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ABSTRACT

This book presents 19 papers on child abuse and neglect. A brief introduction by Health and Human Services Secretary, Margaret Heckler is followed by 13 major issue papers: "Combatting Child Abuse and Neglect" by the assistant secretary for Human Development Services, Dorcas R. Hardy; "What Have We Learned about Child Maltreatment" by James Garbarino; "Stop Talking about Child Abuse" by Donna J. Stone and Anne H. Cohn; "Community Involvement in the Prevention of Child Abuse and Neglect" by Peter Coolsen and Joseph Wechsler; "Child Neglect: An Overview" by Aeolian Jackson; "How Widespread is Child Sexual Abuse?" by David Finkelhor; "What We've Learned from Community Responses to Intrafamily Child Sexual Abuse" by Martha M. Kendrick; "Emotional Abuse of Children" by Dorothy Dean; "Overview: The National Center on Child Abuse and Neglect;" "Providing Child Protective Services to Culturally Diverse Families" by Roland H. Sneed; "Developmentally Disabled, Abused and Neglected Children" by Mark D. Souther; "The Revolution in Family Law: Confronting Child Abuse" by Howard A. Davidson; and "The Military's Response to Child Abuse and Neglect" by Suzanna Nash. Six papers describing programs and projects that deal with child abuse and neglect are also included. The book concludes with a question and answer section on reporting responsibilities and procedures when one knows of or suspects child abuse and neglect, a list of state names and addresses of child protection agencies, and an annotated bibliography of manuals, reports, and other publications of the National Center on Child Abuse and Neglect that deal with child maltreatment. (KGB)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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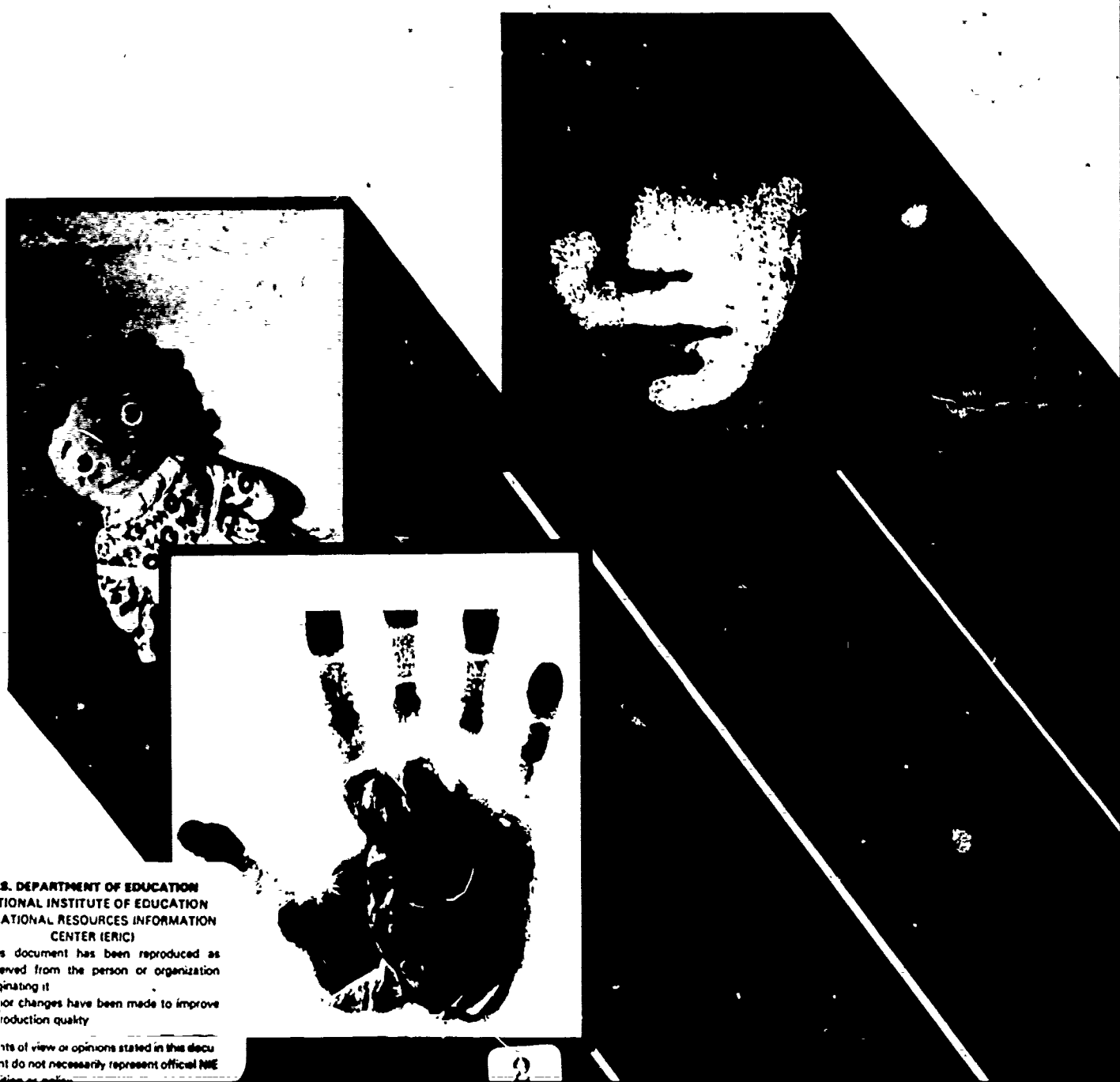

Introduction

This is an important booklet — perhaps the most important booklet you will ever read. Theodore Roosevelt said, "To educate a man in mind and not in morals is to educate a menace to society."

This booklet is about life — about children — about morals — and its purpose is to open doors, windows, *minds* to the problems of child abuse.

In 1982, we received almost one million reports of child maltreatment. Those reported cases represent a 9.2 percent increase over the 1981 total, and allow us to estimate that as many as *1.5 million American children* may be suffering abuse — physical, emotional, sexual.

Those statistics are startling. But they must do more than startle. They must stir all of us to action. The *prevention* — not correction but *prevention* — of child abuse has become critical. Our society is suffering, and will continue to suffer if we do nothing to stop this plague. We know that 90 percent of our juvenile delinquents have been, or currently are, abused children. Those wounded teenagers are headed for an adulthood of chaos and trauma. "Attention must be paid." Ours is not a responsible society unless we strengthen and broaden our educational efforts. Our action, or lack of it on child abuse prevention will affect tomorrow's generations.

The saddest statistics in the growing literature on child abuse are those which trace the "like father like son" — "like mother like daughter" syndrome. Generation after generation.

Our programs and the publication and distribution of this booklet, are efforts to break that cycle.

We welcome and will promote an ever increasing public dialogue on this national problem, so long closeted.

Margaret M. Heckler

Secretary HHS

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Contents

Combatting Child

by Dorcas R. Hardy
Assistant Secretary for Human Development Services

April has been designated as "Child Abuse Prevention Month," and it gives me great pleasure to present this special collection of articles related to child abuse prevention.

We all have a vested interest in the well-being of children. As Abraham Lincoln said:

"A child is a person who is going to carry on what you have started. He is going to sit where you are sitting, and when you are gone, attend to those things which you think are important. You may adopt all the policies you please, but how they are carried out depends on him He will assume control of your cities, states and nations. He is going to move in and take over your churches, schools, universities, and corporations . . the fate of humanity is in his hands."

We at the Federal level recognize that substantial progress has been made over the past decade in discovering, dealing with, and most important, in preventing the problems of child abuse in our society. The greater reality is how much more needs to be done. We are beginning to have a firmer grasp of the causative familial behavior which is the root of child maltreatment. In May of 1982 a study called "Familial Correlates of Selected Types of Child Abuse and Neglect" was published It suggests that family circumstances may be predictive of different types of child abuse and neglect. Gaining a better understanding of the differences between functional and dysfunctional families will have an impact not only on prevention and intervention but treatment efforts as well.

Pinpointing and then working with the dysfunctional family should lead to the ultimate goal. the abolition of child abuse. It takes a total commitment on the part of all who toil in the field of child abuse prevention to achieve this goal.

In this collection are articles written by many of those who toil in the field, and those who have a total commitment to the field of child abuse prevention. The Reagan Administration, too, has a total commitment to child abuse prevention.

We are at a watershed in the field of child abuse prevention. Much has been accomplished and achieved over this past decade. Substantial Federal resources have been directed at researching problems related to child abuse, testing service models and demonstrating ways in which services can be improved.

Solving the problems related to child abuse nationally begins and ends at the community level. Child abuse is a national concern, but it is a community concern first and it must have a community answer. Child abuse will never be solely resolved from Washington.

This is not to imply that the Federal Government lacks a role in dealing with child abuse related problems. Indeed, the role of serving as leader, broker and catalyst remains clearly a tremendous challenge and goal.

Our Federal dollars should be directed toward states, localities and local organizations. We especially need to foster better working relationships and two-way communications with the states.

Additionally, the Federal Government has a responsibility to develop improved management and better, more efficient coordination among limited Federal resources. Our starting premise is that the well-being of the public is primarily a responsibility of individuals, families and the communities in which they live. When social services are needed, they are best defined and administered at the level closest to the problem—state and local governments, local community programs and private voluntary organizations. We cannot afford overlap, duplication and waste among programs; we have a significant stewardship responsibility which requires

intergrated, effective programs.

We must use limited Federal resources wisely. We need to have better coordination with other available re sources at the Federal, state and local levels. That means leveraging federal dollars. It also means concentrating efforts more effectively on brokering and disseminating the most successful projects and programs.

Another leadership challenge for us on the Federal level is to identify new problems areas and uncharted paths that need attention and direction. Child fatalities are a good illustration of this charge. It is almost inconceivable to me that years after we have systematically collected reporting data, we still have a sketchy and incomplete sense of this most tragic form of child abuse nationally.

Another example of this charge relates to developing alternatives to our protection systems. We know, for example, that many families and children reported for known or suspected child abuse and neglect could be much better served by individuals and organizations outside the child protective services system. Likewise, we realize that many children in grave danger or at high risk who need protection do not get reported. It is time to create alternatives, and recognize that there may be better choices to child protective services in certain situations—not child protection.

Child abuse is not a new phenomenon nor is it endemic to one society or another. It is a problem that demands that each and every one of us think more about the value of our children. And just what is the value of a child? There is no price tag high enough, and no words quite adequate to answer this question. Suffice it to say, then, that our children are our past, our present, and most assuredly our future. It is to them that future generations will look for answers and solutions. If we were

to look toward the future through the eyes of a child, we would see only cotton candy, balloons and family outings. Through the eyes of an abused child we would see but gloom.

We, as individuals and as a society, owe it to our children, to ourselves and to the future of this country to prevent child maltreatment of any kind. And together we can strive to prevent child abuse from continuing to rear its ugly head.

With our capabilities, dreams, beliefs and dedication we can help to make everyone understand about kids: You really can't beat'em.

What Have We Learned About Child Maltreatment?

by James Garbarino

James Garbarino, Ph.D., is Associate Professor of Human Development, The Pennsylvania State University.

In January 1981 I informally surveyed 13 nationally recognized research experts on child abuse and neglect[1] to seek some consensus on what we have learned about child maltreatment. That survey revealed that while we are making progress, major questions remain unanswered.[2] This is still true three years later as I update that earlier report. The empirical or clinical studies of child maltreatment now number in excess of one thousand, and each study contains numerous "findings." However, the number of established general "facts" remains relatively small. The panel of experts, together with my own findings, suggest the following as facts established by research evidence:

- Much of the confusion and uncertainty in studying, legislating against, treating and preventing child maltreatment derives from the variety and lack of precision in the definitions used in research, policy, law and practice. For example, estimates of the incidence of child maltreatment range from the tens of thousands, if only life threatening assault and total failure to offer care are used as criteria, to the millions, if we define maltreatment as any form of damaging treatment (emotional, sexual, educational or physical). Nonetheless, analysis based upon a comparison of officially reported cases (as compiled by the American Humane Association) and a broader survey of cases known to any community professional dealing with families (the National Incidence Study supported by the National Center on Child Abuse and Neglect) is reassuring in telling us that we *are* beginning to get reliable information about incidence and prevalence. Real progress has also been made in differentiating among physical, sexual and psychological maltreatment. Moreover, preliminary studies of adolescent victims of maltreatment (approximately 25 percent of the total number of reported cases) suggest that the causes, correlates and consequences probably are somewhat different from cases involving children, and that sex differences in victimization exist across the period from infancy to adolescence.

Even given the problem of definition, however, we do know something about the factors that contribute to child maltreatment:

- It is clear that both psychological and social factors play a role in producing child maltreatment, although debate continues about which is more important.
- Low income and other aspects of social stress are associated with higher rates of child maltreatment, and this was evident in increased rates of child maltreatment during the recent recession and its accompanying increase in unemployment. This relationship appears stronger with respect to infants and young children than with adolescents.
- Some cultures, societies and communities have more child maltreatment than others. Economic pressure, values concerning the role of the child in the family, attitudes about the use of physical punishment and the degree of social support for parents seem to account for these differences. Ethnic and cultural differences appear to exist in both overall incidence and in differences in the relative frequency of different forms of maltreatment—abuse vs. neglect, for example.
- Poor general coping and parenting skills (including those directly involved in discipline) play a significant role in child maltreatment. Social isolation is associated with a greater likelihood of child maltreatment, both because abuse-prone individuals isolate themselves and because they lack the means to participate in their communities.
- Personal characteristics of parents (such as untimely childbearing, physical illness and poor ability to empathize) and children (aversive crying and unresponsiveness, for example) can substantially increase the likelihood of child maltreatment, *particularly* when social stress and social isolation characterize the family. These find expression in relative lack of success in dealing non-violently with problematic behavior by children.
- A history of maltreatment in the parent's background increases the likelihood of child maltreatment, as does the contemporary presence of interspousal violence between spouses.
- Families involved in child maltreatment tend to exhibit a pattern of day-to-day interaction characterized by a low level of social exchange, low responsiveness to positive behavior and high responsiveness to negative behavior. This style may extend beyond the family to the workplace and to school.
- Although many abusive parents exhibit barely adequate personality characteristics, mental illness plays a very small overall role in child maltreatment.

Based on analyses of community responses to child maltreatment, we know that:

- It is very difficult if not impossible to identify reliably *before the fact*, families that will mistreat their children. However, predicting the degree of risk is possible, based upon the known correlates of maltreatment.
- Most community responses to specific cases of maltreatment have been ineffective.
  - ☐ To reduce risks to the youngster, protective services should hold as their foremost goal an adequate, permanent family placement for the child This means preventing removal, if possible, by offering supportive and therapeutic services to the family sufficient to protect the child *and* improve family functioning. If removal is necessary, a realistic decision should be reached quickly regarding permanent placement of the child. If the goal is returning the child to the family, then the family should remain in contact with the child in foster care and rehabilitative services should be offered If the child is to be permanently separated from the family, the child should be placed in a new *permanent* home as soon as possible.
  - ☐ Conventional casework approaches typically result in a 50 percent success rate (at best). Some intensive and resource-laden programs report very low recidivism rates with selected clientele, however
  - ☐ Interdisciplinary teams for case management and development of community services are best. Paraprofessional and volunteer staff in conjunction with mutual help groups can provide effective social support and concrete aid in meeting day-to-day problems. Comprehensive implementation of high quality programs dependent upon heavy involvement of professional staff exceeds current and projected levels of fiscal resources devoted to protective services. Using paraprofessionals, volunteers and mutual help groups is highly cost-effective under most circumstances. Teaching parents skills for successfully handling the problem behavior of children in a non-violent manner is often useful.
  - ☐ Most current treatment addresses parents. Exclusive treatment of parents does not appear to reverse damage of children, however. Generally, children receive no treatment at all, and they may even be harmed by outside intervention that places them in foster or institutional care that is often traumatic in its own right. Even if the initial

placement is benign, the risk of repeated placements is high and a matter of great concern. The issues involved in serving adolescent victims differ somewhat from those involved in serving the needs of children. Resolving custody issues and dealing with negative behavior appear to be greater problems with adolescents.

- ☐ Prevention remains largely unexplored, but results of some studies document its potency and cost-effectiveness. One preventive intervention that has received consistent support is family-centered childbirth.

We know that child maltreatment and the family environments associated with it pose a clear and present developmental danger to the children involved:

- Specific acts of maltreatment produce acute and chronic medical problems that impair growth and development.
- Even if specific acts of abuse are not present, growing up in a family at high risk for maltreatment is associated with developmental damage.
- Children who experience maltreatment may be at substantially increased risk for later delinquency, psychiatric disorders, school failure, self destructive behavior, domestic violence and sexual dysfunction, depending upon the nature, age of onset, duration and family climate of the maltreatment. Existing research does not include sufficient large-scale, longitudinal and well-controlled studies to permit a definitive conclusion about the precise effects of maltreatment, however. Of particular concern are two issues: the role of sexual abuse in generating later sexually dysfunctional behavior and the dynamic links between child abuse and juvenile delinquency.

In short, we know that we are facing a complex problem that requires a wide range of strategies and techniques in the areas of research, public policy and social services. No simple analysis or response is sufficient.

[1] The experts surveyed were Jay Belsky, Robert Burgess (Pennsylvania State University), Anne Cohn (National Committee for the Prevention of Child Abuse); Elizabeth Elmer (Parental Stress Center); Robert Friedman (Florida Mental Health Institute); Richard Gelles (University of Rhode Island); Ray Helfer (Michigan State University); Roy Herrenkohl (Lehigh University); James Kent (The Children's Institute); Michael Lauderdale (The University of Texas) Harold Martin (University of Colorado Health Sciences Center); Eli Newberger (The Children s Hospital Medical Center), and Michael Wald (Stanford University Law School).

[2] J Garbarino, "What We Know About Child Maltreatment." *Children and Youth Services Review, 5*, 1983

Stop Talking

by Donna J. Stone and Anne H. Cohn

Donna J. Stone and Anne H. Cohn are Founder and Executive Director, respectively, of the National Committee for Prevention of Child Abuse, Chicago

It's time to stop talking about child abuse and start doing something to stop it. In the last decade, most of the public has been made aware of the physical and emotional aspects of child abuse and, more recently, of sexual abuse. In addition, professionals and volunteers have learned to work together.

Still, child abuse rates are increasing nationwide. According to a survey by the National Committee for Prevention of Child Abuse (NCPCA), 45 out of 50 states experienced an increase in child abuse in 1983. Thirty-eight indicated that the severity of cases had increased. The number of deaths due to abuse is also on the rise. And each day more stories like the following are told:

"Dear friend,
"I have problem that I don't understand, and I am seeking any help I can get to try and stop it. I have a 16-month-old son, and my husband and I fight in front of him quite often. The last fight we had my husband stormed out of the house, and I went after him leaving the baby alone. I came back later and saw that he had slammed his fingers in the sliding door and was crying. I put him in the playpen and shouted, Nobody gives a damn about you, so just stay there! Then I went out ...."

About Child Abuse

In her particular letter to the NCPCA the woman told of her volatile marriage, of the constant arguing, insults and angry blows, and of her tiny, frightened child who watched it all. She said that whenever her husband made her feel hurt or sad, she made her child feel the same way. "I feel so guilty afterwards," "she wrote, "but of course it's already too late then. There is something in my head that's not right and makes me do it."

Why is child abuse increasing? The reasons are multiple. Certainly, greater public awareness helps account for the rise in reported cases. But our society's neglected values about children and our tolerance of all kinds of violence seem to allow child abuse to occur and permit it to continue. Economic pressures on families can certainly take their toll.

But perhaps most important, as a nation we have been responding to the child abuse problem after the fact. We have focused too much on remedial attention and not dedicated ourselves to stopping the problem *before* it occurs.

It's time to reduce child abuse. Some prevention programs have begun to show success rates. Enough programs exist to prove that prevention can be a reality. And while prevention programs seem to have proliferated recently, more are needed.

We need to greatly increase the numbers of prevention programs that show promise. doing so, perhaps we could reduce child abuse by at least 20 percent by the end of this decade, rather than see it rise. We are personally committed to this goal.

NCPCA has organized a network of thousands of concerned citizens to provide the vehicle for bringing together volunteers in community-based efforts to prevent abuse. NCPA chapters throughout the country are based on the premise that actual prevention best takes place on a community level, and that to be effective, a strong prevention movement must mobilize efforts on three different levels—local, state and national—and from all sectors—corporate and lay.

We know that providing parenting education and support for new and young parents is a particularly important approach to prevention. Many successful prevention progrms use trained volunteers to offer ongoing parent support to new parents. Support or self-help groups, not only for those who have been abusive but also for those who have been victims of abuse, are also effective.

Our experience shows that young children benefit from programs that help them develop skills to protect themselves against abuse. Many of these programs use puppets, plays or movies, like the popular sexual abuse prevention play, "Bubbylonian Encounter," developed by our Kansas Chapter, and the program for latchkey children, "I'm In Charge." Both are being replicated by other chapters across the nation. A unique program to

"Take time out. Don't take it out on your kid."

reach thousands of rural children and their parents incorporated a "petting zoo" at the annual county fair—as workers introduced children to the animals, they presented families with literature on child abuse prevention.

Public awareness efforts can make a difference in stopping abuse. The "No Hitter Day" staged in Kansas last year, and slated for replication throughout the country during Child Abuse Prevention Month, is just one example. NCPCA's new media campaign, with the tag line, "Take Time Out. Don't Take It Out On Your Kid," is another.

In 1972 NCPCA came on the scene as a pioneer in prevention. Making the public aware of the child abuse problem and how to prevent it were critical first steps to reducing the amount of abuse in the United States. Now, our task is to mobilize and assist a concerned public to become aware of good programs and to join us in actively trying to stop abuse. Let's try a new way . . PREVENTION. It worked for the woman whose letter is excepted at the beginning of this article, as her second letter attests:

"Dear NCPCA,
"My relationship with my son has greatly improved since I wrote you my first letter and received your books and got the counseling I needed so badly. I can't thank you enough for your help—especially your letter, which made me feel so much better about myself. You said that my willingness to reach out to you was a positive thing . . . that it reflected on my own strength and the love I have for my child. You said that things could change . . . and you were so right!"

Community in the Prevention

by Peter Coolsen and Joseph Wechsler

Peter Coolsen is Associate Director, National Committee for Prevention of Child Abuse, Chicago, and Joseph Wechsler is Chief of the Clearinghouse Branch, National Center on Child Abuse and Neglect.

Prevention programs in human services are not new. Public health pioneered in this field years ago, and with the emergence of the community mental health movement in the early 1960s prevention became an integral part of mental health programs. In the field of child abuse, however, prevention efforts have lagged.

Most professional concern about child abuse during the past two decades has focused on identification, reporting, and intervention. Only in the last few years has child abuse prevention begun to receive widespread attention.

Why has national interest in child abuse prevention been so long in coming? One reason is that it has taken considerable time for professionals in the field to develop a prevention "mind set." Many professionals involved with treatment had viewed prevention as a luxury and were so preoccupied with "after-the-fact" cases that they did not pay serious attention to prevention efforts. Another reason for the delay is that, in the past, many professionals saw primary prevention as "unworkable," given the complex picture of child abuse and neglect that was emerging from the research. Further, their skepticism was related to the belief that prevention of child abuse and neglect required sweeping social changes far beyond their sphere of influence.

In spite of this reluctance, however, public and professional attention has gradually begun to turn to child abuse prevention. This is partly because the number of child abuse cases reported each year has become unmanageable and the cost of rehabilitation for these families would be astronomical. We have now begun to realize that we must invest much more of our social and economic resources in prevention efforts if we are to have an impact on the problem.

Involvement

Child Abuse and Neglect

Defining Prevention

Since we are beginning to develop an awareness of the need for preventive action in the field of child abuse and neglect, it is essential that we understand the concept. In point of fact, prevention is not very well understood by many professionals in the field. Although prevention takes place on three distinct levels—primary, secondary and tertiary—many professionals group these three together.

Primary prevention in child abuse refers to those efforts aimed at positively influencing parents before abuse or neglect occurs. They key aspects of primary prevention efforts are:

- It is offered to all members of a population.
- It is voluntary.
- It attempts to influence societal forces which impact on parents and children.
- It seeks to promote wellness, as well as prevention of family dysfunction.

Two examples of primary prevention programs in child abuse are those parent-infant support groups which all new parents are invited to join and public awareness and education campaigns.

Secondary prevention refers to those supportive services offered parents who are considered, because of their life situation, to be "at risk." While child abuse or neglect may not have taken place within these families, the probability that it will is much greater than in the general population. The major components of secondary prevention are:

- It is offered to a predefined group of "vulnerable" families.
- It is voluntary.
- It is more problem-focused than primary prevention.
- It seeks to prevent future parenting problems by focusing on the particular stresses of identified parents.

Examples of secondary prevention efforts are support programs for teenage parents and programs for parents of infants with special problems, such as birth defects or prematurity.

Tertiary prevention refers to the services offered to families after child abuse or neglect has occurred. Another name for tertiary prevention is treatment. It is preventive in nature in that it seeks to prevent future incidents of abuse or neglect on the part of the parents or to prevent repetition of abusive or neglectful behavior by the next generation. The key elements of tertiary prevention are:

- It is offered to parents who have been identified as abusive or neglectful.
- It is quasi-voluntary in that often there is legal or societal coercion on parents to seek help
- It focuses on the abusive or neglectful behavior of the parents.

Examples of tertiary prevention are treatment programs for abusive or neglectful parents and programs for maltreated children.

An adequate community prevention program will need to develop strategies on all three levels. However, if the program is going to have an impact on the reduction of child abuse and neglect, it will have to place particular emphasis on primary approaches

Community Involvement

Why should we implement prevention on a community level? Why can't this be done utilizing only trained specialists such as social workers, physicans and teachers?

In reality, professionals do not have the capacity to run prevention programs by themselves. This can only be accomplished through the total involvement of the community. Since large numbers of people are or should be served through primary prevention programs, the cost of running such programs exclusively with professionals would be prohibitive. Also, funds which are

available for child abuse programs today may not be available tomorrow. In order to keep child abuse prevention programs alive, we must acquire broad community support and institutionalize our prevention efforts within major community systems. Child abuse, both cau. and cure, is rooted in the community—its attitudes, values and resources—and an effective prevention approach must tap into all levels of community life.

Lay people can provide leadership and, with the help of professionals, create a comprehensive prevention program for their community. All of the major community forces need to be utilized in this process, including service clubs, business and civic leaders, church groups, health professionals, trade unions, legislators, educators, child welfare professionals and parent groups.

Community prevention programs require that professionals join forces with the political and economic power structure of the community. If a prevention strategy focuses on parenting education, for example, school board members and people who influence school boards are needed. Or, if a parent-infant support program is implemented in the community, hospital administrators, obstetricians, pediatricians, nurses and lay volunteers will have to be involved. Civic leaders and affluent individuals as well as people with political "clout" are necessary participants in community prevention programs.

In addition, the resources of corporations and businesses must be tapped. Professionals have often been reluctant to approach the for-profit sector for assistance because of their unfamiliarity with it or, perhaps, for fear of being co-opted. However, the business community has a strong interest in the general welfare of the community in which it operates. Some corporations have formalized this concern by creating departments of corporate affairs or corporate social responsibility. Professionals and laymen working in community prevention programs must tap this resource by appealing to the "corporate conscience." The benefits may involve not only funding but other valuable corporate resources such as office space or loaned executives.

Other sectors of the community can also be utilized. Traditional service clubs, for example, have taken on new roles in society and many groups such as the Junior Leagues, Womens Clubs and the Council of Jewish Women, as well as the Kiwanis and Jaycees, are already active in programs involving children. In rural areas, homemaker clubs as well as home economists and county extension agents are excellent resources in implementing primary prevention programs. If prevention efforts are to become truly successful, they must harness the resources of as many community institutions and systems as possible.

Starting Points: Communities in Action

Most people in our society believe that the family unit remains, and should remain, our basic social institution, and that under normal circumstances, the care and nurturing of children is the unique province of parents and other family members. Therefore, strengthening and supporting the family is a primary goal for any comprehensive, community-based prevention program. There is general agreement on what constitutes some of the ingredients that contribute to enhanced family functioning and well-being. Family members are better able to cope with their roles within the family and with the demands of life within the larger society if:

- They have some knowledge of child development and realistic expectations about the demands of parenting.
- They have opportunities that encourage successful parent-child bonding and facilitate communication among family members.
- They have an ability to cope with the stresses of infant and child care.
- They have some knowledge about home and child management.
- They have opportunities to share the burdens of child care.
- They have access to peer and family support systems to reduce isolation.
- They have access to social and health services for all family members.[1]

Communities must look for ways to focus and coordinate the activities of the broadest possible range of their

institutions, systems and members, with the goal of developing a responsive and concerned environment in which individuals and families can flourish.

Broadening the Traditional Service Model

Health care, social service agencies and educational institutions must continue to provide professional services to address specific problems and meet specific needs within a community. In addition, these agencies can broaden their mission and actively assist families strengthen their ability to cope on their own

Hospitals and Health Care Facilities. A number of hospitals and health clinics have taken the initiative to reach out to the community, making education available to all families and developing innovative programs to help families at known stress points. The effectiveness of these health care efforts is enhanced by the fact that they are not as "threatening" or punitive as traditional social service agencies sometimes seem. In addition, they are a logical place for outreach efforts since most parents go to them routinely for birthing and other health care activities and at such times are receptive and available for educational efforts.

In one community, for example, a citizen's group worked with hospitals in the area to change traditional practices concerning delivery and postpartum care into a model that facilitated mother-infant bonding and helped families adjust to a new baby. They convinced the hospitals to allow parents 15 minutes alone with their baby after birth and to distribute a brochure to all parents on the importance of mother-infant bonding. The simple act of changing the time of demonstrating child care techniques, such as how to bathe the baby, allowed fathers to attend and encouraged participation by both parents in the care of the infant. Also included in this program were supportive home visits by nurses several times during the first few weeks after mother and child returned home.

Another hospital instituted a program to keep a close check on children brought to the emergency room because of injury. If a child was seen three times, the hospital sent someone to the home to assess the situation and to encourage parents to seek assistance

Social Service Agencies. A second major institution which has traditionally provided services to families with problems are social service agencies, whose primary work will remain by definition and mandate the identification and treatment of those in immediate need. However, some of these institutions are increasingly stressing prevention activities. Provision of comprehensive emergency services, family advocacy, self-help groups and natural helping networks and the use of volunteers in family outreach programs are among the prevention activities being pursued by social service agencies as part of comprehensive child welfare service delivery systems. In addition, social services and child protective service (CPS) agencies still may most appropriately take responsibility for community-wide coordination and integration of prevention efforts. An evaluation of innovative child abuse and neglect treatment demonstration projects found that those affiliated with the local CPS agency were most likely to develop coordinating agreements between other relevant agencies in the community, to provide new or innovative services and to serve the majority of the community

Educational Institutions. Schools are "non-threatening" institutions that touch most families and children during the normal course of events and, thus, are appropriate places to base prevention activities. One of the most critical components of prevention programs and one that is most appropriate to the school setting is education for parenthood. The provision of this information is viewed by many as a necessity for most parents, not just for particular groups. Education for parenthood includes preparation for parenthood (directed at children and adolescents, as well as at newly married couples) and provision of parental skills (provided for expectant parents and for parents at various stages in the development of their children).

Schools can incorporate information on child development and family life into all levels of the curriculum. Some have taken this one step beyond textbook theory into practice. In one class, for example, students experience "mock marriages" to practice making decisions about careers, raising children and coping with life crises. Some high schools now have nursery schools or day care centers on the premises, giving students the opportunity to interact with small children on a regular basis.

Corporate Contributions. The role that businesses and corporations can play in promoting well-being among their employees needs to be explored further. Many companies, recognizing their responsibility to help employees resolve the conflicting demands of work

and family, have instituted such policies as giving employees the right to resume work at the same pay and seniority after personal leaves of absence and permitting them to choose flexible hours on a shorter work week with less pay.

In addition, employer-supported child care programs—the fastest growing area of child care today—are offering a variety of options, ranging from on-site day care centers to vouchers designed to offset all or part of an employee's child care expenses.[2]

Results for many businesses have been impressive. reduced absenteeism and improved job performance and morale The success of these approaches underscores the necessity to think imaginatively about ways to improve life in the community.

Strengthening Informal Support Systems and Volunteer Activities

If we are to reach more families, and reach them early enough to truly *prevent* child abuse and neglect, it is important to develop familiar, nonthreatening, community-based resources that families can and will turn to when they know they need help. An additional benefit of such a shift from services at the institutional level to those that grow from and are run by the community is the potential increase in available services and people to help without any significant increase in funds.

There are many ways community members can apply their own efforts and their community's resources to the primary prevention of child abuse and neglect. The use of volunteers and paraprofessionals in direct service roles in treatment of both identified and high-risk child abuse and neglect families has already been demonstrated to be highly effective. Volunteers have also proven their value in community-based prevention efforts, answering helplines and hotlines and providing emergency child care and transportation services. Volunteers are also being used to augment professional social service workers so that emergency family shelter homes and crisis nurseries can be kept open 24 hours a day. Other ways of using volunteers include providing transportation to take parents or children to appointments for medical, legal or social services; to go shopping for an apartment or job hunting; and to collect food, toys and clothing in the community for use by families in need.

One of the most important services that volunteers can render is to become the extended family that so many modern families lack by acting as grandparents, aunts or uncles, big brothers or sisters, or simply as friends. Volunteers acting as surrogate family members can provide role models for both parents and children, share parenting responsibilities and give parents needed time away, and provide recreational and additional stimulation for children who might otherwise lead very circumscribed lives.

These kinds of activities benefit the volunteers as well, allowing them to share the knowledge and skills they have acquired in their lives. One of the best examples of this is the Foster Grandparent program sponsored by ACTION, the national volunteer agency, in which senior citizens work as homemakers and parent educators and provide children with the special experiences related to having a grandparent figure.

Volunteers and community groups have proven to be a powerful force in promoting community awareness of child abuse, in lobbying for legislation and in fundraising for direct service projects. The political and social action role of interested community members may be the most untapped and potent force waiting to be applied to the prevention of child abuse and neglect.

Conclusion

Primary prevention of child abuse and child neglect is still in an embryonic stage. However, we are beginning to see what kinds of strategies for prevention work best and under what circumstances. More specifically, we can now say that "home-grown," community-based and conceived programs aimed at bettering the lives of *all* families offer the most promise for primary prevention of child abuse and child neglect, as well as for prevention of such related problems as delinquency and drug and alcohol abuse. We know, too, that there are many things that can be done in every community using the community's resources of people, businesses, civic groups, churches and trade unions.

We have come to an exciting point in the development of child abuse and neglect prevention. We are discovering ways in which people may become actively involved in strengthening families, promoting wellness and preventing child abuse and child neglect in their own communities. Perhaps the greatest result of our efforts so far has been the fact that community people, lay and professional, have begun working together and taking an active approach to solving the problem.

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[1] A.H. Cohn. *An Approach to Preventing Child Abuse*. Chicago, National Committee for the Prevention of Child Abuse. 1980.

[2] S.L. Burud, R.C. Collins and P. Divine-Hawkins. "Employer Supported Child Care: Everybody Benefits." CHILDREN TODAY. MAY-JUNE 1983.

Child Neglect: An Overview

by Acolian M. Jackson

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Since the passage of Public Law 93-247 in 1974, which established the National Center on Child Abuse and Neglect (NCCAN), child abuse has received substantially more attention and resources from legislators, researchers, program planners, the media and the public than child neglect. However, as the following statistics indicate, child neglect is the most pervasive, costly and intractable child maltreatment problem encountered by child protective service workers.

Scope of the Problem

- Child neglect is substantiated following child protective services investigations twice as frequently as all forms of child abuse combined, according to data collected by the American Human Association (See Table 1).
- Child fatalities and more severe injury and/or impairment are more frequently associated with neglect than with abuse. While not all states provide information on child fatalities to the national reporting system, the pattern of higher death risk associated with neglect is evident (see Table 2). Furthermore, in a national study of the incidence of child maltreatment, which described the severity of child matreatment as recognized by local child protective services agencies, investigatory agencies and community service agencies, 32 percent of child neglect cases, but only 12 percent of child abuse cases, were found to cause the child serious injury or impairment.[1]
- Children placed in foster care are twice as likely to be neglected as abused, and neglected children tend to remain in foster care twice as long as abused children. A 1977 study of a sample of the 1.8 million children receiving public social service showed that 16 percent of the children in foster care were receiving services primarily because of neglect and five percent primarily because of abuse.[2] An analysis of 1977 national public social services data revealed that children in foster care because of abuse had been in placement an average of 26 months while those in foster care for reason of neglect had spent an average of 46 months in placement—or 77 percent longer.[3] More recently, a study conducted by the American Public Welfare Association found that in 1982, in 17 states with comparable data, neglect was cited as the reason for a child's placement more than twice as frequently as abuse (38,840 cases vs. 17,077 cases).[4]
- The substitute placement costs for neglected children may be four times as great as those for abused children. This estimate is based on the evidence, cited previously, that more than twice as many neglected as abused children are in foster care and that neglected children tend to remain in care almost twice as long.
- The personal and social costs of the diminished lifetime potential of neglected children are only now being gleaned. In a longitudinal study of maltreated children, B. Egland and colleagues found neglected children to be disadvantaged when compared with other maltreated children:

"Neglected children in our sample appeared to have difficulty pulling themselves together to deal with tasks. They were distractible, impulsive, low in ego control, and were the least flexible and creative of all groups in their attempts to solve the barrier task. . . . These children appeared to lack the self-esteem and agency necessary to cope effectively with the environment. In fact, children in the neglect without physical abuse group received the lowest ratings of all groups in both self-esteem and agency at 42 months. This is an unhappy group of children, presenting the least positive and the most negative affect of all groups. These same children were also the most dependent and demonstrated the lowest ego control in the preschool, and, in general, they did not have the skills necessary to cope with various situations."[5]

Demonstration Programs

Little literature is devoted to treating child neglect. A recent article by D. Austin, which provides succinct guidance for CPS staff who work with neglectful families, is one of few on the subject.[6]

In Fiscal 1978, NCCAN funded 19 demonstration projects in five areas: sex abuse, adolescent abuse, maltreatment associated with substance abuse, child neglect and remedial services to maltreated children. In addition, an evaluation contract was awarded to explore client characteristics, services and outcomes within and between the projects. The final evaluation report included information on 986 families. In assessing the severity of maltreatment patterns across all projects, the evaluators concluded that "child neglect and emotional maltreatment result in far more severe damage to a larger percentage of its victims than either physical or sexual abuse. Fifty-five percent of all the cases which resulted in severe harm to the children involved child neglect as the primary type of maltreatment."[7]

In evaluating service effectiveness, they concluded that engagement and retention of maltreating families in treatment programs is a major problem, and that the optimal length of time for successful service to adolescents and adults is between seven and 18 months. Infants and children require longer periods of treatment for successful outcomes. The evaluators also noted that group counseling and education and skill development classes appear to be the most successful methods of achieving positive outcomes with adult clients.[8]

The projects that provided remedial services to maltreated children included a substantial number of neglected children. The final report on this sub-cluster of projects makes a needed contribution to the literature on treating maltreated children (as opposed to adult caretakers).[9] In addition to providing prescriptions for classroom treatment of specified developmental deficits, it describes the desirable characteristics of therapeutic child care settings, including physical arrangements, staff characteristics, and training, program philosophy and service elements. A number of issues papers written by project staff members are appended to the report.

Research On Child Neglect

In 1981, NCCAN funded two projects, now in their third and final year, to conduct field-initiated research on child neglect.

N. Polansky has investigated loneliness (subjective) and isolation (objective) as experienced by neglectful parents when compared with non-neglectful parents in similar circumstances.[10] His findings to date indicate that neglectful mothers perceived themselves to be significantly more lonely than non-neglectful mothers do; they had fewer "significant others" to turn to for either practical or emotional support. There was also evidence that they were rejected in their own communities—they were unlikely to be sought out for assistance and were more likely to be excluded from mutual help networks. These findings were consistent across ethnic groups and in both rural and urban settings.

P. Crittenden's research examined the quality of relationships formed by neglectful parents as compared with those formed by adequate parents and parents who presented other childrearing problems (abuse, marginal maltreatment and abuse/neglect).[11] She reports that the groups did not differ in terms of the number of network members, but that the quality of the network exchanges differed markedly for neglectful parents. Although these parents received more material support—housing, child care and financial assistance than the other groups, they were more dissatisfied with the help they received.

Three distinct network patterns were discerned. The neglectful mothers were immersed in stable but closed networks. They embraced few new relationships, were exposed to few new influences. By comparison, the other three problem groups were involved in open and unstable groups. They saw their friends more often but had more transient relationships. Finally, mothers who provided adequate child care tended to have relationships that were both open and stable.

An important finding with practical implications is the different pattern of relationships between parents and professionals reported for these three groups of mothers. Neglectful mothers tended to withdraw from professionals; they made the interviewer feel rejected as they passively warded off the relationship. The three other groups of mothers tended to manipulate the interviewer, inciting feelings of weariness and guilt as they actively warded off the relationship. The mothers who provided adequate child care tended to be cooperative in their exchanges with the interviewer and aroused the interviewer's interest in continued contact.

Together, these research studies underscore the relative inaccessibility of neglectful mothers, who challenge professionals and volunteers to provide the special, long-term and consistent support they need. Both final project reports will describe the effects of neglect on children and offer recommendations for treatment approaches to neglectful families.

TABLE 1 SUBSTANTIATED MALTREATMENT—PERCENT

(Compiled from *Highlights of Official Child Neglect and Abuse Reporting*, Annual Reports, 1976-1980, American Humane Association)

Type	1979	1980	1981	1982
Major Physical Injury	4	4	4	2
Minor Physical Injury	15	20	20	17
Physical Injury (Unspecified)	3	3	3	5
Sex Abuse	6	7	7	7
Deprivation of Necessities*	63	61	59	62
Emotional Maltreatment	15	13	12	10
Other	9	8	12	10
Number of cases (in thousands)	226	268	236	332

*failure to provide shelter, nourishment, health care, education, supervision, clothing and failure to thrive, as defined by the states.

TABLE 2 FATALITIES ASSOCIATED WITH CHILD MALTREATMENT

(American Humane Association, 1979-82 data)

Year	Total # Reported	# States Reporting	# With Maltreatment Type Known	Cases Associated With Neglect	
				#	%
1979	350	25	261	142	54
1980	421	27	288	123	43
1981	585	25	381	212	56
1982	484	24	282	144	51

Future NCCAN Activities

The Fiscal 1984 grant program includes several priority areas that address special issues in child neglect. The priority statement invited proposals to test innovative program designs and to develop staff training and decision-making guidelines to address the general problem of child neglect.

The category of neglect includes a subcategory, lack of supervision, which accounted for 26 percent of all substantiated child maltreatment in 1982. The 1984 statement also invited proposals to investigate the characteristics and attitudes of parents reported for leaving children unsupervised and to investigate the CPS agencies' response to such reports.

A third priority area focuses on prevention of child abuse and neglect in minority communities. Minority families are overrepresented in abuse and neglect statistics, primarily in the area of neglect. For example, while neglect accounts for three out of five substantiated child maltreatment cases, it represents four out of five cases among black families. Thus, successful programs to reduce child maltreatment in minority communities will have a major impact on the reduction of child neglect.

It is clear that a high priority must be assigned to the prevention, identification and treatment of child neglect. Recent and planned NCCAN-funded efforts, including data collection and demonstration and research grants and contracts, are providing the impetus for increased attention to this special childrearing problem.

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[1]National Center on Child Abuse and Neglect, *Study Findings: National Study of the Incidence and Severity of Child Abuse and Neglect*, DHHS Publication No. (OHDS) 81-30325.

[2]A. W. Shyne and A. G. Schroeder, *National Study of Social Services to Children and Their Families*, DHEW Publication No. (OHDS) 78-30150.

[3]E. V. Mech, *Public Social Services to Minority Children and Their Families, Final Report*, ACYF grant number 90-C-2042, 1980

[4]American Public Welfare Association, Voluntary Cooperative Information System National Child Welfare Data Base, Item No. 10, 1983.

[5]B. Egland, L. A. Sroufe and M. Erickson, "The Development Consequence of Different Patterns of Maltreatment," *International Journal of Child Abuse and Neglect* (in press).

[6]D. J. Austin, "Treating Neglect: Learning How to See, Feel and Touch It," in C.M. Trainor (ed.), *The Dilemma of Child Neglect, Identification and Treatment*, Denver, American Humane Association, 1983

[7]Berkeley Planning Associates, *The Exploration of Client Characteristics, Services and Outcomes*, draft final report, HEW contract number 105-78-1108, 1982.

[8]Ibid.

[9]Berkeley Planning Associates, *Therapeutic Child Care: Approaches to Remediating the Effects of Child Abuse and Neglect*, cluster substudy, HEW contract number 105-78-1108.

[10]N.A. Polansky, P.W. Ammons and J.M. Gaudin, Jr., "Loneliness and Isolation in Child Neglect," *Social Casework* (in press).

[11]P. Crittenden, "The Relationship of Quality of Network Support to Quality of Child-rearing and Child Development," paper presented at the Second Annual Forum for Developmental Research, Virginia Common wealth University, Richmond, Nov. 1983.

How Widespread Is

by David Finkelhor

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Starting in the mid-1970s, child welfare professionals began to notice a dramatic increase in the number of cases of child abuse that involved some kind of sexual exploitation. As such cases continued to mushroom in the late 1970s, these professionals were joined by journalists, publishers and T.V. and film producers who also became alarmed about the problem.

Soon the public was being exposed to a wave of books, magazine articles and television programs describing or, in many cases, graphically portraying this disturbing type of child abuse.

People at all levels, from politicians and policy-makers-to-informed-newspaper readers, came to know that child sexual abuse is one of the most serious forms of child abuse and much more common than was once thought. But exactly how common is it?

Everyone has heard figures: half of all girls, one in four girls, one in 10 boys. Where do these figures come from? Is sexual abuse really this widespread?

Unfortunately, there are no precise and reliable figures on the incidence of child sexual abuse in the United States And there may never be. By its very nature, sexual abuse is a problem that is concealed. Gathering statistics about it is a frustrating and precarious undertaking So the cases actually uncovered by statisticians and researchers may represent only a tip of an unfathomable iceberg.

Nonetheless, several efforts have been made to try to gauge the extent of sexual abuse. Some of these attempts have gotten much closer to the truth than anyone expected.

The American Humane Association (AHA) publishes nationwide statistics on child abuse and neglect. These figures are collected from the 50 individual states, which in turn get their figures each year by counting the cases that were officially reported to each state's child protection authorities.

The American Humane Association's tally of sexual abuse cases reached a high of 22,918 in 1982, the most recent year for which statistics have been assembled.[1]

Although this figure is 10 times larger than the 1,975 cases of sexual abuse tallied in 1976, the first year of the AHA's collection effort, everyone recognizes that even 22,918 is a drastic undercount. It is well known to professionals in the field that a great number of sexual abuse cases are never officially reported and thus would not be included in the AHA count.

To try to improve upon these figures, the National Center for Child Abuse and Neglect (NCCAN) commissioned an even more comprehensive study of the incidence of child abuse and neglect.[2] In the National Incidence Study, conducted in 1979, 26 counties in 10 states were chosen to be representative of the whole country. By using a toll-free telephone number and confidential questionnaires distributed to agencies throughout these counties, researchers hoped to find out about cases that were known to professionals but had not been officially reported.

Extrapolating from the 26 counties to the nation as a whole, the National Incidence Study estimated that 44,700 cases of sexual abuse were known to professionals in the year beginning April 1979. The researchers figured that their procedures uncovered almost twice as many cases as would have been known to the official reporting agencies alone.

Although 44,700 cases of sexual abuse in a single year is a serious problem, even this figure is still considered a gross underestimate. What is missing is information on all the abuse that occurs but is not known to any agency or professional at all. This abuse is known only to victims and perpetrators and, perhaps, to a few family members and friends. This abuse may well constitute the majority.

Child Sexual Abuse?

Surveying Victims

To try to find out about the scope of this unreported abuse, several researchers have taken another approach They have tried to ask victims directly. Unfortunately, there are problems to asking such questions of children who are currently victims. Parents would be unlikely to give permission to interview them, and children might be put in danger of retaliation if they did tell

So, removing themselves one step, researchers have interviewed adults about sexual abuse that may have happened to them when they were children

One of the first researchers to take this approach was Alfred Kinsey in his famous study of female sexuality [3] Kinsey and workers asked 4,441 female subjects if they had ever been "approached while they were pre-adolescent by adult males who appeared to be making sexual advances, or who had made sexual contacts" Twenty-four percent said such a thing had happened to them. This is the source of a widely quoted statistic that one in four women are sexually abused.

There are several important facts to note about Kinsey's estimate. For one thing, more than half of the experiences the women in his study reported involved contacts with exhibitionists only. For another, his figures do not include any experiences occurring to adolescent girls or any abuse at the hands of offenders who were not adults.

Another estimate about sexual abuse based on adults reporting about their childhood comes from a study conducted by this writer, who asked 796 students at six New England colleges and universities to fill out questionnaires about childhood sexual experiences of all types.[4]

Sexual victimization was defined as a sexual experience between a child 12 or under with a partner at least five years older, or between a child 13 to 16 with a partner at least 10 years older. By this definition, 19 percent of the women (approximately one in five) and nine percent of the men (about one in 11) had been sexually victimized. About 20 percent of the experiences were with exhibitionists.

One defect of both this and the Kinsey studies is that they did not use samples that were representative—Kinsey's respondents were all volunteers, and mine were all students. However, three other studies of the prevalence of sexual abuse have been done using more systematic samples.

In 1980, Glenn Kercher, a researcher at Sam Houston State University, and colleagues mailed out questionnaires to 2,000 people randomly selected from all those who held Texas drivers' licenses.[5] In reply to one question, which asked whether the person had ever been a victim of sexual abuse as a child, 12 percent of the females and three percent of the males—of a total of 1,054 respondents—admitted they had been sexually abused.

Under a grant from the National Center for Prevention and Control of Rape, I conducted another study, a household survey of a representative sample of 521 adults in the Boston metropolitan area, all of whom were the parents of children between the ages of six and 14.[6] The adults were asked about sexual experiences they had had when they were children, prior to age 16, with a person at least five years older, which they themselves considered to have been abuse. Under this definition of sexual abuse, 15 percent of the women and five percent of the men had been sexually abused.

The study that has found the highest rate of sexual abuse was one conducted by sociologist Diana Russell, also under a grant from the National Center for Prevention and Control of Rape, who interviewed a random sample of 933 adult women in San Francisco in 1978 about a wide variety of sexual assault experiences.[7] She found that 38 percent of these women had had a sexual abuse experience involving physical contact before they were 18. If non-contact experiences—like encounters with exhibitionists and unwanted advances—were included, the figure rose to 54 percent.

That Russell's figures are so much higher than those of other studies may be attributed in part to the thoroughness of her questions. Where other studies asked adults a single question about sexual abuse, Russell asked 14 separate questions about sexually exploitative experiences, any one of which may have reminded people about some sexual abuse that occurred in their childhood. She also included abusive experiences at the hands of peers in her definition of sexual abuse.

Implications

These surveys have added greatly to our knowledge about child sexual abuse. They have shown that the experience of being molested occurs to an alarming number of children, and that both boys and girls are victims. They have also shown that most victims do not tell anyone, confirming the suspicion that reported cases are only a tip of the iceberg.

Unfortunately, these surveys have not given us a definitive figure for how many children are sexually abused in the United States. Russell's findings cannot be used to say that "more than one out of every two girls is molested," nor could my findings be used to argue that 15 percent of all girls and five percent of all boys are sexually abused.

For one thing, these studies are local and cannot be generalized to the country as a whole. For another, they are studies of adults and we do not know for sure that the current generation of children is having the same experience.

They can be used, however, as general guides for how widespread the problem of victimization probably is. In answering the question about the prevalence of sexual abuse, it is fair to say that "studies of various groups of adults looking back on their childhoods have found that anywhere from nine to 52 percent of the women and three to nine percent of the men were sexually abused."

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What We've Learned From Community Responses To Intrafamily Child Sexual Abuse

by Martha M. Kendrick

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Without question, professionals and volunteers who work with child maltreatment confront some of the knottiest legal issues, thorniest child protection cases and most complex and sensitive family issues when they work with families where there is a problem of child sexual abuse. With a burgeoning national awareness of incest, communities across the country now grapple with a whole new set of problems relating to reporting, treating and preventing child sexual abuse. As incest emerged from the closet over this past decade, professionals faced the stark reality of a nonexistent research or information base and inadequate community "systems" to deal with this growing problem area.

Spurred by the legislative priority incorporated in the 1978 Amendments to the Child Abuse Prevention and

Treatment Act (P.L. 95-266), in conjunction with the establishment of five regional sexual abuse treatment/training institutes, the National Center on Child Abuse and Neglect (NCCAN) funded 14 service improvement demonstration projects in late 1980 designed to upgrade the quality of services available to victims and their families and improve coordination among agencies responsible for intervening in or treating intrafamily child sexual abuse. Federal funding for these projects ceased in September 1983, and the yield from the experiences of these agencies is indeed rich.

What is striking is the commonality of issues and challenges confronted, despite the very different premises and bases from which these programs started. The projects were coordinated by community child abuse council, a police department, a mental health center, child protective service agency units at the city, county and state levels, two Parents United chapters, a children's hospital and two private, non-profit community agencies.* This analysis is drawn from the final reports submitted by each project.

Initial Challenges

Most of the projects seemed genuinely surprised that opposition to their programs was virtually nonexistent. Some, particularly in more conservative areas, anticipated that they would face objections within their communities to launching a program designed to serve incest victims and their families. Projects that seemed to establish themselves successfully and quickly already enjoyed strong support within their agencies or institutions—they were a natural expansion of or adjunct to programs already serving maltreated children. Those which faced the most difficult and, in some cases insurmountable, bureaucratic hurdles seemed to lack good or long-standing institutional relationships at the outset.

The key to success in every single community was the degree to which the program established strong cooperative working relationships with other agencies. Social service and law enforcement agencies were a natural alignment in some places, while in others it took dogged determination and constant efforts to bury "turf" hatchets and competitive instincts. A substantial amount of time was spent in developing protocols and agreements specifying the roles and duties of the cooperating agencies.

A testament to the establishment of effective working relationships and mutual respect is the commitment within the various communities to keep these programs going after Federal funding ended. Only one of the 14 projects closed its doors, and in that instance, alternative arrangements were made to continue services to the families.

A consistently voiced frustration relates to the inevitable turnover in personnel and funding in the coordinating agencies. With law enforcement, child protection, mental health, legal and social service agencies working together, a high level of staff turnover is undoubtedly inevitable. Agencies should plan for this disruption and cross-train as well as provide for continuing communications. Breakdowns in program relationships with cooperating organizations were universally attributed to these personnel gaps and changes. Because of the evolving state-of-the-art in working with these families, the need for ongoing training was also universally perceived as essential.

One of the more important findings is the degree to which the legal system influences how others effectively serve these families. All of the projects recognized that it requires extraordinary amounts of patience, skill and time to work with incest victims and their families. For example, it takes substantially longer to move these cases through most legal systems because of the involvement of both the family and criminal courts. One project noted that "when agencies provided a united front in court, it became almost impossible for the client to have a fair chance of a successful defense."

Yet others criticized inconsistencies in prosecution decisions and articulated frustration with meeting difficult evidentiary standards in this area, particularly with younger children. There was stated recognition that these cases long frustrated district attorneys and law enforcement officials, particularly because of retractions of victims and general discomfort in dealing with children. Almost every project noted the necessity of having the clout of the legal system to keep families involved in a very difficult and painful treatment process. Deferred prosecution and diversion programs for offenders were found to be most effective. Clearly the authority and leverage of the legal system is perceived as an essential ingredient in creating an effective community response.

All of the projects invested a substantial amount of time and creative energy in public education and community awareness efforts. They uniformly found that as

awareness increased, so did reporting and requests for services. Some noted the beneficial effect of these efforts on attitudes and approaches toward victims. All felt they were successful in setting into motion a level of awareness and concern that will continue to generate a community response and concern for prevention.

Incest Victims and Their Families

Many of the projects presented information challenging familiar stereotypes on the dynamics and personality characterizations within these families. Several emphasized the uniqueness of each family and the impossibility of prepackaging treatment approaches. Some families are clearly easier to treat than others. There seems to be greater success in cases where the father has admitted and/or disclosed the abuse, where the spouse believed the abuse occurred and was able to be assertive enough to support the child, and where the father apologized to the child and accepted responsibility for the abuse.

Every program recognized the need for a wide range of treatment modalities—including crisis intervention, casework counseling and individual, group and family therapy. Improving communication skills among family members as well as parenting skills appear to be core central concerns. From a clinical perspective, some of the projects observed that they expected to find more pathology within these families, and they were surprised, for example, at the predominantly normal range of scores on standardized tests.

Whether the marriage remains intact following disclosure of the sexual abuse seems to depend in part on the bias or approach of the responding agency. Several programs did not assess whether or not the family remained intact, but there were significant statistical variations among those who did. Most of the programs now seem to feel that removal of the child from the family should be a last resort; this represents a departure of thinking from a few years back, when removal of the child was often the first action taken. In making a determination, agencies most often look toward whether the mother believes and supports the child and/or whether the father denies the abuse and the mother sides with him rather than the victim.

Programs repeatedly emphasized that the child tended to have poor self-esteem and often felt responsible and blamed herself for the abuse. The importance of believing the victim was cited as an acute need. One project with a primary focus on serving victims cited other needs, including the need to feel good about themselves and their sexuality, the need to improve their communication skills and the need to learn how to develop healthy peer relationships.

Many see the relationship between victims and their mothers as the one most critical and, possibly the one most damaged by incest.

Many see the relationship between victims and their mothers as the one most critical and, possibly the one most damaged by incest. Not surprisingly, victims expressed anger at the mothers either for not being there or for not protecting them. Most programs discovered that the mother's attitude and involvement in treatment was crucial to the progress made by the victim as well as the overall family. The mothers themselves were capable of sabotaging their daughter's treatment, and they often needed empathy and basic peer support to accept and deal with what had happened in their families. More often than not, the mother is torn and her changing allegiance between the father and the child is fairly common, particularly in the early stages of treatment. Changing family alignments and relationships and tremendous internal turmoil face all of these families. Some of the projects noted that mothers had more difficulty when the daughter was an adolescent. Consciously or unconsciously, adolescent girls more often were blamed for the abuse.

One of the striking findings among these projects was the high proportion of cases in which the mothers were child victims of sexual abuse. Programs that added adult "survivor" groups did so both to help mothers understand their daughters' needs and to help them work out their own unresolved problems.

Several programs seemed to feel that it was easier to make progress with victims and mothers than with fathers. Projects stressed that a basic criteria should be that the father take full responsibility for the incestuous relationship, and they emphasized their inability to work effectively with perpetrators who continued to deny the abuse. The necessity of uniquely tailoring treatment sequences was emphasized. Peer support and parent groups seemed to be helpful in assisting perpetrators to work through their problems and increase their own self-esteem. The degree of resistance and rigidity of the offender in treatment was noted as a surprise.

Other Issues and Challenges

An overriding issue expressed by all of the projects is the extraordinarily high "burnout" rate of staff and volunteers and the particular emotional drain on therapists. Therapists and other staff members working with these families need recognition, nurturance, positive feedback, agency support, time out and flexibility in approach and structure.

Several programs successfully incorporated volunteer professionals to provide therapy and extend their own agency capacity. A few noted the particular challenge and mixed results in using client facilitators either to run or to assist staff members in working with peer support groups. Other programs used volunteers to provide transportation, child care, public speaking and community awareness efforts as well as office support.

One of the most startling findings is the degree of sibling abuse in incestuous families. Even in families where there is no sibling abuse, sibling relationships play an important role in treatment for the victim. However, many agencies are hamstrung in their inability to protect these children. Since many state laws are totally inadequate regarding the special needs of siblings, community agencies are often unable to help unless they can establish parental neglect. To do this, agencies often face the difficult task of establishing lack of supervision on failure to report.

Virtually every program had to grapple with substantial increases in reports of male juvenile sex offenders. Most programs now identify the needs of these offenders—who often fall through the cracks in terms of treatment as well as legal handling of cases—as critical. Several programs were surprised to learn that when they began treating adult perpetrators, more often than not they discovered patterns of abuse that began during the adolescent years, usually by victimizing younger children. This finding concurs with other research in the field, which suggests that the adolescent sexual abuser of today, if untreated, is likely to become the adult sexual offender of tomorrow.

Several projects also noted the special needs of parents and siblings (particularly siblings who were victims) of adolescent offenders. They report that the dynamics of adolescent sex abuse seem different from adult patterns. This, too is perceived as another area requiring legislative attention in several states. Finally, these projects also consistently point out that abuse of males is far more prevalent than previously thought, a significant proportion of the male offenders were themselves victimized as children or teenagers.

One of the most startling findings is the degree of sibling abuse in incestuous familes.

Another issue that emerged for several programs relates to the special needs of sexually abused children and adolescents who are placed in family foster care. These children seem to exhibit more severe emotional and behavior problems, which most likely correlate with the type and duration of sexual abuse. Many of the girls had great difficulty in working out foster home relationships and, likewise, many foster parents were neither equipped nor prepared for dealing with them. Training for foster parents and alternatives to family placements, such as group homes, were cited as needs.

On a national level, child sexual abuse programs have no concrete methods of charting their successes or failures. Many, therefore, have resorted to analyzing the reoccurrence of intrafamily child sexual abuse as the cornerstone for measuring success. While several of NCCAN-funded projects noted either an extraordinarily low or nonexistent recidivism rate, others wisely ignored the issue. To measure recidivism as the sole or exclusive barometer of success of an entire program would seem to be short-sighted and foolhardy in the complex interpersonal relationships and family dynamics presented by these cases.

These 24 community programs have contributed significantly to our understanding and awareness of the dynamics of intrafamily child sexual abuse as well as the emerging issues in prevention and treatment.

The cost-effectiveness of these programs must be measured in terms of the larger costs of foster care, institutionalization of children and incarceration of offenders. Perhaps a more important measure of success, however, is the universal perception among these projects that they contributed substantially to their communities by offering these troubled families the hope of a better quality of life.

*A list of projects may be obtained from the National Center on Child Abuse and Neglect, P.O. Box 1182, Washington, D.C. 20013.

Emotional Abuse of Children

by Dorothey Dean

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The manner in which the emotional needs of children are met may be the single most significant factor in determining their attitudes, adjustment and performance.

A child's life may be impacted by emotional neglect, emotional assault or emotional abuse. While all these situations may be abusive, not all such cases could be successfully taken to court to protect the child.

Emotional neglect is an act of omission, frequently the result of parental ignorance or indifference. As a result, the child is not given positive emotional support and stimulation. Parents may give adequate physical care to their child but leave him or her alone in a crib for long periods of time, seldom cuddle or talk to the child or fail to give him or her encouragement and recognition.

A child needs positive interactions, stimulation, security and a feeling of belonging and self-worth which only a concerned parent or caretaker can provide. These emotional needs are continuous throughout childhood and a child whose needs are not met is at a disadvantage and handicapped in the perception of self and in interactions with others.

Emotional assault is an attack on a child inflicted by a parent or another adult or child. It may be a single incident or part of a continuing pattern. Most often it is a verbal assault—critical, demeaning and emotionally devastating. The child feels attacked, vulnerable and, frequently as he or she grows older, defensive. This may lead to counterattacks which often escalate into estrangement and alienation of parent and child. A single, or infrequent, verbal assault is not sufficient to be considered emotional abuse, although the incident itself may be abusive.

In the extremes, both emotional neglect and emotional assault may become emotional abuse and subject to court action.

Emotional abuse is the most difficult type of abuse to define and diagnose. Physical abuse, and some sexual abuse, involves tangible or observable evidence which can be documented and vertified. The victim, if old enough, can describe what occurred. Emotional abuse, however, is intangible. The wounds are internal but they may be more devastating and crippling than any other form of abuse. Emotional abuse also differs from other types of abuse in that the victim may not realize he is being abused and the abuser may not recognize his abusive behavior.

Many reporting laws now incorporate designations of "emotional abuse" or "mental suffering," but fail to define what they mean. Since there is a dearth of case law on emotional abuse, professionals are left in a quandary as to what does constitute emotional abuse and how such reports are viewed by the courts.

There are no consistent, accepted legal criteria for the determination of emotional abuse; the legal interpretation may vary from court to court. Some courts may refuse to recognize even the concept of emotional abuse Consequently, few cases appear before the courts because of the difficulty in establishing both the emotional abuse and the need for legal intervention Behavioral sciences may recognize and accept situations as emotional neglect or abuse which would not be upheld in a court of law. The entire area of emotional abuse requires difficult judgments and most courts are hesitant to intercede unless the effects of the emotional abuse are both extreme and readily apparent.

In this article, emotional abuse can be defined as a chronic attitude or act on the part of a parent or caretaker that is detrimental to, or prevents the development of, a positive self-image in the child This is an extremely broad definition and it should be emphasized that consideration of parents' attitudes or actions should not be limited to isolated instances, which probably occur in all families. Emotional abuse involves a persistent, chronic pattern of behavior toward a child, which then becomes the dominant characteristic in the child's life.

The difficulty in recognizing and understanding emotional abuse, and the fact that many children themselves are unaware of being abused, results in many cases remaining unrecognized.

If a child is unaware of the abuse, and the parent is unaware that he or she is abusing, why should society concern itself?

Children who grow up under negative conditions, constantly being criticized, scapegoated and belittled, are not going to become competent adults capable of developing their full potential. They incorporate the image in which they have been cast by their parents and live with all the negative feelings they have developed as a result. They may develop character and behavior disorders, mental illness or, at best, become persons filled with self-doubt and internal anger. They view themselves as less desirable, less intelligent and less competent than their peers. Handicapped in establishing positive and effective relationships, they develop into adults who are less effective than they could be.

Three categories of emotional abuse have been presented successfully in the San Diego County Juvenile Court. They may be identified as those involving one or more of the following characteristics:

- An act that in itself is sufficient to establish abuse.
- Differential treatment of one child in the family.
- A reduction in the child's functioning that can be linked to abusive treatment.

In preparing a case for court, it is important to identify which of these characteristics or criteria are present and to document each one as extensively as possible. It is also necessary to show that the emotional abuse has had a detrimental effect upon the child.

Emotional abuse is the most difficult type of abuse to define and diagnose.

The following cases of Patty, Mark and Sandra illustrate emotional abuse resulting from an act sufficient in itself to establish abuse.

When Patty misbehaved her parents identified the behavior and made her wear signs labelling it—"I am a liar" and "I hit my little sister" for example—wherever she went.

As punishment for his misbehavior, Mark was made to stand in the front yard clothed only in a diaper. What was embarrassing and shameful for a child became agonizing and humiliating in the extreme for an adolescent.

Discipline and punishment for both Mark and Patty involved public humiliation. The court found both children to be emotionally abused, based on a child's right to reasonable and just discipline in the privacy of the home. Subjecting a child to public scorn was not considered reasonable or positive discipline.

Sandra's situation was similar but with a major difference—the abuse was a one-time occurrence. Because Sandra returned home late one evening, her parents shaved her head. The emotional trauma that resulted affected her school attendance, employment and relationships with others. Sandra would not voluntarily leave her house and when forced to go out she wore a stocking cap to conceal her baldness. The court deemed her punishment inappropriate, resulting in obvious long-term effects and continuing mental suffering.

A type of abuse which most frequently comes to the attention of the courts is that in which there is an observable difference in the way one child is treated compared to other children in the home. Cindy's case is such an example.

When Cindy was eight, she was referred by school authorities. Her teachers were concerned that Cindy was being treated differently at home than her brothers and sisters and felt that she needed protection from the negative attitude displayed toward her. Not only the parents but the other children in the family scapegoated Cindy.

The school staff described a "Cinderella syndrome." Cindy was the child in the family who always wore cast-off clothing, was required to do more household tasks than the other children and was not given the same privileges and opportunities. The other children were allowed to join Brownie troops and Boy Scouts but Cindy was not allowed to join or participate in any outside activities. The family ate in the dining room—except for Cindy, who ate in the kitchen standing at the drainboard. The mother never visited Cindy's classroom nor inquired about her progress.

The contrast between her treatment and that of the other children in the family was obvious, tangible and observable. The parents felt that Cindy was different from the other children, and that her treatment was due to her own inability to integrate well into the family. She was seen as a difficult child over whom rigid discipline and control had to be exercised.

Cindy had been characterized in this way throughout her developmental years. She viewed herself as less intelligent and less desirable than the other children. She was depressed and unhappy about her inability to participate with the family but felt she was bad and did not deserve to be included.

Cindy is typical of many children who, for one reason or another, are rejected by their parents and relegated to a position in the family which makes them unloved and unwanted, and succeeds in making them feel that there is a justifiable reason for the rejection. Like many other children in her position, Cindy did not fight back. She accepted her role without question, or without antagonism. She is one of the youngsters who can become the perpetual victims of society, one of those whose low self-

esteem permits them to be used and abused in an uncomplaining and compliant manner.

Paul is a child whose reduced functioning could be linked to emotional abuse. Paul had been placed in an adoptive home when he was three weeks old. His adoptive parents, a young professional couple, had material advantages and an unquestionable desire to be parents. As Paul grew older, however, he failed to develop some characteristics that his parents found desirable. "Paul was a cute baby, but he isn't a cute child," his mother said. She felt he was less physically attractive than she had expected and she detested the freckles he had developed.

When Paul entered school he did not perform academically as well as the parents demanded or compete successfully in sports. His failure to be an outstanding student was upsetting to both parents, and his lack of accomplishment in sports was upsetting to the father. His parents, in many subtle ways, let Paul know that he was a disappointment to them. Paul got the message early in life that he had been adopted and given a home and, in return, was expected to perform at a standard which he was failing to achieve. Paul later said he felt "like an idiot son that had to be kept out of sight." He was also feeling guilty about failing to meet the needs of his parents.

There are no consistent, accepted legal criteria for the determination of emotional abuse . . .

At 12, Paul was sent to a private military school and returned home only for holidays. Paul's worst rejection by his parents came when he was 14 and was waiting for them to pick him up for Christmas vacation. The students and most of the staff at his school were already gone when he was called into the office and told that his parents were enroute to Mexico City for the holidays They had left without talking to him or explaining why they did not include him in their holiday trip At that point he hated his parents for not loving him, his natural mother for giving him up, and himself for being incapable of holding the love of either.

Paul ran away at age 16 and was referred to court The reduction of functioning he displayed was apparent and documented by the schools he had attended Despite a good I.Q., he had tested progressively lower at ages 12 and 14 than he had at age seven His school records showed lower grades, shorter attention span and acting out behavior after each incident of parental rejection By documenting specific instances when emotional abuse had occurred and showing a chronic pattern of reduced functioning, Paul was accepted by the court as an emotionally abused minor.

Although the parents of Cindy and of Paul may not have understood all the emotional implications of their behavior, they were aware that their actions were causing their child to be distressed, disappointed and isolated. Many times, however, emotional abuse is inflicted without the parents being aware of it or recognizing that they are causing emotional damage to their child. Troy's mother was such a parent.

Troy lived with his mother and elderly grandmother. Troy's unmarried mother had been unwilling to ask a man to accept her illegitimate child. The grandmother frequently told Troy that his father had seduced her daughter and then refused to marry her. Both mother and grandmother identified Troy with the father, to whom they made continuous negative references. Troy was given no recognition for his good behavior, but when he did something wrong he was compared to the father.

By the time Troy was 12 he had successfully incorporated a negative self-image. He considered himself to be lazy, unreliable, untrustworthy and bad. He also bore considerable guilt because of his identification with the father and he saw himself as the reason his mother could not marry. By age 12 he was a chronic runaway. He accepted an image of himself as of no value and believed that he would live out his life causing problems and trouble for other people. He felt his mother would be better off and happier if he were not in the home.

When Troy's mother was interviewed it was evident that she had never thought of Troy as an individual but only as an extension of his father. She loved her son, however, and willingly accepted counseling to reevaluate her relationship with Troy and learn to recognize his good qualities and help build a more positive self-image.

Paul and Troy were referred to court for running away, not for emotional abuse. Paul was made a dependent child on the evidence of emotional abuse. No legal action was taken on behalf of Troy and proving emotional abuse would have been difficult. The pattern was evident, but specific instances of abuse were not documented or linked to dysfunctional behavior.

Many children experience more than one characteristic of emotional abuse. Perhaps the most difficult of all to define, particularly before a court of law, is that in which parents have set such high standards for their children that they can never reach. As a result, the children experience a constant cycle of defeat and failure. The intentions of the parents may be both legitimate and positive but the results can be devastating. Many parents who set high standards and are strict with their children are not abusive. However, when the

standards become so unrealistic that a child can never attain them, and the parent is constantly critical of the child's failure, it becomes abuse.

An agency should ... be an active advocate for children and intervene before a child's reactive behavior becomes the issue.

Parents can maintain high standards for their children yet give them positive feelings about themselves and their abilities. Even if children know they will never achieve the standards, they still feel good about themselves because they receive recognition for their achievements and know that they are loved and a source of pride to their parents.

Ricky's is a classic case, one in which the positive elements were missing. His hard-working, conscientious parents never demonstrated affection toward their children and drove Ricky in the same manner they drove themselves, requiring that he excel in everything. Ricky was the oldest and therefore expected to perform at maximum capability at all times. The demands on the younger children were not as extreme and their punishment for failure less severe. Ricky was an honor student and an Eagle Scout. He had little interest in football but played because it was important to his father. His parents' work ethic required that Ricky work hard and not involve himself in non-productive activities. Friendships were discouraged and when he was not at school he was at home. Family activities were done as a group and he was expected to participate.

Ricky was constantly criticized. Because his father had set impossibly high standards, Ricky was in the untenable position of never being able to satisfy him. No matter how successfully he was viewed by his friends, classmates and teachers, he was seen at home as a failure and a disappointment. Ricky was never allowed to air his feelings at home. The father's control was total and it was evident that Ricky had been indoctrinated and conditioned to the extent that he was unable to develop the normal escape mechanisms usually available to children in similar situations—running away, asserting himself or rejecting his father's standards. Instead, with each rebuttal by his father, he tried harder and continued to experience the cycle of defeat, frustration and rejection. The constant pressure began to be reflected in his performance. His grades slipped from A's to B's and C's, he began to lose weight, and his coach commented that he sometimes seemed disoriented and confused. Under increased pressures, he attempted suicide.

This is a tragic example of a situation in which a parent makes unrealistic demands on a child without considering their effects on him or her. Ricky's parents are similar to others who feed their children well, provide them with good physical surroundings in which to grow, give them appropriate clothing and the advantages that they can afford, and yet fail to nurture them in the most important way: by helping them to develop self-esteem and the knowledge that they are wanted, loved and appreciated. If anyone had suggested to Ricky's parents that they were emotionally abusive, they would probably have been shocked at the suggestion and insisted that all they wanted was to make certain that their son achieved his highest possible potential. Yet they were insensitive to the fact that his most basic need was not being met and neither parent recognized the impact of their behavior on Ricky's emotional health.

Agencies should ... help to establish a network of community services to provide counseling to families in which emotional abuse occurs.

All of the children described here have one thing in common—low self-esteem, accompanied by feelings of guilt and an assumption that they are responsible for being unworthy of their parents' love.

Agencies responsible for the protection of children should take the initiative in developing an action plan if court intervention has not been a recourse in cases of emotional abuse. Such a plan might incorporate the following steps:

- Contact the Juvenile Court and establish agreement on definitions and guidelines for court referrals.
- Document the abuse and its negative impact on the child.
- Use expert witnesses such as psychiatrists and psychologists.
- Determine what other interventions have been attempted and what results were achieved.

Agencies should also:

- Educate both the public and those in the juvenile justice system to recognize and report emotional abuse.
- Be an active advocate for children and intervene before a child's reactive behavior becomes the issue.
- Help to establish a network of community services to provide counseling to families in which emotional abuse occurs.

Emotionally abused children can be protected. Many identified families are willing to accept counseling but if official action is necessary there should be no hesitation by the designated agency to initiate court action to protect a child.

Overview

The National Center on Child Abuse and Neglect

Over the past 10 years, since the Child Abuse Prevention and Treatment Act of 1974 was signed into law, the Federal Government has played a significant role in serving as a catalyst to mobilize society's social service, mental health, medical, educational, legal and law enforcement resources to address the challenges of child abuse and neglect. In that time, many professionals, volunteers and citizen advocates have become aware that child maltreatment is more than isolated instances of children suffering and families in chaos. It is a problem that afflicts the health of the nation as a whole, in terms of both economic and social costs.

The issues raised by child abuse and neglect cut across social, geographical, ethnic and economic boundaries. We estimate that as many as 1,400,000 children were reported victims of child abuse and neglect in 1982. Unfortunately, despite the large number of cases currently reported, we cannot assume that most abused and neglected children are now being identified and helped, because our data indicate that a large number of maltreated children recognized by educational, medical and mental health professionals are not known to the local child protective services.

The Child Abuse Prevention and Treatment Act (P.L. 93-247, as amended) established the National Center on Child Abuse and Neglect, which is placed in the Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services, U.S. Department of Health and Human Services. The Act mandates four major functions:

- Generating knowledge and improving programs.
- Collecting, analyzing and disseminating information.
- Assisting states and communities in implementing child abuse programs.
- Coordinating federal efforts.

Program Development and Improvement

The major thrust of the National Center on Child Abuse and Neglect's (NCCAN) program development and improvement efforts can be seen in the variety of research and demonstration activities funded Since 1975 approximately 375 projects nationwide have received funding to further our knowledge base about preventing, identifying and treating child abuse and neglect. These projects involve multidisciplinary, multi-service delivery systems and encompass virtually every aspect of child maltreatment.

In earlier years, major areas of concentration included: prevention of child abuse and neglect, clinical treatment, public child protective services, legal, juvenile services, prevention and treatment of sexual abuse, ado-

lescent maltreatment (including sexual exploitation), protection of children in special institutions, minority issues, developmental disabilities, mental health services, child abuse in military families, parental and victim self-help.

A number of new project areas which had not received attention previously were funded in Fiscal Year 1983 to broaden and apply our knowledge base even further. These include projects to: strengthen support systems and provide education to parents at their worksites and thereby prevent stress and isolation; test models for the use of therapeutic family day care homes as remedial settings for abused and neglected children; assess informal, non-systematic screening at intake in child protective service agencies, examine alternatives to taking cases to court with an emphasis on reducing the stress on the child; develop model approaches to assessing child fatalities among children already known to the child protective service system; and research projects to assess the state of the theoretical knowledge base for the treatment and prevention of child sexual abuse.

In Fiscal Year 1984, NCCAN identified the following priority areas as meriting further study:

- Remedial preventive projects aimed at maltreated adolescents.
- Building capacity and resources in minority communities.
- Using school systems in preventing child maltreatment and, in particular, defining the role of schools for dealing with the perinatal period.
- Developing procedures for dealing with situations of medical, nutritional and social neglect of impaired infants.
- Developing innovative designs focused on problems associated with child neglect including case decision making, intervention techniques and case management procedures resulting in more effective handling of neglect cases by Child Protective Services.
- Assessing the "lack of supervision" category of child neglect.
- Examining emotional maltreatment from the perspectives of identification, investigation, adjudication and treatment.
- Improving the handling of child sexual abuse cases from initial investigation to litigation.
- Developing strategies that can serve as alternatives to litigation.
- Studying nonprofessional sources of reports of child maltreatment.
- Implementing a variety of previously demonstrated techniques and procedures which can improve services. Included here are areas such as perinatal prevention services in and around hospitals, peer support groups for adults and teenagers, multidisciplinary case consultation teams, and parental self-referral systems. A major initiative in this category involves expansion and replication of parent aide projects nationwide.

Information Function

NCCAN's most significant efforts in this area relate to incidence and reporting data. Through the National Center, the Department of Health and Human Services has funded the American Humane Association to conduct an ongoing national study on child neglect and abuse reporting. This project collects and analyzes statistical information about suspected child abuse and neglect that the states receive from child protective service agencies.

One of the basic strengths of NCCAN's activities lies in its capacity to disseminate information through clearinghouse activities and annual program and research analyses. The clearinghouse data base contains several types of information related to child abuse and neglect, including biographic data and abstracts of published articles, descriptions of public and private programs, excerpts from current state and territorial child abuse and neglect laws, summaries of important court decisions in the field, audiovisual materials, excerpts of Indian Tribal Codes, and narrative descriptions of every state's child protective service system. The clearinghouse serves as a national resource for service providers, public and private agencies, researchers, the Congress and members of the general public.

Ten regional resource centers have been responsible for disseminating information on a variety of family related topics, including child maltreatment and fostering local support networks. The Military Family Resource Center, a joint venture with the Department of Defense and the Department of Health and Human Services, is a coordinative effort begun several years ago to provide information and technical assistance to enhance military support systems on behalf of vulnerable military families worldwide.

Equally important is NCCAN's commitment to identifying and defining pressing issues in the field. During the past year, this was accomplished through a series of symposia on specific issues as well as through the Sixth National Conference on Child Abuse and Neglect, held in September 1983.

Implementation

States' efforts to prevent child abuse represent another significant aspect of NCCAN's authorizing legislation. The state grants portion of the Act provides eligible states with funds to develop, strengthen and carry out prevention and treatment programs. Awards amounting to $6.72 million will be made in FY 1984. The number of states eligible for this funding has jumped from four in 1975 to 49 in 1983. The states currently ineligible for a child abuse and neglect state grant either fail to include in their state statutes a definition of child abuse and neglect substantively consistent with the definition of child abuse and neglect in the Act or fail to meet the Act's requirement to provide a guardian ad litem for the child in every case involving an abused or neglected child which results in a judicial proceeding.

A major purpose of the state grant program is to support start-up activities which, if proven successful, will be continued by the state with other funds. Approximately 30 percent of projects conducted with state grant funds have been continued after the start-up phase using state appropriated funds. Most of the others involved one-time-only activities, such as development of protocols, procedural manuals and central register systems for compiling information or reports. Most exciting to us is the exchange of information among the states about successful projects and effective approaches. Through the leadership of the National Center, an informal yet very effective peer support system of state child protective services agencies has developed over these past years.

Another item of note is that, as mandated by the Act, the National Center on Child Abuse and Neglect, in cooperation with the Federal Advisory Board, has developed and published standards for child abuse and neglect prevention and treatment programs and projects. Entitled *Child Protection. Guidelines for Policy and Program* and *Child Protection. A Guide for State Legislation*, these publications provide useful guidance for the field.

Coordination

The major vehicle for accomplishing the fourth function of coordinating federal responsibilities is the Advisory Board on Child Abuse and Neglect. Established by the Child Abuse Prevention and Treatment Act, the interagency board advises, the Secretary of Health and Human Services on coordination of federal efforts to prevent and treat child abuse and neglect. Specific tasks, such as development of a comprehensive plan for coordinating prevention and treatment programs and development of standards for programs and projects, were required by law and have been successfully accomplished by past boards.

The National Center on Child Abuse and Neglect serves as the executive secretariat for the board. The Commissioner for Children, Youth and Families has been delegated to act as its chairperson.

The Advisory Board is composed of more than 20 representatives from agencies within the Department of Health and Human Services and other federal departments. It also includes seven representatives from the general public appointed by the Secretary. The Advisory Board is an effective instrument for government agencies to commit their energies and resources to activities and programs aimed at strengthening families and reducing the stresses which lead to child abuse and neglect. As knowledgeable peers in the area of social problems, the board is able to create a framework for broadening and strengthening our knowledge base by enlisting the resources of other disciplines and promoting research and information exchange across departmental, agency and discipline lines.

Federal coordination requires a structured organizational forum if it is to be effectively realized. Private citizen involvement insures that federal issues are considered within the context of needs and professional developments in the state and local settings where child abuse and neglect are actually being dealt with. Clearly, one strength of the board lies with the public representatives who are required by a 1978 amendment to the Act. These individuals in particular ask difficult questions and challenge and prod not just the Department's staff but other federal agencies as well to different perspectives on problems relating to child abuse and neglect.

Over the past decade, through the efforts of the National Center on Child Abuse and Neglect and project initiatives supported by NCCAN across the country, we have, as a nation made substantial strides in serving vulnerable children at risk of child abuse and neglect and supporting and strengthening their parents. Through support of the areas described here, NCCAN looks toward a brighter future for these children and their families. It is hoped that improved service delivery for the prevention, protection and treatment of maltreated children will result, hopefully, in decreased numbers of abused and neglected children in this generation of Americans, and the eventual elimination of this problem in generations to come. Our vision at the Department of Health and Human Services and NCCAN is a nation of healthy, happy and wholesome children and families.

Providing Child Protective Services to Culturally Diverse Families

by Roland H. Sneed

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The issue of cultural responsiveness in the provision of child protective services, which has been a concern of the National Center on Child Abuse and Neglect (NCCAN) since its establishment, has accelerated in importance as more and more refugee groups come to our shores, bringing their particular cultural traits and values. Over the last few years, boat people from Southeast Asia, Cuba and Haiti have been added to our Hispanic, black, Native American, white ethnic and certain regional groups who, together, are considered as special populations whose child-rearing practices and family relationships may differ from those of the majority population.

Multicultural issues within the context of child protective services, were the focus of the 1978 National Conference on Child Abuse and Neglect. Various cultural groups organized task forces to assess the needs and concerns of their particular groups. A central concern was the inability of child protective service agencies to adequately serve minority and culturally diverse families.

Research studies conducted with both Federal and private funds emphasize the significance of this issue. For example, a 1978 Children's Bureau study found "differences in the ethnicity and the economic status of neglected and abused children, caseworker's perceptions of the needs in these cases as suggested by stated goals, recommended services, and services provided. The differences in the frequency of the two problems and in the characteristics of the child affected by neglect and abuse have implications for program planning and staff training."[1]

The key words here are "differences in caseworker's perception." In addition, if the value judgments and background of a caseworker reflect a white middle-class bias, his or her perceptions of a particular child abuse and neglect situation will be based on that background If the family is from a different cultural group, and if the worker is not sensitive to differences in their cultural backgrounds, the decisions made about the case and the way it is handled may not be valid.

A number of researchers have pointed out the multifaceted problems of cultural perceptions and responsiveness of child protective service agencies and their workers. For example, in a study of black families, Wade Nobles reports, "As long as therapists and clinicians evaluate the black family process with criteria consistent with non-black cultural reality, the therapeutic process will, at best, become impossible and, at worst become a (psychological) transformation rather than rehabilitation."[2] Teresa R. Boulette asserts, " not only is the Spanish Speaking/Surname culture polluted, distorted and blamed, but the SS/S problems are improperly identified and effective interventions are not considered ... [which] often results from a lack of understanding [of] cultural complexities."[3]

Nobles further emphasizes this point: "By assuming that only one form of family structure is 'normal' and 'healthy' and then proceeding to analyze families belonging to different ethnic and racial groups within this society, we have been led away from clearly understanding the structure and function of the ethnic and racial family."[4] Frank Schneiger summarizes, "A final issue is related to the ability of large bureaucratic organizations to respond to cultural difference in a sensitive

manner which builds upon family strengths which can be found in different forms among different groups."[5]

A careful analysis of these points indicates that the social service system in general uses the results of comparative research to define the potential recipients of services. Nobles and Boulette seem to reason that the comparative research model does not consider the anthropological aspects of culturally diverse groups. Rather, comparing culturally diverse and minority groups to the average white middle-class family may provide distorted results. Schneiger seems to think that the social service system must be able to become sensitive to cultural differences in order to develop the capacity to build upon the strengths of minority and culturally diverse families.

Nevertheless, child protective service workers are mandated to investigate all reports of child abuse and neglect, regardless of the family's cultural or ethnic background and the worker's ability to deal with culturally diverse families. Families with cultural and ethnic backgrounds different from those of the majority population may view this intervention as an intrusion. Thus, an understanding of these different families and their value systems is necessary before positive intervention can occur.

At the first National Conference on Child Abuse and Neglect, the impact of implementing a child abuse and neglect law was reviewed in one workshop, "One Law/Many Child-Rearing Cultures." The workshop report stated:

"Laws, in general, are culturally unbiased and their working is often neutral. To interpret and apply laws with sensitivity, however, one needs factual knowledge and understanding, not only of the laws, but also of the persons and cultures to whom the laws apply. Unfortunately, many people, including many of those who interpret and apply the law, are shortsighted in their cultural view, they cannot see beyond their own culture's attitudes, values, and expectations."[6]

More important, the panel concluded that "one of the dangers of current child abuse legislation is that it can be used, even unwittingly, to coerce minority groups to conform to the majority culture's standards and to punish those who do not conform."[7]

It is clear that each child protective service agency must strengthen its capacity to provide effective services to the various cultural groups within its jurisdiction. A variety of resources have been developed to assist agencies in training workers and administrators to become more sensitive to and understanding of minority cultures.[8]

Comprehensive in-service training should include identification, by staff members and administrators, of cultural values and practices that will lead to the development of policies and guidelines sensitive to the cultural pluralism aspect of childrearing by various cultural and ethnic groups. Such training should be based on current findings of minority/ethnic researchers. It is essential that cultural values and mores of various ethnic groups be recognized and supported by agencies in their efforts to rehabilitate and strengthen families.

In addition to in-service training, CPS agencies should examine other options to improve staff members' sensitivity to cultural pluralism. For example, child protective service agencies can actively recruit and train minority workers as service providers and supervisors, and they can use training materials developed by minority scholars and practitioners to assist their in-service training efforts and case consultation for culturally diverse families.

Indeed, it has been NCCAN's experience that the input from minority and ethnic organizations has broadened our perspective on the cultural styles of families in our society. Although many consider the United States to be a "melting pot," it appears that cultural traits and mores are woven into the fabric of social/ethnic group members and that merely coexisting with another social environment over time does not undo that fabric. However, the inclusion of minority/ethnic members as workers, supervisors and administrators will assist child protective service agencies in more adequately responding to clients who are not of the majority culture.

Community development is another option that child protective service agencies can employ as a means of becoming more culturally responsive. In many communities, committees have been established by policymaking and service organizations to encourage community members' input into the development of pol-

icies and programs that affect their lives. Child protective service agencies should establish similar committees to advise them on how they can demonstrate greater sensitivity to certain community groups. Such committees can work to enhance the relationship between the agency and cultural populations.

Another option for local child protective service agencies is to encourage and support the development of minority and ethnic agencies and coordinate activities with them to better serve families. As Leon Chestang suggested, "In many instances agencies developed and controlled by blacks have served an interpretative and/or pilot function in relation to traditional agencies."[9] Thus, child protective service agencies can benefit by supporting minority/ethnic agencies and according them the same degree of credibility and professional respect that they themselves enjoy.

Finally, child protective service agencies should establish contracts and/or working agreements with minority/ethnic agencies as a resource to aid in the treatment plan for their clients. These contracts and/or agreements could help to instill trust betwen the agencies, which would be of paramount importance in their future capability to address the needs of their culturally diverse constituents.

[1]S Shyne, *National Study of Social Services to Children and Their Families*, DHHS Pub No (OHDS) 78-30150

[2]W W. Nobles, *A Formulative and Empirical Study of Black Families Final Report*, Washington, D.C , U.S. Department of Health, Education and Welfare, 1976.

[3]T R Boulette, "The Spanish Speaking/Surnamed Poor" *Child Welfare Strategy In the Coming Years*, DHHS Pub. No. (OHDS) 78-30158.

[4]Nobles, op cit.

[5]F G Schneiger in J Red Horse, "Culture As A Variable In Human Services," *Child Abuse, Neglect and the Family Within a Cultural Context*, DHHS Pub No (OHDS) 78-30135

[6]D. Hirsch and C Blanchard, *Proceedings of the First National Conference on Child Abuse and Neglect*, DHHS Pub No (OHDS) 77-30074

[7]Ibid

[8]See, for example, T.T. Lasater and F.F. Montalvo, 'Understanding Mexican American Culture. A Training Program, ' CHILDREN TODAY May-June 1982 and A Wilson, "Accomplishments of the Five National Child Abuse and Neglect Minority Resource Centers," Dec 1981, unpublished Limited copies available from NCCAN, P.O. Box 1182, Washington, D.C 20013

[9]L W Chestang, "The Delivery of Child Welfare Service to Minority Group Children and Their Families," *Child Welfare Strategy In the Coming Years*, op cit

Developmentally Disabled, Abused and Neglected Children: A High Risk/ High Need Population

by Mark D. Souther

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Numerous studies have documented the cause-effect relationships between maltreatment and handicapping conditions in children. Shocking examples of the "Battered Child Syndrome" are published daily in the nation's newspapers, and there is no doubt that severe and extreme conditions of neglect may lead to permanent physical, mental and emotional damage. Thus, abused and neglected children are frequently at risk for developmental disabilities.

Child maltreatment is predominantly characterized as a problem in family dynamics. In addition to the "normal" sources of tension faced by families, the child who is different, difficult or has a special need places considerable additional demands upon a family's men-

tal, physical, emotional and financial status. Families with already limited resources simply may not be able to cope with the additional burden of a handicapped child. Thus, handicapped children are frequently at risk of abuse or neglect.

A study now being conducted through the University Affiliated Center for Developmental Disabilities at West Virginia University and the West Virginia Department of Human Services, under a grant from the National Center on Child Abuse and Neglect (NCCAN), has demonstrated a high rate of coincidence between child abuse/neglect and developmental disabilities. In a sample of 125 children receiving protective services in two West Virginia counties, 86 (or 69 percent) of the children were found to have one or more disabilities, including emotional disorders, specific learning disabilities, speech/language impairments and mental retardation. Results from a statewide survey of 263 child protective service workers, completed last December, indicate that in 35 percent of the client children, the conditions of abuse or neglect have resulted in handicapping conditions. The survey also revealed that in 37 percent of the children handicapping conditions have been a possible contributing factor to the occurrence of abuse or neglect.

Four-year-old Mark, for example, had been referred to the Department of Human Services by a neighbor who had noticed cuts and bruises on his face. Upon investigation, the CPS worker noticed healing marks, probably made by a switch, on Mark's legs and fading bruises on the side of his face and neck.

His mother, 29, who had recently been divorced, admitted that she used switches and slaps to the face as punishment. "Mark is too dumb to listen and he never pays attention," she said. She also reported that Mark didn't play with neighborhood children. During the initial visit, Mark wouldn't speak to the CPS worker or respond to his mother.

After deciding to open the case for services, the worker took Mark's medical and behavioral history and attempted to administer a developmental assessment. However, Mark would not respond, and his mother again stated that he was too dumb and that he had always been that way.

The worker arranged for Mark to be seen by a pediatrician at the County Health Department, who gave him a complete physical examination and developmental assessment. It was subsequently determined that Mark, in fact, had a significant hearing impairment and associated delay in language and social development. His mother was very surprised to learn that Mark had a handicap and her attitude toward him began to change when she realized how it affected him.

Mark was scheduled for corrective surgery, and the mother has continued to receive counseling on alternative means of administering discipline and on developing more appropriate means of communicating with her son.

* * *

In order to more adequately meet the needs of developmentally disabled, abused and neglected children, the West Virginia Department of Human Services is implementing systematic screening for developmental disabilities as part of the family assessment process for child protective services casework. The screening activities are expected to result in an increased awareness and recognition of developmental disabilities as factors contributing to family stress; early identification of specific developmental disabilities among the target population, more selective and expeditious use of local service providers, and descriptive statistics relative to the incidence of developmental disabilities among abused and neglected children. Training and implementation activities are also being supported by the NCCAN grant.

Other notable trends and issues that have been identified include the following:

- As child abuse and neglect has been described as a "family legacy," so too are certain types of developmental disabilities passed on to succeeding generations. Several children who are developmentally disabled and abused/neglected have thus fallen heir to a "double family legacy."
- In many instances, children had been identified as being both developmentally disabled and abused/neglected and were receiving appropriate services. However, the participating agencies were not coordinating their respective services, nor were they always aware that they shared the same clients. Because abuse/neglect and developmental disabilities impact upon the entire family, an integrated, multidisciplinary approach to working with the whole family is necessary.
- Just as it has been demonstrated that child protective service workers benefit from developmental disabilities training, so too would developmental disabilities service providers (regular and special educators and health and mental health personnel) benefit from increased knowledge of abuse/neglect recognition, referral and casework strategies. Ultimately, of course, the most important benefactors would be the children and families at risk.

The Revolution in Family Law: Confronting Child Abuse

by Howard A. Davidson

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In 1962 the "battered child syndrome" was first publicly identified. At about this same time, state mandatory child abuse reporting laws also first appeared, and soon every state had enacted similar statutes. Legislation since that time has resulted in a Federal child abuse act as well as comprehensive amendments to Federal child welfare laws. These developments have produced sweeping changes in the legal process of state intervention into the family.

Also in this 20-year span, juvenile and family courts and child protective statutory systems have been expanded, if not transformed. There are now about 150,000 to 200,000 abuse and neglect court cases annually—two cases for every thousand American children—according to the National Center for Juvenile Justice. At the same time, recent U.S. Supreme Court cases have affirmed the primary interest of parents in raising their children free of governmental interference. In addition, several legal scholars have criticized state involvement in child protection, which has led to significant statutory reforms and has given support to some leading judicial decisions.

But the greater demand for financial resources in the early 1980s has had a profound effect on the delivery of child protective and child welfare services. Furthermore, the number of families being assisted by public agencies has continued to increase, as has the reported incidence of child maltreatment. It has thus become more important than ever to study the impact that law has on the entire process of governmental reaction to child abuse.

Analyzing The Statistics

In 1965 the Children's Bureau, (DHEW) initiated a series of nationwide studies on child abuse, conducted within the Child Welfare Research Program of Brandeis University. Although limited to physical abuse, reports compiled in 1967 totaled about 9,500 Ten years later, reports to the American Humane Association (AHA)—of neglect and abuse combined—totaled over 500,000. Another two years later, the AHA had received over 700,000 reports of child abuse and neglect.

This increase is explained partially by the fact that in 1967 state mandatory child abuse reporting laws were still new. Few professionals listed in the laws as "mandated reporters" understood their responsibilities or how to exercise them. But during the following 10 years, state, county and local child protective service agencies developed a sophisticated ability to collect and process reports. Central registries of abuse and neglect reports and case data were promoted and widely established. In addition, the Federal Child Abuse Prevention and Treatment Act (42 U.S.C. 5801, *et seq.*) and the growing media awareness contributed to a mass consciousness-raising.

During this time, the medical community had to learn how to detect child abuse and what steps to take in abuse situations. Although reports from medical personnel have increased over the years, they still account for only 11 percent of the cases reported to child protective service agencies. The largest proportion of reports—close to 36 percent—come from friends, neighbors and other non-professionals.

In evaluating the 1979 data, the AHA found that a small proportion of the reports resulted in court action But over twice as many cases went to court when law enforcement personnel were the source of initial reports, and more cases involving child neglect were brought to court than for child abuse. Furthermore, sexual maltreatment of children—not widely discussed before the late 1970s—was three times as likely to lead to court proceedings as compared to other cases.

Cases that resulted in court involvement also were more likely to result in the provision of short-and long-term services to the family, and especially in the child's

removal from the home, according to AHA. By contrast, mental health, homemaker, and day care services were provided less often in cases that went to court. The AHA data also showed that families in the court sample were disproportionately burdened with problems such as alcohol or drug dependency, health problems of the caretaker and child, inadequate housing, social isolation, spouse abuse and a general inability to cope with the responsibilities of parenting.

Legislative and Judicial Reform

Although most states have amended their child abuse laws within the past 20 years, many statutes still fail to clearly or correctly define and limit when the state may forcibly intrude into the family, remove children, and sever the parent-child relationship. While proposed model laws have proliferated, including many from the Federal Government, some old state laws have been virtually untouched.

This, as well as the broadening of mandatory reporting laws, has caused the numbers of protective caseloads to skyrocket, which in turn has limited the agencies ability to provide prompt investigations, services, and casework supervision. In some states, lawsuits have been filed to address the agencies' failure to protect children or to respect the rights of the family. In addition, appellate courts have struck down portions of statutes, forcing some legislatures to redraft their child protection laws.

State intervention laws should be reformed to establish more precise legal definitions of child maltreatment. Some child abuse laws are still based on vague perceptions and archaic language, such as parental "depravity," "immorality" or lack of "moral care." Rather than make do with outmoded laws, state legislatures should enact ones that are socially responsive and that reflect current divergent values and conditions. New laws that adequately protect children *can* be written without resorting to the vague language that permeates many legislative schemes. Less subjectivity is needed, and catchall phrases like "without proper care" or "injurious to the child's welfare" should be replaced with specific kinds of mistreatment and criteria for determining whether a case belongs under a given category.

The legal profession also needs to help assure that necessary services are readily available to abused and neglected children and their parents. This is particularly true if those services can avoid needlessly separating children from their families. The costs of foster care certainly exceed the costs of parent aide, homemaker, day care, or other home-based services.

The limbo of indefinite foster care also can exert a great psychological penalty on children whose needs for stability in placement and long-term care are acute. Every child, therefore, who either has been, or may be, removed from home because of abuse, neglect or the incapacity of his or her parents should be the focus of careful and timely long-range planning by the intervening child welfare agency, as well as by the court.

We also need to reexamine the state laws that govern the judicial procedures used in child abuse and neglect cases. The lack of procedural due process of law occasionally has resulted in appellate decisions that reverse earlier juvenile court actions and declare underlying statutes unconstitutional. Some of the critical legal areas are:

- in many states, the lack of a requirement for court-appointed counsel for indigent parents (which may be a constitutional violation after the recent Supreme Court case of *Lassiter v. Dept. of Social Services*, 452 U.S. 18 (1981), as well as for independent representation of children,
- the frequent lack of a requirement of adequate notice to parents before juvenile court hearings occur;
- the occasional forcing of a "settlement" on the parents and child; and
- the common failure to assure by law that full hearings are held promptly upon the emergency removal of a child from his or her home.

At child abuse trials in juvenile court, procedural protections too often are lacking. During the adjudicatory phase of these proceedings, rules of evidence sometimes are ignored. For example:

- Opinion testimony is permitted without a proper foundation.
- Case records, reports of clinical evaluations and other documentary evidence are considered by the judge without copies first being made available to counsel for the parents and child.
- The right to confrontation and cross-examination of all witnesses is denied.

- The burden of proof inappropriately is placed on the parents to persuade the court that they are fit to care for their child.
- The child's wishes are not clearly articulated to the judge.

Need for Legal Expertise

Another problem in the child protective system is that judges and lawyers need to more effectively assist child welfare agencies in carrying out their responsibilities and to become more sensitive to the needs of children and families. Social workers who handle child protective cases also require a better understanding of the law and easier access to legal consultation. The National Center on Child Abuse and Neglect, the American Bar Association (ABA) and the AHA have been leaders in efforts to educate and assist child welfare workers. But there rarely have been adequate resource allocations made within child protective and child welfare agency budgets to assure that legal consultation and training needs are met.

Today, many public social service agencies lack their own legal staff and, therefore, depend on the district attorney's, county counsel's or attorney general's office to secure legal representation of their case workers. But these lawyers often are inaccessible when workers need to discuss the possibility of intervention, prepare for court or present their case to a judge.

To rectify this situation, research is needed to gauge the scope of the problem at the state and local levels. Agencies that are successfully utilizing legal help for education and support should be studied, and demonstration projects should be created to test various ways of meeting the legal needs of social workers.

We also must not ignore the need for quality representation of people in the education, mental health, and medical professions. Very few public school systems or large municipal hospitals have full-time attorneys on their staff specifically to provide consultation to personnel on child welfare-related legal issues.

Preparing a lawyer for work in the child protection field should start in law school. Students increasingly are beginning their legal education with prior work experience in human services. Juvenile delinquency courses have been common since the 1960s, and broad family law courses are available at most schools. But few law schools offer special courses or clinical opportunities specifically related to state intervention into the family.

We need to develop a model curriculum that could be used to teach a specialized law school course in child protection litigation, which also could be adapted for graduate students of social work. In fact, universities with graduate schools of both law and social work should explore not only the possibility of joint-degree programs, but also the opportunities for cross-fertilization and sharing of ideas and backgrounds.

In addition, clinical education programs that can give law students a chance to actually handle child abuse and neglect, foster care review, or other child welfare cases must be expanded, for which models already exist at several schools. Government and foundation support should be available for law school legal assistance clinics that demonstrate effective use of students in representation of children, parents, or child protective agencies.

Continuing legal education programs also need to be prodded to devote attention to the child welfare area. The best targets are states that require mandatory continuing legal education and that search for new ideas to add to their curricula, beyond the regular criminal practice, taxation and other programs traditionally offered by CLE projects.

Judicial Improvements

Few educational programs have been provided to train judges on the practical aspects of handling child abuse and neglect cases. Where training programs have taken place, such as in New York, Massachusetts, South Carolina and Reno, they have been quite successful. Several of these programs were cosponsored by, or organized with help from, child protective agencies. Because state legislatures or county commissioners rarely allocate adequate funds for judicial education, chief administrative judges have been inhibited from developing such specialized programs. They may therefore need financial assistance from the federal government or the private sector to undertake this training.

Another important child protective reform is the consolidation of all state intervention cases and intrafamily conflict cases within one specialized court system. While cases involving children and families usually are heard in courts of general jurisdiction, they also are handled in juvenile courts, probate courts and other judicial forums. This lack of consistency in the way child abuse and termination of parental rights cases are handled from court to court causes much confusion. In addition, the court that handles a child abuse matter may be different from the court with jurisdiction over a termination proceeding, custody dispute, or adoption case.

Unfortunately, juvenile court assignments, or the hearing of juvenile cases as part of a full range of criminal and civil actions, often are considered less important within the framework of the judiciary, and these positions go to judges with the least seniority and experience Rotating judges in and out of juvenile and family court positions is common. The result is that once the judges become familiar with the system, they must move on to other areas Although rotation of judges often is favored over an indefinite tenure on a specialized court, most experts would oppose the 3 to 6 month rotation that is so common today. In addition, some judges are assigned to juvenile or family court without having demonstrated a special interest in the social and legal problems of children, youth and families.

The ABA House of Delegates, in approving the *Court Organization and Administration* volume of its Juvenile Justice Standards, has supported the creation of a special family court division of the highest court of general trial jurisdiction of each state In doing so, it has joined with recommendations of the National Advisory Commission on Criminal Justice Standards and Goals and the U S Department of Health and Human Services to broaden the scope and increase the strength of the juvenile court by giving it jurisdiction over a wider array of family-related legal problems.

Representation of Children

Before 1967, when the Supreme Court issued its historic *In re Gault* decision, 387 U.S. 1 (1967), lawyers for children were rarely seen in juvenile courts. But that case, which held that court-appointed counsel for children in delinquency proceedings is essential as a matter of constitutional law, failed to state whether legal representation, a court-appointed advocate for the child often and neglect cases As a result, many children who are the subjects of maltreatment or related termination of parental rights proceedings do not have a lawyer as a matter of right; it is within the discretion of the trial judge to appoint counsel.[1]

Although a growing number of states are, through statutes, court rules or judicial decisions, assuring that abused and neglected children have independent representation, a court-appointed advocate for the child often faces both resentment and hostility from others involved in the case as well as confusion over his or her proper role. But no one would question a criminal defendant's need for a lawyer or that of a corporation being sued. Yet many people believe that the child protection agency and the judge are themselves fully capable of protecting the interests of the parties in child maltreatment cases.

Whether or not the child's court-appointed advocate is a lawyer, he or she needs to clearly understand the parameters of his or her responsibilities. But only a few state laws or court rules, as well as the ABA Juvenile Justice Standards, provide any guidance. Questions continue to be raised throughout the country concerning the proper function of a child's lawyer, guardian *ad litem*, or court-appointed special advocate.

We need to create a new field of specialization for those concerned with representation of children, in order to provide a focus for the resolution of such difficult questions. We also need an acceptable code of ethics or professional conduct for those who would undertake the task of advocating for children in court. Don Bross, founder and executive director of the National Association of Counsel for Children, has suggested the creation of a legal specialization called "pediatric law," in which lawyers would be well versed in all children-related areas of the law. This organization has become a leading force in the improvement of legal skills relating to child protection.

Room for Reform

The ABA has been instrumental in creating, and pointing appropriate criticism at, the system of state intervention and has proposed elaborate remedies for many of the system's ills. The Association also has been at the forefront of legal efforts to assure the protection of children from serious abuse and neglect.[2]

But the profession also should become more involved in community-based interdisciplinary councils and other local activities related to child abuse and neglect. Special bar committees can be created to formally examine state intervention issues, explore law reform options and develop legislative proposals. We also need a concerted approach by the bar towards improving the legal repre-

sentation of parties in child maltreatment cases. Finally, the bar can monitor compliance with Federal child welfare laws, such as the Adoption Assistance of Child Welfare Act (P.L. 96-272), to assure full implementation at the state and local levels.

The protection of children through the legal system, however, only can be achieved if we aggressively pursue our responsibilities to children, parents and child protective agencies alike.

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[1]For further discussion of these issues, see "The Guardian Ad Litem: An Important Approach to the Protection of Children" by Howard A. Davidson, CHILDREN TODAY, Mar.-Apr. 1981 and "Special Child Advocates: A Volunteer Court Program" by Michael Blady, CHILDREN TODAY, May-June 1981.

[2]The American Bar Association has produced a variety of publications about child abuse and neglect. A list of publications is available from the National Legal Resource Center on Child Advocacy and Protection, ABA, 1800 M St., N.W., Suite 200, Washington, D.C. 20036

Efforts to Sensitize the Profession

Sensitizing and training lawyers and judges to help them professionally handle child abuse and neglect cases has been a major goal of the ABA's National Legal Resource Center for Child Advocacy and Protection.

Special child abuse projects involving over 40 state and local bar associations and other legal organizations have been created with modest grants—$1,500 to $4,000—from the Center. The Resource Center, a project of the ABA Young Lawyers Division, has developed three national training institutes, makes presentations at regular ABA meetings, and participates in educational programs of the National Council of Juvenile and Family Court Judges and other organizations as a means to reach large groups of legal professionals. The Resource Center also has assisted programs sponsored by social service agencies that have tried to reach lawyers and judges. While these programs have been too few in number, they have been uniformly successful.

An evaluation of ten federally funded projects providing representation to abused children has been conducted by the Center. In addition, special publications on the legal aspects of sexual abuse and exploitation of children have been developed. This is a particularly troubling form of child maltreatment.

The Military's Response to Child Abuse and Neglect

by Suzanne Nash

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The military services have made a major effort to deal with domestic violence issues, including child abuse and neglect, since the mid-1970s. Family advocacy and other health promotion programs to assist families in stress and to encourage healthy family lifestyles are manpower and operational issues. Domestic violence affects readiness and retention of trained and qualified personnel.

A number of military lifestyle factors may contribute to the incidence of child maltreatment. Mobility is a given for military families, who relocate an average of once every three years, often to overseas installations. Frequent absences of one parent can increase stress for the remaining parent. Many military families find themselves living from paycheck to paycheck or in debt, sometimes because of the excessive costs of frequent relocation. In order to make ends meet, many mothers must work, or the active duty family member may have to take a second job. Foreign-born spouses have added language and cultural differences to deal with, and young couples away from home for the first time often lack basic parenting and communication skills as well as family support.

The Tri-Service Child Advocacy Committee was established in 1975, and in 1981 Department of Defense (DoD) Directive 6400.1 expanded the committee's scope to include other forms of familial violence. The Family Advocacy Committee is made up of DoD, Army, Air Force, Marine Corps, Navy and Coast Guard representatives who oversee and coordinate family advocacy policy at the Department of Defense level and support the individual services' efforts. The directive

also sets forth a 3-pronged multidisciplinary approach to dealing with the problem of family violence in the military. a general educational effort, specific programs for high-risk families and treatment for abuser and victim. The Family Advocacy Committee has targeted the following goals: identification and resolution of jurisdictional issues between military and civilian authorities; the development of a model family advocacy program (based on installation size, needs and resources and including primary, secondary and tertiary services and identification of sources and recipients of services); development of a common data base, reporting format and terminology, and program standards and evaluation criteria.

The services are providing their own regulations to fulfill the mandates of the directive and provide their own training, command and community awareness, treatment and proactive programs. All of the services are involved in extensive training of the professionals dealing directly with families. Although the services' approaches are not identical, most provide for a family advocacy representative at each installation to coordinate case management efforts and administer the day-to-day operations of the installation's family advocacy committee. These multidisciplinary committees are made up of medical, family service, social work, law enforcement, legal and command representatives and others involved with family support and intervention (often including child care, youth activities and school personnel).

Emphasis is on care and support for the entire family unit, and rehabilitation is the option of choice, although prosecution and separation from the service are possible. Also stressed are establishment of formal working and jurisdictional agreements with local and state authorities and coordination of services with civilian communities.

The Hawaii Demonstration Project, one example of multiservice cooperation, is funded by all of the services and combines military programs and resources with those of civilian agencies. Its components are mandated treatment during duty hours for those identified as abusive; outreach to high-risk families, including prenatal care and assistance to families with children born prematurely or with birth defects; and a joint-service abused spouse shelter (with a child development specialist on its staff). In addition, an evaluation of the entire project is being conducted.

The success rate of the treatment program for active duty personnel is 80 percent, and 70 percent of those in the program choose to continue beyond the required time. Command support has been a key element, with commands stressing that abuse will not be tolerated.

The Military Family Resource Center (MFRC), funded in 1980 as a demonstration project by the National Center on Child Abuse and Neglect, has established a clearinghouse on programs, training and research on the military family (with an emphasis on family advocacy) for those dealing with policy issues, managing programs and providing direct services to military families. The MFRC has also fostered cooperation among the services and with civilian agencies and, as a result of its success, will become an agency of the Department of Defense at the beginning of fiscal year 1985.

Programs and Projects

Working With Neglecting Families

by Marilyn Hall, Angelica DeLaCruz and Peggy Russell

Marilyn Hall served as manager of the Child Neglect Project, Children and Youth Project, University of Texas Health Science Center, Dallas. Angelica DeLaCruz and Peggy Russell were social workers with, respectively, the Children and Youth Project's Saldviar Children's Clinic and the Carver Children's Clinic. Their article is reprinted from CHILDREN TODAY, Mar - Apr., 1982.

At times all parents experience some guilt over not providing for their children's needs and wants. It may be not buying that extra costume for dance class, or not listening carefully enough to your child's woes while you are busy preparing supper. This is a normal part of parenting. However, there are parents who continually fail to provide for their children's needs, and usually in many ways. These failures eventually affect the child's health and/or development adversely. Characteristically, these parents do not feel guilty over their omissions, and often simply fail to recognize the harmful consequences of the chronic neglected state of their children.

These families are not rare. In 1978 the American Humane Association counted nearly 47,000 substantiated cases of child neglect.* These are only the cases that have come to the attention of child protective services agencies. One wonders how many neglected children and their families are distressed and not receiving any help or guidance. The neglecting families who are brought to the attention of human service professionals usually are considered the most difficult to treat. The chronic and severe multiple problems that characterize neglecting families drain agency resources and staff time and energy. Often, agencies hesitate to take on these cases because of the tremendous demands they make and the poor prognosis for change.

Staff members of the Children and Youth Project of the University of Texas Health Science Center at Dallas are acutely aware of the problems involved in treating child neglect and sought to demonstrate a cost-effective treatment of the problem through a demonstration project supported by a grant from the National Center on Child Abuse and Neglect. Project staff members believe it offers an optimal setting to treat these difficult families. Its location, the types of services provided, the method of delivery and the use of a multidisciplinary team approach to care all contribute to maximizing treatment outcomes.

The C & Y Project operates through three clinics located on school grounds in a low-income, public housing area of West Dallas. Two pediatric clinics serve all residents from birth through age 12 and the adolescent clinic serves the 13- to 18-year-old group. Combined, the clinics treat over 12,000 children and youth, providing both health maintenance services and acute care to all registrants.

Health care is a primary need of this population which, prior to the C & Y Project's intervention in 1970, was characterized by high infant mortality, morbidity and hospitalization rates. Such a situation is not unusual in urban settings where there is an area, like West Dallas, populated by families whose income is below poverty level, who often live only by public assistance in substandard, high-density housing and who constitute one of three minority groups (black, Mexican American and Southeast Asian).

Clinic staff members are particularly sensitive to multi-problem families and have developed systems to locate new or non-registrants and to follow up on missed appointments. Staff nurses make visits to the homes of all newborns to identify immediate problems and schedule an appointment to register the family at

the clinic If a registered family misses an appointment, the clinic's social worker visits the home. High risk families (such as neglecting families), who traditionally drop out of service systems, are identified and closely monitored.

The multidisciplinary team approach has been the model used to deliver comprehensive health care to children of the community. Each clinic is staffed with a full-time pediatrician (or adolescent specialist), two pediatric nurse practitioners, one licensed vocational nurse, a social worker and supportive clerical staff. Rotating through the clinics are a psychologist, nutritionist and rehabilitation specialist. An attorney consults on legal issues pertaining to child abuse and neglect cases Two of the clinics provide comprehensive dental services and the project subcontracts home-maker services from the local Visiting Nurse Association as needed The multidisciplinary team approach to health care provides multiple resources under one roof and a concentration of staff energies necessary to work with the demands of neglecting families.

The first job of the Child Neglect Project, which began in 1978, was to develop an operational definition of what exactly constitutes child neglect. Staff members perceived neglect to have two main characteristics: It was often a chronic, long-standing problem and it most likely permeated several aspects of a child's life or was so severe in one area it could endanger that life.

With this in mind, project staff members developed an instrument called the Child Neglect Severity Scale that qualifies and quantifies nine categories of child neglect: abandonment, health care, nutrition, supervision, personal hygiene, clothing, shelter, emotional neglect and education [2] The Scale offers both area subscores and a cumulative score. Several of the nine areas include subcategories which involve a total of 21 items (categories and subcategories included). For example, the category of emotional neglect incorporates the subcategories of stimulation, expectation, nurturance and discipline.

Since the level of care a child receives is not absolute, but rather on a continuum, each category and subcategory is explicitly defined according to four levels of care: no problem, mild, moderate and severe neglect. Thus, it is possible to obtain a profile of a family's strengths and weaknesses, as well as a cumulative relative score of the level of neglect. The scale is used in two ways—as a diagnostic tool (to delineate problems and strengths) and as an evaluative tool (to measure change over time).

Neglected children are usually identified in such settings as health facilities, day care centers and schools, or by neighbors. For a number of reasons, a parent will rarely seek help. Neglecting parents (the mother, in our experience) are usually oblivious to the negative effects their omissions have on their children. They often live isolated either physically or emotionally from their extended family and the community. Initially distrustful of intervention efforts, they want to be left alone.

A social worker's first contact with neglecting mothers is usually met with apathy or suspicious but controlled anger. However, once a worker breaks through the initial barriers and establishes a relationship with the mother, he or she finds a scared, frustrated, needy and dependent person who will readily engage with a nonauthoritative and patient individual. Building that trusting relationship is a delicate task.

Intervention

The first step toward engaging a neglecting parent in treatment is to determine a neutral point of intervention. Accomplishing this depends upon the worker's ability to determine what the mother perceives her problem to be, *not* what the health professional or other worker thinks the child's problem is. Telling a neglecting mother that she is not feeding her child correctly, for example, or showing her a declining growth chart only reinforces her poor self-concept and feelings of inadequacy—and makes her withdraw even more from services. However, if the intervention effort is directed first toward the mother and her problems, the effect on the child will eventually be positive. This approach is most effective in situations in which a child's life is not immediately in danger.

This intervention strategy worked effectively with Mrs. Smith, the mother of five children ranging in age from one to 14. A protective services worker had initially contacted the clinic to obtain health services for the children. Visiting the Smith's home, the clinic social worker found the mother and her children, together with Mrs. Smith's brother and father, living in a vermin-infested, 3-room wood frame house with no working utilities. At this time, Mr. Smith was in jail, although he did appear at times during treatment to exacerbate the neglecting situation.

All of the children had major health problems; the diagnosis for the two youngest children was failure to thrive. The children were either not clothed or wore ill-fitting, filthy rags. The two oldest, ages 8 and 14, were not registered in school, and neither the parents nor the school system were successful in getting them to attend.

A variety of emotional and social problems were also prevalent among the children; mental retardation in the 14-year-old; theft and running away in the 8-year-old; the 3-year-old was not toilet trained; and the 2-year-old had no language. The siblings were known to abuse one another physically; their injuries ranged from bite marks to first-degree burns. All of the children lacked social controls and responded to the world in a totally unsocialized way.

The protective services worker felt that he had provided every available service to the family, but he wanted to try a homemaker to see whether the mother could improve the children's physical and nutritional environment. However, the mother had continually refused the offer, saying that she did not need anyone to help her with her house, especially someone who would "spy" on her.

With the protective services worker's cooperation, the project social worker approached the mother from a neutral intervention point—the medical clinic—and encouraged her to talk about what disturbed her the most. Much to everyone's surprise, her most distressing concern was to "get protective services off my back"; she thought she could do that if she could only get the two oldest children to go to school. The social worker renewed the offer of homemaker services, explaining to the mother that the homemaker's specific purpose was to come early every morning and help get the children off to school.

Mrs. Smith readily accepted the offer. Gradually, as she began to trust the homemaker and social worker, Mrs. Smith agreed to have the homemaker's time extended to help her in cleaning the house, cooking nutritious meals and managing her children.

Another mother who continually neglected to give her child medication for a major health problem was found, on a home visit, to be living in overcrowded, deplorable conditions and in a conflicting relationship with her husband. The mother's main concern, however, was how she could obtain Christmas presents for her children. Once the social worker was able to acquire gifts from local churches and the Salvation Army, the mother could accept the social worker's visits and gentle approaches to helping her with many other problems.

On another occasion, a social worker making a home visit was greeted by an angry mother who bodily lifted her into the house and proceeded to scream at her about all the personal injustices she had experienced. As the tirade diminished, the worker was able to empathize with the mother's dilemma, which allowed her to express her greatest concern, her obesity. From there, a treatment plan could be devised.

One of the most successful intervention strategies with a neglecting mother is to accept her on her terms and interact with her in her own environment. Relationships are built in agency waiting rooms, cars, laundromats and neighborhood grocery stores—wherever a family can be contacted.

All project workers report a "click" in their relationship with mothers when trust is gained. Sometimes it takes months and repeated home visits; at other times it can occur in a daylong wait at a clinic. However long it takes, once it occurs the social worker knows that the mother is ready to take some serious steps into treatment.

Treatment

Members of each clinic's multidisciplinary team together evaluate each neglecting family to diagnose the multiple problem areas and develop a treatment plan. Once a plan is implemented, it is reviewed at intervals—ranging from weekly to every six months, depending on the problem—to monitor changes and to modify the plan in accordance with the family's changing needs. Resources provided by other community agencies—housing, day care and supplemental food plans, for example—are often needed for neglecting families, and staff members of other agencies involved with the family are also included in the project's case planning.

The case of the Brown family illustrates one treatment plan.

Ms. Brown, age 18, and her 4-month-old son were brought to the attention of the neglect project by health clinic staff who had observed several problems: the baby's poor weight gain and feeding problems: the poor personal hygiene of both mother and child; the mother's inappropriate expectations of child development (spanking as a way of disciplining an infant, for example); and unstable residence (mother and child rotated living with parents, friends and relatives).

Under the treatment plan, the Browns were referred to a neighborhood parent-child center, where both mother and child received two prepared meals a day. Additional food was provided by the clinic's WIC program, thus alleviating lack of food as a cause of the baby's low weight. Since the parent-child center also offers supervised instruction and modeling in positive parent-child interaction, workers there assisted the clinic worker in helping to teach the mother appropriate responses to her child's developmental stages and mod-

eled successful feeding techniques—steps toward resolving two other problems.

Since poor hygiene is more often a symptom of a problem rather than a problem itself, project staff members decided not to work directly on that area. Invariably, personal care improves as other problem areas are resolved.

The family living arrangement was a long-range problem involving major difficulties in the mother's interpersonal relationships and self-concept. Ms. Brown was considerably immature and sometimes rebellious. She felt quite alone in the world.

Staff members learned that the best approach with Ms Brown was the type of gentle, playful back-and-forth bantering that is often effective with young adolescents In frequent but informal sessions with Ms. Brown—at weekly medical appointments to check her son's progress, for example—the clinic's social worker always made a point of "visiting" with Ms. Brown. The worker discussed whatever the mother was interested in talking about, boyfriends, new clothes, how tough her child was or the unfair treatment she received at home All talks were low-keyed and nonthreatening and were structured in such a way as to include personal humor and positive remarks concerning any part of the mother's life—her mothering skills, the child's weight gain, personal care, clothes and attendance at the center, for example. Gradually, Ms. Brown began to seek out the social worker for help and advice.

The Brown's case was reviewed monthly for any necessary changes in the treatment plan and progress recorded After over a year of treatment, the child's weight gain became medically stable and the feeding problem was resolved. The center and clinic staff also noted marked improvement in the mother's interaction with her child, especially in disciplining him. She also displayed a more mature approach to life by being able to solve problems, follow instructions and meet appointments Her personal hygiene improved dramatically and her residence stabilized.

After a family's situation has stabilized, the case is reviewed every six months. Cases are not terminated—all children cared for by the clinics are on the caseload until they are 18 years old or move out of the target area.

Outcome

Successful outcome with a neglecting family is difficult to determine. Is terminating parental rights and placing children for adoption considered a successful outcome? Or is success a mother who now sends her child to school regularly but continues to live in filthy, hazardous and chaotic surroundings? Should all parents be expected to provide a minimally acceptable standard of child care, or are slow, successive approximations toward that level considered adequate? If so, what is the minimum acceptable level and how long should the parents be allowed to work to attain it—while the child's time clock ticks away?

These are some of the questions that are of primary concern to the project. Staff members feel strongly that all cases must be objectively evaluated, rather than have outcomes based purely on subjective viewpoints or personal values. This objective evaluation is being done with 40 test families every six months during the 3-year period of the grant. The evaluation is reviewed from the child's perspective, since a child has no control or defense against parents' continued omissions of care.

Outcome evaluations can be either global ratings from a knowledgeable group with respect to the previously delineated problem areas, or outcome can be measured using objective tests or tools. The project, in conjunction with measures in the medical charts (growth charts, hematocrit), uses eight tools to evaluate outcomes. One such measure is examining videotaped sequences of the mother interacting with her child. Unbiased raters score these tapes behaviorally, looking at any changes in the quality and quantity of the interaction over time. Other areas being measured include the child's behavior, the social worker's perception of the mother, the mother's personality characteristics, the mother's outlook on life; the child's perception of life, the child's locus of control; and the child's intelligence.

Data collected over the 3-year period are now being analyzed and results will be available later this year.

Families are the nurturing centers for the development of our children today. It is important that these children receive the necessary support, acceptance and opportunities for personal growth in their interaction with their world. When this is thwarted, it is imperative to intervene early and quickly in order to interrupt chronic generational neglect, and to help parents and children work together in meeting the growing demands of today's world.

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*American Humane Association, *National Analysis of Official Child Neglect and Abuse Reporting*. Denver, Colo., Denver Research Institute, 1978.

The Family Support Center: Early Intervention for High-Risk Parents and Children

by Yvonne L. Fraley

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Depressed, apathetic, isolated parents overwhelmed by stresses and low self-esteem are often distrustful or fearful of the very programs designed to help them. They may well avoid Head Start, for example, anticipating rejection and criticism of themselves and their children, or being too apathetic or disorganized to get their 3-year-old ready for school five days a week.

By age three, however, the children have missed crucial developmental experiences. They are often developmentally delayed, particularly in communication, problem-solving, relationship and coping skills and/or the eye-hand coordination skills basic to reading and writing. In addition, they may have acquired the same self-defeating attitudes of their parents, particularly low self-esteem.

If these characteristics lead to early school failure, delinquency or adolescent pregnancy, a new cycle of poverty and impoverishment is begun.

The staff of the Family Support Center (FSC) in Yeadon, Pennsylvania, believes that abusive and abuse-prone parents need concrete help in reducing the stresses which overwhelm them. They need to experience helping professionals whom they can come to like, trust and accept as role models. They need to learn through practice new child-rearing behaviors. In order to do so, they need a loving, nurturing environment because they have usually experienced a lifetime of rejection, threats, criticism and other abuse.

In the meantime, as their parents slowly begin to change their behavior, the children need help from others in overcoming their developmental delays. A loving, nurturing first school experience can shape children's future attitudes toward school, teachers and themselves as learners.

The Family Support Center has developed a multiphase, multidisciplinary approach to intervene directly with parents and their high risk preschool children. Through home visits and a unique Family School, FSC has attempted since 1976 to change parents' patterns of child-rearing and remedy children's developmental delays. FSC has served approximately 250 families and 400 children.

Family Selection

Given limited resources, an abuse prevention program must target families who can be identified as at "high risk" of abuse, and who can be recruited to participate.

Certain personality factors and traits have been identified as common among abusive and neglectful parents. These include a special form of immaturity and associated dependency; extremely low self-esteem and a sense of incompetence; difficulty in seeking pleasure and finding satisfaction in the adult world; social isolation and reluctance to seek help; significant misconceptions about children and fear of spoiling them; a strong belief in the value of punishment; and serious lack of ability to be empathically aware of a child's condition and needs.

These characteristics have provided the basis for identifying families for FSC services. The explanation to potential referring sources includes description of these characteristics. For the media and potential participants, eligible families are described as those "under several severe stresses which can interfere with good parenting."

According to a stress sheet developed by the FSC research coordinator, families served have averaged seven stresses. Common stresses have included: parent abused as child; a mental health problem—for example, depression, suicidal behavior or poor coping ability—on the part of a parent; serious or untreated medical problem of parent or child; divorce or separation; inadequate

income; isolation from friends and relatives, change in living conditions within the last three months; single parent status; and a developmentally delayed or chronically ill child.

About one-third of the families served have been clients of community mental health services.

Criteria For Eligibility

A family with a child four years old or younger is considered "at risk" and eligible for FSC services because of the presence or history of a combination of stress factors, plus one or more of the following factors:

- Actual verified abuse or a suspicion of abuse on the part of a professional for which "hard" evidence is lacking.
- A parent reports regular use of physical punishment as the most frequent means of discipline or expresses fear of losing control and harming a child.
- A pattern of family violence is evident.

About one-third of the families served are referred by Children and Youth Service, the public child welfare agency Only a few families have been mandated to participate, but many have been offered services as an alternative to or as part of a treatment plan including other protective services.

About one-third of the families are referred by other community social service agencies, hospitals, clinics and pediatricians and one-third are considered self-referred—that is, they contact FSC after reading about it in the local papers or hearing of it from program participants.

Most community referrals begin with an exploratory telephone call to FSC to determine whether the client is eligible The referral source then approaches the parent and recommends the services. A community nurse or protective service worker may take the initiative to arrange for a joint home visit. However, most families are able to telephone to request the service themselves. This telephone call is usually followed by one or two home visits. Every effort is made to interview and involve both parents. If the parents decide against participating, they are referred elsewhere if possible and/or the referral source is advised.

Phase I: Counseling Services

Since most of the new families are not sufficiently organized or motivated to sustain office visiting, counselors go to their homes.

Following intake, families are assigned a casework or pediatric nurse counselor who visits weekly (or more frequently) to help the family set goals, reduce the stresses interfering with childrearing and prepare family members for FSC's Family School. This first phase may last from one to six months.

A goal achievement instrument is used to record the goals which the counselor and parent(s) agree to address—for example, improving the family's housing, using the court to obtain child support payments, improving the mother's health and reducing her isolation, bringing the children's innoculations up to date and gaining a better understanding of a child's health problem.

The parents' goals tend to be quite concrete and focused on their own problems. The counselor's efforts begin there. As the relationship develops, parents become more open to discussing their childrearing practices. Many parents are frustrated with a 2- or 3-year-old child who won't mind, or is not toilet trained, or bites and kicks. Focusing their attention on the unmet needs of younger children is more difficult.

Counselors bring 7-minute filmstrips on topics relatd to children's development and try to elicit some discussion around them.

The week before families are scheduled to enter Family School, parents and children visit the school for an hour, by appointment. The child is observed by the teacher and speech and occupational therapists. The mother or father is interviewed about the child's development and speech or motor evaluation is conducted when a child's development seems delayed. All of this information provides the basis for the child's Individual Educational Plan during Family School.

This visit also familiarizes parents and children with the school and staff members.

The entire staff of Family School meets three times during each cycle of Family School to assess the needs of each participating family member and to develop and coordinate educational plans: the week before Family School opens, in order to share the parent's needs and learning goals and the child's educational plan; at mid-term, to assess the degree of success or improvement and whether changes are needed in the goals or in staff members' efforts with parent or child; and the week after graduation, to assess changes and recommend follow-up treatment, counseling or education.

Each parent or parent couple meets with one or two staff members for a parent-teacher conference twice during Family School, once at mid-term and again the week before graduation.

Phase II: Family School

The most innovative service of the FSC is the Family School. One or both parents and all preschool children attend together for 13 weeks, two days a week from 9:30 a.m. to 2:30 p.m.—a total of 130 hours of parent and early childhood education. The program is held in a community church, Trinity United Presbyterian Church in Clifton Heights, Pa.

Parents with cars drive. Other parents pay part of the cost of van service purchased by the agency.

During Phase II; counselors continue to work with parents in their homes to assist families in resolving or mitigating stress factors. The counselors also participate in Family School staff meetings concerning each parent and child to help set realistic goals, keep Family School staff members informed of significant changes in the home situation and keep abreast of progress being made by parent(s) and children.

After the first week, parents spend the first 10 to 15 minutes of each morning in their children's classroom helping them make the transition and sharing with the teacher any significant change in the child. From arrival time until 10:00 a.m. is free time for parents and "free play" for children. Parents spend about 20 minutes unwinding from the morning pressures, talking informally with each other and enjoying a light, nutritious breakfeast served buffet-style in the dining room.

The Curriculum

The school uses a structured, educationally oriented parent curriculum developed by staff and tested with over 200 parents (see accompanying box). The goals of the parent education component are:

- To provide a supportive environment and teach parents how to create and maintain their own support systems.
- To enhance parents' self-esteem through social encounters, sharing of responsibilities, nurturance and experiential learning.
- To help parents form more realistic expectations regarding the development of their children.
- To teach several basic parenting skills—providing children with emotional support, setting limits, reinforcing positive behavior and stimulating children through play.

During "Breakfast Forum," from 10:00 to 10:30 a.m., parents listen to a staff member or community speaker and then discuss a childrearing topic, such as reading with children, helping children learn through play and keeping children well.

"Parent Child Interaction Time" follows the Breakfast Forum. This 45-minute period provides parents with opportunities to practice what they are learning while staff members observe unobtrusively, model appropriate behavior and compliment parents for their efforts and their developing skills.

Parents are carefully prepared for these experiences by an early childhood educator, who describes what they will do and what children can learn from the activities.

The 45 minutes is divided into three segments; "Circle Time," which includes typical nursery school activities except that each parent holds his child, helps the child to follow directions and learn the songs and games; "Planned Group Activities," including arts and craft projects, food experiences and water or sand play; and a 10- to 15-minute period in which each parent and child team engages in an activity suggested by the child's Individual Education Plan or the parent participates in the child's speech or occupational therapy.

During the half-hour following "Parent-Child Interaction Time," parents talk about their experiences with the parent educator.

The 20-minute preparation before "interaction time" and the half-hour follow-up discussion are very important.

Nutrition Education

A major part of the Family School program is nutrition education. Many families enter the program using food that is expensive and prepackaged—but low in nutrition. Each day parents and children receive a nutritious breakfast, lunch and afternoon snack. Emphasis is placed on introducing and demonstrating the use of fresh fruits, vegetables and whole grain foods. Children, parents, volunteers and staff eat lunch together; sharing recipes and eating together creates another level of ambience and peer support.

After lunch, half of the parents and staff clean up together, family style. Most parents are quite willing to help and seem to want to contribute something to the program.

From 1:15 to 2:15, parents engage in a group discussion led by the parent educator. The topics selected are integrated with the "Breakfast Forum" and "Parent Child-Interaction Time." Discussion is stimulated by roleplay, guided fantasy and discussion-provoking questions from the parent educator.

A graduation ceremony is held for parents. This is usually a very emotional time, with parents affirming their growth and their affection for each other and for the staff members and volunteers. Parents receive a certificate, a paperback book on childrearing, recipes from the cook and fresh flowers.

Phase III: Counseling and Peer Support Services

Phase III includes follow-up counseling for about three months after Family School is completed. FSC staff members help parents enroll children in Head Start or nursery school and parents who need ongoing counseling are referred to Family Service or a mental health agency.

Each class of Family School graduates has elected to form a peer support group and to continue meeting monthly with a staff member or volunteer as a resource person. Most groups have met for six months or longer. But friendships among graduates have lasted longer, achieving one of the FSC goals: to help families reduce isolation.

Funding

The Family Support Center originally received a 3-year grant (1976-79) from the Pennsylvania Department of Health to develop a child abuse treatment program. This was followed by a 3-year demonstration grant from the U S Bureau of Education for the Handicapped, supplemented by two 1-year grants from the Pennsylvania Department of Health, to develop a program for handicapped children. In addition, between 1978 and 1981, FSC received a Child Abuse Prevention Grant from the Office of Human Development Services, DHHS.

Since the last of these grants expired in October 1981, the Family Support Center has continued its child abuse prevention and handicapped children's programs with corporate and foundation grants and private contributions, but at a reduced level.

Conclusion

According to a 3-year evaluation, the Family Support Center's intervention strategy can help stressed, dependent, isolated parents considered to be at high risk of abuse and neglect improve childrearing practices and learn to provide their children with the experiences and skills necessary for school success and eventual self-support.* The study found that the program can reduce abuse and neglect, substantially reduce the need for costly out-of-home care and help to maintain and strengthen family life. It is also cost-effective.

**Family School Curriculum*

The *Parent Education Curriculum of Family School*, published by the Family Support Center, contains 78 hours of instruction designed to strengthen parent involvement in the education of their preschool children.

Divided into three subsections, the curriculum includes 22 half-hour presentations on such topics as health, nutrition and children's feelings; 25 one-hour sessions of experiential exercises and discussions, and nine sessions to prepare parents to teach their children, through play, in the classroom.

Copies of the curriculum are $10.00 each, plus $2.00 postage and handling for the first copy and $1.50 for each additional copy. The curriculum may be ordered from the Family Support Center, 2 Bailey Rd., Yeadon, Pa. 19050.

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*Family Support Center, *A Demonstration of An Abuse and Dependency Prevention Program for Infants and Preschoolers*, Yeadon, Pa., Family Support Center, 1981, and K A Armstrong, "A Treatment and Education Program For Parents and Children Who Are At-Risk of Abuse and Neglect," *Child Abuse and Neglect*, Vol. 5, 1981.

Working Together to Treat Adolescent Abuse: Community Agencies Form A Consortium

by Michael Baizerman, Nan Skelton and Shirley Pierce

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A consortium of public and private social and health agencies and private practitioners has served abused adolescents in St. Paul, Minnesota, for one year. The service model works; it meets current demands for lower cost services, minimal government participation and increased public-private cooperation, and it can be replicated in other communities. This article explains how the consortium developed, how it is structured and how it works to provide services to abused adolescents.

Brief History

In December 1975, the National Institute of Mental Health (NIMH) co-sponsored a 2-day "Workshop on Adolescent and Youth Abuse and Neglect" at the University of Minnesota.[1] Soon afterward, NIMH funded a small demonstration program to develop ways of providing services to these youths. The projects also examined the similarities and differences between the phenomena of child and adolescent abuse and neglect.

Ramsey County (St. Paul, Minn.) received one grant and created an adolescent unit in Protective Services, which worked directly with the county Child Abuse Team (then directed by Shirley Pierce). Face to Face, a private St. Paul youth agency offering health and counseling services, began direct services using its own and some county funds. Its director, Nan Skelton, emphasized public education about adolescent abuse and neglect and developed posters and flyers. She talked to young people in the schools and to parent groups and supervised the making of a video presentation in which adolescents talked about their own physical and sexual abuse.

Later federal support was directed to linking abuse services with programs for runaway youth and to enhancing efforts to document and understand adolescent abuse and to finding models of direct service.

St. Paul agencies participated in some of these efforts, as did several other agencies in the metropolitan St. Paul-Minneapolis area. As a result, an awareness of the phenomena of adolescent physical and sexual abuse existed in the community, service models were designed and direct care was offered.[2] All of these experiences made possible the creation of the interagency consortium when public policy and public funding changed.

Public Policy Changes

Profound changes in public policy at all levels have occurred during the last two years. In the domain of socio-health services, emphasis has been on a dramatically reduced governmental role, with a concomitant diminution in public program funding, service evaluation and regulation. The private sector was expected to fill some areas where government used to be and initiatives by private individuals, groups and organizations acting voluntarily and in concert were to be the source of new policies, funding and accountability.

Ramsey County, like other governmental units, reexamined its funds, fiscal sources, public needs and wants, and the capacities of others to meet them. Here, as elsewhere, processes were created to change public priorities and to redirect and reduce public spending. Many in the human services fields feared needed services would be harder to deliver; many foresaw a shrinking human services system and the possible death of their own agencies. Many worried about their jobs and futures. This climate of mourning was the environment in which the consortium was envisioned and created.

This climate, however, also afforded an opportunity to highlight the values and achieve the goals of "integrated services," of "agencies working together to provide services," of the uniting in common cause by public and private agencies, together with private practitioners The crisis legitimized the efforts of some to organize a consortium so that direct services for at-risk and abused adolescents could continue.

The Consortium

What is the consortium? As described in the proposal to Ramsey County to partly finance the Consortium of Child and Adolescent Abuse Services, its purpose was to develop an integrative, cooperative interagency network that would provide services to abused and neglected children, adolescents and their families.

The group of community service agencies would demonstrate "that community agencies can work together effectively and efficiently and, in turn, can work in these same ways with public agencies" and it would support Ramsey County "in its attempt to meet our community's abuse and neglect problems."

Consortium members pointed out how the county would benefit by allowing this model to be tried:

- The County Board could contract for service and gain a large resource network for a dollar outlay *less* than the then current county dollars allocated for abuse services.
- The consortium model would demonstrate that during this time of radical political, economic and social change, a model of *cooperation* between and among service organizations could reduce administrative overhead and more effectively serve a specific risk population.
- If the consortium and county could make this agreement work, it could serve as a model that could be replicated locally.
- Where there is potential for abuse, children and adolescents would have access to an intervention and treatment system that would begin to reduce the cycle of abuse and neglect for the residents of the county.

Finally, it was expected that a close fit would be made with the county's abuse/neglect plan and activities The consortium would allow the county to focus services on a population with urgent needs, thus freeing the county's own resources so that county protective services could more effectively meet the highest priority cases.

It would offer a comprehensive coordinated secondary referral source and also serve as an early identification system for protective service referrals. Finally, by working in conjunction with county protective services, the consortium would expand the county's child abuse program Consortium Members.

The private agency members are Face to Face, a community youth agency with a history of work with abused adolescents, North End Rice Health Center, a community agency without an exclusive youth focus; Lutheran Social Service, a major private social service agency; and two local hospitals that have long been a basic unit in the county's child abuse network, Bethesda Hospital's Crisis Center and Children's/United Hospitals. The two public agencies are St. Paul Central High School and the Ramsey County Nursing Service. (The latter is staffed by public health nurses who do home visits.) The private practitioners include a psychiatrist (who directs, on a part-time basis, the hospital crisis center) and a psychologist with long experience in the child abuse field.

Each agency member was asked to participate because of previous involvement in adolescent abuse, because it employed individuals with particular skills or a history of work in abuse and/or because it had the specific resources needed—the schools, for example, had a "captive population" of youth, while Lutheran Social Service already had groups for wife abusers and a counselor who worked with adolescent, female prostitutes.

A small group concerned with these issues had orignally met with the director of each agency to discuss the proposed model. The model was presented as an emergent idea which would be given conceptual form by members and actual form in the day-to-day provision of services.

A service plan with client projections was agreed to and this was the basis of a grant proposal to the Ramsey County Board, which approved a grant of $63,000 for one year of services to about 300 adolescents (and their families). This is approximately 21,000 to 22,000 total contacts between agencies and clients, ranging from case-finding to after-care services. Included are acute cases closed by the Ramsey County Welfare Department and referred for longer-term care. Each agency and practitioner offers one or more of these services and, most important, once a client receives a service from a member agency, all the serices of other members are available without cumbersome referral. This is one of the contributions members make to the consortium. Member contributions more than match county funds when staff time, office space, travel and the like are added in. In this way, the county grant is increased and more services can be given per public dollar. In 1981, the consortium was a potential model. It became a real system in 1982.

Intake can be done by any of the seven member agencies. The intake agency is expected to sit with the

referring agency to insure that the reasons for referral are clear and to include that agency in a service plan, when appropriate. The intake agency decides whether it can do an assessment and if it cannot, the agency can ask any consortium member for assistance. This help is immediate. If consultation from other members is requested by the intake worker, he or she is responsible for insuring that this is given, quickly. The consultant meets with the intake worker to review findings and to plan services. Throughout the process, emphasis is placed on joint working relationships.

To insure this, a part-time coordinator is available to members who need help in using the consortium system or any outside service system. She is the consortium's "problem finder" and "problem solver": she explains to staff workers of member agencies how the system should and can work and describes her roles as "trouble shooter," system monitor and coordinator between the consortium and other local human services systems.

Six-Month Evaluation

The contract between Ramsey County and the Consortium stipulated four evaluation outcomes by July 1982:

- Consortium membership will assess for appropriateness 100 percent of the referrals from Protective Service and will accept 60 to 75 percent of the referrals.

  CPS referred 20 adolescents to the consortium. All were assessed for clinical services ("appropriateness"). All 20 youths were accepted and given clinical service.
- Of the CPS intake referrals made to the consortium, the consortium will reduce the percentage of cases that reappear with a substantiated abuse according to the following timetable (expectancy to be determined upon receipt of CPS data regarding this): July, September and December, 1982.

  Of the 20 youths (100 percent) referred by CPS to the consortium between January and June, two were sent back to CPS because of a new abuse incident. (Data through September are currently being analyzed.)
- Of the consortium clients who are high risk for abuse but inappropriate for reporting to Protective Services, the consortium will ensure that no more than 20 percent appear in the Protective Services system with a substantiated abuse.

Of the 296 adolescents and parents served in the first six months, seven were referred to CPS for an abuse incident. Of these, all seven adolescents were cases of substantiated abuse.

- Consortium membership will report 100 percent of all suspected abuse cases to Protective Services.

The consortium reported seven (100 percent) of all suspected abuse cases to CPS.

Using other data, the consortium provided 2,834 units of service between January and June 1982 at a total cost to the county of $23,710. It did not bill for 1,778 services in that period provided to Ramsey County residents. Consortium member agencies also provided 466 administrative hours toward the development of the consortium system at no cost to the county.

The county agreement also stipulated that at least three new agencies would be invited to participate, and discussions have begun with a local maternal and infant care project serving pregnant adolescents in the public schools, a local hospital (not currently a member), several youth agencies and a health agency affiliated with a settlement house serving the black community.

Recently, the county agreed to fund the consortium through 1983 at almost the same level—$60,000—as the original grant.

On another level, the consortium works for its members by providing an opportunity to meet regularly and to work together on common issues. Beyond these practical ends, members have a sense that *some* things can be done if they join with others. The experience seems to be a source of optimism for the members. Membership in a viable group has personal rewards beyond those associated with work. This is well known although often forgotten when organizing services. For example, more than 10 of 11 consortium workers responded to a midyear survey by agreeing that services for clients and work with colleagues had improved during the period. All workers reported improvement in their effectiveness because of the consortium.

As a model of services, the consortium has rich potential for diffusion into other areas—in services for pregnant adolescents, for example, or for juvenile delinquents.

The relevant scholarly literature on interorganizational relations, agency interaction, agency networks and systems of human services agencies suggest some of the potentials of and the barriers to the creation of such a service system. Need led us to test theory, and the result is a viable model of adolescent services.

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[1]See "Violence Towards Youth. Themes from a Workshop" by Jane Berdie, Michael Baizerman and Ira S Lourie, CHILDREN TODAY, Mar.-Apr. 1977.

[2]See, for example, "Adolescent Prostitution" by Michael Baizerman, Jacquelyn Thompson, Kimaka Stafford-White and An Old Young Friend. CHILDREN TODAY, Sept.-Oct. 1979

Some Case Studies and the Consortium

Without the consortium, many adolescent abuse victims and potential victims would "slip through the cracks" in the system. The commitment between the organizations within the consortium allows each member speedy and immediate access to the multiplicity of services needed. Not only does the consortium make available direct services and funding for the victims and their families; it provides support for the workers themselves. The resources and commitment of other consortium members make it possible for individual workers to handle very difficult situations.

The following case studies are representative of the abused clients served by the consortium. These clients agreed to share their histories, their real names have not been used.

Beth

Beth, age 19, was a prime candidate to continue with her own children the abuse cycle that she had learned as a child. Her parents often fought and were separated when she was quite young. From the time she was seven and until she was nine, she saw her two pre-teenage sisters being sexually molested by her mother's live-in boyfriend. Beth escaped sexual abuse because relatives became aware of the situation and got the boyfriend out of the house. Beth's sisters went on to become prostitutes at an early age.

When Beth was 14, a neighbor in his late 20s, a photographer, persuaded her to come to his house to model for a "fashion magazine." When they got to his studio he began to beat her and chase her around the house. At knife point, he violently raped her—anally, vaginally and orally.

The rape was never reported. The mother blamed Beth, a typical response from this type of passive mother.

The abuse damaged Beth's self-esteem, violated her self-respect and damaged her trust in people, especially men. She has continued to carry around with her a built-up anger and rage.

Beth was married at age 16 and had two children within the first three years of marriage. Her husband verbally and physically abused her to the point that her face is permanently disfigured, then deserted her. Beth decided she couldn't take it anymore. She was frightened, anxious and depressed and had difficulty functioning in her job. Afraid that she might abuse her own children, she sought the help of a member agency within the consortium.

The social worker in charge of Beth's case called upon other consortium members for services. Visiting nurses have provided education within the home to teach Beth how to care for her children and their health has improved.

A visiting nurse and her husband have volunteered to be parent substitutes to Beth so she now has the support of some stable adults in her life.

Other consortium members have provided the social worker with support and collateral consultation. They also have provided services or links with other organizations for other members of Beth's family.

Through therapy, Beth is beginning to be able to take charge of her own life and end her role as victim. She is beginning to recognize the rage inside her and is learning to effectively deal with it. She is aiming for a productive, meaningful life for herself and her children.

Through the combined efforts of consortium members, Beth has had the resources to help her change her life. There is every reason to believe the treatment of Beth's psycho-sexual problems will be successful and that the pattern of abuse will be halted.

Andrea

Andrea, 17, has been a prostitute since she was 13 years old. Her parents are divorced, and her father had

Andrea legally declared an emancipated minor. Hence he does not have to pay child support. She has lived with her mother off and on. Her mother is afraid that Andrea is a bad influence on her younger sister, and she is also tired of being "ripped off" by Andrea every time she decides to return to hooking in the street.

Andrea wants to "do life differently." She's been kicked out of her own mother's house, been beaten by her pimps and customers and she doesn't know how to live a straight life away from the streets.

Teenagers like Andrea don't ask community agencies for help. They're scared and they distrust authorities. A street social worker in the consortium found Andrea.

Andrea had never been busted, so she doesn't fit into any system. She needs shelter, food, medical care and counseling. But she doesn't qualify for aid under the adult or juvenile systems. She's pregnant, depressed, suicidal and helpless. But she now trusts the street social worker and others within the consortium who are trying to help her. Through the consortium, she has been provided medical care on an outpatient and inpatient basis, psychiatric care, food, shelter and counseling from the social worker.

Andrea's pregnancy was not deliberate but a subconscious move to get her out of prostitution, to help her keep a man to replace her hooker identity with a mother identity.

Society sees adolescent prostitutes as criminals, but the consortium sees them as victims. In cases like Andrea's, the consortium is trying to help these adolescents learn to live a normal life and prevent their children from being abused.

Andrea, with a 9th-grade education, has passed the GED and now is applying to school so that she can learn a skill and be self-sufficient.

Carl

Carl's dad was a chronic alcoholic who abused his wife and children. After trying for years on her own to protect the children, his mother obtained a court order to get him removed from the house for physically abusing Carl, age 17, and his younger sibling.

The mother sought counseling from an agency within the consortium that she felt would be sensitive to her religious values. After a few sessions of family therapy, the social worker realized that Carl needed a psychiatric evaluation. He seemed depressed and withdrawn during the counseling sessions and had become good at hiding his feelings.

The psychiatrist discovered that Carl had virtually been destroyed spiritually and physically. He was in extreme emotional pain, was delusional and hallucinating and spent hours on end in his room absolutely motionless. Because of his odd behavior he had also become a scapegoat at school. Carl was contemplating suicide.

Carl was hospitalized under the care of a consortium psychiatrist and drug therapy was instituted. He was transferred to another hospital within the consortium for specialized adolescent psychiatric inpatient services. Gradually, Carl has become more responsive and doctors feel that he may not have been psychotic but probably was gravely depressed. He'll be transferred to a residential center to continue nurturing his self-esteem and health. His mother also is undergoing individual therapy as well as family therapy with Carl and his sibling.

The consortium network made it possible for the social worker to have immediate access to a psychiatrist and clinical psychologist for prompt diagnosis and intervention. Thus, a suicide was probably prevented.

Veronica

Two years ago, when she was 14, Veronica accidentally discovered that her father and older step-sister engaged in sex. Unbeknownst to Veronica, his incestuous relationship had been going on for 3-1/2 years. (The father has served time in jail and is now back with the family.)

Veronica was not sexually abused, nor was her younger sister. But siblings of abuse victims often are neglected within the organized public systems because attention is directed to the victims and the abusers. However, siblings of abused victims often manifest the identical behavior problems of an actual victim.

Veronica began to rebel against her parents and the school, and she became self-destructive. Her family model had not taught her how to deal effectively with her feelings, and her anger towards her father and stepsister manifested itself in destructive behavior. Both Veronica, now 16, and her younger sister, age nine, are potential victims of physical and/or sexual abuse and are potential abusers of the next generation.

The consortium arrangement provides the resources necessary to intervene in an effort to break the abuse cycle. Consortium agency members have cooperatively provided individual counseling to Veronica at school and at the community clinic to help her appropriately deal with her feelings in a nondestructive way. Psychological and psychiatric services have been used by the social worker for collaborative consultation, testing and co-therapy with family members.

Special Child Advocates: A Volunteer Court Program

by Michael Blady

Michael Blady, C.S.W., served as National Project Director of the Court Appointed Special Advocate project. National Council of Jewish Women, New York City. His article is reprinted from CHILDREN TODAY, May-June 1981.

For Lauren Rothstein, a volunteer Court Appointed Special Advocate (CASA), the case of 16-month-old Matthew and his infant brother John was particularly trying.

The children had been left at a Jacksonville, Florida, crisis center by the mother and a man she identified as her husband. She had explained that she had just come to Jacksonville, and gave a local hotel as her address. Her money had been "lost or stolen," she said, and she needed a few days to pull herself together and get a job.

The mother never returned to collect her children and investigators for the Jacksonville Department of Health and Rehabilitative Services (HRS) discovered that she had checked out of her hotel, leaving no forwarding address.

The children, who were in poor health, were placed in a hospital. The HRS caseworker later located the mother in Jacksonville, where she had been selling her blood for cash, and she also located the children's maternal grandparents. Neither the mother nor her parents, however, had an interest in caring for the boys.

When contacted, the father, who was in jail on conviction of burglary, said he had a "drinking problem" and although he was due to be released shortly, it was evident that he might not be able to provide the children with a stable home life. However, the children's paternal grandmother in Indiana wrote to the caseworker to say that she was interested in the welfare of the boys.

Meanwhile, the children were placed in temporary foster care and the case was taken to court. At this time, Lauren Rothstein joined the case as Court Appointed Special Advocate (CASA), under a volunteer program sponsored by the Jacksonville Section of the National Council of Jewish Women. Her task was to investigate the case and to present to the court an independent evaluation and a recommendation for a disposition that would be in the boys' best interests.

Rothstein reviewed all documents and spent more than 12 hours on telephone and in-person interviews with everyone involved in the case, including the director of the crisis center, the foster mother, a hospital social worker and the children's caseworker. In her report, she recommended that the children be continued in temporary foster care for six months in order to give the father—who had expressed genuine concern for the children—time to get a job, set up a home and receive counseling for his drinking problem. At a court review at the end of the six months, the court would try to determine whether placement with the father and his mother would be possible, contingent on their continued interest in the boys and demonstrated ability to care for them. If not, the CASA volunteer recommended that proceedings be initiated to free the children for adoption.

Rothstein will continue to be the children's advocate until the case is resolved, visiting the children, their father and foster parents to make sure that the services mandated are being offered and accepted.

The case of John and Matthew is one of many now being handled by CASA volunteers from the National Council of Jewish Women (NCJW). In addition to the Jacksonville branch, NCJW Sections in Greater Dallas, Texas and St. Louis, Missouri have been operating CASA projects since January 1980. This past June, the Worcester, Massachusetts and Greater Harrisburg, Pennsylvania Sections joined the national program.

Evolution of the Project

The National Council of Jewish Women's concern for the proper representation of children involved in neglect and abuse proceedings grows out of its 87-year-long commitment to the rights of children. In the 1970s, NCJW focused its concern on children labeled status offenders.

The CASA program evolved from the Council's highly respected 1975 study, *Children Without Justice*. Among other things, the report revealed that many lawyers appointed to represent juveniles were "illattuned to the legal and social atmosphere of the (juvenile)

court." It also noted that contact between attorneys and children amounted to "only a few minutes of conversation in a court waiting room just before the case is called."[1]

Early in 1979, NCJW's Justice for Children Task Force (now the Children and Youth Task Force) met with the Edna McConnell Clark Foundation to discuss possible implementation of programs to address such problems. The Foundation, which has focused on problems of foster care, suggested that many of the problems involved in representation of children in the juvenile court also existed in the child welfare system.

The Foundation urged us to consider, among other ideas, a program of volunteer guardians *af litem*. (The phrase *ad litem* is Latin for "for the case.") Could NCJW develop a program similar to the one then (and now) operating in the King County (Seattle), Washington, Juvenile Court? Such a program, it was suggested, could work within and with the support of the courts, but it would not be administered by the courts. The volunteer guardian *ad litem* (GAL) idea, we were told, was supported by the Children in Placement Project of the National Council of Juvenile and Family Court Judges.

Traditionally, the guardian *af litem* (usually, but not necessarily, an attorney) was appointed by the court to represent children considered incompetent because of age; thus, the GAL acted as an adversary in court proceedings. Currently, in child abuse and neglect cases where the child is neither plaintiff nor defendant, the GAL functions more as an advocate.

Conventional wisdom holds that the public or private child welfare agency or department of social services represents the child's needs. However, an agency, through its attorney, is usually faced with a conflict in petitioning to remove a child from home—that is, in trying to prove its case—it may be difficult to be objective about the child's needs.

It was also thought that the court's responsibility in neglect and abuse cases to protect the child's interest provided an adequate safeguard that the child's interests would indeed be represented. However, a judge is also responsible for rendering an impartial and equitable decision based on the merits of the case. "Impartiality is lost if the judge becomes an active advocate for the child."[2]

Clearly, then, there was a need for a person to present the court with an independent evaluation of and recommendation for what is in the child's best interests. This need is recognized by the Child Abuse Prevention and Treatment Act of 1974 (P.L. 93-247), which requires that states seeking Federal funding for child abuse programs appoint a guardian *ad litem* for children involved in abuse and neglect cases which result in judicial proceedings.[3]

The CASA Role

We began with the assumption that the foster care system as it is ideally designed to operate is a good one for the protection of children. Problems occur when the adults who are parties to the actions and proceedings fail to perform their proper functions or fulfill their responsibilities. Thus, the CASA's main role is to see that the system operates as ideally as possible by ensuring that everyone does what he or she must in order to establish a permanent home for the child.

As Howard A. Davidson has noted, no code of ethics or commonly-accepted set of standards prescribes the duties of a GAL.[4] In the CASA project, a volunteer lay guardian *ad litem* is responsible for presenting to the court an independent evaluation of and recommendation for what is in the child's best interest, both immediate and long-term.

To determine this, the volunteer interviews everyone who is involved with the case. This includes, but is not limited to, attorneys, psychologists, education specialists, child welfare workers, police and school officials and, of course, the natural and foster parents and the child.

The role of the CASA is not to duplicate the work of the social worker; it is to ask the difficult questions about the social worker's findings and recommendations that the judge and attorneys might ask if they had the time to fully investigate the circumstances. (One person has described the role of the CASA as being "the eyes, ears and legs of the judge.").

Time is the really important factor here. Unlike the social worker who carriers a large caseload, the attorney who is trying to build or maintain a practice, or the judge whose docket is so crowded that he or she cannot carefully deliberate on a case, the CASA has the luxury of devoting herself to one case at a time. The volunteer has the time to talk to more people, explore innovative service alternatives and carefully monitor the child's post-disposition progress, to ensure that the agencies deliver the services detailed in the case plan and to see that the natural parents avail themselves of what is offered.

Philosophically, at least, the CASA volunteer supports the view that the child's best interest can be served by returning him or her to the natural family—if this is at all possible—or by recommending that the child be freed for adoption or, in rare cases, placed in permanent foster care. The volunteer may recommend continuation of temporary foster care, but mainly to provide time for

troubled parents to receive counseling or other services. The ultimate goal is a permanent resolution of the matter.

Program Organization

The CASA program began in July 1979 with a $300,000 2-year grant from the Edna McConnell Clark Foundation. NCJW's foster Care Committee (of the Children and Youth Task Force) considered more than 30 NCJW Sections, of different sizes and with varying levels of sophistication in program management, that were interested in sponsoring a project.

The committee was looking for communities in different parts of the country that had a demonstrated need for a volunteer-run CASA project. Volunteers and foster care committee staff members visited several cities, where they interviewed juvenile and family court judges, elected officials and county commissioners, and executives of public and private child welfare agencies. The site selection team also sought groups which had a demonstrated commitment to and experience with the juvenile justice system and which also had the membership, leadership and fiscal strength to handle the complex start-up phase and successful operation of a CASA project.

Each project in the sites chosen was allocated $18,000 for start-up costs and a year's operation. A volunteer chairwoman, selected by the area president, worked with a volunteer steering committee to begin the project.

Each project chairwoman and steering committee developed a budget and workplan, hired a part-time professional coordinator and sought the cooperation of the courts and local department of social services. They also organized a Community/Professional Advisory Board which, depending on the site, may include representatives of the court and public and private child welfare agencies, mental health and legal professionals; locally elected officials; corporate executives; members of other volunteer organizations, representatives of local news media;

The advisory board serves three major functions. to advise the chairwoman and the coordinator on policy and practical issues, to broaden the volunteer base beyond the local section members so that CASAs represent the diversity of ethnic, racial and cultural groups in the community, and to actively support and participate in fundraising (a challenge that the projects will soon be facing).

Every potential volunteer is interviewed by the coordinator, primarily to discover the special skills, strengths and weaknesses the volunteer possesses. Knowledge of a volunteer's skills, such as fluency in a second language or expertise in early childhood learning, for example, enables the coordinator to assign a volunteer to a case in which she can be the best possible advocate for a particular child. Those few candidates who are screened out during this intitial interview are usually rejected because they have some bias which could hinder them from making an objective assessment of a child's needs.

Vounteers who are not members of the NCJW Sections are welcome, and each project has developed methods to recruit volunteers from the community.

The coordinator organizes volunteer training based on a model outline developed by the NCJW Foster Care committee, which describes the foster care system and the functions of public child welfare agencies. It also explains the judicial process and the CASA's role in it. On a practical level, the outline offers guidelines for conducting interviews and writing reports and includes exercises in values clarification, to help volunteers uncover hidden biases in themselves. Each project also conducts in-service training sessions and educational programs in such areas as sexual abuse and cultural issues.

Individual projects may modify the length and content of training to fit local conditions. In Jacksonville, for example, some "classroom" exercises are eliminated because some of the volunteers have prior direct service experience. Instead, volunteers accompany case workers from HRS on a field visit and then participate in supplemental seminars on specific practices, such as interviewing, and on particular topics—learning disabilities, for example.

The relationship of the CASA's to the courts and the social welfare agencies varies with the respective "climates" in the different cities. In Greater Dallas and St. Louis, where GALS appointed to represent children are lawyers, the CASAs work with and alongside the GALS, adding the volunteers' exhaustive evaluations and recommendations to the attorneys' legal advocacy. In Jacksonville and Worcester, the CASA is usually the sole independent advocate for the child, unless the nature of the hearings and case make the presence of counsel necessary. In Harrisburg, the CASA serves as guardian *ad litem* while the Public Defender functions as counsel for the child.

An important function of the project coordinator is to represent the program to the professional community. Because the CASA reviews the work of the foster care caseworker and monitors the delivery of services, there is potential for some competition between the professional worker and the volunteer. The coordinator must be able to defuse differences when necessary and maintain good working relations with the departments of social services.

Experience shows that, for the most part, relations among the CASA coordinator and volunteers and the local departments and caseworkers are good. Usually, the CASA supports the recommendations of the caseworker and helps to ensure that the court's disposition of the case is adhered to. Sometimes, the CASA is able to reach parents when a caseworker can't. By making sure that the parents understand that she is a volunteer and that her only stake in the process is to see that the child, and the family, receive the best services possible, she can often convince a resistant parent to cooperate in the development and implementation of a service plan.

Through their direct experience with the foster care system, CASAs can, and have, become more effective advocates for system-wide improvements in child welfare service delivery. They learn first-hand the frustrations of caseworkers working under limitations of time, resources and available service options. NCJW Sections, in particular, have been able to play a major advocacy role because of their long-established reputation and credibility in the area of juvenile justice.

Evaluation

It is still too early to tell how much of a difference the CASAs are making for the children involved in the system; NCJW is still gathering hard data. An evaluation consultant is developing an administrative self-assessment profile and interview and case-review schedules; the data collected should enable project directors and advisory boards to see whether their goals are being met and to set new goals for the future.

Comments from the field indicate that the CASA project is doing well. In its first 6-month report, the St. Louis Section noted that several of its CASAs have decided to devote all their volunteer time to the project, giving as their reasons the "... responsible paraprofessional nature of the job, the chance to do direct service, and the value of working with families whose children are in foster care."

A Jacksonville judge who sits on the juvenile bench wrote to the project chairwoman, "I am happy and proud to say that our confidence [in deciding to cooperate with the project] was not misplaced. The judges have been very satisfied with the services rendered by the CASA volunteers."

The Greater Dallas Section reported that, as of November 30, 1980, its 46 volunteers and professional staff had given more than 4,000 hours to the CASA project. Other community professionals gave 1,400 hours of their time. The cost to a community for just the salaries and expenses of such professionals would be staggering.

The Future of CASA

Now that they have completed their first year of operation, the three original CASA projects are working to secure funding to ensure their continuation. Jacksonville is now receiving funds from the state as part of a demonstration project, and Greater Dallas has asked for support from its county government. St. Louis is vigorously seeking support from corporations, foundations and private individuals.

The Foster Care Committee is compiling a "how-to" manual (scheduled for publication in the fall of 1981) and is working on a national training effort to create a cadre of volunteers from the existing projects to serve as advisers to other NCJW Sections and community groups planning to develop similar projects.

The future of the CASA project looks bright but, as with any good service project, there is room for expansion. Three additional NCJW Sections have become involved in CASA projects—Greater Detroit, Greater Miami and Suncoast (St. Petersburg and Clearwater, Fla.). Greater Detroit's project, which operates in the Oakland County (Mich.) Juvenile Court, involves an interesting variation on the CASA model: volunteers are assigned to cases of children who have already been freed by the court for adoption, to ensure that a permanent living situation is established for the child as soon as possible. The two Florida Sections are participating in projects that are part of that state's volunteer guardian *ad litem* demonstration program.

The National Council of Jewish Women is grateful for the support and commitment of the Edna McConnell Clark Foundation, which continues to provide financial support.

The Foster Care Committee is also grateful to the directors of other advocacy projects around the country who have shared their training materials, time and devotion with us. Through CASA and our other projects, the NCJW will continue to develop ways to improve the foster care system for those children who require a temporary home outside their family.

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[1]Edward Wakin, *Children Without Justice. A Report by the National Council of Jewish Women*, New York, 1975.

[2]U.S. Department of Health and Human Services, *Representation For the Abused and Neglected Child: The Guardian Ad Litem and Legal Counsel. DHHS Publication No. (OHDS) 80-30272, August 1980.*

[3]*Child Abuse Prevention and Treatment Act. P.L. 93 247, as amended. (Sec. 4(b)(2)(g), 42 U.S.C. :e 5101 et seq.*

[4]For a discussion of areas of consensus regarding the role of a guardian *ad litem*, see Howard A. Davidson, "The Guardian Ad Litem. An Important Approach to the Protection of Children," CHILDREN TODAY. Mar Apr 1981.

Child Abuse Prevention Starts Before Birth

Ed. note. Since 1979, the National Center on Child Abuse and Neglect (NCCAN) has supported projects designed to reduce the incidence of child maltreatment in high risk families by enhancing the bonds between parents and their newborn children, particularly infants who are premature, chronically ill or at risk of developmental delays. Conducted by hospitals, universities and community service organizations, the projects are working to reduce isolation of families (including many single-parent families) with newborns and alleviating much of the stress that may have escalated without project assistance.

One perinatal prevention project, funded by NCCAN in 1981 and conducted at Sacred Heart Hospital, Pensacola, Florida, is described in the following article by Pauline Moulder, staff writer with *Southern Catholic* magazine. Her article is reprinted with permission from *Southern Catholic*, Nov. 1982.

by Pauline Moulder

The joyous young couple experience the miracle of life with the birth of their first child. Once the baby is taken home from the hospital, unless there are attendant medical problems, hospital staff presume all is well. They are no longer concerned. The parents are on their own to work out any adjustment problems.

Statistics, however, show that family life is far from ideal. Divorce and child abuse are becoming much too commonplace in our society. solutions must be found to stem the tide of these tragedies and others that cause damage to the family unit.

In 1981, in an attempt to enhance the family life of its patients and improve the perinatal services in the hospital, Sacred Heart Hospital in Pensacola received a Federal grant to adopt the Perinatal Support Services Project from the University of Virginia Medical Center in Charlottesville. The purpose of the perinatal program, as stated by Liz Fitchard, RN, perinatal education coordinator, is prevention—prevention of complications and early identification of problems that might possibly exist. Since the project, 150 participants from hospitals in the Gulf Coast region have begun training and are learning the skills necessary to identify the needs of potentially "at risk" patients.

"My main responsibility," Fitchard says, "is educating the support personnel. the physician, RN's, LPN's and any others who come in contact with a pregnant woman and/or her newborn child. I attempt to raise their level of education and help them identify mothers who might have babies who would require the intensive care nursery, which may necessitate separation of mother and child."

"We contact the hospitals and tell the staff that we have a professional education program and ask if they would be interested," she explains. Via a follow up phone call, an appointment is made with the administrator, director of nurses, and/or chief of obstetrics or

pediatrics. A staff member of the perinatal unit at Sacred Heart Hospital then visits with them to explain the program, review a schedule of events and have them determine whether they have a need to participate. If the hospital accepts, one of the first things to do is identify the needs and the type of care they can provide to patients.

"Two of their nurses come to our hospital to attend a 2-week workshop." Fitchard explains. "The nurses then return to their hospitals with the materials to institute the program. It's an ongoing process. We continue to go out to these hospitals for continued contact and, hopefully, we will be able to continue to maintain contact with them for refresher sessions."

Some of the medical problems the perinatal program deals with, according to Fitchard, are previous history of maternal complications during labor and delivery, toxemia and a diabetic mother or one who has had children who have had problems. "If we can help hospitals to identify their quality of care," Fitchard says, "it's either going to improve services or we're going to recognize the fact that we aren't prepared to help these mothers and they will be transported to a center where the proper equipment and staff are available. By this means, we hope that the mothers will have a better labor and delivery process with fewer complications. The child will be born in a much healthier state and therefore will not require prolonged intensive care nursing."

For many physicians and nurses, the program might just be a refresher course. For others it will provide new information. However, the basic idea of the program is to make each hospital aware of its own needs and capabilities, with the major emphasis on teamwork. "We work as a team on different professional levels from various professional backgrounds with one goal in mind, and that is to help the patient in their family situation," she said.

Carol Busch, the hospital's director of grants, explains perinatal as the marriage between obstetrics and neonatal medicine which covers that period of time from the onset of pregnancy through the first 28 days of life. "We have found," Busch says, "that for regular pregnancies as well as definitely high-risk pregnancies, proper prenatal care, health education and nutrition will greatly improve the chances for a healthy baby." She also notes the importance of bonding—strengthening family relationships and helping to draw families closer together instead of splitting them apart. Such bonding is accomplished by inviting and encouraging parents to come into the nursery to spend time with the new baby while it is in the hospital.

"We believe in starting as early as possile, even before the baby is even born, to provide education and support to prevent medical consequences and situations that may later lead to a greater incidence of child abuse," says Busch. "That was the reason for our interest in the project and why we looked for funding to help us to expand the education, social service and medical intervention in order to be able to provide for better quality of life and to meet a community need. Whereas child abuse has become a national and certainly a local problem across the Florida Panhandle the hospital is also interested in prevention of medical problems and conditions that will lead to medical problems."

Janet Schwind is the social worker who conducts an initial interview with each clinic patient to see if she may have a need for services provided by the grant. Problems with finances, housing and stress all are factors that place an expectant mother at risk. Schwind's job is to identify these problems at an early stage and to set up the proper referrals. Patients are followed by Schwind through their delivery, and they see her on a regular basis until they are discharged from the hospital with the baby.

Marcia Moreland, MSW, project coordinator, does follow-up studies on the patients and contacts them periodically to see how well they have adjusted to their new addition. "You take, for instance, a family that was expecting a healthy child, made plans to take their baby home and have a happy life. All of a sudden they are faced with the news that their child is ill," Moreland says. "The circumstances immediately put the family in a crisis situation. Something that has never happened to them before happens, and they may not know where to turn for help. Another situation," she says, "may be a mother who delivers in another hospital and her baby is transported from there to here. The transporting team does work with the family in explaining the situation, but we have mama over there recovering from delivery, the child here, and dad who wants to be with mom and with the child. That's a very rough situation."

Moreland explains that a social worker can help parents discuss what's going on and help them work through the feelings they have about what's happening

and possibly find some resources. "If the family doesn't have the economic means to handle the situation, the social worker may be able to find the necessary help, such as housing via contract with a local motel," she says.

"The pregnancy can be stressful even if it is a wanted pregnancy," Moreland continues. "A couple who is going to have their first child is going from the role of husband and wife into the role of parents. A couple who is going to have their third child is adding one more child to that family, which means that siblings are going to have to be prepared for the expansion."

There are other stressful situations. Families have many concerns. Are we going to be able to care for the baby properly, afford the financial responsibility, provide enough love to the baby, have enough time to meet the needs of each individual child as well as the needs of the spouse? Moreland asserts that the perinatal team can help struggling families by discussing problems, seeking alternatives and counseling them in general.

"Few of us receive education as to how to be a parent. It's like, well, you were a child once and your parents are your role models," she says. "You might want to do things differently, but where will you get that education?" The perinatal team helps parents locate places where they can go for moral support. It's a caring-type of delivery of services. The team members try to see everyone in either the perinatal or intensive care unit to offer them a chance to discuss how they're feeling and possibly refer them to where they can get some needed assistance.

That caring concern doesn't stop once the new parents leave the hospital. "Our services," Moreland adds, "are offered as a part of the hospital's Intensive Care Nursery Unit at no extra charge. There is a social worker available at the clinic during most of the clinic hours during routine medical appointments. We also do some supportive work in terms of phone calls during a crisis." Moreland says. "One of the things that can happen in a crisis is that a family can lose the ability to function as a family and sometimes just someone who can point an individual in a particular direction can help the person and the family to get back on the right track."

Some people are under more pressure than others. There may be marital problems which might be escalated by the pregnancy, single pregnant mothers and adolescents who, along with their families, need support. The perinatal team is there to help.

"We also follow up with parents after the child is both delivered and discharged from the hospital. It's a carry-over of the caring, not, 'Hey, well, you delivered and your baby's discharged, we have no further interest in what's happening to you.' We are interested," says Moreland. "We're interested in the family and by being able to provide some follow-up it shows that the hospital isn't just interested during the time that the baby's in the hospital."

The hospital and staff realize that they cannot treat just the medical and physical aspect of the person. A person is a whole being, comprised of not only physical aspects but also emotional, spiritual and intellectual aspects. Likewise, pregnancy isn't something that affects only one person. Pregnancy affects other people who touch one's life, such as grandparents, sisters and brothers, the husband or boyfriend.

"Rather than 'prevention of child abuse,' we prefer the term 'family enhancement' Moreland says, "because when you can enhance the family you are, in essence, possibly preventing abuse. The program prevents more than child abuse—it prevents other problems, too. Parents who feel overwhelmed by caretaking responsibilities and feel guilty because sometimes they wish they didn't have any children are reassured to know that there are other parents who also feel that way at times and that it doesn't make you a bad person."

Bubbylonian Encounter

Bubbylonian Encounter is a play designed by the Kansas Chapter of the National Committee for Prevention of Child Abuse specifically for elementary school-age children, a population that constitutes 50 percent of all sexual assault victims. The 30-minute production involves three characters who use humor, drama and audience participation to communicate various types and effects of human touching. It looks at the positive and negative aspects of touching, including forced sexual touching, and gives specific information to children about steps to take if forced sexual touching should occur.

The production aims to teach children that they have the right to protect their own bodies and to seek help when touching feels bad or confusing; that sexual abuse can be harmful and is against the law; and that sexual abuse can happen by someone they know, even a family member.

These objectives are accomplished by giving children a vocabulary that helps them to discriminate between various touching experiences. In addition, a leading character models the process for seeking help when a child feels helpless to protect himself or herself. A critical component of the play is the professional consultation and training that is a part of each performance. This consultation, to professionals and parents, includes a discussion of the play, its objectives and effectiveness, as well as significant facts about the problem. Separate consultation, in the form of teacher/counselor training packets, is available for children to reinforce and clarify the play's messages and to help them manage individual emotional responses.

Bubbylonian Encounter is resulted from the collaborative efforts of the Kansas Committee for Prevention of Child Abuse, Theatre for Young America and Johnson County Mental Health Center. The play has been presented at the Kansas Governor's Conference for Prevention of Child Abuse, the National Center on Child Abuse and Neglect Conference, the International Conference on Child Abuse and Neglect in Amsterdam and the Second National Conference on Sexual Victimization of Children.

Prior to these performances, the play was tested with 82 children in grades 3-6 to measure what they learned in viewing the play. The results of the pretest/post-test demonstrated that:

- 99 percent were able to recognize forced sexual touching from other forms of touching.
- 82 percent knew how to respond appropriately if sexually assaulted.
- 86 percent understood that family members could sexually abuse them.

Additionally, almost all of the children said they enjoyed the play.

Bubbylonian Encounter has been incorporated into the curriculum of 17 school districts in Kansas, and it has recently been adapted into a screenplay.

The 3/4 and 1/2 VHS videotape rents for $40.00 per week, applicable toward the purchase price of $200 for a tape or $350 for a 16mm film. Information on ordering may be obtained from the Kansas Committee for Prevention of Child Abuse, 435 S. Kansas, 2nd Floor, Topeka, KS 66603.

Reporting Responsibilities and Procedures*

The National Center on Child Abuse and Neglect often receives questions from citizens and professionals about reporting responsibilities when one knows of or suspects child abuse and neglect. Here are some of the most frequently asked questions:

Who Handles Reports of Child Abuse and Neglect?

Primary responsibility for dealing with the problems of child abuse and neglect is vested in state and local agencies. Each state has laws requiring the reporting of known and suspected child abuse and neglect cases; reports are investigated by public social service or law enforcement agencies in the local community. Preventive and treatment services for both the children and families involved are provided by local public and private agencies.

The Federal Government has no authority to investigate specific cases of child abuse and neglect nor the practices of child protective services agencies, which are regulated by state and local laws.

What Do State Reporting Laws Require?

The enactment of child abuse and neglect reporting laws by state legislatures began in earnest in the early 1960s. Today all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico and the Virgin Islands have reporting legislation. In general, these laws mandate the reporting of suspected maltreatment, provide penalties for failure to report, provide immunity to reporters from legal actions associated with the report and define reportable conditions.

*Abstracted from *Everything You Always Wanted to Know About Child Abuse and Neglect and Asked* prepared by the Clearinghouse on Child Abuse and Neglect Information.

Who Must Report?

Due to the medical profession's description and identification of battered children, legislators have looked to the medical profession as the class most likely to discover child maltreatment. Today every jurisdiction requires physicians to report suspected child abuse, with laws that either specifically mention physicians or by a more general directive, such as "practitioner of the healing arts," or "any health professional". In addition, associated medical personnel such as nurses, dentists, osteopaths and interns are required to report suspected child maltreatment in many states.

As the public understanding of child abuse and neglect has grown, so too has the number of professions mandated by the states to report suspected maltreatment. The realization that child abuse and neglect may not be limited to severe physical abuse and that medical treatment for severely abused children may not be sought in time to avoid permanent injury or death has coincided with a dramatic increase in the number of professions specifically mentioned in state laws as mandatory reporters, to include those with frequent contact with children, such as teachers and child care professionals.

Thus, the trend in mandatory reporting laws appears to be toward broadening the base of possible reporters. This is accomplished either by mandating that "any person" with reason to believe that child is being maltreated report, or by specifically listing the professions required to report. A wide variety of professions are mentioned in various state reporting laws, with teachers, school officials or personnel and social workers named most frequently.

Who May Report?

In general, anyone suspecting that a child is being mistreated may report that suspicion. A number of states provide specific statutory authority for permissive, rather than mandatory, reporting. However, many states make no provision for permissive reporting because they mandate reporting by everyone. If in doubt as to the requirements in your state, check with your state CPS agency.

Are There Penalties for Failure to Report?

Yes. While the identification of maltreated children needed to get help to them and their families ultimately depends upon the responsiveness of a concerned community, the vast majority of states impose a criminal and/or civil penalty for failure to report when mandated by law to do so.

Can I Be Sued for A Mistaken Report?

No. All jurisdictions provide immunity from civil or criminal liability for reporters acting in good faith. While the majority of states qualify their immunity provisions with the requirement that the report be made in good faith, 20 states as of 1979 included a presumption of the good faith of reporters in their reporting laws.

What Conditions Must Be Reported?

Every jurisdiction requires that suspected cases of child abuse and neglect be reported. Over the years, the range of reportable conditions found in state laws and the definitions of abuse and neglect have broadened. Today, many state laws specifically include sexual abuse, emotional or mental injury, and threatened harm among their reportable conditions, as well as the traditional definitions of child abuse which include physical injury and severe neglect.

In all states, a reporter is not required to know or to be certain that a child has been abused or neglected as defined under state law. Reporting laws apply whenever the individual reporter has reason to believe or suspects that maltreatment is occurring.

What Happens If I Report Someone?

While the exact procedures may vary from state to state, generally a child protective service worker will visit the reported family as soon as possible after the report is made. This initial contact is made to determine if the child is in immediate danger and to begin assistance or treatment if needed by the family. Depending upon the urgency of the situation, the CPS worker will then take appropriate action which could include, in drastic circumstances, removal of the child from the home. Such actions are rare and employed only when there appears to be immediate danger to child's health or safety. In some states and circumstances, law enforcement personnel might be called upon to assist the CPS worker or might respond to the report, if there is an indication that the child needs immediate transportation to a medical facility or other police services.

In some states, the reporting laws permit certain mandated reporters, such as doctors, to keep the child in

protective custody if the reporter has reason to believe that the child would be returning to a dangerous environment and additional abuse. The authority to remove a child from home is necessarily limited, however, and a court hearing is required, usually within a few days, to keep the child in shelter care. Also, some states require mandatory reporters to file written reports following the oral report. These reports are particularly necessary and useful should any sort of legal action result.

What Can I Do To Help Prevent Child Maltreatment?

Get involved. Know what services exist to help troubled families in your community, and work toward establishing services where the needs remain. Support crisis nurseries, emergency shelters, parenting classes, parent aide programs, parental self-help groups, community networks, counseling and mental health centers, and all forms of assistance to families in crisis. Most importantly, if you know of such a family, report to the authorities so that this service need can be identified and treated.

Where Do I Find Reporting Information?

Since the responsibility for investigating reports of suspected child abuse and neglect lies at the state level, each state has established a child protective service reporting system. NCCAN annually compiles the descriptions of the reporting procedures in each state. Listed below are the names and addresses of the child protective services agency in each state, followed by the procedures for reporting suspected child maltreatment.

Alabama:
Alabama Department of Pensions and Security
64 North Union
Montgomery, AL 36130

Reports made to county 24-hour emergency telephone services

Alaska:
Department of Health and Social Services
Division of Family and Youth
Services
Pouch H-05
Juneau, AK 99811

Reports made to Division of Social Services field offices.

American Samoa:
Government of American Samoa
Office of the Attorney General
Pago Pago, AS 96799

Reports made to the Department of Medical Services.

Arizona:
Department of Economic Security
P.O. Box 6123
Phoenix, AZ 85005

Reports made to Deparment of Economic Security local offices.

Arkansas:
Arkansas Department of Human Services
Social Services Division
P.O. Box 1437
Little Rock, AR 72203

Reports made to the statewide toll-free hotline (800) 482-5964.

California:
Department of Social Services
714-744 P St.
Sacramento, CA 95814

Reports made to County Departments of Welfare and the General Registry of Child Abuse (916) 445 7546 maintained by the Department of Justice.

Colorado:
Department of Social Services
1575 Sherman St.
Denver, CO 80203

Reports made to County Departments of Social Services.

Connecticut:
Connecticut Department of Children and Youth Services
Division of Children and Youth Services
170 Sigourney St.
Hartford, CT 06105

Reports made to (800) 842-2288.

Delaware:
Delaware Department of Health and Social Services
Division of Social Services
P.O. Box 309
Wilmington, DE 19899

Reports made to statewide toll-free reporting hotline (800) 292-9582.

District of Columbia:
District of Columbia Department of Human Services
Commission on Social Services
Family Services Administration
Child Protective Services Division
First and I Sts., N.W.
Washington, DC 20024

Reports made to (202) 727-0995.

Florida:
Florida Department of Health and Rehabilitative Services
1317 Winewood Blvd.
Tallahassee, FL 32301

Reports made to (800) 342-9152.

Georgia:
Georgia Department of Human Resources
47 Trinity Ave., S.W.
Atlanta, GA 30334

Reports made to County Departments of Family and Children Services.

Guam:
Child Welfare Services
Child Protective Services
P.O. Box 2816
Agana, GU 96910

Reports made to the State Child Protective Services Agency at 646-8417.

Hawaii:
Department of Social Services and Housing
Public Welfare Division
Family and Children's Services
P.O. Box 339
Honolulu, HI 96809

Reports made to the hotline operated by Kapiolani-Children's Medical Center on Oahu, and to branch offices of the Division on Hawaii, Maui, Kauai, Mokalai.

Idaho:
Department of Health and Welfare
Child Protection
Division of Welfare
Statehouse
Boise, ID 83702

Reports made to Department of Health and Welfare Regional Offices.

Illinois:
Illinois Department of Children and Family Services
State Administrative Offices
One North Old State Capitol Plaza
Springfield, IL 62706

Reports made to (800) 25-ABUSE.

Indiana:
Indiana Department of Public Welfare
Division of Child Welfare -
Social Services
141 South Meridian Street, 6th Floor
Indianapolis, IN 46225

Reports made to County Departments of Public Welfare.

Iowa:
Iowa Department of Social Services
Division of Community Programs
Hoover State Office Building
Fifth Floor
Des Moines, IA 50319

Reports made to the legally mandated toll-free reporting hotline (800) 362-2178.

Kansas:
Kansas Department of Social and Rehabilitation Services
Division of Social Services
Child Protection and Family Services Section
Smith-Wilson Building
2700 W. Sixth
Topeka, KS 66606

Reports made to Department of Social and Rehabilitation Services Area Offices.

Kentucky:
Kentucky Department for Human Resources
275 E. Main St.
Frankfort, KY 40621

Reports made to County Offices within 4 regions of the state.

Louisiana:
Louisiana Department of Health and Human Resources
Office of Human Development
Baton Rouge, LA 70804

Reports made to the parish protective service units.

Maine:
Maine Department of Human Services
Human Services Building
Augusta, ME 04333

Reports made to Regional Office or to State Agency at (800) 452-1999.

Maryland:
Maryland Department of Human Resources
Social Services Administration
300 W. Preston St.
Baltimore, MD 21201

Reports made to County Departments of Social Services or to local law enforcement agencies.

Massachusetts:
Massachusetts Department of Social Services
Protective Services
150 Causeway St.
Boston, MA 02114

Reports made to Regional Offices.

Michigan:
Michigan Department of Social Services
300 S. Capitol Ave.
Lansing, MI 48926

Reports made to County Departments of Social Welfare.

Minnesota:
Minnesota Department of Public Welfare
Centennial Office Building
St. Paul, MN 55155

Reports made to the County Department of Public Welfare.

Mississippi:
Mississippi Department of Public Welfare
Division of Social Services
P.O. Box 352
Jackson, MS 39216
Reports made to (800) 222-8000.

Missouri:
Missouri Department of Social Services
Division of Family Services
Broadway Building
Jefferson City, MO 65101
Reports made to (800) 392-3738.

Montana:
Department of Social and Rehabilitation Services
Social Services Bureau
P.O. Box 4210
Helena, MT 59601
Reports made to County Departments of Social and Rehabilitation Services.

Nebraska:
Nebraska Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, NE 68509
Reports made to local law enforcement agencies or to County Divisions of Public Welfare.

Nevada:
Department of Human Resources
Division of Welfare
251 Jeanell Dr.
Carson City, NV 89710
Reports made to Division of Welfare local offices.

New Hampshire:
New Hampshire Department of Health and Welfare
Division of Welfare
Bureau of Child and Family Services
Hazen Dr.
Concord, NH 03301
Reports made to Division of Welfare District Offices.

New Jersey:
New Jersey Division of Youth and Family Services
P.O. Box 510
One S. Montgomery St.
Trenton, NJ 08625
Reports made to (800) 792-8610.
District Offices also provide 24-hour telephone service

New Mexico:
New Mexico Department of Human Services
P.O Box 2348
Santa Fe, NM 87503
Reports made to County Social Offices or to (800) 432-6217.

New York:
New York Department of Social Services
Child Protective Services
40 N. Pearl St.
Albany, NY 12207
Reports made to (800) 342-3720 or to District Offices.

North Carolina:
North Carolina Department of Human Resources
Division of Social Services
325 N. Salisbury St.
Raleigh, NC 27611
Reports made to County Departments of Social Services.

North Dakota:
North Dakota Department of Human Services
Social Services Division
Children and Family Services Unit
Child Abuse and Neglect Program
Russel Building, Hwy. 83
North Bismarck, ND 58505
Reports made to Board of Social Services Area Offices and to 24-hour reporting services provided by Human Service Centers.

Ohio:
Ohio Department of Public Welfare
Bureau of Children Services
Children's Protective Services
30 E. Broad St.
Columbus, OH 43215
Reports made to County Departments of Public Welfare

Oklahoma:
Oklahoma Department of Institutions, Social and Rehabilitative Services
Division of Social Services
P.O. Box 25352
Oklahoma City, OK 73125
Reports made to (800) 522-3511.

Oregon:
Department of Human Resources
Children's Services Division
Protective Services
509 Public Services Building
Salem, OR 97310
Reports made to local Children's Services Division Offices and to
(503) 378-3016.

Pennsylvania:
Pennsylvania Department of Public Welfare
Office of Children, Youth and Families
Bureau of Family and Community Programs
1514 N. 2nd St.
Harrisburg, PA 17102
Reports made to the toll-free CHILDLINE (800) 932-0313.

Puerto Rico:
Puerto Rico Department of Social Services
Services to Families With Children
P O. Box 11398,
Fernández Juncos Station
Santurce, PR 00910

Reports made to local offices or to the Department.

Rhode Island:
Rhode Island Department for Children and Their Families
610 Mt. Pleasant Ave.
Providence, RI 02908

Reports made to State agency child protective services unit at (800) 662-5100 or to District Offices.

South Carolina:
South Carolina Department of Social Services
P.O. Box 1520
Columbia SC 29202

Reports made to County Departments of Social Services.

South Dakota:
Department of Social Services
Office of Children, Youth and Family Services
Richard F. Kneip Building
Pierre, SD 57501

Reports made to local offices.

Tennessee:
Tennessee Department of Human Services
State Office Building
Room 410
Nashville, TN 37219

Reports made to County Departments of Human Services.

Texas:
Texas Department of Human Resources
Protective Services for Children Branch
P.O. Box 2960
Austin, TX 78701

Reports made to (800) 252-5400.

Utah:
Department of Social Services
Division of Family Services
150 West North Tempie, Room 370
P.O. Box 2500
Salt Lake City, UT 84103

Reports made to Division of Family Services District Offices.

Vermont:
Vermont Department of Social and Rehabilitative Services
Social Services Division
103 S. Main St.
Waterbury, VT 05676

Reports made to State Agency at (802) 828-3433 or to District Offices (24-hour services).

Virgin Islands:
Virgin Islands Department of Social Welfare
Division of Social Services
P.O. Box 500
Charlotte Amalie
St. Thomas, VI 00801

Reports made to the Division of Social Services.

Virginia:
Virginia Department of Welfare
Bureau of Family and Community Programs
Blair Building
8007 Discovery Dr.
Richmond, VA 23288

Reports made to (800) 552-7096 in Virginia, and (804) 281-9081 outside the state.

Washington:
Department of Social and Health Services
Community Services Division
Child Protective Services
Mail Stop OB 41-D
Olympia, WA 98504

Reports made to local Social and Health Services Offices.

West Virginia:
Department of Welfare
Division of Social Services
Child Protective Services
State Office Building
1900 Washington St. E.
Charleston, WV 25305

Reports made to (800) 352-6513.

Wisconsin:
Wisconsin Department of Health and Social Services
Division of Community Services
1 W. Wilson St.
Madison, WI 53702

Reports made to County Social Services Offices.

Wyoming:
Department of Health and Social Services
Division of Public Assistance and Social Services
Hathaway Building
Cheyenne, WY 82002

Reports made to County Departments of Public Assistance and Social Services.

RESOURCES

The following list provides bibliographic information and brief annotations on manuals, reports and other publications of the National Center on Child Abuse and Neglect that deal with various aspects of child maltreatment.

Single complimentary copies are available, as long as the supply lasts, from:

Superintendent of Documents
U.S. Government Printing Office
Retail Distribution Division/Consigned Branch
Washington, D.C. 20402

Requests for all publications should include the full title and document ordering number—(OHDS) 79-30197, for example.

* * *

The following publications, aimed primarily at professionals in the field, provide information on methods of identifying, preventing and treating child abuse and neglect.

Child Abuse and Neglect Information Management Systems. Klaus, S.L.; Lauscher, S. (OHDS) 79-30165, 30 pp., 1978.
The major themes and issues raised at the Second National Conference on Data Aspects of Child Protective Services are summarized. Topics covered include state approaches to the development and maintenance of central registers, client tracking and case management capabilities, current problems and issues, and future prospects. Appendices include a review of state statutes, and a summary of two research studies involving data collection on a nationwide basis.

National Study of the Incidence and Severity of Child Abuse and Neglect. Study Findings. (OHDS) 81-30325, 56 pp., 1981.
This volume presents the findings of the NCCAN-funded National Study of the Incidence and Severity of Child Abuse and Neglect. Subjects covered include an overview of the study objectives and definitions, statistics on the numbers and kinds of cases reported to child protective services agencies, breakdowns of incidence estimates for the major categories of child maltreatment, and demographic factors associated with the recognition and reporting of child maltreatment.

National Study of the Incidence and Severity of Child Abuse and Neglect: Study Methodology. (OHDS) 81-30326, approx. 300 pp., 1981.
This volume contains three technical reports on the Incidence and Severity Study: (1) Sample Design and Estimation Procedure, (2) Operational Definition of Child Maltreatment, and (3) Data Collection Methodology. It also includes several appendices containing child protective services (CPS) data forms, county CPS report logs, an agency contact sheet, and an agency fact sheet

Selected Readings on the Enhancement of Social Services Management Systems. Roth, R.A. (OHDS) 80-30273, 99 pp., 1980.
Six papers on ways to improve social service management systems are reprinted herein. Specific topics covered include the Goal Attainment Scaling (GAS) method of developing client treatment plans, the teletape information gathering and dissemination approach, and applications of management tools and information gained from Federal demonstration projects in the field.

* * *

The following publications in the "user manual" series provide practical information for professionals and others. While most manuals are designed to meet the specific needs of a certain category of worker

(nurses, child protective service investigators and law enforcement officers for example), they may also be useful to other professionals and to concerned members of the general public.

Adolescent Abuse and Neglect. Intervention Strategies. Fisher, B.; Berdie, J., Cook, J., and Day, N. (OHDS) 80-30266, 62 pp., 1980.
Problems and issues specific to intervention in cases of adolescent abuse or neglect are discussed. Topics covered include the identification and reporting of adolescent abuse and neglect, investigation, assessment and treatment planning, and the provision of on-going services. An appendix lists seven assessment tests which may be used to determine an adolescent's educational needs.

Child Neglect. Mobilizing Services. Hally, C., Polansky, N.F., Polansky, N.A. (OHDS) 80-30257, 42 pp., 1980.
This manual discusses manifestations of neglect and ways in which it can be remedied. Areas covered include characteristics of neglectful parents, treatment approaches, and guidelines for placement. A Childhood Level of Living (CLL) scale is appended.

Child Protection in Military Communities. Broadhurst, D.D., Eastey, R.S., Hughes, W., Jenkins, J.L., Martin, J.A. (OHDS) 80-30260, 76 pp., 1980.
Child maltreatment within the armed services is examined. Specific topics discussed include stresses found in the military lifestyle, jurisdictional issues, military child advocacy programs, and a model approach for military/civilian cooperation. Appendix materials include a sample military/civilian agreement, and military reporting and emergency response procedures.

Child Protection. Providing Ongoing Services. Ragan, C.K., Salus, M.K., Schultze, G.L. (OHDS) 80-30262, 92 pp., 1980.
Intended primarily for child protective services workers in the field, this manual is designed to offer practical guidance in evaluating and working with families where abusive or neglectful behavior is present. Topics discussed include assessment of service needs, provision of direct services, assessment of client progress, foster care services, and termination of services and followup.

Child Protection. The Role of the Courts. Landau, H.R., Salus, M.K.; Stiffarm, T., Kalb, N.L. (OHDS) 80-30256, 73 pp., 1980.
This manual is designed to provide child welfare professionals with an understanding of the processes and procedures of juvenile court systems. Topics discussed include case preparation, presentation of testimony, and the use of witnesses. A separate chapter reviews court proceedings involving Native American children.

Child Protective Services. A Guide for Workers. Jenkins, J.L.; Salus, M.K., Schultze, G.L. (OHDS) 79-30203, 89 pp., 1979.
This manual discusses the role of child protective services (CPS) workers in preventing, identifying, and responding to child abuse and neglect. Specific topics covered include investigation techniques, assessment of the situation, design and implementation of service plans, and preparation for and participation in judicial proceedings. An appendix contains standards applicable to the role of the child protective services worker.

Early Childhood Programs and the Prevention and Treatment of Child Abuse and Neglect. Broadhurst, D.D.; Edmunds, M.; MacDicken, R.A. (OHDS) 79-30198, 69 pp., 1979.
This manual is designed for persons involved in programs that offer child care or educational development services to children of preschool age, including Head Start, nursery school, and day care center personnel. Specific topics include the recognition of child maltreatment in an early childhood program setting, reporting and prevention roles, and possible treatment and therapy approaches.

Family Violence. Intervention Strategies. Barnett, R.B.; Pittman, C.B.; Ragan, C.K.; Salus, M.K. (OHDS) 80-30258, 81 pp., 1980.
The nature, extent and possible treatment of domestic violence are examined in this manual. Special attention is given to the role of child protective services workers in assisting violent families. Specific areas covered include the causes and effects of domestic strife, intervention strategies, and program development techniques.

The Nurse's Role in the Prevention and Treatment of Child Abuse and Neglect. Broadhurst, D.D., Heindl, C.; Krall, C.A., Salus, M.K. (OHDS) 79-30202, 63 pp., 1979.
The roles and responsibilities of nurses in identifying, reporting, treating and preventing child abuse and neglect are discussed. Specific topics covered include indicators of problems in the child and in the parents, the assessment and treatment planning processes, prevention and treatment approaches, and interagency coordination and cooperation. An appendix includes standards applicable to the role of nurses.

Parent Aides in Child Abuse and Neglect Programs. Gifford, C.D.; Kaplan F.B.; Salus, M.K. (OHDS) 79-30200, 57 pp., 1979.
Intended to assist child protective services workers and other child care professionals, this manual provides information about the development and implementation of parent aide programs. Specific topics discussed include the goals and general structure of programs; the parent aide/client relationship, program development; and supervision, training, and evaluation. Sample application and evaluation forms are included.

Preventing Child Abuse and Neglect. A Guide for Staff in Residential Institutions. Harrell, S.A.; Orem, R.C. (OHDS) 80-30255, 47 pp., 1980.
Forms of institutional maltreatment and ways to prevent them are discussed. Specific topics include factors contributing to institutional child maltreatment, reporting and investigation of child maltreatment, and institutional policies. Appendices include (a) standards on residential institutions, (b) a sample policy on resident rights, and (c) a sample disciplinary code for residents.

Reaching Out: The Volunteer in Child Abuse and Neglect Programs. Fisher, N. (OHDS) 79-30174, 55 pp., 1979.
Directed both to child protection agencies featuring volunteer programs and citizens concerned about the child maltreatment problem, this volume outlines ways in which volunteers can help. Specific topics covered include volunteer recruitment, the types of programs and services in which volunteers can be utilized, and procedures for integrating volunteers into the overall service program. A sample volunteer information sheet and a recruitment flyer are included.

The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Broadhurst, D.D.; Knoeller, J.S. (OHDS) 79-30193, 55 pp., 1979.
This manual provides information on the role of police officers and other law enforcement personnel in the identification, treatment, and prevention of child maltreatment. Specific subjects covered include the rationale for law enforcement involvement, reporting, intervention approaches such as arrest and protective custody, and referral to the courts and other agencies. Standards applicable to law enforcement officers are contained in an appendix.

Supervising Child Protective Service Workers. Ballew, J.R.; Salus, M.K.; Winett, S. (OHDS) 79-30197, 48 pp., 1979.
The responsibilities of the child protective services (CPS) supervisor are discussed in this manual. Areas covered include staff selection and recruitment, skills and techniques of CPS supervision, recordkeeping, worker burnout, and dealing with incompetent or unsuitable workers. A supervisor's self-checklist is included in the appendix.

Treatment for Abused and Neglected Children. Martin, H.P. (OHDS) 79-30199, 66 pp., 1979.
Designed primarily for use by child protective services workers, this manual discusses various aspects of the treatment of child abuse and neglect victims. Specific topics covered include immediate and long-term medical care, the provision of a safe home environment and the treatment of developmental and psychological problems. Possible negative effects of various treatment techniques are also discussed.

* * *

The following reviews, bibliographies, catalogs, directories and other materials provide information on child abuse and neglect research, publications, programs, laws and other relevant topics.

American Indian Law: Relationship to Child Abuse and Neglect. (OHDS) 81-30302, 56 pp., 1981.
The status of Native American tribal law on child abuse and neglect is examined in this publication. Specific topics covered include jurisdictional conflicts, the background, purpose, and applications of the Indian Child Welfare Act; and the legal systems in effect on Indian reservations. Appendices include a compilation of tribal code provisions pertaining to child abuse and neglect and the text of the Indian Child Welfare Act of 1978.

Data Aspects of Child Protective Services: A Report from the 4th National Conference on Data Aspects of Child Protective Services. (OHDS) 80-30291, 9 pp., 1980.
This report summarizes the views and experiences of the agency staff members participating in the Fourth National Data Aspects Conference. Topics discussed include computerized versus manual data systems, information sharing and problems of confidentiality, and the use of data systems for case management, program management, and fiscal and program reporting.

National Analysis of Official Child Neglect and Abuse Reporting, 1979. American Humane Association, (OHDS) 80-30232, 106 pp., 1981.
This document contains a descriptive analysis of reported and substantiated child abuse and neglect cases reported to child abuse and neglect protective services and related agencies during 1979. Specific areas covered include reporting summaries by Federal regions, statistical profiles of the involved families and the nature of the reported maltreatment, and the response of the child protective services units.

National Analysis of Official Child Neglect and Abuse Reporting, 1978. American Humane Association, (OHDS) 80-30271, 44 pp., 1980.
This publication presents a descriptive analysis of documented child abuse and neglect reports during 1978. Material covered includes an overview of national reporting statistics and techniques used in collecting and analyzing these figures. Topics summarized in accompanying tables include the source of report and substantiation, type of maltreatment, relationships between perpetrators and victims, stress factors present, and services provided.

National Analysis of Official Child Abuse and Neglect Reporting, 1977, (OHDS) 79-30232, 108 pp., 1979.
This report contains a descriptive analysis of reported and substantiated child abuse and neglect cases reported to child abuse and neglect protective services and related agencies during 1977. Specific topics covered include an overview of the extent of reported child abuse and neglect nationwide, statistical breakdowns by the type of maltreatment and type of perpetrator, and a comparison of the 1976 and 1977 data. Appendices contain the National Standard Reporting Form used in the survey, and a computer printout of the 1977 data from Level I participants.

1978 National Conference on Child Abuse and Neglect. (OHDS) 80-30249, 234 pp., 1980.
This volume summarizes the proceedings of Third Annual Conference on Child Abuse and Neglect held in New York City in April, 1978. It includes the text of major plenary session speeches, presentations by the winners of the "Best Paper on Child Abuse and Neglect for 1978" competition, and descriptions of the conference workshops and training sessions. Also included are descriptions of 36 demonstration projects funded by the National Center on Child Abuse and Neglect.

A Marketplace of Community Programs
Distributed at the Sixth National Conference on Child Abuse and Neglect (Sept. 1983), this publication describes about 170 child abuse and neglect prevention and treatment programs nationwide, and serves as a sourcebook for creative and innovative projects.

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