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

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

Prepared for

Office of Child Development, Washington, DC

1 Nov 76

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E. H. WHITE & CO., INC.

National Center on Child Abuse and Neglect.
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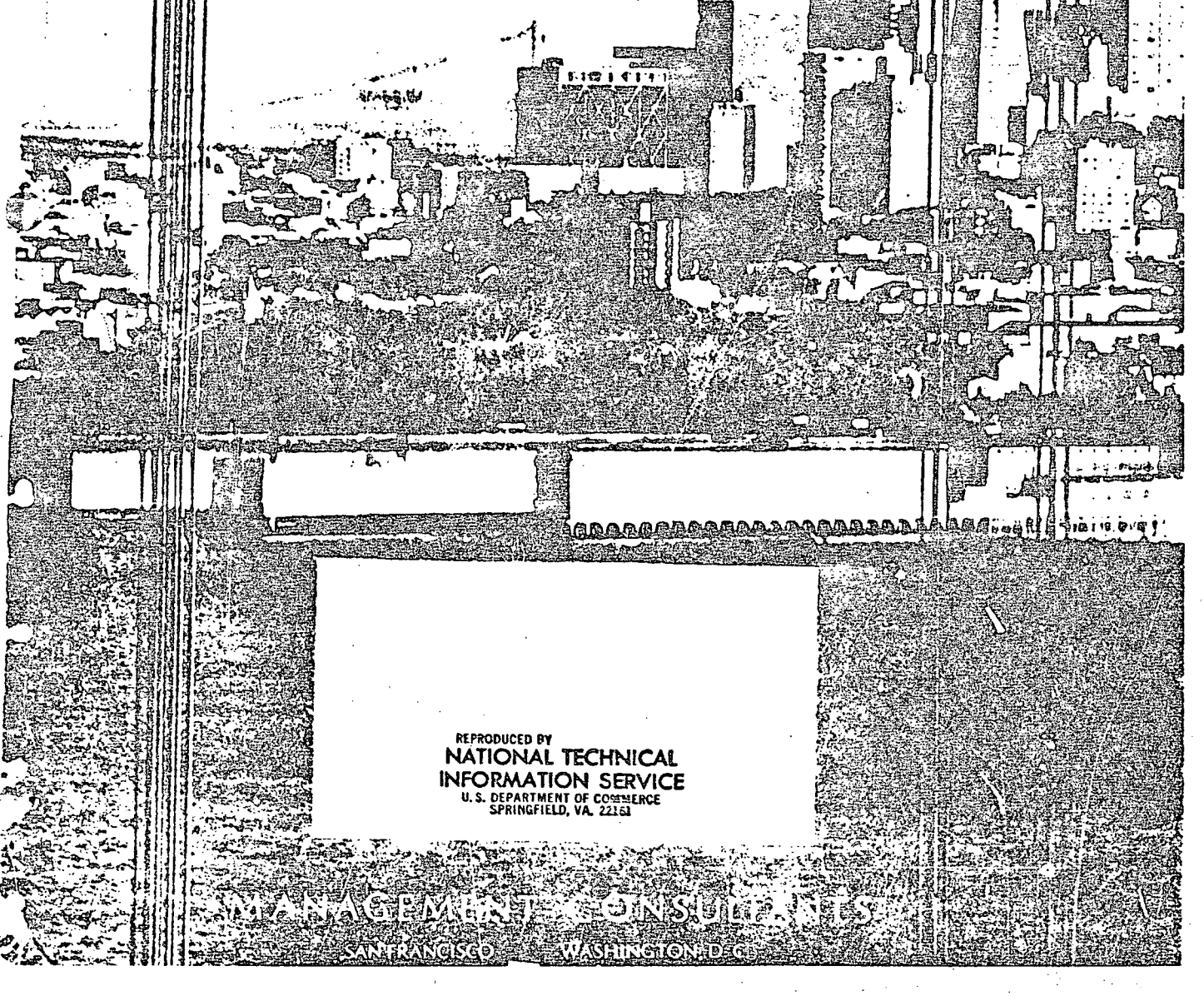
Volume II



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347 CLEMENT STREET
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VOLUME II

TABLE OF CONTENTS

INTRODUCTION

The following pages contain a condensation of the Project Profiles which were prepared for each of the twelve demonstration centers. Of necessity, all of the information which was compiled and synthesized for each center is not contained in this volume. However, the complete Profile, along with a Community Context section which is contained in a separate volume, is available from the Office of Child Development, National Center for Child Abuse and Neglect.

Each of the Project Profiles contains a discussion of the issues involved in starting-up and describes issues of staffing. The organization structure of the center is described, the linkages established are identified, and the legal issues with which the center has been involved are discussed. In the profile, the community concerns of the center, and its program priorities are discussed. The final two sections of the profile list the goals and/or objectives of the center and display and discuss statistical information concerning the center's operation.

II. CENTER PROFILES

A. PROFILE FOR THE FAMILY RESOURCE CENTER

ALBUQUERQUE

1. START-UP ISSUES

The grantee for the Family Resource Center of Albuquerque is the Social Service Agency (SSA), the state's mandated child protective agency. At the time of award of the grant, although SSA had considerable skill and experience with abuse and neglect cases, the agency was plagued by worker-overload and staff turnover, lack of training, lack of a systematic or multidisciplinary intervention apprcach, and gaps and flaws in the service coordinating mechanisms.

The most important start-up issue, therefore, was restructuring and transfering the ongoing program to a new site, and especially implementing a new team approach (this approach is discussed in Section 8 of this report). Roles and objectives and modes of functioning as a team were discussed and clarified at a weekend retreat held in October of 1975.

Some staff members working with the new Consultation/Education component were functioning also as caseworkers. Wearing "two hats" caused some initial communication and understanding problems which were dealt with by instituting a monthly staff meeting to deal with communicating the efforts, achievements, and problems of this program component to the rest of the staff.

The staff also decided that the team approach would function more smoothly if several workers were assigned only to intake and the remaining team members were given the ongoing case responsibility.

Family Resource Center had to work out a viable relationship with SSA for determining what would be the criteria for accepting cases at each agency, since in effect there are now two mandated protective service agencies in Albuquerque. Also, policies and procedures had to be formalized for transfering cases from one agency to another, and for maintaining case records and responsibility.

Another start-up issue was confidentiality in cases where FRC decided to utilize the resources of another agency, such as Mental Health/Mental Retardation Center. This agency had required written release by the client; however, procedures were worked out whereby FRC may receive confidential records without the clients written release, but the client must be told about the information sharing. FRC has been very careful to maintain confidentiality.

Providing transportation for clients to the center and to outside agencies for appointments was a start-up issue and continues to be a source of occasional problems.

The start-up of the child therapy center is as yet not accomplished, though it was to have been in operation

by May, 1976 (other priorities and responsibilities have interfered with its functioning as planned.)

2. STAFFING

State approval through SSA, of the job specifications for FRC personnel was obtained in March of 1975. In April, the Coordinator and Administrative Assistant were hired. From May through November of 1975, the hiring of the remainder of staff was achieved. Included on the staff of about 25 employees are ten former SSA protective service workers. Special staff consultation has been contracted with Bernalillo County MH/MR and this agreement was in place by July, 1975. FRC employees follow the personnel policies for other SSA workers.

Training was given to all new staff by child development consultants and other in-service training is on-going and the team approach (multidisciplinary) utilized by the center allows for a unique kind of continuing experiential training. Additionally, FRC is one of several agencies that sponsors a fall symposium for protective service workers and makes available training and technical assistance to other agencies.

3. ORGANIZATIONAL STRUCTURE

An organizational chart is shown on the following page.

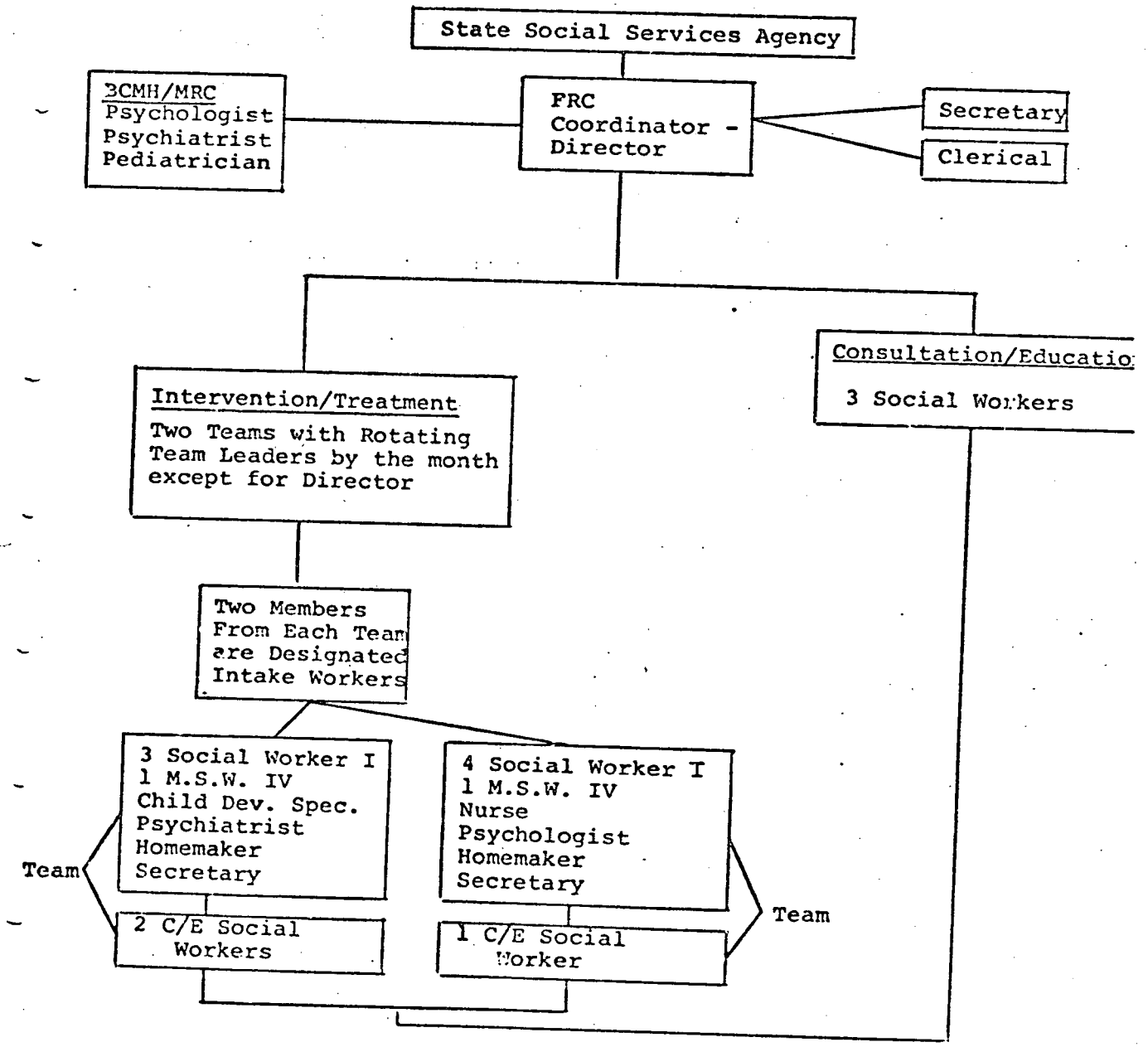
The management style of the Center is a decentralized one, where the coordinator is the only staff person having authority over members of the two teams. However, reporting relationships seem clearly defined and the rotation of team leader responsibility insures that all team members will feel responsibility in a relatively equal way.

The team members themselves have developed and refined written criteria guidelines and procedures for routing clients for testing, or other varied services, and the team meetings focus on setting or updating case goals.

4. LINKAGES

FRC was instrumental in developing the Consortium, the primary protective service system linkage mechanism. FRC identified a number of agencies involved in specific child protective functions and several that could provide anciliary services to enrich the service options. All agencies (about 15) were contacted and asked to select a staff member to serve on the Consortium. The group

ORGANIZATIONAL CHART



meets frequently and discusses both systemic issues/problems in working together, and specific case issues. Certain FRC staff members have been assigned several of these agencies and act as the FRC liaison. If a different FRC staff person has an issue to discuss with another agency, they work through the FRC liaison rather than directly.

The FRC staff feels that the Consortium to date has enhanced the service system in several ways by familiarizing the community with FRC and other agencies, communicating each agency's scope of services, hindrances to service provision waiting lists, eligibility requirements, etc., and developing overall role responsibility guidelines, follow-up systems, etc. but some functioning problems are apparent, and FRC feels that the Consortium could and should do more.

The Consortium has formalized its mechanisms only by an initial exchange of letters form the involved agencies agreeing to particpate. There is a chance, however, that the group might eventually formalize other procedures.

In addition the Consortium, FRC has developed informal linkages with a few other agencies with which an occassional working relationship is needed for specific cases.

5. LEGAL ISSUES

FRC is constantly involved with the court since it is the mandated agency. While there have been no major problems with the legal system, there have been a series of small practical problems.

(a) Dealing with emotional abuse in court. While the FRC staff recognizes emotional abuse, it is not always possible to "prove". Interpretation of any definitions vary widely from judge to judge and person to person.

(b) Dealing with judges. In the past, there were 12 rotating judges and no separate children's court. Recently, however, the judges themselves decided to elect a judge to deal with all juveniles. While this may be an advantage over the old system, it is too early to tell. In the past, FRC workers have found that certain personalities among the judges have sometimes been an obstacle to legal/protective service case management agreement.

(c) Reporting burden. The continuing relationship with the courts generates a massive amount of paperwork. While the time and energy expended here is burdensome, it is considered totally necessary.

6. COMMUNITY AWARENESS

(a) A general campaign is on-going that includes the development and sponsoring of TV and radio spots, and newspaper ads.

(b) Fact sheets on FRC and on New Mexico reporting laws and abuse/neglect indicators and characteristics have been circulated by the center.

(c) NCCAN posters have beer distributed throughout Albuquerque.

(d) FRC maintains a lending library, including NCCAN filmstrip scripts.

(e) Speaking engagements are arranged through the Consortium or through the center itself.

(f) A newsletter has been published.

7. PROGRAM PRIORITIES

Over the past three quarters, FRC's pricrities in terms of dollars expended have been in the following categories: case management and review, investigation, multidisciplinary team case review, individual adult counseling, diagnosis, residential shelter, homemaking, special child therapy, staff development, administration, community education, coordination, and legal assistance.

More complete breakdowns of FRC data may be found in the MIS Quarterly statistical summaries, especially Report 2, Linking Costs to Services, and Report 4, Expenditures by Function.

8. PROGRAM GOALS AND APPROACHES

Below is a list of FRC's goals and objectives.

GOAL I

TO PROVIDE A COMPREHENSIVE EVALUATION AND TREATMENT APPROACH TO CHILD ABUSE AND NEGLECT CASES IN BERNALILLO COUNTY.

Objective 1

That evaluation services be available directly or coordinated for all appropriate cases including: social diagnosis, psychiatric evaluation, psychological testing, educational evaluation, speech and hearing evaluation, pediatric examination.

Objective 2

That treatment services be available directly or coordinated for all appropriate cases including: individual psychotherapy, family therapy, group treatment, play therapy, infant stimulation, casework treatment, homemaker service.

Objective 3

That concrete services be available through coordination with the Social Services Agency or other agencies for appropriate cases including: foster care, day care, emergency shelter, medical care, financial assistance, employment counseling and training, legal aid.

Objective 4

That decision making and case planning be thorough and of high quality.

Objective 5

That the Family Resource Center provide a multidiscipline team approach solving the problems of child abuse and neglect.

Objective 6

That instruments be designed to measure service effectiveness.

GOAL II

TO PROVIDE 24 HOUR INTAKE COVERAGE AND EMERGENCY RESPONSE.

Objective 1

That a phone system with the FRC number be available on 24 hour basis.

Objective 2

That a rotating staff schedule be established for adequate coverage.

Objective 3

That publicity be accomplished related to developing awareness of 24 hour report capability.

Objective 4

That necessary communication and coordination between appropriate agencies occur to insure effective emergency services to families in need.

Objective 5

That specific criteria be spelled out regarding sorts of situations that will constitute emergency response.

Objective 6

That an adequate form of compensation for staff members on call be arranged.

GOAL III

TO PROVIDE PROMPT AND THOROUGH INTAKE SERVICES ON ALL REFERRALS CONSISTENT WITH STATE LAW AND AGENCY POLICY.

Objective 1

That a case acceptance criteria be developed.

Objective 2

That diagnostic guidelines related to problem substantiation be developed, to expedite and improve decision making and entry of case into system.

Objective 3

That procedures be developed to insure swift and proper movement of the case into intake and between program components.

Objective 4

That intake be specialized and composed of 2 staff members from each team.

Objective 5

That intake staff be trained in investigation, diagnostic technique and crisis intervention.

Objective 6

That intake and emergency services be available immediately if required.

Objective 7

That appropriate agencies be worked with regarding their role in emergency intake situations.

GOAL IV

TO PROVIDE A COMMUNITY ORIENTED PROGRAM WHICH IS BASED ON SHARED COOPERATION AND RESPONSIBILITY FOR CHILD ABUSE AND NEGLECT IN BERNALILLO COUNTY.

Objective 1

That a community education program be developed to promote understanding among lay and professional sectors regarding the dynamics of child abuse and neglect.

Objective 2

That a public awareness campaign be developed aimed at altering attitudes, increasing sensitivity toward reporting and promoting community involvement and responsibility for the problem.

Objective 3

That a community advisory board be formed and actively participate in the implementation of the program.

Objective 4

That a consortium of community agencies be formed to communicate and coordinate efforts in serving abusive and neglecting families.

GOAL V

TO PLAN, DEVELOP AND IMPLEMENT A VOLUNTEER PROGRAM DESIGNED TO WORK DIRECTLY WITH APPROPRIATE CHILD ABUSE AND NEGLECT CASES.

Objective 1

That cases be identified which can best be served by a volunteer.

Objective 2

That FRC staff be organized to provide adequate supervision for volunteers and maintain case responsibility.

Objective 3

That a recruitment effort be implemented through the media and with groups and organizations.

Objective 4

That applicants be interviewed and screened.

Objective 5

That a training program be made available to each prospective volunteer.

GOAL VI

TO PROVIDE A STATEWIDE CONSULTATION AND EDUCATION TO COUNTY SSA STAFF AND SELECTED GROUPS.

Objective 1

That a training curriculum be developed for use by protective services staff statewide.

Objective 2

That specialized training curriculum be developed for application and the development of the multi-discipline approach.

Objective 3

That an instrument to measure community program effectiveness be developed for statewide use.

Objective 4

That FRC staff provide consultation to other communities as required.

GOAL VII

TO DEVELOP A MORE COMPREHENSIVE INDEPTH KNOWLEDGE AND UNDERSTANDING OF THE PROBLEM OF CHILD ABUSE AND NEGLECT IN BERNALILLO COUNTY AND TO DEVELOP PRESCRIPTIVE METHODS FOR EFFECTIVELY RESOLVING THE PROBLEM.

Objective 1

That a research design be developed for the purpose of determining etiology and evaluating treatment effectiveness.

Objective 2

That all substantiated cases voluntarily receive psychological testing for the purpose of gathering characteristic data.

Objective 3

That all external evaluation data collection be accurate and timely.

Objective 4

That current research findings and general literature be utilized and applied to improvement of efforts at FRC.

Objective 5

That all valid research findings and treatment methods be written and disseminated to interested parties nationally.

Goals I, II, and IV have been approached primarily through the FRC team approach. No case worker "owns" a case; all cases belong to the team, but are primarily managed by one assigned worker. This format provides that all cases come before the team at certain intervals and therefore receive the benefit of a multidisciplinary group decision.

Goal II has been met, but has been a problem. New Mexico mandates 24 hour coverage but makes no financial provision for its mandate to SSA! The FRC staff, on a rotating basis, are on call 24 hours, but SSA policies require all compensatory time to be made up within two weeks. FRC staff have not been able to compensate themselves for their time on 24-hour rotation due to the heavy on-going work load.

Achievement of Goal V has met some obstacles and volunteers have, to date, not played the role that FRC had hoped. However, new strategies to recruit and keep able volunteers are being developed and tried.

Goal VI has proved to be extremely ambitious, due to the need for consultation and education in the Albuquerque

area. The project is trying to "play down" the need for statewide traveling to provide T and TA while still being responsive to requests from other areas in the state.

Strategies for achieving Goal VII are currently being worked out in connection with consultants and another agency.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The Tables and figures presented below contain information on costs for each functional service area (for the year and by quarter), unit costs, indicators of problems, and the case flow diagram for the year. A brief commentary accompanies each table or figure.

Table 1 shows the actual costs expended and total value of services in each of five functional service areas, and also gives a breakdown of client services in the areas Services to Families and Services to Children*. The actual cost of all services provided by the Family Resource Center, as derived from the MIS data, was $270,871, and total value of services was $275,636. Casework Activities accounted for 37.1% of the actual budget and 37.2% of the total value of services. In the areas Services to Families and Services to Children, approximately 15% and 5% of the budget were attributed to those services.

Among the client services, the data show that physchological services were emphasized by FRC. It is also in this client service area that a substantial donation of services were received. Donations were also noted in the client service area of support.

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*Each of the functional service areas is defined by its MIS service categories on the following page.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTER: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	270,871	100.0	275,636	100.0
PROGRAM OPERATIONS	99,414	36.7	100,121	36.3
COMMUNITY ACTIVITIES	18,474	6.8	18,561	6.7
CASEWORK ACTIVITIES	100,405	37.1	102,459	37.2
SERVICES TO FAMILIES	39,263	14.5	40,745	14.8
SERVICES TO CHILDREN	13,315	4.9	13,750	5.0
CLIENT SERVICES:				
MEDICAL	1,827	0.7	1,986	0.7
PSYCHOLOGICAL	30,200	11.1	33,616	12.2
LEGAL	3,891	1.4	3,891	1.4
SHELTER/CUSTODIAL	4,869	1.8	5,145	1.9
SUPPORT	9,450	3.5	11,332	4.1
EDUCATIONAL	1,277	0.5	1,300	0.5
CRISIS INTERVENTION	1,494	0.6	1,494	0.5

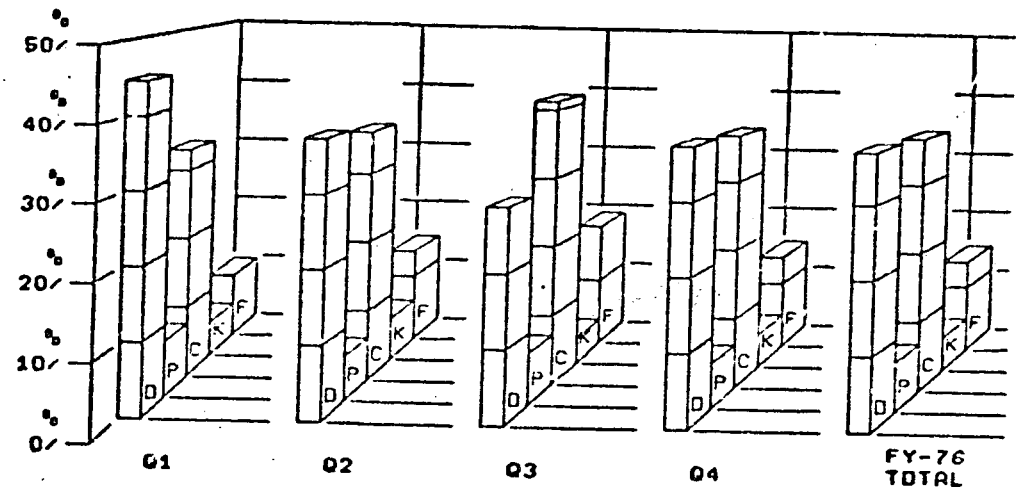
Figures 2 and 2A graphically display actual cost and total value in the five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that after the first quarter in which almost 45% of the budget of the Center was expended on Program Operations, the percentage of actual cost in this service area dropped to 30% and remained at or below that level for the remainder of the year. Consistently, the smallest percentages of actual costs were allocated to Community Activities and Services to Children with less than a 10% allocation for any quarter for either area. In the functional area, Services to Families, the range of percentage allocation was a low 10% in the first quarter to a high of slightly less than 20% in the third quarter, resulting in an average for the year of approximately 15%. The percentage of actual cost allocated to Casework Activities remained fairly stable throughout the four quarters with an average over the four quarters of approximately 37% of actual costs being expended in this area.

Figure 2A indicates that the total value expenditures closely paralleled the percentage of actual cost data. There was no change in the relationship of the service areas when total value was examined.

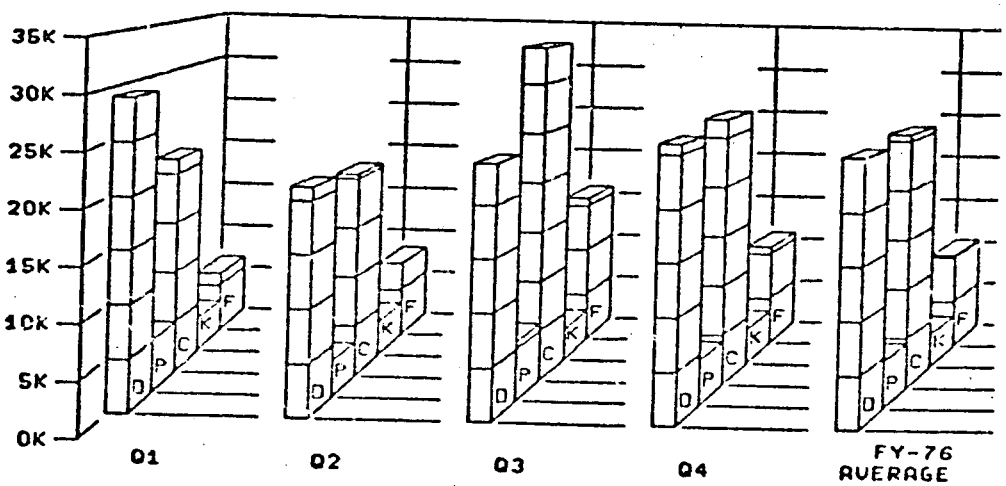
FIGURE 2- ACTUAL COST PER SERVICE AREA BY QUARTER, FY-76



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

FOR ALBUQUERQUE

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



In Table 2, the unit costs per child and family for the last two quarters of the fiscal year are shown. The reader is referred to Volume I, Pages 22-24 for a detailed discussion of the methodology for computing these figures, and the resulting difference between these values and the values shown in Figure 3.

TABLE 2

Six Month Unit Costs

ACTUAL COST PER CHILD	$316
TOTAL VALUE PER CHILD	316
ACTUAL COST PER FAMILY	727
TOTAL VALUE PER FAMILY	757

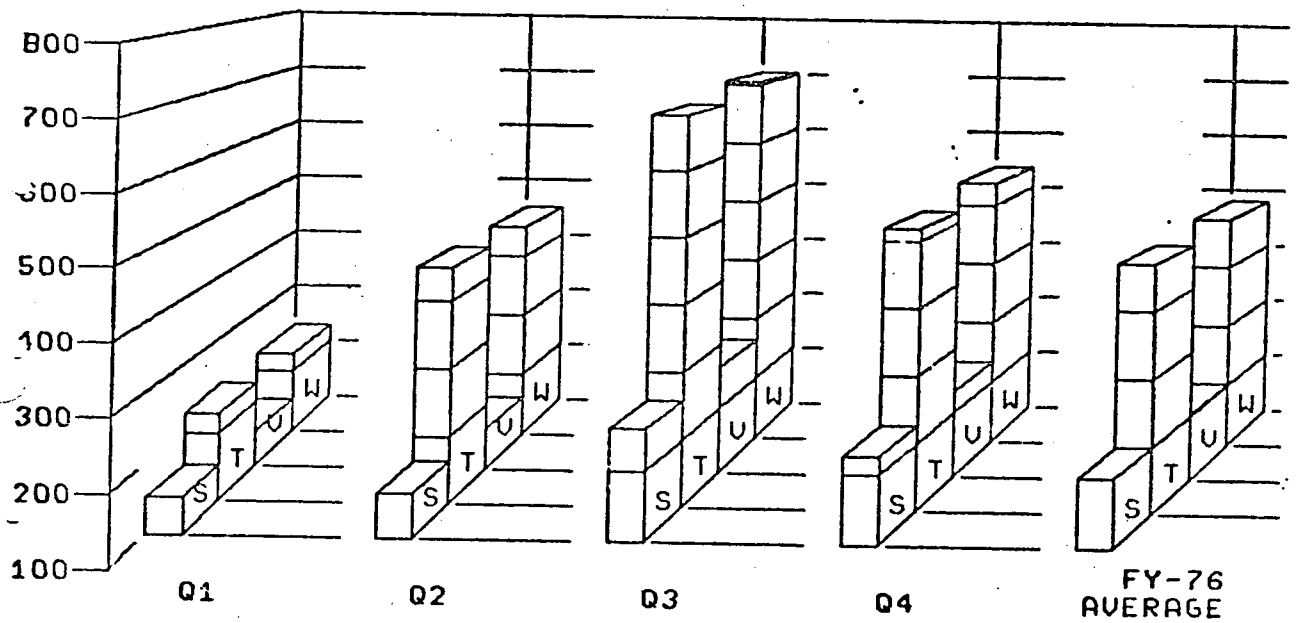
For the six month period from 1 January 1976 to 30 June 1976, the actual cost per child and family at FRC were close to the median reported for all centers of $318 and $719, respectively. The total values per child and family reported by the Center were considerably below the medians of $486 and $942 reported by the aggregate of the 12 centers.

Figure 3 provides a visual display of the unit cost per child and per family for each quarter of the fiscal year and the average unit costs for the year. The figure depicts actual cost and total value data.

The average actual cost per child for FY 1976 was approximately $200. During the first two quarters, the unit cost was lower than $200, but it was higher in the latter two quarters. The actual cost per family showed a similar pattern. In the first two quarters of the fiscal year, the actual cost per family was approximately $250 in the first quarter and $450 in the second quarter. These unit costs were shown to be almost $700 per family for the third quarter, and slightly more than $500 per family in the fourth quarter. The average unit cost for the year was approximately $500 per family.

The pattern for total value per child and per family was similar over the four quarters. The data indicate that few donated services were received at the Center as the total value figures per child and per family were almost identical to the actual cost figures. The average total value per child and per family over the year were nearly identical.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR ALBUQUERQUE

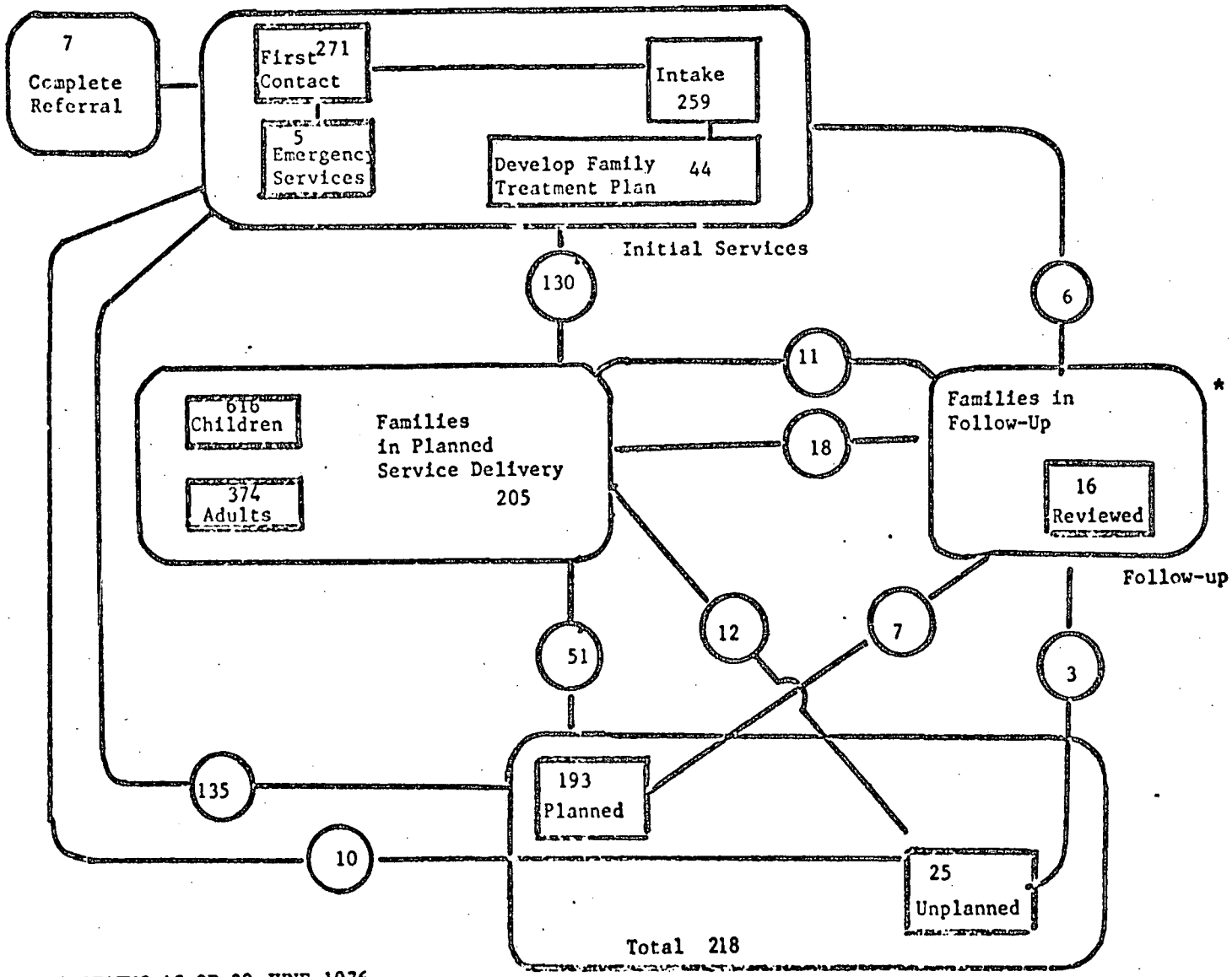


KEY

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

Figure 4 contains data concerning the flow of clients through FRC. For the period from 1 January through 30 June 1976, a total of 205 families (including 374 adults and 616 children) received planned services. Emergency services were provided for five cases. As of 30 June 1976, 10 families remained in follow-up and through this six month period, 16 cases were reviewed. Two hundred eighteen cases were terminated from the Center's caseload. Of this number, 193 (88.5%) were planned terminations.

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 displays a summary of the flags raised by the MIS that indicate potential problems that are being encountered by the Center.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVERS FOR THE YEAR	2
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual expenditures in service category 1 (administration) and dividing the sum by the actual total cost to determine whether these costs were lower or higher than 25% of the actual costs expended. At the FRC, 18% of actual costs was expended in administrative costs. Sixty-three percent of the center's actual resources were expended in service areas, therefore these expenditures exceeded the 50% service expenditures needed to be adequate in this area.

B. PROFILE FOR BELTON, TEXAS

(CAN-DO)

1. START UP ISSUES

The grantee agency for CAN-DO (Child Abuse and Neglect Demonstration Organization) is the Central Texas Council or Governments, or CTCOG. This council includes in its membership county government representatives, with 22 cities, 8 school districts, 6 special districts, and population of about 250,000 including 66,000 military personnel stationed on or near Fort Hood Army Base, the largest army armored installation in the country. The catchment area for CTCOG and CAN-DO covers about 6,540 square miles. CTCOG is primarily a planning agency, and CAN-DO was conceived as a planning, coordinating, and capacity building agency rather than being primarily a direct service provider.

The major issues affecting implementation of the project follow:

(a) Clarification of CAN-DO's relation to the Department of Public Welfare: While the state mandated child protective agency for Texas strongly supported the CAN-DO concept from the beginning, during start-up, the mechanics of how CAN-DO would support, complement, extend, and coordinate services to abusing/neglecting families were at issue. The hiring of the Treatment Services Coordinator was seen as a critical step. The person selected has both

a strong DPW and social services background. Additionally, confidentiality of DPW records was a concern. It was agreed that while access to DPW files was needed in cases where CAN-DO provided services and resources, copies of these files would not be removed from DPW offices.

(b) Establishment of a process to interface and coordinate with the military community. With DPW, CAN-DO coordinated the placement of civilian resource representatives on the Ft. Hood Child Protective Council in an effort to encourage more military referrals to outside agencies. An initial "turfism" problem over foster home placements was resolved with Army Community Services by an agreement to use only military crisis homes in certain cases. Ft. Hood's Community Services staff is currently firmly supporting CAN-DO's efforts and working closely with CAN-DO personnel on several fronts, including becoming increasingly involved in the Volunteers in Action Program.

(c) Establishing a positive community response. CAN-DO initially had to counter the "bad image" DPW had in the area when the grant was awarded. Additionally, many other service agencies felt threatened by CAN-DO. Much leg work was done by the staff to promote the program by explaining CAN-DO's function and demonstrating a true

desire to work with all existing service resources. CAN-DO effectively solicited community recommendations concerning gaps in services with the result that agencies not only began to communicate actively, and work closely with CAN-DO, they also were able to assess and begin to correct their own service gaps and weaknesses.

2. STAFFING ISSUES

The main staffing issue was the need to recruit persons familiar with the area's resources and capable of enhancing and developing resource alternatives. This was not a particular problem, and all key staffers were in place within the first two months of the program. The Project Director is a retired military officer whose last assignment was at Ft. Hood. Thus, his talents in the areas of grantsmanship and administration were enhanced by his direct knowledge of the military lifestyle and the social service systems on the post. While CAN-DO funds do not pay any DPW salaries, the appointment of Ms. Cathy McGilvray as area DPW Supervisor about the time CAN-DO was starting up has been a tremendous boost to the morale of the area's DPW workers and has positively effected CAN-DO staff's enthusiasm as well. Ms. McGilvray is in constant close communication with CAN-DO, and has played a decisive lea-

dership role in helping to set CAN-DO's direction.

The project has had less good fortune in recruiting and keeping a good secretary because the pay for this position is very low.

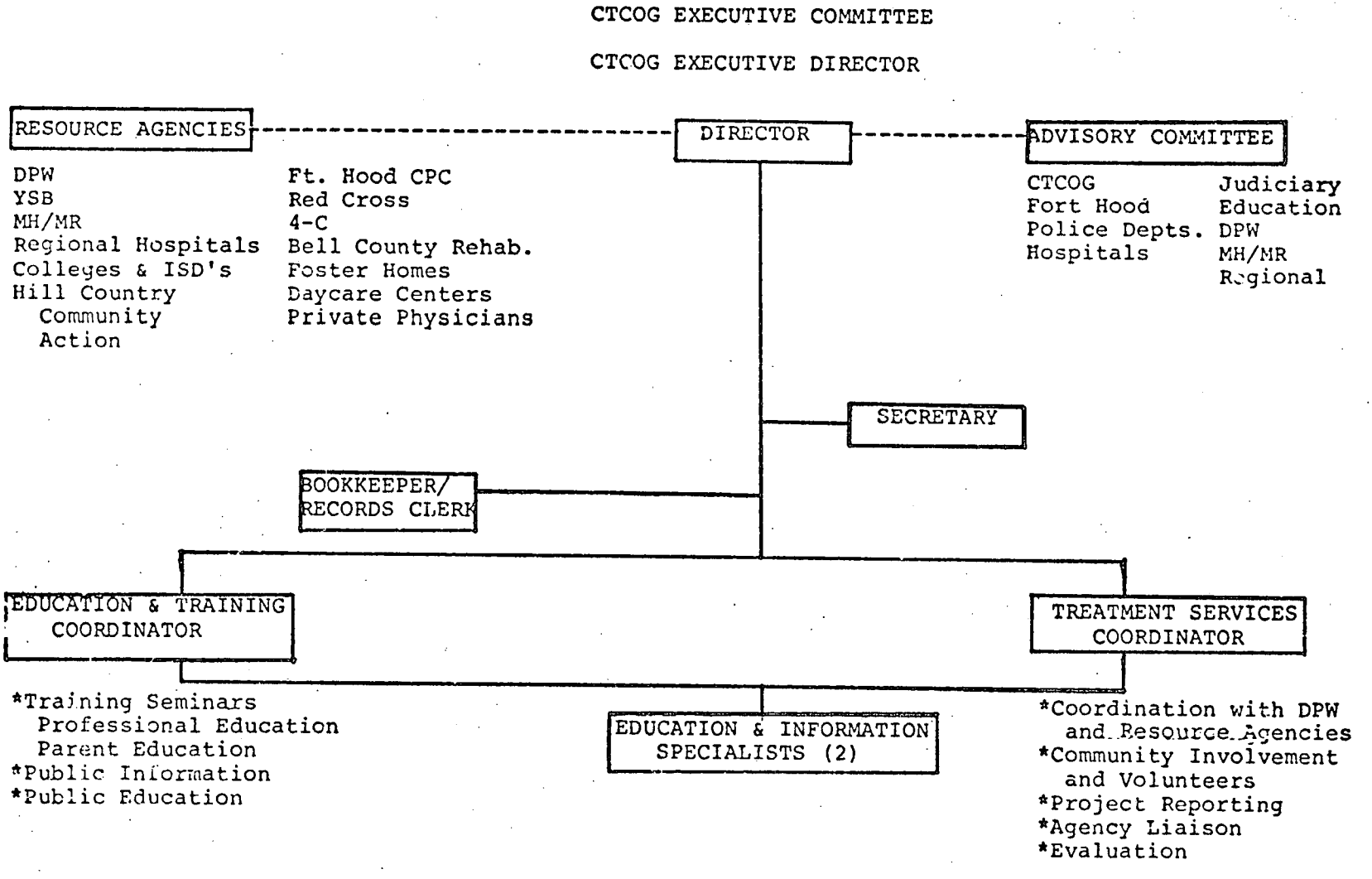
3. ORGANIZATIONAL STRUCTURE ISSUES

CAN-DO's smooth operation depends in large part on the transmission of information back and forth between a large number of agencies. Because CAN-DO's own staff is small, each employee has a clear idea of exactly what is expected of every staff member. The organizational structure appears to be very responsive to the coordinating needs of the region, and the clearly defined roles of each staff seem to provide the mechanism for quality feedback to and from all participating agencies. An organizational chart follows.

4. LINKAGES WITH OTHER AGENCIES

Refer to the organizational chart above for a listing of the primary resource agencies linked with CAN-DO. All of these linkages are detailed in contract agreements which list specifically what services an agency can provide to children or abusing/neglecting families. When CAN-DO staff

CAN-DO ORGANIZATIONAL CHART



originally contacted agencies to discuss formal service agreements a form was provided on which the agency listed all of its specific services. In some cases, these listings served as a mini self-assessment, and the agencies have since that time developed new services or improved old ones. Based on the responses of the area's service agencies, CAN-DO identified service gaps and in some cases assisted in the development of new direct services or new agency linkages. There have been a few minor problems with agencies billing CAN-DO for a service which was not successful, appropriate, or in a few cases, when the client failed to show. These have been worked out successfully, and policies and guidelines for payment now exist.

5. LEGAL ISSUES

There have been no legal issues involving CAN-DO to date. However, the agency is quite interested in matters relating to legislative reform of child welfare in the state. In October, 1976, CAN-DO helped CTCOG sponsor a legislative forum which featured speakers and discussion of possible and pending child welfare legislation. One issue discussed at the forum was the ways of raising the level of AFDC support, since currently five of the seven CTCOG/CAN-DO counties have no AFDC boards and therefore no funding source for foster care.

The counties that do have AFDC boards can authorize $3.00 per day per child for support, while the necessary funds are actually about double that figure. In January, $4.00 per day will be paid, but this is still inadequate.

CAN-DO, (functioning as an extension of DPW) uses the definition of abuse as it appears in the Texas DPW Social Services Handbook:

> "Abuse is defined as non-accidental infliction or threat of infliction of physical injury, or emotional or mental damage to a child by a person responsible for a child's health or welfare. It is also the withholding of needed care for a child. Abuse is usually corroborated by medical, psychiatric, or psychological personnel."

6. COMMUNITY AWARENESS CONCERNS

CAN-DO has devoted much time and effort to preparing materials that will raise community awareness of the problem of child abuse/neglect. Three staff members are involved in these activities: the Education & Training Coordinator who directs public information efforts, and two Education & Information Specialists, who assist in materials preparation, public relations efforts, presenting programs and community data collection. To date and continuing, these efforts have included presentations to a number of target groups--professionals, including medical, day-care, law enforcement, school teachers; high-school students; civic and church groups; etc.

A CAN-DO pamphlet, quarterly report, and newsle[illegible] been published. News releases and billboard c[illegible] been conducted. Recruitment for foster homes and v[illegible]nteers have involved intense, highly visible campaigns. The project makes available several films and various slide presentations and visual aids to community groups and high school, college and graduate students. A reader's theatre is in the works which will utilize high school students as actor/readers. The Volunteers in Action (VIA) program has been publicized and promises to help extend community awareness, particularly within medical facilities where "high risk" mothers and families will be the target group.

7. PROGRAM PRIORITIES

CAN-DO's stated goals and objectives are summarized in the following section of this report, Program Approaches, Strategies, and Goals.

In general, these project priorities have been supported by funds allocation over the past year. The MIS quarterly summaries, particularly Reports 2 and 4, Linking Costs to Services and Expenditures by Function, respectively, reveal that the categories consistently receiving the greatest CAN-DO attention are: Special Child Therapy, Coordination, Community Education, Identification/Outreach, Resource Development,

Multidisciplinary Team Case Review, Psych. Evaluation, Crisis Nursery, Day Care, and Adult Counseling. If the ambitious volunteers program currently in its start-up phase is successful, we might expect lay therapy to become one of the major categories in terms of expenditure of time rather than dollars.

8. PROGRAM APPROACHES, STRATEGIES, AND GOALS

The overall approach at CAN-DO is that if an abusing or neglecting family needs services that are more comprehensive or specialized than those DPW can regularly provide, CAN-DO will arrange for the services, or provide payment, provide transportation and follow the case to stability or resolution. However, DPW remains the primary case manager in most instances. There are few services offered directly by CAN-DO, but the staff's knowledge of resources in the community and the close contact that is maintained by CAN-DO with its contract agencies has generally led to smooth service delivery of the needed services. CAN-DO is under obligation to investigate all other funding sources before agreeing to pay for the needed service from OCD monies. The services that CAN-DO provides directly are listed below:

(a) M.A.T. (Multidisciplinary Advisory Team). This team is available on a voluntary basis to DPW workers who

wish to involve several professionals in determining the course of a particular abuse/neglect case. While the team has undergone two different restructurings, and its mechanisms are still being refined, DPW workers have responded positively (by questionnaire) to the idea of continuation of the team.

(b) Volunteers in Action(VIA). The VIA program, though a direct service developed by CAN-DO, has been designed to involve DPW workers in a supervisory capacity. The Volunteers have served in a big brother/big sister role, and have provided crisis day-care, babysitting, or residential shelter.

In a new section of the VIA program, volunteer lay therapists who will receive 25 hours of training arranged by CAN-DO and given by CAN-DO, Hospital staff, DPW, and a MSW consultant. The program is scheduled to be "piloted" in two hospitals in Fall of 1976. Hospital staff will identify "high risk" families in the pre-natal and new-born clinics. The volunteers will make contact with the family, explain the program and the services, and be the primary provider of these services. The key to the success of the program involves finding enough committed volunteers who can, in turn, gain the trust of families identified.

(c) CAN-DO operates a clothes chest and arranges for emergency supplies for families in crisis to be donated or purchases.

(d) Community Education Services. These have been discussed under Section 6 above.

The following are a list of CAN-DO's stated goals and objectives:

GOAL I

Increase Public Awareness

- Through a multi-media approach, stimulate awareness of the child abuse/neglect problem.

GOAL II

Disseminate Information on Identification and Reporting

- Conduct community programs to promote identification and reporting of child abuse/neglect.

GOAL III

Encourage Reporting

- Develop and conduct professional training programs designed to reach groups who have frequent contact with children such as hospital staffs, police and school teachers and administrators.

GOAL IV

Establish and Coordinate a Regional Registry

- Establish and coordinate a regional statistical information system.

GOAL V

Develop Preventive Programs

- Develop and conduct a primary prevention program for high school students and young adults.

- Develop and coordinate a Parents' Aide Program for the benefit of high risk parents.

- Organize and monitor a parent training program for the benefit of high risk parents.

GOAL VI

Develop Continuum of Services, Pre-natal Through Alleviation of Consequences

- Establish a treatment resource coordination system; develop sub-systems for referral and follow-up of treatment services provided to children and adults involved in abuse and/or neglect.

- Assist DPW supervisors and caseworkers in the review of difficult cases by the establishment and operation of a multiprofessional advisory team.

- In coordination with DPW, establish and administer a volunteer program to provide direct and indirect services to families and children involved in child abuse and neglect.

- Organize and monitor a parent training program for the benefit of DPW clients.

GOAL VII

Arrange for Facilities to Fill Gaps in Services

- Provide for the establishment of emergency foster care for children designated by the Department of Public Welfare

- Assist DPW in the recruitment of foster parents and the provision of a supplementary training program for foster parents after recruitment

- Develop and coordinate a Parent Aide program for the benefit of DPW clients

- Through CAN-DO grant funds, provide for evaluation and treatment services to child abuse and neglect cases for which no other resources are available.

9. RELATIONSHIP TO NCCAN

CAN-DO's director, Jack Knox, has high praise for his NCCAN Project Officer, Mr. Roland Sneed, who has been extremely helpful and has responded in a timely and creative manner to all of CAN-DO's various requests for information, suggestions, and assistance.

10. STATISTICAL INFORMATION

The following pages contain statistical information complied from the Management Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on costs for each function service area (for the year and by quarter), unit costs, indicators of problems, and the case flow diagram for the year. A brief commentary accompanies each table or figure.

Table 1 shows the actual costs expended and the total value of the services in each of five functional service areas. It also gives a breakdown of client services provided in the area Services to Families and Services to Children.* The actual cost of all services provided by

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* Each of the functional service areas is defined by its MIS service categories on the following page.

the CAN-DO Center of Belton, Texas, as derived from the MIS data, was $231,429, and the total value of these services was $245,473. After Program Operations, which accounted for 49.6% of actual cost and 47.1% of total value, program emphasis was directed to Community Activities. $66,743 (28.8%) was expended in this area, and with the addition of donated services, this figure became $69,226 (28.2%) in total value. The next priority area, as indicated by the MIS data, was in Services to Children with an expenditure of $28,615 (12.4% of actual cost), giving total value of $32,053 (13%).

Among the client services, data show that more resources were expended for psychological services than any other service. In actual cost, $26,763 (11.6%) was spend on psychological services. The total value of these services was $30,131 (12.3%).

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$231,429.	100.0	$245,473	100.0
PROGRAM OPERATIONS	114,780	49.6	115,557	47.1
COMMUNITY ACTIVITIES	66,743	28.8	69,226	28.2
CASEWORK ACTIVITIES	6,589	2.9	6,783	2.8
SERVICES TO FAMILIES	14,702	6.3	21,854	8.9
SERVICES TO CHILDREN	28,615	12.4	32,053	13.0
CLIENT SERVICES:				
MEDICAL	$1,050	0.5	1,051	0.4
PSYCHOLOGICAL	26,763	11.6	30,131	12.3
LEGAL	0	0	0	0
SHELTER/CUSTODIAL	6.727	2.9	6,810	2.8
SUPPORT	5,205	2.3	11,337	4.6
EDUCATIONAL	3,557	1.5	3,564	1.5
CRISIS INTERVENTION	5	0	1,014	0.4

Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

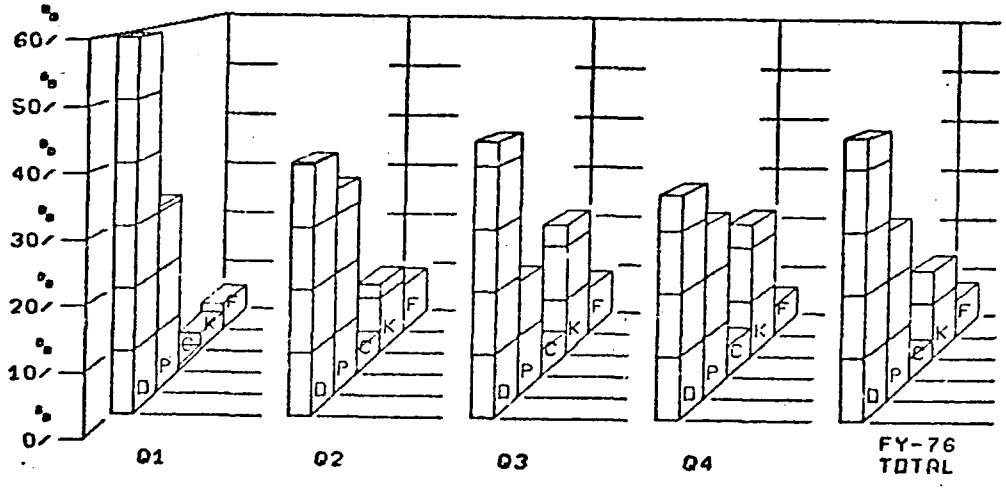
NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that the average percentage of actual cost expended in the Program Operations functional service area (almost 50%) is somewhat misleading due to the unusually high percentage of costs expended in this area during the first quarter (60%). The percentage of actual cost attributed to Program Operations in the second, third, and fourth quarters was 45% and lower. Figure 2 also shows that the service area of greatest emphasis for the Center was Community Actitivites.. In this service area, more than 30% of actual cost was allocated to Community Activities in the first, second, and fourth quarters, with only the third quarter showing an allocation of less than 30%. The average allocation for the year was slightly less than 30%.

The next area of emphasis was demonstrated to be Services to Children. The average allocation to this service area for the year was approximately 12% of actual cost, with 22% of the budget allocated to this area in the third and fourth quarters, and slightly more and less than 10% allocated in the first and second quarters, respectively. In the functional service area Services to Families, the allocation for the year remained at or less than 10% of actual cost with an average for the year of less than 10%. Casework Activities received the smallest proportion of the budget of this Center with less than a 5% allocation in any quarter.

The configuration of Figure 2A is somehwat different than that of Figure 2 indicating that substantial donations were received in the second, third, and fourth quarters. The net result of these donations was to show that relatively fewer resources were spent in Program Operations than would be expected, given the percentage of actual cost expended in this area. However, the relationships between the other functional service areas remained the same, with more total resources being allocated for Community Activities and fewest for Casework Activities.

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

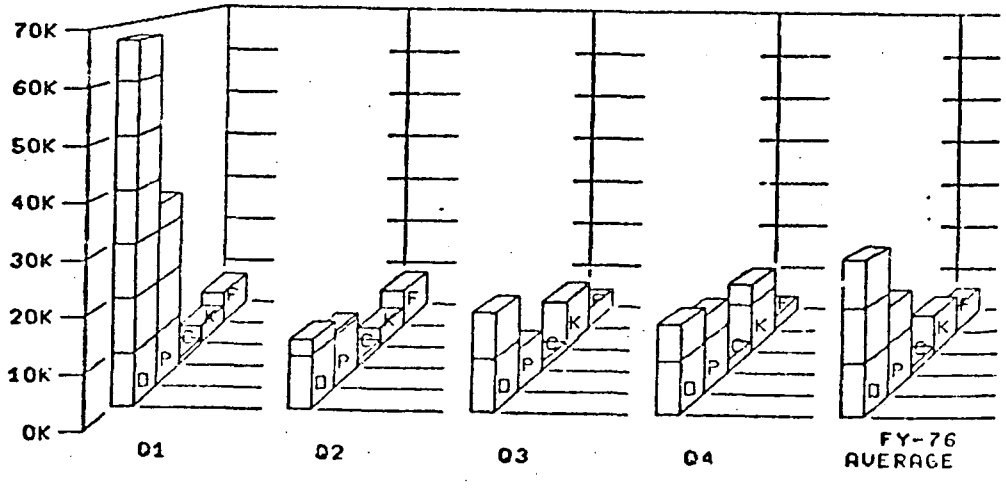


KEY
D- OPERATIONS
P- COMMUNITY ACTIVITIES
C- CASEWORK ACTIVITIES
K- SERVICES TO CHILDREN
F- FAMILY SERVICES

FOR

BELTON

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



In Table 2, the unit costs per child and family for the last two quarters of the fiscal year are shown. The reader is referred to Volume I, page 22-24 for a detailed discussion of the methodology for commuting these values, and the resulting difference between these values and the ones shown in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

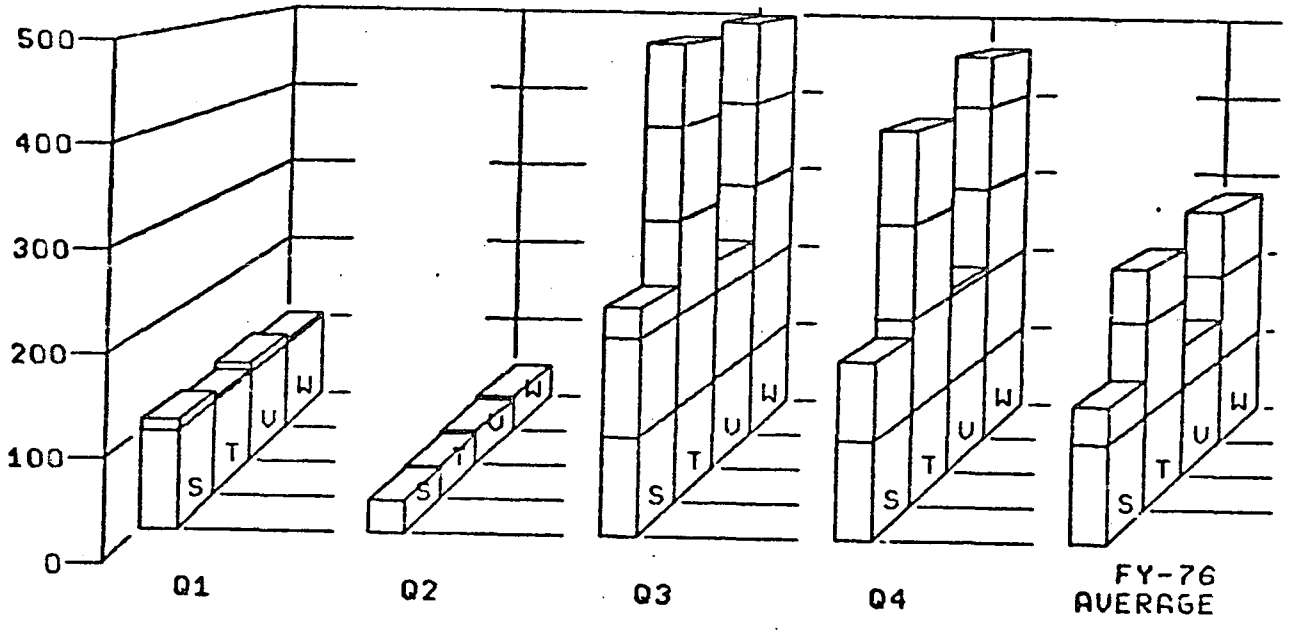
ACTUAL COST PER CHILD	$320
TOTAL VALUE PER CHILD	347
ACTUAL COST PER FAMILY	710
TOTAL VALUE PER FAMILY	771

For the six month period from 1 January 1976 to 30 June 1976, the actual cost per child and family at CAN-DO were close to the median values reported for all centers of $318 and $719, respectively. The total values per child and family reported by the Center were considerably below the median of $486 and $942 reported by the aggregate of the 12 centers.

Figure 3 provides a graphic display of the unit costs per child and per family for each quarter and the average unit costs for the year. The figure shows actual cost and total value data.

It is extremely easy to see, from the configuration of the data, that the Center did not become fully operational until the third quarter (Jan. to Mar., 1976). The unit costs, both actual cost and total value per child and family, were unusually low for the first two quarters. However, in the third quarter, the actual cost and total value per child was approximately $233, and the actual cost and total value per family was approximately $500. Except for error in measurement, these figures were virtually repeated for the fourth quarter. Therefore, the average figures for the year could be somehwat misleading.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR BELTON



KEY

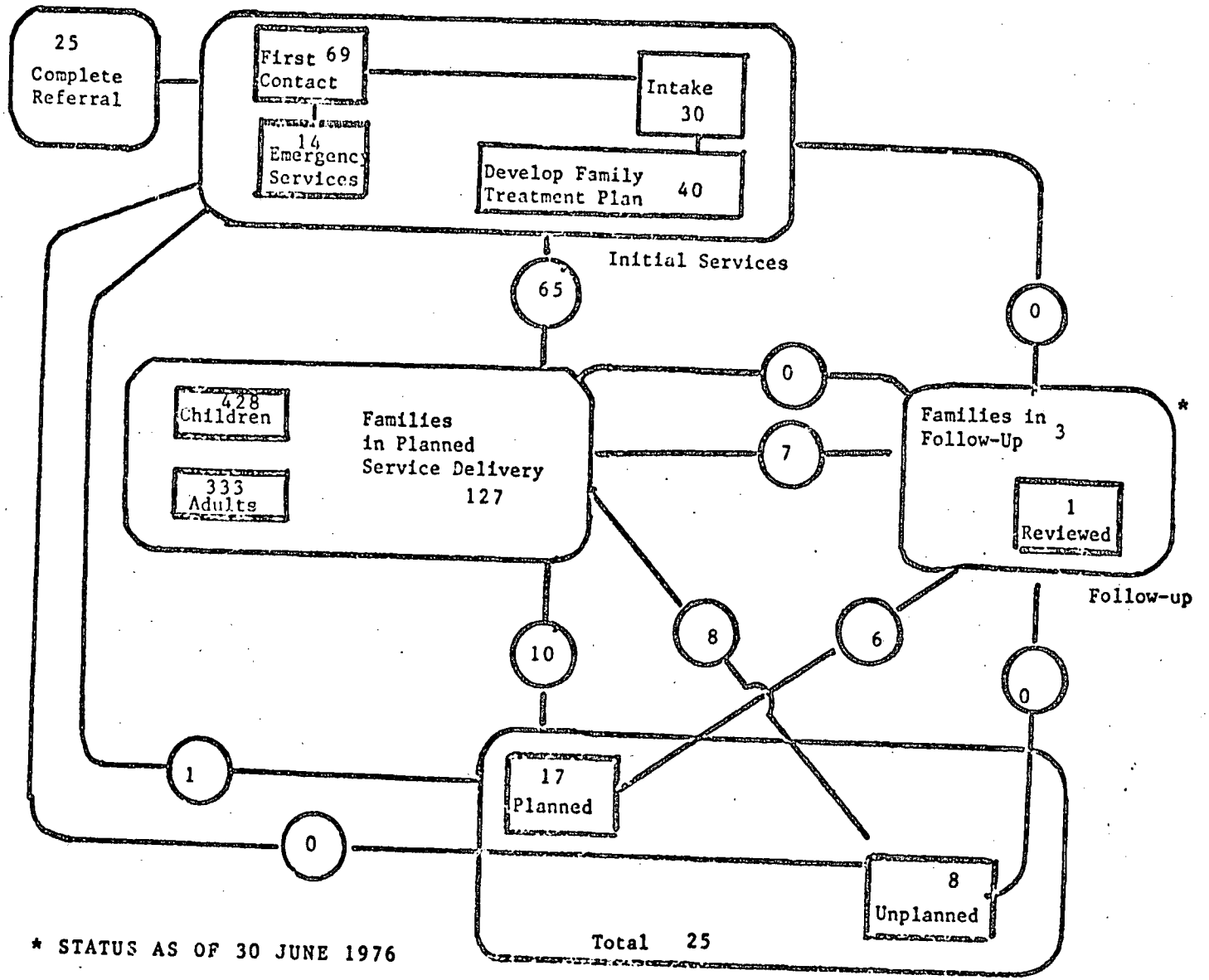
S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
U- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

Client flow information is reproduced in Figure 4. For the six month period from 1 January to 30 June 1976, a total of 197 families (including 33 adults and 428 children) received planned services at CAN-DO. An additional 14 families received emergency services during this period. At the conclusion of this six month period, three families remained in the follow-up and one family had been reviewed. Twenty-five families were terminated during this period. Seventeen or 68% of these terminations were planned terminations.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR BELTON
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JULY 1975 - JUNE 1976

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 displays a summary of the "flags" raised by the MIS that indicate potential probelms that are being encountered by individual centers.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVERS FOR THE YEAR	1
KEY STAFF VACANCIES (as of 30 June 1976)	0

Administrative costs were calculated by adding the actual expenditures for the year in service category #1 (Administration) and dividing this sum by the actual cost to determine whether these costs were higher or lower than 25% of the actual costs expended. At 14% of actual cost was spent in administrative costs -- considerably lower than the cut-off point. Fifty percent of actual cost expended in the combined services area excluding Program Operations was seen as adequate. The Center's expenditure was 50.4% -- just exceeding the adequacy level.

C. PROFILE FOR THE METROPOLITAN AREA PROTECTIVE SERVICES

CHICAGO

1. START UP ISSUES

The Metropolitan Area Protective Services has been bereft with start-up problems. The Project did not become fully operational until 16 months after the initial funding period. In addition to implementation problems, it is felt that the project has become bogged down in red-tape, thus producing demonstration operations and results that are not as efficient and effective as they can be.

The initial start-up issues involved the securement of a facility for center activities, the second issue involved hiring of staff, the third involved the fiscal arrangements through the state structure. While the evaluator was never fully able to pinpoint the exact cause of the problems, these problems continued to be reflected in the overall effectiveness of the project as a demonstration center.

2. STAFFING ISSUES

Due to the idiosyncratic hiring practices of the State Civil Service System in the State of Illinois, it was difficult for the project to secure permanent employees during the early phases of project start-up. Many employees were hired on a temporary basis and the problem as explained by the project director became so intricately complicated that the problem became almost incomprehensible.

Staff turnover has been higher than any other demonstra-

tion center.

3. ORGANIZATIONAL STRUCTURE

The Council for Community Services of Metropolitan Chicago spearheaded the formation of a group of private child welfare agencies, and formed a consortium known as the Group for Action Planning. Other agencies joined with the child abuse and neglect team at Childrens Memorial Hospital to develop a network to serve families reported by the hospital under the Illinois Child Abuse Act.

The Illinois Department of Children and Family Services (IDCFS) decided to establish a Comprehensive State Plan for the identification and treatment of neglected and abused children and their families. MAPS represents the culmination of that effort. MAPS is a consortium of private and public agencies who are working interdependently to provide services to abused and neglected children and their families. The MAPS project is federally funded, with the State Department of Children and Family Services serving as the grantee. DCFS contributes to the funding of the demonstration center and is also a member of the MAPS Policy Board. The grantee agency also approves and pays for services contracted with provider agencies whose Executive Directors or their designee are also members of the Board.

The Protective Services Policy Board consists of representatives from the agencies who serve as participating agencies with the demonstration center network. Board membership

is a contingent on continued provision of service or board-judged pertinence to the system. The board functions by majority rule of present voting members with half the membership in attendance to form a quorum.

In 1975, OCD felt that the size of the board mitigated against an effective policy-making process, while the composition of the policy-making body left its board members subject to accusations concerning conflict of interest. Allegedly, action was taken to remedy the conflict of interest issue.

4. LINKAGES WITH OTHER AGENCIES

While MAPS' major purpose is to coordinate consortium services, it appears that the complete coordination and delivery of services (from assignment of cases to participating agencies to receiving service reports from these agencies regarding service and fiscal expenditures) still provides an opportunity for improvement. In some cases, participating agencies have closed cases and not reported case termination to the demonstration center until up to six months later. Additionally, there is an opportunity for MAPS to "ride herd" on these agencies to participate and cooperate in the fullest manner. Thus, record-keeping procedures are commonly less than complete forcing the center to estimate the units of service and costs that a participating agency has delivered.

5. LEGAL ISSUES

MAPS is bound by the Illinois State Child Abuse Act of 1965. As MAPS is under the jurisdiction of the Department of Children and Family Services, the same State laws that apply to DCFS also apply to the demonstration center. There have been no priority legal issues other than a Foster Care suit against DCFS during fiscal year 75-76. The suit involved the establishment of a new foster care rate for private and participating agencies and that legal issue has been resolved.

6. COMMUNITY AWARENESS CONCERNS

MAPS has printed and distributed brochures in English and Spanish. The brochures provide information about the demonstration center program, and provide a listing of services and a phone number to call for reporting and/or direct aid regarding child abuse and/or neglect activities.

MAPS also paid $30,000.00 to have a training film produced. The evaluator has never seen the film, however, has been told that the film is of high quality and has been utilized as a training film for various professional groups who are in the child abuse and neglect fields.

7. PROGRAM PRIORITIES

While Program Priorities are specified in the Center Goals and Objectives, it is questionable as to whether or not these are actually being met. MAPS has consistently ranked first among all demonstration centers in terms of amount of monies spent during any one quarter. Upon closer examination, one finds that the allocation of funds to particular categories have been erroneously applied due to a lack of understanding regarding MIS service categories.

MAPS greatest expenditures seem to come under residential shelter, counseling activities, and indirect costs. Additionally, actual costs per child and actual costs per family seem to be much higher than other demonstration center costs. During the last quarterly visit an attempt was made to locate some of the costs of the projects that appeared to make operational cost soar. It was determined that some funds that are utilized were being inappropriately logged and were haphazardly allocated to other service categories, or grossly estimated.

8. PROGRAM APPROACHES, STRATEGIES, AND GOALS

The original goals of the project are as follows:

1. To provide a comprehensive program of medical, social, psychological, psychiatric, legal and other services to abusive and neglectful families on the North side of Chicago.

2. To implement and refine a coordinated service

delivery model, integrating public and private service agents, professionals, from various disciplines, service-providing and contracting for service functions, centralized coordination and policy-making.

3. To demonstrate that the model of integrated services and case management techniques employed on this project are both feasible and sufficiently more efficient and effective at meeting the needs of abuse and neglect families than current practices to warrant replication in other areas of Chicago as well as other large urban areas.

4. To build upon the implemented service delivery system so that the entire Chicago area will eventually be served by such a coordinate set of linked services.

5. To maximize adaptability both within the system as a whole and service programs of individual resource agents participating or cooperating with the system through centralized system monitoring, casetracking, policy-making, resource allocation, parental education, and case and program consultation.

After six months it was realized by the demonstration center that these goals while admirable, were too global in

scope. Additionally, because of the numerous start-up problems that the center was experiencing, it was decided that internal goals for the operations of the center were in need of implementation. These internal goals can be reviewed on pages 18-19 of the Center's Profile. The main body of these internal goals involved drafting written policies and procedures for the center and the participating agencies. Additionally, these goals were concerned with finalizing contracts in order for the project to become fully operational. The internal goals actually amount to activities that the center needed to engage in for operational clarity and project efficiency.

SUMMARY

It is felt by the evaluator that the Metropolitan Area Protective Services of Chicago has an opportunity to make the best use of its time, money or staff members. The demonstration center appears to have become bogged down and not enough activity appears to be occurring with respect to child abuse and neglect activities. The evaluator feels that the main responsibility for the current state of affairs rests with the Center's need to implement a comprehensive non-bogging system that will allow it to take corrective management action.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The Tables and figures presented below contain information on costs for each of the five functional service areas (for the year and by the quarter), unit costs, indicators of problems, and the case flow diagram for the year. A brief commentary accompanies each table and figure.

Table 1 shows the actual costs expended and total value of services in each of the function services areas, and also gives a breakdown of client services provided by the Center in the areas Services to Families and Services to Children*. The actual cost of all services provided by MAPS, as derived from the MIS data, was $426,264. Total value of those services was $501,919. After Program Operations, which accounted for 36.5% of actual cost and 35.1% of total value, the greatest expenditure was in the area of Services to Families with $106,180 (24.9%) being expended. The actual costs for Services to Children and Casework activities were similar, each comprising slightly more than 15% of all expenditures.

Among the client services, the data indicate that psychological services were emphasied at MAPS with 17.3% of actual costs and 15.4% being so expended. Thirteen percent of actual cost was spent in for shelter and/or custodial care.

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* Each of the functional service areas is defined by its MIS service categories on the following page.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	426,264	100.0	501,919	100.0
PROGRAM OPERATIONS	155,569	36.5	176,174	35.1
COMMUNITY ACTIVITIES	35,802	7.9	37,587	7.5
CASEWORK ACTIVITIES	64,774	15.2	93,823	18.7
SERVICES TO FAMILIES	106,180	24.9	112,948	22.5
SERVICES TO CHILDREN	65,939	15.5	81,287	16.2
CLIENT SERVICES:				
MEDICAL	1,236	0.3	11,781	2.4
PSYCHOLOGICAL	73,908	17.3	77,108	15.4
LEGAL	7,272	1.7	10,582	2.1
SHELTER/CUSTODIAL	55,373	13.0	65,707	1.3
SUPPORT	33,818	7.9	34,505	6.9
EDUCATIONAL	7	0	25	0
CRISIS INTERVENTION	505	0.1	507	0.1

Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

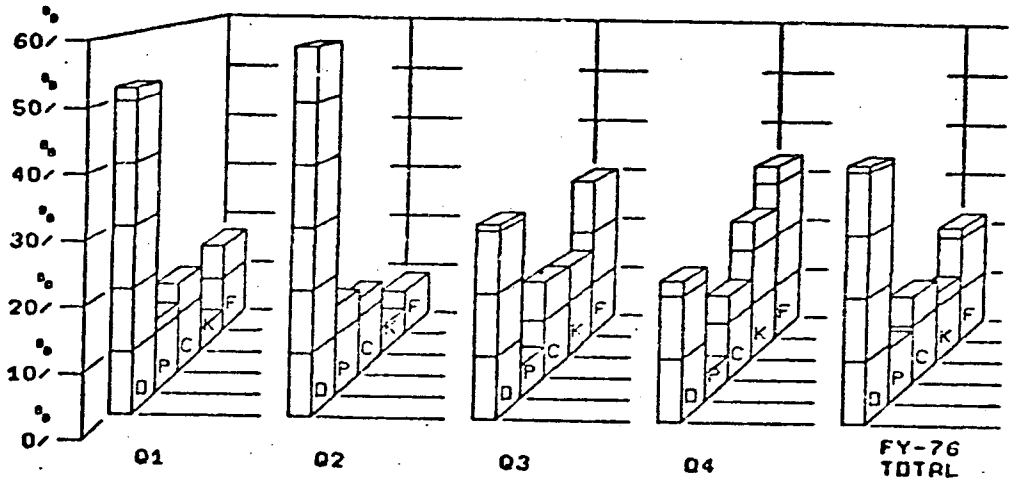
NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

In Figure 2, the data display demonstrates the fact that the functional service area of Program Operations was above the 50% level during the first two quarters, slightly higher than 30% in the third quarter, and approximately 23% of actual cost in the fourth quarter. The allocation to this area averaged slightly over 30% for the fiscal year. The area of greatest emphasis in this Center can be seen to be Services to Families with an average allocation for the year of approximately 22%. The low allocation of less than 10% occurred in the second quarter and the highest allocation of 35% of actual cost occurred in the fourth quarter. In the Casework Activities Service area, the allocation remained fairly consistent throughout the year with approximately 15% of actual cost expended in this area. There was not this consistency in the allocation of actual cost to Services to Children. From a low in the first two quarters of an approximate 5% allocation, the allocation of actual cost was increased to 18% and 25% in the third and fourth quarters, respectively, resulting in an average allocation for the year of approximately 13%. The lowest priority functional service area for the year, although not necessarily in each quarter, was Community Activities, with an average allocation for the year of 10%. However, the allocation in the first two quarters was more than 10% of actual cost, and considerably less in the latter two quarters.

Figure 2A shows the results of substantial donations

to MAPS in the third and fourth quarters, primarily in the Services to Families and Services to Children service areas. These donations were basically medical services However, the final configuration of these data approximate the percentages shown in Figure 2.

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

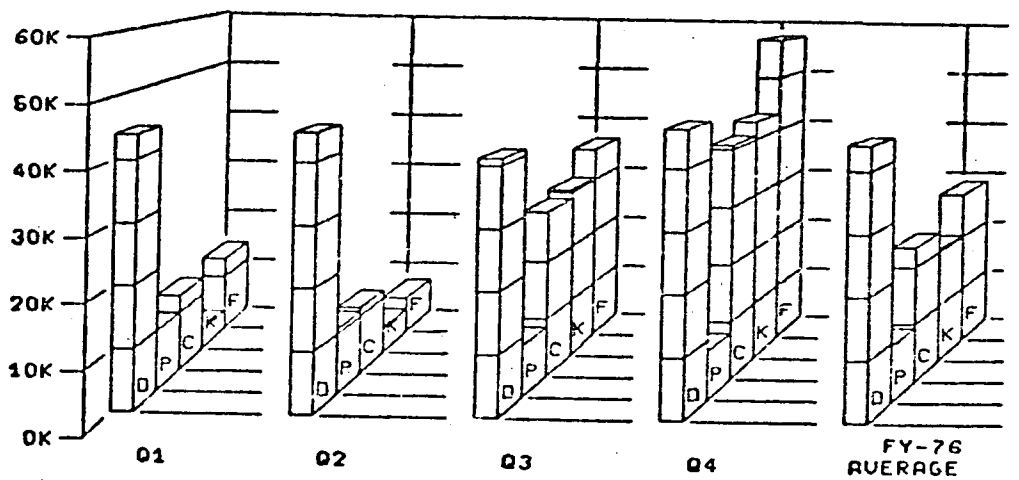


KEY
D- OPERATIONS
P- COMMUNITY ACTIVITIES
C- CASEWORK ACTIVITIES
K- SERVICES TO CHILDREN
F- FAMILY SERVICES

FOR

CHICAGO

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



In Table 2, the unit costs per child and family for the last two quarters of the fiscal year are shown. The reader is referred to Volume I, page(s) 22-24 for a detailed discussion of the methodology used in computing these values, and the resulting difference between these values and the values shown in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

ACTUAL COST PER CHILD	$1,022
TOTAL VALUE PER CHILD	1,275
ACTUAL COST PER FAMILY	2,218
TOTAL VALUE PER FAMILY	2,761

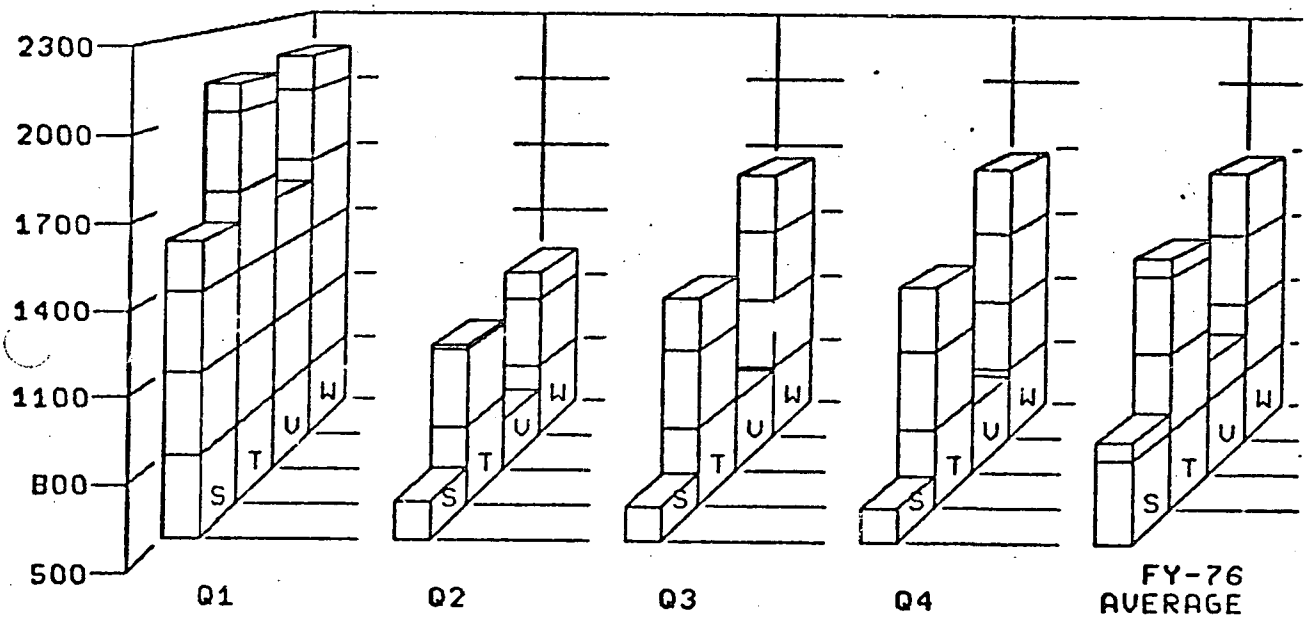
For the six month period from 1 January 1976 to 30 June 1976, all unit costs of MAPS were considerably higher than the median values reported for all Centers.

In Figure 3, the units costs per child and per family for each quarter and the averages for the year are displayed. The figure shows actual cost per child and family, and total value per child and family.

In the first quarter, all four values were unusually high, indicating a very low caseload and concommitantly high unit costs. Both actual cost and total value per child were over $1,600, and actual costs and total value per family were over $2,000. In the second through fourth quarters, these figures were considerably different. Actual cost per child in each of those quarters were approximately $600 while total value per child ranged from $600 to $800, resulting in average unit costs for the year of slightly more than $800 per child in actual cost, and $1,000 per child in total value.

Actual cost per family for the second, third, and fourth quarters were approximately $1,100, while total value per family in these quarters ranged from a low of $1,200 in the second quarter to approximately $2,000 in the third and fourth quarters. The FY 76 averages were approximately $1,500 actual cost per family, and $1,700 total value per family.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR CHICAGO



KEY

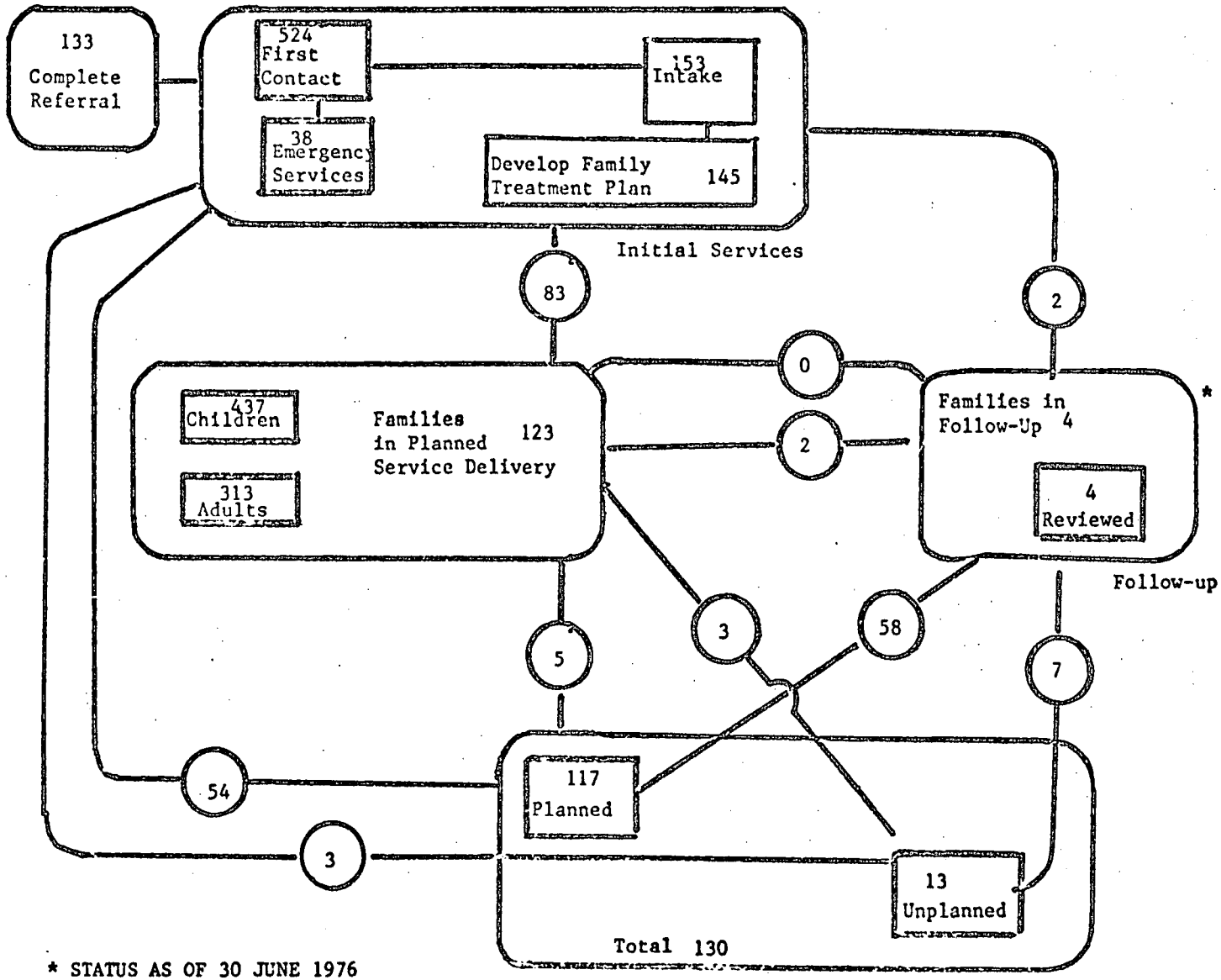
S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
U- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

Figure 4 displays the flow of clients through MAPS for a six month period. One hundred twenty-three families, composed of 313 adults and 437 children received planned services at MAPS from 1 January to 30 June 1976. Additionally, 38 families received emergency services. As of 30 June 1976, four families remained in follow-up status. During this period, 130 families were terminated from the Center's caseload. Ninety percent (117) of these terminations were planned.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR CHICAGO
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JULY 1975 - JUNE 197

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 displays a summary of the "flags" raised by the MIS that indicate potential problems that are being encountered by the individual centers.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVERS FOR THE YEAR	3
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual expenditures for the year in service category #1 (administration) and dividing the sum by the actual total cost for the year to determine whether those costs were higher or lower than 25% of the actual costs expended. At MAPS, 21% of actual cost was spent in administration, a figure somewhat lower than the cut-off point. Fifty percent of actual costs expended in the combined service areas, excluding Program Operations, was seen as an adequate level of expenditures. MAPS expenditures were 63.5% of actual cost, and therefore no warning flag was raised in this area.

D. PROFILE FOR THE CHILD AND FAMILY ADVOCATES

EVANSTON

1. START UP ISSUES

Child and Family Advocates of Evanston represents a consortium of agencies who decided to incorporate in order to secure funds and coordinate activities. At the request of the Child and Family Advocates of Evanston, Inc., the Evanston Mental Health Services, a local tax-supported mental health coordinated planning agency provided CFAE with a part-time staff member. The staff member coordinated the efforts of the group, designed a child abuse and neglect program and searched for funding.

2. STAFFING ISSUES

Initially, the demonstration center hired a project administrator, Social Work Coordinator, and a secretary/ bookkeeper. As staff needs increased, a statistical research records management coordinator, and an additional social worker were added to the staff.

Salaries:

The staff salaries were rather low in comparison to other demonstration centers in the area, as well as other parallel positions in the nation. The CFAE membership board, however, approved raises of the demonstration staff personnel and it is currently

felt that the salaries are commensurate with other agencies performing similar functions.

3. ORGANIZATIONAL STRUCTURE ISSUES

There appear to be no serious organizational issues thus far. CFAE has at its stern a Board of Directors, that is elected from the general membership. The Board of Directors is empowered to exercise final responsibility for all financial, policy, and program decisions. They are required to meet quarterly or upon demand. There also exists an advisory council that makes recommendations on program policy, and as a general sounding board on typological questions concerning cases encountered in the treatment program. The composition of the general Board of Directors initially reflected a membership of professionally oriented people however, the composition of the Board has been expanded to include business oriented persons. This was done for fund-raising purposes.

4. LINKAGES WITH OTHER AGENCIES

CFAE was conceived of as a demonstration center whose primary activity would be the coordination of abuse and neglect services. The CFAE MIS reports reflect this conception even

though the actual amount of direct services provided by the center has increased over time. Direct Services have been provided under special and unique circumstances. Usually, the attempt has been not to overload the participating agencies and in some instances, the unique sensitivities of transferring a case to a participating agency would have possibly jeopardized successful treatment of the case. At one point in time there was a problem with some participating agencies in that these agencies were reluctant to "take on", as it were, outreach activities and/or difficult hard-core cases. These problems through the ingenuity of the demonstration center staff have been ameliorated.

5. LEGAL ISSUES

Legislation and Policy

A CFAE Board member has been selected to help formulate guidelines for the Illinois Law Enforcement Commission. The Illinois Law Enforcement Commission set up guidelines for the Omnibus Crime Bureaus' Juvenile Deliquency Section. These guidelines are based on implementing delinquency prevention programs which will demonstrate the relationship between delinquency and child abuse and neglect. CFAE regularly communicates with United State Senators and Representatives from Illinois through written correspondence.

Legal Advocacy

Northwestern University Legal Clinic acted in a liaison capacity during the early stages of CFAE formation. An attorney from Chicago, Illinois, aided the CFAE board in formulating its by-laws, non-profit status and remains on call as CFAE's legal administrative assistant on tax related matters. Additionally, the Child Advocate Association is concerned with Children's rights and has been helpful to parents who are CFAE clients. Legal Aid Society of Chicago and Evanston are part of the Legal arm of the center.

6. COMMUNITY AWARENESS CONCERNS

Community Awareness through Community Education has been relatively successful throughout the life of this project. Initially, some negative publicity about the demonstration center was printed in one of the local newspapers, however, this negative attitude has been successfully erased. CFAE has facilitated the parental stress hotline activities through advertising, and CFAE services have been aired on ABC and NBC. 10 radio talk shows, each 30 minutes in length have been presented, and 2 CFAE staff members have appeared on 2 television talk shows.

In addition to the media, CFAE has extended its community awareness campaigns to the schools and helped set up treatment

units within these facilities.

7. PROGRAM PRIORITIES

Program priorities for CFAE have involved Support Services, Counseling activities, Case Management and Review, Crisis Intervention, Identification and Outreach, and Diagnosis. CFAE has consistently reported the smallest budget and the lowest indirect costs of any center. The center provides primarily coordinating services, and is a model of efficient operation.

8. PROGRAM GOALS AND APPROACHES

Approach

The basic philosophy of CFAE is to enhance family life through the coordination and deliverance of services to families and their members, to educate the community, lay and professional, regarding special needs of families, and to develop specialized services and train staff to deal with parents and children to prevent child abuse and/or neglect.

CFAE treatment consists of the following components:

1. Counseling, Individual, couple, family, group and child.

2. Homemaking services, Emergency services, Crisis Intervention services
3. Residential Shelter, Emergency Shelter, Parent/ Aide/Lay Therapy
4. Transportation/Waiting and Day Care
5. Training and Technical Assistance to other professionals in related fields

Strategies

Program planning was initially formulated by the grant writers. Ongoing management planning and feedback is provided to the Project Administrator by the CFAE advisory Council whose membership is drawn from the general membership of CFAE.

Program Goals

Please refer to Volume I of the profile (pp 15-16) for a complete listing of CFAE Goals, Objectives and Performance Standards. The overall project goals are reproduced below.

PROJECT GOALS AND PERFORMANCE STANDARDS

The Objectives of CFAE are:

1. To negotiate and re-negotiate service agreements with relevant professional counseling units to allow for the coordination of professional counseling services.
2. To negotiate and re-negotiate service agreements with homemaker and child care services to allow for their coordination into a comprehensive child abuse program.

3. To determine the need for a twenty-four emergency (crisis intervention) homemaker service, as distinguished from an unusual hour homemaker service or an emergency shelter program.

4. To re-negotiate a service agreement to recruit and train lay therapists to continue this new fimension of child and family services.

5. To re-nogiate a service agreement to provide a twenty-four hour hotline system for child abuse and neglect.

6. To continue to support a parent "self-help"group to aid in the development of parenting skills.

7. To negotiate a service agreement to allow for the planning and implementation of a child abuse and neglect campaign with school personnel, P.T.A.'s, religious groups, service club groups, professional groups, and police and hospital personnel.

8. To administer a client record management system to allow for the coordination of these services.

9. To initiate training sessions and in-service training sessions for professional and lay workers who are involved in children and family services.

10. To negotiate and establish channels of cooepration with the Illinois Department of Children and Family Services (DCFS).

11. To work with DCFS and the Illinois Children's Home and Aid Society to develop emergency shelter and emergency foster home programs.

12. To continue to cooperate with the Child Advocate Association for legal services to be available to children and families involved in child abuse and neglect.

To cooperate with E. H. White and Company, the Health, Education, and Welfare evaluation subcontractor, to improve management and delivery system processes.

To continue to expand the structure of Child and Family Advocates to allow for greater community support for its goals.

STANDARDS OF PERFORMANCE

Signed contracts with proposed professional counseling, homemaker, lay therapist, child care, public awareness, and hotline units.

To calculate the number of hotline calls and the referrals from the hotline to Child and Family Advocates of Evanston (CFAE) services.

To increase the number of child abuse and neglect cases serviced by participation CFAE units.

To calculate the number of speeches, lectures, and seminars before professional, school, church, service, and community groups.

To calculate the number of new volunteers to work with units serving child abuse and neglect cases.

To calculate the number of training sessions for professional and lay personnel involved with child abuse and neglect.

To calculate the number of services arranged for children and families involved with child abuse and neglect.

To calculate the use of emergency homemaker services.

To calculate the increase of child care services for children involved in child abuse and neglect.

To calculate the number of Parental Stress Groups, meetings, and individuals involved in the self help program.

To calculate the number and increase in professional workers involved in child abuse and neglect cases.

To calculate the number of meetings with the Department of Children and Family Services, the Evanston Police, hospital units, the Child Advocate Association, and other relevant service groups to demonstrate effort to rationalize a comprehensive service delivery system for child abuse and neglect.

To calculate the reports received from the Northwestern University Management Team that are relevant to the services of CFAE.

To calculate the number of community (lay or non-service) individuals represented in the membership and Board of Directors of CFAE.

To evaluate the performance of the lay therapist program.

To evaluate the performance of the homemaker program.

To evaluate the suitability of child care services.

To evaluate the performance of professional counselors utilized by CFAE.

To evaluate the performance of CFAE personnel.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Mangement Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on costs for each of five functional service areas (for the year and by quarter), unit costs, indicators of problems, and the case flow diagram for the year. A brief commentary accompanies each table and figure.

Table 1 shows the actual costs expended and total value of services in each of the functional service areas, and also gives a breakdown of client services provided by the center in the area Services to Families and Services to Children.* The actual cost of all services provided by the Evanston

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* Each of the functional service areas is defined by its MIS service categories on the following page.

Mental Health Services, as derived from the MIS data was $139,476. The total value of these services was $158,386. The largest single expenditure was made in the area of Services to Families -- $41,251 (29.5% of actual cost). With the addition of donated services in this area, $48,436 or 30.6% of total value was directed to this area.

Among the client services provided by the Center, Shelter and Custodial Services were emphasized as indicated by an actual expenditure for the year of $23,635 (17%). There was also a heavy emphasis in the provision of Psychological Services with an actual expenditure of $2,764 (15.6%).

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$139,476	100.0	$158,386	100.0
PROGRAM OPERATIONS	31,255	22.4	33,653	21.3
COMMUNITY ACTIVITIES	22,658	16.3	26,536	16.8
CASEWORK ACTIVITIES	19,214	13.8	21,451	13.5
SERVICES TO FAMILIES	41,251	29.5	48,436	30.6
SERVICES TO CHILDREN	25,098	18.0	28,310	17.9
CLIENT SERVICES:				
MEDICAL	$152	0.1	$3,132	2.0
PSYCHOLOGICAL	21,764	15.6	25,687	16.2
LEGAL	0	0	1,980	1.3
SHELTER/CUSTODIAL	23,635	17.0	24,035	15.2
SUPPORT	15,267	11.0	15,269	9.6
EDUCATIONAL	10	0	56	0
CRISIS INTERVENTION	5,225	3.8	5,793	3.7

Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

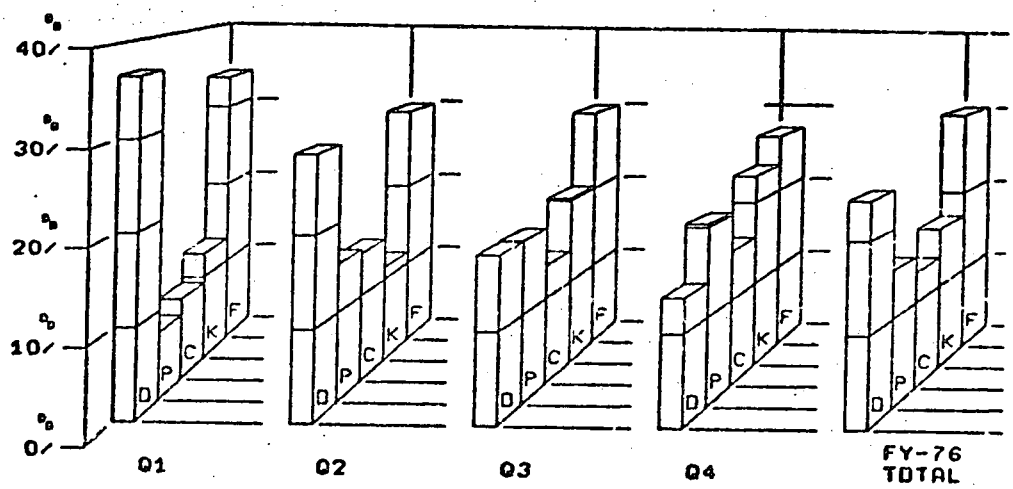
NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that the Center has been remarkably consistent in its use of resources for the entire fiscal year. From the first quarter, and each quarter throughout the year, a heavy emphasis was shown in the functional service area Services to Families with a low of approximately 25% of actual cost (fourth quarter) and a high of 35% of actual cost (first quarter) expended in this area, for an average expenditure of 30% for the year. In the service area Program Operations, the Center showed consistent reduction of operations costs in each succeeding quarter, beginning with an allocation of approximately 37% in the first quarter and ending with an allocation of 15% in the fourth quarter for an average expenditure in this area of 25% of actual cost.

In the remaining three service areas -- Community Activities, Casework Activities, and Services to Children -- the percentage of actual costs allocated was between 10% and 20% in each quarter. On the yearly average, a slightly higher allocation was made to the Services to Children functional area, followed closely by Community Activities and Casework Activities.

The configuration of Figure 2A is remarkably similar to that of Figure 2, indicating that total value of expenditures with the addition of donated services closely paralleled the percentages of actual costs for each service area.

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

FOR

EVANSTON

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

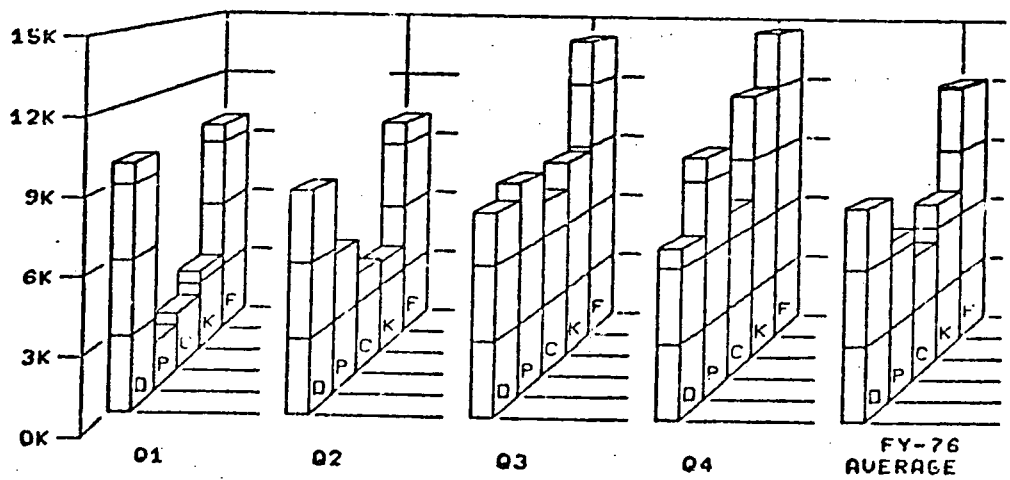
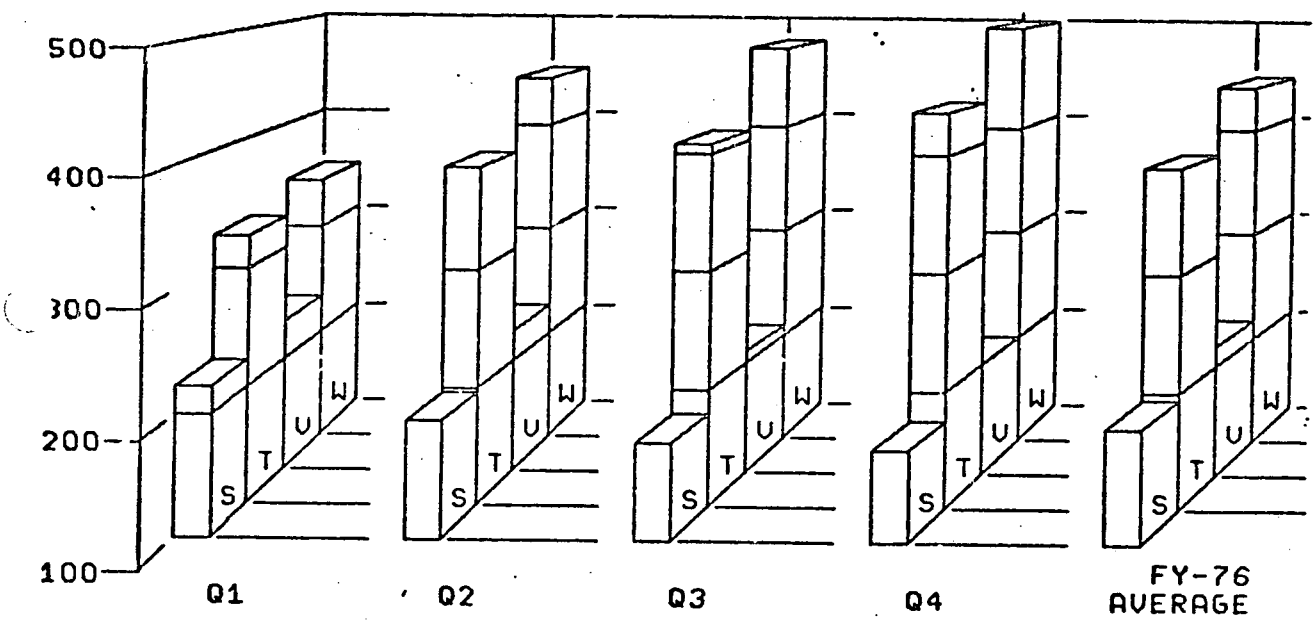


Figure 3 provides a visual display of the unit costs per child and per family for each quarter and the average unit cost for the year. The figures display actual cost and total value data.

For FY 1976, the average actual cost per child was $200 and the average total value per child was slightly higher than $200. These figures were somewhat reduced each successive quarter of the fiscal year. However, the exact reverse trend was observed for actual cost and total value per family. From a low of approximately $340 actual cost per family and $350 total value per family in the first quarter, these figures increased each successive quarter to approximately $450 actual cost per family and $500 total value per family in the fourth quarter. The average actual cost per family was $400 for the year, and the average total value per child was approximately $450 for the year.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR EVANSTON



KEY

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

In Table 2, the unit costs per child and family for the last two quarters of the fiscal year are shown. The reader is referred to Volume I, page for a detailed discussion of the methodology used in computing these values, and the resulting difference between these values and the ones shown in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

ACTUAL COST PER CHILD	$294
TOTAL VALUE PER CHILD	339
ACTUAL COST PER FAMILY	736
TOTAL VALUE PER FAMILY	850

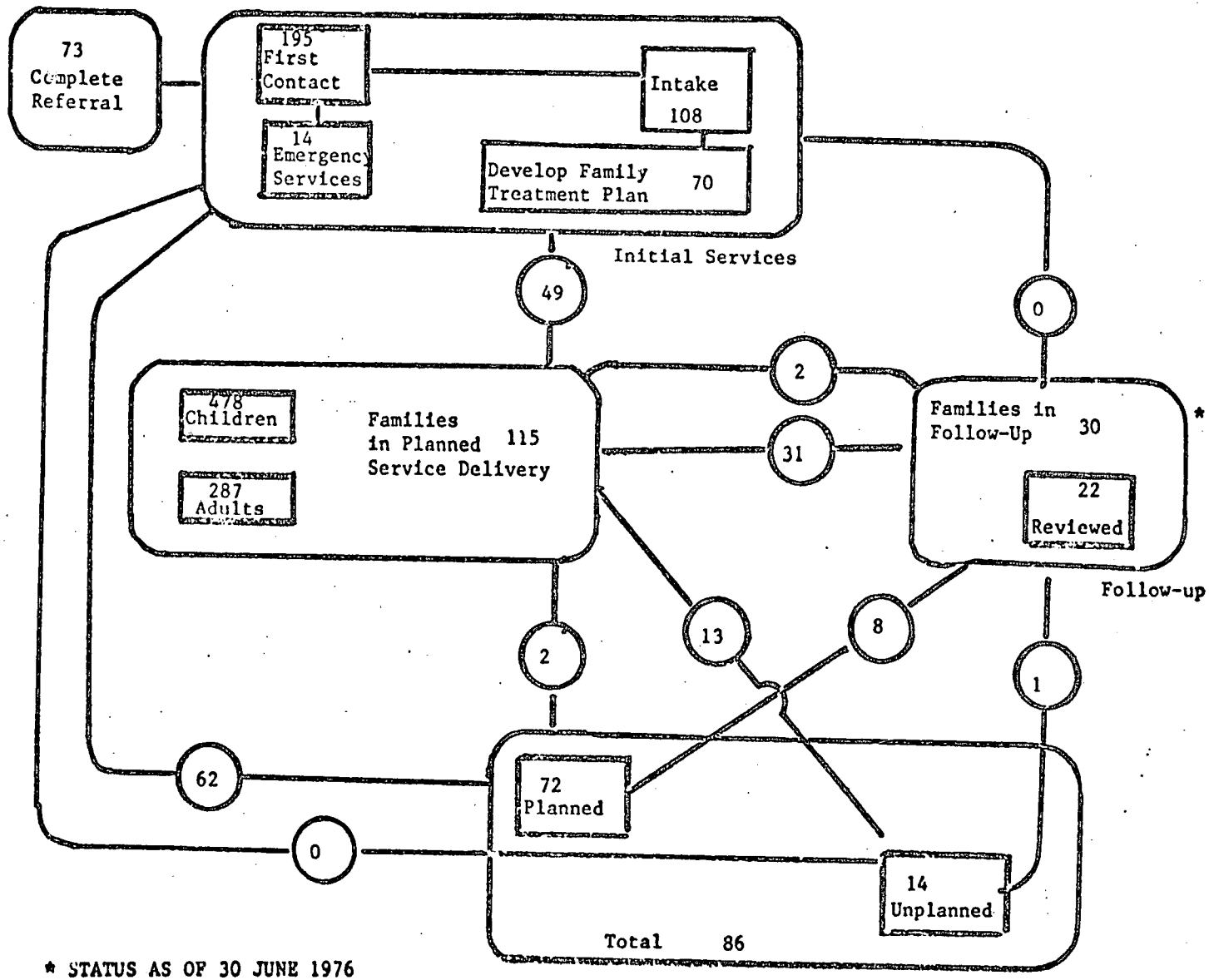
For the six month period from 1 January 1976 to 30 June 1976, the actual cost per child and total value per child at the Center were somewhat lower than the median figures reported for the aggregate of twelve centers of $318 and $486, respectively. The Center's six month unit actual cost per family was somewhat higher than the median of $719 reported by all centers, but the total value per family was lower than the median of $942.

In Figure 4, the client flow for a six month period is documented. From 1 January to 30 June 1976, a total of 115 families received planned services at CFA. An additional 14 families received emergency services during this period. At the conclusion of the fiscal year, 30 families remained in follow-up status. Eighty six families were terminated from the Center's caseload. Seventy-two (83.7%) were planned terminations.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR EVANSTON
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 -JUNE 1976

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 displays a summary of the "flags" raised by the MIS that indicate potential problems that need attention at the various centers.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (1 if low, otherwise OK)	OK
STAFF TURNOVERS FOR THE YEAR	2
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual expenditures for the year in service category #1 (Administration) and dividing that sum by the actual total cost for the year to determine whether those costs were higher or lower than 25% of the actual costs expended. At CFA, 12% of actual cost was spent in administration, a figure considerably lower than the cut-off point. Fifty percent of actual cost expended in the combined service areas, excluding Program Operations, was seen as an adequate level of service expenditures. The Center's service expenditures were 77.6% of actual cost -- a figure much higher than the adequate level of 50%.

E. PROFILE FOR CONNECTICUT CHILD ABUSE AND NEGLECT DEMONSTRATION CENTER

1. START UP ISSUES

The Connecticut Child Abuse and Neglect Demonstration Center (CCANDC) requested a six month preoperational phase for planning and development in its original proposal to the Office of Child Development. As this phase of the proposal was not funded, a number of problems were experienced in the beginning operations of the Center.

(a) Site Selection. The CCANDC is a part of the State Connecticut services to children delivery system (the OCD grantee is the Department of Children and Youth Services (DCYS), Protective Services Division), and DCYS felt that the Center should be located in Hartford near medical facilities due to the program emphasis on a multidisciplinaty approach to treatment of abuse and/or neglect. After considerable search, the present facility was located. The house, which is owned by Mt. Sinai Hospital, is one block away from the Hospital, and the Unviersity of Connecticut Pediatric Clinic, located at the Burgdorf Health Center, is also one block away from the Center.

(b) The Retreat. The Retreat was given high priority in the proposal which was submitted to OCD, but due to the loss of the planning and development phase of the program,

the retreat was not implemented as originally envisioned. The original plan called for a series of weekend retreats in which entire families would play and work together toward common goals. Center staff would provide guidance and counseling during the weekend, and hopefully, a new approach to diagnosis of family problems would evolve. Although a successful teenage retreat was held, the lack of planning time inhibited successful implementation of the original plan.

2. STAFFING

One of the purposes of DCYS in proposing a Demonstration Center for Abuse and Neglect was to discover more effective and efficient methods for dealing with abuse and/or neglect cases using regular State Civil Service social work personnel; therefore, all staff of the CCANDC were selected in the same manner that workers are selected for other social service agencies within DCYS. The five case workers are Bachelor Degree Level social workers. Additionally, the Center provides field placements for five second year social work students from the University of Connecticut School of Social Work. The casework staff is rounded out by the addition of two social work aides, chosen from the surrounding Hartford community. Because of the large number of Spanish-speaking clients served by the Center, both casework aides are Spanish-speaking.

In keeping with the multidisciplinary approach to treatment of abuse and/or neglect cases, the Center has the services of two physicians -- an internist from Mt. Sinai Hospital, and a pediatrician from the University of Connecticut Department of Pediatrics. Both physicians, who work half-time with the Center, conduct medical evaluations for clients of the Center and participate in all case reviews.

Throughout this fiscal year, all staff of the Center have been involved in various inservice training workshops dealing with issues surrounding abuse and/or neglect. Some of these workshops have been provided by DCYS and therefore were open to all DCYS workers, while others have been conducted for only the Center staff.

The personnel policies which govern all State of Connecticut employees are operable for the staff of the Center. The hours worked by Center employees (with the possible exception of adjustments that are made for evening coverage of the Center), the wages paid to Center staff, grievance procedures, vacation, etc., are the same as those for all other State employees.

3. ORGANIZATIONAL STRUCTURE

In discussing the organizational structure of the CCANDC, it is first necessary to identify its place in the structure

of the State of Connecticut social services system. Between October, 1974 and January, 1976, all agencies which serve the children of Connecticut were administratively transferred to DCYS so that a single State agency could coordinate those services. The Center, then, is one of the agencies under the Division of Protective Services within DCYS, and as such the director of the Center reports to the Director of Protective Services. The Connecticut Departmental Research and Evaluation Office is responsible for all evaluative activities which concern the Center. Ultimately, however, the Commissioner of DCYS is responsible for all aspects of the CCANDC.

Within the Center itself, the Director is responsible for overall coordiantion and direction of all activities of the Center and its staff. Each of the two Casework Supervisors, who report to the director, are responsible for two or three case workers, two or three social work students, and one case aide. Clients are referred to the project physicians by any of the persons responsible for case management (caseworkers, students, or aides).

There is presently a data coordiantor who is responsible for compiling data and sending it to the Departmental Research and Evaluation Office. This position did not exist at the time that the original Profile for the CCANDC was written, and therefore is not included in the organizational chart.

Another important aspect of the Center's organizational

structure is the Advisory Board which consists of persons from the private and public sector who are involved in different activities concerning abuse and/or neglect. The Board, which began as a Steering Committee of persons who actively worked on the original proposal to ICD, has recently expanded its membership and is working to modify and clarify the goals and objectives of abuse and neglect treatment.

4. LINKAGES ISSUES

The CCANDC has been able to establish a number of contractual and informal relationships with the metropolitan Hartford Community. Each of these relationships will be briefly discussed below:

a. Contractual Arragements

(1) Mt. Sinai Hospital. The project internist is on the staff of Mt. Sinai Hospital and the facility is therefore used for the medical evaluations of of the adult clients of the Center.

(2) University of Connecticut School of Pediatrics. The project pediatrician is on the faculty of the University of Connecticut in Pediatrics and conducts medical evaluations for children at University of Connecticut Medical Center in Farmington.

(3) YMCA. A contract was negotiated with the YMCA to provide the facilities for the retreat program.

(4) University of Connecticut School of Social Work. Social work students are given field placements at the CCANDC and a faculty member of the school acts as liaison between the project and the school.

(5) Connecticut Child Welfare Association. The CCWA is responsible for the operation of the Careline (Hotline) which links emergency after hours calls to the Center in order to provide 24 hour, seven days per week coverage. The CCWA is also responsible for conducting the Public Awareness campaign for the Center (see section 6 below).

b. Informal Arrangements

(1) Community Maternal and Infant-Care Program. Eligible mothers are referred to CMIC for prenatal and continuing care during the first year of an infant's life.

(2) The Salvation Army. Through DCYS, the Salvation Army agreed to provide emergency shelter for clients of the Center.

(3) Day Care. Through an agreement with Ms. Joanne Wells, free day care is provided for eligible families upon referral of CCANDC.

(4) University of Connecticut School of Nursing. The Center will provide field placements for eligible nurses who are participating in a seminar in a Master Clinician Program.

The above relationships, both formal and informal, attest to the success of the Center in establishing necessary linkages within the community. The one area that was not successful was the legal arrangement that was desired with the University of Connecticut Law School. The proposal to OCD stated that two second or third year law school students would serve a modified internship at the Center. However, the mechanisms that would allow that to happen did not exist and could not be operationalized during the first year of the program. The basic concept has not been abandoned and will be further explored by the staff of the Center and the Advisory Board.

5. LEGAL ISSUES

The CCANDC counts itself among the fortunate in that it operates under legislation that is specific concerning what is abuse, who must report it, who must investigate it, how soon the investigation must take place, etc. Therefore, there is no conflict between Protective Services and Police Departments as is often the case with abuse and/or neglect. Even

Police are mandated to report all suspected cases of abuse and neglect to Protective Services.

The law carefully specifies the oral and written reporting procedures for suspected cases of abuse, and states that a 96 hour hold on a child can be granted when a physician feels it is warranted so that investigation can be conducted. Additionally, juvenile court procedures are specified, and a confidential registry is mandated.

Although the legislation concerned with abuse and neglect is quite specific, there are still areas in which further clarity is desired -- particularly as it relates to definitions of abuse and neglect. Therefore, the staff of the Center along with other interested persons are constantly working to up-date the law and for additional appropriations to more faithfully enforce the legislation.

6. COMMUNITY AWARENESS CONCERNS

There are two primary activities of CCANDC concerned with community awareness -- the Public Awareness Campaign which the CCWA is contracted to conduct, and Grand Rounds. Each of these is further described below:

a. Public Awareness Campaign. Under its contract, the CCWA has sponsored seminars on child abuse and neglect, and showed films and film strips

to increase awareness of the existance of abuse. Additionally, CCWA maintains a Speakers Bureau, has produced a number of handouts that include copies of the Connecticut child abuse legislation, has produced public service spots advertising the Careline on television and radio, and has given a thirty-minute NBC television public service presentation.

b. Grand Rounds. Grand Rounds is one of the more exciting innovations of the CCANDC. Using a medical model in which "cases" are presented and discussed for teaching/learning purposes, the staff of Center presents a case summary. General information is provided by an expert from fields such as child psychology or psychiatry, child development, etc. These formal presentations are followed by an interchange between the audience, the staff of the Center, and the visiting expert. The audience of Grand Rounds generally consists of persons from schools, social agencies, the police departments, the fields of medicine, clergy. Approximately 100 persons are in attendance at Grand Rounds each month.

In addition to these structured activities, staff of the

Center conduct training seminars and child abuse and neglect awareness seminars when they are requested to do so by private or public agencies.

7. PROGRAM PRIORTIES

The areas of program emphasis can be deduced from both the goals of the program (see section 8) and the relative expenditures of the Center is various program components. For the past three quarters, the major categories of expenditures for the CCANDC have been in the functional area of casework activities, followed by the functional area services to families. For both areas, in each quarter, more than 25% of all actual expenditures have been made in each functional area. Within the service areas, program emphasis, as evidenced from expenditures have been in the psychological area, followed by medical services, and crisis intervention.

8. PROGRAM GOALS AND APPROACHES

In order to udnerstand the program of the CCANDC, it is necessary to list both the goals and objectives of the Center:

GOAL I

TO OPERATE A COMMUNITY HOSPITAL-BASED CHILD ABUSE AND NEGLECT

EVALUATION UNIT PROVIDING SHORT-TERM INTENSIVE TREATMENT FOR CLIENTS

Objective 1

To provide investigation and treatment of abuse and/or neglect at the time of need.

Objective 2

To develop and use a multi-disciplinary approach to case management with responsibility and accountibility resting in the case manager.

Objective 3

To test the effectiveness and generalizability of experimental treatment techniques particularly those developed in the works of Weissman, Zolba, Kempe, and Halfer.

Objective 4

To provide a unique training environment for professionals in the area of child abuse.

GOAL II

TO PROVIDE THOROUGH MEDICAL EVALUATIONS OF ABUSE AND/OR NEGLECTED CHILDREN AND THEIR PARENTS AS A THERAPEUTIC TOOL FOR PROTECTIVE SERVICES WORKERS.

Objective 1

To provide initial documentation of abuse and neglect of children.

Objective 2

To provide a means of monitoring the improvement (or lack thereof) of the condition of children who have been abused and/or neglected.

Objective 3

To provide documentation of subsequent acts of abuse and/or neglect.

Objective 4

To diagnose or rule out abnormalities of the abused and/or neglected child, e.g., hyperactivity, hearing loss, etc., that may be contributory factors to the parents' difficulty in nurturing or relating to the child.

Objective 5

To identify and subsequently treat physical or psychological abnormalities in parents which are contributing to their difficulty in nurturing or relating to their children.

Objective 6

To provide a clear and well-defined starting point for casework that illustrates the Protective Service Workers' "care" for the family.

GOAL III

TO AROUSE PUBLIC AND PROFESSIONAL AWARENESS OF CHILD ABUSE AND NEGLECT IN THE STATE OF CONNECTICUT AND TO PUBLICIZE THE CHILD ABUSE AND NEGLECT PROGRAM AT THE CONNECTICUT CHILD ABUSE AND NEGLECT DEMONSTRATION CENTER.

Objective 1

To dramatize and underscore the existence of child abuse and/or neglect as a social problem in local communties in Connecticut.

Objective 2

To assist professionals in recognizing and suspecting child abuse.

Objective 3

To familiarize professionals with Connecticut child protection legislation, their own reporting responsibilities, and the reporting procedures.

Objective 4

To provide an opportunity for professionals and lay persons to ask questions, share problems and potential solutions already encountered in protecting children.

GOAL IV

TO PROVIDE TWENTY-FOUR HOUR ACCESS TO SERVICE FOR CLIENTS OF THE EIGHT TOWN TARGET AREA SERVED BY CCANDC.

Objective 1

To provide a mechanism wherein the public may report suspected abuse and neglect cases with the same legal protection from civil and criminal liability afforded to professionals.

Objective 2

To offer a neutral, supportive "friend" for potentially abuse

or abusive parents as a first step in securing help.

Objective 3

To provide information about child abuse and neglect to professionals and private citizens.

Objective 4

To assist callers in protecting children at night, during weekends, and on holidays when public agencies are traditionally closed.

GOAL V

TO REWRITE THE GUIDELINES FOR THE RETREAT PROGPAM SO THAT IT CAN BE OPERATIONAL AND FULFILL THE ORIGINAL OBJECTIVE OF PROVIDING THREE CONSECUTIVE WEEKENDS FOR ENTIRE FAMILIES IN WHICH THEY CAN, SEPARATED FORM THEIR USUAL ENVIRONMENTS, LIVE AND PLAY TOGETHER IN A PROGRAMMED SETTING.

The CCANDC has been successful in working towards the accomplishment of the first four goals and their objectives as evidenced by their expenditures in areas relating to those goals. Only in the area of the retreat program has there been less than satisfactory accomplishment. The retreat program has been substantially revised from the original proposal, but due to the fact that the Center operated without a permanent director for almost six months this calendar year, the retreat program has not been implemented. However, a

permanent director has now been with the Center since July, 1976 and a new contract has been negotiated with the YMCA, it would seem that the retreat program should soon be operational.

9. STATISTICAL INFORMATION

The following pages contain statistical information on costs by service area* (annual data and quarterly data), unit costs, case flow, and problems encountered at the Center. Table 1 displays actual costs and total value for each of the five functional service areas for the period from 1 July 1975 to 30 June 1976. The actual cost of providing all services to the clients of the CCANDC, as derived from MIS data, was $201,402. With the inclusion of all donated services, the total value of these services was $236,318. $62,173 was spent in Program Operations, accounting for 30.9% of actual funds expended. An additional $17,550 in donated Program Operatior value was received by the Center, for a total value in this area of $79,723 (33.7%). Actual cost and total value were fairly evenly distributed between Casework Activities and Services to Families. In the former area $46,485 (23.1%) in actual cost and $54,268 (23%) in total value was expended, and in the latter area, the actual cost expenditure was $46,038 (22.8%) and the total value of Services to Families was $54,366 (22.6%).

Among the client services areas, Table 1 shows that the two

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*Each of the five functional service areas is defined by its MIS service categories on the following page.

areas of priority for the Center, as indicated by the MIS data, were Medical Services ($32,085 for 15.9% of actual cost) and Psychological Services ($21,569 for 10.7% of actual cost). The donated services in these areas did not change the order of priority, although the data indicate that more substantial donations were received in the psychological than in the medical area.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$201,402	100.0	$236,318	100.0
PROGRAM OPERATIONS	62,173	30.9	79,723	33.7
COMMUNITY ACTIVITIES	26,549	13.2	28,408	12.0
CASEWORK ACTIVITIES	46,485	23.1	54,268	23.0
SERVICES TO FAMILIES	46,038	22.8	53,366	22.6
SERVICES TO CHILDREN	20,157	10.0	20,553	8.7
CLIENT SERVICES:				
MEDICAL	$ 32,085	15.9	$ 32,294	12.7
PSYCHOLOGICAL	21,569	10.7	27,281	11.5
LEGAL	2,749	1.4	3,896	1.7
SHELTER/CUSTODIAL	2,610	1.3	2,785	1.2
SUPPORT	1,909	1.0	1,989	0.8
EDUCATIONAL	1,771	0.9	1,858	0.8
CRISIS INTERVENTION	3,502	1.7	3,816	1.6

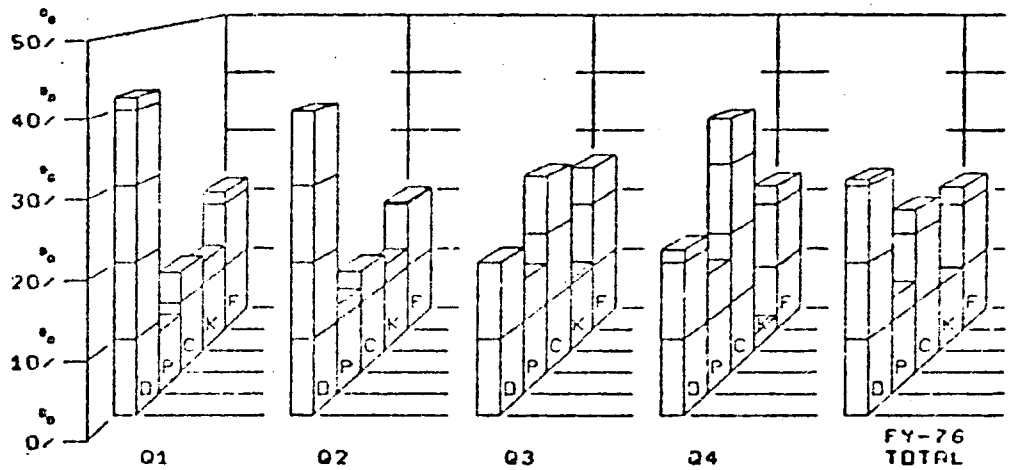
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

In the functional service area of Program Operations, Figure 2 shows considerable differences between the percentage of actual costs expended in the two halves of the fiscal year. In the first two quarters, the percentages of actual cost expended for Program Operations was approximately 42% in the first quarter and 38% in the second quarter. In the third and fourth quarters, however, these percentages were reduced to 20% and 22%, respectively for an average percentage for the year of approximately 31%. In the service area Services to Families, the Center was fairly consistent in its percentage of actual costs allocated. The average percentage of actual cost expended on Families was approximately 23% with a high in the third quarter of 27% and a low in the second quarter of slightly less than 20%. In the service area Services to Children, the percentage actual cost allocated remained fairly stable for the first three quarters at between 15% and 12%, but dropped rather drastically in the fourth quarter to less than 5%, resulting in an average allocation of 10% in this area for the year. The percentage of actual cost allocated to Casework activities showed great variance in the four quarters. Approximately 15% of actual cost was expended in this area during the first and second quarters. In the third quarter, the percentage increased to approximately 25%, and increased even more in the fourth quarter to approximately 33%. The average for the year was approximately 23%. In the remaining area, Community Activities, the percentage of actual cost increased from a low of 9% in the first quarter to highs of approximately 15% in the third and fourth quarters. The average allocation for the year was 13%.

The configuration of Figure 2A closely approximates that of Figure 2 for the first two quarters, but is at mild variance with Figure 2 in the latter two quarters. In quarter 3, there was a substantial donation to Program Operations because the Center used the services of acting co-directors in the absence of a permanent director. While this Program Operations continued for the fourth quarter, other administrative costs were reduced. The configuration of the average of total value per service area is similar to that of Figure 2 however.

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

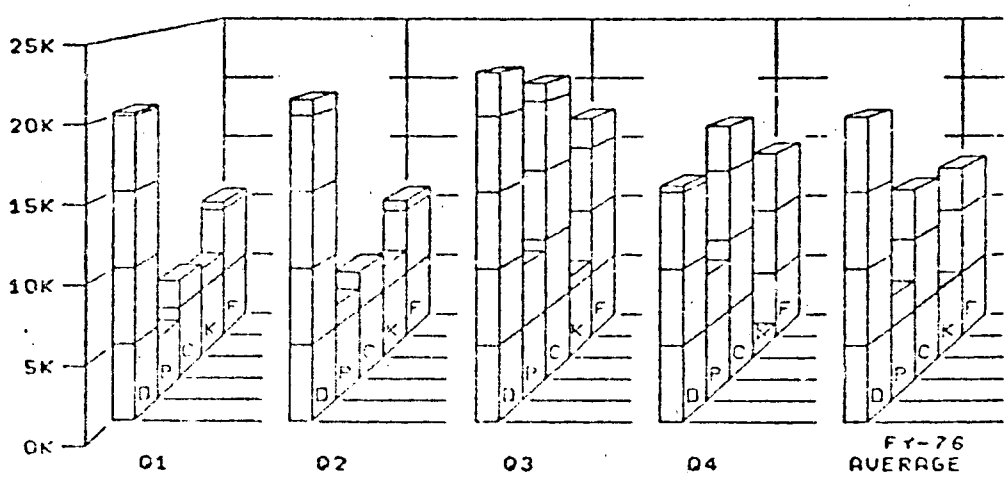


KEY
D- OPERATIONS
P- COMMUNITY ACTIVITIES
C- CASEWORK ACTIVITIES
K- SERVICES TO CHILDREN
F- FAMILY SERVICES

FOR

HARTFORD

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

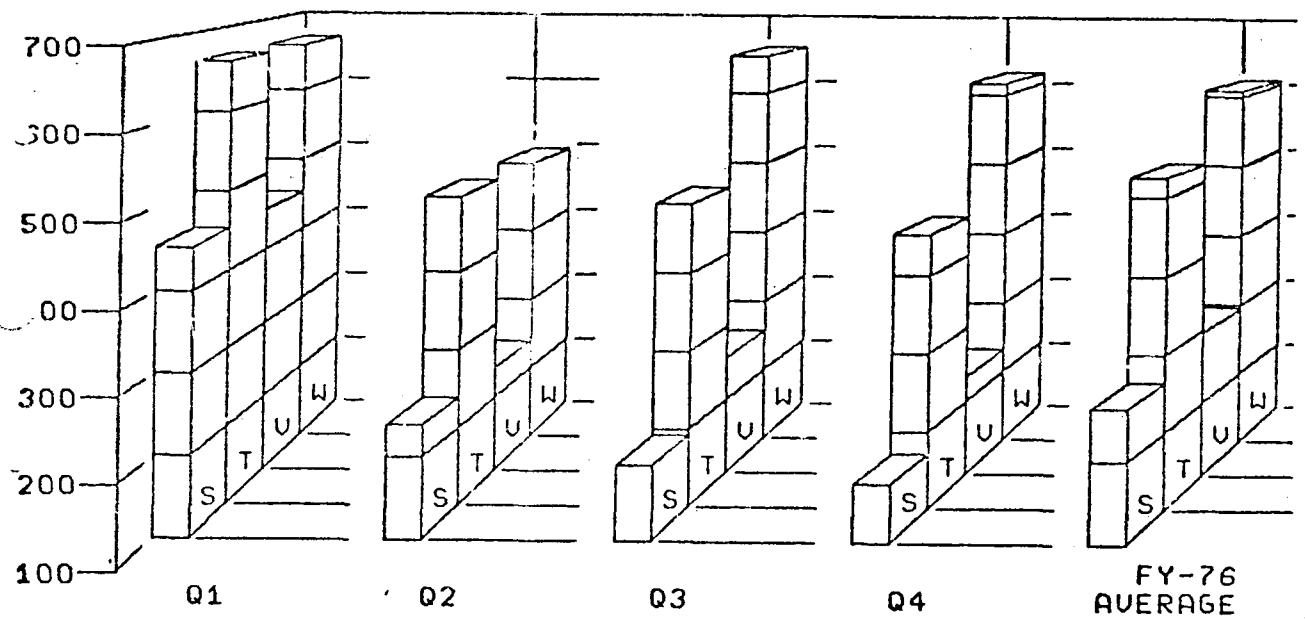


In Figure 3, the unit costs per child and per family for each quarter and the average unit costs for the year are displayed. The figure shows actual cost per child and family, and total value per child and family.

The unit costs in the first quarter are shown to be much higher than those of any subsequent quarter due to a small caseload and generally slowness in becoming fully operational. However, all unit costs were stabilized from the second quarter onward. Actual cost per child ranged from approximately $220 in the second quarter downward to approximately $180 in the fourth quarter. The total value per child ranged between $220 and $250 for those three quarters. The averages for the year were slightly less than $300 actual cost and total value per child.

Actual cost per family remained between approximately $450 and $500 for the second, third and fourth quarters. No donated services were reported by the Center in the second quarter; therefore actual cost and total value per family were identical ($500). However, in the third and fourth quarters, donated services raised total value per family to approximately $650 and $620. The average unit costs for the year were slightly higher than $500 actual cost per family and slightly higher than $600 total value per family.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR HARTFORD



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

Table 2 presents the unit costs per child and family for the period covering the last two quarters of the fiscal year. The reader is referred to Volume I page(s) 22-24 for a detailed discussion of the methodology for calculating these units, and the reason for the difference between the values presented here and those in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

ACTUAL COST PER CHILD	$225
TOTAL VALUE PER CHILD	304
ACTUAL COST PER FAMILY	595
TOTAL VALUE PER FAMILY	850

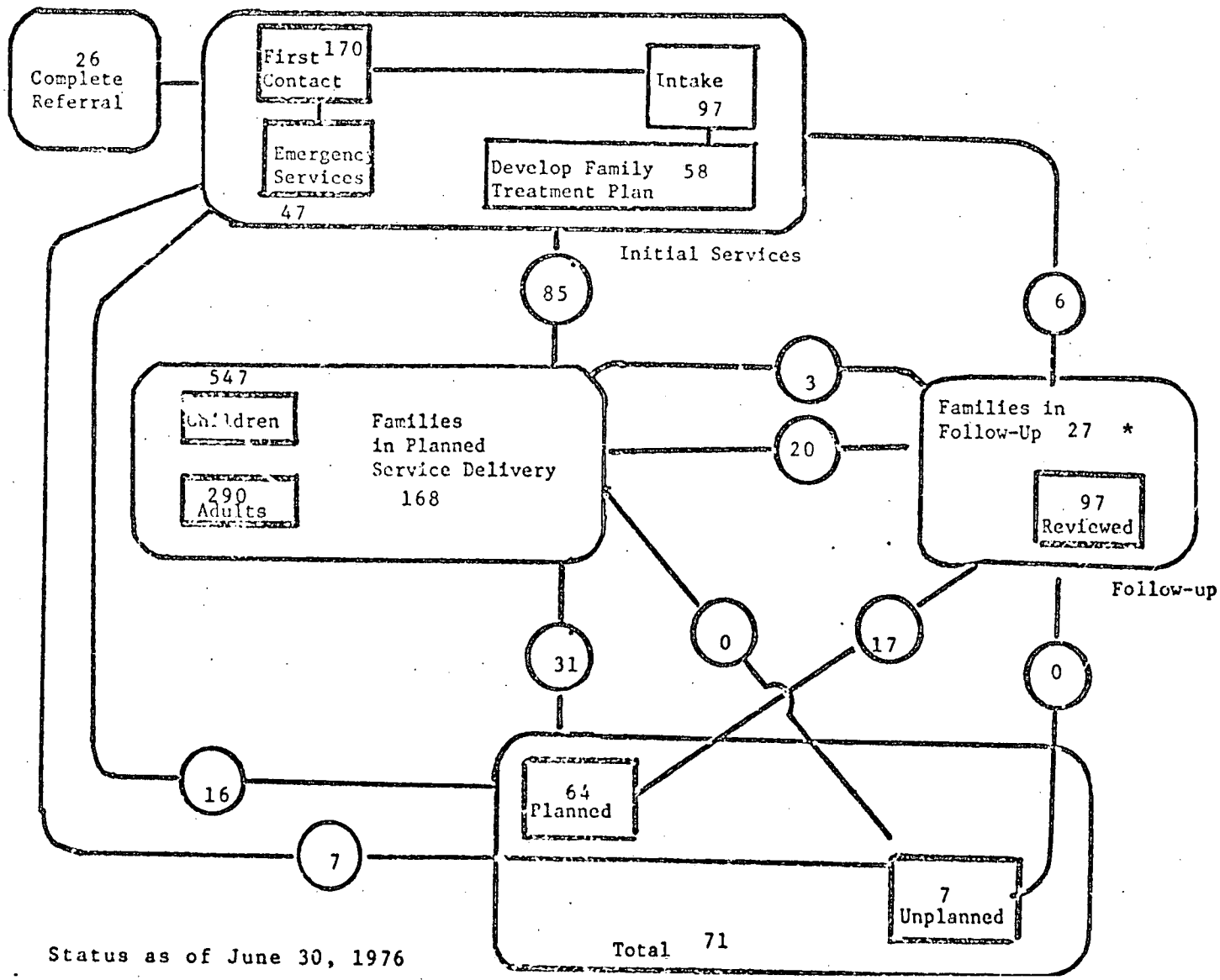
The actual cost and total value for providing services to a child of the Hartford Center were considerably lower than the medians of $318 (actual cost) and $486 (total value) reported by all centers. The actual cost and total value unit costs per family were also lower than the median values reported by the aggregate of twelve centers. The median actual cost per family was $719 and the median total value per family was $942.

Figure 4 provides a graphic representation of the client flow of the CCANDC from 1 January 1976 to 30 June 1976. The figure shows that 168 families received planned services during that six month period. There were 290 adults and 547 children in those families. Additionally, 47 families received emergency services from the Center during those six months. At the conclusion of the fiscal year, 27 families remained in follow-up. Seventy-one cases were terminated from the Center's caseload during this period. Sixty-four of those terminations (90.1%) were planned.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR HARTFORD
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 - JUNE 1976

FIGURE 4



The Management Information System provides a set of warning "flags" which indicate that potential problems are being encountered by a particular center. Table 3 summarizes information provided by the System.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (1 if low, otherwise OK)	OK
STAFF TURNOVER THIS YEAR	8
KEY STAFF VACANCIES (As of June 30 1976)	2

Administrative costs were calculated by adding the actual costs coded to service category #1 (administration) and dividing that sum by the total actual cost. Fifteen percent actual cost was coded to administration, a figure less than the 25% that would have elicited a warning flag. Fifty percent of actual cost allocated to service areas, excluding Program Operations, was seen as adequate service expenditure. The CCANDC percentage of actual cost was 69.1%, indicating that the level of service expenditures was more than adequate.

F. PROFILE FOR THE FAMILY STRESS CENTER

HONOLULU, HAWAII

1. START-UP ISSUES

(a) Funding Level: Originally, the HFSC was given an indication of a funding level of $350,000 and proceeded to negotiate with potential sub-contractors within the constraint of this figure. However, the actual funding level was $300,000. As a result of this variance, HFSC was forced to renegotiate dollars and services to be provided with each of its sub-contractors. The decreased budget resulted in one sub-contractor cancelling out of his contract because of lack of financial resources needed to perform the proposed sub-contract work.

(b) Leadership: There is no overall single CPSC Director with a centralized responsibility for planning, implementing, monitoring and decision-making regarding daily CPSC operations. The existence of two coordinators for the CPSC (medical and social service) created some difficulties in the beginning and lines of authority and lines of communication were not as clear as they should be.

(c) Communication: While there are monthly meetings of representatives of DSSH and HFSC where vital operational and administrative information is exchanged, results of these meetings infrequently gets down to the level of the

social workers. Consequently they feel somewhat estranged from both DSSH administration and the HFSC staff.

(d) Worker Burn-Out: During the initial phase of operation, social worker burn-out was a critical problem. There was a 100% burn-out rate among the first five workers. This was attributed to the high average caseload of 40 cases as compared to an average caseload of 15 for Catholic Social Services workers.

(e) Intake and Follow-up Units: The DSSH houses its CPSC, which includes eight social workers, at the Kauikeolani Children's Hospital. The DSSH Follow-up Unit is located at the DSSH South Family and Children's Services Unit. Thus the DSSH Intake and Follow-up Units are geographically and administratively separated. This has lead to communication difficulties as well as difficulties in the case transfer process. Frequently, workers from these units do not meet to review a case prior to transferring it. Follow-up workers are not involved in conferences where treatment plans are developed and in some cases don't feel a part of the decision-making process and feel that the goals that were set were unrealistic.

2. STAFFING - Child Protective Services Unit

The staffing configuration of the CPSU consists of:

1 Social Work Supervisor

8 Social Worker IV's

2 Clerical

1 Social Service Aide

2 Logisitc Aides

Social Work Supervisor, Child Protective Services Unit: The Social Work Supervisor is a full-time employee of the State of Hawaii's Public Welfare Division, Department of Social Services and Housing and is housed at the Child Protective Services Unit at Children's Hospital. The Supervisor is administratively on an equal par with the Medical Director, Children's Protective Services Unit in administering the daily operations of the center in their respective fields. Together, they are the administrators of the center. Unresolved social and medical problems at the center level are referred to the next higher echelon of their respective agencies for resolution. The Social Work Supervisor is responsible for ensuring the unit's delivery of appropriate social services; reviewing and assigning cases to workers; reviewing completeness and accuracy of case actions. The Social Work Supervisor reviews workload requirements, determines priorities of action, establishes, maintains, and enforces operational procedures and maintains liaison with other public welfare

Supervisors. The Supervisor also analyzes and utilizes statistical reports for effective management and gives guidance and consultation for improving skills and knowledge.

CPSU Social Workers: CPSU Social Workers view their role as carrying out the child abuse and neglect law as created by the state legislature. They see themselves as not being totally child-oriented but as "family protectors".

The Social Worker IV positions are located in the Child Protective Services Unit, Social Services Section I, Oahu, Branch, Public Welfare Division, Department of Social Services and Housing.

CPSU Psychologist: The two Psychologists of the Child Protective Services Unit are part-time and function on a retainer from the Kauikeolani Children's Hospital. The Psychologists serve in two overlapping capacities. They provide input regarding the circumstances of all parties involved in a child abuse and neglect case and seek to stabilize the vicissitudes which characterize the consideration of any subject as emotionally charged as the neglect or abuse of a child. They are typically trained in the psychology of both normal and abnormal development and develop assessment skills in this area which utilize both clinical observation and the administration of specific tests and measurements.

Logisitc Aides: The 2 Logistic Aides were trained by the Training Specialist in the psychodynamics of child abuse and neglect. They are supervised by a CPSU Aide Supervisor. Their primary role is to carry out logistical activities assigned to them and thereby free up the Social Workers to concentrate on more complex activities.

3. ORGANIZATIONAL STRUCTURE

In 1956, Operation Help was conceived by the Family Court, the Honolulu Police Department and the former Department of Public Welfare to provide emergency protective services to children and families coming to the attention of the police. A mandatory child abuse reporting law was enacted in Hawaii in June, 1967 requiring reporting of child abuse to the Department of Social Services and Housing (DSSH) by doctors, dentists, osteopaths, others engaged in the healing arts, social workers, nurses, teachers, and coroners. Legislation passed in 1968 mandated the DSSH with responsibility to provide protective services to children in the state. In 1969, legislation was enacted which permitted anyone to report child abuse and further established the Children's Protective Services Unit (CPSU) within the DSSH. A contract was executed between the CPSU and Kauikeolani Children's Hospital to

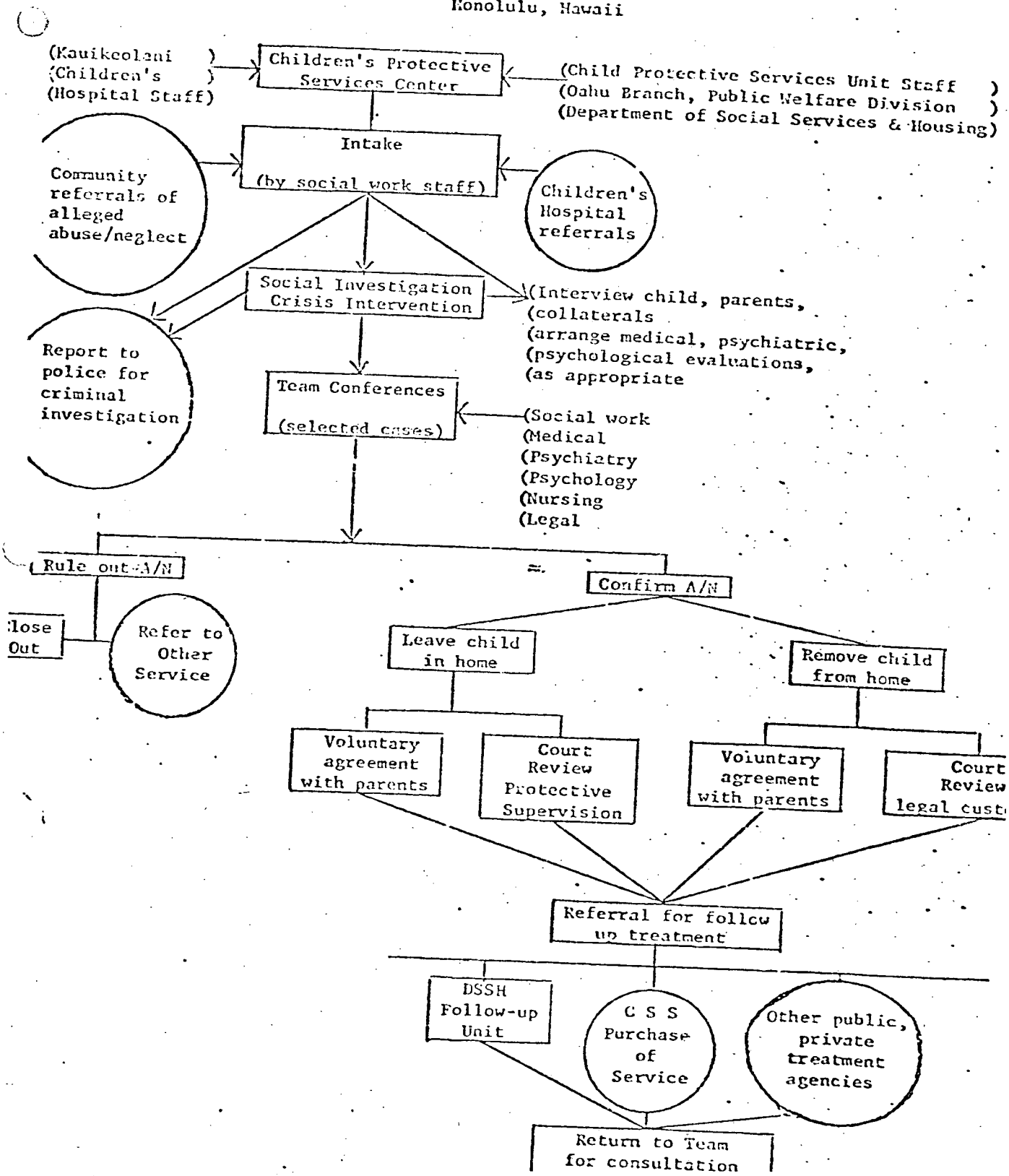
establish the Children's Protective Services Center. By 1972, Hawaii had one of the highest child abuse reporting rates in the nation. In 1973, a contract was established between the DSSH and Catholic Social Services under the Title IV-A purchase of service program for provision of long term follow-up services to families identified as confirmed child abuse or neglect cases. This contract involves approximately five MSW's and provides services only to AFDC families, per Title IV-A rules and regulations.

Kauikeolani Children's Hospital and the Children's Protective Services Unit (CPSU) function together to provide an interwoven network of abuse and neglect services to the Oahu community. CPSU is a crucial part of the child abuse and neglect system in Oahu. The CPSU was established within the Department of Social Services and Housing in 1969 and retains eight social workers and a social work supervisor. Goals of the center are to receive and investigate complaints involving child abuse and neglect, provide immediate social services on a twenty-four hour basis to protect the child from further neglect or abuse, and to assist parents and caretakers in resolving problems that provoke the neglect and abuse of a child. CPSU social workers are responsible for investigating all alleged cases of child abuse and neglect which come to

their attention and for developing a service plan for the client. The total investigative process is usually completed in three months. The service plan may include providing services such as counseling, medical care, babysitting, emergency shelter and psychological evaluation. Usually at the end of three months and following the development of the plan, a referral is made to either the long-term follow-up unit of DSSH or the long-term follow-up unit of Catholic Social Services for implementation of the plan. Between 50 and 100 cases of child abuse and neglect are reported to CPSC each month.

Kauikeolani Children's Hospital functions as the grantee for the child abuse demonstration program, the Hawaii Family Stress Center. Children's Hospital is the only pediatric center on Oahu and is the only hospital with a Class One rating for emergency services in Hawaii and the Pacific Basin. The hospital has ready access to medical, social, and legal services on a twenty-four hour basis and is the base of the University of Hawaii's teaching and in-service training program for pediatrics. In part, the hospital was given administrative responsibility for the demonstration center because it was felt that the hospital would have the most flexibility in mobilizing the private sector and community at large to engage in a more effective child abuse/neglect service delivery system.

Process of Handl[illegible]use/Neglect Cases
By Children's Protective Services Center
Honolulu, Hawaii



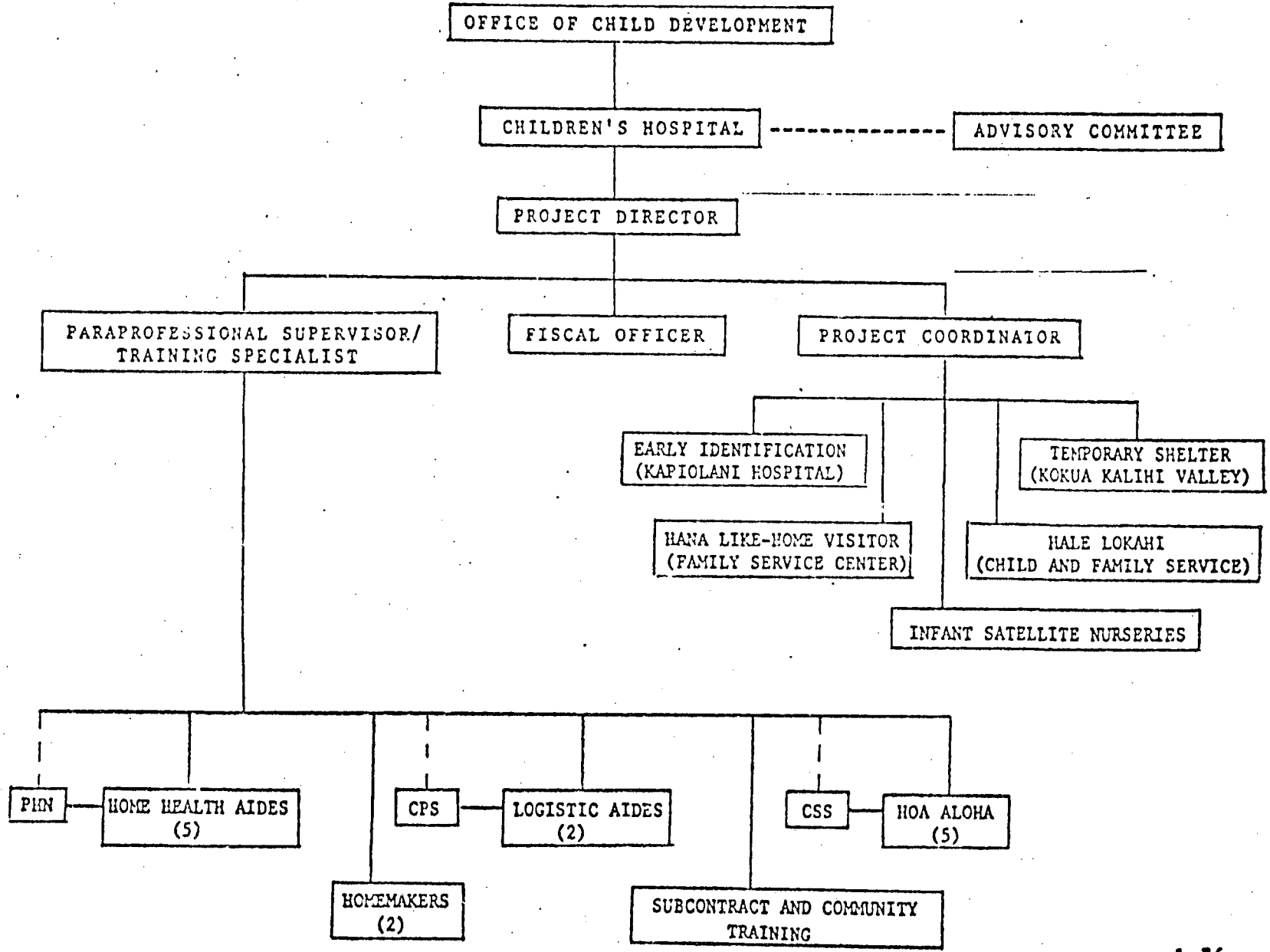
Kauikeolani Children's Hospital has two [illegible] assigned to work with and out of the Children's [illegible]e Services Center. The CPSC Medical Director is a [illegible]-time employee of the Children's Hospital and is responsible for providing medical consultation to the CPSC social workers and the court. The Medical Director also functions as the point of contact between the Center and community physicians and as a consultant to those seeking a medical opinion pertinent to child abuse and neglect. A Nurse Coordinator works under the administrative direction of the Medical Director. With the approval of the Director of Nursing at Children's Hospital, she serves as a consultant on cases of abuse and neglect and is available up to twenty hours a week.

Hawaii Family Stress Center: The Hawaii Family Stress Center has been designed to develop and coordinate a comprehensive system of services to deal effectively with the problems of child abuse and neglect. The Project Director is a child psychologist who spends two days a week at the Center directing program efforts. A full-time Project Coordinator and Paraprofessional Supervisor/Training Specialist round out the professional staff.

Goals and objectives are as follows:

(a) To coordinate and unite the efforts of public and private agencies in providing comprehensive child abuse services.

HAWAII FAMILY STRESS CENTER



(b) To Identify and provide intervention for high risk families to precipitate abuse and to increase parental self-esteem and parenting motivation in areas which enhance the personal, social and physical growth of the abused or neglected child.

(c) To fill gaps in services, such as emergency nursery care, shelter care for parents and children, homemaker services, long-term follow-up services, parents anonymous, or self-help groups, and preventative services.

(d) To increase reporting, reduce recidivism, increase the numbers of high risk families who develop positive parent-child relationships.

(e) To increase the functioning of target group families by increasing problem solving skills.

(f) To improve the functioning of personnel in the child abuse care system through in-service training, accessibility to a wider variety of resources and stimulations of participation in a comprehensive effort rather than in a compartmentalized manner.

4. LINKAGES ISSUES

The Hawaii Family Stress Center has established a strong working relationship through subcontracting with the following agencies.

The Hawaii Family Stress Center currently has four sub-contractors:

(a) Kokua Kalihi Valley has been established as an emergency shelter for spouses and children who have been or are in danger of being abused. It is available for an average of six days when it is unsafe for a mother and child to remain at home. Staff of the Kokua Kalihi Shelter Care Program include the Director and the Assistant to the Director. Referral for other supportive services are arranged by the staff. While 50% of the clients who utilize this facility are "self-referrals", many are referred by the police, CPSC workers, or the crisis line. Following an orientation to the shelter by the director, clients are provided counseling and other support services.

(b) Hale Lokahi Family Services Center was established as an integrated family services center in Waianae. This center coordinates the activities of several agencies in providing services to families under severe stress and at high risk of child abuse. Community education in child abuse and neglect is a major component of the center. The center also serves as a meeting place for other com-

munity organizations and groups. A maximum of sixty families can be served at any one time. Core staff of the center consist of one full-time Director and one full-time Work Coordinator. In addition, the center gets some staff time from the Leeward Children's Mental Health Teams and three volunteers who are part of a special state employment program. Family therapy is the center's largest program. Foster home placements, crisis intervention and infant stimulation/child development services are also provided.

(c) The Hana Liki Home Visitor Program utilizes paraprofessionals to make home visits to families identified by the Early Identification project to work with parents in developing a positive relationship with their newborn. Staff at the Home Visitor Program consist of one Program Coordinator, three paraprofessional home visitors (3/4 time), one secretary, and one accountant (1/2 time).

(d) The Early Identification Project has the primary goal of screening mothers in the Kapiolani Hospital and Kaiser Hospital prenatal clinics for maternal stress factors and behavior that place their newborns at possible high risk for abuse or neglect. Identification of high stress mothers is accomplished under the overall aegis of the Post-natal Counseling Project at Kapiolani Hospital. The Second goal of the project is to make a referral to a helping, non-stigmatizing confidential source of intervention for families found to be under high stress.

The Hana Like Home Visitor Program retains paraprofessionals as an experimental follow-up program.

The Training Center component of the HFSC is a paraprofessional program which maintains an identity apart from the HFSC grant. The Dynamics of Child Abuse and Neglect is a five unit course accredited by Honolulu Community College and offered every seven weeks. Training sessions are limited to ten members. Emphasis is on the skills one needs for work in child abuse and neglect. Priority of accpetance to the training is given to persons on the Grant including any sub-contractor or social worker currently working in child abuse and neglect and members of Mental Health Teams. To date, 34 individuals have been trained.

A paraprofessional pool consisting of five Home Health Aides, two logistics Adies, and five Hoa Aloha Lay Therapists receive training and supervision at the center. Logistics Aides are assigned to the CPSU Social Workers and have no specific caseloads. They are assigned cases by need and are under the functional supervision of Social Service Aide III who is also a paraprofessional. They relieve CPSU workers of routine work activities such as transportation, babysitting, taking families to appointments, assisting with food stamps, etc. The Hoa Aloha Lay Therapists provide services to the most severe cases involving child abuse and neglect and are assigned to

the long-term follow-up unit of Catholic Social Services. They are on a 24 hour call for work 20 hours per week. The therapists presently serve 10 cases and will work up to a total caseload of 25-30 cases. The five Home Health Aides who have been assigned to the Public Health Nursing, Department of Health, have a caseload of 10-20 families each. One third of their caseload is comprised of confirmed cases. The overall goal of the program is to reduce the incidence of pre-abuse/neglect crises among target families and strengthen their parenting skills in order to prevent child abuse and neglect.

Other Community Linkages That Feed into the CAN System

(a) Catholic Social Services Long Term Treatment Unit was established in 1973. This program is responsible for implementing an on-going and adequate treatment program for the child and parents. Staff includes a MSW supervisor and five MSW level case workers. The maximum caseload assigned per worker is 15, sc that the static capacity of this service is 75. Anticipated dynamic capacity is approximately 75-150 cases, depending on length of service

Intake procedure is initiated by the DSSH Social Services Section. The Coordinator makes an immediate decision to accept or reject a referral based on available information on the case and caseload capacity of the workers. The scope of services offered includes individual

therapy for parents and children, group therapy, combinations of individual and group therapy, and initiation of parent self-help groups. Services are provided in phases, each of which has specific growth goals for the parents and child and is designed to increase the effectiveness of the parents in handling personal, marital and parental problems and responsibilities.

(b) Honolulu Police Department, Juvenile Crime Division: Two investigations take place when child abuse and neglect are reported to the police. A social investigation is conducted by the CPSC and a criminal investigation is conducted by the police. Both investigative reports are subsequently submitted to the Prosecutor's office in all cases that are investigated by the police. The police department also has the authority to remove a child from a dangerous situation without a court order. A hearing must be held within 48 hours.

(c) Family Court Judge: Family Court has exclusive jurisdiction over parents who are criminally charged and hears civil as well as criminal cases. The court also has jurisdiction over children and can take action as legal and physical custodian. Staff includes seven Family Court judges and two special service workers who monitor all services and coordinate with agencies that are providing special services to child abuse and neglect cases. 85% of all cases heard are substantiated.

(d) Children's Mental Health Teams, Division of Mental Health, Department of Health: There are eight Children's Mental Health Teams situated around the island of Oahu and on three outer islands. The majority of child abuse and neglect cases are referred by CPSC to the teams for therapy, psychiatric and psychological evaluation and treatment services. However, child abuse and neglect is not a specialty of the teams and negotiations are underway to establish child abuse/neglect teams in each of the centers. Sixty-one staff members provide services to child abuse/neglect case families and a typical case-load for involved workers is 15 to 20 cases. After a case has been investigated, services generally begin within one month. The Mental Health Teams usually work on a case for three months. More than one half of the cases drop out before the services are completed.

(e) Suzannah Wesley is at present only involved in child abuse cases when a parent enrolled in one of their activities becomes involved in potential or actual abuse. Often, if a client family is found to have child abuse problems, the family is referred to Public Health Nursing.

(f) Moiliili Community Center frequently receives referral calls from neighbors, teachers and counselors in the neighborhood regarding suspected cases of abuse and neglect. The agency takes any information available

and immediately report to the CPSU. The Agency is concerned with the need for long term remedial and developmental services for the abused or neglected child.

(g) Liliuokalani Children's Center has a child abuse section which received referrals from CPSU, parents and relatives. Cases not received from CPSU are reported and a decision made jointly as to which agency will provide service. The agency frequently works with young, unwed mothers. Services to families focus upon training, child-rearing practices and personal and marital counseling. Counselors work with parents in coping with their children's behavior. When parents cannot control their own emotions with their children the agency advises the parents that the agency will take the parents to court if the behavior persists. The agency frequently follows through to show the parents that the agency is truly concerned for the child. Counselors also work directly with children. Counselors coordinate efforts in child abuse casework with CPSU, Children's Hospital for testing, mental health clinics, other social service agencies, law enforcement agencies, schools and other organizations in the child's environment.

(h) Parent-Child Center of Kalihi works with groups of parents. Families involved in actual and potential child abuse are frequently among their clientele. One social worker and two psychological consultants are

are available for casework. Cases are reported to CPSU and the agency refers any cases which they cannot handle to CPSU.

(i) Public Health Nursing Service in Hawaii has been one of the major purveyors of family-centered health and health related services with the aim of strengthening the family as a unit and more particularly, in the area of child rearing and parenting. In 1973, 39% of the agency's resources were utilized for services to women, infants and preschool children. During the past five years, however, there has been an appreciable decline in services to families with pregnant women, infants and preschool children.

On Oahu, Public Health Nurses participate in special classes for pregnant students in two of the four school districts, however, at best, this intervention reaches only a small number of pregnant women.

Because of concerns expressed by Public Health Nurses during the past year, attempts have been made to identify parents "at risk" of child abuse or neglect. Although many parents have been identified as "at risk", there has been no community coordinated program to assist these parents. Staffing constraints within the Department of Health have limited the ability of Public Health Nursing to respond to these needs.

(j) Tripler Army Medical Center: Any child examined in the Tripler Army Medical Center (TAMC) Emergency Room who is suspected to have been abused or neglected is admitted to the pediatric medical or surgical ward. The attending physician fills out a report, a copy of which is forwarded to the TAMC Social Work Service immediately, in order to enable the pediatric social worker to initiate the psychosocial evaluation. Parents and other relevant individuals are interviewed. Collateral information from other sources is obtained.

The medical and social work recommendations are reviewed in the Child Abuse Management Committee for determination of abuse or neglect and to recommend a disposition. The Chief of the departments of Pediatrics, Psychiatry, Social Work, Administration, the Judge Advocate, and Army Health Nurse are official members of this committee. Either the medical consultant or supervisor from CPSU is usually present. The investigation is thus conducted by TAMC, unless CPSU has previously been involved in the case. If the TAMC committee confirms the abuse or neglect, the case is reported by the TAMC social worker to the CPSU by telephone and in writing. If return to the home is deemed unsafe for the child, temporary foster placement is sought.

Upon referral, CPSU takes over casework and the TAMC worker maintains liaison with the case. Medical care is

provided at Tripler. Periodic feedback to the committee is conducted. Long term follow-up care is provided by DSHH Child Welfare Units, private agencies, or the military Family Life Centers.

Projected Programs of the HFSC

(a) Homemaker Program: Two Homemakers are in the process of being trained by the HFSC Paraprofessional Supervisor/Training Specialist. Homemakers will be assigned to cases which indicate:

(1) high risk of rebattering,
(2) absence of caretaker (mother)
(3) significant neglect,
(4) inability to manage a number of children,
(5) long term inability to manage requiring teaching in home management.

The homemaker will meet with the case manager, homemaker supervisor and mother to discuss needs for assistance as perceived by the mother. The mother will discuss the work that she can do and the areas where she needs help. A service agreement will be made to be signed by the head of the family, homemaker, supervisor and case manager.

The primary objective of the homemaker program is to provide emotional support and assurance to the family, working in consonance with the social worker's goals. The homemaker will be providing assistance with household

tasks, training in home management and help in meeting emotional needs of the mother.

(b) Emergency Child Care: Emergency child care is being developed as a resource for parents involved in or at risk of child abuse during times of stress when they need to be separated from the child. Emergency child care will be utilized by families involved in or at high risk of child abuse or neglect who are identified by the HFSC or Children's Protective Services Center. The service will be utilized on a voluntary basis by the parents, with the consent of the case worker and as an integral part of a network of services.

Emergency care will be distributed geographically to meet the needs of families in high risk areas. Twenty-four hour care will be available for a maximum of 5 children at one time for as long as 72 hours at one time. In some areas a house or child care center will provide this service as a center-based program; in other areas home caregivers will be on call to take children into their homes. Care-givers will be carefully screened and trained in child care and the dynamics of child abuse and neglect by the HFSC.

(c) Parents Anonymous: Several programs affiliated with the HFSC are planning to start Parent Anonymous groups including Hale Lokahi, Hana Like and Catholic Social Services. Parents Anonymous will be set up on all of the islands.

5. LEGAL ISSUES

(a) Legal Consultation: An attorney experienced in the dynamics of abuse and neglect serves as a consultant to the Hawaii Family Stress Center. The primary function of the attorney is to asist in obtaining court custody where specialized assistance is needed. The attorney has developed a training curriculum and conducted a course for Protective Services workers in preparation for and taking of cases to court. A total of 51 Protective Services and Child Welfare workers from DSSH, Child and Family Services, Liliuokalani Children's Center and Catholic Social Services have participated in this training to date.

(b) Family Court Attorney: The counselor from the Attorney General's Office was assigned on a full-time basis to Family Court in 1975. The counselor brings all cases before Family Court on behalf of the State and the referring agency (usually DSSH). Evidence is presented to grant emergency custody within 48 hours. A second hearing is held in thirty days. The District Attorney General must prove that the child comes under the court's jurisdiction. If the DAG prevails, the child is placed in a suitable environment and the agency is granted temporary legal custody. A review hearing is held every six months. If the DAG does not prevail, the child

is returned to the home and the legal case is closed.

6. COMMUNITY AWARENESS

Training Center - Family Stress Center

The Training Center component of the Family Stress Center was not initially conceived as a part of the original grant. However, the numberous calls and requests to the Family Stress Center for child abuse and neglect information and presentations led to its eventual evolution as a separate and important component.

Mission: The Training Center has a program for training para-professionals somehwat separate from the HFSC Grant. It is based more on community needs.

The Dynamics of Child Abuse/Neglect is a 5 credit course accredited at Honolulu Community College and offered every 7 weeks by the Center. There are ten people in each training session. Currently there are 5 social workers from DSSH, 3 Hoa Alohas from CSS. The emphasis is on the qualities one needs for work in CAN. Students are selected giving priority to any who are on Grant including any sub-contractor, any social worker, private, or DSSH who are currently working in CAN, members of Mental Health Teams.

Training is based on common human needs. An abusive parent profile is studied along with the profile of an abused child. Community resources are utilized. Students are trained to assume the role of a helping person.

Staffing: Core staff of the Family Stress Training Center include:

1 Paraprofessional Supervisor/Training Specialist

1 Secretary

Services: The Center provides training for FSC paraprofessionals, professionals from various disciplines including 5 "temporary" Social Workers of the DSSH long-term Follow-up Unit and interested lay people. A brcad array of community education activities have also been undertaken. The Center's curriculum in the dynamics of child abuse and neglect has recently been accredited for five units by Honolulu Community College. To date thirty-four individuals have been trained.

All paraprofessionsl (Home Health Aides, Hoa Alohas, Logistic Aides) have a one hour supervisorial conference with the Training Specialist once a week. Usually, their respective functional supervisors attend these conferences. In addition, there is a one hour per week "Peer Support" Conference for each group of paraprofessionals.

7. PROGRAM PRIORITIES

Report 2 (Linking Costs to Services) of the three previous Quarterly MIS reports indicates the following priorities for the Demonstration Center program:

October-December 1975:	Personnel Development, Resource Development, Individual Adult Counseling, Support Services, Emergency Shelter.
January - March 1976:	Parent Aide/Lay Therapy, Transportation/Waiting, Emergency Shelter.
April - June 1976:	Parent Aide/Lay Therapy, Transportation/Waiting, Emergency Shelter.

8. PROGRAM GOALS AND APPROACHES

For a discussion of program goals and objectives, see preview sections on Organizational Structure and Linkages issues.

9. STATISTICAL INFORMATION

The following pages contain statistical information concerning the actual cost and total value by functional service area (for the year and by quarter), unit costs, case flow, and problems encountered by the Center. Table 1 displays actual cost and total value for each of the five functional service areas for the period from 1 July 1975 to 30 June 1976. The actual cost of providing services to the clients of the Family Stress Center, as derived from MIS data, was $306,909. Total value of all services provided by the Center was $348,572. Program Operations accounted for the largest percentage of actual cost and total value, with $148,186 or 48.3% of actual cost and $155,269 or 43.3% of total value expended in this area. Among the other functional service areas, the largest actual cost and total value expenditures were in the Services to Families area. $84,312 (27.5%) actual cost and $118,383 (33%) total value was expended in this area. In the area Services to Children, 11.2% of actual cost ($34,484) and 11.4% of total value ($40,790) was expended.

Among the client services provided to the clients of FSC, MIS data indicate that the emphasis was on the provision of psychological services. $50,750 (16.5%) in actual cost and $69,575 (19.4%) of total value was expended

for psychological services. The next two areas of emphasis were Shelter/Custodial Services, which accounted for 11.3% of actual cost (13.6% total value), and Support Services which accounted for 9.2% of actual cost and 8.4% of the total value of services provided by the Center.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$306,909	100.0	$358,572	100.0
PROGRAM OPERATIONS	148,186	48.3	155,269	43.3
COMMUNITY ACTIVITIES	18,953	6.2	19,416	5.4
CASEWORK ACTIVITIES	20,974	6.8	24,714	6.9
SERVICES TO FAMILIES	84,312	27.5	118,383	33.0
SERVICES TO CHILDREN	34,484	11.2	40,790	11.4
CLIENT SERVICES:				
MEDICAL	4,393	1.4	4,468	1.3
PSYCHOLOGICAL	50,750	16.5	69,575	19.4
LEGAL	1,190	0.4	1,776	0.5
SHELTER/CUSTODIAL	34,562	11.3	48,725	13.6
SUPPORT	28,242	9.2	30,270	8.4
EDUCATIONAL	7,045	2.3	8,903	2.5
CRISIS INTERVENTION	1,401	0.5	4,392	1.2

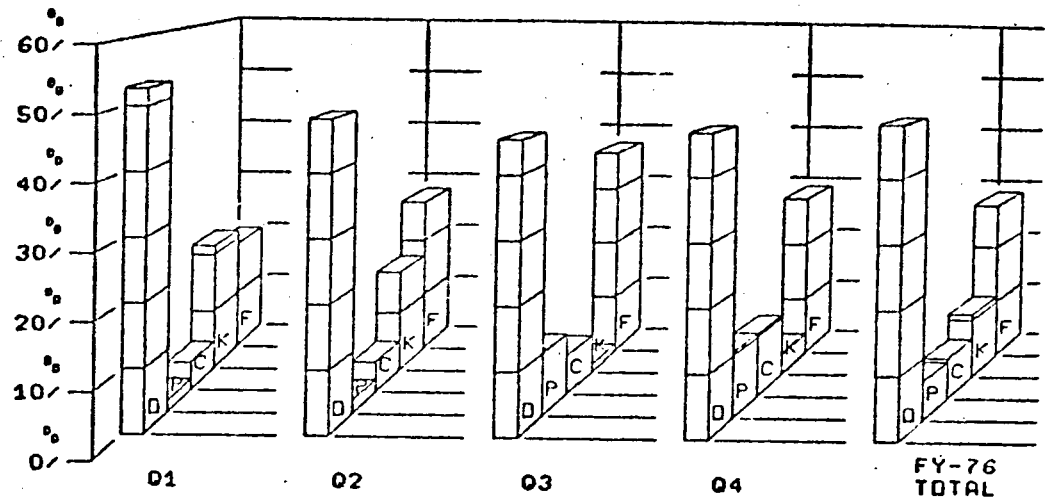
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that the Center was fairly consistent in the Program Operations costs for the entire fiscal year. The percentage of actual costs allocated to this functional service area remained close to 50% for the year. The next area of priority as evidenced by the data was in Services to Families. The average percentage of allocation for the year was approximately 28% of actual cost of operating the Center. However, there was considerable variation in the percentages among the different quarters. In the first quarter, the percentage was slightly less than 20%, in the second and fourth quarters, the percentage was approximately 27%, while in the third quarter, 36% of actual cost was allocated to families. In the remaining three service areas -- Community Activities, Casework Acitivites, and Services to Children -- the average percentages of expenditures were quite similar. The average actual expenditure in the area of Children's Services was slightly higher than 10%, and in the other two areas approximately 5%.

In Figure 2A, the configuration of the data closely approximates that of Figure 2 indicating that either donated services were fairly evenly distributed among the functional areas, or the absence of substantial donations.

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

FOR

HONOLULU

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

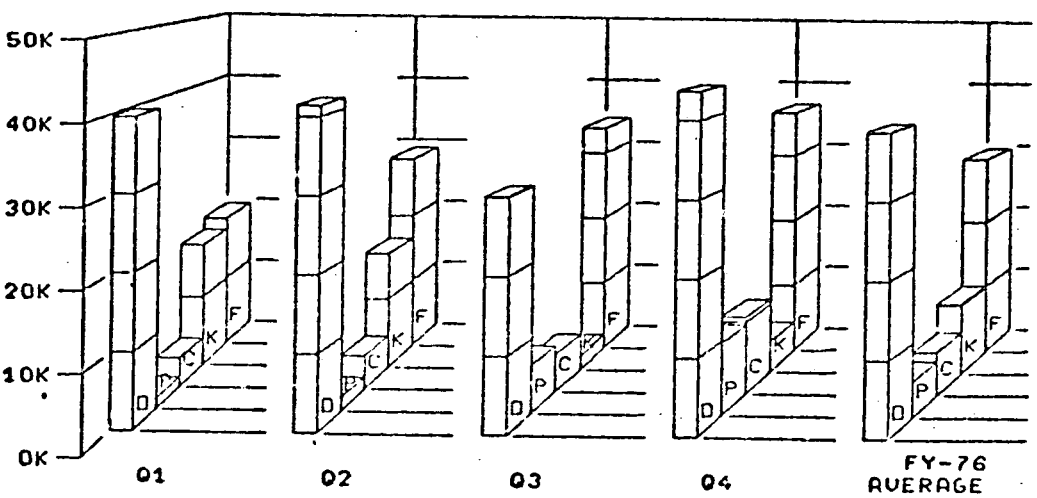


Table 2 presents the unit costs per child and family for the period covering the last two quarters of the fiscal year. The reader is referred to Volume I pages 22-24 for a detailed discussion of the methodology for calculating these units, and a discussion of the reason for the difference between the values presented here and those in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

ACTUAL COST PER CHILD	$444
TOTAL VALUE PER CHILD	541
ACTUAL COST PER FAMILY	847
TOTAL VALUE PER FAMILY	1,033

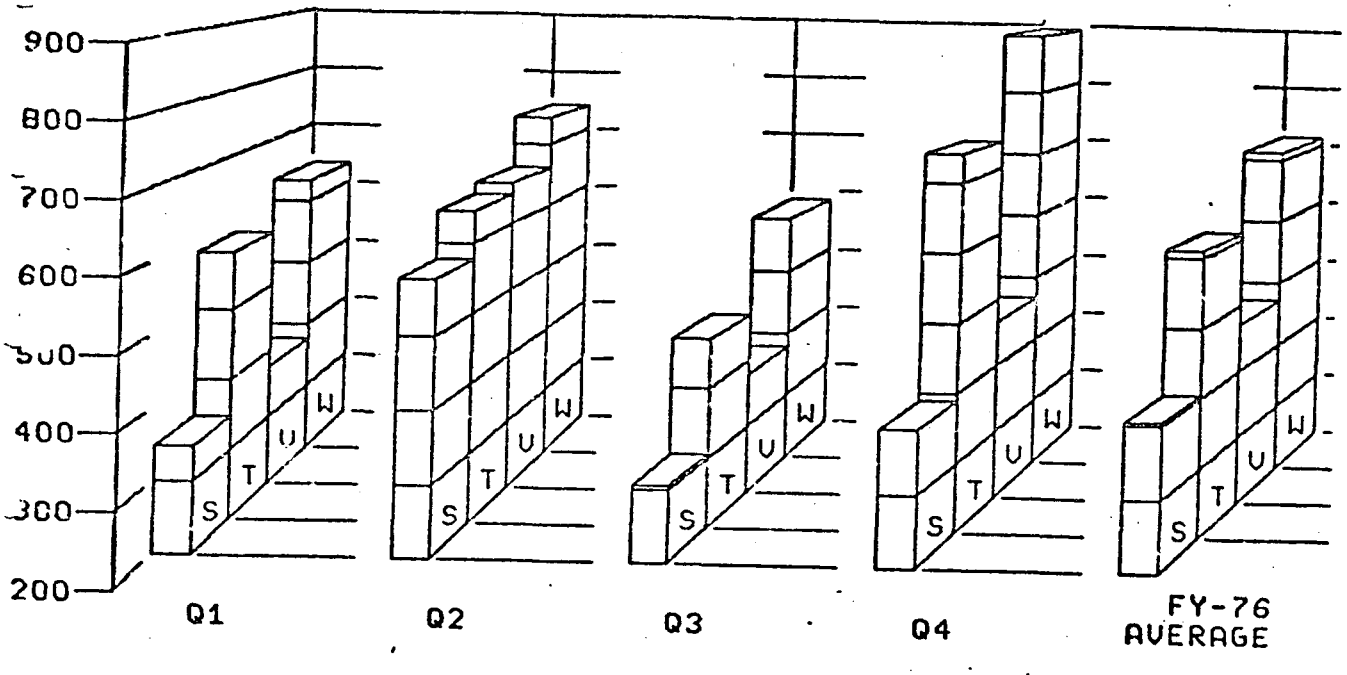
The actual cost of providing services per child was $444, somewhat higher than the median of $318 reported by all centers. The Total value per child was also higher than the median value of $486 reported by all centers, but was somewhat lower than the average total value per child of $563. The actual cost and total value per family were also higher than the medians reported by the aggregate of twelve centers, but again, those unit costs were shomewhat lower than the average reported by all centers.

In figure 3, the unit costs per child and per family for each quarter and the average unit costs for the year are graphically reproduced. Actual cost per child and family, and total value per child and family are shown.

Actual cost and total value per child remained fairly close throughout the year, but the sets of figures varied considerably from quarter to quarter. In the first both unit costs were approximately $350 per child. In the second quarter, actual cost per child was slightly less than $600 per child, and total value per child was approximately $650. In the third quarter, actual cost per child dropped to approximately $300 and total value per child had a similar drop to $350, while in the fourth quarter, these unit costs wer $400 and $450. Given that variation in unit costs by quarter, it is not extremely meaningful to speak of the average unit cost per year. Data from FY 1977 will determine whether these unit costs have finally stabalized.

The data are similar for actual cost and total value per family. The unit costs were highest in the fourth quarter and lowest in the third quarter.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR HONOLULU



KEY

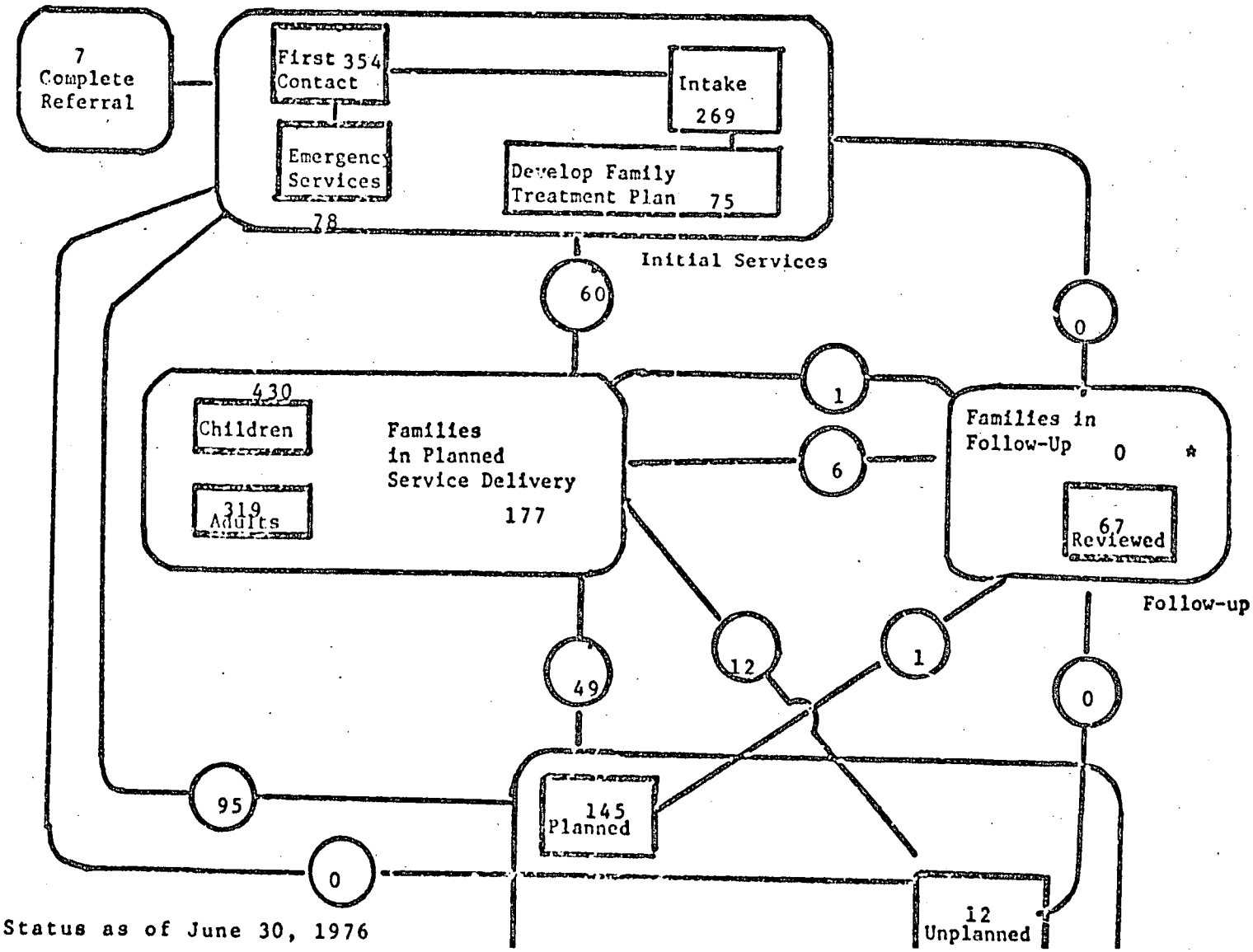
S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
U- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

Figure 4 provides a visual depiction of the client flow of FSC for a period including January 1, 1976 to June 30, 1976. The figure shows that 177 received planned services during this six month period. There were 319 adults and 430 children in those families. In addition, 78 families received emergency services from FSC. There were no families in follow-up, as of 30 June 1976, although 67 cases had been reveiwed at that time. One hundred-fifty-seven cases were terminated from the Center's caseload, and 92.4% of those terminations were planned.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR HONOLULU
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 -- JUNE 19

FIGURE 4



* Status as of June 30, 1976

The Mangement Information system provides a set of warning "flags" which indicate which of a specified set of problems are being encountered by the center each quarter. Table 3 provides a summary of that information for the year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if High, otherwise OK)	H
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVERS THIS YEAR	4
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual costs incurred during the year in the service category #1 (Administration) and dividing that sum by the total actual cost. At the FSC, 27% of actual cost expended were incurred in administration. This figure was higher than the 25% level that was seen as a maximum figure. Fifty percent of actual cost allocated to service areas, excluding Program Operations, was determined to be a minimum level of service expenditure. 51.7% of actual cost was expended for service -- a figure just higher than the minimum.

G. PROFILE FOR THE FAMILY DEVELOPMENT PROGRAM

NEWARK

1. START-UP ISSUES

(a) Site selection and development. Site selection was a problem in Newark particularly in the Martland Hospital neighborhood due to the large number of old, badly maintained, gutted or fire prone buildings.

However, the selection problem was minor compared to the problems in preparing the site. Major renovations were needed.

(1) State bureaucracy - approvals were needed from the legislature and the office of the Governor. These reviews were quite slow.

(2) College (College of Medicine & Dentistry of N.J.) bureaucracy and state fiscal crisis ground renovation to stand-still several times because of lack of carpentry, personnel, administrative overload, etc. This was a major problem.

(3) Because of the above, the program had to operate out of borrowed space at Martland Hospital. The space was extremely limited and the program was definitely hampered by this situation until December, 1975.

(b) Coordinating with DYFS (Department of Youth and Family Services) the state mandated Protective Service Agency. There is a terrible fiscal crunch in this agency which is a part of its chronic problems. DYFS must be involved in every CAN case so that FDP is affected by DYFS problems. This problem continues and no resolution is in sight unless the DYFS funding increases.

(c) Relationship with Contract Agencies. The center has certain supervisory role problems with two of the major contract agencies; one providing homemakers, and the other providing psychotherapy and evaluation. The center had to resolve how contract agency staff are to function as part of the FDP team while still employed by another agency.

(d) Dealing with isolation of Martland area clients. Voluntary participation in services, particularly group services has been a problem since the program started. This is an extraordinarily depressed community where most clients have no telephones and question both motivation and trust of the service provider.

2. STAFFING

Hiring done through CMDNJ: The college had to approve all job descriptions and salary levels. Some staff

came from existing college social service staff, others were recruited from outside. The center wanted a person with a strong DYFS background as nursing/medical training coordinator. The center was fortunate in locating a nurse who had worked for DYFS to fill this position.

The college bureaucracy is slow in filling vacancies that have occurred. The secretary/office manager was underpaid initially. The Director lobbied to upgrade both her salary and job descriptions.

All staff received general CAN training and most staff received specialist instruction related to their functions as FDP team members. (FDP has provided much training and is responsible for segments of the curriculum for all students in pediatrics, obstetrics and gynaecology). Technical assistance for other professionals is also available from FDP through Symposia, workshops, etc. The project has often become involved with other agencies in jointly providing training.

3. ORGANIZATIONAL STRUCTURE

FDP's Director is also the Social Work Supervisor for Pediatrics at CMDNJ. Therefore, he is not located full-time at FDP site, but maintains an office in the hospital as well, keeping close contact and communication

with hospital staff. The staff consists of a Case Coordinator who monitors all direct service provisions, maintains all necessary contact with DYFS, and is responsible for all case files. The Training Coordinator maintains a small library of CAN materials; plans and presents program curriculum on an on-going basis to students in classes and on rotation in various hospital wards and departments. She also provides T and TA to other professionals. The direct service staff consists of para-professionals (mostly black and hispanic since this is the ethnicity of the client population served), under the supervision of the Family Life Education coordinator - 4 Family Developers, and a transportation aides.

Homemakers provide services under contract from CHR-ILL. Another contract agency, YDC, performs all regular psychological counseling and evaluation. (There are 3 YDC workers regularly involved with FDP clients and 4 homemakers from CHR-ILL.)

FDP staff also includes consultants who attend weekly meetings of the Dispositional Conference, a multidisciplinary team.

THE FDP organizational structure has clear supervisory and reporting relationship which seems to function smoothly. The director's management provides firm guidance for the staff.

4. LINKAGES

The FDP proposal detailed the plan to utilize CHR-ILL and YDC for regular treatment services. Although problems have arisen, these agency linkages have been important, and contract services have ben used more than originally anticipated.

Linkage with DYFS has been frustrating, in spite of all good intentions, due to the impact of budget cut-backs at the state level and the resulting strain on DYFS workers. Unfortunately, relief does not seem to be forthcoming. For example, FDP had hoped that DYFS workers would be able to participate in dispositional conferences. Genreally, however, the workers have been too busy to personally be there, and have participated only through telephone conference calls.

Linkage to other clinics and departments (Family Planning, Family Health, Ob-Gyn, etc.) within the CMDNJ is often a natural result of development of a comprehensive family plan by FDP. There is no data to indicate problems with these linkages, though located at different sites throughout the large, rather unwieldly hospital facilities.

More informal kinds of linkage (with other hospitals for example) have resulted due to interest and requests for

assistance from other agencies. One hospital to which FDP provided TA and grant writing assistance has received Title XX monies.

5. LEGAL ISSUES

FDP became quite involved the Spring and Summer of 1976 in lobbying against a piece of legislation which would return reporting by physicians and hospitals to law enforcement. (Only since the law was changed in 1974 to require reporting to DYFS rather than law enforcement has reporting from physicians and hospitals increased to the point that protective services can begin to protect a segment of NJ's abused or neglected children and to help the parents and guardians). FDP has aggressively contacted agencies and associations in an attempt to round up all possible professional support against this bill. As of this writing the bill was still much alive, but there seemed good chance of "tempering" the effects due to the well coordinated and loud protests in which FDP has played an active role.

The Dispositional Conference Team includes a lawyer, as many of FDP's clients are under some court supervision. There has been some concern at FDP over the privacy issues, as it relates to the particular Martland community, where

a client is likely to be on welfare and/or receiving other public services and support. These are the clients who are continually tracked through increasingly complex state and federal bureaucracies, who can not "buy" privacy or lack of detection by the system. For example, some FDP client families may voluntarily release their children to foster care during stressful or crisis periods. This is far different than a forced removal from the home.

6. COMMUNITY AWARENESS

Because FDP was designed to serve only the number of abused/neglected children and their families that could be identified through MHU, there has, to date, been no "PR" campaign, as FDP could probably expect a deluge of referrals if intake were open to all of Newark.

During the baseline study data collection, the evaluator found that some agencies in the Newark community knew almost nothing of the program. At this time, however, the site had been occupied just barely over a month, and "open houses" were planned to explain the program and facilities to interested professionals and other agencies in the area.

The real focus of community awareness for FDP has been on the community of medical and nursing students and

practitioners of the CMDNJ-MHU. In this area, a careful, concentrated, and on-going strategy has been developed. The results of this effort were immediately apparent in a dramatic increase in identification and reporting with the MHU facility.

FDP has had occasional direct and indirect contact with community awareness efforts for the wider community through their communication with the CAN Resource Project at nearby Rutgers University.

7. PROGRAM PRIORITIES

According to the MIS Quarterly Summaries for the past three quarters, FDP priorities have been reflected by a concentration of expenditures toward the following categories: homemaking, education services, case management and review, couple/family counseling, staff development, community education, individual adult counseling, parents anonymous (which in this case, refers to development of a locally based parents self-help group rather than a branch of the national organization) and crisis intervention.

Since this is a hospital-based project, large sums are generally reported by Newark as donated under the categories emergency medical care and medical care for children

Reports 2 and 4 of the MIS Quarterly Summaries (Linking Costs to Services and Expenditures by Function) are the source for additional information in this regard.

8. PROGRAM GOALS AND APPROACHES

The following list of FDP goals and objectives have been summarized from the list the FDP staff prepared. Because of space constraints, activities relating to each objective are not listed.

GOAL I

TO DEVELOP A MODEL, HOSPITAL-BASED, MULTI-FACETED, FAMILY FOCUSED TREATMENT COMPONENT.

Objective 1

Determine patterns of abuse and neglect in the community and hospital patient population.

Objective 2

Determine service needs of abusive and neglectful families

Objective 3

Plan a comprehensive coordinated service program

Objective 4

Secure staff to carry out program goals

Objective 5

Acquire project site.

Objective 6

Prepare for hospital-program interface.

GOAL II

TO DEAL MORE EFFECTIVELY WITH THE MANIFESTATIONS AND CONSEQUENCES OF ABUSE AND NEGLECT BY DEVELOPING A SYSTEM OF MULTI-DISCIPLINARY INTER-AGENCY ASSESSMENT AND REVIEW

Objective 1

Formulate a prototype of such a system.

Objective 2

Select individuals for participation in the primary mechanism (Dispositional Conference) of the system.

Objective 3

Prepare members for their participation in the Dispositional Conference.

Objective 4

Acquire psychotherapy/counseling and homemaker services through contracts with community agencies.

Objective 5

Provide other essential services to project families, including:

Medical evaluation, treatment, follow-up and home health education - through hospital and public health nursing services.

Family advocacy with community agencies and institutions - through efforts of project and DYFS social worker as well as other project staff.

Self-help groups - aided in their development by project staff and housed at the project site.

Child placement - through DYFS

Family Planning - through hospital and community programs.

Hot Line - through DYFS Office of Child Abuse Control hot line.

Day Care - through approved facilities and supported by public assistance and child welfare funds.

Other services which are indicated - through referral

GOAL III

TO PROMOTE COORDINATION AND CONTINUITY OF SERVICES TO ABUSIVE AND NEGLECTFUL FAMILIES

Objective 1

Coordination of the provision of the appropriate combination of services to project families, including follow-up and review

Objective 2

Strengthen and develop the community protective service system.

GOAL IV

IMPROVE THE EFFECTIVENESS OF HEALTH CARE PRACTITIONERS AND DELIVERY SYSTEMS IN THE IDENTIFICATION, TREATMENT AND PREVENTION OF CHILD ABUSE

Objective 1

Train hospital staff regarding:

- legally mandated and institutional procedures for reporting
- program goals and operation
- recognition of abuse and neglect
- etiology of abuse and neglect
- management and treatment

Objective 2

Train medical, nursing, social work and other students in allied health areas in the college or cooperating programs regarding (same as practitioners).

Objective 3

As time allows, offer educational and program consultation to other health care agencies, training programs or professional organizations.

Objective 4

Help advance the state of the art and science regarding child abuse and neglect

GOAL V

TO CHANGE OR MODIFY THE DESTRUCTIVE POPULAR STEREOTYPES OF ABUSIVE AND NEGLECTFUL FAMILIES AND THE PROTECTIVE SERVICE SYSTEM THROUGH WHICH THEY PASS.

Objective 1

Conduct a public awareness campaign utilizing and including the popular media.

Generally, Goals I and II were the goals relating to intitial program planning and development. Goals III, IV, and V deal with the on-going efforts.

While some aspects of the FDP treatment system have been left open-ended, the staff hopes to be able to refine their strategies during the course of the demonstration effort to the point that time-limited treatment models can be defined, and treatment goals established on the basis of these models.

However, as long as the Community served by Martland Hospi retains its leadership near the top of almost any negative indicator one can name, the possibilities of a continuing

high level of stress (the kind that contributes to creating abusive/neglectful family life situations), are high. The project goals for this center are being approached by the staff with recognition of, and appreciation for the client universe and the implications on this demonstration effort.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The Tables and Figures presented below contain information on costs by service area (for the year and by quarter), unit costs, indicators of problems, and the case flow diagram for the year. A brief commentary accompanies each table or figure.

Table 1 gives the actual cost expended and total value of services in each of the functional service areas and also gives a breakdown of client services in the functional areas Services to Families and Services to Children.* The actual cost of all services provided by the Family Development Program, as derived from MIS data, was $297,411 and total value of these services was $439,191. Examination of Table 1 shows that it was primarily donations for

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* Each of the functional service areas is defined by its MIS service categories on the following page.

client medical services that accounted for the difference in actual cost and total value of services. There were also substantial donations in shelter/custodial services. For FY 1976, the emphasis at the FDP in terms of actual costs and total value was in the areas of Services to Families ($94,014 actual cost for 31.6% of the budget) and Services to Children ($111,355 in total value or 25.4% of the total value of services provided by the Center).

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 19

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$297.411	100.0	$439,191	100.0
PROGRAM OPERATIONS	157,321	52.9	167,577	38.2
COMMUNITY ACTIVITIES	10,497	3.5	11,985	2.7
CASEWORK ACTIVITIES	33,513	11.3	42,182	9.6
SERVICES TO FAMILIES	94,014	31.6	97,627	22.2
SERVICES TO CHILDREN	2,066	0.7	119,820	27.3
CLIENT SERVICES:				
MEDICAL	$55	0	111,355	25.4
PSYCHOLOGICAL	41,554	14.0	42,280	9.6
LEGAL	0	0	151	0
SHELTER/CUSTODIAL	603	0.2	9,007	2.1
SUPPORT	23,450	7.9	23,720	5.4
EDUCATIONAL	22,397	7.5	22,683	5.2
CRISIS INTERVENTION	8,021	2.7	8,251	1.9

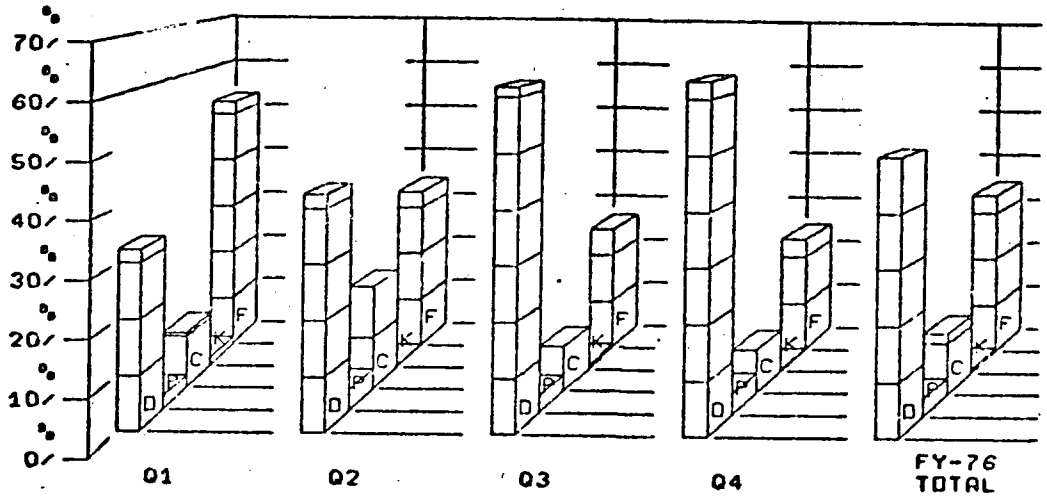
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that the percentage of actual cost expended in the various functional service areas was somewhat different for the first and last halves of the fiscal year. In the first two quarters, Program Operations accounted for 33% and 43% of the actual budget, while in the latter two quarters, these figures were over 60% of the budget, resulting in an average for the year of 53% expenditures in this area. A reversed pattern was seen in the area of Services to Families. In the first two quarters, the expenditures in this area accounted for over 50% (1st quarter), and over 30% (2nd quarter) of the budget. In the third and fourth quarters, the expenditures for Family Services was approximately 25% of the actual budget, resulting in an average for the year of approximately 32%.

The area of lowest expenditures, in percentage of actual cost, was Services to Children. The percentage of actual cost expended in this area was approximately 1% in each quarter. However, examination of Figure 2A will show the result of substantial donated services in this area. Of the remaining service areas, the average expenditure in Community Activities for the year was approximately 4%. This figure remained fairly stable throughout the year. The service area Casework Activities also remained fairly stable throughout the year with an average expenditure of approximately 11%.

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

FOR
NEWARK

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

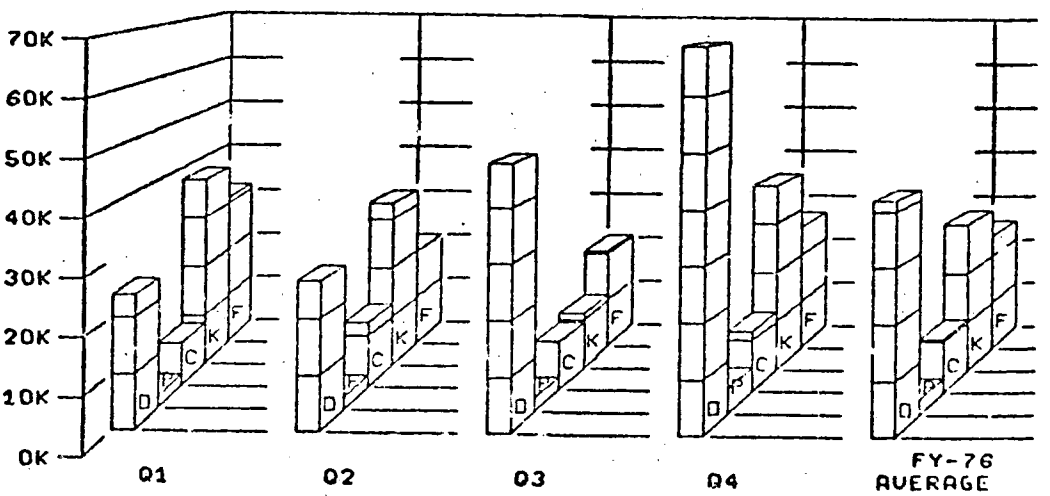


Table 2 presents the unit costs per child and family for the period covering the last two quarters of the fiscal year. The reader is referred to Volume I, pages (22-24) for a detailed discussion of the methodology for calculating these units, and a discussion of the reason for the difference between the values presented here and in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

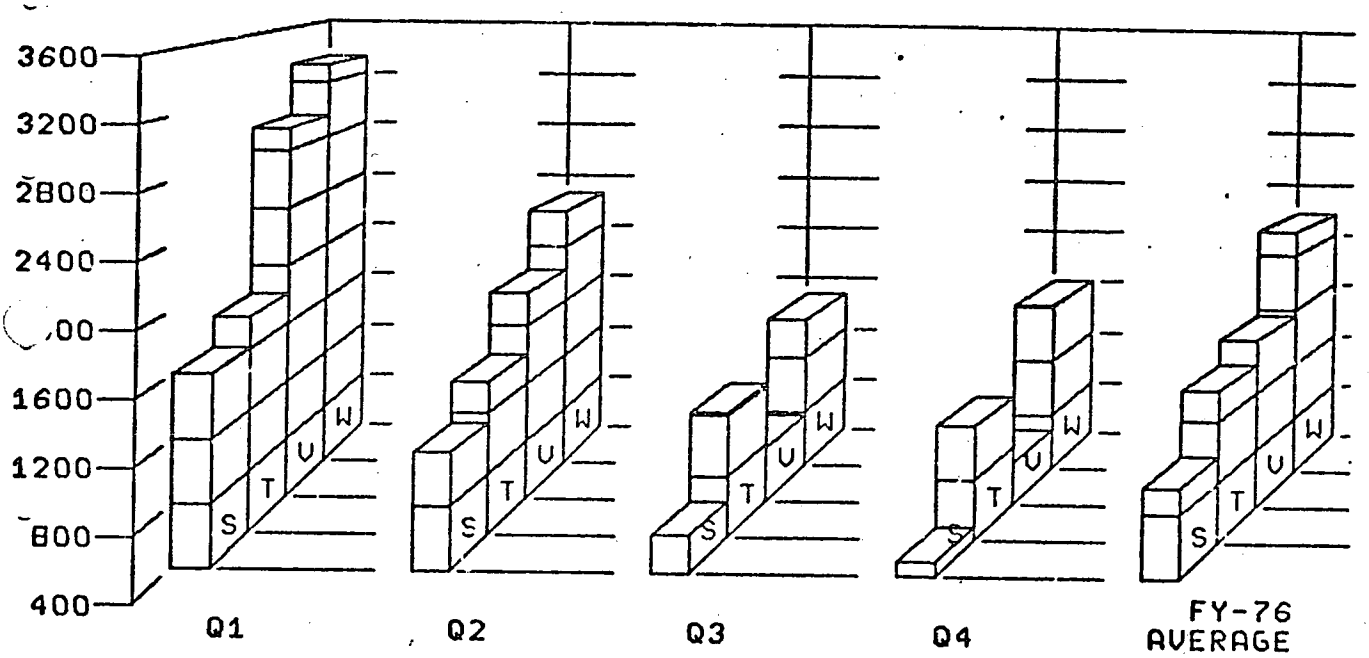
ACTUAL COST PER CHILD	$ 793
TOTAL VALUE PER CHILD	1,048
ACTUAL COST PER FAMILY	1,842
TOTAL VALUE PER FAMILY	2,435

The actual cost and total value of providing services per child at the Family Development Program were considerably higher than the mean and median figures reported by the aggregate of twelve demonstration centers. Similarly, the actual cost and total value per family were higher than the mean and median values reported by all centers.

Figure 3 graphically produces the unit costs per family and per child. The data shows actual cost and total value per child, and actual cost and total value per family.

The data show that the unit costs in the first quarter were quite high, due to a small caseload and the fact the Center was just becoming operational. These unit costs were adjusted downward each quarter thereafter, with the result that average unit costs for the year were approximately $1,000 actual cost per child, $1,600 total value per child, $1,400 actual cost per family, and $2,200 total value per family.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR NEWARK



KEY

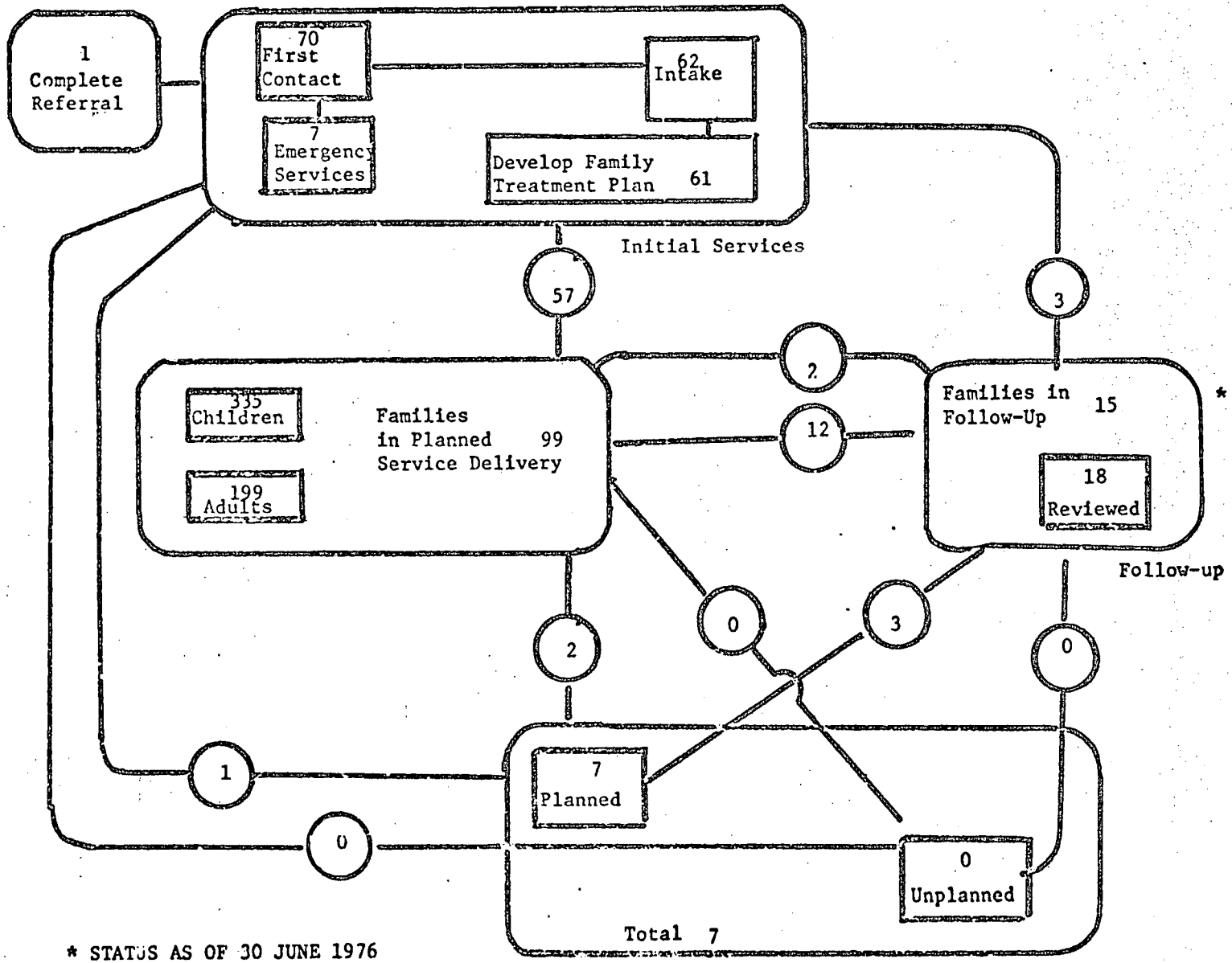
S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
V- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

In Figure 4, the client flow of the Family Development Program is shown in a Case Flow Diagram. For the six month period from 1 January 1976 to 30 June 1976, there were 99 families that received planned services at FDP. Additionally, 7 families received emergency services during that period. At the conclusion of the fiscal year, there were 15 families in follow-up and 18 cases had been reviewed. Seven families were terminated from the Center's caseload during this period, and all terminations were planned.

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR NEWARK
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 - JUNE 19

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 presents a summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during a quarter.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	L
STAFF TURNOVER THIS YEAR	2
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual costs incurred during the year in service category #1 (administration) and dividing that sum by the total actual cost. At the FDP, only 10% of actual cost expended were in administration -- well below the maximum of 25%. Fifty percent of actual cost allocated to services areas, excluding Program Operations, was determined to be a minimum level of service expenditure. Only 47.1% of actual cost was so expended, therefore service expenditures received a warning flag for low service expenditures.

H. PROFILE FOR THE WILTWYCK SCHOOL

BROOKLYN

1. START UP ISSUES

The Wiltwyck School program has a noteworthy history that shapes its approach to the needs of children - children who are often desperately in need. In 1937, The Wiltwyck School established a residential treatment center for neglected and delinquent Black boys from New York City. It provided minority children an alternative to the state training schools and to this day serves over one hundred boys at the facility in upstate New York. The program was expanded over the years to meet other needs of the families of the children they served. These services included half-way houses, family therapy and foster homes. In addition, the program was made available to children of any race, color, or religion.

Wiltwyck decided to develop a visible service presence in the three major areas of the city where the bulk of the children clustered - Harlem, Bedford-Stuyvesant, and South Bronx. The center in the Bedford-Stuyvesant area of Brooklyn was opened in 1972. The program in Bedford-Stuyvesant incorporated several components: Day Center Program, After School Program, Homemaker Services, and Youth Services Program. The homemakers were used in a court-diversion effort to improve the home environment for delinquent youths. This range of services was subsequently available for the CAN project.

The demonstration center, called the Bedford-Stuyvesant Family Services Program, was funded beginning January of 1975. Several factors made start-up of the center easier than was the case for other demonstration centers. The project director and trained homemakers were already on staff, working space was immediately available, the center was known by community residents, and relationships were previously established with other community agencies. Recruiting and training additional staff was the principal activity during the start-up phase.

The only start-up issue (not covered elsewhere under staffing and linkage issues) revolved around other grants whose awards were pending. If these other grants were awarded to the Brooklyn Center, new facilities and a new project director would have been needed. Certain implementation activities were thus delayed. When these grants were not received, these issues were moot.

Another more general issue encountered was the tremendous demand for services for high risk families. On one hand, there are so many families in the catchment area that could fall in this category, that the extent of the commitment of the demonstration center to these families was questioned. On the other, these families would not be entitled to protective services under the current New York State plan for Title XX services. The center feels strongly that the

needs of these families should be met and has communicated with appropriate state officials on this matter. With the referral of many substantiated cases from BCW, the center's focus has shifted to these families.

2. STAFFING ISSUES

(a) Hot-line Coverage. Problems in staffing the Help Line resulted from the need to provide 24 hour coverage. This necessitated having a staff member on call at all times. This duty was rotated among the staff members. However, staff members were not satisfied with the initial method of compensation for this requirement and the matter was subsequently resolved. This matter is discussed here not because of its seriousness but since it is a consideration for future projects which place heavy demands on staff both on and off duty.

(b) Multi-problem Families. To encourage rapport with the clients, it was the policy of the center to have each family assigned to one homemaker. However, BCW referrals included many severely dysfunctional families that required 5 day a week homemaking services. The resultant stress and frustration for individual homemakers led to a change in policy. For multi-problem families needing intensive services,

two homemakers will alternate in providing services and reassignments are made as required in protecting the mental health of the workers.

3. ORGANIZATIONAL ISSUES

Operational experience led to a restructuring of organizational relationships, including hiring another M.S.W. Under the old structure, the combined administrative and counseling duties of the Coordinator of Family Services resulted in decreased effectiveness. Also, there was not sufficient time to improve the skills of the homemakers as lay therapists. Another Community Care Worker (M.S.W.) was hired who had a clinical background. This eased the counseling load of the Coordinator of Family Services. Further, the responsibility for supervising the homemakers was divided among the two Community Care Workers and this permitted greater focus on the therapeutic role of the homemakers by providing them with more training and supervision. The restructuring of the organization has improved the functioning of the project.

4. LINKAGES WITH OTHER AGENCIES

(a) Perhaps, the most crucial issue to arise in establishing the center was the lack of referrals from the

Bureau of Child Welfare. The few cases referred initially were not substantiated. Several meetings were held to remedy this situation and with the assistance of Mr. Jose Alfaro, a state official, it was resolved. Indeed, the cases since referred are among the most demanding and difficult the center has handled. Blame for the prior situation was placed on administrative bottlenecks of both parties, but a contributing factor may have been the center's lack of previous experience in the specific area of child abuse/neglect.

(b) To the extent that the culture of poverty produces child neglect and abuse, these problems will be found in Bedford-Stuyvesant. In addition, the social service delivery system in that section of the city was strained prior to New York's fiscal crunch - now it appears completely overloaded. A typical caseload for a child maltreatment social worker is reported to be 70 to 90 families per worker. Further, the coordination of services to children in New York City and the integration of such services through planning and coordinating bodies present special and unique problems which may not exist in smaller communities. Wiltwyck sponsored a community conference in 1973 to begin dealing with these issues. Judges, local politicians, research experts, representatives of funding agencies, and other community leaders were invited. Youth councils and many local agencies were

also represented. This provided a unique opportunity to discuss service needs for youth and to jointly develop plans which could begin to meet those needs.

Out of this conference, interested private and public agencies formed the Central Brooklyn Committee on Youth and Family Services. This committee has been meeting voluntarily since September, 1973 to determine which needs could be realistically met through the joint efforts of its members. Their goals include identifying available services and promoting their use by community residents. Child abuse and neglect were natural concerns of this group. Thus, they supported Wiltwyck's proposal for a demonstration center with commitments of support, cooperation, and services. Subsequently, many services for Wiltwyck's clients have been provided through referral to member agencies. Yet, the majority of those services have come from just a few of those agencies.

5. LEGAL ISSUES

Anonymity. The client data collection forms developed by Berkeley Planning Associates utilized the client's name to establish correspondence between the different forms. The center objected to this as an invasion of privacy. A uniform coding system was subsequently developed for all centers.

Labelling. Early in the program, the center had difficulty with the request to classify its client families as abusing or neglecting. This issue arose in cases where there had been no legal determination of abuse or neglect although the center was relatively certain abuse/neglect had occurred. The center felt it would be liable for libel, if case records were reviewed under the Freedom of Information Act and it was disclosed that such parents were classified as abusing or neglecting without legal determination. Since many of the early clients fit these criteria, it was an important issue and they were classified as "high risk." In time, the caseload has shifted more towards substantiated cases.

Court Activities. The center coordinates legal assistance for all members of the family and gives testimony, as required. A unique feature of Wiltwyck's program is that it provides assistance to children in the client families who have court-related difficulties apart from abuse or neglect.

6. COMMUNITY AWARENESS CONCERNS

The Advisory Board for the Brooklyn Wiltwyck center provides an important link to the community at large. This

body is comprised of community members and teens as well as representatives of schools, clergy, and agencies. Its active support is quite helpful to the center and aids in communicating the availability of the program's services.

Flyers and posters were designed and distributed as an early public awareness effort. The availability of the Hot-Line provided the feedback link in this chain of communication.

To create awareness of the needs of high risk families, extensive correspondence was carried on with the Task Force developing the state plan for Title XX. These communications are documented in Appendix K of the full profile for this center.

7. PROGRAM PRIORITIES

The operational priorities of the center can be judged in terms of relative expenditures in various service areas. This information is derived from Reports 2 and 5 of the quarterly MIS. Community Activities and Services to Families each accounted for roughly 20% of actual costs during the year. However, in the last quarter, Services to Families were 28% of actual costs while Community Activities dropped to 9%. This is a

natural consequence of the center becoming more operational in providing services and needing to spend less effort in creating public awareness. Support Services and Psychological Services, accounting for 14% and 11% of actual costs respectively, were the major emphases of the project during the last two quarters of the year. The center's strategy of providing concrete services at the point of entry was reflected in the fact that the two largest individual cost categories for the last quarter were Homemaking (10%) and Lay Therapy (5%).

This strategy provides a chance for immediate help and improvement in the home situation, a chance for further determination of needs, and a chance that other needed services will be accepted by the family.

8. PROJECT GOALS

As used here, the term "goal" is used to mean the global aims of a program, while an "objective" is a specific element of the program set up to achieve a given goal. The intent of this delineation is to measure achievement of goals by associating one or more performance indicators with each objective. The goals, objectives, and performance indicators were developed by key staff members with the assistance of the contractor. The indicators are not included here for reasons of space but may be found in the full profile.

GOAL I

TO ALLEVIATE THE EFFECTS OF CHILD ABUSE AND NEGLECT

Objective 1

To provide an effective Homemakers Service (including lay therapy and advocacy).

Objective 2

To provide Homemakers with good training.

Objective 3

To implement referral activities and maintain an up-to-date resource directory.

Objective 4

To provide transportation and babysitting so that families can receive needed services.

Objective 5

To contribute to the Central Brooklyn Committee on Youth and Family Services.

Objective 6

To provide therapeutic counseling for adults and youths.

Objective 7

To form parent self-help groups.

GOAL II

TO REDUCE THE INCIDENCE OF CHILD ABUSE/NEGLECT.

Objective 1

To provide and promote the Help-Line for crisis intervention.

Objective 2

To reduce household stress for families in caseload.

Objective 3

To provide preventative counseling.

Objective 4

To provide family assessments.

Objective 5

To follow-up families after they leave the active case-load.

GOAL III

TO EXPLORE THE DYNAMICS OF BLACK FAMILY LIFE THAT RELATE TO CHILD ABUSE/NEGLECT.

Objective 1

To review the existing research.

Objective 2

To integrate research findings into the program and into staff training.

Objective 3

To collaborate with other agencies which focus on the Black family.

Objective 4

To maintain case files adequate for research purposes.

Objective 5

To integrate research component into program.

Objective 6

To disseminate findings through publications and conferences.

GOAL IV

TO MANAGE PROGRAM EFFECTIVELY

Objective 1

To periodically review goals and objectives using performance indicators

Objective 2

To refine case management procedures.

Objective 3

To minimize the cost per family while maintaining quality service delivery.

Objective 4

To utilize information generated for reporting requirements in program management.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on cost by service area (for the year and by the quarter), unit costs, indicators of problems and the case flow diagram. A brief commentary accompanies each table and figure.

Table 1 gives the actual cost expended and the total value of the services in each of five functional service area* and also gives a breakdown of client services in the

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* Each of the functional service area is defined by its MIS service categories on the following page.

functional areas Services to Families and Services to Children. The actual cost of all services provided by the Wiltwyck School Demonstration Center as determined by the MIS data, was $183,114 and total value of these services was $234,147. Program Operations accounted for 47.6% of actual cost with an expenditure of $87,162 in this area. The total value of Program Operations was $90,175 or 38.5%. The highest priority service areas, as indicated by the MIS data, were Community Activities and Services to Families. The actual expenditures in these areas were $34,797 (19%) in Community Activities, and $33,491 (18.3%) in Services to Families. Only 1.6% of actual cost was expended in Services to Children, but substantial donations in this area raised the total value of services to 9.4%.

Among the client services, Wiltwyck School emphasized support services with 11.6% of actual cost and 10.7% of total value being used in this area.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 197

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$183,114	100.0	$234,147	100.0
PROGRAM OPERATIONS	87,162	47.6	90,174	38.5
COMMUNITY ACTIVITIES	34,797	19.0	36,163	15.4
CASEWORK ACTIVITIES	24,708	13.5	27.238	11.6
SERVICES TO FAMILIES	33,491	18.3	58,711	25.1
SERVICES TO CHILDREN	2,956	1.6	21,860	9.4
CLIENT SERVICES:				
MEDICAL	27	0	3,778	1.6
PSYCHOLOGICAL	10,296	5.6	17,418	7.4
LEGAL	3,230	1.8	11,585	5.0
SHELTER/CUSTODIAL	347	0.2	10,805	4.6
SUPPORT	21,250	11.6	24,993	10.7
EDUCATIONAL	539	0.3	11,159	4.8
CRISIS INTERVENTION	758	0.4	833	0.4

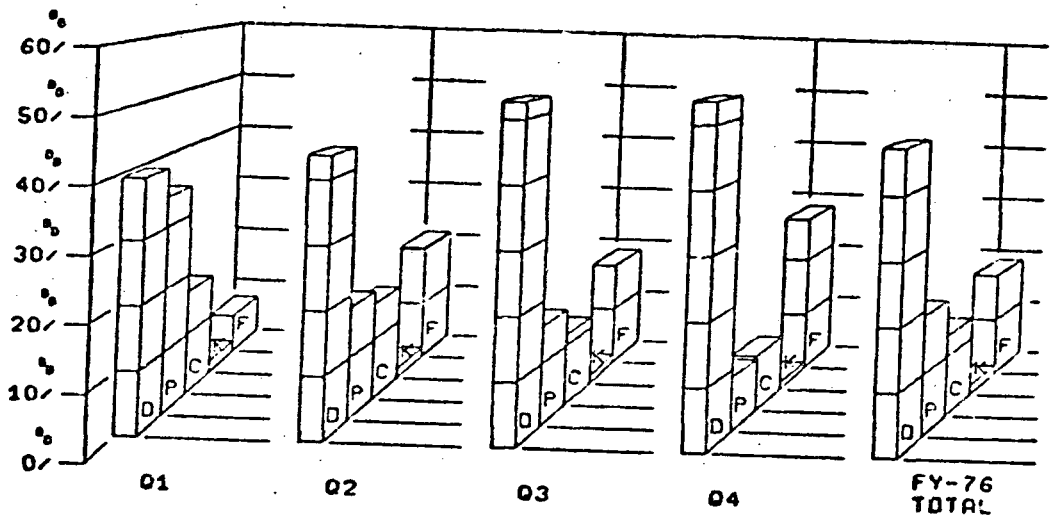
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that there was a steady increase in the percentage of actual cost expended in Program Operations over the four quarters. The figure also shows that Community activities were stressed in the first quarter, but received smaller percentages of actual costs in the succeeding quarters. The percentage of actual cost devoted to Casework Activities remained fairly stable during the first two quarters but declined in both the third and fourth quarters. There was a gradual, although not steadily upward, increase in the percentage of actual cost expended in Services to Families. In the area Services to Children, the percentage of actual cost remained very low throughout the year.

Figure 2A shows a similar configuration to Figure 2 with the notable exception of the amount of total value expended for Services to Children. The data indicate that the substantial donations services received by the Center were used primarily in this area.

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



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

FOR

NEW YORK

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

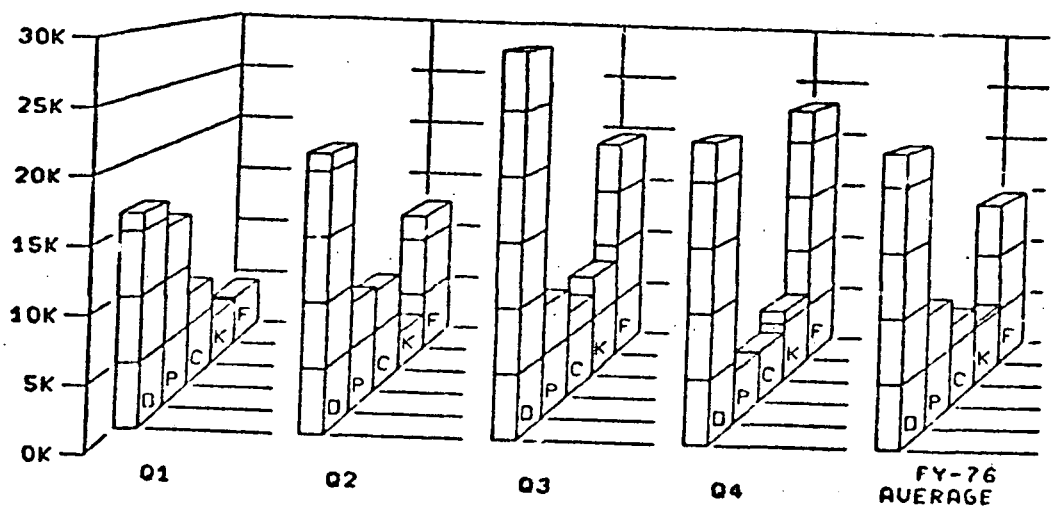


Table 2 presents the unit costs per child and family for the six month period from 1 January 1976 to 30 June 1976. The reader is referred to Volume I, pages 22-24 for a detailed discussion of the methodology for calculating these units, and a discussion of the reason for the difference between the values persented here and in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

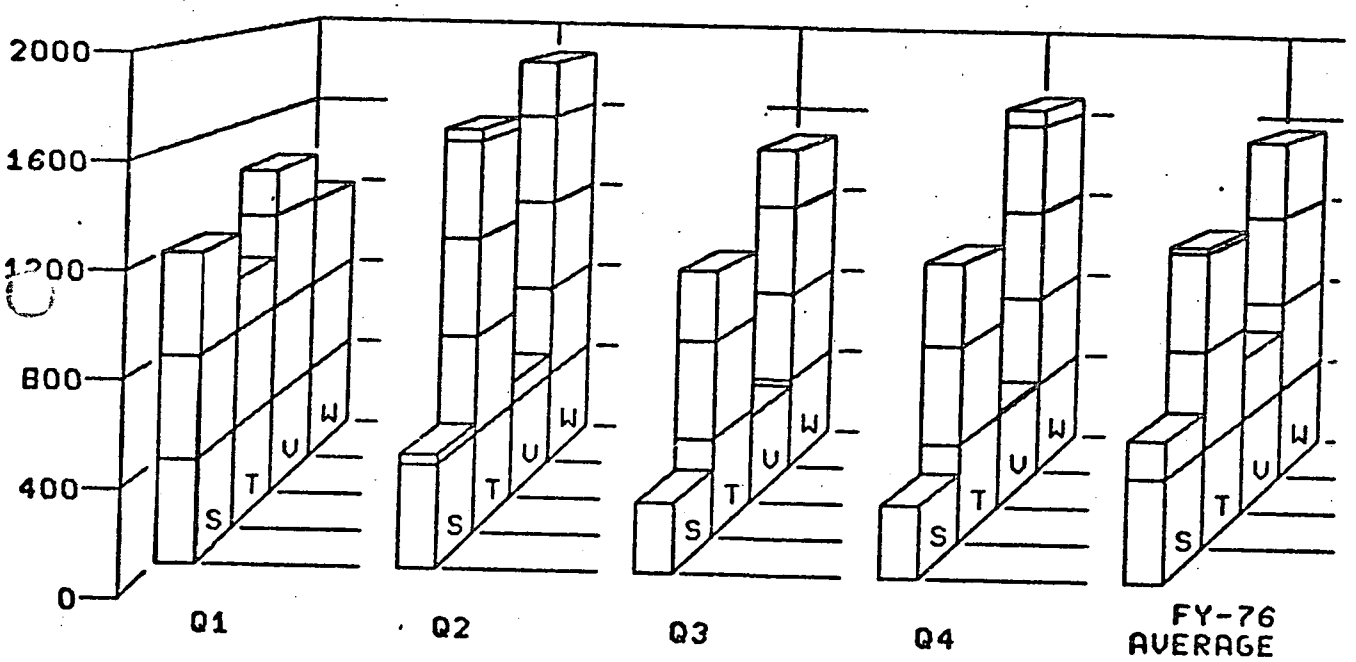
ACTUAL COST PER CHILD	$304
TOTAL VALUE PER CHILD	427
ACTUAL COST PER FAMILY	1,224
TOTAL VALUE PER FAMILY	1,718

The actual cost and total value per child of the services provided by the Center were both somewhat lower than the medians of $318 (actual cost) and $486 (total value) reported by all centers. However, the actual cost and total value per family were higher than both the average and the median of those values reported by the aggregate centers.

Figure 3 presents a visual representation of the unit costs per family and per child. The data, which shows all units for each quarter and the average for the year, shows actual cost and total value per child, and actual cost and total value per family.

The data shows that the unit costs were quite high during the first quarter. However, in the second quarter and thereafter, the actual cost and total value per child dropped by more than 50% and remained at that level for the remainder of the fiscal year. A different trend was noted for unit costs per family. The actual cost and total value per family increased in the second quarter, decreased in the third quarter, and remained fairly consistent in the fourth quarter.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR NEW YORK

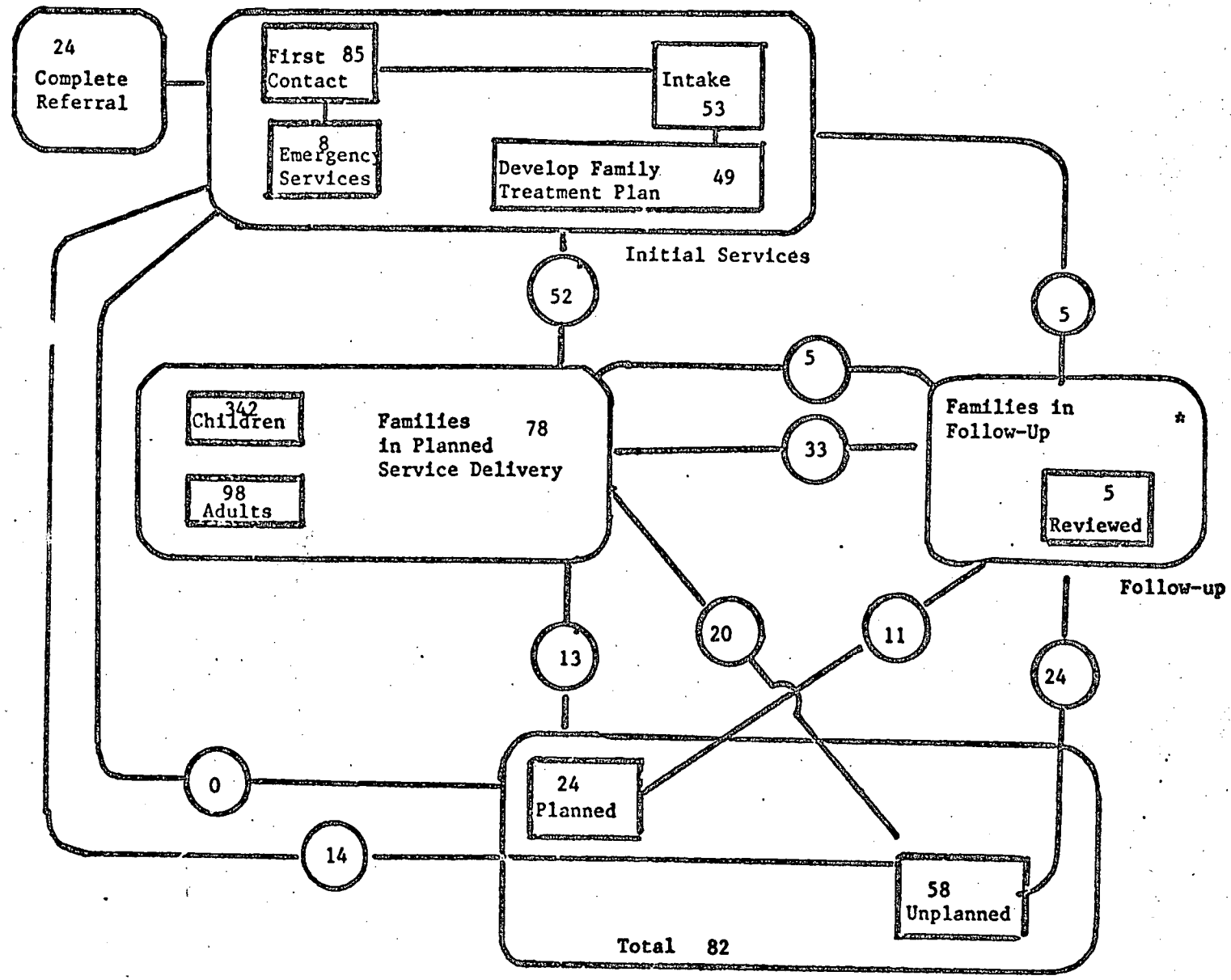


KEY

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

Figure 4 shows the client flow of the Wyltwyck School for a six month period from 1 January 1976 to 30 June 1976. For that period, 78 families received planned services from the Center. In those families were 98 adults and 342 children. Additionally, eight families received emergency services. At the conclusion of the fiscal year, 39 families remained in follow-up. Eighty-two families were terminated from the Center's caseload. Twenty-nine percent of the terminations were planned, and the remainder (71.7%) were unplanned terminations.

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 present summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during a quarter. The present data set includes warning flags for the entire fiscal year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVER THIS YEAR	1
KEY STAFF VACANCIES (As of 30 June 1976)	1

Administrative costs were calculated by adding the actual cost incurred during the year in service category #1 (Administration) and dividing that sum by the total actual cost. At the Center, 20% of actual cost was expended in the administration category. This figure was below the 25% figure which was established as the maximum expenditure for this category. Fifty percent of actual cost allocated to services areas, excluding Program Operations, was determined to be a minimum level of service expenditure. At Wiltwyck, 52.4% of actual cost was spent in service expenditures, therefore no warning flag was received in this area.

I. PROFILE FOR THE URBAN INDIAN CHILD

RESOURCE CENTER OAKLAND

1. START-UP ISSUES

The Urban Indian Child Resource Center (CRC) is rather unique among the twelve Demonstration Centers in that it is not, strictly speaking, a child abuse and neglect demonstration center. Although abuse and neglect cases are among the case-load of the Center, the Center also attends to many other needs of urban Indian children and their families (see Section 8).

The start up issues which faced the CRC are discussed below.

a. Defining the catchment area. In the original proposal which was submitted to OCD, it was stated that the CRC would provide services for all Indians residing in the nine county Bay Area. It was estimated that the Indian population in those counties was between 45,000 and 62,000. It became apparent during the Center's early operational days, that the distance involved in traveling between those counties made the cost of delivering services prohibitively expensive. Additionally, the majority of the requests for services came from the urban areas within a 20 mile radius of the Center. Therefore, a decision was made to define the target population as those Indian families residing in the cities of San Francisco and Oakland. However, the Center still responds to the needs of Indian families who live outside this target area in emergency situations.

b. Defining the Scope of Services. One of the problems which faced the Center at its inception and with which the staff still grapples, is defining the scope of services which will be offered to Indian families. The requests for services which the Center receives may range from conducting a home study for placement of an out-of-state Indian child in a Bay Area home to helping an Indian family navigate through the county social service system. As a method for determining what services were presently available to Indian families in the Bay Area, a directory was compiled by the CRC. As a first step in limiting the scope of services provided directly by the Center, services which are already available to Indian families are not duplicated by the Center.

2. STAFFING

All staff positions at the CRC were advertised throughout the Indian community, even though non-Indian applicants with "Cultural understanding of the American Indian and a sincere desire to serve the Indian community" were also considered. The staff of the Center are governed by the personnel policies of the Indian Nurses of California, Inc., the OCD grantee, and the Indian Nurses also constitute the policy making board of the Center.

The family representatives who serve as caseworkers for CRC have participated in a number of inservice training sessions. This training, which has been conducted by the Executive Director, the family representative supervisor, and an outside consultant, has covered topics such as methods of investigation, methods for conducting home studies, case management procedures, etc.

The CRC is a private institution and as such, has no systematic relationship to other institutions which offer similar services.

3. ORGANIZATIONAL STRUCTURE

The Executive Director of the Center is responsible to the Board of Directors and has overall fiscal and administrative responsibility for all aspects of the Center's program. In addition to the Board, there is a Technical Advisory Committee composed of persons with expertise in areas such as Child Psychology, Child Psychiatry, Law, Native American Child Rearing, Child Development, and Public Health. This Committee, which is directly responsible to the Executive Director, offers information and advise to the staff of the Center in those various areas.

The Executive Director specifically supervises the family representative supervisor, the executive secretary, and

the coordinator of volunteers. She maintains contact with other agencies, and coordinates the use of outside resources such as legal services, additional social work services, educational services, and the spiritual services of medicine men.

The Family Representative Supervisor is responsible for the coordination and development of the services offered by the CRC. She supervises the four family representatives and the family representative aides who provide casework services to the clients of the center. In addition, she supervises and offers inservice training to the homemakers and the community youth workers.

The Family Representatives provide the backbone of the services which are provided through the CRC. They are the persons who actively manage the case load of the Center and coordinate or deliver the needed services of their clients.

The support staff of the Center consists of a part-time bookkeeper, the Executive Secretary, a receptionist/typist, and a clerk/typist.

In addition to the regular staff, there is a cadre of volunteers who regularly work at the Center. Those positions include, in addition to the Coordinator of Volunteers, the Data Coordinator, The Child Rearing Coordinator, the Parenting Coordinator, and the Family Support Network Recruiter.

4. LINKAGES ISSUES

The linkages which the CRC has established are of two distinct types: 1) linkages with other agencies in the Bay Area and nationally which serve Indian populations; and 2) linkages with non-Indian service organizations. In the former category, there are monthly meetings with Interagency, an organization of agencies which service the Indian community; and Intertribal, an organization of social service agencies for Indian people. In order to help establish and continue relationships with non-Indian agencies, informal meetings have been held with many private and public agencies. In addition, a series of conferences were funded by the Association of Bay Area Governments in which a statement was developed concerning the needs of the Indian Community for distribution to public agencies.

5. LEGAL ISSUES

Many of the problems which confront the Indian community are legal in nature; therefore many of the activities of the CRC are geared to helping Indian families obtain the legal aid which is needed. This is particularly true for cases in which the child or children are in danger of being permanently removed from the home without, in the opinion of the CRC staff,

sufficient cause.

The CRC is also involved with the Policy Review Commission, a nationwide Task Force on the Federal Posture toward American Indians. Their involvement has primarily been in the form of participation in hearings and preparation and delivery of dispositions. The Center is currently involved with the Citizen Advisory Council and the Committee for the California Child Advocacy Act.

6. COMMUNITY AWARENESS CONCERNS

The community awareness concerns of the CRC are somewhat different than those of the other eleven demonstration centers. As the concerns of this Center are much broader than just abuse and neglect, the staff of the Center feel an obligation to educate the Indian community to the availability of services from private and public agencies. This is being done through a Family Support Network which serves a dual purpose of disseminating information throughout the Indian community, and providing homes which can serve as temporary shelter for Indian children and families in need. All families within the Family Support Network meet monthly for a potluck supper.

Concurrently, there is a need to educate public agencies to the unique problems of the Indian Community. Indian

families newly arrived to the Bay Area from reservations seem overwhelmed by the many agencies which must be confronted when social services are needed, particularly after having become accustomed to dealing with one large agency -- the BIA. Additionally, there is often a jurisdictional dispute regarding whether the County service system, or the BIA should provide services for Indian families.

7. PROGRAM PRIORITIES

The program and staff of the CRC began to stabilize in the last two quarters of FY 1976, and therefore the data from those two quarters will be used as evidence of the priorities of the program of the Center.

For both these quarters, the functional area services to families received the largest percentage of actual cost expended in a service area. However, in both those quarters, the percentage of actual cost expended toward program operations (administrative costs, overhead, etc.) was higher. In both of those quarters, casework activities were the next highest program priority as indicated by the percentage of actual cost expended in that service area, followed by community activities, and services to children.

In the service areas, support services were the highest priority of the Center, and psychological services the second

highest priority as indicated by the percentages of the budget expended in those areas. For the CRC, support services include, but are not limited to services such as:

1. advocacy in non-support cases
2. securing an Infian home for permanent or temporary placement of children
3. advocacy in legal guardianship cases
4. assisting in applying for BIA schools
5. advocacy in eviction cases
6. advocacy for visitation rights of a natural mother
7. location of resources to help family become established in the community
8 returning runaway teenagers

8. PROGRAM GOALS AND APPROACHES

The overriding goal of the Urban Indian Child Resource Center is "... to insure that Indian children in the San Francisco Bay Area are provided with the necessary physical and emotional support within the Indian community so that the children can develop and thrive."*

In order to achieve that goal, the following goals and objectives were developed:

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*page 7 of the original Proposal for Funding.

GOAL I

TO PROVIDE ACCESS TO SERVICES FOR AMERICAN INDIAN CHILDREN IN NEED OF PHYSICAL OR EMOTIONAL CARETAKING

Objective 1

Identify American Indian children in the San Francisco Bay Area in need of physical or emotional caretaking

Objective 2

Provide training in the use of available services for the parents or other responsible persons of children in need.

Objective 3

Provide assurance that services, once offered, are utilized for the needs of the children identified.

GOAL II

TO DELIVER A VARIETY OF SERVICES TO INDIAN CHILDREN

Objective 1

Placement of Indian children in Indian homes, when foster home care is indicated.

Objective 2

Coordinate medical services for Indian Children.

Objective 3

Provide alternative systems to juvenile hall placement for Indian Youth.

Objective 4

Coordinate special treatment for Indian children with psychological or physical developmental problems.

Objective 5

Provide nutritional help for Indian children when necessary

Objective 6

Teach Indian philosophy and cultural background through Parenting Education classes so that Indian children will be acquainted with their heritage.

Objective 7

Provide Juvenile Court advocacy for Indian children

Objective 8

When needed services are not immediately available, provide short term emergency services through the auspices of the Center.

GOAL III

TO PROVIDE COORDINATION AMONG SERVICE AGENCIES.

Objective 1

To provide information and technical assistance to other community-based organizations wishing to establish programs

Objective 2

To inform public and private agencies of the special need of Indian children and their families

Objective 3

To coordinate service delivery for Indian adults so that they can provide needed physical and emotional caretaking for Indian children.

GOAL IV

TO EVALUATE THE IMPACT OF THE CENTER ON THE CHILDREN AND FAMILIES SERVED, ON THE INDIAN COMMUNITY, AND ON THE COMMUNITY AT LARGE.

The CRC has attempted to reach its goals and objectives by providing information and services to any Indian children and their families who are referred to them or request services. Often, the services requested have been outside of the stated objectives of the Center, but when possible the Center has attempted to either provide the service or refer the clients to agencies which could provide the services.

Their overall approach to the achievement of goals and objectives could be identified as one of definition and refinement. The staff has begun to continually examine their goals, define them in terms which are performance and behaviorally oriented, and then to examine the activities which they engage in to determine whether or not they are on or off target. As the program of the Center has matured, the staff has determine that, in the main, they are working in directions which will ultimately result in the achievement of their goals.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on cost by service area (for the year and by quarter), unit costs, indicators of problems, and the case flow diagram. A brief commentary accompanies each table and figure.

Table 1 gives the actual cost expended and the total value of the services in each of five functional service areas* , and also gives a breakdown of client services in the functional areas Services to Families and Services to Children. The actual cost of all services provided by the Urban Indian Child Resource Center, as determined by MIS data, was $143,351. Total value of these services was $171,869. Program Operations accounted for 47.5% of actual cost with an expenditure of $68,076. The total value for Program Operations was $80,992 or 47.1%. In the remaining service areas, the largest percentage of actual cost was expended in Services to Children ($25,522 or 17.8%). Community Activities and Casework Activities had similar actual cost expenditures. In both services areas, the percentage of actual cost was slightly higher than 14%. The lowest expenditure was in the area of Services to Families ($8,512 or 5.9%).

Among the client services, the CRC emphasis was in Support Services (11.5% of actual cost and 10% of total value). All other client services were less than 3% of actual cost and 4% of total value.

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* Each of the functional service areas is defined by its MIS service categories on the following page.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$143,351	100.0	$171,869	100.0
PROGRAM OPERATIONS	68,076	47.5	80,992	47.1
COMMUNITY ACTIVITIES	20,465	14.3	29,333	17.1
CASEWORK ACTIVITIES	20,776	14.5	21,922	12.7
SERVICES TO FAMILIES	8,512	5.9	9,439	17.6
SERVICES TO CHILDREN	25,522	17.8	30,183	5.5
CLIENT SERVICES:				
MEDICAL	$ 2,967	2.1	$ 2,967	1.7
PSYCHOLOGICAL	4,768	3.3	5,576	3.2
LEGAL	4,240	3.0	6,858	4.0
SHELTER/CUSTODIAL	3,863	2.7	4,291	2.5
SUPPORT	16,431	11.5	17,252	10.0
EDUCATIONAL	1,298	0.9	2,199	1.3
CRISIS INTERVENTION	467	0.3	479	0.3

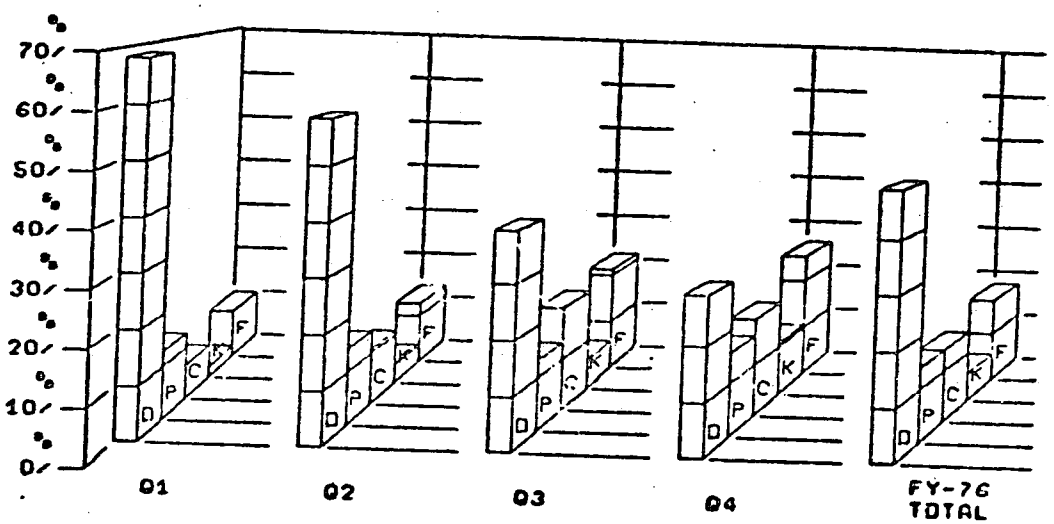
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that Program Operations declined each quarter through the fiscal year. The Figure also shows that Services to Families and Services to Children increased each quarter. Although the increase did not go through the fourth quarter, the percentage of actual cost allocated to Casework Activities increased for the first three quarters of the fiscal year. The percentage of actual cost in this area remained stable for the fourth quarter. Community Activities remained fairly stable throughout the year.

An examination of Figure 2A shows that the configuration of the data for the first and second quarter was similar to that of Figure 2 which indicates that few donated services were received by the Center during those quarters. In the last two quarters of the fiscal year, Figure 2A shows the results of substantial donations in the area Community Activities.

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

FOR

OAKLAND

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

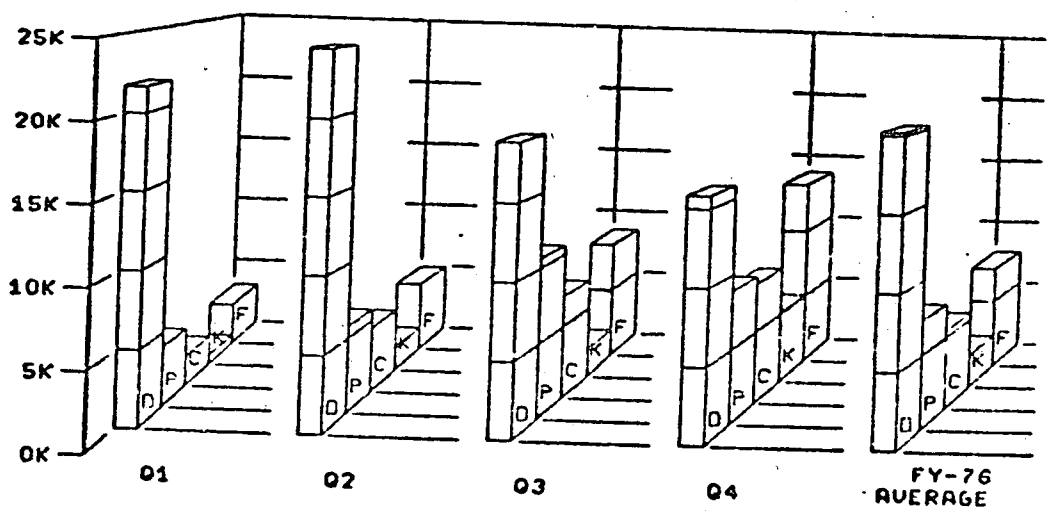
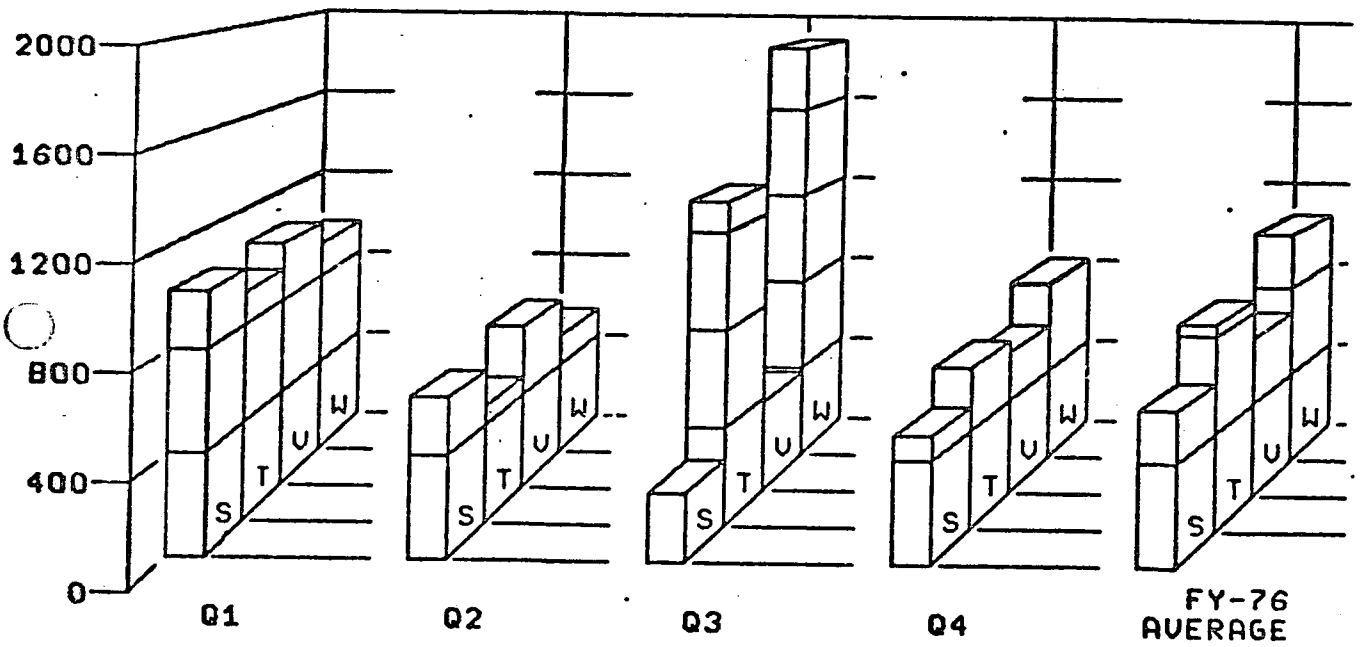


Figure 3 graphically presents the unit costs per child and per family. The data, which shows all units for each quarter and the average for the year, depicts actual cost and total value per child, and actual cost and total value per family.

The Figure shows that unit costs per child decreased in each of the first three quarters of the year, but rose almost to the second quarter level in the fourth quarter. The unit costs per family showed no consistent pattern over the year. The family unit costs were lower than the unit costs for children during the first two quarters of the year. In the third quarter, the unit costs per family more than doubled from the previous quarter, but were reduced to previous levels in the fourth quarter.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR OAKLAND



KEY

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

Table 2 presents the unit costs per child and family for the six month period from 1 January 1976 to 30 June 1976. The reader is referred to Volume I, page(s) 22-24 for a detailed discussion of the reason for the difference between the values presented here and in Figure 3.

TABLE 2

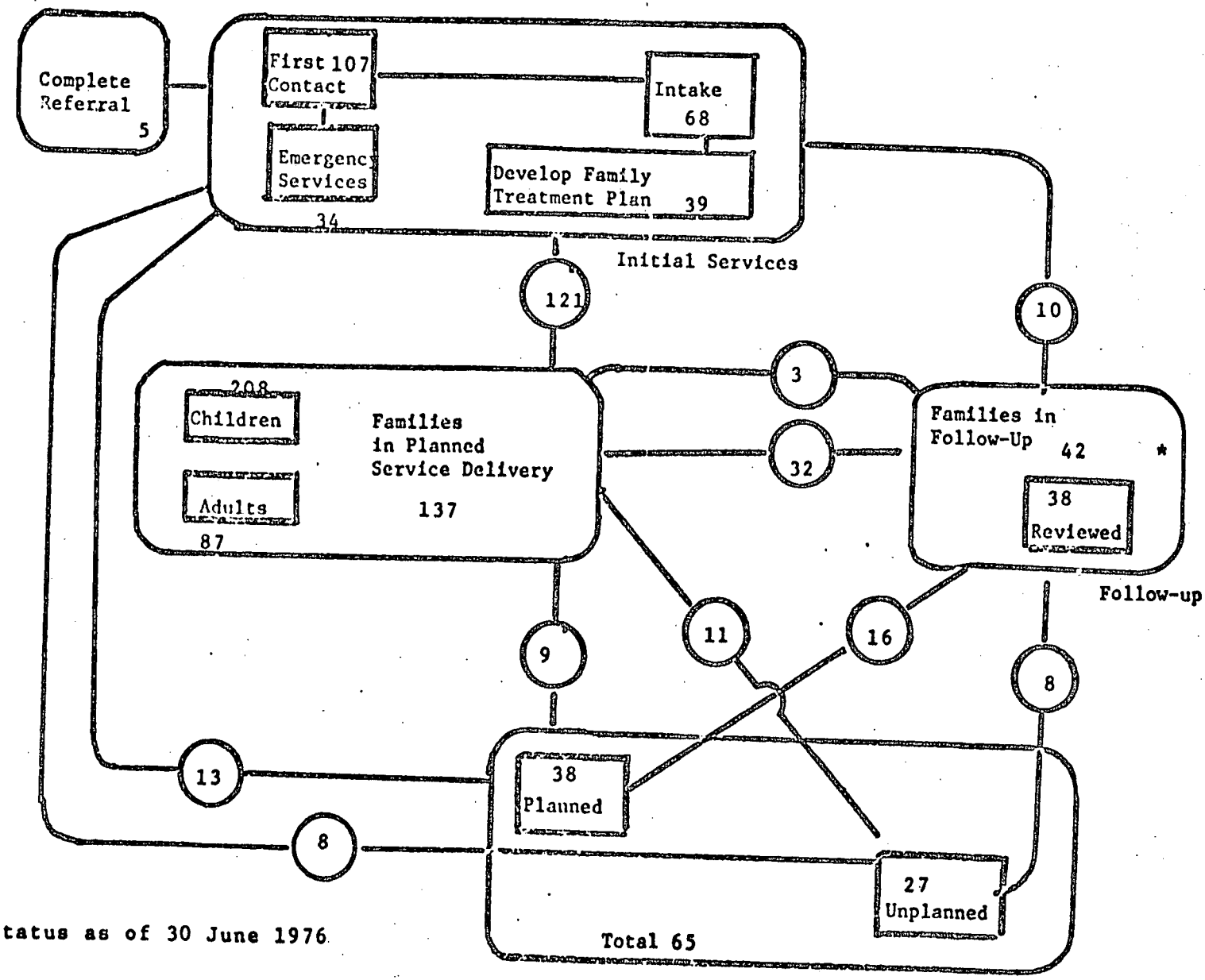
SIX MONTH UNIT COSTS

ACTUAL COST PER CHILD	$415
TOTAL VALUE PER CHILD	544
ACTUAL COST PER FAMILY	552
TOTAL VALUE PER FAMILY	723

The actual cost and total value per child for services provided by the Center were both higher than the median values reported by the aggregate of 12 centers (actual cost, $318; Total value, $486). However, both unit values were very close to the average values reported by all centers. Actual cost and total value per child, were considerably lower than both the mean and median reported by all centers.

Figure 4 shows the client flow of the CRC for a six month period from 1 January 1976 to 30 June 1976. For that period, 175 families received planned services from the Center. In addition, 34 families received emergency services. At the conclusion of that six month period, 42 families remained in follow-up and 38 families had had their cases reviewed. Sixty-five families were terminated from the Center's caseload during this period. Thirty-eight or 58.5% of those terminations were planned.

FIGURE 4



* Status as of 30 June 1976

Table 3 presents a summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during a quarter. The present data set includes warning flags for the entire fiscal year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, Otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVER THIS YEAR	5
KEY STAFF VACANCIES (As of June 30, 1976)	0

Administrative costs were calculated by adding the actual cost incurred during the year in service category #1 (administration) and dividing that sum by the total actual cost. At the CRC, 20% of actual cost was expended in the administration category. This figure was below the 25% figure which was established as a maximum expenditure for this category. Fifty percent of actual cost allocated to service areas, excluding Program Operations, was determined to be a minimum level for service expenditures. At CRC, 52.5% of actual cost was spent in service expenditures, therefore no warning flag was received.

J. PROFILE FOR ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN PHILADELPHIA

1. START-UP ISSUES

St. Christopher's Hospital for Children was founded in 1875 as a community hospital for children, serving the poor of the North Philadelphia area. Since 1947, it has housed the Department of Pediatrics of Temple University School of Medicine, and has developed into a major medical center for children. It offers an essentially complete array of services for children, ranging from primary care in Children and Youth and Model Cities programs to such tertiary care activities as open heart surgery, renal dialysis, and renal transplantation.

Most of the hospital's clients come from the North Philadelphia area, which has an approximate population of 350,000 (1970 Census) and has been designated a poverty area. In 1973, St. Christopher's handled over 7,000 inpatient admissions, nearly 100,000 outpatient visits, and nearly 50,000 visits for emergency services. That year, the hospital reported 123 cases of child abuse or neglect to the Department of Public Welfare, over 25% of all cases reported in Philadelphia.

One of the chief concerns during the early stages of the center is the integration into the hospital's system as a whole. Issues related to this surfaced in three different areas: federal reporting requirements, the

change in responsibility for child abuse and neglect cases, and the location of the center apart from the immediate hospital complex.

a. The delays in submitting timely MIS reports was occasioned in part by the fact that the bookkeeping cycle employed by hospital administration did not match the timing required for federal reporting. A resolution to this problem seemed to have been made with the decision to hire an administrative assistant to help with record keeping and reporting. Yet several months later the position has still not been filled (see further discussion under section 3, Organizational Issues).

b. Since St. Christopher's had been handling a large number of abuse and neglect cases prior to the funding of the center, it already had much experience and a system for handling these cases that was known throughout the hospital. The center was funded to provide extensive comprehensive services for which the hospital did not have sufficient resources previously. Appropriately enough, all full time positions were filled by persons new to the hospital. During the transition period, when case responsibilities were passing from Medical Social Services to the center, certain confusions and ambiguities arose. For

example, the question of who should handle families previously known to Medical Social Services was encountered. Most of these issues were resolved in time, yet they are noteworthy in that similar issues are likely to arise in establishing centers in other hospital settings.

c. Lack of space for the center in the hospital proper led to the acquisition of a site a couple of blocks away. This led to some minor difficulties in communications and in ease of holding dispositional conferences, yet it is also related to the more general issue of visibility. During the start-up phase the Project Director felt that lack of visibility in the community, in the hospital, and among community agencies slowed progress to some extent. However, ongoing operations have led to a general increase in awareness of the center and this factor has been minimized. Aother difficulty connected with the site was its need for renovation. The exterior of the building was quite dilapidated and the interior needed to be converted in office space. Procedural matters slowed the renovation process considerably and work still remains to be done.

2. STAFFING ISSUES

a. Project Director Selection: The selection of the

Project Director was the responsibility of a committee. The hospital received over forty applications for the position. This required lengthy and extensive screening but provided a number of well-qualified candidates. In fact, both the Project Director and Assistant Project Director were selected from this pool.

b. Staff Selection: An innovative aspect of staffing for the center is the use of the group interview in the staff selection process. The process was used in initially choosing the Family Resource Workers and in replacing the Assistant Program Director. A meeting of all candidates for the Family Resource Worker positions was held to explain the duties involved, to provide for interaction and discussion among the candidates, and to know the candidates better. The candidates were then asked to list those with whom they would most like to work. With six candidates for five positions, the fact that the ratings were unanimous is interesting if not startling. Due to the psychological stress of this work and the need for support and rapport among co-workers, this process could prove useful in starting other abuse/neglect centers.

In replacing the Assistant Program Director, two group interviews were held, one with the Executive Committee and the other with the Family Resource Workers. Each group

had a meeting with all three candidates (M.D.'s) present and then ranked them in order of preference. The same two persons filled the top two slots of the separate ratings but in different order. It is noteworthy that the first choice of the Family Resource Workers was selected.

There have been subsequent problems with this process, however. It was decided that another M.S.W. was to be hired by the center. The staff felt the candidate should be bilingual while the Project Director did not perceive this as necessary. (There are already two or three Spanish-speaking staff members and less than 10% of the clients speak Spanish.) A qualified candidate experienced in abuse/neglect was thus lost to the project. Also, the position has still not been filled after several months.

c. Another staffing note of interest is the use of men in the role of Family Resource Workers. The original proposal called for "mature women, preferably mothers" in that position. Subsequent events have shown the effectiveness of a male in that role, particularly in the Puerto Rican subculture.

3. ORGANIZATION ISSUES

a. Decentralized Decision-making: The Program

Director, formerly Medical Director of the hospital, is a non-directive style administrator. The Executive Committee is the policy-making body for the center, yet their decisions are not always implemented by other components of the hospital administration. Hiring decisions are made by the staff members as a group. This decentralized decision-making has produced delays in reporting, in hiring needed staff and in completing renovations. The Project Director thus has the responsibility for day-to-day operations but does not have the authority commensurate with that responsibility. This has been the principal source of problems for the center. It is further confounded by the ambiguous relationship between the center and Medical Social Services discussed next.

b. Medical Social Services: The center is located in a separate facility and its staff functions as a distinct unit. The Project Director has no formal reporting relationship with the Social Services Coordinator (i.e., director) according to the organization chart. Yet for "historical" reasons, much effective control is exercised by Medical Social Services. This is mentioned not because this control has been detrimental, per se, but since it adds another level of ambiguity and delay to the organizational structure.

4. LINKAGES TO OTHER AGENCIES

The center purchases no services from other agencies. This project is well-regarded by all the agencies contacted during the Community Baseline Study and has a good working relationship with D.P.W. Referrals are received from Family Court, Temple Hospital, Episcopal Hospital, D.P.W., Child Abuse Prevention Effort (a hotline), Philadelphia Parent Child Center, Children's Aid Society, Get Set Day Care, and other day care centers.

5. LEGAL ISSUES

Beyond providing testimony and serving as advisor to Family Court, the center has not confronted any substantive legal or legislative issues.

The center receives frequent requests for speakers and participants for panels, conferences, and workshops.

6. COMMUNITY AWARENESS CONCERNS

The Family Resource Center held a one-day workshop involving panelists from nearly all agencies dealing with child abuse and neglect in the Philadelphia area. The principal speaker was the eminent Dr. Ray E. Helfer. Over

ten special topics were covered in various workshop sessions. It was considered quite successful.

The center frequently provides speakers and panelists for conferences and public meetings. Several F.R.C. staff members were instrumental in putting on a nurse's conference on abuse/neglect. The Project Director is scheduled to participate in a television program devoted to violence in the family produced by the local C.B.S. affiliate.

7. PROGRAM PRIORITIES

The operational priorities of the center can be judged in terms of relative expenditures in various service areas. This information is derived from Reports 2 and 5 of the quarterly MIS. Services to Families (21%) and Casework Activities (14%) were the two major service areas relative to actual cost. Roughly 15% of actual costs were expended on the various psychological services provided by the center. The largest individual cost categories were Lay Therapy (8%), Case Management and Review (6%), and Multidisciplinary Team Case Review (5%).

8. PROJECT GOALS

As used here, the term "goal" is used to mean the global aims of a program, while an "objective" is a specific element of the program set up to achieve a given goal. The intent of this delineation is to measure achievement of goals by developing one or more performance indicators for each objective. In conjunction with the contractor, the center will develop such indicators during future site visits. The center will then have a valuable tool for self-assessment. The goals and objectives listed below have been abstracted from two sources: the 1976 Continuation Grant Application and the notes from a one-day staff seminar conducted by the contractor.

GOAL I

TO REDUCE THE INCIDENCE OF CHILD ABUSE AND NEGLECT.

Objective 1

To identify families involved in abuse or neglect that are in need of center services.

Objective 2

To identify high risk families in need of intervention.

Objective 3

To assess the needs of identified families.

Objective 4

To minimize environmental stress on the family

Objective 5

To improve the self concept of parents.

Objective 6

To improve parenting skills.

Objective 7

To teach homemaking skills.

Objective 8

To improve parents ability to relate to others.

Objective 9

To provide crisis intervention.

Objective 10

To help families utilize existing resources and community services.

Objective 11

To develop resources available to these families.

Objective 12

To provide advocacy and assist families in securing legal rights.

Objective 13

To follow-up families after treatment.

Objective 14

To serve families cost effectively.

GOAL II

TO INCREASE THE AWARENESS OF PROFESSIONALS IN THE HOSPITAL AND IN OTHER AGENCIES THAT DEAL WITH ASPECTS OF ABUSE AND NEGLECT.

Objective 1

To participate in hospital rounds, when appropriate.

Objective 2

To involve doctor in dispositional conferences when possible.

Objective 3

To sponsor seminars and workshops on child abuse and neglect.

Objective 4

To participate in seminars, workshops, and conferences.

GOAL III

TO INCREASE AWARENESS IN THE GENERAL COMMUNITY ABOUT THE PROBLEMS OF ABUSE AND NEGLECT.

Objective 1

To provide speakers for community meetings.

Objective 2

To arrange for media coverage of items and events relating to abuse and neglect.

GOAL IV

TO INCREASE THE FUND OF KNOWLEDGE ABOUT THE NATURE, FAMILY DYNAMICS, AND TREATMENT OF CHILD ABUSE AND NEGLECT.

Objective 1

To maintain case records sufficient for both in-house and federal research requirements.

Objective 2

To submit accurate MIS reports thus permitting meaningful comparisons across centers.

Objective 3

To conduct research and to publish findings.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Informaqion Systems (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on cost by service area (for each quarter and the yearly average), unit costs, indicator of problems, and the case flow diagram. A brief commentary accompanies each table and figure.

Table 1 gives the actual cost expended and the total value of the services in each of five functional service areas*, and also details client services which comprise the areas Services to Families and Services to Children. The actual cost of all services provided for the clients of the Center was $148,093 as determined by MIS data. Total value of these services was $274,492. Program Operations accounted for 50.5% of actual cost, but only 31.4% of total value. In the remaining functional services areas, Services

* Each of the functional service areas is defined by its MIS service categories on the following page.

to Families received the largest percentage of actual cost (23.8%) and Services to Children the lowest (1.4%); however, substantial donated services were received for children. Over $115,000 in inputed value was received in the area Services for Children, accounting for 42.7% of the total value of services received.

Among the client services, psychological services accounted for 10.1% of the actual cost of providing services to clients. However, the substantial donation of medical services for clients resulted in 41.3% of total value being in that area.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 1976

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$148,093	100.0	$274,492	100.0
PROGRAM OPERATIONS	80,723	54.5	86,103	31.4
COMMUNITY ACTIVITIES	9,201	6.2	9,617	3.5
CASEWORK ACTIVITIES	20,805	14.1	20,974	7.6
SERVICES TO FAMILIES	35,239	23.8	40,551	14.8
SERVICES TO CHILDREN	2,125	1.4	117,247	42.7
CLIENT SERVICES:				
MEDICAL	$ 1,487	1.0	$113,303	41.3
PSYCHOLOGICAL	14,915	10.1	16,640	6.1
LEGAL	857	0.6	4,322	0.2
SHELTER/CUSTODIAL	1,417	1.0	4,147	1.5
SUPPORT	9,972	6.7	9,995	3.6
EDUCATIONAL	2,714	1.8	3,389	1.2
CRISIS INTERVENTION	6,002	4.1	6,002	2.2

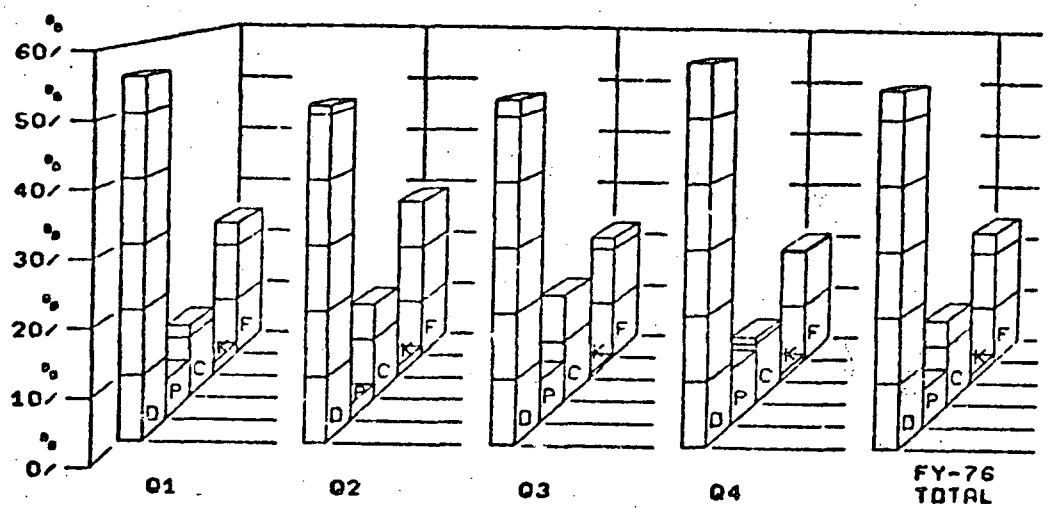
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	0. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that Program Operations were quite high the first quarter and remained so throughout the fiscal year. Services to Families received the largest percentage of actual cost during each quarter, and the level of those expenditures did not vary much from quarter to quarter. There was also not variation from quarter to quarter in the percentage of actual cost allocated to the other functional service areas.

The configuration of Figure 2A was similar to that of Figure 2 for the first quarter, but in the second quarter, the donated services to children was shown. These donated services were evident in each of the subsequent quarters.

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

FOR PHILADELPHIA

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

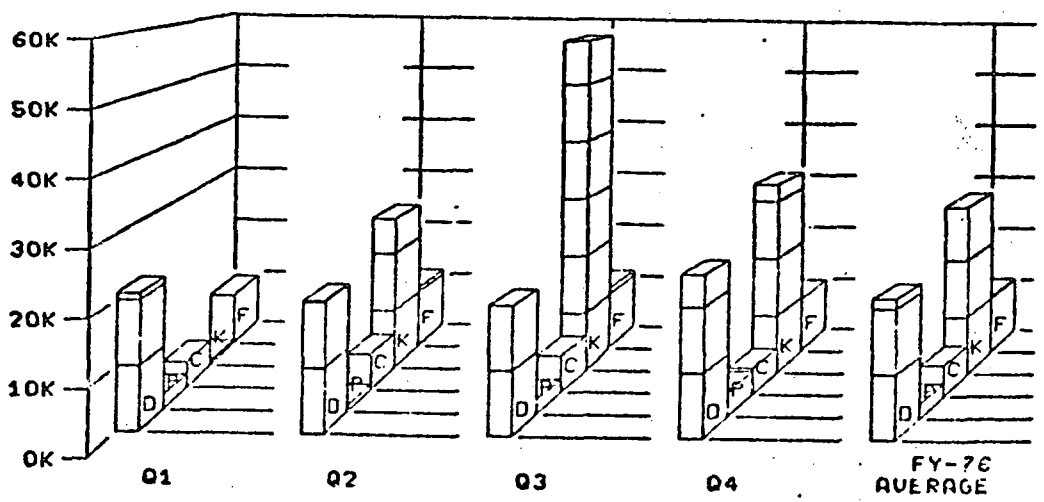


Table 2 presents the unit costs per child and family for the six month period from 1 January 1976 to 30 June 1976. The reader is referred to Volume I, page(s) for a detailed discussion of the reason for the difference between the values presented here and in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

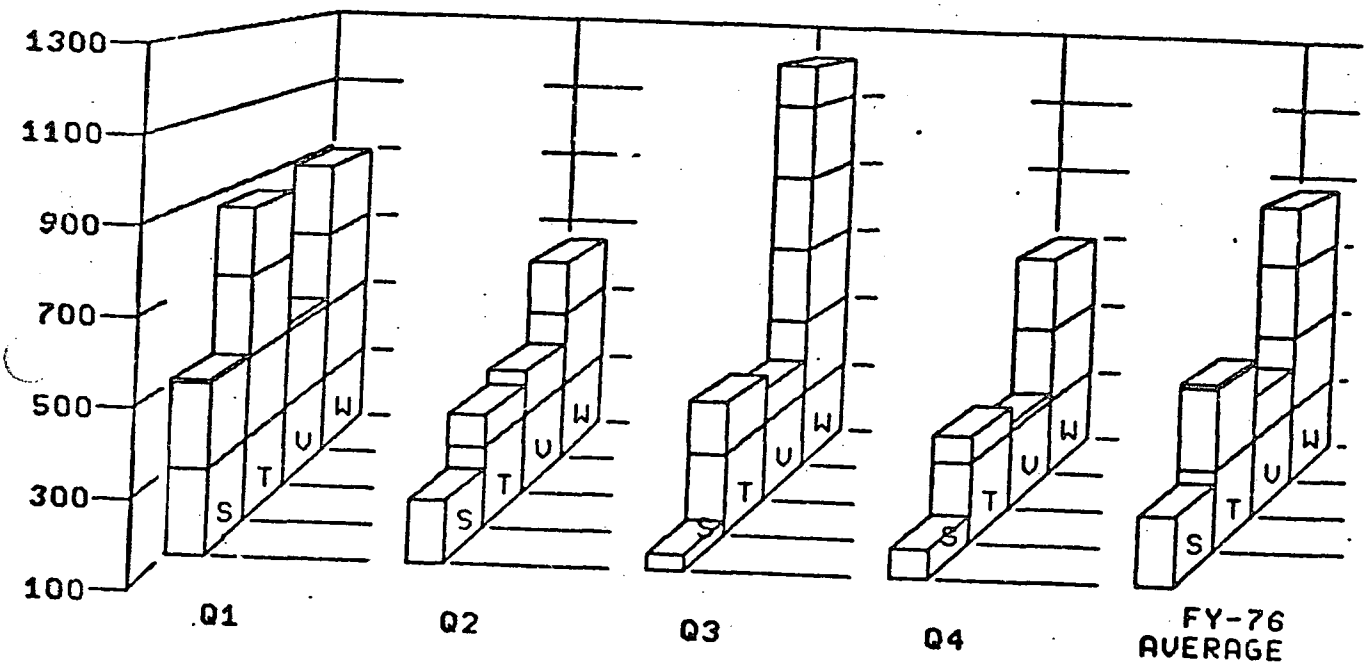
ACTUAL COST PER CHILD	$ 279
TOTAL VALUE PER CHILD	655
ACTUAL COST PER FAMILY	605
TOTAL VALUE PER FAMILY	1,417

The actual cost per child at St. Christopher's was lower than both the average and median of all centers, but the total value per child was higher than both the average and median of the aggregate centers. The same pattern was evident for the family unit costs. The actual cost per family was lower than the median and average that was reported by all centers, but the total value per family was higher than both aggregate units.

Figure 3 graphically presents the unit costs per child and per family. The data, which shows all units for each quarter and the average for the year, depicts actual cost and total value per child, actual cost and total value per family.

The figure shows that actual cost per child decreased for the first three quarters of the year, but increased somewhat in the fourth quarter. The total value per child followed a similar pattern but the reductions were not so great. Actual cost per family showed a general downward trend throughout the year, but this trend was not evident in total value per family. The total value per family decreased in the second quarter, but substantially increased in the third quarter before dropping again in the fourth quarter.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR PHILADELPHIA



KEY

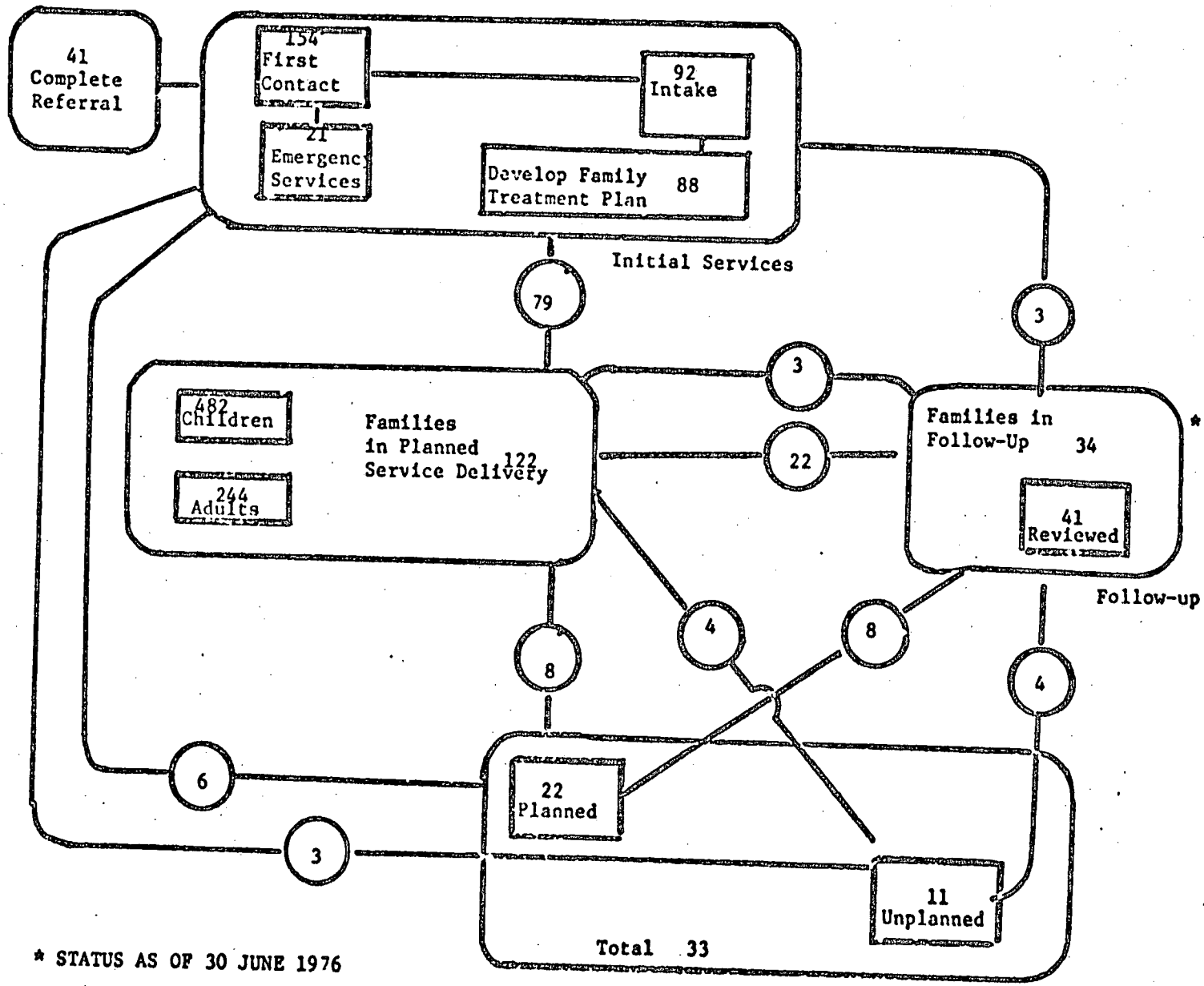
S- ACTUAL COST PER CHILD
T- ACTUAL COST PER FAMILY
V- TOTAL VALUE PER CHILD
W- TOTAL VALUE PER FAMILY

Figure 4 shows the client flow of the Center for a six month period from 1 January 1976 to 30 June 1976. For that period, 122 families received planned services. There were 244 adults and 482 children in those families. Another 21 families received emergency services at the Center during that period. At the conclusion of the fiscal year, 34 families were in follow-up. Thirty-three cases were terminated from the Center's caseload. Twenty-two (66.7% of those terminations were planned).

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR PHILADELPHIA
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 - JUNE 19?

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 presents a summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during a quarter. The present data set includes warning flags for the entire fiscal year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	L
STAFF TURNOVER THIS YEAR	3
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual cost incurred during the year in service category #1 (administration) and dividing that sum by the total actual cost. At this Center, 20% of actual cost was expended in the administration service category. This figure was below the 25% figure which was established as a maximum expenditure for this category. Fifty percent of actual cost allocated to service areas, excluding Program Operations, was determined to be a minimum level of adequate service expenditures. At this Center, 45.5% of actual cost was spent in service expenditures-- a figure lower than adequate.

K. PROFILE FOR SAN DIEGO COUNTY'S YMCA FAMILY STRESS CENTER

1. START UP ISSUES

The YMCA Family Stress Center of San Diego County is one of two of the 12 NCCAN Demonstration Centers whose parent organization is a private social service agency rather than a protective service agency or a medical institution. However, because any agency dealing with child abuse and neglect must always interact with the established and legally mandated systems within a community, the YMCA sought and achieved the cooperation and participation of San Deigo County from the earliest planning states.

In 1973, the Community Child Abuse and Neglect Coordinating Council was formed, with 55 participating agencies and professionals encompassing the full range of available public and private health, welfare, and social agencies. This council, the county Probation Department, Welfare Department, and several local law enforcement agencies were all instrumental in identifying needs and gaps in protective and family services in the county.

The YMCA Human Development Department, already involved with and committed to services for families, conceived the child abuse and neglect demonstration treatment center proposal with considerable input from the council and its individual members. The county expected from its liaison with the YMCA that some relief

would be provided by the new center for the overloaded protective service workers assigned to abuse/neglect. The YMCA, additionally, wanted to provide a service resource which would encourage self-referral and treatment before serious abuse or neglect occurred, rather than reacting to it after crisis. In this way, the philosophical basis was an alternative to other protective service resources existing in the county in 1974.

There were two major start-up issues in establishing the Family Stress Center:

(a) Defining the catchment area. The County made its participation and substantial donations contingent on the demonstration center being/becoming a resource for the entire county. Since all of the existing CAN systems operated from a county-wide base, the YMCA bought into this concept. However, due to the relatively vast size of the county certain limits had to be immediately set on the scope of services the project could realistically provide to every corner of the county.

(b) Site selection and permit approval. In San Diego county, any of a number of areas or municipalities could have been chosen as the FSC site, based on identified and felt needs for such a resource. The "south bay" town of Chula Vista (rather than a central San Diego or

north county site) was eventually agreed upon by the county and YMCA) and an appropriate facility located with a minimum of difficulty. However, concern by residents of the area over "what kinds of people a CAN treatment center would bring to the neighborhood" delayed the issuing of the needed Conditional Use Permit until the Project Director had made numerous visits to neighbors to explain the project and win neighborhood support.

2. STAFFING ISSUES

(a) Hiring: There were dozens of qualified applicants for a handful of professional positions. The county notified employees from Welfare, Dependent Childrer and the Probation Departments of the available positions at Family Stress Center. The Project Director selected three of the county's applicants (all MSWs who had had considerable contact with abuse/neglect through their county positions). One staff member is a former Probation Officer. The Treatment Director (MSW), and two other treatment counselors (one RN with a pediatric specialty, and one with a Masters in Psychology and working toward her Ph.D.) were selected from other applicants by the Project Director, based on past family service experience as well as attitude and enthusiasm for the project. The non-professional staff includes two B.A. level persons,

a paraprofessional (homemaker) an office manager and a secretary.

(b) Salaries: San Diego County's donation to the Demonstration Project came partially in the form of personnel who were directly responsible to the new center but whose salary continued to be drawn from the county agency from which the person had been recruited. However, the majority of the staff were hired by the YMCA and are paid by OCD monies administered by the YMCA. From the beginning a rather high level of resentment was apparent because County salaries were considerably higher than YMCA salaries for equivalent credentials and workload. Recently, the YMCA has taken steps to help equalize professional staff pay.

(c) Staffing Adjustments: The YMCA's proposal for the FSC made certain staffing projections which have needed modification as the project evolved. For the most part, changes regarding professional staff have been minor. The support (homemaking, transportation) and clerical staffing needs were originally rather seriously underprojected, but a recent small supplementary grant from OCD for fiscal '76-'77 has allowed the center to hire two additional employees.

(d) Staffing of New Cases: During the summer of 1976, the existing workload, illnesses, and vacations caused FSC to close Intake on a temporary basis, except to select cases and certain County (Court) referrals. Procedures for the regular weekly case staffing meeting have been modified a number of times, and are currently based upon several considerations; including,

- what is the severity of the case?
- which staff member's experience seems most relevant to the known circumstances?
- which staff member has the time to provide or arrange for the needed services?

3. ORGANIZATIONAL STRUCTURE ISSUES

FSC is a relatively decentralized organization, with professional staff involved in a variety of activities, and several program components, simultaneously. However, the Project Director remains highly visible and accessible to all staff and there have been few communication problems between functional program areas and among the staff members themselves.

The largest problem, thus far, from an organizational point of view, seems to have been meeting reporting deadlines. However, this seems to be less the result of bad communication than work overload and in a few cases, careless record-keeping.

4. LINKAGES WITH OTHER AGENCIES

While FSC was based on the idea of wide ranging cooperation among CAN agencies, the FSC-MIS reports have indicated relatively minimal coordination of services by the Center (98% direct, 2% Coordinated for the past 2 quarters). There have been indications from the "established" CAN treatment agencies that in fact the actual linkage among agencies is not living up to the concept. There has also been an occassional philosophical and/or procedural clash between the FSC and other agencies which has resulted in expressions of hostility from the "older" CAN treatment agencies toward the "newcomer" agency, FSC. However, the capability appears to exist to weather and resolve these issues via the FSC Advisory Board (made up primarily of individuals from other CAN service organizations with which there is FSC linkage) and the Community Child Abuse and Neglect Coordinating Council, a county-wide organization of some 50 member agencies and groups, of which FSC is a member.

5. LEGAL ISSUES

(a) Since FSC is not a direct arm of the legally mandated CAN network, legal issues have not been a priority

for the project. However, the FSC Director has authored a model bill and made it accessible to policy makers at the local and state levels.

(b) In establishing the Hotline, FSC's Goal II, Objective 6, stated that this hotline would be operated "within parameters of exisitng local and state regulations regarding Child Abuse and Neglect, and in cooperation with child protective services, Probation Department, and local police departments." While it was originally intended that a legally binding set of written procedures would be established, the agencies involved have preferred to operate on a case-by-case basis. In instances where a "516" is filed (the required written report) a hotline call may lead to joint investigations involving one or more law enforcement agencies. FSC has followed the lead of the Probation Department in determining the "case type" (i.e., abuse, neglect, abuse and neglect, or high risk). High risk is the only category for which a "516" report is not required. (To date, the majority of FSC cases have been abuse, including sexual abuse, and high risk.)

While the state CAN reporting law defines abuse as physical injury or injuries which appear to have been inflicted upon a minor by other than accidental means by

any person, the county has attempted to provide additional definition toward an abuse definition. The Coordinating Council has recently distributed guidelines for all agencies.

Abuse may have occurred when a minor is suspected of having:

(1) phsyical injury or injuries inflicted by other than accidental means;

(2) been sexually molested;

(3) been inflicted unjustifiable mental pain or suffering;

(4) been caused or permitted to be caused injury to a minor by a person having care or custody;

(5) been caused to be placed or permitted to be placed by a person having the minor's care or custody in a situation in which the minor's health or person is injured.

(c) FSC input has, in a few instances, not been solicited by the Court when case reviews involving FSC clients occur, even if the client family has been receiving FSC services for a year or more. This seems to be further evidence of intra-agency hostility (see Section 4 above). The FSC staff is troubled by this attitude and is attempting to bridge the gap.

(d) The donation of rooms within the Chula Vista Salvation Army Facility for a day-care center compelled FSC to seek and acquire state licensing for the facility, staff, and services.

6. COMMUNITY AWARENESS CONCERNS

One of FSC's start-up activities was to launch a highly visible and assertive public relations campaign handled by Gary Beale's Public Relations Firm. This has been, seemingly, very successful (based partially on the percentage of self-referrals received and the positive response of citizens and professionals to the PR campaign). The Center has made its professional staff available to a wide variety of other agencies, shcools, citizen groups, etc. for training, lectures and discussions, film presentations, the offering of center resources and a variety of other efforts and activities geared toward raising the level of community and professional awareness. One area of major focus during fiscal '76-'76 was to reach the huge number of military families in the San Diego area, many of which are young and transient and of various ethnic or cultural groups who must deal with a high degree of specific kinds of stress. Efforts are also being made to reach families living in the more rural area of the county, where migrant farm labor is commonplace. FSC's brochures

and pamphlets have been printed in Spanish as well as English and all counselors have at least a basic knowledge of the Spanish language. FSC utilizes donated office, recreational, classroom and counseling space in the Escondido YMCA (Palomar "Y") and FSC counselors and student interns staff this facility on a rotating basis. Other sites around the county (hospitals, schools, other Branch Y's) have been used by the project for classes or other public forums.

7. PROGRAM PRIORITIES

While program priorities have largely been specified in the Center Goals and Objectives, the most convincing evidence of these priorities may be discovered by looking at the MIS reports for the year, particularly Report 2 (Linking Costs to Services). The service categories consistently receiving the largest allocation of FSC funds are: Counseling Services (Individual, Couple/Family, Group, and Children's Group), Case Management & Review, Crisis Intervention, Day Care, Babysitting, Education Services, and Transportation/Waiting, and Identification/ Outreach. In general, funds allocation at FSC has supported the stated program priorities, goals and objectives.

8. PROGRAM APPROACHES, STRATEGIES, AND GOALS

(a) Approach: The overall philosophical approach of FSC is that helpful services, not punishment, should be offered to abusing, neglecting, and high risk families, by a staff that has the capability to assess individual family needs and provide the necessary or desired treatment.

FSC treatment has five major components:

(1) Counseling - Individual, couple, family, group, child.

(2) Positive Parenting Instruction - A series of classes which offer parents a chance to reprogram their behavior by learning new options to "abuse/neglect".

(3) Access to the licensed Child Care Center.

(4) Homemaking services and instruction, and Emergency or Crisis services in the home or at the Center.

(5) Special Instruction or activities/referral, as needed.

Additionally, FSC has tried to provide as much T and TA to other professionals in the county as possible, in order to help enable other agencies to be able to recognize CAN and provide appropriate direct and referral services.

(b) Strategies: Program planning was initially projected by the grant writers (the Project directors and YMCA Human Development Department personnel with County CAN system input). On-going management planning and feedback is provided to the Project Directors by the FSC Advisory Board whose members are drawn from other components of the CAN Service network and related social service agents.

To date, FSC has not solved the problem of developing funding for the long-range operation of the demonstration project after the three year OCD grant expires. This has become an objective of third year operations.

(c) Program Goals: A complete list of FSC Goals and Objectives as well as commentary on what has been achieved, and where applicable, how achievements of goals and objectives will be measured may be found in Volume I of this Profile. The overall project goals are summarized and reproduced below:

GOAL I

To provide a mode toward public awareness of the problem and motivation for key individuals to do something about the problem.

GOAL II

To provide a 24 hour hot-line for parents, families, and community members who are directly and peripherally involved in child abuse and/or neglect. This service shall be county-wide.

GOAL III

To provide a large and adequate facility that will accomodate the 24 hour hot-line, office space for intake and treatment services, group meeting rooms, a parent drop-in lounge, space for limited child care, and to be located on or near fourth avenue, proximate to the south bay family YMCA in Chula Vista, California.

GOAL IV

To provide comprehensive and multi-disciplinary intake service comprised of appropriate professionals and para-professionals to insure adequate screening, diagnosis, and prognosis of all those referred to, or seeking to make use of, the Family Stress Center.

GOAL V

To develop a comprehensive series of treatment services, to be made available to all those seeking services or referred to the Family Stress Center.

GOAL VI

To provide a comprehensive system of supportive services to be made available to all those referred to or seeking service from the Family Stress Center for the prupose of providing adjunctive support to the treatment process to further enable the abuse/neglect family to understand and more effectively deal with stress which has previously led to abuse/neglect and to create or increase ties or inter-relationships between the family and the community.

GOAL VII

To develop a follow-up system in order to determine family and individual functioning as well as incidents of abuse and/or neglect for all those who have recieved service from the Family STress Center.

GOAL VIII

To comply with local, state, and Federal laws regarding child abuse and to cooperate and/or participate with other child abuse projects in the county.

While FSC rapidly established its program with a minimum of problems and has developed all of the mechanisms to achieve it stated goals, assessing goal attainment must ultimately be based on whether the center has met its quantified performance standards, as detailed in the April '76 Continuation Application (and reproduced in Volume I of the profile. Length constraints for this volume prohibit listing these performance standards herein.) The Family Stress Center has also made an effort, through their follow-up mechanism (Goal VIII) to provide client evaluation of the quality of center services, and through public forum evaluation questionnaires (Goal I) to assess the quality of public presentations.

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on cost by service area (for each quarter and the average for the year), unit costs, indicators of problems, and the case flow diagram. A brief commentary accompanies each table and figure.

Table 1 gives the actual cost expended and the total value

of the services in each of five functional service areas*, and also details the client services which comprise the areas Services to Families and Services to Children. The actual cost of all services provided for the clients of the Family Stress Center was $181,238 as determined by MIS data. Total value of these services was $234,626. Program Operations accounted for 41.6% of actual cost, but only 33.6% of total value. In the remaining functional service areas, Services to Families received the largest percentage of actual cost (32.7%) and total value (29.6%). Community Activities, Casework Activities, and Services to Children evenly divided the remaining actual cost expenditures.

This pattern was not repeated for total value due to substantial donated Services to Children. This service area accounted for 22.8% of the total value of the services provided by the Center.

Among the client services, 23.7% of actual cost was expended for Psychological Services. There were substantial donations received by the Center in Shelter/Custodial services which accounted for 17.9% of the total value of services provided by the Center.

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* Each of the functional service areas is defined by its MIS service categories on the following page.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 197(

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$181,238	100.0	$234,626	100.0
PROGRAM OPERATIONS	75,377	41.6	78,765	33.6
COMMUNITY ACTIVITIES	16,016	8.8	17,442	7.4
CASEWORK ACTIVITIES	14,747	8.2	15,499	6.6
SERVICES TO FAMILIES	59,322	32.7	69,383	29.6
SERVICES TO CHILDREN	15,776	8.7	53,537	22.8
CLIENT SERVICES:				
MEDICAL	$ 366	0.2	$ 366	0.2
PSYCHOLOGICAL	43,020	23.7	56,101	23.9
LEGAL	0	0	0	0
SHELTER/CUSTODIAL	10,368	5.7	42,022	17.9
SUPPORT	6,556	3.6	6,702	2.9
EDUCATIONAL	4,241	2.3	4,588	2.0
CRISIS INTERVENTION	10,547	5.8	10,547	4.5

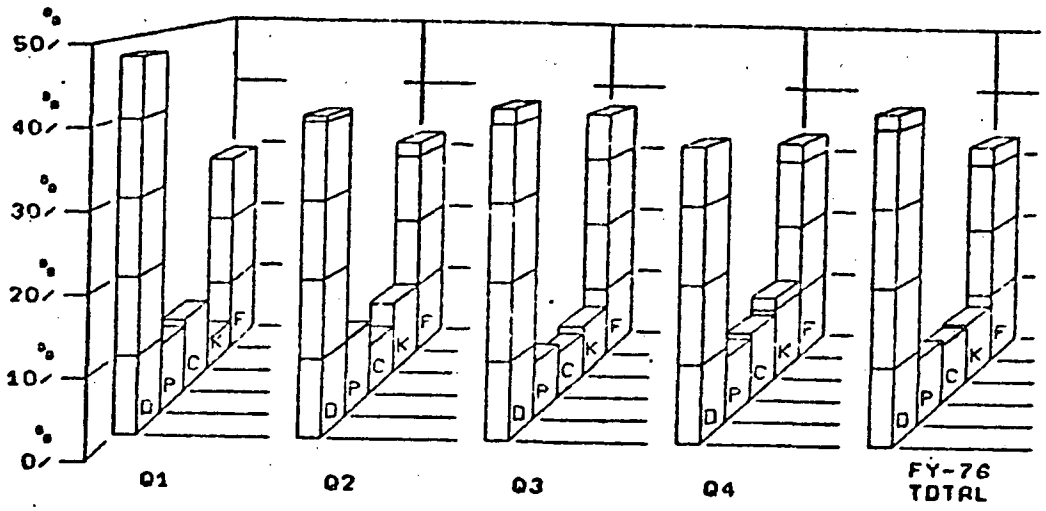
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	00. General Overhead
	1. Administration
	2. Research
	3. Evaluation
	4. Staff Development
Community Activities	5. Community Education
	6. Coordination
	7. Legislation and Policy
	8. Prevention
	9. Identification/Outreach
Casework Activities	10. Investigation
	11. Diagnosis
	12. Case Management and Review
	13. Multidisciplinary Team Case Review
	14. Follow-up
	15. Referral
Services to Families	16. Legal Assistance
	17. Adult Pyschological Evaluation
	18. Emergency Shelter
	19. Crisis Intervention
	20. Medical Care
	21. Individual Adult Counseling
	22. Parent Aide/Lay Therapy
	23. Couple/Family Counseling
	24. Group Counseling/Therapy
	25. Parents Anonymous
	26. Education Services
	27. Homemaking
	28. Transportation/Waiting
	29. Emergency Funds
Services to Children	30. Psychological Evaluation
	31. Crisis Nursery
	32. Emergency Medical Care
	33. Residential Shelter
	34. Day Care
	35. Babysitting
	36. Medical Care
	37. Special Child Therapy
	38. Group Counseling

Figure 2 shows that Program Operations were higher in the first quarter than in the second through fourth quarters. The latter three quarters were quite close in the percentage of actual cost expended in this area. There was little variation in the percentage of actual cost expended in Services to Families throughout the fiscal year. During each quarter, these expenditures represented the largest percentage of actual costs expended, excluding Program Operations. The remaining three service areas -- Community Activities, Casework Activities and Services to Children -- showed little variation in percentage actual cost during the year.

Figure 2A had a similar configuration to Figure 2 for the first quarter of the fiscal year, but donated services change the relationships of the service areas during the remaining quarters. The figure shows that there were substantial donations in Services to Children (second quarter) and Services to Families (fourth quarter).

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

FOR

SAN DIEGO

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

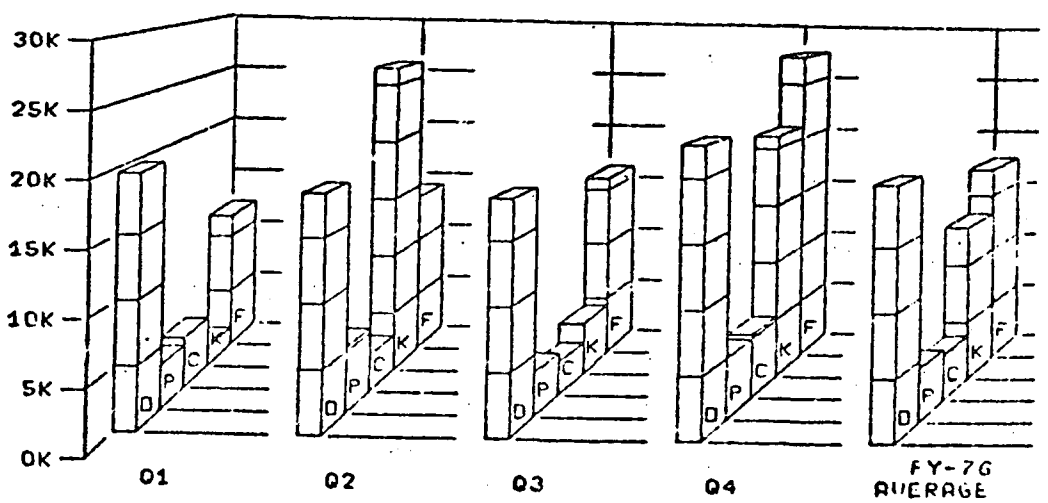


Table 2 presents the unit costs per child and family for the six month period from 1 January 1976 to 30 June 1976. The reader is referred to Volume I, page(s) for a detailed discussion of the methodology employed in calculating these units, and a discussion of the reason for the difference between the values presented here and in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

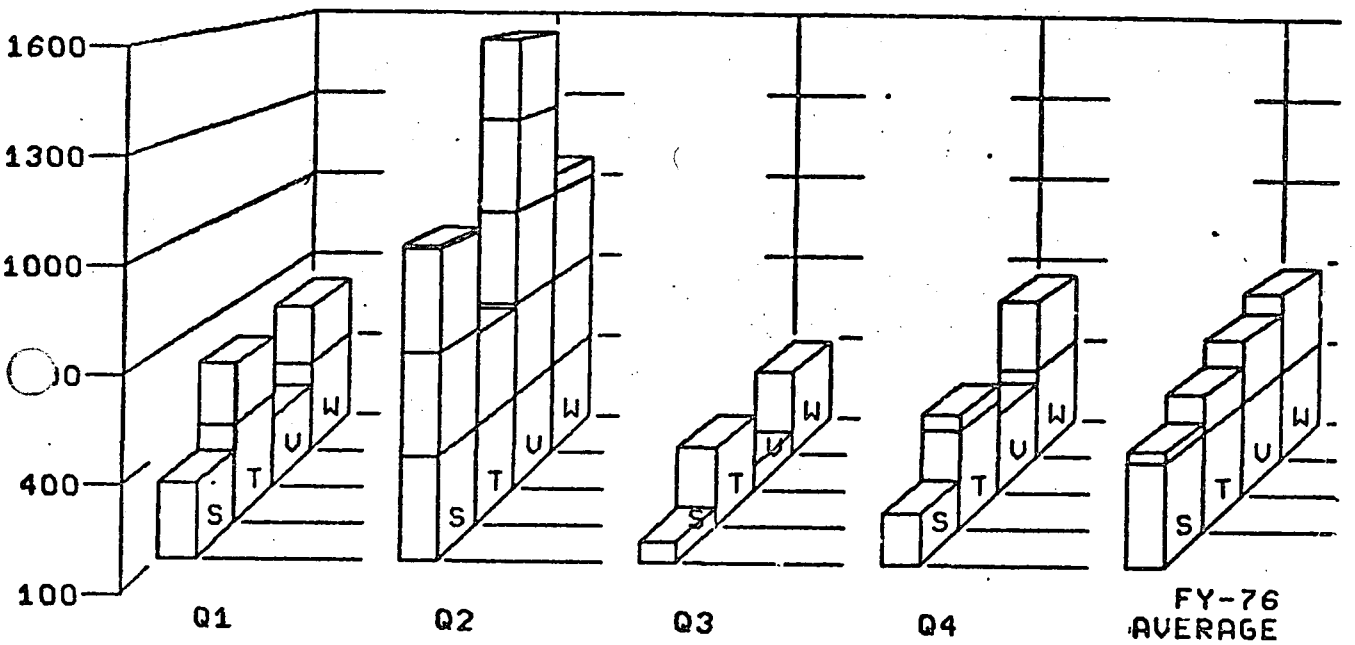
ACTUAL COST PER CHILD	$293
TOTAL VALUE PER CHILD	379
ACTUAL COST PER FAMILY	528
TOTAL VALUE PER FAMILY	683

All unit costs at the FSC were lower than the averages and medians reported for the corresponding units by the aggregate of all centers.

Figure 3 graphically presents the unit costs per child and per family. The data, which shows all units for each quarter and the average for the year, depicts actual cost and total value per child, and actual cost and total value per family.

The figure shows that all unit costs had great variation during the year. The actual cost per child increased substantially in the second quarter. Total value per child increased even more during that quarter. However, in the third quarter, both unit costs were greatly reduced, and had a moderate increase in the fourth quarter. The same pattern was evident for the family unit costs. There was a substantial increase from the first to second quarters, with an even greater reduction evident in the third quarter. As with the other units, the fourth quarter showed a moderate increase in unit costs from the third quarter.

FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR SAN DIEGO



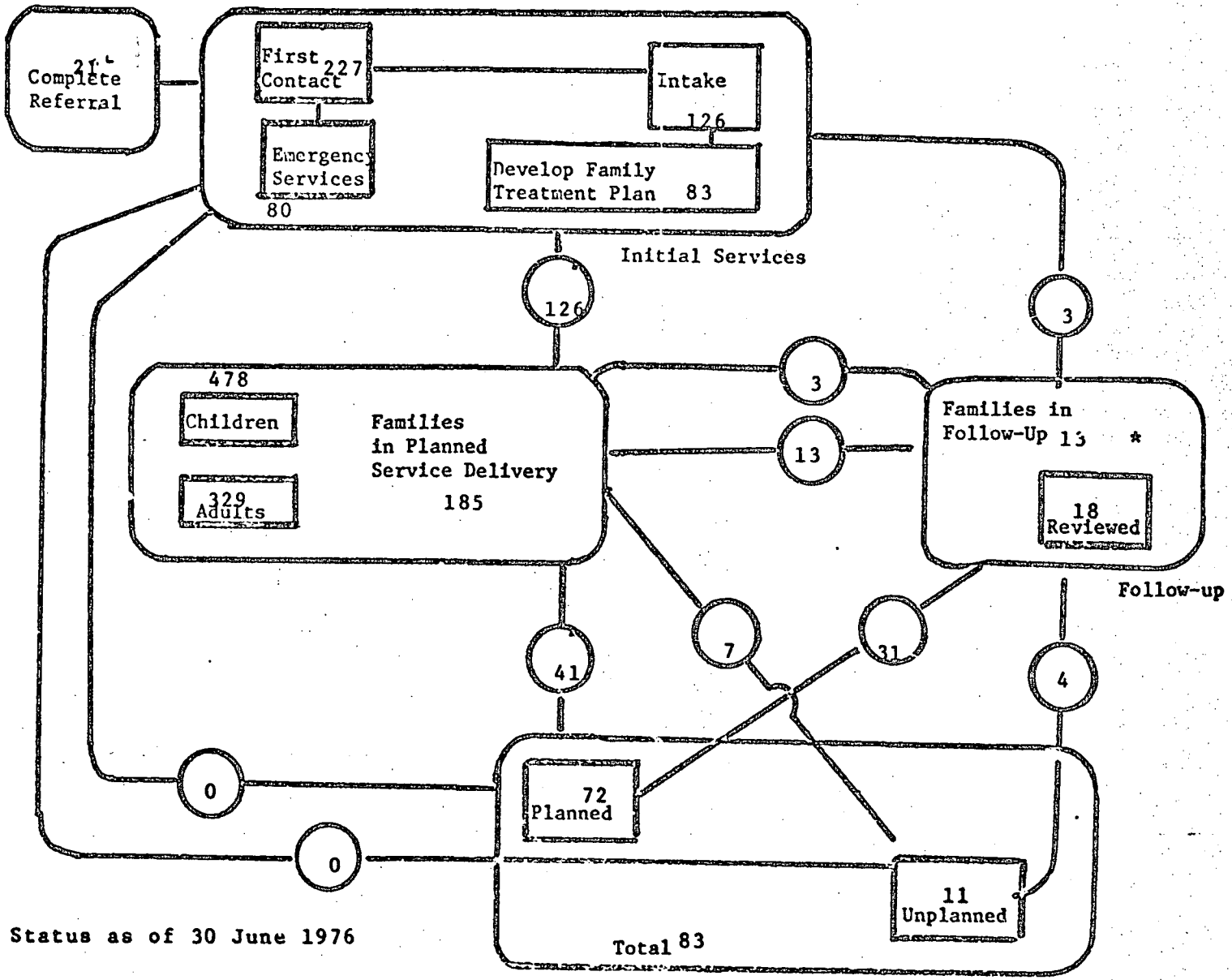
KEY

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

NCCAN DEMONSTRATION CENTERS
CASE FLOW DIAGRAM FOR SAN DIEGO
ALL CASES

MIS QUARTERLY REPORT
COVERING PERIOD JAN 1976 - JUNE 19

FIGURE 4



* Status as of 30 June 1976

Figure 4 shows the client flow of FSC for a six month period from 1 January 1976 to 30 June 1976. During that period, 185 families received planned services from the Center. In those families, there were 329 adults and 478 children. In addition, 80 families received emergency services. As the quarter concluded, 13 families were in follow-up. Eighty-three families were terminated from the Center's caseload. Seventy-two (86.7%) of those terminations were planned.

Table 3 presents a summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during a quarter. The present data set includes warning flags for the entire fiscal year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVER THIS YEAR	1
KEY STAFF VACANCIES (As of June 30, 1976)	0

Administrative costs were calculated by adding the actual cost incurred during the year in service category #1 (administration) and dividing that sum by the total actual cost. At this Center, 11% of actual cost was expended in the administration service category. This figure was well below the 25% figure which was established as a maximum expenditure for this category. Fifty percent of actual cost allocated to service areas, excluding Program Operations was determined to be a minimum level for adequate service expenditures. FSC expended 58.4% of its actual resources in services, therefore no warning flag was received in this area.

L. PROFILE FOR THE CHILD PROTECTION CENTER WASHINGTON, D.C.

1. START UP ISSUES

(a) Initially, the Intake function was rotated amongst all workers. Recently there has been some discussion as to the appropriateness of this function for pediatricians. It is felt that pediatricians should exclude their services to only medical areas. A decision is expected on this shortly.

(b) The present system relies too heavily on court intervention and long term foster care. In FY75, over 600 children were petitioned as neglected and 2900 children were in foster care for an average of 6-7 years. Direct costs for foster care alone were over $11,000,000. Currently, the Children's Coalition on Abuse and Neglect proposes that foster care should be time limited and strenuous efforts should be made to ensure the child's speedy return home.

(c) Central registry may be an important tool to identify and treat child abuse and neglect. However, it raises a number of serious questions which must be thoroughly studied and resolved. Of concern are issues which touch upon the purposes and uses of the register, the methods to be employed, its projected effectiveness and costs, the prospects for interstate cooperation, the agency which will be charged with its maintenance, the precise information to be collected

and circumstances for such collection, the identification of a monitoring body, and certain civil liberties questions including access, expungement, confidentiality, and other safeguards.

2. STAFFING

An "ad hoc" precursor team carried out activities at Children's Hospital that antedated the NCCAN Demonstration Center grant. Four positions on the professional Staff (a half-time pediatrician, a 1/5 time public health nurse, a ½ time psychiatric nurse, and the Director) were filled by persons from the precursor team who participated in the design of the Demonstration Project. The following chart displays the staffing pattern of the ad hoc precursor team and the new staff of the Demonstration Center

CHILDREN'S HOSPITAL CHILD ABUSE PERSONNEL

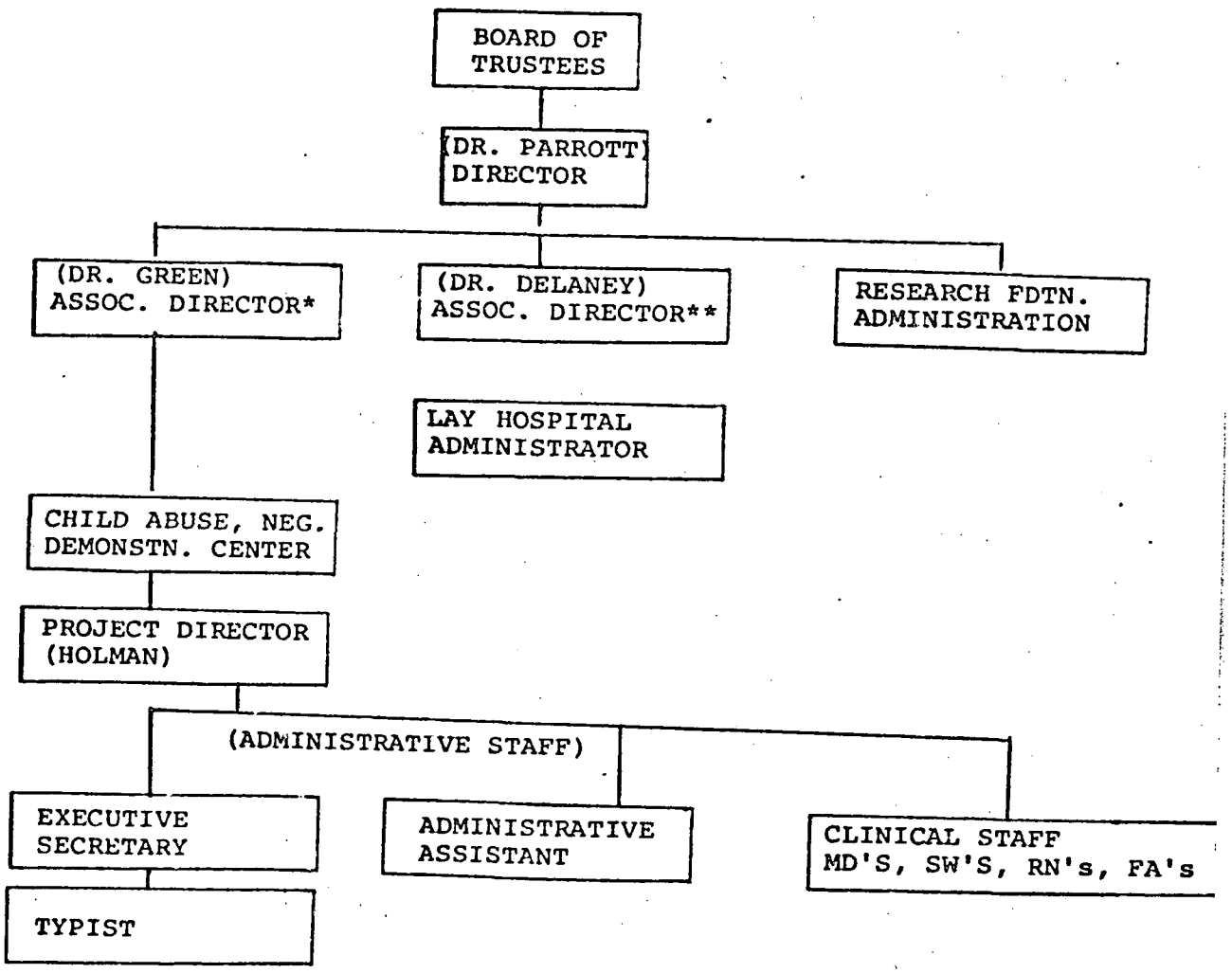
(Positions are held full-time where not otherwise noted)

AD HOC PRECURSOR TEAM	NEW TEAM
¼ time pediatrician (Ficker)	½ time pediatrician (Ficker)
1/5 time public health nurse (Kauffman)	1/5 time public health nurse (Kauffman)
¼ time psychiatric (Neill)	¼ time psychiatric nurse (Neill)
1/5 time social worker (Shannon)	½ time psychiatrist
1/5 time social worker (Steele)	Social workers (2)
1/5 time social worker (Clark	psychiatric nurse
Others -	public health nurse
House staff	psychologist
Psychiatry staff	pediatrician
	Family Advocates (5)

Administrative Staff	Administrative Staff
Chief (Green)	Project Director (Holman)
Secretary (Glasco)	Administrative Asst. (Word)
	Secretary (Thomas)
	Typist (Vaughn)

3. ORGANIZATIONAL STRUCTURE

A table of organization depicting the relationship between the Children's Hospital and National Medical Center and the Demonstration Center reflects the following:



*OFFICE OF CHILD HEALTH ADVOCANT
**PATIENT CARE AND EDUCATIONAL COORDINATION

4. LINKAGES ISSUES

The Demonstration Center has made strong efforts to establish linkages with other community agencies and groups. The Center is represented on the Interdepartmental Inter-agency Committee for Neglected and Abused Children which has approximately 15-18 members from most major agencies. Staff members have also initiated the first Black Parents Anonymous group in the country. Staff is working with a variety of agencies including the Police Department, Department of Human Resources, Public Health Nurses and Homemakers. In addition the Center provides mental health consultation to the courts under a grant from LEAA. The Center has also trained medical teams in other hospitals and HMO's as well as school system personnel .

5. LEGAL ISSUES

For a discussion of the major legal issues, the reader is referred to Section I, item C, Central Registry discussion.

6. COMMUNITY AWARENESS CONCERNS

The Demonstration Center has a very active program in the area of community education. Some of the activities

undertaken include:

- Mental health consultation (psychological testing, psychiatric evaluation, advice and testimony) to the court. This service is contractual and subsidized by a grant from the U.S. Department of Justice (208 cases a year).
- Community education on child abuse and sexual abuse:
  - a). Training medical teams in other hospitals and H.M.O's.
  - b). Training school system personnel.
  - c). Teaching professionals in graduate education.
  - d). Teaching practicing professionals through professional associations and employing orgnaizations.
  - e). General community education via the media.
  - f). Police, FBI, probation officer and public prosecutor education.
  - g). Invited expert testimony on child abuse legislation reform.
  - h). Participation in community agency meetings on protective services, adoption, termination of parental rights.
  - i). Development of resources (day care, emergency foster care) now absent in the system.
  - j). Development of liaison with other agencies (e.g., legal, placement, educational).
  - k). Developed and indexed a library with written, and audio-visual materials. Community agency resource file. Medical teaching slide presentation (100 cases in file).

l). Revised in-hospital protocols on child abuse and sexual abuse and are conducting on-going training of house staff and nurses.

m). Publishing and Research -- One staff article has been accepted by a nursing journal. Two are now in draft. One epidemiological study is underway using police data. Psychiatrist has designed a construct model for the treatment of abusive families which is being team-tested. Quarterly newsletter.

7. PROGRAM PRIORITIES

Report 2 (Limiting Costs to Services) of the Quarterly information and reporting system indicates the following as priority areas for the Demonstration Center.

October-December 1975:	Personnel Development, Resource Development, Diagnosis
January-March 1975:	Case Management and Review, Multi-disciplinary Team Case Review, Psychological Evaluation (Adult)
April-June 1976:	Case Management and Review, Multi-disciplinary Team Case Review, Psychological Evaluation (Adult)

8. PROGRAM GOALS AND APPROACHES

Beginning March 1975, the Demonstration Center Project Director had developed the following discreet objectives for the Center.

OBJECTIVES FOR DEMONSTRATION CENTERS
(Office of Child Development)

I. To increase and improve the delivery of comprehensive services to those involved in abuse and neglect.

II. To find effective methods for the organization and utilization of resources, and for the delivery of services which will: prevent the occurrence of abuse and neglect, and alleviate its consequences when it occurs.

III. Provide facilities adequate to staff and client needs.
- A. Rent space.
- B. Renovate.
- C. Equip with furniture.
- D. Order supplies.
- E. Decorate and make comfortable.

IV. To Operationalize the system.
- A. Further refine the state of the clinical art.
  1. Monitor and revise services as indicated.
  2. Keep staff abreast of developments in the field.
  3. Research and publication activities.
- B. Allocate budget and human resources within the Project.
  1. Record time, caseload and money data.
  2. Compare above data to program objectives.
  3. Revise activity or objectives as necessary.

V. Initiate a model records system, including:
- A. Cooperation with OCD Evluation in refining inter-project instrument.
- B. Develop in accord with the above:
  1. Clinical records
  2. Client tracking system
  3. Caseload records
  4. Trauma index

C. Develop and perfect a protocol recording system appropriate to clinical, placement, and forensic decision-making.
D. Meet grantor requirements for status reports and continuation funding applications.
E. The exploration of Central Registry options and constraints.
F. Involve staff in reporting systems and feedback of data.

VI. Research and evaluations:
A. Use OCD Evaluator-generated data for project evaluation.
B. Collect and analyze cost-benefit data on a sample basis for use in decision-making and Project evaluation.

VII. Plan for program growth and survival:
A. Explore third-party billing mechanisms.
B. Justify the viability of the Project to Children's Hospital National Medical Center and OCD through quality performance and community visibility.
C. Identify sources and seek funds from local and Federal grants agencies and private foundations.

VIII. Spin-off assessing of the Project:
A. The passing of model child-abuse legislation for the District of Columbia
B. Reduce fragmentation of services by improving cooperation and communication between agencies
C. Identify and fill service gaps (e.g., day care, infant residential treatment).

To successfully realize these goals a companion set of services were also delineated. They are listed below:

CLINICAL SERVICES TO CLIENTS

I. Identification of cases of non-accidental injury.

A. On-call round-the-clock
B. Guidance to referral agencies and individuals
C. Medical examination
D. Psycho-social assessment
E. Admission to hospital
F. Liaison with other agencies
G. Liaison with police
H. Counseling parents re legal process

II. Services to the Child.

A. In-patient medical and psychiatric treatment
B. Out-patient periodic medical assessment
C. Psychological assessments (?)
D. Psychotherapy (?)

III. Services to the parents.

A. Psychological assessment
B. Counseling/psychotherapy (group, individual, couples, family)
C. Supportive home visits
D. Payment for transportation and baby sitting
E. Crisis intervention and telephone response (round-the-clock)

IV. Services to others.

A. Counseling for foster parents and other caretakers.
B. Assessment and treatment of siblings
C. Liaison with other agencies
D. Education of professional and lay community through lectures, conferences, media.

V. Services not offered by the Project but to be sought, solicited, and arranged when appropriate.

A. Narcotics treatment
B. Alcoholism treatment

C. Placement of child
D. Medical care for parents
E. Specialized medical care for children
F. Day care
G. Special education
H. Crisis day care
I. Home maker service
J. Financial assistance
K. Vocational training
L. Housing

VI. Services not to be offered at the outset, but possibly to be developed.

A. Parents anonymous groups
B. Child management classes

VII. Services to the Corporation Counsel on contract.

A. Consultation to private doctors
B. Psychological evaluation for parents and children
C. Medical and psychiatric consultation
D. Expert testimony

9. STATISTICAL INFORMATION

The following pages contain statistical information compiled from the Management Information System (MIS) data submitted each quarter by the Center. The tables and figures presented below contain information on cost by service area (for each quarter and the average for the year), unit costs, indicators of problems, and the case flow diagram. A brief commentary accompanies each table and figure.

Table 1 gives the actual cost expended and the total value of the services in each of five functional service areas*,

* Each of the functional service areas is defined by its MIS service categories on the following page.

and also details the client services which comprise the areas Services to Families and Services to Children. The actual cost of all services provided for the clients of this Center was $300,442 as determined by the MIS data. The total value of these services was $453,043. Program Operations accounted for 44.2% of the actual cost of providing services, but only 22.9% of the total value of those services. Excluding Program Operations, Casework Activities accounted for the largest percentage of actual cost expended. However, substantial donated medical services to children increased the total value of Services to Children to 38.8% of total value.

TABLE 1: COSTS BY SERVICE AREA

COVERING PERIOD JULY 1975 THROUGH JUNE 19

TOTAL NUMBER OF CENTERS: 12
TOTAL NUMBER REPORTING: 12

FUNCTIONAL AREA	ACTUAL COST	PER CENT	TOTAL VALUE	PER CENT
TOTAL	$300,442	100.0	$453,043	100.0
PROGRAM OPERATIONS	132,883	44.2	135,335	29.9
COMMUNITY ACTIVITIES	24,322	8.1	24,322	5.4
CASEWORK ACTIVITIES	71,143	23.7	72,153	15.9
SERVICES TO FAMILIES	45,345	15.1	45,345	10.0
SERVICES TO CHILDREN	26,749	8.9	175,888	38.8
CLIENT SERVICES:				
MEDICAL	$ 8,766	2.9	$157,905	34.9
PSYCHOLOGICAL	47,096	15.7	47,096	10.4
LEGAL	5,057	1.7	5,057	1.1
SHELTER/CUSTODIAL	6,247	2.1	6,247	1.4
SUPPORT	2,535	0.8	2,535	0.6
EDUCATIONAL	1,134	0.4	1,134	0.3
CRISIS INTERVENTION	1,259	0.4	1,259	0.3

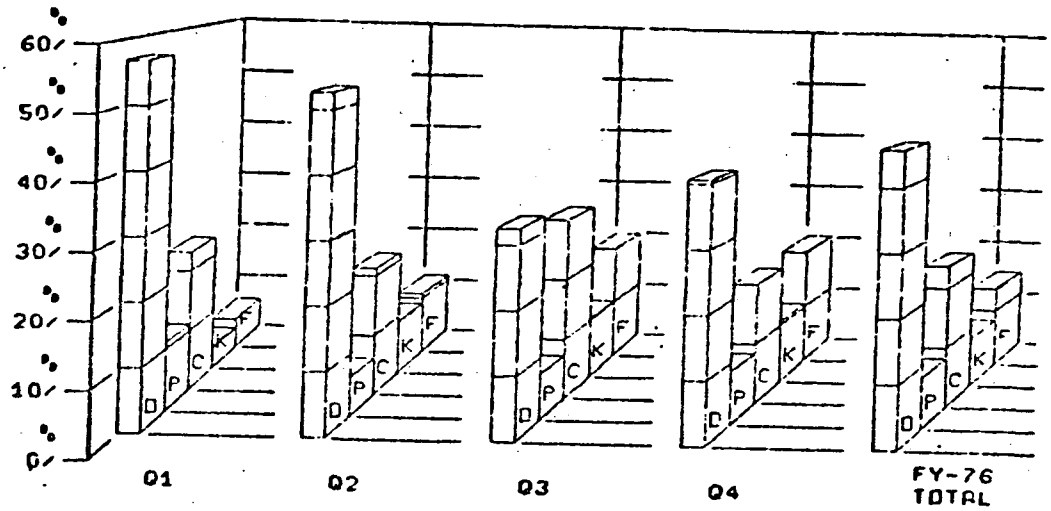
Figures 2 and 2A graphically display actual cost and total value in five functional service areas. The service areas divide all service categories of the Management Information System into disjunct subsets according to the beneficiary of the service:

NAME OF THE SERVICE AREA	SERVICE CATEGORIES
Program Operations	#0. General Overhead 1. Administration 2. Research 3. Evaluation 4. Staff Development
Community Activities	5. Community Education 6. Coordination 7. Legislation and Policy 8. Prevention 9. Identification/Outreach
Casework Activities	10. Investigation 11. Diagnosis 12. Case Management and Review 13. Multidisciplinary Team Case Review 14. Follow-up 15. Referral
Services to Families	16. Legal Assistance 17. Adult Pyschological Evaluation 18. Emergency Shelter 19. Crisis Intervention 20. Medical Care 21. Individual Adult Counseling 22. Parent Aide/Lay Therapy 23. Couple/Family Counseling 24. Group Counseling/Therapy 25. Parents Anonymous 26. Education Services 27. Homemaking 28. Transportation/Waiting 29. Emergency Funds
Services to Children	30. Psychological Evaluation 31. Crisis Nursery 32. Emergency Medical Care 33. Residential Shelter 34. Day Care 35. Babysitting 36. Medical Care 37. Special Child Therapy 38. Group Counseli

Figure 2 shows that Program Operations were initially quite high, but were reduced in the second and third quarters. There was a slight increase in Program Operations for the fourth quarter. Casework Activities were highest in the third quarter, but the percentage of actual cost incurred for the other three quarters was nearly the same. The percentage of actual cost expended on Services to Families showed a general increase through the year. After an initial low percentage of actual cost devoted to Services to Children, there was an increase in that percentage for the second quarter that remained for the remainder of the year. The percentage of actual cost spent in Community Activities remained fairly stable throughout the year.

Figure 2A shows that there were few donated services reported during the first two quarters of the fiscal year. Beginning with the third quarter, substantial donated services were received in Services to Children.

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

FOR

WASHINGTON

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

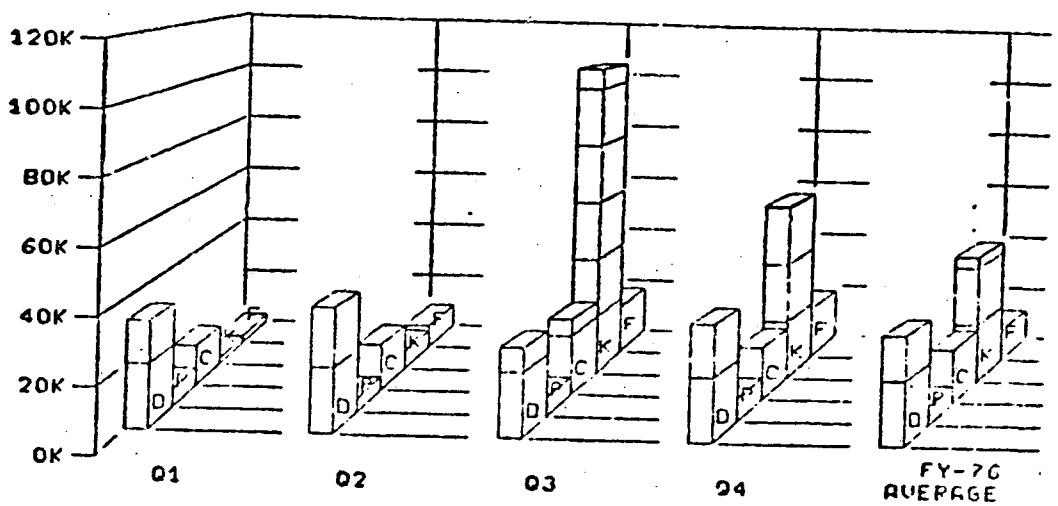


Table 2 presents the unit costs per child and family for the six month period from 1 January 1976 to 30 June 1976. The reader is referred to Volume I, page(s) 22-24 for a detailed discussion of the methodology employed in calculating these units, and a discussion of the reason for the difference between the values presented here and in Figure 3.

TABLE 2

SIX MONTH UNIT COSTS

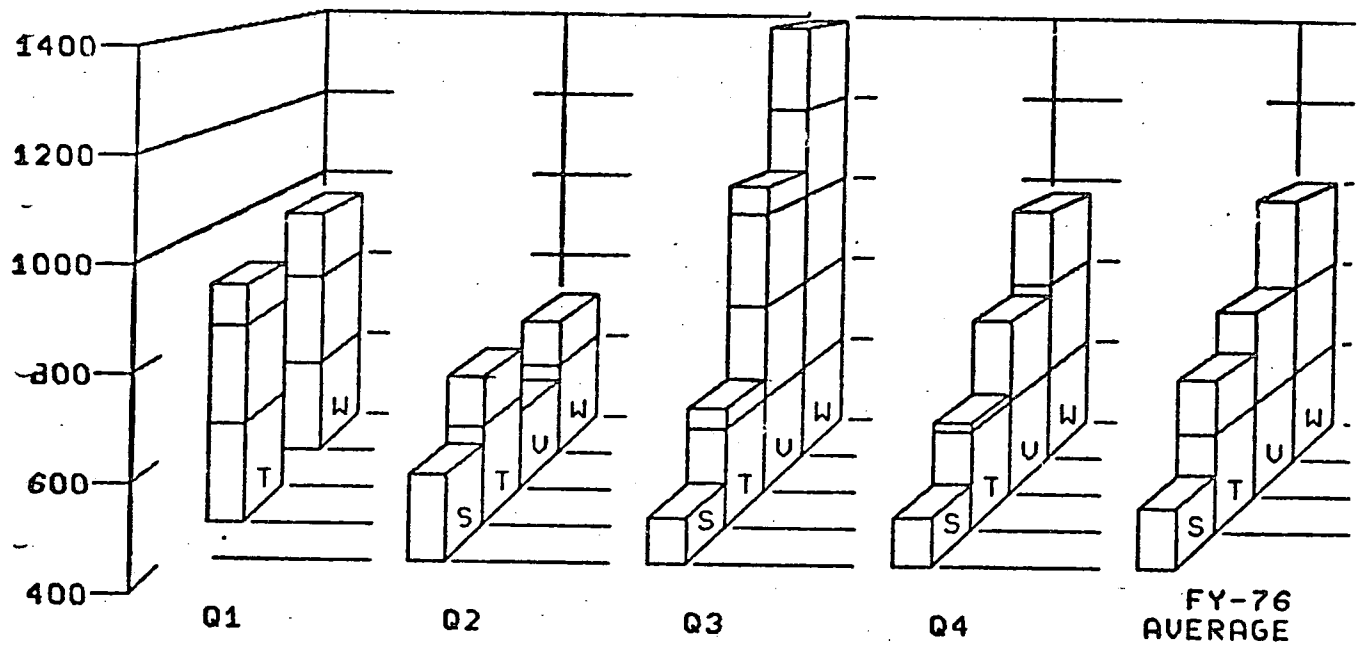
ACTUAL COST PER CHILD	$ 537
TOTAL VALUE PER CHILD	997
ACTUAL COST PER FAMILY	671
TOTAL VALUE PER FAMILY	1,249

The actual cost and total value per child were considerably higher than the average and median unit costs reported by the aggregate of 12 centers. However, the actual cost per family was lower than both the average and median reported by all centers, but the total value per family was higher than both unit costs.

Figure 3 graphically presents the unit costs per child and per family. The data, which shows all units for each quarter and the average for the year, depicts actual cost and total value per child, and actual cost and total value per family.

Unit costs per child were not reported for the first quarter. Beginning with the second quarter, actual cost and total value per child were identical. In the third quarter, actual cost decreased, but total value per child increased substantially. While actual cost per child remained stable in the fourth quarter, the total value per child decreased somewhat. Actual cost per family showed a downward trend through the year while total value per family varied considerably from quarter to quarter.

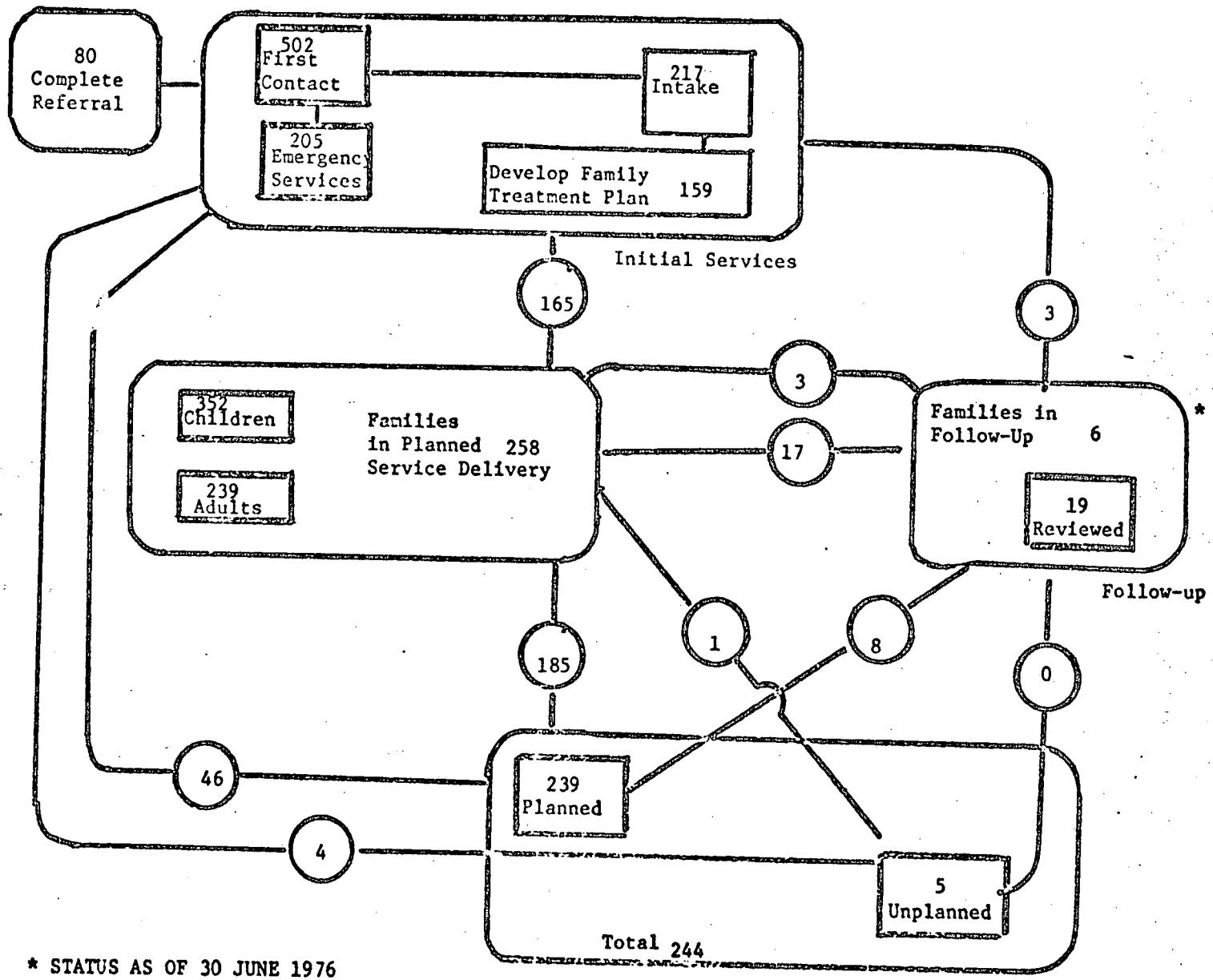
FIGURE 3- UNIT COSTS BY QUARTER, FY-76
FOR WASHINGTON



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

Figure 4 shows the client flow of the Center for a six month period from 1 January 1976 to 30 June 1976. During that period, 258 families received planned services from the Center. Additionally, 205 families received emergency services from the Center. At the end of the fiscal year, 6 families remained in follow-up. A total of 244 cases were terminated from the Center's caseload during this six month period. Two hundred thirty-nine (98%) of those terminations were planned.

FIGURE 4



* STATUS AS OF 30 JUNE 1976

Table 3 presents a summary of the warning "flags" which are produced by the Management Information System to indicate which of a specified set of problems are being encountered by the Center during the quarter. The present data set includes warning flags for the entire fiscal year.

TABLE 3

INDICATORS OF POTENTIAL PROBLEMS

ADMINISTRATIVE COSTS (H if high, otherwise OK)	OK
SERVICE EXPENDITURES (L if low, otherwise OK)	OK
STAFF TURNOVER THIS YEAR	7
KEY STAFF VACANCIES (As of 30 June 1976)	0

Administrative costs were calculated by adding the actual cost incurred during the year in service category #1 (administration) and dividing that sum by the total actual cost. At this Center, 17% of actual cost was expended in the administration service category. This figure was below the 25% figure which was established as a maximum expenditure for this category. Fifty percent of actual cost allocated to service areas, excluding Program Operations was determined to be a minimum level for adequate service expenditures. At this center, 55.8% of its actual cost was expended in services, therefore no warning flag was received in this area.

END

DATE

FILMED

7-9-79

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