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National Center on Child Abuse and Neglect. Evaluation of Twelve Demonstration Centers. Volume I

E. H. White and Co., San Francisco, CA

Prepared for
Office of Child Development, Washington, DC

1 Nov 76

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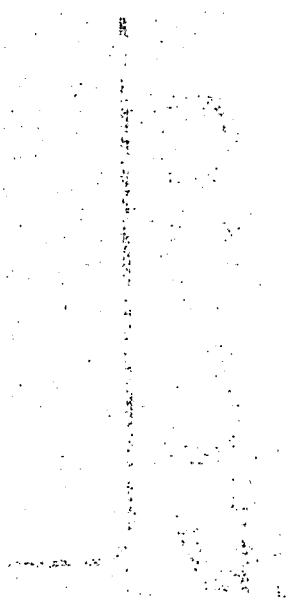

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VOLUME I

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DRAFT ANNUAL REPORT

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

EVALUATION OF TWELVE DEMONSTRATION CENTERS

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EVALUATION OF NCCAN DEMONSTRATION CENTERS: ANNUAL REPORT

TABLE OF CONTENTS: VOLUME I

TABLE OF CONTENTS: VOLUME I (continued)

LIST OF FIGURES: VOLUME I

LIST OF TABLES: VOLUME I

LET US SPEAK LESS OF THE DUTIES OF
CHILDREN AND MORE OF THEIR RIGHTS -
JEAN JACKQUES ROUSSEAU

SPARE THE ROD AND SPOIL THE CHILD -
BIBLIOTHECA SCHOLASTICA

A. EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This report presents the findings of Phase II of the process evaluation of the twelve Demonstration Centers that were funded in January, 1975, by grants from the National Center on Child Abuse and Neglect (NCCAN). Operations of these centers for the year ending June 30, 1976, are summarized and some discussion is provided of the histories of the twelve projects during the start-up phase and prior to the grant award. Detailed treatment of individual centers is contained in the second volume of this report.

The information assembled in this report comes from two major sources: on-site interviews conducted by the field staff of E.H.White & Company, Inc., with demonstration center and other local agency personnel; and from statistical data on staffing, clients, costs, and service deliveries, provided directly by demonstration project Directors or their staff through the Management Information System (MIS) forms designed during Phase I of this evaluation.

In general, the results of the process evaluation to date are encouraging, in that all twelve of the Centers have achieved operational status, and are carrying out their primary mission of delivering comprehensive services to families involved in child abuse and/or neglect. Although two or three projects experienced substantial rates of staff turnover, administrative problems were no greater than anticipated in programs of this

sort, dealing as they do with innovative approaches to problems which our society has traditionally denied, ignored, or referred to law-enforcement agencies.

One unfortunate feature of the data is that the MIS forms and categories were revised in January, 1976, so that in many cases it is not possible to aggregate or compare data from the last two quarters of 1975 with the first two quarters of 1976. In some cases only the two quarters involving the same MIS forms are reported below. In others four quarters are reported, since no changes were made, or the changes were sufficiently small that slightly different data categories can reasonably be combined.

CLIENTS SERVED

On June 30, 1976, 1247 families were receiving comprehensive services according to a treatment plan developed by Demonstration Center staffs. These included 1,575 adults and 2,621 children as recipients of planned services. During the first six months of 1976, an additional 710 families left planned service delivery status: of these,91 had unplanned terminations, 213 entered follow-up, and 406 had planned terminations of treatment services. Although direct comparison with 1975 data is not possible, at least 160 families completed planned services during the first two quarters of the MIS's operation (when several centers were not yet operational), so that at least 2,100 families, including more than 4,000 children, received planned services from the program during FY-76.

In addition to these planned services, emergency services (services provided prior to development of a treatment plan) were received by 551 families during the two 1976 quarters, and 443 cases were referred to other agencies. (Here "referral" means that arrangements were made for another agency to take on the responsibility of case management; specific services provided to families in a Center's caseload are regarded as "coordinated" services received through the Demonstration Center program, whether the cost of such services is borne by the NCCAN grant, by other Center funds, or by other sources. Cases receiving "referral" in the terminology of this report have left the caseload of the Demonstration program, although they may subsequently be subject to the attention of the NCCAN Summative Evaluation.)

Between January 1 and June 30, 2,526 cases of abuse and/or neglect, or of families at high risk thereof, came to the attention of the twelve Centers. The 443 referrals thus represented about 17.5% of the families contacting the Centers. Since half of the Centers reported fewer than eight referrals per quarter, it appears that "creaming" (rejection of difficult cases) could not have been a widespread practice among the intake facilities of the program.

Among families receiving planned services (the caseload, for purposes of calculating unit costs and similar basic indicators) the largest group (40%) involved confirmed or suspected abuse, 23% neglect, 11% abuse and neglect, and 26% high risk of abuse or neglect. Thus, the program emphasizes child abuse

treatment and prevention, rather than child neglect. Estimates of the national prevalence of both phenomena usually regard neglect as the more common, although abusive parents may be more likely to be reported to service agencies, owing to the nature of their problem. Since the MIS requests "type of case" information only at six-month intervals, the proportions listed above are for the quarter ending June 30, 1976; the corresponding 1975 data omits the "high risk" category, and predates the full staffing of some of the Centers. The next annual report, which will be based upon FY-77 MIS reports, will include information on sexual abuse cases as a separate category. Since some Centers operate special components dealing with such cases, which tend to involve older (beyond age five) female children, the addition of this category is expected to provide additional detail on an aspect of child-abuse which includes problems and activities somewhat different from the classic "battered child" syndrome.

TYPES OF CENTERS

There is no end to the classificatory systems which could be applied to the twelve Centers (although they could at most produce only twelve categories). For purposes of the process evaluation, however, the Office of Child Development has been interested in two aspects of their organization: administrative-base and delivery mode. Two types of the first classifier are distinguished: hospital based, and social service agency based. Although NCCAN had at one time intended to award half the demonstration grants to hospitals and half to social service agencies, in the end only four Centers were located in medical facilities: Honolulu, Newark, Philadelphia, and Washington, D.C.

The remaining eight Demonstration Centers are regarded here as social service-based, despite the heterogeneity of grantees that is apparent upon reading the descriptions of individual projects in Volume II of this report: Grantees include a number of State agencies, a consortium of county governments, a YMCA, and other sponsors different from the protective service agencies probably envisioned as "typical" social service agencies by Office of Child Development planners at the inception of the Demonstration Centers program.

The second typology focusses on the mode of delivery of services: were services provided directly by Demonstration Center staff (or by professionals or volunteers under the direct supervision of Center staff), or were services provided by other agencies, under purchase agreements or other coordinating arrangements? This distinction was meant to dichotomize centers into <u>direct</u> service projects (which answered "yes" to the first question), and <u>coordinated</u> service projects, which operate primarily by subcontracted services.

As the Centers actually set up their programs, the majority operated in <u>both</u> modes, providing some services directly and purchasing or otherwise securing others for their clients from other sources. This is hardly surprising, since the social service agencies are not usually in a position to have "in-house" medical, legal, or foster-care services, for example, and the majority of grantees used a

portion of their budgets to hire staff to specialize in counseling adults or children involved in abuse or neglect; it is unlikely that many full-time jobs in this area existed prior to the activities of NCCAN. For purposes of the process evaluation, Centers were asked to tabulate separately (during alternate quarters) the service deliveries that were provided directly and those provided through coordinating arrangements. On the basis of other reporting forms from the same projects, costs were assigned to each service category. A value of the percentage of client-service costs (i.e., ignoring indirect costs) provided directly, and its complement, the cost of coordinated services as a percentage, was calculated for each of the twelve Centers. On the basis of data for the quarter ending March 31, 1976, this yielded the following estimates of service delivery modality:

DEMONSTRATION CENTER SITE (NEAREST URBAN CENTER)	% DIRECT CLIENT SERVICES	% COORDINATED CLIENT SERVICES
Albuquerque, New Mexico	100	0
Washington, D.C.	99	1
San Diego, California	98	2
Philadelphia, Pennsylvania	96	4
Hartford, Connecticut	85	15
Oakland, California	78	22
Newark, New Jersey	60	40
New York, New York	54	46
Chicago, Illinois	48	52
Evanston, Illinois	35	65
Belton, Texas	27	73
Honolulu, Hawaii	0	100

These statistics are based upon the actual cost to Centers, and exclude donations of labor and services; that is, they reflect how the projects used their budgets, rather than the total value of services received by their clients. The latter

could similarly serve as a basis for calculating the index of service modality, and the results would certainly show a strong shift in the direction of "coordinated" services. The difficulties involved in accurately appraising (and even of tabulating) donated services, especially the value of medical service donations, which totalled nearly $400,000, led to the somewhat arbitrary definition of service modality on the previous page. The six Centers ranking highest on the percentage of client services directly provided (78% or more) are aggregated as "Direct" service projects in the figures displayed below. The remaining six Centers, which provided 40% or more of their actual cost of services through coordinating agreements, are aggregated as "Coordinated" projects in the same data displays. This classification depends, for its validity, upon the accuracy with which Centers reported their service deliveries, and can be made with greater precision after several quarters' data have been collected.

Comparison with the quarter ending September 30, 1976, shows only moderate stability, with Chicago and Honolulu exhibiting shifts of more than 40 percentage points, and Belton and Hartford changes of more than 25. The Honolulu data is probably in error, but that project nevertheless is primarily coordinated, through several subcontractors. Actual operational changes have occurred in service modality since the earlier quarter, as Centers completed staffing and staff training, so that the indices shown on page six generally reflect the direct vs. coordinated services as currently provided at the twelve Demonstration Centers.

ALLOCATION OF RESOURCES

In collaboration with two other contractors conducting evaluations of NCCAN demonstration projects, the E.H.White & Company NCCAN Evaluation Team defined thirty-nine categories of costs and services within which the twelve Demonstration Centers report costs and service deliveries for the MIS. (In fact the MIS originally used 31 categories until January, 1976, so that some of the information in Volume III of this report covers only the last two quarters of FY-76.) These are not individually treated in this report outside of Volume III, so that their names and definitions are not included in this section of the Annual Report. These categories are primarily intended for the convenience of local project managers, who are provided by the MIS with service utilization detail and cost estimates for individual program components.

Of more general interest are the "functional areas" which the MIS forms by combining logically related service areas. Two different sets of service areas are provided:

(1) On the basis of the type of beneficiary, five areas are distinguished, which form disjunct subsets of the total operating budget of each Center;

(2) On the basis of the nature of the service, seven areas are distinguished which form disjunct subsets of the total cost of services to clients, but excluding the costs of case integration and case management activities, as well as excluding overhead costs and community activities not focussed on clients in the active caseload.

The service areas within the first classification are the following:

(A) Operations. This includes occupancy and overhead costs, administrative costs, research and evaluation costs (including the costs of cooperating with the process evaluation), staff training, and other indirect costs

(B) Community Activities. This includes costs of community awareness activities, coordination with other agencies, activities to influence legislation affecting the field, activities to affect the policies of public and private organizations dealing with child abuse and neglect, activities to upgrade the skills or awareness of professionals, outreach activities to promote contact with potential clients, prevention activities to identify families or pregnant women at risk of abuse or neglect, screening of children in day care or school facilities, and other activities directed at families not yet in the intake stage of the Center caseload.

(C) Casework. Initial contact with actual or suspected cases, investigation and diagnosis, development of treatment plans, reviews of client progress (by one worker or by a team), contacts with clients in follow-up (who have terminated treatment), referral of cases to other agencies to assume case management responsibility.

(D) Services to Families. All specific client services, provided as part of a comprehensive treatment plan or on an emergency basis, for which an adult or the family as a whole is the focus of treatment. These include certain counseling and therapy activities, shelter for abused spouses, crisis intervention, educational activities such as parenting, homemaking, nutrition, or child development classes, transportation of clients, and emergency funds.

(E) Services to Children. All client services for which the child is the primary recipient. Includes testing, counseling, therapy, medical care, day care, babysitting, and foster care.

The five service areas listed above are used to account for all of the expenditures and donations utilized in each Center's program. The second system of classification allocates the direct client service costs (areas D and E above) to seven client service areas, according to the nature of the service:

(F) Medical. All medical and hospital services to adults or children.

(G) Psychological. All psychological, counseling, and therapy (other than physical therapy) services, including Parents Anonymous, whether provided by lay or professional workers.

(H) Legal. All legal and courtroom activities, including preparation of documents and testimony, but excluding efforts to obtain legislative action or to draft laws. (These fall into B above.)

(I) Shelter/Custodial. Day care, baby-sitting, foster care, and emergency shelter services are in this category.

(J) Support. Homemaking, transportation, and emergency funds provided to reduce the stress on client families.

(K) Educational. Parent education classes intended to increase the skills and knowledge of client families.

(L) Crisis Intervention. Activities in reaction to crises in the clients' lives, such as emergency home visits or unscheduled conferences at the Center; also the maintenance of a "hot line" to receive telephone calls from clients and other interested persons.

The seven categories listed for direct client services are intended to reflect the NCCAN goal for the Demonstration Center Program of providing comprehensive services to persons involved in child abuse and neglect; they presumably represent distinct areas of need which, in the absence of the Demonstration Center, would require referral to several agencies, if such services were available at all in the community. By reducing the problem of "fragmentation of services," the Demonstration Center in theory can efficiently meet the complex needs of families involved in abuse and neglect. The resources that the program allocated to these service areas provides an indication of the relative priorities assigned to these service components.

Table 1 below shows the aggregate costs assigned to the service areas during FY-76 for the Demonstration Program as a whole. "Actual Cost" refers to funds obligated from the Center budgets (whether from their federal grant or from other sources). "Total value" adds to this the imputed value of all donations.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 75 THROUGH JUNE 76

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

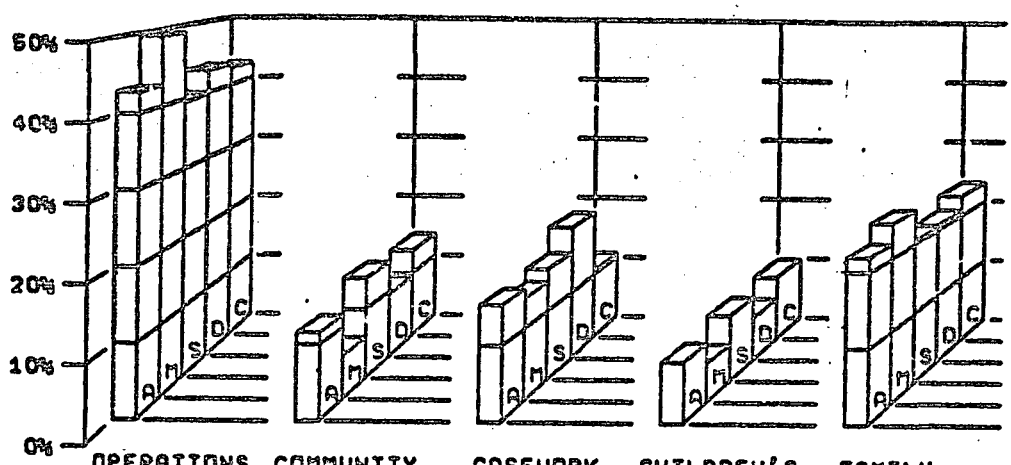
FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$2,830,000	100.0%	$3,583,672	100.0%
PROGRAM OPERATIONS	1,212,919	42.9%	1,299,444	36.3%
COMMUNITY ACTIVITIES	302,477	10.7%	328,596	9.2%
CASEWORK ACTIVITIES	444,133	15.7%	503,466	14.0%
SERVICES TO FAMILIES	624,679	22.1%	737,532	20.6%
SERVICES TO CHILDREN	245,792	8.7%	714,634	19.9%
CLIENT SERVICES:				
MEDICAL	54,411	1.92%	444,466	12.40%
PSYCHOLOGICAL	378,828	13.39%	438,313	12.23%
LEGAL	28,489	1.01%	50,201	1.40%
SHELTER/CUSTODIAL	202,552	7.16%	227,692	6.35%
SUPPORT	174,084	6.15%	188,899	5.27%
EDUCATIONAL	45,990	1.63%	60,858	1.70%
CRISIS INTERVENTION	39,186	1.38%	44,487	1.24%

It can be seen that the total actual cost reported by the twelve centers was $2,830,000. (This does not represent a rounded figure; the forty-eight quarterly MIS reports from which these data are derived listed costs summing to this value. The mathematically inclined reader might wish to verify the evaluator's calculation that the probability of such a result is 10,000 to 1.) According to the first set of service categories, the largest part of this (42.9%) went into indirect costs, although as Figure 2 below shows, this overhead declined during the year from values near 50% to values below 40%, as Centers became operational. About 10% of costs went to Community activities, 16% to Casework, 22% to Family services, and almost 9% to Children's services.

An additional $750,000 in donated space, materials, and services were reported by the Centers, most of which was in the area of services to children ($460,000 --these are rounded figures). Donations raised the proportion of total value devoted to Children's services to almost 20%, while the other areas declined somewhat in their relative allocations.

Among client services, about half of the actual cost was devoted to Psychological services ($378,828), with Shelter/Custodial ($202,552) and Support ($174,084) the only other areas accounting for 2% or more of the actual cost. The same rank of service areas held for allocations of total value, except that Medical donations of $390,055 raised that area to the largest value among client services, accounting for more than an eighth of the total value of program operations.

FIGURE 1- % ACTUAL COST PER SERVICE AREA BY CENTER TYPE, FY-76



KEY

A- MEAN FOR ALL CENTERS
M- HOSPITAL BASED CENTERS
S- SOCIAL SERVICE BASED
D- MORE THAN 50% CLIENT SERVICES DIRECTLY PROVIDED BY CENTER STAFF
C- MORE THAN 50% ACTUAL COST COORDINATED

FIGURE 1A- $ TOTAL VALUE PER SERVICE AREA BY CENTER TYPE, FY-76

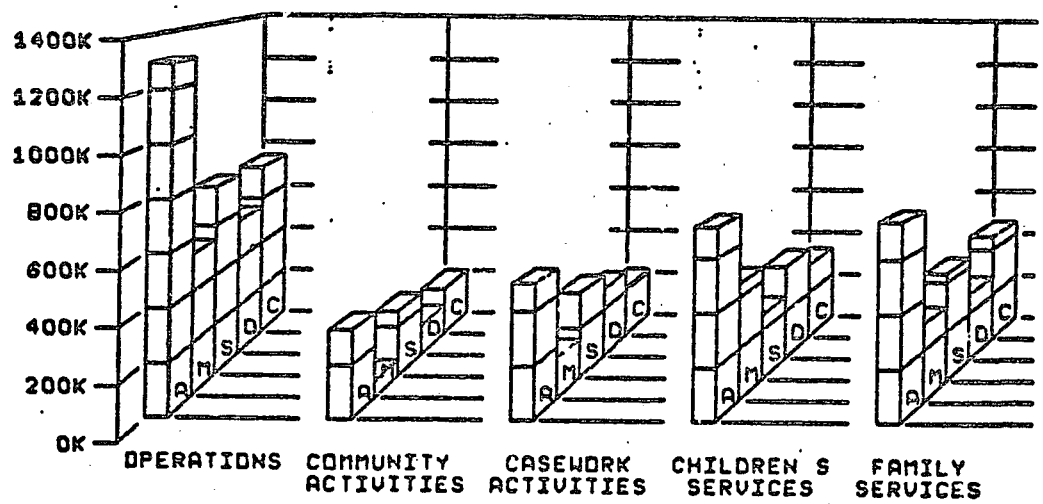


Figure 1 above shows graphically how the actual cost was allocated among the five initial functional areas for each of the four types of Centers (which for brevity shall be referred to as Direct, Coordinated, Social, and Medical; as noted in the earlier discussion, of course, most Centers function in all four ways, but these names characterize specific groups of Centers). Since service modality was defined on page 6 in such a way that two Medical and four Social-based projects are in each service modality classification, the two typologies are "orthogonal" in the experimental-design sense: there is no a priori correlation between service modality and administrative base, as would have been true if a less symmetrical dichotomy had existed (such as three Medical Centers in Direct, or if unequal Direct and Coordinated projects received grants). Since Figure 1 expresses costs as percentages of the total budget for each type of Center, the fact that there were twice as many Social projects does not affect the comparison. The estimates of costs are perhaps more reliable for the Social projects, however, since they are based on a larger "sample" of Centers, though hardly a random sample.

According to the Figure 1 data for FY-76, there is virtually no difference between Direct and Coordinated Centers in the rate of indirect costs (Operations), but Medical projects show substantially higher overhead (roughly 50%) than Social projects (about 40%), measured in terms of actual cost. Since this scale is "ipsative," meaning that a fixed total (100% of costs) must

be divided among the five functional areas, it follows that the Social projects must show higher rates than Medical in at least one other area. This they do, in both Community activities (14% versus 6%) and Children's services (10% versus 5%). To repeat, these figures represent actual cost, and the situation is somewhat different for total value. Coordinated projects surpassed Direct in the same areas by smaller margins, and also in Family services, where Medical projects (25%) had larger allocations than Social (20%). The largest difference between service modalities was in Casework, where Direct-service Centers unsurprisingly incurred almost twice the cost of Coordinated projects (20% versus 11%).

While these allocations reflect distinct differences in patterns of expenditure (and presumably, of program priorities), even the largest of them is not very great, and the five areas ranked in the same order across all four Center types, with one exception. (This was that Coordinated projects spent more on Community activities than on Casework, and even this may be an artifact of the first quarter, when an unanticipated reduction in the effective size of the Demonstration grants required the Coordinated Centers to renegotiate most of their subcontracts. As noted above on page 9, paragraph B, the cost of time spent arranging service agreements is assigned to the Community activities area.) One source of potential error in these data is that projects may inadvertently fail to report expenditures, so that the actual costs are underestimated. A comparison of the costs shown for individual Centers in Volume II, Table 1,

with the size of the Demonstration grant awarded to each Center would identify sites at which such underreporting may be a problem. Since Centers may have unexpended FY-76 monies, however, and since the "actual cost" data of Figure 1 includes all federal, state, local, and private funds obligated by the Centers (i.e., not merely the Demonstration grants), the task of validating actual costs reported is not an easy one.

Figure 1A, in a similar format, but showing dollars, rather than percentages, displays the total value of costs and donations allocated by each type of Center to the same five functional areas. The symbol "K" along the ordinate means "$1,000." Since total dollars, rather than averages or percentages are shown, the fact that there are half as many Social as Medical projects must be taken into account when comparing administrative bases. Unless the histogram of Social is twice as high, the Medical Centers are showing a higher proportional rate of expenditure. Because there are six of both types, the service modality data are directly comparable, however.

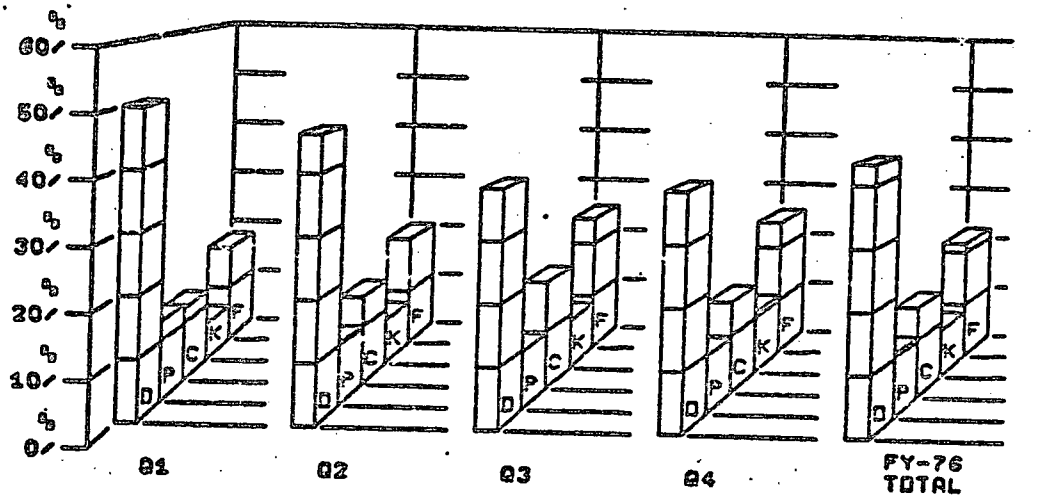
According to the Figure 1A data for FY-76, Coordinating projects showed a higher value of indirect costs ($760,000 versus $540,000) than Direct did, and a higher grand total by about $300,000 for the sum of all areas. This yields a difference in overhead rates, with Direct (35%) lower than Coordinating (38%). Coordinating Centers also reported more Family services, $460,000, versus $270,000 for Direct. Hospital-based Centers reported proportionally higher values in the same two areas, but obtained

such large donations (primarily of medical services) in the area of Children's services that most of the value (64%) in this area was reported by the four Medical projects. So large were these donations, in fact, that the overhead (Operations) for Medical Centers represented only 33% of their total value, versus about 38% for Social Centers.

The results shown in Figures 1 and 1A, paradoxically, would appear to support arguments that <u>both</u> types of administrative base Centers surpassed the other type in controlling indirect costs, depending upon whether actual cost (Figure 1) or total value (Figure 1A) were the basis of comparison. The reader's possible temptation to dismiss as fanciful the large donations of services to the Hospital-based programs ought to be examined carefully: these reflect the value of services provided to the client, and may <u>not</u> have been available in the absence of the atmosphere of professional awareness that a Demonstration Center would be expected to create or contribute to in its catchment area. Severe cases come to the attention of Hospitals, and the cost of medical care is relatively high. A related issue is discussed in the section below dealing with unit costs.

Results are more straightforward for the comparison of service-delivery modality: only small differences, again in both directions, are observed using actual cost or total value to estimate the rates of indirect costs for Direct and for Coordinated Centers, with differences within each type larger than the difference between the two.

FIGURE 2- ACTUAL COST PER SERVICE AREA BY QUARTER, FY-76



KEY
D- OPERATIONS
P- COMMUNITY ACTIVITIES
C- CASEWORK ACTIVITIES
K- SERVICES TO CHILDREN
F- FAMILY SERVICES

FIGURE 2A- TOTAL VALUE PER SERVICE AREA BY QUARTER, FY-76

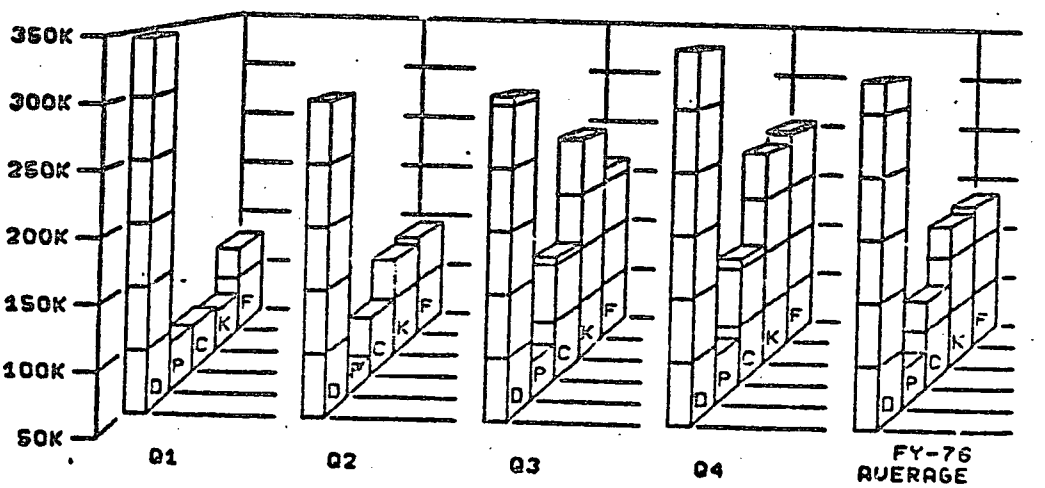


Figure 2 displays graphically the allocation of actual costs among the five initial service areas for the aggregate of all twelve Centers during the four quarters of FY-76 and for the year as a whole. As in Figure 1, the percentage, rather than the dollar cost, provides the units.

As Figure 2 indicates, the rate of indirect costs declined during the first three quarters, with the cost of Operations in the fourth quarter (38.5%) virtually the same as in the third (38.3%). This general decline in the aggregate data overhead conceals rather complex fluctuations at the individual Centers: only at two, Evanston and Oakland, did the proportional cost of Operations decline throughout FY-76, and in two others (Newark and New York) they increased during each quarter, an unanticipated result.

The percentage of actual cost allocated to Community activities declined somewhat from 13% to 10% over the year, while the direct client service areas increased: from 7% to 11% for Children, and from 17% to 25% for Families. Casework generally increased from 12% in the first quarter to 16% in the last, with a peak in the third of 18.6%. Thus the data show a trend towards reduced overhead and increased allocation to client services of their proportionate actual costs. The similarity of third and fourth quarter data suggests that the pattern of expenditures may have stabilized.

Figure 2A on the same page shows similar data based upon the allocation of total value among the same areas in the same

time series, but with total dollars, rather than percentages, as the metric. Since the grand total value increased every quarter, these dollar values do not represent the same percentages from quarter to quarter; for example, although the total value of Operations increased between the second and third quarters, the proportion of total value devoted to operations declined over the same period, because of larger increases (associated with donations) in the other four functional areas. Figure 2A shows the absolute dollar values for each area by quarter, rather than the relative allocation.

Results in Figure 2A show that Operations and Community activity values are greatest in the first and last quarters, while the other three areas showed increases after each quarter (although Children's services peaked in the third). The total value of services increased every quarter; this result probably reflects both improved reporting practice, a last-quarter effort to avoid the loss of carry-over funds, and increasing success in utilizing other agencies to obtain services for clients. As in Figure 2, the fourth quarter data more closely resemble the third quarter than either of the 1975 reporting periods, suggesting that the program allocations of total value are stabilizing, and that the MIS aggregate fiscal information is fairly reliable. The FY-76 averages are reasonable indicators of program priorities for the Operations and Community activities areas, but not for the Casework and Client service areas, which have substantially increased their allocations of total value since January, 1976, corresponding to the completion of start-up activities at most Centers.

UNIT COSTS BY FAMILY AND BY CHILD

A traditional index of efficiency of any service program, and a planning aid to others wishing to provide similar services, is the cost per recipient. The MIS of the Demonstration Centers produces four such indicators, showing the actual cost and the total value of the program per family and per child. In each case, the aggregate of all service areas (rather than client services only or some other subset of expenditures) is divided by the number of families or of children receiving planned services. Thus, the recipients of emergency services who do not enter the planned service caseload, or clients still in intake at the close of the reporting period are not considered in calculating the unit costs. The rationale for this definition is that the goal of the program is to provide comprehensive planned services, but the effect is to somewhat understate the number of persons benefitting to some degree from the Demonstration Program. No purpose would be served, however, if the estimated unit costs were lower than the real costs that should be anticipated by agencies hoping to establish a similar project having a given caseload capacity. Indirect costs are included in the unit costs because it is difficult to imagine a situation in which services could be provided to clients without incurring such indirect costs.

Each quarter the MIS estimates the unit costs for each Center and for the pooled expenditures of all twelve, using the

number of families or children receiving planned services during the quarter as the divisor of expenditures reported for the quarter. An "annualized" value is obtained by multiplying this quarterly estimate by four. This can be interpreted as the projected cost over a year of providing services to the number of clients reported for that quarter. Figure 3 below and (for individual Centers) in Volume II of this report displays these quarterly estimates for the four quarters of FY-76, and shows an "average" that is the simple mean of the four quarterly estimates of each unit cost index.

Table 2 and Table 2A below show unit costs for the last two quarters of FY-76. The reader will note that these values are different from those of Figure 3, and the explanation for this seeming discrepancy follows:

Table 2 and 2A are calculated by dividing actual costs or total value by the number of recipients receiving planned services during the six months from January 1, 1976, through June 30. (The number of children is not obtained directly, but is estimated from the ratio of children to families reported at each Center in Figure 4 below; families are obtained directly.) Since some (in fact most) clients received planned services in both quarters, the number of recipients over the six months is less than the sum for both quarters (which counts many clients twice). For this reason, the unit costs shown in Tables 2 and 2A run higher than those shown in the Figure 3 Quarterly estimates. No error of arithmetic is involved; the two displays simply define "unit costs" in analogous, but different ways.

One consequence of this method of calculation is that Centers which retain clients in planned services over a long period of time are assigned higher unit costs than Centers reporting the same expenditures and having the same caseload capacity which "turn over" their cases more rapidly: Cases that are terminated, whether by the agreement of the Center staff or in an unplanned fashion by the client, permit new cases to be added as service recipients, and reduce the unit costs reported by a Center. Thus, the unit cost data reflect case flow, as well as "efficiency" in the usual sense. This complicates the interpretation of these data, but the reader is reminded that any statistic which attempts to summarize program operations in a single number will have its limitations.

Another obvious limitation of the unit cost indices is that they do not take into account the quality or intensity of treatment services: a large unit cost could show that the client was provided with an abundance of services, or that the Center had a large overhead rate. It will be the task of the Summative Evaluator, recently designated, to determine whether differences reported in the units costs reflect differences in the effectiveness of project services.

For the purposes of this report, Table 2 is based upon the last two quarters of FY-76 because comparable MIS forms are available for that period, and because the substantial start-up costs incurred by most Centers do not inflate the data for these two quarters. During this period, 1789 families, and an estimated 3728 children, received planned

TABLE 2: UNIT COSTS FROM JANUARY 1, 1976, THROUGH JUNE 30, 1976.

	AVERAGE	LOW	MEDIAN	HIGH
ACTUAL COST PER CHILD	$ 413	$ 225	$ 318	$ 1022
TOTAL VALUE PER CHILD	563	304	486	1275
ACTUAL COST PER FAMILY	862	528	719	2218
TOTAL VALUE PER FAMILY	1173	683	942	2761

TABLE 2A: UNIT COSTS FROM JANUARY 1, 1976, THROUGH JUNE 30, 1976 BY CENTER TYPE.

		AVERAGE	LOW	MEDIAN	HIGH
ACTUAL COST PER CHILD:	D	$ 331	$ 225	$ 305	$ 537
	C	510	294	382	1022
	M	502	279	491	793
	S	374	225	310	1022
TOTAL VALUE PER CHILD:	D	500	304	462	997
	C	638	339	509	1275
	M	796	591	826	1048
	S	459	304	378	1275
ACTUAL COST PER FAMILY:	D	623	528	600	727
	C	1221	710	1036	2218
	M	883	605	759	1842
	S	849	528	719	2218
TOTAL VALUE PER FAMILY:	D	939	683	777	1417
	C	1527	771	1376	2761
	M	1401	1033	1333	2435
	S	1042	683	787	2761

LEGEND: D = Direct service Centers (more than 75% of client costs)
C = Coordinated service Centers (less than 75%)

M = Hospital-based Centers
S = Social service agency based Centers

treatment services, and the aggregate actual cost of the program was $1,541,260. An additional imputed value of $558,009 increased the total value of the program to $2,099,269. Direct projects served 1075 different families and 2020 children; Coordinated served 714 families and 1708 children. The four Medical projects served 656 families and 1155 children; the eight Social Centers served 1133 families and 2573 children.

The median cost per family, as shown in Table 2, was $719, and the average was $862. (The average is far above the median because although nine Centers were below the mean, the three remaining, which included the two largest budgets, had actual costs per family above $1,200.) Cost per child was less than half these values, reflecting the greater number of children. The total value per family had a median of $719, and a mean of $1,173, with smaller unit values per child. The range of each index is large among the twelve Centers, with the highest level at least four times the lowest for all four measures.

Table 2A displays the corresponding data for each of the four types of Centers (Direct, Coordinated, Medical, Social) distinguished earlier in this report. These results are easy to interpret: Coordinated Centers reported much higher unit costs and unit values than Direct-service Centers, and Medical projects reported higher unit costs, and much higher unit values, than Social service-agency based Centers. The median cost per family for Direct Centers was $600, versus $1016 for Coordinated; the mean showed an even sharper difference. Only one Direct project had a higher cost per family than the Coor-

dinated Center reporting the lowest rate, so the distributions were nearly disjunct. The other three unit costs and values showed basically the same pattern, with smaller, but still substantial differences. While the reasons for this large disparity are not obvious, it should be noted that the Coordinated Centers had an average total of 119 families in planned services for the period, versus for Direct Centers 179 (more than 50% more). No Coordinated center had 179 cases. This difference in capacity (or rate of flow, as explained above) is hard to account for, but may possibly involve, in part, the need for Coordinated Centers to support both their own indirect costs and those of the subcontractor actually delivering the services.

Medical projects showed higher average and median unit costs and values on every indicator, although the difference in unit cost per family is only about 5% of the Social Centers' rate. As the reader may have anticipated from the earlier descriptions of donated medical services, the total values per child and per family are much higher for the Hospital-based projects. There is much more overlap, however, in the range of these Center-types from administrative base than in the service-modality types: the Medical projects with low unit costs appear to be far more efficient than several of the Social Centers. The discussion of the limitations on interpreting unit costs, which began this section, should be kept in mind before drawing conclusions from these results. Until the summative evaluation provides information on treatment effectiveness, however, these data raise the possibility that the Coordinated

service mode Centers and the Hospital-based Centers may be relatively expensive means of providing comprehensive services. Presumably NCCAN will permit more operational data to accumulate before even tentatively accepting this. Do the several types of Centers handle the same kinds of cases, do they treat problems of comparable severity, and are the treatment services provided of comparable quality? These are questions anticipated by OCD prior to the award of the Demonstration Grants, but they are questions which still cannot be answered with any certainty, and in some cases the answers must await the results of the summative evaluation. While the statistical indices reported above show differences among the several types of Centers, the meaning of these differences will become clearer after the process and summative evaluations have developed more information, and after the Demonstration Center managers have made program adjustments to operational problems which may lead to unnecessarily high unit costs. Alternatively, it may be that effective treatment requires very high levels of resources, and that some Centers presently reporting very low costs are not creating the necessary changes in the behavioral patterns of the majority of their clients. The Demonstration program must operate with limited resources, but its purpose is to provide for the welfare of the children and their parents. While the MIS may seem to emphasize costs and values, that is only because of their convenience in describing program activities. Impact upon clients is the "bottom line," and this present evaluation is primarily intended to describe the twelve Centers in sufficient detail that differences in effectiveness

identified by the summative evaluator can be plausibly related to common or unique characteristics of the Centers and their program components.

This concludes the "Executive Summary," which was intended to present the major findings of this report. It was felt to be appropriate to include considerable statistical detail, and several explanations of the procedures by which the numbers were derived, and the effect of these definitions upon the interpretation of the data. Other important quantitative results for the program as a whole are given in the last section of Part B of this Volume, and in Volume III. The data in Table 3, "Indicators of Potential Problems," give an important summary of the warning flags produced by the MIS as a result of each Center's output for the final quarter of FY-76. To these should be added a potential problem alluded to on page 26 above: the actual cost per family for the last two FY-76 quarters was below $850 at all except three Centers: New York ($1,224), Newark ($1,842), and Chicago ($2,218). It will be the task of the MIS during FY-77 to determine whether these Centers are able to increase their caseload or control their expenditures in such a way that the future unit cost per family is less at variance with the rates of the other Centers.

B. GENERAL NARRATIVE

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1. Introduction

In November, 1974, the Office of Child Development of the Department of Health, Education and Welfare invited several 8(A) small business firms to submit proposals to assist the National Center on Child Abuse and Neglect to prepare for and to evaluate the twelve Child Abuse and Neglect Demonstration Center programs.

The major purpose of this engagement was to evaluate the feasibility, efficiency and effectiveness of different strategies (modalities) for organizing, mobilizing, and bringing resources to bear on the identification, prevention, and treatment of child abuse and neglect.

The output objectives of the proposed engagement, as stated in RFP 38-75-HEW-OS, were to:

- Determine the efficiency and effectiveness of medically based and social service agency based client-oriented child abuse and neglect centers with certain program variations.
- Determine the efficiency and effectiveness of different service delivery modalities in medically based centers and in social service agency centers with certain program variations.

- o Identify approaches to the delivery of services to those involved in abuse or neglect which are worthy of replication and sissemination to others.

2. The Broad Nature of Child Abuse and Neglect

The abuse of children takes many forms. Neglect of children results from acts, or failure to act on the part of the parents.. The neglecting parents are either:

(a) Doing things which directly bring about neglect of their children

(b) Not doing things which they should be doing to avoid neglect.

In category (a) above, we find such actions as desertion, abondonment, excessive drinking, refusing to support as well as forms of physical punishment. In category (b) above, we find such things as failure to provide needed medical attention, housing, clothing or food, failure to give propre schooling, training and constructive discipline. Even more important is the failure to give a child the love and affection, the sense of belonging and the secutiry which is so important to a proper personality development and self-concept.

Thus, child abuse and neglect may be defined as those activities (singular, accumulative) which induce physical and/

or emotional trauma in children and are the results of non-accidental actions of the parents or other individuals with whom the child interfaces. In recent years, Dr. DeFrances, Director of the Children's Division of the American Humane Association, has defined eight categories of abuse and neglect. They are:

- Physical Abuse

  The non-accidental actions of parents or other individuals that induce physical trauma. The 'Battered Child Syndrome' in which multiple long bone fractures are often coupled with subdural hematoma present the classic example of repeated child abuse.

- Sexual Abuse

  Acts of sexual abuse ranging from molestations such as indecent exposure, and fondling to full intercourse, rape and incest. These acts may be executed by parents, relatives, neighbors and other individuals.

- Moral Abuse And/Or Neglect

  The exposure and/or forceful inducing of children into activities such as: prostitution, production and/or viewing of pornography, incest, homosexual activities, rape or other activities which may be illegal and at a minimum should only occur with two consenting adults.

- o Emotional Neglect

  The failure to provide the child with adequate supervision and protection which are prerequisites to physical and/or psychological development.

- o Medical Neglect

  The failure to provide medical examinations, innoculations against disease, and other medical services which the child requires to insure physical well-being.

- o Educational Neglect

  The failure of the caretaker to insure that the child is able to comply with state requirements which determine the minimal level of education that the child must receive and/or the failure to provide the child with the items or materials necessary for school.

- o Community Neglect

  The failure of the community to provide adequate schools, housing, medical facilities and other services which are necessary for the development of physically and emotionally sound children.

While the focus of abuse and neglect has been on the child, there remains the Parent (Caretaker). Recently, attempts have been made to implement and improve treatment services made

available to them. Some of the most encouraging efforts in this regard are occurring under the auspices of such organizations as:

- o Parents Anonymous in Los Angeles, California
- o The Children's Trauma Center in Oakland, California
- o Parental Stress Service in Berkeley, California
- o The National Center for the Prevention and Treatment of Child Abuse in Denver, Colorado
- o Family Care Center in Los Angeles, California
- o Family Life Achievement Center in Chicago, Illinois

Staff members of E. H. White & Co., under an early (January '74) OCD/Child Abuse effort, interacted with and interviewed many of the major participants of these programs. Child abusers have been described as immature, impulsive, dependent, angry, rejecting and demeaning individuals. Many of the parents are emotionally immature and their emotional makeup remains at the arrested adolescent stage. They have a low frustration tolerancr level so that when problems arise that they can't cope with, they strike out. These parents feel insecure and unloved, and look to their small children as a source of reassurance and comfort. Another type of abusing parent is one with borderline intelligence who has a difficult time functioning and doing routine tasks; one who during marital strife use the child to get at each other. Many

abusive parents have inaccurate perceptions and expectations of children. They demand performance from their children that is clearly beyond the ability of the children and ignore the child's own needs, limited abilities and helplessness. Abusive parents feel a "sense of righteousness" in punishing children who do not live up to such principles. Still another type of abusive parent is the emotionally disturbed parent -- those that are mentally ill. Some of these parents have emotional problems that are reflected in other characteristics, i.e., alcoholism, drug use, character disorders. There are several common dynamics which usually set abusive parents apart from others. There is a definite lack of positive mothering that they themselves experienced during childhood. Most abusive parents were themselves mistreated and abused as children. They are taught to believe that physical violence against children is an appropriate disciplinary action.

The Child -- The Caretaker -- The Indicent! Dr. V.J. Fontana of the New York City Mayor's Task Force on Child Abuse and Neglect estimated that in 1973, 50,000 children could be expected to die and 300,000 be permanently injured by maltreatment. Statistics strongly suggest that child battering is probably the most common cause of death in children today, out numbering deaths caused by any infectious diseases, leukemia, and auto accidents. The actual incidence of abuse

to children in the United States is impossible to cite. There may be millions of children who are or have been the victims of one or more of Dr. De Francis' categories of abuse and neglect defined above. There are estimates on the numbers of physically abused and battered children, but many experts disagree on their accuracy. The main cause for their disagreement is thelack of uniformity in reporting. For every case that comes to the attention of the public, it is estimated that 12 cases to undetected/unreported. It is suggested that many private medical doctors are reluctant to report such cases involving middle or upper income families whom they have dealth with over the years. Yet, because low income families (individuals) have to deal with county hospitals and emergency hospital rooms, they seem to be disproportionately reported. In summation, the necessary statistics are not available for estimating the current national rare. Differences in criteria for case finding, a variety of reporting biases, (some based on differences in reporting laws across states and others on personal and institutional practices) are among the major obstacles to accurate estimation. However, it is known that the reporting rate is increasing probably as a function of increasing public and professional awareness of the problem. As an example of this increase, it can be noted that a national survey in 1968 (Gil, 1969) identified about 5,000 confirmed cases of physical abuse. By 1970, however, New York City

alone was reporting about 3,000 cases annually (Kempe & Helfer, 1972). It is strongly suspected that the true incidence of physical abuse to children is substantially larger than the reported incidence (e.g., see results of a National Opinion Research Council survey reported by Gil, 1969).

3. History and Legislation of Child Abuse/Neglect

The maltreatment of children is not an acute problem. Its existence cannot be separated from the social, economic, and political history of our society. It has been justified for ma-y centuries by the belief that severe physical punishment was necessary either to maintain discipline, to transmit educational ideas, to please certain Gods, to expel evil spirits, or because of religious beliefs and practices.

Circumcision, castration, foot-binding, cranial deformation, slavery are all documented examples of this malpractice. Urbanization and the machine age led to other forms of child abuse and to increasing mortality. Children had always worked but when the reign of the machine began, their work often became synonymous with slavery. When parents rebelled against these conditions and refused to send their children to work, poor children-paupers-from the workhouses, who had no parents were put to work in the mills. They were starved, beaten and in many other ways maltreated. Many succumbed to occupational

diseases, and some committee suicide; few survived for any length of time. Even though the child stirs the most tender emotions in mankind, cruelty to children has always prevailed. As a direct result of an indicent reported by Fontana (Vincent J., 1964, The Maltreated Child), the Society for the Prevention of Cruelty to Children was founded in New York City in 1871. Following the example of the New York Society, many other societies with similar objectives were formed in different parts of the country. Many of these early efforts to assist and protect were spearheaded by the American Humane Association udner the aegis of local societies. These organizations formed the basis of the early private protective services that were the seed for the network of protective service agencies today. Early efforts focused on:

- Creation of shelter care for children without homes
- Creation of detention facilities to avoid jailing children
- Abolition of baby farms
- Promotion of child labor laws
- Promotion of child protection services

Considerable debate at the Federal level made Congress increasingly aware of the need for legislation in the area of child abuse. In 1912, the President signed into law a bill that would authorize the creation of a Children's Bureau

and the developmetn of a special Bureau to do research and provide information about children. With the passage of the Social Security Act in 1935 (as amended in 1962), Child Protective Services became the responsibility of Public Child Welfare. Impetus was given to Child Services programs as they were mandated to provide child welfare for "neglected, dependent children, and children in danger of becoming delinquent." In 1963, all of the 50 states began passing laws making it mandatory for meducakm law enforcement, social worker and school personnel who suspected child abuse and neglect to report the incidence to the agency or public office stated in law. For a variety of reasons, the enforcement of this law met with only partial success.

That child abuse and neglect were problems, was generally accepted and recognized. The testimony of expert witnesses to Congress in November, 1973, revealed a concensus on the multi-faceted and complex nature of the problem, and of the need to assure the universal accessibility to continuous comprehensive care for all abused children and their families. By 1974, this issue had become one of national concern. The gravity and magnitude of this concern was reflected in the actions of the Congress and the President which resulted in the passage of the Child Abuse Prevention and Treatment Act, P.L. 93-247, signed into law January 31, 1974. The stated purpose of the Act include, "To provide financial assistance

for a demonstration program for the prevention, identification and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes."

In accordance with this legislation, the Secretary of Health, Education and Welfare established the National Center on Child Abuse and Neglect (located in the Office of Child Development) and authorized it to make grants to and enter into contracts with public agencies or non-profit private organizations (or combinations thereof) for demonstration projects and programs designed to prevent, identify, and treat child abuse and neglect. On September 17, 1974, the Department of Health, Education and Welfare formally anncunced it was launching a new three and one-half year demonstration program to:

> "establish centers to meet the comprehensive needs of children, their families, and others who may be involved in instances of child abuse or neglect."

The objectives of the demonstration program were to:

(a) Increase and improve the delivery of comprehensive services to those involved in abuse and neglect.

(b) Find effective methods for the organization and mobilization of resources and for the

delivery of services that would prevent the occurrence of abuse and neglect and alleviate its consequences when it occurred.

Key features of the demonstration program were discerned and it was expected that attention to the operation of those programs would result in information of value for replication or modification by others.

On October 5, 1973, a solicitation for Demonstrations of Child Abuse and Neglect Programs (at local and state levels) was released. This demonstration program was jointly funded by the Office of Child Development, Social and Rehabilitation Service, Health Services and Mental Health Administration, and the Office of Education. The intent of this solicitation was to fund child abuse and neglect projects at state, county, and local levels under the administration of public and voluntary agency direction.

Subsequently, eleven multi-disciplinary demonstration projects for the coordination, integration and augmentation of services for the abused and/or neglected child and the family were awarded. Following those a3ards (June, 1974) the Public Health Service, through a Contractor, undertook the evaluation of the operations of those eleven centers. That Contractor was charged to carry out two basic tasks:

(a) To monitor the activities of each grant continuously and provide feedback to the Project Officer as well as the grantee.

(b) To design and perform an evaluation to determine the impact grantees had on the population and systems in question.

More specifically, that Contractor was asked to:

(a) Develop instruments and plans for baseline data collection and uniform reporting forms for use by all projects

(b) Develop detailed data collection and analysis plans

(c) Perform a formative evaluation to measure that the objectives of each project were clearly specified and that intermediate objectives were specified quarterly.

(d) Perform a summative (overall) evaluation to measure the differential impact of demonstration projects on the communities served.

On October 24, 1974, the Department of Health, Education and Welfare formally announced to 8(A) contractors its intent during FY'75 to fund two special demonstration efforts (with an estimate of twelve grant awards each). These efforts were for:

(a) Child Abuse and Neglect Demonstration Program(s)

(b) Child Abuse and Neglect Demonstration Centers

More specifically, the Department of Health, Education and Welfare released a request for technical proposal (RFP-38-75-HEW-OS) to assist the National Center on Child Abuse and Neglect in all steps necessary to prepare for and to evaluate the Child Abuse and Neglect Demonstration Centers Program. Applications for grants for these Demonstration Center programs were to be submitted November 5, 1974, and grants were to be awarded December 31, 1974.

Twelve such Demonstration Centers were funded. They are:

Demonstration Centers	Service Delivery
John Cosgrove, NCCAN Demonstration Center Director College of Medicine and Dentistry Dept. of Social Services 65 Bergen Street Newark, New Jersye 07107 (201 643-8800 X2484	Direct
Ms. Mary Holman, Director NCCAN Demonstration Center-Child Protection Center Research Foundation of Children's Hospital 2125 13th Street, N.W. Washington, D.C. 20009 (202) 835-4000 - 438-4475	Direct
Odele Childress, Director NCCAN Demonstration Center St. Christopher's Hospital for Children 2600 N. Kaukini St. Honolulu, Hawaii 96817 (808) 538-6135	Coordinated
Mr. James Bogle, Director NCCAN Demonstration Center Evanston Mental Health Services 1601 Sherman Ave. Evanston, Ill. 60201 (312) 475-2908	Coordinated
Ms. Agnes Williams, Exec. Director NCCAN Demonstration Indian Nurses of California, Inc. 390 Euclid Oakland, Ca. 94610 (415) 832-2386	Direct
Mr. Wayne Holder, Director NCCAN Demonstration Center Family Resource Center 8016 Zuni, S.E. Albuquerque, N.M. (505) 262-1911	Direct
Ms. Norma Totah Connecticut Child Abuse and Neglect Demonstration Center 94 Branford St. Hartford, Conn. 06112 (203) 566-3040	Direct

Demonstration Center	Service Delivery
Mr. Dennis Depcik, Director Metropolitan Area Protective Services 1630 West Armitage Ave. Chicago, Ill. 60622 (312) 276-3550	Direct/Coordinated
Mr. Donald Gibbs, Director The Wiltwyck School, NCCAN Demonstration Center 1239 Fulton St. Brooklyn, New York 11216 (212) 632-9400	
Mr. Jack Knox, Director CAN-DO, NCCAN Demonstration Center P.O. Box 729 Belton Texas 76513 (817) 939-1801 (ASK FOR CAN-DO)	
Mr. Gary Matthies NCCAN Demonstration Center Family Stress Center 577 Third Ave. Chula Vista, Ca. (714) 425-5322	

The Centers were given a six month start up period and their doors were to open for service July 1, 1975. The Demonstration Centers were selected for participation by a zxz matrix encompassing programs with either a medical base or social service base and providing either direct or coordinated services.

The presentation that follows reviews the activities and sources of these centers to date. Because ofthe idosyncracy of the information and reporting system, only statistical data from the period January 1, 1976-June 30, 1976 has been included in this report.

Although progress on some fronts is being made, the comprehensive evaluation of child abuse and neglect involves many people from different backgrounds and disciplines. It is safe to say that many of these people will have different perspectives on how to carry out evaluative (program's impact) efforts. It is only logical that an increased understanding and improved cooperative relationships and interactions between these individuals will provide the multi-disciplinary guidance necessary to reduce the incidence of child abuse and neglect.

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4. Program Profiles

a. Start-up Issues

As the twelve Child Abuse and Neglect Demonstration Centers became operational, there were a number of problems which each center had to face. While the majority of these problems or start-up issues were unique for individual centers, there were issues which were shared by a number of the centers. Among those issues which four or more of the centers had to deal with are the following:

(1) Site selection. Finding suitable facilities for the operation of the Center was a problem for a number of the demonstration centers. In the case of one center, the problem involved locating an area within a large county as well as securing a facility for operation. A few of the centers have relationships to state structures and organizations which complicated the acquisition or renovation of acquired sites due to the abundance of red tape that was generated by the State. However, within reasonable periods of time, all centers did acquire sites and have or are in the process of renovating those facilities.

(2) Clarification of the relationship of the centers to existing agencies. For almost half of the demonstration

centers, there were agencies already established that provided some degree of service to persons involved in child abuse and/or neglect situations. As the "new" agency, it was necessary for some of the centers to create or clarify procedures and to establish positive working relationships with Departments of Welfare or other similar agencies. In many instances, this clarification process has moved smoothly and is working well for both the center and the involved department or agency. However, in other instances, these problems are still being worked through.

In addition to the above start-up issues, a number of issues were common to only two centers. They are briefly discussed below:

(1) Restructuring a program and transferring it to a new site. Two of the CAN demonstration centers were already handling child abuse and neglect cases before they were funded by OCD. The funding as a demonstration center necessitated some restructuring of the old program and transferring it to new facilities. For both of those demonstration centers, their previous experience in child abuse and neglect acted as a negative force as it impeded the center in its efforts to become completely operational. However, both centers were able to make a successful transition.

(2) Defining intake and follow-up procedures. As a part of the early operation of these centers, it was necessary to clarify and/or change the intake and follow-up procedures which were being used in order to facilitate communication between the number of persons who had some measure of responsibility for clients.

(3) Relationships with contracting agencies. Two of the centers have a large number of subcontracts with other agencies who provide the bulk of the services for their clients. One of the start-up issues which had to be dealt with (and in one case is still being dealt with) was the relationship of the demonstration center to the sub-contractor. The provision of feedback to the center from the sub-contractor concerning the services provided for specific clients was one of the areas in which procedures had to be developed. Another concerned the completeness of the feedback which was provided.

(4) Defining the catchment area. Two of the centers had the problem of establishing and defining by area the population that they would serve. In both cases, the original area that was defined in the proposal was too large, in terms of geography and population, to provide the type of services that the centers wanted to provide. Both centers were able to work out a method for realistically restricting their target areas.

Other start-up issues were unique to individual centers and are discussed in the individual center profiles contained in Volume II of this report.

b. Staffing

Most employees were hired during 1975 on the basis of their congruence with the grant proposal job descriptions. The need to obtain staff through the hiring mechanisms of sponsoring State, hospital, or college administrations tended in several cases to increase the time required to complete staffing beyond the projected schedule, and also reduced the control of Project Directors and Executive Boards over staff selection. In one case particular, the requirements of the Illinois Civil Service regulations were identified as the source of serious problems for the Chicago MAPS project in filling staff positions with persons sought by the Center managers. Several Centers had service agreements with local agencies so that donated staff (such as from the Hawaii Child Protective Service Unit, and the California Department of Corrections in San Diego) functioned directly within the Center organization, permitting fuller staffing than the NCCAN grant alone would have provided. Although Centers generally are subject to the various federal laws and excutive orders which pertain to equal employment opportunity, the Oakland project was successful in recruiting an all-American Indian staff. Since the clients of this project are all Indians, this will facilitate greater rapport between caseworkers and clients.

The judgment of some other Centers may be open to question for their inability to match the ethnicity of their service population to the workers selected to staff the program.

At the close of FY-76 the twelve Demonstration Centers reported 171 full- or part-time permanent paid employees. Of these, thirty-three (or 19.3%) were primarily administrative, twenty-nine (or 17%) were support staff, and 108 (or 63.2%) were primarily direct service staff, with one employee unclassified. More than three-quarters (129, or 75.4%) of employees were female, and less than a quarter (42, or 24.6%) were male, according to the MIS data. Despite this great preponderance of women on the payroll the majority of Project Directors were men.

This permanent staff was supplemented by 129 auxiliary staff, including 6 temporary employees, 61 unpaid volunteers, and 42 consultants. Most of the volunteers were reported by the Belton Center (45), and most of the consultants were retained by the Oakland Center (22). Until January, 1976, the MIS forms classified professional workers as either Social Workers, Health Workers, or "Other". For the quarter ending December 31, 1976, these were 32.7% Social, 31% health, and 12.3% other. For all quarters, about 85% of Center employees worked more than 20 hours per week.

To staff a program, a project must both recruit and retain personnel. The NCCAN Demonstration Centers reported 31 terminated employees during FY-76, for a turn-over rate of only 18.2%, but seventeen vacancies occurred during the last quarter of FY-76. Must of this was in the clerical positions, where budgets tended to provide unrealistically low compensation. As a result, capable secretaries tended to leave for better jobs, while unskilled applicants could not be economically trained in clerical skills.

All centers devoted efforts to staff training. Some developed specific curricula and materials for training project staff and other community persons, both lay and professional. Some utilization of the NCCAN Resource Centers were also reported. Other Centers relied primarily on outside contractors to provide training. Relatively little exchange of training materials appears to have occurred among the twelve project. In the future the several Resource Centers may be able to identify the training needs of project staff and to find existing training packages that can serve as a basis for training tailored to the individual needs of a Center.

c. Organizational Issues

There is a great range of organizational structures among the demonstration centers. Classifying the 12 centers according to type of sponsoring organization one obtains 8 (eight) types. With such diversity, no generalization predicated on sponsoring agency, per se, is feasible. The types are:

(1) State Protective Services-
Albuquerque, Hartford

(2) Joint Operations of State and Hospital-
Honolulu

(3) State Hospitals (distinct from Protective Services) -
Newark

(4) State Sponsored Consortium of Public and private agencies -
Chicago

(5) Consortium of public and private agencies (independently incorporated)-
Evanston

(6) Multi-County Organizations (dealing with social issues)-
Belton

(7) Private Organizations (dealing with social issues) -
Brooklyn, San Diego, Oakland

(8) Private Hospitals-
Philadelphia

(9) Public Hospitals -
Washington

On another organizational dimension, the internal structures range from the traditional hierarchical organization to more democratic forms. The stressful nature of working with abusing/neglectful families suggests the possibility that a non-hierarchical organization may prove more supportive to direct service staff. This aspect will be considered more fully in the future.

The centers may also be classified as to whether direct service staff is mostly professionals or mostly paraprofessionals. There are several centers in both of these classifications. Clearly, the staff composition relates to matters of cost effectiveness and this issue will be evaluated at a future date.

Perhaps the most noteworthy organizational parameters are those embodied in the original design of the NCCAN demonstration centers program: organizational base and service modality. There are eight social service-based centers and 4 hospital-based centers; the centers have been evenly separated by whether most services are provided directly or by other agencies. Some striking preliminary findings on these matters are discussed elsewhere with regards to unit costs.

Finally, the organizational issues that relate to operations during the year are discussed below.

(1) In Philadelphia, the paraprofessional workers hold group interviews with all protective staff members. This process has delayed the hiring of a much needed social worker. This is related to a more general problem of decentralized decision making discussed fully in that center's profile.

(2) In Evanston, the governing board was expanded to include members of the business community to improve fund raising efforts.

(3) In Hartford, there were difficulties hiring needed staff because of a freeze on hiring in the state government.

(4) In Newark, there was a delay in acquiring facilities because of a need for approval at the state level.

(5) In Brooklyn, the working relationships had to be reorganized to meet the demands of the work.

(6) In Chicago, OCD felt the board was too large for effective decision making and that there was potential conflict of interests.

d. Linkages Issues

Each of the CAN demonstration centers has established linkages with other organizations or agencies. Those linkages can be classified as consortium linkages, contract linkages, or informal linkages. Each type of linkage is briefly discussed below.

(1) Consortium Linkages. For some of the centers, a consortium of organizations and agencies has been involved with the CAN demonstration center from the beginning. The original proposal to OCD was conceived and written by the consortium and the consortium members act as advisory board members to the center. In at least one instance, some of the agencies which participated in the conceptual beginnings of the center and helped shape the direction in which the center would go, have moved into sub-contractor roles of various sorts. In all cases, however, the consortium remains involved with the center and helps guide the center in policy issues.

(2) Contract Linkages. All of the centers have linkages with organizations or persons representing organizations and agencies by use of contracts. The contract linkage has been used primarily to provide services for clients that could not be provided by the staff of the center. As an example, most of the centers do not have a child psychiatrist among their staff; therefore, when

the services of a psychiatrist is warranted, there is a person, on contract, who provides that service. Many of the contracts have been negotiated for long periods of time, while others are for only short periods.

(3) Informal Linkages. Many of the donated service- which all centers receive are a result of the informal linkages which have been developed during the duration of the OCD contract. Although the center generally does not pay for services which are received via the informal linkages, often those services can be paid for from Title XX funds. All centers emerge in activities which can lead to further informal linkages so that the more and better services for clients can be provided.

e. Legal Issues

Because the abuse or neglect of children is a criminal activity the file of the Demonstration Centers are of an extremely sensitive nature, and the maintenance of confidentiality of records is necessary both as an ethical matter and because of the potentially actionable nature of the case file information. A number of project employ digital coes sustituted for all references to the identities of the clients on the Client Record Forms. Such file security procedures are appropriate, although they introduce the possibility of problems for the summative evaluation, if the decoding keys were defective or unavailable when it becomes necessary to contact Center clients.

In addition to confidentiality and civil liability, the criminalization of abuse and neglect creates a potential problem at many Centers in that self-referrals of abusive parents under the mandatory reporting statues of several jurisdictions, must be brought to the attention of law enforcement agencies. The threat to the therapeutic relationship of "calling the cops" on families seeking help is evident, and affected Centers have dealt with the problem in various ways. A Probation Officer attached to San Diego Center as a counselor is assigned responsibility for the mandatory investigation, for example, and similar agreements to deter the entry of police workers into certain cases identified by the Centers have been made, formally or de facto, by Centers which have investigative

capabilities. Where court and police agencies have been closely involved in the Center program, difficulties arising from law enforcement priorities have been minimal. Some Centers, such as in Albuquerque are the mandated investigative agency, which is perhaps the ideal solution if the Center has the manpower to perform this function.

A related legal issue is the need for Center staff to know the law, court procedures, and efficient ways of meeting court requirements arising from casework. Most Centers have arranged for training in these areas, and some have been active as resources to other professional workers in their catchment areas, even developing manuals to advise social, medical, educational, and other professionals of their duties, liabilities, and best procedures in connection with cases of suspected abuse and neglect. While this duplicates a potential function of the Resource Centers, the many local variations in definitions, laws, and procedures make this an efficient utilization of the understanding and experience of legal issues available to the Demonstration Centers.

While this section deals primarily with the Centers' response to the legal system, the Centers have also been active seeking better legislation to deal with child abuse and neglect. Several Centers, such as Honolulu, have assisted in drafting and lobbying for model legislation

in the area, while the New Jersey Center has rallied support for the defeat of a reactionary proposed law which would have the effect of eliminating hospitals and physicians from the reporting system, by requiring them to notify law enforcement agencies. (It is well known that such a procedure, as opposed to the present reporting to Protective Services, creates a conflict of interest for most physicians, thereby endangering the unreported children.) The Oakland program engages in advocacy activities relating to the national status of Indian children.

A final legal issue faced by many Centers arises from the only approximate correspondance between the local legal definitions of child abuse and neglect, and the circumstances in which the Centers intervene. Some laws are not specific, while others result in reports based upon lack of supervision or unusual housekeeping practices that are less acute threats, compared with other situations, to the child's life or well-being. Thus the "high risk" category is sometimes used where no legal determination has been made on a strong suspicion of abuse and neglect. The diversity of laws obliges the Centers to use local definitions of abuse and neglect, increasing the heterogeneity of the "case type" data treated in Volumes I and II of this report, and sometimes removes the motivation for parents to cooperate with a Center, if the language of the law does not cover some unusual child-rearing

practice. Many adults would not participate in treatment activities if the Centers were not an alternative to case management by law enforcement agencies.

f. Community Awareness

There has been an extremely broad range of activities carried out by the demonstration centers to increase awareness of the problems of child abuse and neglect. Each of the centers has performed several of the activities listed below. It is notable that some centers feel that they cannot afford to publicize their services since they already have extremely full caseloads.

General Public Awareness

(1) Design and distribute flyers and fact sheets (bi-lingual, where appropriate)
(2) Produce and/or sponsor radio and television spots (including ten 30 minute radio talk shows by one center)
(3) Provide public speakers
(4) Establish a lending library including audio visual materials.
(5) Recruit volunteers at foster homes
(6) Establish and publicize hot line

Specialized Awareness Efforts

(1) Provide in-hospital education for professionals
(2) Provide education for professionals in education, law enforcement, and social service agencies
(3) Develop resources and perform liaison activities
(4) Establish a lending library including audio visual materials

(5) Publish articles in professional journals

(6) Publish newsletters

(7) Produce a training film for professionals

(8) Conduct and/or sponsor seminars and workshops

(9) Present a college course "Dynamics of Child Abuse and Neglect" for paraprofessionals

g. Program Priorities

Looking at program priorities across all twelve demonstration centers, the contractor found the following areas of priority in descending order:

Case Management & Review	(7 centers)
Individual Adult Counseling	(5 centers)
Multidisciplinary Team Case Review	(5 centers)
Couple/Family Counseling	(4 centers)
Crisis Intervention	(3 centers)
Home Making	(3 centers)
Parent Aide/Lay Therapy	(3 centers)
Identification/Outreach	(3 centers)
Psychological Services	(3 centers)
Day Care	(2 centers)
Educational Services	(2 centers)
Transportation/Waiting	(2 centers)
Diagnosis	(2 centers)
Special Child Therapy	(2 centers)
Baby sitting	(1 center)
Crisis Nursery	(1 center)

The heavy emphasis on casework activities is seen as an endeavor to maintain a smooth patient flow and to provide effective services. The next major emphasis on Identification/ Outreach; Crisis Intervention and Counseling (lay and professional) are logical sequential expectations from the service delivery systems involved. The provision of other services in discreet categories flow from this.

Overall there were no discernable trands between centers providing direct or coordinated services, or those operating from a medical or social service base.

By "priorities" in the above discussion and tabulation is meant that a service area was among the four highest of the 30 service categories among the Casework and Client Service areas in expenditures for FY-76 for a Center.

h. Goals/Approaches

The contractor carried out a thorough review of individual goals for each of the individual demonstration centers. Although we detected wide variance in how specific goals for the individual centers were labeled, a content analysis revealed the following primary goals for an overwhelming majority of the centers:

- Provide comprehensive child abuse and neglect (CAN) services
- Provide broad range of Community Education activities
- Provide comprehensive staff training in child abuse and neglect.

Additionally, at least one third of the centers articulated goals in the following two areas:

- Provide 24-Hour Emergency Services
- Develop and implement a strong Preventive Program

While these were articulated as goals, they may well be viewed as necessary objectives for meeting the more global goals listed above.

Finally, the following goals were listed by one center each:

- Explore cultural aspects of CAN
- Develop a system for multi-disciplinary-interagency assessments
- Develop a Regional CAN Registry

Overall, there were no discernible trends between centers providing direct or coordinated services, or those operating from a medical or social service base.

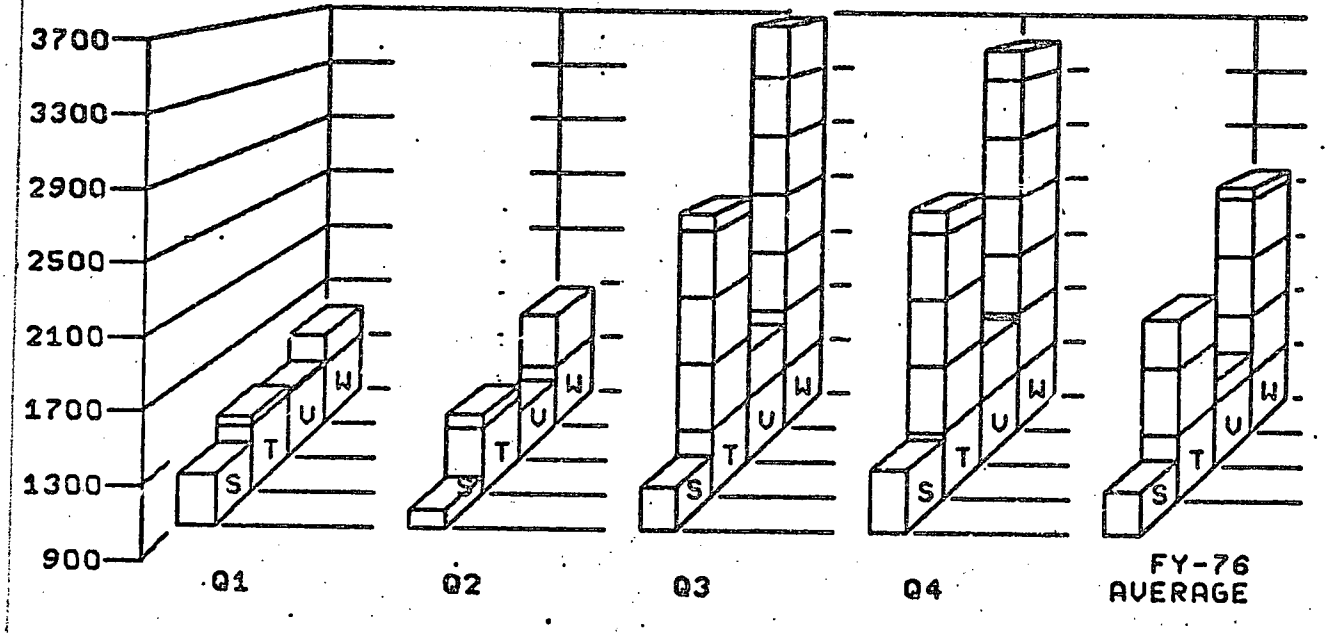
i. Statistical Information

The MIS has produced various indicators of the cost and productivity of Center operations. The Executive Summary section of this report (pages 1 through 29) displays the most fundamental of these: the allocation of costs to service areas (Table 1 and Figures 1, 1A, 2, and 2A) and the expenditures per recipient receiving planned services (Table 2). These results showed overall rates of indirect expenditures near 40%, large donations of medical services, increased expenditures each quarter of FY-76, and certain differences among the various Center types, which were sensitive to whether actual cost or total value was used to measure expenditures. For the last two quarters of FY-76, the twelve Centers reported a median actual cost of $318 per child and $719 per family; the median total values were $486 per child and $942 per family. Relatively large variation was reported among Centers, with actual cost per family ranging from $528 (the lowest value, for the San Diego Center) to $2,218 (the highest value, for Chicago) a typical distribution. Large differences were found in these unit costs, with Coordinated projects generally reporting higher rates than Direct service projects, and Medical higher than Social by a smaller margin.

This section discusses further statistical detail on the program as a whole. Additional information is provided in Volume III of this report. Volume II presents corresponding statistical indicators for individual Demonstration Centers.

Figure 3 on the next page shows the median unit costs by quarter and the mean unit cost by quarters for each FY-76 quarter. Because extreme values reported for number of cases tended to distort the mean for the first two quarters, the median gives a more accurate picture of the year, although the means are included to express the aggregate expenditures divided by caseload. Expenditures in Figure 3 are measured in dollars. As is explained on pages 22-24 of the Executive Summary above, these quarterly estimates of unit cost are obtained by dividing the number of recipients of planned services during each quarter into the expenditures for that quarter, and multiplying the result by four to obtain an "annualized" estimate. Since this last operation would only give the same result as dividing total expenditures for the year by total recipients during the year if no recipient left the caseload, it amounts to an estimate of the cost of providing services to one recipient for twelve months. Since in fact clients leave the caseload and are replaced by others, the method of calculation used in Table 2 (recipients during the period January through June, 1976, divided into expenditures for the same period) gives a lower unit rate than the annualized quarterly estimates of Figure 3, because the same dollars are divided by a larger number of clients. Put in another way, Figure 3 gives unit costs based upon twelve months of treatment services, while Table 2 gives unit costs based upon the actual duration of services during a six month period; for many clients, services were provided for fewer than six months during that period, during which they left or entered the caseload.

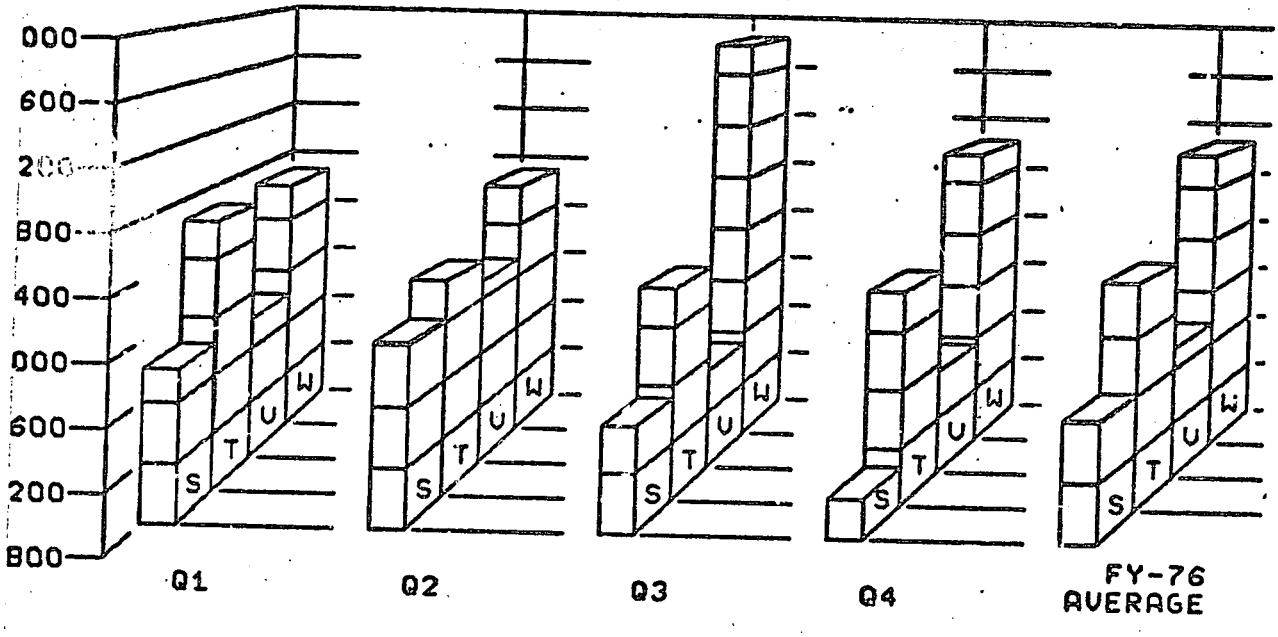
FIGURE 3- MEAN UNIT COSTS BY QUARTER, FY-76



KEY

S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
V- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

FIGURE 3- MEDIAN UNIT COSTS BY QUARTER, FY-76



KEY

S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
U- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

Results for the annualized quarterly estimates in Figure 3 show that the mean cost of treating a child for a year, as an average of the four quarterly estimates, was about $1,150, and the corresponding median value was $1,600. The actual costs per family were $2,000 (mean) and $2,400 (median). These "cost of capacity" rates are about four times the "cost of actual clients" rates shc n in Table 2. Total values were somewhat higher, although the median was less sensitive to the large donations reported by some Centers than was the mean, which rose to $1,450 per child and $2,550 per family, rounded to the nearest $50.

Over the four quarters of FY-76 the median actual cost per child declined from over $2,000 in the second quarter to just over $1,000 in the fourth quarter, while actual cost per family remained essentially fixed at $2,300 for the last three quarters. All median rates were lower for the last quarter than for the average of the four quarters. This concludes the discussion of Figure 3 annualized quarterly estimates of unit costs for the twelve Centers.

For purposes of the present report, five stages of case integration are used to describe the status of families who come to the attention of the Centers. Figure 4 below, the case flow diagram, shows the number of families at each stage during the last two quarters of FY-76, and the number of families making transitions from one stage to another during the same period (as numbers entered in circles between the

symbols for the stages). The numbers of children and adults in planned service delivery represent the total during the third quarter incremented by values estimated from the number of families entering planned service delivery status in the fourth quarter.

The five stages distinguished in Figure 4 are:

(1) Initial Services. (These include intake, diagnosis, the development of a treatment plan, and emergency services provided prior to the development of a treatment plan.)

(2) Complete Referral. (Cases not retained in the caseload, but for which some other agency is found to accept case management responsibility.)

(3) Comprehensive Services. (Cases receiving planned services after the development of a comprehensive family treatment plan.)

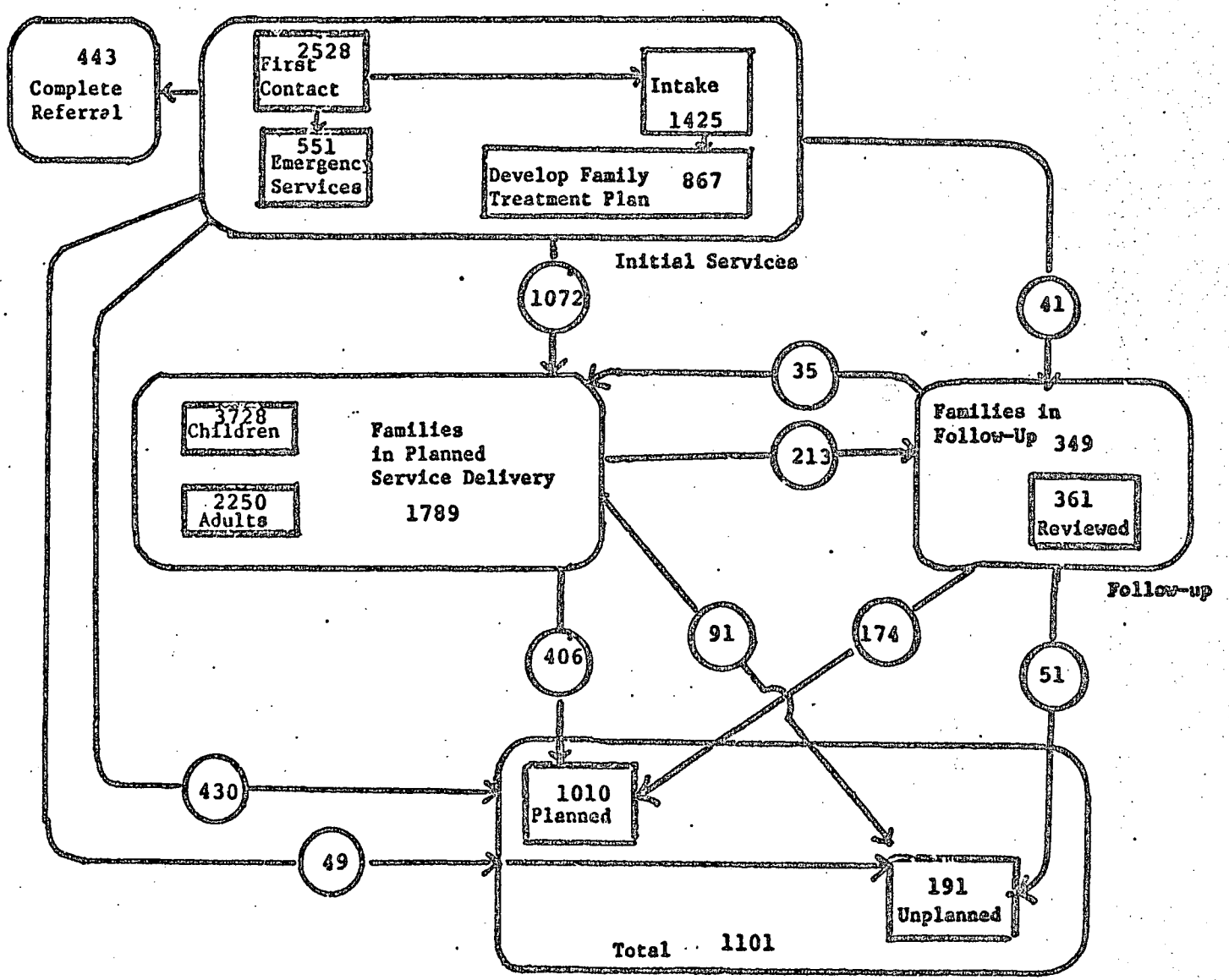
(4) Follow-Up. (Cases for which the delivery of planned services is completed, but for which a review of service needs is on-going or planned.)

(5) Terminations. (Cases not in stage (2) but for which no further attention by the Center is contemplated, either through completion of planned services, or loss of contact.)

Figure 4 shows that 1,734 families received planned services during the first six months of 1976 (the period for which comparable data categories are available). These included 3,726 children and 2,250 adults. Of these families in planned service delivery, 1,072 (or 60%) began to receive planned services during the period, while 810 left planned services, and 35 reentered planned service delivery after a follow-up review subsequent to the completion of the planned treatment services. Of the 810 leaving planned service status, 213 entered follow-up, and 497 were terminated.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR
ALL CASES

FIGURE 4



Of these terminations, 406, or 81%, were planned, and the remainder unplanned. Of the total of 2,528 potential cases making contact with the Centers during this period, 443, or 17.5% were referred to other agencies for services, while 1,425 received intake (56.7%), and 867 (34.3%) had family treatment plans developed. An additional 479 families (19.7%) were terminated prior to the delivery of initial planned service; the majority of these terminations (90%) were planned. There were 1,247 families in planned service delivery status at the end of the fiscal year, an increase from 1,105 at the end of the third quarter. Thus the capacity of the Centers, in terms of the number of planned service delivery cases on a given day, is about 104 families at the "average" Center. The somewhat larger caseloads discussed earlier were based upon the number of families in planned services <u>during</u> a quarter or some longer interval of time. These data also show that the program had not yet reached an equilibrium by the end of the fourth quarter, since more cases were entering planned service delivery than were leaving that status. Similar case-flow diagrams for individual Centers can be found in Volume II of this report.

In addition to the indicators of program performance discussed above, the MIS produces certain warning flags to call attention to statistical indicators whose values may be related to operational problems at the individual Centers. Table 3 below shows those indicators for the last quarter of FY-76; the meaning of the symbols is defined as follows:

TABLE 3: INDICATORS OF POTENTIAL PROBLEMS

CENTER LOCATION	ADMINISTRATIVE COST	SERVICE COST	STAFF TURNOVER (Q/S)	KEY STAFF VACANCIES
ALBUQUERQUE			1/ 1	
BELTON			1/ 1	
CHICAGO			0/ 1	
EVANSTON			0/ 1	
HARTFORD			7/ 8	2
HONOLULU	H		1/ 2	
NEWARK		L	0/ 0	
NEW YORK		L	0/ 1	1
OAKLAND			1/ 3	
PHILADELPHIA		L	1/ 1	
SAN DIEGO			1/ 1	
WASHINGTON			4/ 5	

Administrative and service cost data are based upon the last two quarters of FY-76, while "Key staff vacancies" are based upon staffing as of 30 June 1976. "Staff Turnover" shows the number of permanent employees terminated during the last two quarters of FY-76. Administrative cost is flagged if it exceeds 25% of the actual cost of operations for the period. Service cost is flagged (L = "LOW") if it falls below 50% of the actual cost for the period."Service Costs" are all costs outside the "Operations" area defined for Table 1.

ADMINISTRATIVE COST: This is flagged "H" (for High) if the cumulative actual costs assigned to this service category in the MIS exceeds 25% of a Center's actual costs for the last two quarters of FY-76.

SERVICE COST: This is flagged "L" (for Low) if the cumulative actual costs assigned to the thirty-five service categories outside the "Operations" area for the two last quarters of FY-76 are less than 50%.

STAFF TURNOVER (Q/S): This shows two numbers: the number of employees terminated during the last quarter of FY-76, and the cumulative number terminated during both of the last two quarters. (Terminations during the start-up phase are disregarded

KEY STAFF VACANCIES: This shows unfilled key positions as of June 30, 1976.

The data in Table 5 show that only one Center, that in Honolulu, was cited for high administrative costs, which were 31.7% of the actual expenditures. This is intended as a warning of high indirect costs, but the Honolulu Center was not flagged for low service costs, since the other indirect categories were well-controlled. Discussions with the evaluator indicate that this flag may be an artifact of the Center's incorrect assignment of staff time in support of specific service activities to the "administrative" cost category.

Three Centers (Newark, 63%; Philadelphia, 55%; and New York, 53%) reported indirect costs above 50% of actual expenditures, so that the MIS alarm for "Low" service expenditures was sounded. The same Centers were cited in both quarters tabled here, so the reported rates seem to be reliable. Philadelphia and New York both reported substantial donated services that reduced the indirect allocation of total value to less than 40%, but no such

silver lining is evident in the case of Newark. The indirect costs charged by Martland Hospital restrict the ability of the Center management to reduce this relatively high overhead. It should be noted that all four of the Centers receiving flags are located in relatively high cost-of-living areas, although some of the Centers not cited by the MIS are similarly situated.

The Staff Turnover data have conspicuous values for Hartford and Washington. The Office of Child Development is aware of the efforts at these sites to fulfil their goals, and the reorganizing activities at these Centers are appropriate to the preoperational Phase II through which the Demonstration Centers were scheduled to develop by this period, which closes the eighteenth month of the program since the initial grant award. By making adjustments so that the programs meet local needs in a comprehensive and efficient fashion, as understood by the local community, it is anticipated that the program will, during operational Phase,III display a useful range of viable program models, which can be replicated in their successful features under various community environments.

C. METHODOLOGY

C. METHODOLOGY

The National Center for Child Abuse and Neglect Demonstration Centers are charged with the responsibility of initiating a wide range of activities and of performing critical functions deemed pertinent and essential to the identification, prevention and treatment of child abuse and neglect. The goals of the demonstration centers are:

(1) to increase and improve the delivery of comprehensive services to those involved in abuse and neglect; and

(2) to find effective methods for the organization and utilization of resources and for the delivery of comprehensive services, which will prevent the occurrence of abuse and neglect, and alleviate its consequences when it occurs.

On January 2, 1975, the Office of Child Development of the Department of Health, Education and Welfare awarded to E. H. White & Company a contract to conduct an evaluation of the twelve individual programs that were funded under the National Child Abuse and Neglect demonstration program. The purpose of the formative evaluation is to:

(1) Assess the relative effectiveness of different program variations by determining the efficiency of hospital-based and social service agency-based client-oriented child abuse and neglect centers;

(2) Determine the conditions under which each of the program variations works best by determining the efficiency of different service delivery modalities in medically-based centers and in social service centers;

(3) Collect and assess descriptive data about the occurrence, consequences, remediation, and prevention of child abuse and neglect by identifying approaches to the delivery of services to those involved in abuse or neglect which are worthy of replication and dissemination to others.

The twelve demonstration projects awarded NCCAN grants in January 1975 have completed the initial phases of their activity. During Phase I, the start-up period, staff were assembled and trained, agreements with other local providers of services were negotiated, the mechanics of the link with NCCAN were explored, some acquaintance with the evaluation staff and with preliminary versions

of the information system was made, and services to clients was commenced at every project.

The Annual Report describes the subsequent "preoperational" phase of these projects, called Phase II. In this stage trained staff are in place, cases are being processed, and services are being delivered, but management is proceeding in an essentially experimental manner. Phase II policies, procedures, and program configurations are tentative, exploratory, and seeking to identify "best" ways of achieving project goals and objectives.

The major activities of the contractor in conducting this evaluation can be grouped under the following five headings, or evaluation components:

1. Standardization of procedures across projects and coordination with other evaluation contractors.
2. Management assistance activities conducted on-site by evaluation staff during visits to projects.
3. Develop, document, train staff in the use of, and implement a Management Information System (MIS) providing quarterly descriptions of project staff, case flow, service deliveries and costs.
4. Collection of baseline information des-

cribing projects, their communities, and local service delivery systems related to program assessment.

5. Examination of technical questions, involving the differential cost and effectiveness of project services and configurations relative to case types, client characteristics, and environmental variables.

The first component has resulted in a conference, held in October 1975 attended by representatives of three evaluation contractors and of the Office of Child Development. The thirty-nine service categories defined in Volume III of this report were the result of those discussions. In addition, t the distribution of uniform Client Record Forms developed by the Joint Demonstration Project contractor, and the use of standardized data categories and reporting forms at the twelve Demonstration Centers, has imposed some comparability upon the descriptions of the several projects (components 3 and 4 above).

The second component consists of the monitoring function performed by the evaluation field staff, who advise NCCAN of conditions at the twelve sites, and, as management consultants, are available as a resource to project managers. While

the evaluation staff does not interfere in the administration of the Centers, certain data management procedures necessary to the evaluation have been suggested by field staff to Centers encountering problems in implementing the MIS.

The MIS is the third and largest component in terms of the program and evaluator resources required for its maintenance. It produces the operational data that comprise the bulk of this report, and most of the remainder of this section will provide detail on the methods employed in the MIS calculations.

The fourth component, baseline information, has been collected at all sites during February-April 1976, and is separately reported. The same information, dealing with the community characteristics and service delivery systems, will be updated during Phase III of the evaluation in 1977.

The last component, the treatment of technical questions, involves the analysis and synthesis of MIS and baseline data. Because of the change in MIS reporting forms instituted in January 1976, many questions will be reserved for a future time when at least four comparable quarters of data are available for examination. Volume III below, however, examines some of the issues subsumed under technical questions.

The original design of the Demonstration Program envisioned a "factorial design" of crossed dichotomies (Medical - and Social - agency administrative base, versus Direct- and Coordinated-service delivery mode), with three replications of each combination of service mode and administrative base. The pattern of grant awards did not conform to this design, so that the analysis-of-variance approach to the MIS data, recommended by the proposed equal cell frequencies, has been dropped in the statistical analysis presented here. This analysis avoids parametric statistical inference, and does not regard the grantees as a "sample" of anything (in the sense of a randomly chosen group). The comparison of mean values on various indices among the different type-of-Center categories is repeatedly presented, however. The reader must exercise personal judgement in determining whether the peculiarities of the individual Centers that make up these groups permit any generalizations to "other projects of the same type".

There is probably no problem in the distinction between hospital-based and social-service based agencies, although the Newark and Philadelphia Centers characterized their professional staff as predominantly "social", rather than

"health" workers in the last (December 1975) quarter in which the MIS collected such data. The Social Service agency-based Centers are, in addition, quite heterogeneous in their orientation. The distinction, however, is reasonably clear, and the underlying administrative (hospitals and businesses) and professional (medicine versus social work) differences between the managers of the two types of Centers may be expected to express itself in operational differences.

The other classification, Direct versus Coordinated service modality is less clear-cut. As noted on page 6 of this report, most centers provide some services directly, and arrange for others through other agencies. The MIS does not classify Centers directly, but computes an index of service modality by which the Centers have been partitioned at the median (which fortunately corresponds to a fairly wide gap in the distribution of the index used). Thus, service modality is a dichotomized continuous variable, and it is possible for a Center to change its classification from one quarter to another. The present report uses data from the period January 1, 1976 to March 31, 1976, to classify Centers by modality. The computational basis for the index is provided on page 6 above.

In calculating the cost associated with a service category, the information comes from each Center's MIS input form D report of purchased and donated services (which assigns subcontract costs and the value of donated services, in dollars, among the 39 service categories, and from the form C time log samples, which allocate working hours (over a ten-day sample each quarter) for each worker among the same 39 categories. The actual cost of wages and salary accrued for services for the entire quarter is divided in proportion to these hours among the categories. Thus, suppose that a reimbursed volunteer worked a total of 10 hours during the sample of time logs, and provided during the quarter hot-line services with an estimated total value of $250, at an actual cost of only $50. If 80% of her time were allocated to Crisis Intervention, then $50 x 80% = $40 would be added to the actual cost of Crisis Intervention. The total value of the same category is $250 x 80% = $200 for this worker. On MIS Input form E, "Other Costs and Donations", Centers can allocate expenditures to specific service categires or to a "general allocation", which distributes expenditures among the 39 service categories in proportion to the actual cost of time log labor costs. All expenditures are accrued, which means that they are charged to the quarter in which they are incurred, rather than to the quarter in which they are paid. The sum of time log,

form D, and form E expenditures across all service categories is the estimated total for a center for the quarter.

Costs per service unit are obtained by dividing the expenditures for a service category by the number of service units reported to have been delivered in the quarter. For each case type within a Center, these service unit costs are estimated to be equal, but the MIS obtains different service unit costs for the aggregate data by case type by dividing the sum of proportional costs (within each service category) by deliveries for each case type.

These and the other MIS statistics must be regarded as estimates of the "true" values, because sampling errors and errors of omission (not tabulating deliveries, recipients, or expenditures) or of classification (assigning expenditures or deliveries to the wrong category or case type) cannot be eliminated entirely without increasing the cost of the MIS to levels incompatible with the Demonstration Program goals. The values reported here, however, are the best estimates of program characteristics, and are intended to provide detail on the performance and priorities of the Centers that will assist in the assessment or replication of the program.

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