, a widely representative community committee, to fulfill these objectives. Hopefully, this committee will continue working for system changes after the project has ended.

All of these new directions are indications of system progress even though the overall effectiveness of the community's response to abuse problems to date is perceived by most community agencies to be deficient. PACER's contribution has been creating an environment for community participation in improving large system problems on a local level by increasing the awareness and education of professionals in the schools, hospitals, police and HRS.

Community System Operations

In 1971, a new Florida statute mandated the Social Economic Services (SES) to become the centralized agency for conducting investigations and carrying out case management functions for all child abuse and neglect cases. All community agencies and citizens are required by this law to report any known incident of abuse or neglect. These reports are to be made to the state-wide emergency hotline or the local district office of SES.

Most agencies in Pinellas County, including the police, hospitals and schools, have developed procedures for reporting directly to the local district office of SES (only about 5% of the reports to Pinellas County SES are received from the Central Registry), but representatives of these agencies feel that the current reporting system has a number of problems created by the inadequacies of the existing structure to handle the large number of reports and to provide adequate supervision to families investigated and substantiated as abuse or neglect clients.

Bottlenecks were created in the system when SES was given sole responsibility for investigating all cases of abuse and neglect without the concomitant provision for additional required resources or the development of a structure to work with the increased demand upon the agency.

Since 1971 there has been a vastly increased number of referrals to SES from sources who had previously been providing investigation and intervention with clients themselves. Prior to the passage of the new law, the police had received reports and completed investigations of cases before referring either to SES or the State Attorney's office. Now, according to the law, they are required to refer all cases directly to SES and investigate only those few cases of sexual abuse or criminal physical abuse. Due to the hospitals' increased awareness to the law's mandate and educational efforts increasing staffs' knowledge of abuse and neglect indicators, hospitals in the area have developed a more systematic procedure for reporting cases immediately to SES and currently rely solely on SES to complete the investigative function. Relying on SES relieves them of fear of suit or the potential disruption of the medical plan of treatment for the child by the family. While hospital staff seem to be good about reporting public patients and children seen in the emergency room, statistics indicate that physicians are still not reporting their private patients.

The schools usually report cases of abuse/neglect to SES. They have recently instituted new reporting procedures in which teachers report to their principal all suspected cases of abuse and neglect. The principal, in turn, reports to the school's social worker. The school social worker may or may not make a home visit before contacting SES. The social workers in the schools prefer to delegate all investigation to SES because these intrusions into the families often disrupt their working relationships with families and interfere with the child's education. Many of the children reported to SES from the schools are children with attendance problems who are considered to be neglected because they are being deprived of an education.

Thus, the centralization of the reporting and investigation functions, encouraging the police, hospitals, and schools to refer clients to SES for investigation, has contributed to bottlenecks in SES.

The Central Registry also contributes to the bottlenecks in the system. Because the Registry is not computerized, the staff must hand tabulate all calls and record keeping, and cannot speedily code and relay reports to local districts. Currently, there is a 3-4 month delay between receipt of a report and notification of the local SES office. After a 3-4 month delay, the SES staff cannot adequately investigate these reports or give meaningful assistance, since in many cases the family's situation has changed considerably in the interval. Recently some of these problems with Central Registry have improved.

In 1975 another legislative bill was passed requiring the complete reorganization of HRS. SES as one major department within HRS was drastically altered. The intake function for all abuse, neglect and dependency

cases is now carried out by a centralized intake unit within SES. Workers skilled in working with dependency clients and those skilled in investigating abuse and neglect are now working with both kinds of clients interchangeably. Little or no orientation and training of staff was provided prior to their assumption of these new responsibilities. Furthermore, the reorganization planning committee had estimated that this new system would require nearly three times the manpower that was actually assigned. For these reasons, staff of SES are experiencing overwhelming morale problems which may also be interfering with the agency's functioning.

Because of the backlog of cases created during the reorganization, the central intake unit was referring cases to supervision units before a thorough investigation and assessment had been made. Supervision units felt overworked and resented this imposition created by centralized intake. Further, because youth dependency workers were now handling intake they often did not recognize abuse or neglect situations. For a long time the supervision units felt they were receiving a disproportionate number of abuse to dependency clients. Now the central intake system seems to be working better. Workers understand their jobs better and the intake structure is finally completed. But some of the improvement may be partly due to the recent agreement between the juvenile division of the police department and HRS. This agreement stipulates that juvenile detectives will co-investigate abuse reports with HRS workers, collecting criminal evidence when appropriate and as preparation for possible court intervention. This new partnership assures the family that their legal rights are protected and also that evidence necessary in court is collected. This agreement is a positive step because the youth officers are very well trained and highly informed professionals who have a good understanding of abuse and neglect and their role in protecting children.

Not surprisingly, there are also a number of gaps in the treatment planning and services provided to families under HRS supervision. Clients usually only receive counseling, case management, or removal of child, and are in treatment for anywhere from six months to several years. Tentative findings indicate that a low percentage of clients actually get referred to community agencies for treatment service. Most clients are referred for services within HRS, e.g., welfare assistance, food stamps, foster care, Title XX benefits. There is strong indication that abuse/neglect clients are not receiving necessary medical services. The social worker from the Children's Medical Services has begun a campaign to inform both HRS and school social workers about the medical services available through their agency. Consequently, there has been improvement among workers in providing medical services to their clients.

The large caseloads, often above 30 cases per worker, have led to a situation where those clients in immediate crisis receive the workers' attention and other clients are left to fend for themselves.

Another problem in the community which contributes to HRS's problems in providing services to clients is the territorial lines drawn between community social agencies. Agencies appear to be isolated from each other,

each providing its own services to its own clients and very rarely coordinating services for mutual clients. Until recently, there had been few efforts to build a network of services that could address the diverse need of abuse and neglect clients. The SES staff is overwhelmed and has little time or energy to invest in building such a treatment network, and in the past no other agency in the community has wanted to tackle such a challenge. PACER has begun to fill this gap through a variety of education and coordination efforts. It is quite likely, however, that effects of PACER's efforts will not be felt in the system for several years.

Caseload Size and Case Outcomes

There is little reliable data for the years 1973-1976 available from the schools, hospitals, courts and HRS in Pinellas County to describe changes from year to year. The data available consist of summary figures for the number of abuse/neglect reports to HRS and data from the PACER's review of a sample of HRS case records for the years 1971 to 1974. While these years do not cover the activity of the project, one does gain some insight into the caseload characteristics and begin to understand some of the problems in this community system.

HRS records indicate that the number of reports of abuse and neglect tended to increase from 1871 in 1973 to 2246 in 1974, but then decreased in the next two years (1975-1976) from 2017 to 1978 reports. The increase in reporting in 1974 could be due to the extensive education sponsored by the state when introducing the Central Registry. There are several possible explanations for the decreased numbers of reports in 1975 and 1976. One is that bottlenecks occurred in the Central Registry that delayed or misplaced referrals to the local districts. A second explanation is that the organizational changes within HRS occurring in 1975 and 1976 played some role. Workers in HRS's supervision units report that abuse and neglect reports decreased when dependency workers were combined with protective service workers in the central intake. Apparently dependency workers were less likely to recognize abuse and neglect complaints as valid. After the intake personnel received more training and feedback from protective service workers, the number of abuse and neglect cases increased. Also, community professionals indicated in interviews that they were reluctant to report abuse/neglect situations to HRS because of the confusion within the organization. They feared that by reporting a child to HRS, and not having any assurance that the family would receive an adequate assessment or services, they were only placing the child in further danger with its parents. It is unlikely that the decrease in the last few years is due to fewer children in Pinellas County, since recent statistics indicate that there are over 90,000 school age children in Pinellas County. This represents an increase in school age children in the last few years.

The second source of available data that describe some of the characteristics of the abuse/neglect caseloads in HRS is a sample review of 406 case records, nearly 11% of the closed case records for 1971-1974. This sample consists of cases in which workers made at least one field visit, but does not include cases that were closed through office visits, letters or phone conversations.

In this sample, 32% of abuse/neglect children reported were under three years of age, 19% were between the ages of four and seven, 16% were between the ages of eight and 11, and 22% were between 12 and 14. The primary types of abuse were beatings (47%) and bruises(25%). Burns were the third largest type of abuse (11%). The largest situations of neglect reported were disorganized households (39%) and unattended children (26%). Only 7% of the neglect reports were cases of malnutrition.

Twenty-five percent of the abuse/neglect reports were from neighbors, 19% from police, 9% from relatives, 7% from schools, 4% from hospitals, 3% were self-referrals, and only 2% from physicians. The reporting patterns in this sample indicate that neighbors and police are the primary sources of reports. Schools and hospitals seem to be a minor source of reports, and physicians are the least likely professionals to report child abuse and neglect cases to HRS. Unfortunately, data on the sources of reports are not available for the last two years to demonstrate whether PACER's extensive educational program has changed the reporting patterns of the schools, hospitals, and physicians.

Of the 406 cases reviewed in this sample, 55% of the reports were considered valid, 39% were invalid, and 6% were of unknown status. In 19% of the cases considered valid, reabuse occurred. Eighty-seven percent of the reabuse cases were investigated. Of the 30 children placed in foster homes, 20% were returned home in less than three months, 43% remained in foster homes for 3-12 months, and 7% were placed for over a year. Of the 104 cases in which final disposition hearings were held, 33% were returned home, 27% were permanently removed from their homes, 15% were placed under a court order, 11% were placed under temporary custody, and less than 1% were placed for adoption.

Legislation

The Florida State legislature has had a major impact on the current functioning of the child abuse system in the state. In 1972, after establishing the statewide "hotline," and widespread publicity, the number of reports increased to 19,120 and for the combined first three years there were 75,314 reports of abuse and neglect in the state.

In comparison with the rest of the country, these rates are extremely high. For example, in looking at the 21 states for which data is available for 1973, Florida, with 26,500 reports, is twice as high as any other state except Michigan and four times as high as all but four other states. Pinellas County has experienced the same high reporting rates as the remainder of the state. In 1973, there were 3249 reports of alleged abuse or neglect received in Pinellas County.

In 1975, there was another major legislative change which had direct impact on the functioning of HRS and the child abuse system in Pinellas County. In response to widespread criticism of HRS regarding mismanagement and inefficiencies, the state legislators ordered a complete reorganization of that department, including the SES. In addition to the high number of reports which had completely overloaded the system, the agency was now further

disabled by major organizational changes. Programs were shifted, categories of services were discontinued or integrated into other areas of service. As a result of these changes, a central intake was established to handle dependency clients, juvenile offenders, and abuse or neglect clients. The changes are still being implemented and the full impacts of this restructuring has not yet been felt. Workers are now in new surroundings, often in other parts of the state, with new client loads, and with fewer resources than promised to do the job.

The hospitals, police, schools and social service providers report that they too have been disrupted by these massive changes within SES. They do not know to whom to report, who is responsible for what functions, nor if they can assume that clients referred to SES will ever receive services. Problems which already existed in the child abuse system have only been made more clear by this present turmoil. If only one agency is mandated to serve abuse and neglect clients, and that agency is completely disoriented, one might assume that services to clients will also be disrupted.

In 1974, the Juvenile Welfare Board held a legislative workshop to which they invited the Pinellas County delegates to the state legislature. The PACER project director presented in the workshop a discussion of the changes needed in the Florida Child Abuse Law to bring it into compliance with the Mondale requirements. After the workshop, PACER's director maintained correspondence with a legislator. Together they wrote a proposed new law. In April of 1975, the new bill was introduced into the state legislature and was passed in June of 1975. There are still some weak areas in the law, but the PACER staff plans to wait another year before suggesting additional revisions.

Community Resources

Over the last two years only the demonstration project's resources have changed the allocation of manpower and financial resources to abuse/neglect problems in the county. No significant changes have been made by the major institutions, hospitals, schools and police.

In addition to adding substantially to the manpower available in Pinellas County to deal with abuse and neglect problems, the demonstration project has made efforts to add several innovative programs that could increase the system's capabilities to provide treatment and prevention services. One new service introduced and supervised by PACER was a parent aide program. Eighteen parent aides were made available to SES workers to assist them in providing intensive services to their clients, and have been working with individual families providing transportation, lay therapy, assistance in receiving day care, treatment and medical care. The parent aides, unlike the overworked SES workers, are able to provide clients with the intensive, long-term relationship needed to work through personal problems.

While this service is appreciated and used by some HRS workers, others have not availed themselves of this opportunity, and still others for a variety of reasons have discontinued the parent aide's involvement with their clients. As part of their "preventive" focus, the parent aides have

recently begun to work with self-referrals who call PACER for assistance. These clients tend to be high risk or potential abuse cases who are ineligible to receive services from HRS.

Another preventive service introduced by PACER is a series of child management classes established in the public school's Adult Education Program. In a year's time the classes have grown and are now available four nights a week in various parts of the country. Close to 300 people have attended over the year.

PACER also hired two legal interns to work with the State Attorney in researching and documenting cases which are presented in court. The HRS workers, never adequately trained to prepare cases for court, had made inefficient use of court time and many cases had been removed from the court because of improper documentation. The legal interns work with the state attorney in providing training to HRS workers in preparing for court presentations. Individuals who work in the court report that HRS workers now seem better prepared, clients' rights are now better protected, and court cases flow more efficiently through the system.

A New Parents' Information System (NPIS) was implemented by PACER on a demonstration basis this year. New parents were interviewed in their homes and presented with packets of information regarding community services available for new parents, families and children. The interviewer was trained to identify high risk families and to direct those families to appropriate social services. Of the total number of families interviewed (162), 43 (27%) were considered to be in need of services. Out of this total number of families interviewed, those families which were considered to be at extremely high risk was 10.8%.

PACER has also sponsored two Parents Anonymous groups in the county. Attendance has been low and progress is discouragingly slow, but the service does provide a meeting place for high risk parents who are reluctant to use professional assistance. In the last year, one group became very active and positive change in the lives of several families occurred. HRS workers tend to refer clients to this service.

A medical multidisciplinary team was viewed by PACER as a critical tool for increasing the skills of HRS workers in diagnosis and treatment planning, improving the current level of case management, and as a method for motivating the various community professionals to become participants in providing treatment for abused and neglected clients. In January 1976 the Family Consultation Team, housed in All Children's Hospital, began reviewing cases referred to the team by HRS staff. The team became a community-wide effort after a presentation by Dr. Kempe's Denver team at the child abuse conference sponsored by PACER in the spring of 1975. After the conference a prominent local physician, with assistance from PACER, assumed responsibility for implementing this team. Many months of effort by this physician and PACER were required before the team became a reality and began meeting regularly. HRS workers report that through the Family Consultation Team they have become more aware of community resources available for their clients and have also been helped to improve their treatment planning skills. However,

most workers have not brought their cases to the team, and more work is needed to encourage workers to avail themselves of the team's expertise and support.

Community System Coordination

The only formal coordination agreements between HRS and other community agencies are those mandated by law. All community agencies, including the courts, police, hospitals and schools, are required to refer all suspected abuse/neglect clients and reports directly to HRS. HRS, in turn, is only required to send copies of its reports to the court when it is seeking specific court dispositions. Recently HRS signed an agreement with the juvenile division of the police department to assist them in investigating abuse reports. This agreement gives HRS intake workers added resources and coverage for 24-hour immediate response to abuse reports. There are indications that this agreement has improved investigation and assessment functions in HRS. Informal agreements exist between the schools and the PACER project to provide education and training to school social workers and teachers. HRS also has informal agreements with PACER regarding the use of parent aides, parent education classes, Parents Anonymous groups, and education and training resources. PACER in turn occasionally requests specific assistance from HRS staff when offering educational training sessions held in the community. All other coordinative efforts between agencies are highly contingent upon individual workers' personal working relationships with staff in other agencies, and usually occurs in response to treatment planning for individualized cases.

Since the advent of the Family Consultation Team there has been additional opportunity to bring together many different disciplines to assist HRS staff in diagnosis and treatment planning for their clients. In turn, as the team reviews HRS cases it suggests treatment plans requiring coordination of community resources. One potential consequence of the team's efforts might be the development of formalized ties between community agencies and SES.

Education and Public Awareness

The PACER project has taken on the major responsibility for providing education and training in Pinellas County. PACER has concentrated on providing education to the medical society, schools, law enforcement agencies, SES, social service providers, and civic groups.

The schools, including day care providers, college and high school students and school social workers and teachers, have received the greatest amount of education from PACER. HRS received the lowest number of educational training sessions. Recently, as a result of the reorganization, HRS has felt a strong need for more extensive training and is talking with PACER about developing a series of training sessions for the intake and supervision workers.

There has been extensive media coverage in Pinellas County, including TV talk shows, radio talk programs, and newspaper articles. The effectiveness of this media coverage is indicated by the results of a recent poll

taken in a local shopping center. Nearly 90% reported child abuse was a major problem in Pinellas County. Over 90% said they would report any suspected case to the Central Registry or SES. These data provide one indication that the general community is aware of the child abuse problem and is very knowledgeable about their reporting responsibilities and the requirements of the state law.

In addition to these educational efforts, PACER has organized and implemented three major conferences. The first conference, held in 1975, included Dr. Kempe's team from Denver. The attendance was nearly 250 people. As a result of that conference, a leading pediatrician became committed to implementing the child trauma team. The second conference, in the spring of 1976, focused on developing coordination between agencies in the community. Nearly 550 people attended and 92% of those replying to the conference evaluation survey reported that they were extremely pleased with the conference's effectiveness. In January of 1977 the final conference was held, focusing on coordination problems in the county. Nearly 300 professionals were in attendance.

The hospitals report that they are now beginning to provide information about abuse and neglect in their own service training programs. Other community agencies are also beginning to use PACER's visual aids and materials in their in-service training programs. The police have begun to participate in many of the educational programs on abuse and neglect presented by PACER and are helping to inform professionals about the police officers' role and contribution in abuse/neglect.

The Panel for Family Living: Tacoma, Washington

Summary

The child abuse and neglect system in Pierce County, Washington has improved in several ways since the Panel for Family Living became a federal demonstration program. The changes can be traced in part to the Panel's activities, which began several years prior to the federal grant award. It is not possible to know to what extent the Panel's federal grant activities, versus those that were already set in motion by this volunteer group, are responsible for the changes. One can conjecture, however, that the changes would have occurred much more slowly had the Panel's activities not been significantly increased as of May 1974.

Perhaps the most significant improvement is increased communication, understanding and familiarity among those individuals and agencies constituting the county's child abuse and neglect system. Well over 80 individuals, representing some 25 agencies, are active in the Panel's activities. Minimally, this involves attendance at the Panel's monthly breakfast meetings; for many, however, it means committing 8-10 hours per month for committee meetings, speaking engagements and the like. Regardless of the form of participation, the result is that those individuals working with child abuse cases know each other, and are aware of each other's resources. Referrals can be made to someone already known, and problems can be discussed informally, as can individual cases. Resources in the community can be used more cleverly. While coordination between agencies was not a problem prior to May 1974, coordination seems to have improved as a result of improved communication.

The second most significant improvement is multifold, in part growing out of a reorganization within the local Children's Protective Services Department. In 1975, the department, which previously had about 15 social workers all handling intake and treatment, developed a special intake unit with six social workers, leaving the remaining social workers to carry out the treatment services. The impetus for the change came most directly from the fact that CPS was overloaded, social workers felt overworked, often inappropriate cases were kept for six months because intake was inadequate, and very few cases received treatment services. The fact that the two CPS supervisors actually brought about a change may well be in part due to the fact that they had both been active in Panel activities, becoming increasingly concerned with how the whole system functioned. The founding of the Panel itself was a response to the unacceptable situation CPS was in and thus may have served to highlight the problem. The results of the change include: quicker and more thorough intake by CPS, more appropriate handling and referring of cases by CPS, increased communication among agencies coming in contact with CPS and increased respect for, and thus desire to work with, CPS.

Other important changes in the system include: expansion of service capability primarily through the Panel's services (which may well decline when the Panel's federal funds run out), and expansion of the numbers of agencies concerned with abuse and neglect in the county, in part because of the Panel's activities.

In general, one can say that the Panel has helped to spark interest in the abuse/neglect problem in the community, has been an important source of new ideas and concerns about the problem and has helped to generate a spirit of cooperation and coordination rarely seen in this field.

Community System Operations

The child abuse and neglect system in Pierce County appears to be functioning better in many areas than it was prior to the Panel for Family Living's receipt of federal funds. The Panel's activities helped influence these changes, as did the reorganization of the local Children's Protective Services (CPS).

The system is not completely centralized, but it appears to be more so than three years ago. CPS serves as the focal agency in the system. Although not all cases are channeled through CPS, relatively recent revisions in the state law which mandate that protective services be provided to all cases, whether identified by law enforcement or protective services (previously cases identified by law enforcement were not included in this mandate), undoubtedly resulted in a greater percentage of identified cases being channeled through CPS than in the past.

CPS handles many of the functions of a model system, often in concert with other agencies. Identification of cases is handled by CPS, the police and sheriff's office, the schools, and other service agencies as well as the general public. Only recently have health professionals started to identify and report cases, and only recently has the school system begun a program of training teachers in identification. Investigation and Diagnosis is the joint responsibility of CPS and law enforcement agencies; reporting between these two agencies and joint investigations seem to have increased since revisions in the state's reporting law. When appropriate, the court system becomes involved in investigations. Treatment planning for abuse and neglect cases is primarily handled by CPS; in cases where the juvenile court becomes involved in treatment decisions, court workers often rely on recommendations from CPS workers, perhaps more now than previously. Smaller scale efforts at treatment planning occur at other service agencies working with abuse and neglect cases, including the Panel's outreach/counseling workers or the Panel's Diagnostic Team while it was in existence. Even Mary Bridge Children's Hospital, through its SCAN team, now does treatment planning and case review, even after a child has left the hospital. A CPS worker is often involved in these activities. Many agencies in the community actually provide Treatment services to abusive and neglectful families, yet the majority of identified (i.e., labeled) cases receive treatment through CPS. A second provider of services to abusive and neglectful families has been the Panel, which has served approximately 100 parents a year (less than 10% of the number served by CPS). The local community mental health center, the public health nurses, and Mary Bridge Hospital's Maternal and Child Health Program are examples of other agencies that have been providing services to abusive and neglectful families; it appears that these agencies are all more aware of the fact that they have abusers and neglectors in their caseloads than previously. The amount of Referrals among agencies seems to have increased; CPS in particular is referring many more cases elsewhere than previously, although at the same time CPS has developed an interest in expanding the types of services offered in-house. All agencies seem more aware

of the services existing in the community and are likely to make more thoughtful referrals. Placement continues to be handled by the foster care units in the Department of Social and Health Services. Termination is determined by those agencies handling cases. At CPS, termination decisions are now made more frequently on the basis of the clients' best interests, not the workers (this is due to the CPS reorganization which reduced the long-term treatment workers' caseloads and thus reduced the pressure to close cases prematurely).

The Pierce County system has not developed any notable activities in the areas of Outreach, Prevention or Follow-up, with the exception of some of the Panel's community education activities.

The system does not seem to have any significant tracks or subsystems. Almost all identified cases are channeled through the same agencies, with the same procedures. This is probably more true now than previously because the system in general has become more coordinated. A few private agencies in the county appear not to report non-severe cases that they hear about or identify, and instead appear to provide services to these cases themselves.

As mentioned above, the system does not have any well developed outreach, prevention or follow-up activities. In addition, the county has no specialized services for abused and neglected children, no 24-hour counseling hotline and limited services for sexual abusers.* The system has become more complete than prior to the Panel's receiving federal funding. The Panel has expanded the community's parent education class and group therapy capacity, as well as adding a parent aide program and a multidisciplinary diagnostic team, both of which have small but not insignificant service capacities, and a centralized Speakers Bureau to conduct community and professional education sessions. Most of these activities, however, may well disappear after Spring 1977.

The county system has few duplications in functions. The only duplication of any consequence is that on occasion CPS and law enforcement separately investigate cases; this appears to occur less often now than three years ago, perhaps because of the revised reporting law and improved relations between these agencies.

At the time the Panel was funded by OCD/SRS, the community system had several serious bottlenecks. Most importantly, CPS had an overburdened staff, with caseloads that were too large, and with little time to conduct adequate intakes. Delays between the time of initial reports and actual investigations and diagnoses were often considerable. With the reorganization of CPS, this problem in the system was virtually eliminated. The new Intake Unit is able to respond more quickly and more thoroughly to referrals; cases needing services receive them more quickly and are actually receiving services rather than merely being open cases in a worker's caseload.

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* The only service available now is a new series of group therapy sessions offered by CPS. The County has established a Task Force on sexual abuse, which to date has sponsored a well-attended conference, and which may be instrumental in the future in rectifying this gap in service.

A second bottleneck in the system had to do with the ease and timing with which cases were seen in the Juvenile Court. The problems seemed to be tied to the Juvenile Court Judge. Since this judgeship is an annually rotating position, the problem appears or disappears as different judges accede to the bench.

Caseload Size and Case Outcomes

It is not possible to determine whether there have been changes in the total numbers of abuse and neglect cases reported in Pierce County and the dispositions of these cases since the demonstration program began because of the lack of data from all key agencies. However, data gathered from Children's Protective Services, the Juvenile Court and the sheriff's department provide a good indication of the changes likely to be occurring in other agencies in the county.

Table 1 displays the CPS caseload data from January 1974 through December 1976, Table 2 displays the Juvenile Court data for the same period, and Table 3 displays data from the Sheriff's office for 1975 and 1976. It is apparent that all three agencies have handled more abuse/neglect cases over the three-year period. CPS showed approximately a five percent increase in reports received, the Juvenile Court approximately a 25 percent increase (primarily in numbers of abuse cases), and the Sheriff's office a 16 percent increase. The reason for these increases may be the expanded awareness on the part of the community about what constitutes abuse and neglect cases and the reporting requirements; the state's revised reporting law also may have influenced the rather dramatic increase in the number of abuse cases referred to the courts; and finally, some theorize that worsening economic conditions locally may have resulted in increased numbers of actual cases.

The data from CPS indicates that the number of reports where no abuse or neglect is found to exist has increased by 11 percent in 1975, and has decreased by 10 percent in 1976. The CPS staff suspect that with increased attention to child abuse and thus increased publicity about CPS, more people reported to CPS in 1975 and many of these reports were inappropriate. The formation of a special Intake Unit in CPS during 1975 allowed certain social workers to undertake more thorough investigations, resulting in the detection of these inappropriate cases. The intake workers have been carefully providing referral agents with feedback about the cases they have been referring; perhaps the reduction of inappropriate referrals as well as the general reduction in number of referrals reflects the fact that referral agents are now more sophisticated about those cases which are appropriate to refer. In addition to the intake workers' activities, the Panel's education activities undoubtedly help to explain these changes.

A study of the sources of reports to CPS, the Juvenile Court and the Sheriff's office reflects only modest changes. In general, CPS is receiving reports from the same sources with three notable differences: more reports are being received from health agencies than previously, far fewer reports are coming from neighbors than in past years, and a greater percent of the reports are anonymous. The Juvenile Court is also receiving reports

from essentially the same sources with two exceptions; a substantially larger percentage of reports are being received from CPS and other social agencies, and spouses and other relatives are reporting fewer cases. And, the most notable changes in source of referrals to the sheriff are an increase in reports from CPS and schools and a slight decrease from hospitals and neighbors. The conclusions derived from these data are that health agencies are more aware of child abuse and neglect problems than previously, perhaps because they have been provided education in this area, in part from the Panel, and are now more likely to report directly to CPS than to law enforcement; and CPS is more likely to report cases to the Juvenile Court, perhaps because of the revised reporting law. No information is currently available to explain the reduced reporting by neighbors and relatives, nor the increased numbers of anonymous reports.

Table 1

Caseload Data, Children's Protective Services, 1974-1976

	1974	1975	1976
Total number of reports	1977	1299	1355
Percent reports where no abuse/neglect exists	22%	33%	23%
Percent families referred to juvenile court for removal of the child	1.6%	2.5%	3.2%
Source of Reports:			
Court	1%	3%	3%
Law enforcement	5%	3%	5%
Schools	12%	11%	12%
Private physicians	2%	2%	3%
Health agencies	2%	7%	9%
Local offices	10%	5%	5%
Other social agencies	6%	6%	5%
Relatives	15%	17%	16%
Neighbors	32%	28%	18%
Anonymous	3%	6%	10%
Other	10%	14%	15%

Table 2

Caseload Data, Remann Hall Juvenile Court, 1974-1975

	1974	1975
Volume of Reports:		
Abuse	161	222
Neglect	72	82
Unknown	8	--
Total	241	304
Source of Referral:		
Protective services/other social agencies	16%	32%
Private physician	--	--
Hospital	2%	1%
Law enforcement	44%	47%
School	3%	1%
Court	7%	2%
Self referral	7%	9%
Spouse	13%	5%
Sibling	--	--
Relative	8%	1%
Friend/neighbor	--	--
Anonymous	--	--
Other	1%	1%
Unknown	--	--
Selected Court Dispositions:		
Commitment	0.5%	0.5%
Probation	0.5%	0.5%
Permanent ward	3.0%	1.0%
Temporary ward -- for supervision	14.0%	14.0%
Temporary ward -- for placement	27.0%	26.0%
Continuance	3.0%	2.0%
Referred to DSHS/CPS	19.0%	13.0%

Table 3

Pierce County Sheriff's Department: Juvenile Division

	1975	1976
Total number reports received	49	57
Percent abuse	61%	44%
Percent neglect	39%	56%
Percent of total reports substantiated	53%	72%
Source of Referral:		
Protective services	37%	44%
Physician	--	--
Hospital	10%	4%
Law enforcement	4%	4%
School	4%	9%
Relative	12%	11%
Acquaintance/neighbor	24%	19%
Anonymous	2%	4%
Self-referral	--	2%
Other/unknown	4%	5%

The selected dispositions of cases from the Juvenile Court data suggests that child abuse and neglect cases coming to the court's attention do not fare any differently than previously; however, when interviewed, court workers suggest that whether or not the same number of children may be placed out of the home or minimally receive court supervision as in the past, more and more of these placement or supervision decisions are voluntary on the part of the parent and are negotiated with the parent prior to a court hearing.

Legislation

The Washington State Child Abuse and Neglect Reporting Law was revised during the time of the Panel's functioning as a demonstration. The main change in the law concerns the reporting of cases and provision of protective services. As previously, law enforcement agencies and protective services are mandated to receive reports. However, with the new law, law enforcement must provide protective services to those reports received, necessitating the referral of those reports to protective services, and protective services must now report cases to law enforcement as well as the Prosecuting Attorney. These cases cause protective services to be more clearly a focal point of the system than previously. The law additionally includes the following provisions: the child at risk must now be assigned a Guardian ad Litem; hospitals can now detain a child until the next court day without consent; clergymen need not now report but all other professionals must continue to do so. Members of the Panel actively campaigned for certain changes in the law, but in general, not those that passed the legislature.

Community Resources

Pierce County has experienced modest expansion in the resources committed to abuse and neglect during the demonstration period. Most of the expansion has been accounted for by the Panel's own programs; this will likely change when the Panel's federal funds run out.

Key agencies with staff members specifically committed to abuse and neglect include: Children's Protective Services, with approximately 15 full-time social workers; the County Sheriff's Office, with the equivalent of one officer 60 percent time; the Tacoma city police, with one officer 60 percent time; the County Juvenile Court with five dependency workers at approximately 50 percent time and six intake workers at approximately 25 percent time; and Mary Bridge Children's Hospital with a very much part-time SCAN team and two part-time social workers. These staff commitments have not substantially changed during the last three years with the exception of the Sheriff's office, which previously assigned abuse/neglect cases to any juvenile officer, and Mary Bridge Hospital which previously had no SCAN team or social workers. The schools essentially have no personnel specifically assigned to work on abuse and neglect, although awareness is high and school social workers, nurses and teachers do identify and work with cases of abuse and neglect.

When surveying resources from most of the service agencies in the county, it appears that the county has close to a full complement of desirable adult services, although not necessarily enough of them, with the exception of a 24-hour counseling hotline. Children's services are much more scarce, with no agency in the county specifically serving abused and neglected children.

The Panel has contributed several new staff resources and many more services to Pierce County in addition to the Panel's five full-time paid professional staff members (which include a training specialist, a community relations specialist, and two treatment workers, as well as the director). Non-paid staff resources have included parent aids (approximately eight), parent education teachers and group therapists skilled in working with abuse and neglect (approximately eight and four, respectively), and the Diagnostic Team members skilled in reviewing child abuse and neglect cases. All but some of the parent education teachers and the group therapists are resources to the community generated after the Panel received federal funding. (It is not known yet how these resources will be utilized once the Panel's federal funds run out, although some of the parent education teachers have begun classes elsewhere.) Although the Panel was providing some education prior to federal funding, as a demonstration project the Panel has brought to the community greatly expanded educational and training activities, including a centralized Speakers Bureau.

Community System Coordination

While the Pierce County child abuse and neglect system was more coordinated than most communities' systems prior to the federal funding of the Panel, it appears that the system has improved during the demonstration effort. All agencies perceive greater cooperation and coordination between themselves and others in the system. The changes seem to result directly from a reorganization of Children's Protective Services as well as from some of the Panel's activities.

Coordination mechanisms between Children's Protective Services, the local police and sheriff's office, hospitals and the County Juvenile Court have existed informally for a long time, dating back to the founding of the Panel several years before it became a demonstration project. As discussed earlier, Children's Protective Services reorganized in 1975, creating an intake unit to handle all reports, investigations and diagnoses, and a treatment unit to provide services to cases on a long-term basis. The result of the reorganization was that a small number of CPS workers, rather than all 16, conduct the majority of interactions CPS has with other agencies in the community. Because other agencies only have to relate to a small number of CPS workers, they report that it has been much easier to establish informal working relationships with CPS, the focal agency in the system. (It does not appear that the Panel had any role in the CPS reorganization although those CPS supervisors who made the reorganization decision were active members of the Panel.)

In addition to the improved informal relations between agencies, several formal and informal arrangements have emerged within the last two years. CPS and the Panel established a formal written agreement on the referral of cases between the two agencies; following this, and perhaps as a catalytic response, CPS developed a similar formal written agreement with Madigan military base. CPS has also established agreements with the schools and local hospital with respect to standardized reporting. The Panel itself also developed formal agreements with Parents Anonymous and Mary Bridge Children's Hospital. And finally, as a result of the revised state reporting law, CPS and law enforcement have a formalized reporting relationship with the prosecuting attorney, in addition to the previously mandated reporting relationship between CPS, law enforcement and the Juvenile Court.

Interagency collaboration appears to be more typical in Pierce County than in other communities, and has grown during the past three years. Different agencies are concerned with eliminating duplication and working together, particularly on individual cases, and on preserving each other's autonomy in certain functional areas. This spirit, which one encounters in all the key agencies, is very likely due to Panel activities. The Panel, through its membership meetings and Committee activities, provides forums for workers in the community to get together, learn more about each other's functions and work, and perhaps most importantly, to get to know each other. Many staff members from all key agencies participate in Panel activities and the friendships developed among individuals in these different agencies seem to have enhanced the agencies' desires and abilities to work together. A good example of efforts to collaborate is the Panel's Education Committee's High School Teachers Workshop series, a two-year planning effort by individuals not only from the schools but from all key agencies in the community which finally took place in April of 1976 and was repeated in March of 1977. And, the Panel's Speakers Bureau has come to be regarded as the central recipient of most speaking requests; individuals from all key agencies serve as speakers for the bureau.

The nature of the collaborative arrangements between agencies is encouraging. There is more information sharing on cases; agencies seem to trust each other's conclusions on cases more readily; and joint investigations (between CPS and law enforcement) seem to go more smoothly. However, it does not appear that concerted efforts have been made to iron out all inefficiencies in the system. Some gaps and duplications remain. One can assume that if those aspects of the Panel's activities that serve to bring different community agencies together continue, some of these more difficult aspects of collaboration may be worked out.

As a final note on coordination, it should be pointed out that while a community-wide task force on child abuse and neglect existed in Pierce County under the auspices of the Panel, prior to the Panel's federal funding, the infusion of additional monies has been very directly responsible for the impressive expansion of this task force (from about 20 to over 80 active members) and for the diversification of the task force's activities.

Education and Public Awareness

The amount of education and training on abuse and neglect for both professional and community people in Pierce County has increased substantially during the past three years. While the national attention to the child abuse and neglect problem may in large part account for the increased demand for such education, the provision of this education has been primarily by Panel staff and Panel members.

All key agencies state that staff members have received substantially more abuse/neglect education during the past three years than in prior years. It is felt that the variety, amount and quality of the training has resulted in a much better informed group of professionals working with abuse and neglect, and thus higher quality of services being offered. Also, the training has helped to break down stereotypes about different agencies; for example, police officers are not seen as "the bad guys" as they once were. In addition, all key agencies state that they have received more requests for training and thus have been providing more training to others, often through the auspices of the Panel's Speaker's Bureau, than before. The education and training provided has not been "planful," i.e., directed at identified target groups, but rather has been on a request-received basis.

The Panel itself had done significant education and training. With over 180 presentations made to professionals and community groups during each of the three years, the Panel reached over 25,000 people. Most of these sessions were directed toward students, usually of high school age, but a wide range of professional groups have been addressed as well. (Professionals in the community have additionally received some education from planned activities at the Panel's breakfast meetings.) The Panel also provided over 30 TV, radio or newspaper educational activities directed at the general public. The main topics covered in the educational activities included the etiology and dynamics of abuse, the state reporting law, and the functions of the Panel.

Although more and more individuals, representing different agencies and groups (including Parents Anonymous) have become involved in providing education and training, the organizing responsibility for providing these activities has increasingly become that of the Panel's paid staff. Agencies in the community regard education as a primary role of the Panel and appear to be interested in channeling many of the requests that they receive for education through the Panel's Speakers Bureau. Although the courts, for example, would not refer a request from a school for a talk on the role of the court to the Panel, requests for more general talks on abuse and neglect would be referred.

The Protective Services Demonstration Project: Union County, New Jersey

Summary

The Union County demonstration project began to operationalize the centralized child abuse system mandated in the Dodd Law, and began to give meaning to the law's intention that "the best interests of children be protected by both the courts and social service agencies." They accomplished this by developing a network of services available to families that relate to the social-economic needs as well as emotional needs of families. The protective service agency has become a funnel through which clients are directed to therapeutic services in the community without having to negotiate the system alone.

Consequently, as the community agencies have become more involved with the project and increased their awareness of the abuse and neglect problem, they are playing more active roles in advocating for both the project and clients to ensure an ongoing financial and philosophical commitment from the state.

In addition, the coordinative relationships between the project and the police, courts, and prosecutor's office have improved, making investigation and court presentations smoother and more considerate of children's best interests. The legal analyst has also assisted protective service workers in better documentation of court presentations. As a result, the judges feel that they can make better decisions for the children's futures.

Community System Operations

Formerly through the project's advisory board, and now through the Union County Child Protection Council, there exists a forum for coordinating the community effort in addressing the shortcomings in the community system and an impetus for social change to the project. Therefore, in those situations when speedy investigations are required, the hospital social worker will call the prosecutor's office or the police. The prosecutor's office and the police state that they then contact DYFS regarding the hospital's referral, but often time has elapsed. Thus, there is some slippage and cases get lost. A particular problem with this reporting arrangement between the prosecutor and the project is the difference in the criteria used in judging whether a case should be criminally prosecuted or referred to DYFS for treatment intervention. Consequently, if cases are reported directly to the prosecutor's office and then reported to DYFS, they are subjected to the discretion of the prosecutor and may not be referred to protective services immediately. Due to the educational and coordinative efforts of the project's legal analyst, many of these differences in definition and criteria regarding case investigation and disposition with the police and prosecutor are being resolved. A new DYFS policy was implemented during the third year in which all DYFS workers must report abuse cases that meet certain criteria, as defined in a formal policy agreement between DYFS and the statewide Prosecutor's Association, to the prosecutor's office.

Another factor that had contributed to delays by DYFS in investigation of referrals was the amount of time spent in commuting between Elizabeth and outlying areas in the county. This was specifically a problem with referrals from Plainfield. Although the project has the use of an office in the United Family and Children's Society in Plainfield, it is not well utilized. In the third year DYFS established a Plainfield office that houses its own screening unit, and response and supervision workers on a rotating basis from the project. This new facility has solved the problems of delay in investigation caused by commuting distances.

One improvement in the Union County child abuse system has been to increase treatment resources for all clients who receive services from the demonstration project. Through partnership agreements with local private social agencies, the following services have been made available: individual, couples, family or group counseling; lay therapy; day care, homemaker services; visiting nurse services; crisis intervention; 24-hour hot line, 24-hour coverage; parent education classes; medical care; temporary placement of children; parent line; and advocacy services. In addition to these services, the project began a multidisciplinary team in Elizabeth to review difficult cases and to improve diagnosis and treatment planning by project staff.

Outreach and prevention efforts with high risk or potential child abuse families are almost non-existent in Union County. The project's own minimal efforts in the areas of prevention and outreach have been mostly educational speeches with community groups, schools, colleges and local agencies on identification, etiology of child abuse, and increased knowledge of the project's purposes. The Elizabeth public school system operates an exciting preventive program providing day care and education to children of high school students, preventing high school dropouts and also modeling health parenting skills to teenage mothers. Currently, there are no plans by any other community agency to develop outreach and preventive activities. As resources have become more scarce in New Jersey, agencies are struggling just to maintain current program levels and the community seems to have little capacity for developing preventive programs.

Caseload Size and Case Outcomes

It is difficult to determine from available data the actual increase in reported incidence of child abuse and neglect cases in Union County. Unfortunately, the data collected for the years 1973, 1974 and 1975 are not comparable. For example, 1973 and 1974 data represent numbers of children reported and 1975 data represent number of families reported. The following table, however, indicates that there is definitely some increase in reporting, although probably not the exact increase shown.

Table 1

Numbers of Referrals to Protective Service Agency, 1973-1976

	1973	1974	1975	1976
Total number of referrals*	380	372	547	na

*The referrals include abuse, neglect, and other miscellaneous problems.

Data available to state-wide evaluators indicate that Union County has had the most significant increase in reports and referrals of any county in New Jersey. These increases may be a reflection of the intense educational and coordinative efforts by the project with the schools, hospitals, police, prosecutors, and community agencies regarding the etiology of abuse and neglect, reporting procedures, and information about the project's purposes and services.

Legislation

The Dodd Law on child abuse was passed in 1974 and implemented January 1, 1975, and established DYFS as the mandated agency to receive all reports. Under the earlier law, the prosecutor's office had played part of this role. The law has not changed since the inception of the project. A legislative committee of the project's advisory board was appointed to review the Dodd Law and to draft recommendations for amending the law. This amendment is still pending. Many sections of the law were vague and confusing, the definitions of abuse and neglect were subject to wide interpretations, and reporting requirements and responsibilities were unclear.

One bottleneck in the legislative area has been a recent change in policy by a local hospital, which, responding to its legal advisor's recommendations, refused to examine or treat any child without parental consent or court order. This action was motivated by a growing concern about potential lawsuits. The project legal analyst has negotiated arrangements for special phone court orders to be made available to the hospital in those situations where parents refuse permission for examination and treatment of their children. The hospital has agreed to perform exams on children that are placed in the shelter, but otherwise the hospital has not relented on its legally protectivist stand. This incident has strengthened the committee's motivation to make the law's intention more explicit.

The committee drafted a tentative revision to the law and sent it to the Citizen's Committee for Children of New Jersey, the original task force that advocated more services to children. The project legal analyst is a member of its Public Policy Committee, which reviews legislation regarding children. A bill was also drafted to amend language in the Dodd Law to give hospitals the right to examine and treat children without parental consent.

In the meantime, the county prosecutor, with the endorsement of the legislative committee, drafted his own bill to the state legislature, requiring all doctors to report to the prosecutor's office directly. When the bill did not pass, a new policy was implemented that required all DYFS workers to report all cases of abuse to the local prosecutor's office.

Community Resources

Increases in manpower resources assigned to work with abuse and neglect clients in the last three years have been the addition of the 19 project staff members and a lay therapist, and a specially trained juvenile police officer to work closely on an informal basis with project response workers doing investigations in Elizabeth. Because of the project, average abuse and neglect caseloads have been reduced from 25-30 cases to 15-20 cases, creating the potential for clients to receive more individualized attention.

The other major increase in manpower resources allocated to work with abuse and neglect clients has been among the private agencies contracted by the project. Through their participation with the project, the equivalent of four MSW social workers, eight lay therapists, one public health nurse, six teaching homemakers, and day care slots have been added (197 at one point; currently 10 PRS slots).

More difficult to estimate are the increased staff contributions from other agencies in the community who are seeing the abuse/neglect clients whenever requested through informal agreements with the project.

The hospitals, schools and courts have not significantly changed the number of staff assigned to work with abuse and neglect clients during the last three years. These agencies depend on the protective service project to provide treatment and case management services for most abuse and neglect clients.

In addition to these manpower changes, many new services for abuse and neglect clients have become available in Union County since funding of the demonstration project. Most of these have been added by protective services, but other community agencies are also now providing additional services, as indicated in Table 2.

Table 2

Comparison of Services to Abuse/Neglect Clients, Before and After Initiation of Union County Demonstration Project in 1974

Services	Protective Services	Court	Police	Hospital	Schools	Other Agencies
Investigation	x, +	+	x, +	x, +		
Outreach						
Diagnostic team case review	x					
Social work counseling	x, +			x, +	x, +	x
Parent aide/lay therapist	x					x
Group counseling	x					x
Parents Anonymous						
Individual/couples counseling	x					x
24-hour reporting	x, +					
Crisis intervention	x					x
Child management classes	x					x
Provide referrals to others	x, +			x, +	x, +	
Homemaking						x
Outpatient care				x, +		
Medical care				x, +		
Public health nurse	x					x
Residential care	x, +					
Day care (Title XX, purchased)	x, +					x
Therapeutic day care	x					
Crisis nursery						
Removal of child	x, +	x, +	x, +			
Foster care	x, +					
Advocacy/ancillary service	x, +					
Follow-up						
Protective service	x					
Transportation	x					x

CODE: + = services provided before project

x = services provided since project

Community System Coordination

Coordination of social services, as in many communities, has always been a major problem in Union County. In order to implement the intent of the Dodd Law, the DYFS project was faced with improving coordination and referrals to the project as well as developing a network of services for clients supervised by the project.

The target agencies most associated with referrals to the project were courts, schools, police, prosecutor's office, and hospitals. The legal analyst and project director developed formalized agreements and procedures for referral and mutual handling of cases with the prosecutor's office, courts and police. Informal agreements have been made with several individual schools and hospitals throughout the county. Although there have been problems between the project and these agencies in the past, e.g., the hospitals had been dissatisfied with the delays by project staff in investigation of referrals, and there are differences in philosophy between the prosecutor and the project staff, most agree that many of these conflicts have been resolved by the recent effort to have more frequent communication among all concerned parties. All agencies enthusiastically report that the project has made much progress in improving community relations.

In the past, the Union County Protective Services Unit of DYFS lacked a network of agencies to which they could refer their clients with any guarantee that services would be delivered. Now, after three years of project operation, there has been a substantial increase in the number and kind of services available to the project as described above.

Coordination between private agencies and the project was developed partially by contracting with private agencies to deliver both the counseling and concrete services to the project's clients. Homemakers, visiting health nurses, day care, family service agencies, Red Cross transportation and Kean College parent line were among the agencies the project contracted with. To facilitate coordination, a legal analyst, administrative assistant and the liaison unit were assigned within the project to oversee the daily workin relationships with all contract agencies. Through the creative use of private social services in the community, the project has minimized duplications of services in the community and has made it possible for local, traditional agencies to become involved in delivering meaningful services to multi-problem families.

Another area in which the project enhanced coordination with private agencies was through their advisory board, made up of representatives from all the major social agencies in the community. The advisory board has been the forum for airing many of the problems associated with tying together public and private agencies, e.g., agencies' accountability, budget issues, disagreements regarding territory and responsibility, referral procedures, and selection of appropriate clients for services.

Education and Public Awareness

Over five years ago, the Citizens' Committee for Children of New Jersey began a campaign to increase the community's knowledge and awareness of child abuse and to expose the gross deficiencies in community services available for children. Due to the impetus created by their campaign and continued vigilance in educating the community, the project received community support to develop a new model for protective services which could make available more intense advocacy and treatment services to families and children in trouble.

Since the project's beginning three years ago, the staff, along with the Citizen's Committee, continued the commitment to increase the community awareness and included educational efforts as part of the project's responsibilities. The project spent a great deal of time in the first year speaking with schools, courts, police, community groups, college classes, hospitals, day care organizations, mental health agencies, and other professional groups, trying to increase the knowledge of the participants in the areas of stress factors leading to abuse and neglect, the detection and reporting procedures outlined in the law, and the project's efforts to provide treatment alternatives to prosecution or removal of children from homes. In the project's educational focus they have concentrated on increasing the community's trust in protective services as a therapeutic intervention with families.

In keeping with their commitment, the project staff has conducted or participated in over 15 TV appearances, five radio spots, three press conferences, one open house, one county-wide conference run by the project, and over 150 separate educational presentations. Of these educational presentations, about 50% were concerned with improving the knowledge of the etiology of abuse, about 20% focused on increasing reporting knowledge, and about 30% emphasized the project's purpose and operation. Most of these educational efforts took place during the first and third years. During the second year the project concentrated on improving inter-agency coordination and education. However, the project director, legal analyst, planner-trainer, and community liaison continued to speak with community groups, police, schools, day care providers, and college classes.

During the second year, the project increased the amount and diversity of in-service staff training, and used these opportunities to invite protective service workers from other offices and welfare workers in the county to participate with them.

During the third year, a greater variety of project staff, at various levels, became involved in public education and speaking engagements. This increased the total number of community education requests that could be filled and also offered a welcome respite from case management responsibilities.

The police department has also participated in some of the workshops offered by the project, and has invited the project's legal analyst to attend their meetings and talk with the officers regarding the problems of abuse, reporting procedures, and coordination efforts. Two of the officers in the juvenile division have attended a special workshop on abuse and neglect, and are considered to be the department's "experts" on child abuse. The police in turn give talks to the community, primarily the elementary grades of school and civic groups, in which they incorporate information about abuse and neglect.

The hospitals have intensified their efforts to educate the doctors and nurses regarding child abuse, detection and reporting. Recently the community hospital in Elizabeth set up a new educational department which will be responsible for educating the staff and community groups. Muhlenberg Hospital, a teaching facility, is also increasing the level and depth of education to residents and staff doctors regarding abuse and neglect and the proper procedures for handling cases seen in the hospital.

APPENDIX D

Possible Impacts of Community Education

There are several ways by which the effectiveness of the projects' educational efforts might be assessed. The first, a systematic evaluation of changes in knowledge and attitudes among those receiving the education regarding child abuse and neglect, was beyond the scope of this evaluation, except for a cursory examination of key agency representatives' perception of increased knowledge and awareness among their staffs, which will be described subsequently. A second and perhaps less defensible indicator is changes in the practices, particularly the reporting practices, of those educated. Changes in state reporting laws, national and local public awareness campaigns and a myriad of other factors not associated with the projects may well affect changes in reporting rates. However, because it is likely that education, per se, has some direct or indirect affect on reporting, we have sought to determine if such relationships exist in the demonstration communities.

Table D.1 illustrates the overall change in the communities' reporting rates between 1973 (pre-demonstration) and 1976, after the projects had been operating for several years. For many years the prevailing viewpoint has been that actual cases of child abuse and neglect are under-reported for a variety of reasons; the demonstration projects responded to this belief by consistently encouraging expanded reporting, with interesting subsequent changes in reporting. There has been a large, in many cases substantial, increase in the number of reports to protective services in every community where comparable data was available except Neah Bay, Tacoma and St. Petersburg. The very small and stable number of reports from Neah Bay is thought typical by residents of the reservation; although they acknowledge that certain forms of behavior which might be labeled child neglect are chronic problems and are rarely reported as such. The small proportional increase in reports in St. Petersburg is partially explained by the tremendous increase in statewide reporting which occurred in 1972 after implementation of a new state law and expanded media coverage when reports increased dramatically. Thus, reporting was already extremely high prior to the demonstration project's implementation. The reduction

in reporting in Tacoma is thought by local professionals to be due to increased knowledge, which has resulted in fewer inappropriate reports.

Table D.1

Changes in Volume of Reports and Rates of Report Substantiation by Community, 1973-1976

Project	Number Reports to CPS			Percent of Reports Substantiated		
	1973	1976	Percent Increase	1973	1976	Percent Difference
Adams County	206	554	169%	83%	82%	— 1%
Arlington	270	377	40	70	84	+14
Baton Rouge	378[a]	538	42	NA	NA	--
Bayamon	83	105	27	44	56	+12
Arkansas	112	279	149	NA	NA	--
Neah Bay	2	2	--	NA	NA	--
St. Louis	623	2012	223	58	65	+ 7
St. Petersburg	1871	1978	6	55	55	— 1
Tacoma	1977[b]	1355	—34	78	77	— 1
Union County	380[c]	547[c]	43	NA	NA	--

[a]Data from CPS, demonstration project, hospital and Sheriff's Department combined for 1974.

[b]Data for 1974.

[c]These data are not strictly comparable as the 1973 figures represent children reported, while the 1976 figure represents families. The proportional increase is, therefore, an under-representation of unknown size.

The increased reporting from the remaining projects ranged from 27% in Bayamon to over 220% in St. Louis. Again, there is some relationship between the amount of education provided by the demonstration projects and the increases in reporting rates, as Table D.2 illustrates.

Table D.2

Comparison of Project Educational Efforts and Changes in Reporting Rates

Project Educational Efforts	Range of Increased Reporting Rates (1973-1976)
Communities with high effort:	
Tacoma	–34%
St. Petersburg	+ 6
Adams County	+169
Communities with moderate effort:	
Union County	+43%
Arkansas	+149
St. Louis	+223
Communities with low effort:	
Neah Bay	0%
Bayamon	+27
Arlington	+40
Baton Rouge	+42

As mentioned earlier, many other factors besides the amount of education provided by demonstration projects in their communities which relate to increases in reporting, notably changes in state laws, national media coverage of the problem, previously high or low reporting rates, and education carried out by other community groups or individuals. It does appear, however, that in some communities where

projects provided more education, the proportional increases in reporting rates were high.

A change in the proportion of reports which are substantiated upon investigation is another indicator of the success of the projects' educational efforts as the efficient functioning of the community child abuse and neglect network depends, in part, on not being overloaded with inappropriate cases (e.g., financial, legal, marital problems without accompanying child maltreatment). Although data on rates of substantiation are not available for each community, the changes in six communities for which data are available (see Table D.1) show no relationship to the amount of education received, or the change in reporting rates in those communities (which might indicate that too much emphasis had been placed on simply reporting cases without accompanying explanations of the appropriate type of referrals). Other community factors such as size or the agency in which the demonstration project was located also are not associated with achieved change in substantiation rates. A content analysis of the education and training presented or of other community factors might elucidate some factors responsible for the differences in substantiation rate changes, but currently no data exist to carry this out.

In addition to overall changes in reporting rates, another indicator of successful project-sponsored education would be changes in reporting rates among those groups or individuals toward whom most of the education was focused. The following table (Table D.3) depicts changes in the proportion of reports received from select agencies, professionals, and individuals within each community. Although it is clear that there is extreme variation in the source of report changes for each community for which comparative data are available, an examination of the data does point out several trends. First, the most consistent increase in reports across communities was from school personnel; ranging from close to 20% to over 800%, which reflect the projects' focus on this group. At least 10% and as much as 19% of each communities' reports came from the schools in 1976. There is a corresponding general decrease in reports from the Courts, by as much as 350%, in all communities except Tacoma. This decrease is most likely a reflection

Table D.3: Changes in Reporting Sources by Community, 1973-1976

Proportion of all reports received from:	Adams County			Arlington			Baton Rouge			Bayamon			Arkansas			Tacoma		
	1973	1976[b]	% diff.	1973	1976	% diff.	1973	1976	% diff.	1973	1976	% diff.	1973	1976	% diff.	1973[d]	1976	% diff.
Protective Services (CPS)	2%	12%	+10%	29%	19%	-10%	9%	13%	+4%	10%	12%	+2%	-%	3%	+3%	10%	6%	-4%
Physicians	2	-[c]	-[c]	1	3	+2	3	1	-2	-	-	-	7	12	+5	2	1	-1
Hospitals	21	7	-14	9	5	-4	7	9	+2	2	9	+7	2	5	+3	2	11	+9
Law Enforcement	14	6	-8	7	6	-1	4	9	+5	2	1	-1	7	3	-4	5	5	-
Schools	6	15	+9	2	19	+17	9	12	+3	18	17	-1	11	10	-1	12	14	+2
Court	2	-	-2	11	5	-6	3	-	-1	7	4	-3	9	2	-7	1	2	+1
Other Community Agency	18	24	+6	9	7	-2	2	-	-2	9	10	+1	13	13	-	6	4	-2
Family Member	15	-[c]	-[c]	19	32	+13	36	28	-12	32	31	-1	16	16	-	15	15	-
Acquaintance	14	32[c]	-1[c]				16	15	-1	13	14	+1	34	24	-10	32	17	-15
Self-Referral	2	4	+2	13	4	-9	3	1	-2	5	2	-3	-	3	+3	-	-	-
Other	2	-[c]	-[c]	1	-	-1	10	9	-1	2	-	-2	2	8	+6	13	25	+12
	100% N=206	100% N=404		100% N=279	100% N=377		100% N=315	100% N=396		100% N=83	100% N=105		100% N=112	100% N=279		100% N=1197	100% N=1299	

[a]Unless otherwise noted, data refers to CPS referrals, or a combination of CPS and other agencies' referrals.

[b]Estimates based on 1975 data from the demonstration project and extrapolated data from CPS.

[c]Referrals from physician, relatives, acquaintances and anonymous collapsed into one figure. Percent difference relates to these collapsed figures.

[d]Data for 1974.

of national trends toward therapeutic intervention, changes in state laws directing the report receipt function to CPS rather than the Courts, and the educational efforts of the projects. It was surprising to note that, despite the current interest in improving the reporting of medical personnel (physicians and hospitals), the data indicate very mixed success, with almost as many communities reporting a decrease in the proportion of referrals from these two sources as those reporting an increase. An impressive 12% of the community referrals in Arkansas were from physicians in 1976, but in the remainder of the communities this proportion was still only 1-3%. Referrals from law enforcement and other community agencies, two other target groups of the projects' education efforts, also show mixed changes in reporting, with some communities showing increases of 100% or more in referrals from these sources and others showing equally high proportions of decreases.

The final area one might have expected to observe an increase in reporting rates as one consequence of the projects' community education efforts would have been self-referrals, since much of the education presented to community groups stressed an elimination of the stigma attached to child abuse and neglect problems and increased knowledge of the therapeutic (rather than punitive) approach being taken by community agencies. Conceivably, this might have encouraged more parents to voluntarily seek out help for their problems; an examination of the data, however, does not bear this out. Among the four communities for which comparable data are available (Adams County, Arlington, Baton Rouge and Arkansas), two witnessed major increases in self-referrals (100% and 300%) but in the other two equally substantial decreases occurred (200% and 225%). The conclusion must be that, in the short-run at least, increased community education does not appear to encourage increased reporting from the people actually experiencing child abuse and neglect problems in their lives.

The final area in which the achievements of the projects due to their educational efforts can be assessed is the perception by community agency representatives that, in general, professionals and community

citizens are currently more knowledgeable about various facets of the child abuse and neglect problem than they were prior to the projects' implementation. Based on interviews with a wide range of community representatives (from agencies such as CPS, the court, law enforcement agencies, hospitals and schools), it appears that all projects have had almost unqualified success in this regard. In each community, interviewees responded that there has been substantially increased education occurring during the three-year demonstration period, and that, by and large, it was the demonstration project that was most responsible for this visible effort. Those interviewed also perceived that both community professionals and citizens were, in fact, much more knowledgeable about the states' reporting laws, and the agency(ies) to whom reports should be made. In many cases, agency representatives viewed one of the demonstration projects' roles as that of community education and training, and maintained that the projects were, and should be, the focal point of all system education and training.