

COMPREHENSIVE EMERGENCY SERVICES

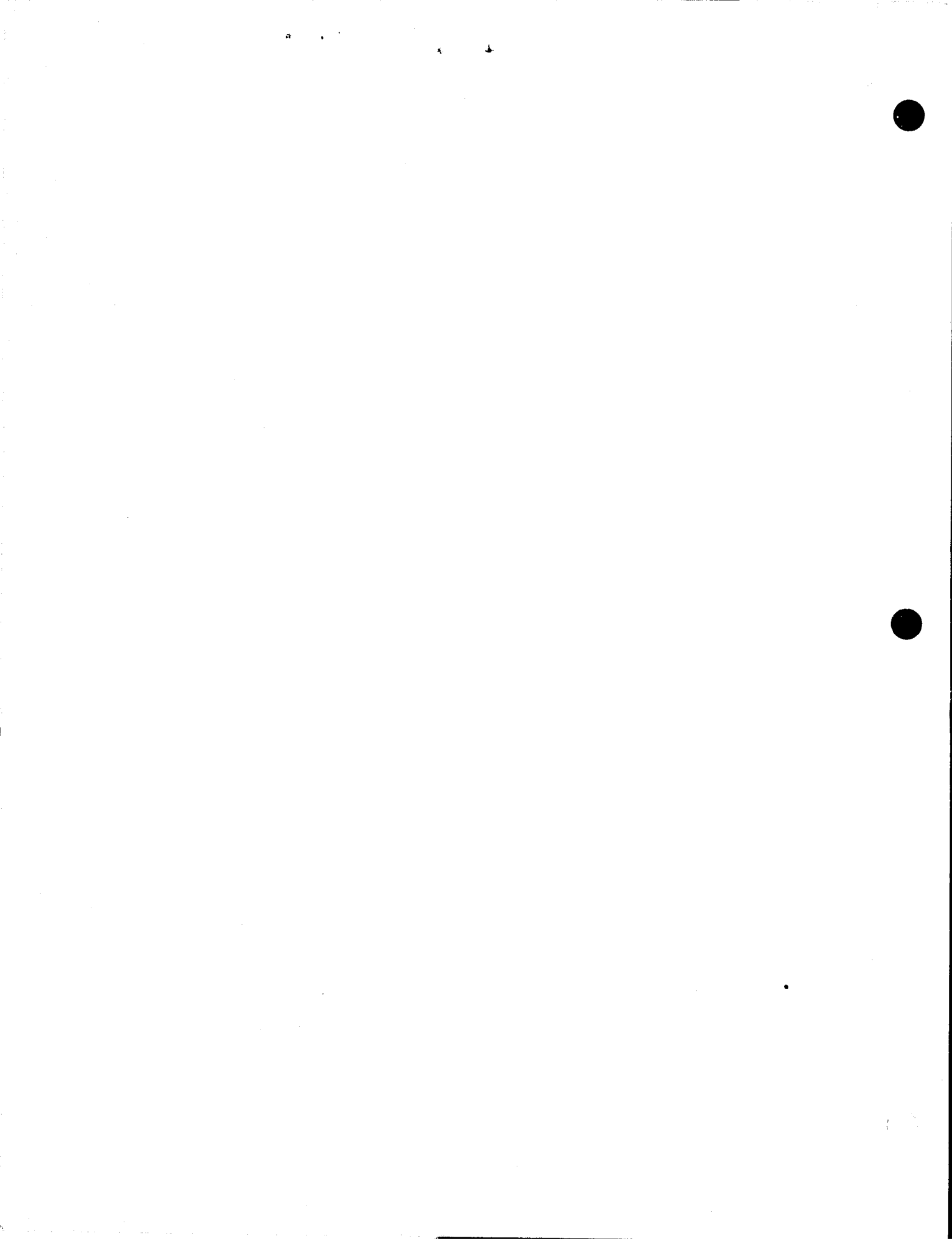
Community Guide

Second Edition

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
an Development Services / Administration for Children, Youth and Families
Children's Bureau

DHEW Publication No. (OHDS) 77-30120

49263



COMPREHENSIVE EMERGENCY SERVICES

COMMUNITY GUIDE

SECOND EDITION

Prepared by Staff

of the

NATIONAL CENTER FOR COMPREHENSIVE
EMERGENCY SERVICES TO CHILDREN

Center Director	Patricia W. Lockett
Assistant Center Director	Donna J. Jared
Field Program Specialist	Valeria Sweeney
Information Exchange Specialist	Ray Hawkins
Center Coordinator	Chris Beam

320 Metro Howard Office Building
25 Middleton Street
Nashville, Tennessee 37210

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development Services
Administration for Children, Youth and Families
Children's Bureau

DHEW Publication No. (OHDS) 77-30120

This document was prepared by the staff of the National Center for Comprehensive Emergency Services to Children in Crisis, Nashville Urban Observatory, pursuant to contract HEW-OS-74-216 with the U. S. Children's Bureau, Department of Health, Education, and Welfare. It was developed as a part of the National Center's mission to prepare and disseminate mixed-media materials to communities interested in organizing and operating a coordinated system of 24-hour emergency services to children and their families.

TABLE OF CONTENTS

	<u>PAGE</u>
Acknowledgments	
Preface	
Introduction	1
Chapter	
I	
CES: A BRIEF DESCRIPTION	5
II	
CES IN METROPOLITAN NASHVILLE, BEFORE AND AFTER . . .	9
Metropolitan Nashville	9
Relationship of Agencies Prior to CES	11
Concern Can Bring About Action	15
CES Coordinating Committee	17
Program Impact Data	21
Statistical Resumé of the Nashville Project . . .	23
III	
COMMUNITY ACTION FOR CHILDREN AND FAMILIES IN CRISIS	29
How to Achieve a Cohesive, Coordinating Committee	31
Steps for Implementing a CES System	33
Organization	33
Implementation	40
Maintenance	43
IV	
COMMUNITY SELF-STUDY	47
Survey of Needs	53
V	
PLANNING FOR CES COMPONENTS AND COST FACTORS	59
Building the Components and Cost Factors to be Considered	59
Cost Effectiveness of Nashville's CES Program . .	64

Chapter		<u>PAGE</u>
VI	COOPERATIVE PLANNING WITH GOVERNMENT	67
	Role of the Social Work Professional	68
	Suggestions for Communicating with the Political System	70
VII	SOME SPECIAL CONCERNS	77
	Development of CES in Rural Areas	77
	Special Attention for Minority Children	80
	Special Needs of Adolescent	81
	Decisions in Suspected Child Abuse Cases	83
VIII	PROBLEMS RELATED TO ADMINISTRATIVE AND SUPERVISORY SUPPORT	87
	Staff and/or Agency Resistance to Program Changes	87
	Administrative Structure	88
	Supervisory Role	89
IX	EMERGENCY INTAKE	95
	Purpose and Philosophy	95
	Specific Services	97
	Procedure for Twenty-Four-Hour Emergency Intake	99
	Intake Process	102
	Staffing	104
	Overtime	107
X	OUTREACH AND FOLLOW-THROUGH	109
	Purpose and Philosophy	110
	Transfer to Outreach	112
	Continuity of Service	116
XI	EMERGENCY NEIGHBORHOOD CRISIS CENTERS	119
	Purpose and Philosophy	119
	Specific Services	121
	Use of Consultation Teams	124

Chapter		<u>PAGE</u>
XII	EMERGENCY SHELTER FOR FAMILIES	127
	Purpose and Philosophy	128
	Criteria for Service	130
	Staff and Job Description	130
	Facilities	133
	Social Service Process	135
	Specialized Residential Programs	137
XIII	EMERGENCY CARETAKERS	139
	Purpose and Philosophy	139
	Staffing and Recruitment	140
	Specific Services Provided	146
XIV	EMERGENCY HOMEMAKERS	149
	Purpose and Philosophy	150
	Specific Services Provided	151
	Recruitment of Emergency Homemakers	156
	Other Procedural Considerations	157
XV	EMERGENCY FOSTER FAMILY HOMES	159
	Purpose and Philosophy	159
	Recruitment of Emergency Foster Family Home	161
	Standards for Emergency Foster Home Service	163
	Coordination	164
	Staffing	166
XVI	EMERGENCY SHELTER FOR ADOLESCENTS	169
	Purpose and Philosophy	170
	Specific Services Provided	171
	Criteria for Service	173
Appendix A		
	AMENDMENT TO TENNESSEE CODE ANNOTATED -	
	SECTION 37-230 (b)	177
	SENATE JOINT RESOLUTION NO. 24	178
	SENATE JOINT RESOLUTION NO. 28	180

Chapter	<u>PAGE</u>
Appendix B	
MAJOR FORMS	181
Appendix C	
NATIONAL CENTER FOR CES	209

CHARTS

I	COORDINATING COMMITTEE IS ESTABLISHED	38
II	COORDINATING COMMITTEE WORKS ON PLANNING AND ORGANIZING A PROGRAM	39
III	COORDINATING COMMITTEE SUPPORTS OPERATION	42

TABLES

PROGRAM IMPACT DATA	21
COST ANALYSIS DATA	26
TOTAL NASHVILLE CES COSTS	65

ACKNOWLEDGMENTS

Grateful acknowledgment goes to those persons who not only struggled together in the development and implementation of the Nashville Davidson County Project but all those persons across the country who are committed to the development of improved service delivery to children and their families.

We are most grateful to Beatrice L. Garrett, Foster Family Specialist, CB/OCD/HEW, whose continued support has made this effort possible.



PREFACE

We at the National CES Center are deeply indebted to persons across the country who have assisted with these revisions. The Community Guide was prepared originally with input from the participants who attended the National CES Conference, October 1974. Since then Regional workshops have been conducted across the country at which the Community Guide has been offered as a tool for guiding communities in the development of CES systems. In so doing, we have had identified for us certain areas which should be addressed.

It was with these in mind that revisions were made. It was immediately evident that the original Guide dealt almost exclusively with the average-sized city and had not addressed the problems related to implementation in an isolated rural community. In this Guide we have addressed the problems of developing and implementing CES in a rural community. We have also identified the distinct advantages of reorganizing service delivery in a smaller community where communication and coordination is generally less complex.

Maintenance of a CES system becomes an ongoing concern almost as quickly as a system is implemented. Therefore, we have dealt with this as the final phase in the development. It will be an ongoing concern for communities if they hope to maintain a viable operation. There must be an investment by the community on an ongoing basis.

We have highlighted for emphasis the problems in our country relative to the older youth and certain other most vulnerable children such as the Native American and other minority children. Despite the progress being

made to improve the services to children and their families, these children continue to be victimized. The oppression which is still so much a part of our country is so clearly reflected by the plight of such children and the attitude of our institutions. We have emphasized the need for the planners of CES to be mindful of such. We hope too that CES offers to many of you sufficient challenge to mobilize your communities for improved services to such children.

INTRODUCTION

This Guide has been prepared to assist communities throughout the United States in developing comprehensive emergency service systems to serve children and families in crisis.

*Comprehensive Emergency Services is defined as a child welfare service designed to meet any family crisis or impending crisis which requires social intervention for purposes of planning to protect children whose health, safety, and/or welfare is endangered with primary emphasis on those children who will reach the attention of the Juvenile Court, as neglected, unless there is immediate casework intervention.*¹

CES is not limited in its focus to abused, neglected, or dependent children; therefore, it is not just a child protective service. It has elements of both protection and prevention. It is a specialized social service to children aged 0-18 and their families. The family is the focus for the service impact. The preservation of an intact family is the primary objective. The emphasis is toward providing a safe environment for the child with as much continuity as possible. CES includes a wide range of options for care of the child in crisis.

The CES system was first designed to serve Metropolitan Nashville, a city selected to demonstrate this program because it was considered an "average" community--not the best nor worse. It was believed that a system tested in Nashville would provide valuable information which could be utilized in other communities of similar size and, with modification,

¹Metropolitan Nashville's CES program established this definition as a guide to serving children in crisis.

could be adapted to both larger and smaller communities throughout the country.

This Guide is based primarily on the experience gained in developing the CES system in Metropolitan Nashville and Davidson County, Tennessee. It has been developed primarily by persons who were directly involved in Nashville's system from the beginning, persons who invested much of themselves in the administration of programs to serve children and families over a period of several years and who have firsthand knowledge of the system's development and implementation. Therefore, it has sometimes been difficult to obtain total objectivity in assessing "what happened" and "who made it happen". In an effort to maintain as objective a view as possible, others involved in the development of the system have been asked to provide their views of its beginning and development, to test out and validate the judgment of the writers.

It is not intended that other communities replicate exactly the Nashville System. It is hoped only that the Nashville experience might serve as a guide for others wishing to develop a coordinated comprehensive emergency services program for children and their families.

This volume is divided into three major sections. Chapter I through VIII deals primarily with the developmental aspects of CES. A brief description of Metropolitan Nashville is given to provide the reader with background information on the development of the CES system. This is followed by chapters providing: information for administrators in the community developmental aspects of the system; the importance of evaluation of present programs and program needs of each community; planning for development of each component within established social service structures; a discussion of the importance of working with the political system;

special problems identified in the Nashville experience as areas to which communities should be alert; and, finally, the importance of good administrative and supervisory support.

The second section, Chapters IX through XVI, describes more specifically the operational aspects of each component of the Nashville CES System as well as one chapter on Emergency Neighborhood Crisis Centers as established in Buffalo, New York. These chapters discuss such topics as purpose and philosophy, specific services provided, procedures, recruitment of personnel, coordination, etc.

In the final section, Appendix A includes information on some legislation which may be of help to other states. Appendix B includes a variety of forms used in the program which are for review only. It is recognized that each agency will have some forms already in use which can be adapted. Other forms will need to be developed to suit particular needs, both within the agency and between agencies. Appendix C provides a brief description of the National Center and its function.



CHAPTER I

CES: A BRIEF DESCRIPTION

Comprehensive Emergency Services is a system of coordinated services designed to meet emergency needs of children and their families in crisis, providing options in care which will protect children and reduce the trauma induced by the crisis. It provides a vehicle for cooperative program planning between agencies and involves a concentrated effort to provide quality service to neglected, dependent, and abused children on a twenty-four-hour basis, including weekends and holidays. CES seeks to maintain children in their own homes during crisis situations. In cases where separation from the home environment is necessary, services are provided to children and their families which promote a more orderly, less damaging placement of children. The system consists of the following components which are considered basic to any CES system.

Twenty-four-hour Emergency Intake
Outreach and Follow-through
Emergency Shelter for Families
Emergency Caretakers
Emergency Homemakers
Emergency Foster Family Homes
Emergency Shelter for Adolescents

When woven into a cooperative network, these services provide a protective framework within which a community can serve its children. The system revolves around the child to offer the best solution to his dilemma, rather than casting the child into a chain of events which is more damaging than the original crisis. For some communities additional components of services, such as *Emergency Neighborhood Crisis Centers* and *Emergency Day Care Service*, may be identified as needed and can be planned and developed as a part of the system.

The entire system of service as provided by CES for children in crisis must interrelate in such a way as to facilitate the most effective service delivery. CES must have the flexibility to respond immediately, at any hour, to emergency problems confronting children and their families. In so doing, it must be capable of providing a wide range of both tangible and non-tangible services to the child and his family. These services must be directed primarily toward protecting the child while preserving the intactness of the family, if at all possible.

Each component of the service must interrelate with all the other components in such a way that there are no gaps in service to the family. The system must have the capacity to monitor itself and detect gaps as they occur. It must maintain an advocacy role which will enable it to obtain the needed service as expeditiously as possible.

Families and children must have immediate access to each component without being encumbered by referral procedures that delay the provision of service. Therefore, referral procedures must be simple and easily executed. This makes movement through the system easier for the child and his family.

This flow is not easily achieved unless components are built into a system under one coordinating mechanism. This can best be achieved by having the basic components administered through one primary agency. The services which are supplemental or supportive to CES must be forced to be responsive to families (food stamp certification, mental health clinics, etc.). All CES staff become advocates for those families CES serves.

The internal coordination and monitoring of the CES system must be ongoing to assure that each component remains viable and sufficiently

staffed. As breakdowns occur they must be readily identified and immediately corrected.

Many CES systems may be developed by large multi-functional agencies such as Departments of Social Services. It is imperative that CES be identified as a specialized service program within the agency and that the system not be rendered ineffective by the familiar phenomenon, "bureaucratic red tape", which is so much a part of most public agencies. Coordination between CES and other child welfare services within an agency must be carefully planned and maintained for optimal use of all services.

CES must make its purpose and objectives clearly known to the community. Visibility is an essential ingredient, one that will greatly determine the success or failure of a program. Not only should the telephone number of the twenty-four-hour emergency intake unit be highly publicized, but there must be an organized effort to inform the entire community of the service. Once the service is "advertised", a commitment is made and the community will expect the "advertiser" to live up to its claims, to do so with immediacy, and to offer quality service.

Communities designing a CES system may find that, in defining their own needs, some existing programs should be altered in focus. With planning, these programs may be modified to become one or more of the basic components of the CES system or to enhance the community's CES with supplemental services not formerly available. Such supplemental services could include a treatment facility for emotionally disturbed children or a group home for older children unable to adjust to a family situation.

Most communities already have one or more of the basic components of a CES system or could have with some minor shifting of programs. Other components will have to be developed to complete the system and truly meet the needs of children in crisis. CES must become an integral part of the total child welfare program so that all basic child welfare services are available when needed beyond the crisis stage.

Since CES was designed initially for an urban community, modification will be necessary to adapt the system to the needs of some communities, particularly rural communities. To accomplish this, careful examination of each component in relation to the community's size and needs must be made. Additionally, various cultural patterns will need to be understood and taken into consideration. *It is believed that the basic concept of the system can be applied to any community. Only by matching concern with concerted effort can communities consciously avoid the neglect they now are inflicting on children and youth in crisis. CES offers an alternative concept; individuals can offer the personal commitment to make comprehensive emergency services a reality in their community.*

CHAPTER II

CES IN METROPOLITAN NASHVILLE BEFORE AND AFTER

For the reader to understand how the CES system developed and functioned, a brief description of Metropolitan Nashville is provided and is followed by a discussion of the primary agencies involved in the development of Nashville's CES system. This chapter is included to point out some of the problems Metropolitan Nashville faced and to provide a comparison for other communities in terms of size, number of agencies to be involved in planning, etc. As communities look at the development of CES, those that are larger or smaller than Nashville may find it necessary to adjust their program planning accordingly. Large cities may require a more complex system with possibly a central coordinating unit and the remaining CES components clustered in a number of geographical locations.

Some metropolitan cities may wish to identify specific areas where the reported incidence of abuse or neglect is high and plan for a system to serve that specific area. This could be achieved through an Emergency Neighborhood Crisis Center, patterned after the demonstration project in Buffalo, New York and funded by CB-OCD-HEW. This program incorporated many of the attributes of the CES system. Such a center could house and/or coordinate the basic CES components.

METROPOLITAN NASHVILLE

Nashville, a community of approximately 500,000 people, is served by fifteen colleges and universities including two medical schools, Vanderbilt and Meharry. It is in the heart of the so-called Bible belt

and is, therefore, a city of over 700 churches and many different religious groups. Recognized as the home of country music, with the Grand Ole Opry and Opryland, it has developed one of the largest music and recording industries in the country. This industry often brings to Nashville families who become stranded and in need of a variety of social services. Nashville is a banking and insurance center. Its urban renewal program has been considered outstanding. It now boasts six legs of interstate, connected to an inner loop, making for expeditious transportation to, from, and through the city. It has approximately a 20/80 racial balance between black and white. While Nashville has had its share of racial problems related to the integration of public facilities, busing to schools, etc., it has achieved the current level of integration with less violence than many cities have experienced. It has its share of ghettos, both black and white. Low income housing is supplied by nineteen public housing projects including five high-rises for the elderly, which is not sufficient to meet housing needs. Last but not least, Nashville is the State Capitol, which has considerable impact on its overall employment and economic status. The cost of living is 91% to 92% of the National Urban average.

In April, 1963, the city and county governments were consolidated into one Metropolitan government by Metropolitan Charter which was adopted June, 1962. It is one of the few consolidated city-county governments and one of the most complete. The Metro Charter was written by men of vision, who had a determination to make this government into one that truly serves its people. As a result, there has been a dedication on the part of the primary writers of the Charter to bring about change in Nashville, in many areas, and much work to make it an outstanding

community. These were men with great pride in their community, who set high standards in their goals for education, urban renewal, social and rehabilitative programs, cultural development, etc. Fortunately, this same level of interest and concern exists for programs serving children.

There is no intention to imply that Metropolitan Nashville became a reality without its share of problems. There have been many. From those difficult days at the outset of the consolidation of county-city systems until the present, new and larger problems have developed due to increasing urbanization and growth. Metropolitan Nashville did become a reality and problems have been and are gradually being resolved. Persons at many levels have learned the importance and art of working together.

RELATIONSHIP OF AGENCIES PRIOR TO CES

To understand the problems Nashville faced in developing its CES system, one must be aware of the public and voluntary agencies and how they related to each other. Metropolitan Nashville is a community with many of the strengths and weaknesses in its social service program which may be found in other average communities.

Nashville had and continues to have its problems between agencies. Deep-seated tradition in terms of roles and responsibilities initially hampered the development of the system. Feelings between agencies had to be dealt with and time allowed for resolving and handling these feelings before movement toward a new system could be made. Agencies were threatened by losing some of the traditional responsibilities they had maintained as well as by a change in funding.

Davidson County Office of the Tennessee Department of Human Services²

The Tennessee Department of Human Services, a state administered program, maintains county offices which are responsible for program implementation in each county. The Davidson County Office was and is the second largest in the state. Prior to implementation of Supplemental Security Income, this office was responsible in Metropolitan Nashville for all categorical assistance programs (OAA, AB, AD, AFDC, Food Stamps, and Medicare) and for social service programs. With implementation of SSI, the adult categorical programs for income maintenance (OAA, AB, AD) were shifted to the Social Security Administration. The Davidson County Office of the Tennessee DHS continues to be responsible for AFDC, Food Stamps, and Medicare. It maintains responsibility for social services to adults and to families and children. Social Services provided to families and children include protective services, foster family services, services to unwed mothers, adoption services, day-care licensing, homemaker services, comprehensive emergency services, etc.

Since there were few choices for emergency care prior to CES, one of the major problems was in providing appropriate care for children and families caught in crisis situations. Often against the professional judgment of caseworkers, recommendations were made which resulted in placement of children for long periods of time. Consequently, staff was frequently frustrated. Often, children had to be placed in an institutional setting for temporary care, where they remained for long periods of time. This was due to a lack of resources for planned placements and long court dockets which delayed adjudication proceedings. While awaiting a decision

²Tennessee Department of Public Welfare prior to May 20, 1975.

regarding the child, families sometimes disintegrated or disappeared. Often, children were placed in the Metropolitan Children's Home, now Richland Village (see below), a neglect/dependent petition filed, and temporary custody remanded to the DHS office before the staff was even notified of the situation. Receipt in the county office of the custody order or a phone call from Metropolitan Children's Home was often the first knowledge the DHS staff had of the case situation. Funding for foster care was complicated as both local (23%) and State (34%) government shared this responsibility with the federal government, which made funds available through the AFDC-FC (43%) program. None of the State allotment of CWS funds (Title IV-B) were used for direct cost of foster care.

Metropolitan Social Services

This agency, formerly known as the Metropolitan Welfare Commission, acquired two children's homes when the city-county governments were consolidated. Until that time, Metropolitan Social Services had been primarily an agency to provide emergency financial assistance and was operated and funded by county government. The old city government had maintained two children's homes, one for white children and one for black children. Operation of these homes, plus two homes for the aged, became a function of Metropolitan Social Services. This agency spent much time and effort gaining community support for consolidating the two children's homes and obtaining funds to begin a building program to provide modern, cottage-type facilities for these children. This effort was very successful. All the old buildings have been demolished, and the facility, now known as Richland Village, is new and modern. This facility served as the emergency shelter program for children of all ages (up to eighteen) until the implementation of CES. Richland Village was frequently over-

crowded, as there was no way to control the number or condition of the children (taken by police and remanded by court to Richland Village). Even though there was a sixty-day time limit for being housed at Richland Village, children often stayed beyond this limit for many different reasons. Statistics showed that during 1969, 23% of the children placed at Richland Village stayed more than three months.

Because of the funding by local government of a large share of the direct cost of foster care and the local funding needed to maintain Richland Village, the two agencies responsible for operation of these programs often were in conflict over the allocation of monies.

Metropolitan Juvenile Court

The Juvenile Court had responsibility to make adjudications on all neglected, dependent, abused, and delinquent children on whom petitions were filed, as well as other responsibilities related to children. When neglect/dependent petitions were filed, temporary placements were made by the Juvenile Court, investigations were made by probation officers (as well as by DHS protective service workers), hearings were held by the Juvenile Judge, and temporary adjudication of custody of the child was made. The Juvenile Court referred by phone all neglect/dependent petitions to a DHS intake worker. Copies of custody orders, placing the child in temporary custody of the DHS were then mailed. These referrals were made after petitions were filed, and in many instances, DHS was not involved prior to the petition. Just as DHS staff was frustrated by the lack of resources for these children in crisis, so was the Juvenile Court.

Metropolitan Police Department

Police officers actually signed the petition in approximately one-

third of all neglect/dependent cases and frequently picked up the children, took them to the Juvenile Court, and then to Richland Village. This process required hours of valuable time of the Youth Guidance Division of the Police Department which was needed for law enforcement concerns. Beyond this was the effect such a procedure had on the children involved. It is necessary only once to see the frightened, lost look on the face of a child to have it indelibly printed on one's mind.

Other Agencies

Among other agencies providing care for neglect/dependent children were: Tennessee Preparatory School, a public facility for children ages 6 to 18, operated by the Tennessee Department of Education; AGAPE, a private church-sponsored agency providing foster family homes; and Madison Children's Home, a church-sponsored agency providing both foster group homes and foster family homes. These agencies seldom were involved in providing emergency care but served primarily as resources for children needing planned placement after the court hearing. They did and still do serve as valuable placement resources.

CONCERN CAN BRING ABOUT ACTION

The Nashville CES system grew out of a concern in 1968-69 by local government of the need for additional shelter care for the increasing number of children being brought before the Juvenile Court on neglect/dependent petitions. It was concerned not only for the children but for the cost. Already local government was providing tax dollars for the support of Richland Village, which was always filled to overflowing, and for an appropriation of \$100,000 each year to the County Office of the Tennessee Department of Human Services for direct cost of children in

foster family homes. (This was increased to \$125,000 for fiscal 1974)

There was concern on the part of the staff at Richland Village and of the local Department of Human Services for the number of children coming into care who could have remained at home if adequate services were provided. There was concern for the number of very young children coming so precipitously into a system which provided physical shelter, food, etc., but provided little to meet their emotional needs. There was concern for the increasing demands for foster homes and with it the overtaxing of limited foster care funds. There was concern for the further breakdown in families once separation had occurred and for the difficulty in restoring families to a functioning level. There was concern for the length of time children remained in shelter care (at a cost to taxpayers) because they could not be returned home, and other resources were not available. Often, children remained at Richland Village for several weeks simply because the court docket was so full that hearings could not be set earlier to return them home. There was concern for the number of older children coming to the attention of both the court and the social agencies who needed long-term therapeutic group care which was simply unavailable. As a result, some older teenagers actually stayed in the shelter facility for a year or more because of lack of resources. This caused many problems between the agencies since this was in violation of the purposes of the facility.

Out of these concerns, local government contracted with Dr. Marvin Burt and Louis Blair of the Urban Institute of Washington, D. C., to study Nashville's neglect/dependent system.³ Approval for both state and local

³Marvin R. Burt and Louis H. Blair, Options for Improving the Care of Neglected and Dependent Children (Washington, D. C., 1971).

public agencies to participate in this study was obtained. This action set in motion agencies working together to compile necessary data. The study focused on Nashville's fragmented system of services and pointed to the need for a well-planned, coordinated system. It pointed the way for needed changes which would alter agency roles and functions in serving children in crisis.

CES Coordinating Committee

A committee was formed to begin working on solutions to the problem. The committee was actually brought together initially by a staff member of the Mayor's Office and included representatives of the Department of Human Services, Richland Village, Metropolitan Social Services, Metropolitan Juvenile Court, Metropolitan Police Department, Metropolitan Public Health, Metropolitan Public Schools, and representatives of other "citizens" groups such as the Junior League and Council of Jewish Women.

Implementation of the CES system in Metropolitan Nashville required that these agencies work together for a period of several months, and plan for changes within each agency. During these months the committee members gradually developed a better understanding of the programs, problems, and the limitations of each agency. A new appreciation and respect for the work of each agency occurred. Specifically, the committee members developed a better understanding of:

1. the child welfare programs of DHS, particularly the protective service and foster family service programs; the need for foster care funds, and how they were expended
2. the problems at Richland Village; the cost of operation, the frustrations in having no control over the number of children

sent there by the Court, and the severe problems of many of the children

3. the overloading of the Juvenile Court docket by neglect/dependent petitions filed inappropriately (60% of the total number of children removed from their families were returned home following the Juvenile Court hearing) and the number of children coming before the court for whom there was no adequate resource

At times, there was an almost helpless feeling as to how the system could be modified and new resources developed. Yet, the committee had become committed to trying to find a way. Sharp disagreement within this group, which occurred in the beginning, gradually ceased. With the assistance of the Mayor's staff, the committee began trying to find new ways of funding programs to change the system.

The local DHS was designated as the agency to design the CES system and develop a proposal for a demonstration grant. DHS became the designated agency since it had legal responsibility for children determined to be neglected and/or abused. The proposal was developed and funded under a contract with the Children's Bureau, Department of Health, Education, and Welfare, for three years beginning July, 1971, and ending June, 1974. The local DHS had the following components of service: emergency intake, caretakers, homemakers, foster family service, and outreach and follow-through. DHS was also responsible for the role of coordination.

Richland Village changed its program from emergency shelter for children of all ages to two separate programs; (1) two-week emergency shelter for appropriate adolescents and (2) long-term treatment for pre-

delinquent youth. (Statistics showed that 17% of children aged 10-18 on whom neglect/dependent petitions were filed also had delinquency records. Some six months following implementation of CES, an emergency shelter for families was developed and operated by the Salvation Army. The Juvenile Court developed a special protective service unit of probation officers to work closely with the emergency intake staff.

All these agencies worked together to develop proposals for funding to begin at the same time, since their programs were interdependent. Funds were obtained from LEAA, Title IV-A, UGF (United Way), and local government. Later, when federal guidelines were changed and Title IV-A funds could not be used for family shelter, State funds were obtained through special legislation and allocated through the DHS to Richland Village and the Salvation Army for continuation of their emergency shelter programs. As problems arose over funding, specifically Title IV-A, the Council of Community Services and members of various citizen groups provided leadership and influence with State legislators to obtain needed State funds for program continuation.

Without the help and encouragement of the staff of the Mayor's Office, development of the CES system might never have occurred. It was a new experience for local government to be willing to work with the local County Office of the Tennessee Department of Human Services in such a supportive way. In Chapter III what was learned during those months, plus information from communities with similar programs, has been translated into a guide for community action.

This new system⁴ of emergency services to children and their families

⁴Marvin R. Burt and Ralph Balyeat, "A New System for Improving the Care of Neglected and Abused Children", Child Welfare, Vol. LIII, March, 1974, p. 3.

brought about a successful reform and reorganization of services to children and families in crisis. With completion of the demonstration project (June 1974), the DHS components are being continued under state administration like any other child welfare program. Some additional state funds for its continuation and for expansion to other urban communities have been obtained. Components in agencies other than DHS continue to operate with the same funding sources.

The program impact of the CES system, in terms of services rendered, is reflected in the following tables. A final report by Dr. Marvin Burt and Dr. Ralph Balyeat shows that referrals involving children increased by 92% with 68% of the total referred being made at night or on weekends. These were those cases which required immediate intervention both after and during normal working hours. Suspected child abuse referrals constituted 7% of the total number of referrals. However, the overall increase in referrals of suspected child abuse was 274% increasing from 50 referrals in 1969-70 to 182 in 1973-74. The year prior to CES 482 children (38% of the total referred) were placed at Richland Village as compared to 67 children in 1973 (3% of the total referred). No children under six were placed at Richland Village under the new system. This was an overall reduction of 86%. From 1970 to 1973 CES brought about a reduction in neglect/dependent petitions of 48% (602 to 266).

In 1973 emergency caretakers cared for 33 children, preventing precipitous removal, and emergency homemakers maintained 527 children (21% of the total referred) in their homes. Emergency foster homes provided care for 158 children (6% of the total). Without these services many of these children would have been placed in Richland Village for emergency shelter, and neglect/dependent petitions would have been filed.

The number of children on whom petitions were filed who had previously had N and D petitions filed declined from 196 in 1969-70 to 23 in 1973-74, a reduction in recidivistic cases of 88%.

PROGRAM IMPACT DATA

CES Component Description	Prior to CES 1969 - 70		CES 1973 - 74		% of Increase- Decrease CHANGE
	Total	% of Total	Total	% of Total	
<u>Cases Screened by CES 24-Hour Intake</u>					
• Families	680	---	991*	---	+ 48%
• Children	1260	---	2422*	---	+ 92%
<u>Complaints/Referrals Received and Actions Taken by CES</u>					
• Required Immediate Intervention					
-after normal working hours	not available	---	397*	---	+ 39%
-during normal working hours	not available	---	277*	---	+ 28%
• Referred to Outreach and Follow-through					
-after normal working hours	not available	---	109*	---	+ 11%
-during normal working hours	not available	---	207*	---	+ 22%

TOTAL					+ 100%
<u>Effect of CES System in Relation to Cases Screened</u>					
<u>Neglect/Dependent Petitions Filed</u>					
• Children	602	48%	266	11%	- 56%
<u>Cases Screened No Petitions Filed</u>					
• Children	770	61%	2156	89%	+ 180%

*Data on Cases Screened by CES 24-Hour Intake and on Complaints/Referrals were collected on a calendar rather than program year basis. Therefore, the figures above represent an average for 12 months during the period January, 1972 to March, 1974.

PROGRAM IMPACT DATA
(continued)

CES Component Description	Prior to CES 1969 - 70		CES 1973 - 74		% of Increase- Decrease CHANGE
	Total	% of Total	Total	% of Total	
<u>Emergency Caretakers Assigned</u>					
• Families	not available	---	13	1%	
• Children	not available	---	33	1%	
<u>Emergency Homemakers Assigned</u>					
• Families	not available	---	134	13%	
• Children	not available	---	527	21%	
<u>Placement with Emergency Foster Family Homes</u>					
• Families	not available	---	96	10%	
• Children	not available	---	158	6%	
<u>Placements at Richland Village (number of children)</u>					
• Petitions	262	21%	35	1.4%	- 87%
• Voluntary Placements	220	17%	32	1.3%	- 85%
TOTAL	482	38%	67	3%	- 86%
<u>Richland Village Placements by Age of Entrants</u>					
• Children Six and Over	302	24%	67	3%	- 78%
• Children Under Six	180	14%	-0-	-0-	- 100%
TOTAL	482	38%	67	3%	- 86%
<u>Recidivistic Cases*</u>	196	33%**	23	1%	- 88%
<u>Suspected Child Abuse Referrals</u>	50	4%	182	7%	+ 274%

*The number of children on whom petitions are filed who had previous N & D petitions filed. The recidivistic rate, i.e., the percentage of children on whom petitions are initially filed who are abused or neglected again by the end of the subsequent year, declined from 16% in 1969-70 to 9% in 1973-74.

**This percentage is based on the total number of N & D petitions filed (602).

STATISTICAL RESUME OF THE NASHVILLE PROJECT

The objectives of the Nashville Davidson County Demonstration Project were to:

1. reduce the number of children being removed precipitously from their homes
2. reduce the number of children going through the legal system unnecessarily
3. plan orderly placements for children who must be placed
4. set goals for children who come into emergency care with decisions to return to their parents or relatives
5. develop placements that better meet the needs of children who must remain in care

The criteria for the attainment of these objectives related to:

1. a reduction in the number of N & D petitions (56%)
2. a reduction in the number of families with one or more children named on N & D petitions (54%)
3. an increase in the number of complaints and referrals where no petition was required (180%)
4. a decrease in the number of children placed in some type of substitute care (51%)
5. a reduction in the number of children placed at Richland Village as a result of N & D petitions (87%)
6. a reduction in the number of children under age of six who were placed at Richland Village (100%)

The total number of referrals received by the emergency services unit of the Department of Human Services from April 1, 1972 to March 31, 1974

included 1,981 families with 4,845 children, an average of 991 families and 2,423 children per year.

1,349 families with a total of 2,922 children required the services of the emergency unit. 1,012 or 51% of these referrals were after normal working hours, thus indicating the importance of the new twenty-four-hour coverage.

Based on the examination of case files, the temporary placements made and the number of children who ultimately returned home or to relatives (60%), Marvin Burt's study projects that the use of twenty-four-hour intake screening by a caseworker could result in a reduction of at least 180 petitions per year without any backup resources being available. With the addition of these components as was done with the Nashville Project, a reduction of up to 400 N & D petitions per year was a probable estimate.

The service components provided intake and outreach staff with options for handling situations, options not previously available to them. The efficient utilization of such component gradually evolved during the second year of operation.

Caretaker service perhaps was not utilized to the fullest extent even then due to reasons as given in the chapter which describes this component. From April 1972 through, caretakers served a total of 45 families with 105 children. It was anticipated that this component would serve some two families per month. The use of this component was limited, however, to situations that could be quickly and thoroughly screened to assure both the legal and physical safety of the caretaker.

Over the two-year period an average of just over one (1.1) situation received the services of this component. Duration of assignment ranged from 30 minutes in a minor accident case to 72 hours in a situation where a

foster mother was critically ill. The average assignment was approximately twenty-four hours, with over 75% of the cases involving nighttime duty. 51% of the situations where a caretaker was assigned involved a child left unsupervised.

Homemakers service provided the continuity by offering a longer-term option to removal. The scope of this component ranged from short-term intervention to assumption of full and indefinite responsibility for children. In 1972-73 eight emergency homemakers provided service to 127 families with a total of 537 children. In 1973-74 there were 10 homemakers who provided services to 134 families with 525 children. Of the total number, 294 children from 78 families were identified as children who would have had petitions filed on them under the old system.

These were situations which fit into situational categories where petitions would have been routinely filed under the old system because this option was not available. If a parent was hospitalized on an emergency basis, a shelter placement following the filing of a petition was the only alternative available to law enforcement.

Of the 294 children identified as children who would have entered the judicial system under the old system, 32 of these children later had petitions filed after having been maintained by emergency homemakers over a period of time. In both years almost half of the cases required a homemaker service for more than one week and in 1973-74, 11 per cent required over six weeks of extended care.

Emergency foster homes were available to supplement the two previously mentioned components. In 1972 there were 156 children placed and in 1973-74 there were 158 placements.

Of the placements in 1972 and 1973, 25 per cent and 21 per cent respectively were by voluntary agreement of the parent compared with fewer than 5 per cent in 1971.

On the average children spent 2.5 weeks in emergency foster placement in 1972 and 3.1 weeks in 1973. Over one-third of the children in both program years either spent less than one week or over eight weeks in emergency foster placement. 40 per cent of the placements were made in the period of July through September and only 3 to 5 per cent respectively were made during the months of December and May.

Lack of supervision (28%), abuse of the child (23%), and lack of habitable housing (16%) are the reasons most frequently cited for placements in emergency foster care.

COST ANALYSIS

The total costs for the two years of operation of the CES program in Nashville is as follows:

	(\$000)		
	Program Year 1972-73	Program Year 1973-74	Total Costs
Department of Human Services	95	131	226
Juvenile Court	89	70	159
Richland Village	29	31	60
Total	213	232	445
Less Richland Village Costs	244*	269**	513
Net Costs	(31)	(37)	(68)

*17,001 days of care @ \$14.36 in 1972-73

**17,001 days of care @ \$15.82 in 1973-74

The average daily "caseload" of about 57 children at Richland Village in 1969 generated 17,001 days of care per year.

"Caseload" indicates the number of children present at any time during that day as opposed to bed load which includes the number of children present overnight or bed capacity. As children must be fed, supervised, and administered to whether they remain overnight or not, "caseload" is a better cost indicator.



CHAPTER III

COMMUNITY ACTION FOR CHILDREN AND FAMILIES IN CRISIS

Community involvement and planning in the development and maintenance of a CES system is essential. Good programs have been developed over the years only to fail because of lack of planning and real cooperation and communication between agencies. Talking about cooperation is not enough; it must be actualized. When communities have problems between agencies in coordination and planning, agency relationships must be clarified before a CES system can operate effectively.

This chapter has been designed to outline a step-by-step process for community planning, development, and maintenance of CES. The process may not develop in exactly this order. Every community is different with different levels of development, and with unique methods of communication between agencies and the political structure which provides financial support to programs. All this will have to be taken into consideration as each community action group follows this guide. Remembering always that there are certain basic ingredients, as with a recipe, the chef can always add his own touch--seasoned to taste. In this guide, the basic ingredients are included. The way to blend or season is discretionary.

There is a big difference between agencies having several components of CES with informal referral procedures and a true CES system. A CES system requires planning together by establishing written agreements, so everyone is clear as to mutual expectations. It is also important to have a plan for the review of an ongoing program and problems that surface. When the system truly works, each element in the system complements the others.

Each seeks to be supportive of the other, realizing that the failure of any element can jeopardize the functioning of all others, thereby reducing the effectiveness of the whole.

The coordinating committee becomes the cohesive mechanism that binds the total system together. This committee spearheads the entire effort from the first step through implementation. The committee's function, however, does not stop here; it goes beyond the implementation of CES. Such a committee must have ongoing involvement in the development and maintenance of the system for the duration.

Human service delivery programs are vulnerable and too often subject to political change. Therefore, programming often takes on a "yo-yo" effect. Administrators who are committed to viable programs are constantly battling to maintain and/or implement more effective services. If the composition of the coordinating committee is made up of agency representatives and citizens in the community dedicated to improved services to children, this composite can become a stable source of both power and influence. As supportive or not so supportive politicians and administrators come and go, the CES system need not be adversely affected. The committee needs, however, to constantly bring new key people on board.

In following this outline for community action, one needs to realize it will not always move smoothly, that some steps may take weeks to implement, while others take only a short time. There must be someone willing to take the leadership in forming the committee and once formed, keeping it working together.

Achieving a working committee dedicated to implementation of a CES system is the first step. This group must come together committed to resolving the problems of fragmented, ineffective service delivery to

children and their families in crisis. This will be the primary focus of the group always. Each agency or discipline must be prepared to make the necessary adjustments to accomplish this end.

How to Achieve a Cohesive, Coordinating Committee

The following principles of cooperation and collaboration are suggested (not in order of priority) for community leaders involved in developing a coordinating committee.

1. Need: There must be an identified need for emergency services in the community and the committee must be ready to move toward meeting the need. (Otherwise, the community will have to be educated to the need.)
2. Goals: Goals must be established to meet identified needs and be relevant to all parties concerned. They must be realistic, attainable, mutually agreed upon, and behaviorally specific. Goal accomplishment should be documented and communicated to all group members.
3. Representative Sub-Committees: Sub-committees representing the major interests must be formed. These are essential for pre-planning, planning, and serving in an ongoing capacity.
4. Communications: Communications must be open, must be established and maintained with a willingness both to express one's self freely and to listen carefully. Input must be ongoing.
5. Leadership: Natural leadership should emerge, but may change.
6. Procedures: There must be consensually defined procedures. (Who is responsible? What are the activities? When will it be accomplished?)

7. Mutual Trust: Trust develops from patience, understanding, honesty, awareness, and sensitivity to individual and community group feelings.
8. Commitment: There must be both agency and individual commitment to a particular project or task.
9. Risk Taking: There must be a willingness to take individual, agency, and group risks--the risk to legitimize the particular group and the differences within the group.
10. Full Consensus: Consensus through accommodation is preferable to the imposition of "rules and regulations".
11. Pride in the Group: Its purpose and goals can move the group toward mutual respect and appreciation for its members.
12. Evaluation: Evaluation must be ongoing for the purposes of altering, adding, or deleting goals and to monitor all follow-up according to behavior of group members and results of actions.

Some check points for collaborative behavior within the group are:

- coordination of efforts
- subdivision of activity
- pressure to achieve
- number of communications (participation)
- attentiveness to fellow members
- mutual comprehension of communications
- orientation and orderliness
- productivity per unit of time
- quality of product and discussion
- friendliness during discussion
- pride in functioning of the group

STEPS FOR IMPLEMENTING A CES SYSTEM

Organization

For those persons interested in helping a community plan for a CES program, the following suggestions are made:

1. Start with a neighborhood or community that is dissatisfied with the system or non-system as it now serves children. These communities will have persons who are sufficiently concerned about children in crisis to diligently work toward a better system. The key to development of CES is an overriding, common interest and commitment to children by persons in key positions, both in agencies serving children, citizens, and individuals in political or governmental positions.
2. Start at the highest level of authority possible, within both local and State government, to obtain the political support needed.
3. Make leaders of the community aware of the harm done to children by the lack of effective service to maintain children in crisis at home and how often such crisis situations occur.
4. Determine where responsibility for these children is lodged among the agencies and which agency has legal responsibility for protective services to children. Identify key persons within the agencies to contact initially for beginning involvement.
5. Choose the 'right' person from among those individuals identified to bring a representative group together. This person must be one who is respected by the agencies and who has the ability to communicate well. It may be an agency person, a political leader with authority, or both. The source for this leadership

is usually there in the community ready and waiting to be tapped. This person provides a catalyst for the effort by generating interest and creating a working committee. The CES coordinating committee then must not only encompass representation from all factions, but such representatives must be truly committed to improved service delivery to children and their families.

6. Include in this representative group, persons from those agencies directly involved in the care of children, representatives of local and State government, planning councils, lay citizens (such as board members or members of various groups interested in social welfare concerns), etc. (To obtain the most realistic picture of the needs of children and their families in crisis within any community, it is recommended that the make-up of any representative group include individuals involved in direct service to children and their families in crisis. These individuals may be front-line field workers in various community agencies or agency intake workers and telephone intake personnel both in the professional and non-professional realm.)

Rural areas with a widely dispersed population pose a very special problem in providing early intervention in crises that potentially can endanger children either as victims of abuse or neglect.

In planning for CES in these communities, it is important to tie into groups that provide for social contact and interaction. Most easily identified is, of course, the church. Here the church can provide a prime vehicle for increasing public awareness as to the nature of abuse and neglect as well as offering the

potential source for reporting/casefinding. There are, of course, other groups that provide social outlet for individuals in these areas that should be represented on the committee. It is important to involve these resources as they most likely have an impact upon the population as well as having an ability to expedite planning for improved service.

7. Present the concept of CES to this group and determine their interest in working together to document the extent of the problem of children in crisis in their own community. If these are persons already concerned over what is happening to children, they will welcome the opportunity to identify the totality of the problem so that a better way to provide services can be found. The following steps to form a cohesive group are essential:
 - a. The group organizer should elicit verbalization of concerns, grievances, ideologies, and hopes from those individuals involved in direct service in existing community agencies.
 - b. Ideas, concerns, and suggestions, as well as problems identified, should be listed and recorded according to specific agencies and community services rather than specific to the personalities and names of individual persons represented in the group.
 - c. All recording of group discussion and activities must be shared and clarified with all group members.
 - d. Individuals must be enabled to clearly verbalize their own purposes and goals for attending such a representative group and discuss what they hope to accomplish through the process of the specific group if it is to continue meeting and working.

e. After the statements of individual purposes and goals are elicited, the group must reach consensus regarding a group purpose and group goals.

This group can become a coordinating committee for the purpose of studying the needs of children and families in crisis. It may be necessary for this group to meet several times on a weekly basis before it becomes a formalized coordinating committee.

8. Focus on concern for children from the outset. (See Chart I)

As committee members representing various agencies focus on this concern, resistance to change and adherence to traditional agency roles and responsibilities gradually give way. There develops a willingness to discuss shifting of programs and creation of new programs if children's needs will be better served. Focus on this concern must be repeated over and over again. In the process, the committee needs to give due consideration to the following questions:

- a. If the community is to support and legally require the reporting of incidences involving children who are neglected, abused, or in danger of being so, is it willing to provide the kinds of services needed by these children and their families?
- b. Are agencies truly committed to prevention of neglect and abuse and to strengthening families so children can remain with their parents?
- c. Can local and State governmental agencies work together with private agencies to develop a cooperative system of services and be willing to reorganize existing agency roles and responsibilities to better serve children and families?

- d. Can political leaders be involved in planning and supporting program development?
 - e. Is there a community conscience that will guide the development of an improved system of services?
 - f. Does the committee believe in the CES concept to the extent that it is willing to devote the time, effort, and energy required to establish such a system?
9. Identify members of the coordinating committee who can become facilitators. These will be persons with technical knowledge within their agencies, persons who know the social welfare system in the community and understand how it interacts. These facilitators should form a smaller working sub-committee to begin analysis of the current system, gather basic data necessary, and begin formulating a plan which can be presented to the coordinating committee. This sub-committee should work as a team, with one member selected to call the sub-committee together at regular intervals to review progress. This team should agree upon a plan for action to include:
- a. identification of strategies
 - b. specification of roles
 - c. distribution of tasks
 - d. evaluation procedures

Time limits for obtaining necessary information and presenting a plan to the coordinating committee should be set. (To obtain the data base needed and to identify program needs for children and families in crisis, utilize the materials in Chapter IV, page 47 Community Self-Study.)

CHART I

COORDINATING COMMITTEE IS ESTABLISHED

ITS FOCUS: CONCERN FOR CHILDREN AND FAMILIES IN CRISIS

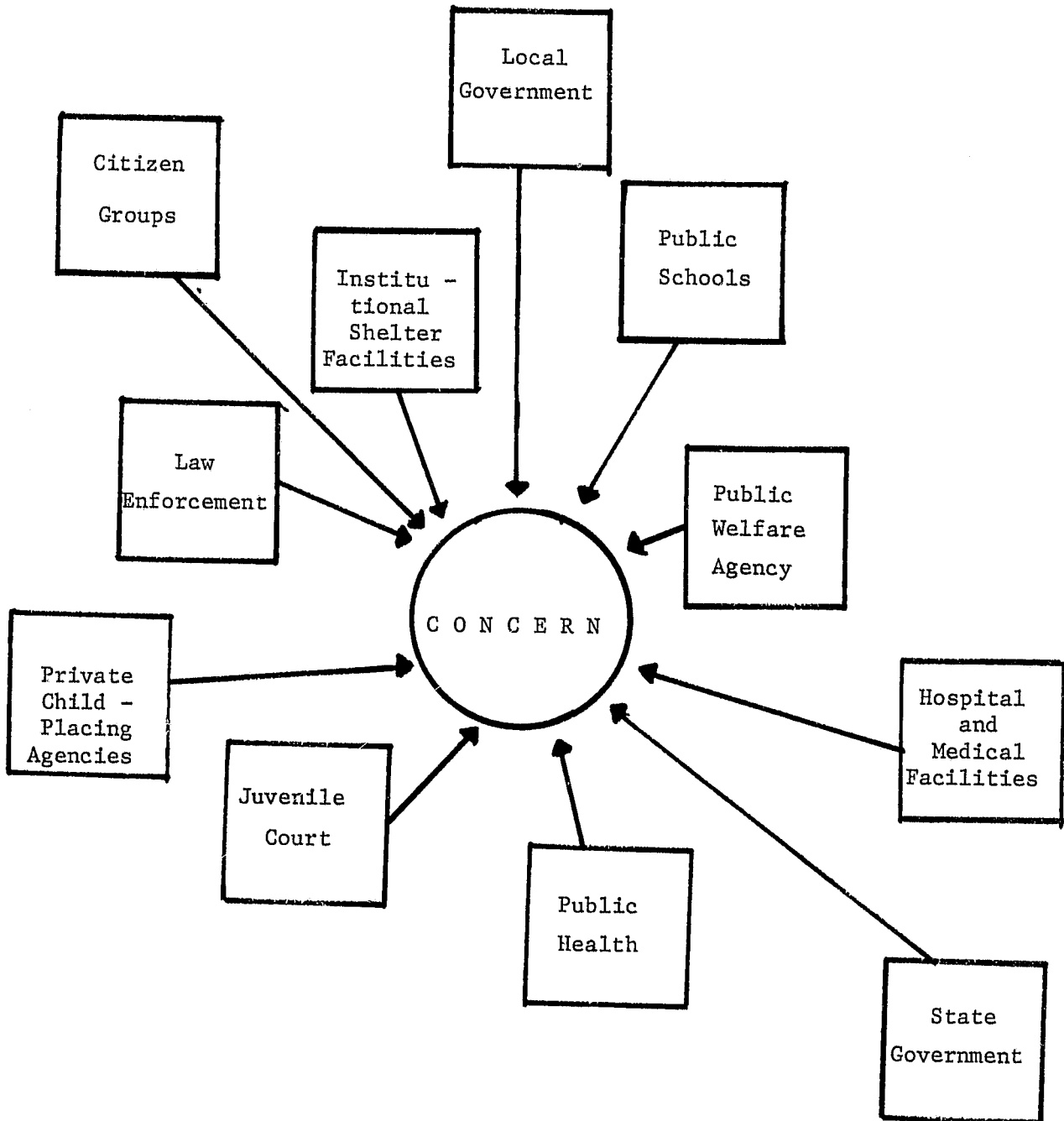
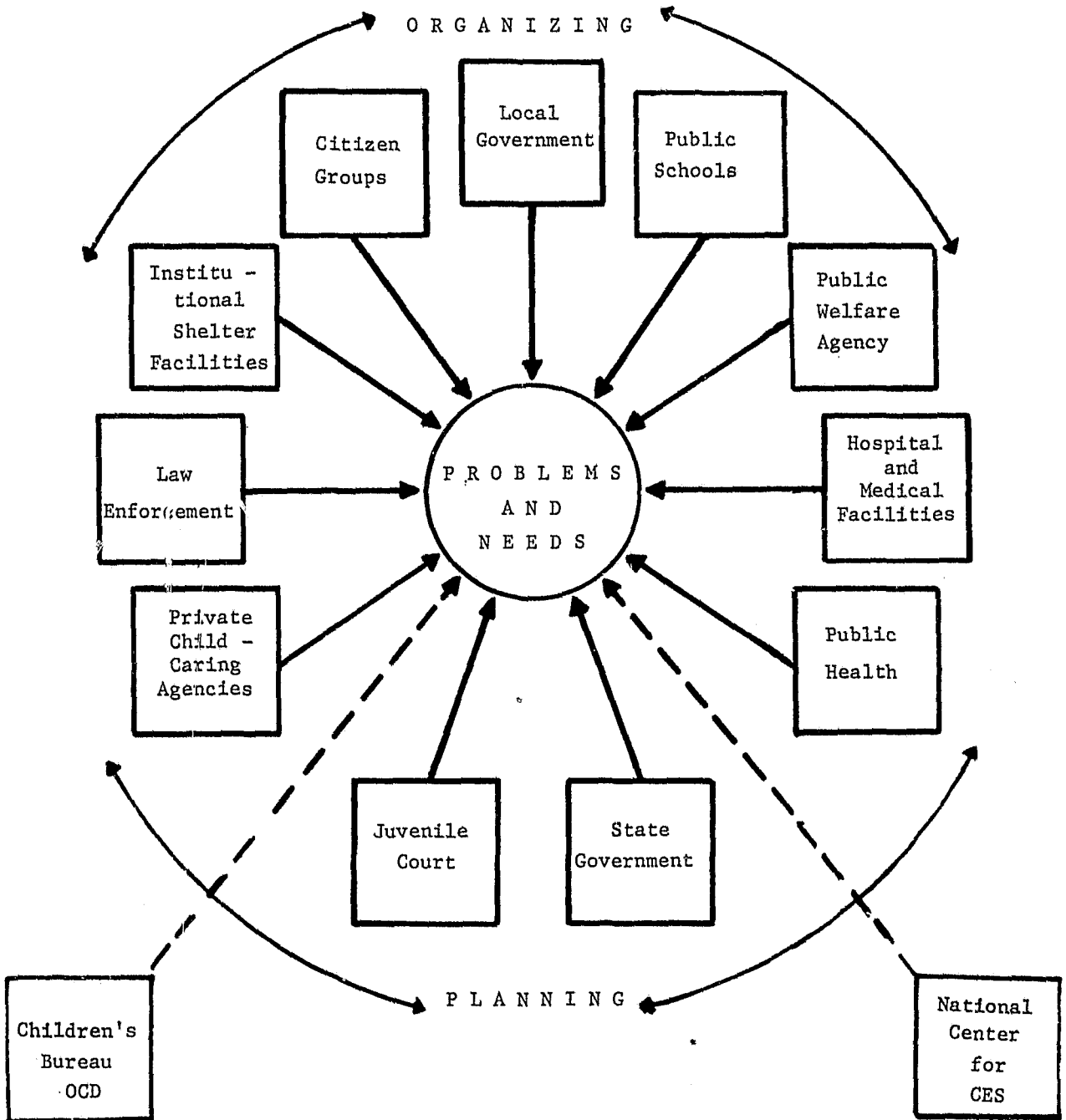


CHART II

COORDINATING COMMITTEE WORKS ON PLANNING AND ORGANIZING A PROGRAM

ITS FOCUS: PROBLEMS AND NEEDS OF CHILDREN IN CRISIS



When focus can finally be moved from concern only to planning and organizing a program based on common perceptions of problems and needs, the group will have become a cohesive, coordinating body. (See Chart II)

Implementation

1. Once the coordinating committee becomes an organized, planning group, with its common purpose being to develop a CES system based on recommendations of the working sub-committees, it will need to do the following:
 - a. Plan the specific components needed for the community and identify the most logical agency (or agencies) to provide the service components. State laws may place responsibilities for the care of children within specific agencies.
 - b. Plan staffing based on projection, not on the current level of complaints and requests.
 - c. Project an increase of complaints and referrals as a result of visibility and availability of service. (In Nashville, the number of referrals increased by 46 % for families and 92% for children. The average number of children referred per family increased from 1.8 to 2.5. There was a 274% increase in reported child abuse.)
 - d. Determine the numbers of complaints now being received and the numbers of requests for emergency assistance. Estimate the number of emergency intake and outreach staff, emergency homemakers, emergency foster family homes, emergency caretakers, etc., that will be needed.
 - e. Determine the additional cost of this system of services over cost now being expended by the community, local and State.

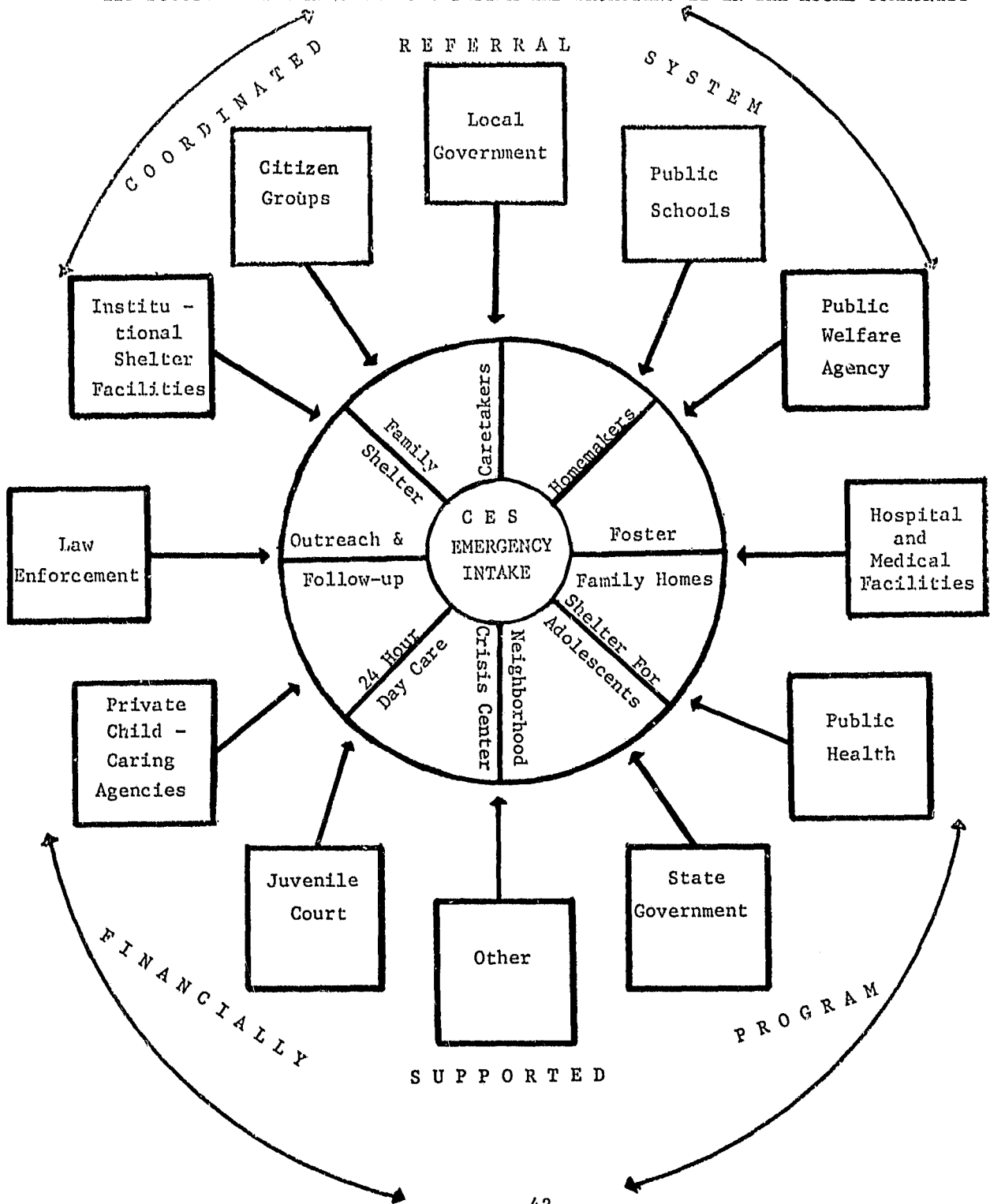
(See section on cost factors for Nashville's CES system, Chapter V.)

- f. Obtain the assistance of the total group in developing needed additional financial support and in reallocating monies now available for services. If the group is truly representative and has been sufficiently informed and motivated, the members can be of tremendous value in helping educate the total community to the CES concept and in obtaining commitments for financial support from local and State government.
2. Prior to the beginning of the CES system, a well coordinated referral plan between all agencies involved and between the various components is essential. These procedures should be in writing between the agencies and signed by all, including social agencies, juvenile courts, police departments, medical facilities, etc.
3. Once the system begins to function, a period of time will be needed for agency functions to shift and adjust. Timing between agencies is most important. There will be failures to coordinate in the first months and it is imperative that flexibility in the system be maintained to meet the unusual situation and that patience and understanding prevail between staff members of the various agencies. It is not easy to change old traditions, agency roles, etc.
4. Regular meetings of the working sub-committee, composed principally of representatives of the primary agencies and including those persons responsible for program implementation, are vitally important to facilitate the functioning of the new system.

CHART III

COORDINATING COMMITTEE SUPPORTS OPERATION

ITS FOCUS: MONITORING THE CES SYSTEM AND PROMOTING IT IN THE LOCAL COMMUNITY



Maintenance

As the system is established and becomes functioning, the committee should shift its focus to include maintenance. The CES system's vitality is measured through this capability. As malfunctions are detected, such is funneled through the coordinator to the committee for action. As current gaps are detected in service delivery to families, this also becomes a matter for the coordinating committee.

A multidisciplinary sub-committee needs to be involved in the assessment process of individual situations in the system. Records must be kept of those service needs which are either not available or inaccessible, to be used as evidence for documentation of service gaps or ineffective service delivery.

Once a recurrent need is documented and presented, the coordinating committee has an obligation to either develop the resource on its own through some representative agency or it must make the community aware of the need, and how this unmet need affects children and their families.

This same documentation will detect system dysfunction or breakdowns in the basic components. In each case the appropriate administrative heads of such must not only document the problems but come prepared to offer solutions which can be quickly implemented. Even though this might be accomplished without the involvement of the coordinating committee, the documented evidence with recommended solutions and realistic time frames for remedying each problem needs to be brought before the committee. Complete control with decisions which are subject only to the individual administrative structure is what is to be avoided as such decisions-making is often narrow-sighted and not all encompassing. Social work administrators must avoid the mistaken notion that social service delivery to families

with child neglect and abuse problems are their sole domain. If this multifaceted problem is to have the benefit of the best possible decision-making, there must be a truly multidisciplinary approach. Service delivery must have the involvement from all disciplines, even to overseeing the efficiency and effectiveness of the service delivery mechanism.

Hopefully, the committee can, in addition to detecting service gaps and planning for resources, assume the responsibility for defining the most appropriate role and function of the various elements within the system on an ongoing basis. This, hopefully, will help maintain its efficiency. There is presently much duplication and fragmentation of service delivery in human services. The classic example is the parent who is subjected to contacts from some six to eight agencies, some of whom have no knowledge of the others' involvement, which is not only inefficient but lends itself to having service providers work at cross-purposes.

We have already spoken to the advantages of a central intake point for all situations of a child in crisis which includes the abused/neglected/dependent child. Child care legislation has mandated the responsibility for such situations to a given agency or agencies; however, agency procedure continues to perpetuate buck passing, thus allowing children to be lost in the bureaucratic maze that exists in almost all public agencies today. Even in areas where increased monies and expert personnel have flowed into child protective services, there continues a certain inefficiency that dilutes the effectiveness of the service for a high percentage of the children and their families.

There is often a lack of philosophical agreement even among social work agencies and almost always among varied disciplines. A physician might

refer a child fully expecting the immediate removal of a child as his image of a child protection unit is just that, one of removing children. The coordinating committee provides in addition to clarification of roles some information exchange and reinforcement of philosophy. That in itself can be a monumental task considering the divergent authoritative viewpoints which persist in this country. Nevertheless, if the committee assumes a shared responsibility for the decision-making not only on the initial entry point but throughout, they have a vested interest in the outcome of each situation. This is as it should be, just as the monitoring function becomes a composite investment in the CES system. This becomes one way to preserve a healthy balance to the delivery of emergency services. It allows for meaningful input from the community to include both secondary services in a larger child protection system as well as representation from "power sources", consumers, citizens' groups, and others.

Large bureaucracies certainly do not lend themselves to the incorporation of this much monitoring or "control" from others "outside" the system. Agencies will, therefore, resist this as a logical and rightful function of the coordinating committee. New systems set up across the country must objectively assess this critical issue and decide how best to maintain a viable system. When CES systems are in operation long enough, we might have a truer indication of the effectiveness of these recommendations in avoiding the onset of bureaucratic erosion; the same erosion that has traditionally overtaken innovative services, rendering them ineffective in their delivery of service to families and accountable only to the management hierarchy.

This chapter has set out the organizational process for the planning, development and maintenance of CES. Each community must adapt these steps to their individual communities. How rapidly this process will evolve is dependent on a number of factors, the greatest of which is the community's concern for its children and its commitment to providing adequate resources. If this concern and commitment is sufficient, a committee which is truly representative will be able to promote improved service delivery to children and their families in crisis. The Comprehensive Emergency Service system provides an effective entry mechanism for a broad population. It provides both protective and preventive services for vulnerable children during a crisis. Most of all it provides for a coordinating and planning mechanism for this population which will continue to seek the widest range of options for children directed to maintaining a child safely in his own home or, if this is not indicated, to providing the alternate care most helpful to him.

CHAPTER IV

COMMUNITY SELF-STUDY

In order to facilitate planning for a CES system, certain essential information is needed. This can be obtained through an assessment of the community's present ability to handle protective service referrals and referrals where families are in crisis situations which could lead to neglect or abuse of children if the situation is not resolved.

A good starting point is to have a sub-committee gather and complete information, as possible, on the services now available in the community. Key agency staff should either have or be able to provide this basic data for the committee within a short time. The advantage of having committee members which represent various agencies and services to cooperate in this task is that a composite of knowledge is obtained.

Factual information regarding programs in the community that provide direct services to children and families in crisis includes: the number, kind, and location of protective service referrals being received; the number of neglect/dependent petitions being filed; the number of children requiring foster family services; the number of children being brought into shelter care by law enforcement officials; the age range of children in the above groups and reasons for the actions taken. This information can be utilized in determining the kind and size of components that need to be developed. Obviously, if a higher percentage of the total number of children are very young as opposed to being older youth, it will affect the design of emergency services for the community.

Most communities will already have a number of services that provide care for children. The sub-committee must then review existing programs to determine:

1. What child welfare services already exist and in what agency?
 - a. Are services providing emergency care available on a twenty-four-hour, seven day per week basis?
 - b. Are services appropriately utilized or is the lack of other resources causing available services to be used inappropriately for some children? (For example: Are children being removed from their families when temporary supervision and care in the home could keep the family together and strengthen the home? Are very young children being placed in institutional type shelter because no emergency services are available? Are older, disturbed youth being placed in foster homes from which they run away because they cannot adjust to family life?)
 - c. Are services sufficient to meet the needs of all children and families in crisis?
 - d. Are all available services working together in the most efficient way?
 - e. Are there gaps and duplication in services?
2. The assessment of services should not only survey those services locally available, but include those that are dependent upon sources outside the locality, i.e. teaching hospital in a Metropolitan area some distance away.
3. It is important to include the informal service delivery systems, especially when an individual has assumed a service delivery role to a community.

4. What additional programs are needed to form a complete system?
5. Which agency has legal responsibility for protective services to children?
6. What program, if any, needs to be altered in focus?
7. What agency roles and responsibilities will be affected, and how?
8. What problems will arise over overtime pay for public employees?
9. Uniform availability of a service or lack of it throughout the geographic area. Lack of availability of a service should reflect rationale, i.e. geographic inaccessibility, cultural bias, etc.

In order to plan for the size staff required to implement various components of emergency services, the committee needs to consider several factors. Allowances must be made for the increase in referrals when program visibility is achieved. Otherwise, staff will be unable to manage the increased workload. The following should be considered:

1. What are the assigned functions of each agency?
2. How do agencies relate? What kinds of communication and other interagency cooperative mechanisms exist?
3. What number of positions within agencies are assigned to protective or emergency services?
4. Is the number of staff members assigned sufficient to provide casework supervision and follow-through to families?
5. Are workloads so high staff members can manage to work through a crisis situation but not follow-through?

To provide legal protection to both children, families, and staff of CES, a review of existing legislation should be made. This is important prior to beginning a CES system, since in some states it may be necessary

to obtain amendments to existing statutes in order to implement some services. The following items relative to identification of legislative bases for services to children are suggested:

1. Review what services are mandated to which public agencies, specifically relating to services to children.
 - a. What legal problems will exist for agencies providing emergency intake, caretaker and/or homemakers services in relation to entering homes without parental consent? Will there be a need for amendments to present state statutes?
 - b. What are the legalities involved in removing children from their homes to provide protection and who has this authority? Does the law need amending to provide greater protection to the child and to place this authority within child welfare jurisdiction?
2. Consider particularly mandates to departments (or divisions or other like designations) of social services; family (or juvenile or like designation) court; department (or division, etc.) of corrections; state, county, and municipal police.
3. Review how these mandates are reflected in that agency's policy manual.
4. Review how these policies are carried out in that agency's day-to-day operation.
5. Review legislative mandates as they may have bearing on non-public agencies (e.g., directives for purchase of service/care).
6. The review of legislation should take into account that some services may be provided by sources other than formalized agencies.

It is important to remember that a truly comprehensive service delivery system will seek involvement and commitment from all levels of control and sources of power within the total community. In seeking to obtain commitment to active concern for children and families, no institutions, leadership, or influence should be overlooked in assessing needs and resources. Of major importance is that adolescents and other special interest groups be closely involved in all phases of both the community survey and the compilation of information on existing services. Although not a special interest group, certain localities may present special needs and problems. A prime example is the implementation of CES in a rural county.

Bear in mind differences, be they geographic or cultural, that effect major variations in the same delivery system. The establishment of a CES system in a rural area should take into account the particular values and needs of that area. It is especially important that there be some survey of the informal system of service delivery in smaller communities where there is likely to be many informal arrangements for such.

In communities where part of the population is a cultural minority, the planning efforts cannot exclude these groups. Such children are generally the most vulnerable. Non-English speaking segments of the population must be considered when planning for emergency intake screening. The recruitment, selection, and hiring of some bilingual staff with knowledge of the cultural variations will become a primary consideration at some point.

The Native American child living on a reservation represents a special group which must be given due consideration when planning. The reservation represents not only a separate geographic area but a separate cultural,

judicial, political, and social entity. As CES is introduced to the Native American population the existing power sources will ultimately determine the success of implementation on the reservation. The dominate culture cannot plan and implement for the Native American population.

The benefits of a Comprehensive Emergency Service system are no less applicable to the Native American reservation, the Black ghetto of a large metropolitan area, etc.

The following data collection forms are provided to assist in obtaining a survey of community needs. It is suggested that copies be made and provided to appropriate committee members to complete and return for a tabulation of information. Additional data will be identified as needed by the committee. It is recommended that the survey of need form provided here be adapted to the specific community.

SURVEY OF NEEDS

I. When a family is in crisis, which agency(s) do they call?

II. Are there informal resources available that the family in crisis may turn to?

III. Who is responsible for Protective Services in your community?

Legally responsible _____

Other _____

IV. Which agency(s) receives referrals?

Department of Public Welfare _____

Juvenile Court _____

Police Department _____

Other (specify) _____

Number of children on whom neglect - dependent petitions are filed per month _____

Number of children placed in temporary shelter care per month _____

Number of complaints received per month

Families _____

Children _____

Number of abuse referrals per month

Families _____

Children _____

V. What kinds of services are now available?

<u>Service</u>	<u>Provider</u>	
	<u>Formal</u>	<u>Informal</u>
() Emergency Foster Family Homes (24 hour)	_____	_____
() Foster Family Homes (other)	_____	_____
() Homemakers (teaching)	_____	_____
() Emergency Homemakers (24 hour)	_____	_____
() Emergency Caretakers (24 hour)	_____	_____
() Answering Service (after normal work hours)	_____	_____
() Emergency Intake Service (24 hour, weekend, holidays)	_____	_____
() Protective Service Intake (8 a.m. - 4:30 p.m., Mon. - Fri.)	_____	_____
() Outreach and Follow-through	_____	_____
() Emergency Shelter for Families	_____	_____
() Emergency Shelter for Adolescents	_____	_____
() Institutional Care	_____	_____
() Group Homes	_____	_____
() Treatment Facilities (Older Youth)	_____	_____
() Counseling for Parent Child Conflicts	_____	_____
() Neighborhood Crisis Centers	_____	_____
() Twenty-four Hour Walk-in Day Care	_____	_____
() Other (specify) _____	_____	_____
_____	_____	_____

VI. How are programs related to Comprehensive Emergency Services funded in your community on a yearly basis?

Protective Services

State _____
Local (Gov.) _____
Private _____
Other _____

Foster Family Services

AFDC-fc _____
State _____
Local (Gov.) _____
Private (purchased and other) _____
Other _____

Emergency Shelter

State _____
Local (Gov.) _____
Private _____
Other _____

Homemakers

State _____
Local (Gov.) _____
Private _____
Other _____

Institutional Care

State _____
Local (Gov.) _____
Private _____
Other _____

Other

VII. Do those informal sources for services receive any reimbursement or support? If so, through what means; if not, how are they supported?

VIII. Are available services for children in crisis coordinated in your community? Describe:

Are there agreements between agencies? written () or verbal ()
List, such as:

Dept. of Social Services - Juvenile Court	_____
Dept. of Social Services - Police Department	_____
Dept. of Social Services - Other child caring agencies	_____
Informal Service Systems	_____

How do the agencies relate, both positive and negative? Describe:

Are there formalized (written) referral procedures? List:

What are the informal referral procedures? Who are they between and how effective are they?

Are there specific individuals within the agencies designated to receive and process referrals? List agencies and describe procedure briefly:

Are there regular meetings for review of agreements, procedures, and problems?

IX. What gaps in services are there in your community for providing emergency services? List.

Could some services now being provided be shifted to include additional services for a more complete system? THINK; then describe what shifts or changes might be possible and estimated additional cost, if any.

If additional monies would be needed, from where would they most logically need to come?

State _____
Local (Gov.) _____
Private _____
Other _____

List individuals and/or groups, both political and non-political, who would need to be contacted to begin discussion. What would this need to include?

CHAPTER V

PLANNING FOR CES COMPONENTS AND COST FACTORS

Once the community self-study has been completed, the committee should be able to determine those components needed to build a CES system appropriate to the community's needs. Whatever the size of the community, CES can be developed if careful and thoughtful consideration is given.

BUILDING THE COMPONENTS AND COST FACTORS TO BE CONSIDERED

Most communities already have one or more of the basic components which can be the beginning of building a CES system. In some instances the major emphasis needs to be on coordination of programs now in existence. In any event emergency services can be built into existing programs as is illustrated:

Twenty-four-Hour Emergency Intake

This component can be an expansion of protective service intake which is an eight hour, five day a week service. A given number of protective service workers in a unit can rotate on intake and provide follow-up through the crisis. A protective service unit will already be crisis oriented even though it does not cover nights, weekends, and holidays. By rotating five workers for on-call duty, twenty-four-hour emergency intake service can be implemented. The additional cost to the agency will be minimal in return for the service rendered. The cost for the answering service in Nashville averages \$25 a month or \$300 a year. The cost of overtime pay for the five workers equalled the additional salary of one worker.

An alternative to having a unit of workers rotate on call is to have one worker full-time as the on-call intake person after hours. All emergency calls received after normal working hours are handled by this person who makes a report and turns the case over to another worker the following morning. This plan has its disadvantages because immediate outreach by the worker receiving the initial emergency provides for better continuity of service.

For a community of 500,000 the additional cost to provide twenty-four-hour coverage is equivalent to the salary and transportation cost of one worker plus approximately \$25 per month for the answering service. The exact cost will vary from state to state depending on salary scales and transportation allowances.

Obviously, in a larger community additional staff is required. Statistics on reported child abuse and neglect, plus the projected increase expected with publicity of the program, should give planners the information needed to determine the number of additional staff required to initiate this service.

Emergency Caretakers

Like the answering service, this cost is minimal. While caretakers may not be used as frequently as some other services, they are most important when needed. Keeping a child or several children in their home through a combination of caretaker and homemaker service is far less expensive, in the long run, than the cost of foster family services or institutional care for a period of several weeks. The caretaker can be provided through contracts with individuals for a weekly retainer fee plus minimum wage for the hours worked. The cost will vary from year

to year depending on the use of the caretaker service. (In one year of the Nashville project caretakers were used to provide services to fifty children at a cost of \$3,465.25, or approximately \$70 per child.)

There was not the most efficient utilization of this component for several reasons. One related to the rigid guidelines that were set out initially which were designed to encourage staff to be aware of their responsibility for the safety of the caretaker and to remind the caretaker of her responsibility for the protection and safety of children. This was quite contrary to the other components where there was a minimum of difficulty in gaining access to the service. Much of this related to apprehension about the total system and the need for the system to operate without incident.

Emergency Homemakers

Homemaker services on a twenty-four-hour basis will be a new experience for most communities. Many agencies have maintained an 8 a.m. to 4:30 p.m. homemaker service for years but have not attempted round-the-clock care. Present homemaker services may be expanded to twenty-four-hour service or a new unit of homemakers may be added to serve as emergency homemakers. The regular homemaker unit could then provide backup services primarily for teaching purposes. In the Nashville program during the year 1973 eleven homemakers provided services to 134 families maintaining 525 children in their own homes. Cost of salaries for a supervisor and eleven emergency homemakers was \$59,880.00 and transportation was estimated to be \$5,900.00 for a total cost of \$65,780.00. This is an average cost of \$124.00 per child to be maintained in his home versus being placed in a foster family home or an institutional shelter facility. This cost does not include administrative overhead, which would increase the total cost by approximately

17%, depending on the agency. Program year 1973 was used as an example for cost factors as it was the only year of the project that ten or more homemakers were maintained for the full year. This was not because of lack of applicants, but because of difficulties within the administration to get appointments approved. A waiver of educational requirements that homemakers must have a high school diploma was necessary and this was not obtained until after the project was in its second year.

Cost of homemaker services will vary in relation to salary scales and transportation allowances. The number of homemakers required depends on the size of the community and the identified need for service. More homemakers available on a twenty-four-hour basis can reduce the number of emergency foster family homes needed. Nashville planned for fifteen homemakers in its program but never filled all the positions. The program could easily have used fifteen homemakers. Some children came into care who could have stayed at home if more homemakers had been available when needed.

Some thirteen teaching homemakers were used to follow situations requiring long-term support to a family. These were generally situations where parenting skills were such that long-term support was required to equip the family to know how to care for their children.

This service was one which had been ongoing for a number of years within the Department of Human Services. It has been a successful ongoing supportive service to families in difficulty, one which is often underrated as to its value in a child protection system for maintaining children in their own home.

Emergency Foster Family Homes

These homes, available any hour of the day or night, including weekends, are a tremendous asset to any community. When a child must be removed from his home to protect him, a family setting reduces the trauma of that removal. To the extent possible, such homes should be located in the child's neighborhood and should be as close to surroundings familiar to him as possible. Emergency foster homes in the Nashville CES project were provided a monthly retainer fee of \$150.00 and accepted children at any hour. In addition to the monthly fee, regular cost of care payments were made per child, based on the number of days of care, as with any child in foster care. For program year 1973 the cost of emergency foster care, including the monthly retainer fee and reimbursement for care, totaled \$26,285.32 for 158 children. This is an average of \$166.00 per child.

In addition two foster care workers were required full-time to work with the foster families, provide service to the children and recruit additional foster homes. The cost for these workers, salary plus transportation, was \$15,960.00. Supervision cost an additional \$4,780.00 ($\frac{1}{2}$ time of one supervisor). This made the total cost of emergency foster family service, including cost of direct care and salaries of professional staff, \$47,025.00 or an average of \$297.00 per child. This does not include medical expenses which were incurred for many children. (This does not include administrative overhead.)

Cost of this service will vary depending on established reimbursement for cost of care payments and monthly retainer fees to families. Some states are now paying service fees or salaries to all foster parents.

Consideration should be given to fringe benefits and, especially, paid vacations, for these parents truly earn a paid vacation and turnover probably would be reduced by these practices.

Outreach and Follow-through

Most communities have protective service workers or units of workers depending on the size of the community and agency. This protective service staff can become the basis for outreach and follow-through. For those communities who do not have protective services and who plan to set up this service, the primary cost will be the salaries of workers, transportation allowances, cost of supervision, and administrative costs. This will vary according to the number of workers needed. The additional staff needed for service will depend on the anticipated increase in protective service caseloads with twenty-four-hour intake.

The Nashville project did not sufficiently project the need for additional staff in this unit and the workloads became entirely too large. As a result, follow-through and supervision of families beyond the crisis stage was the weakest part of the program. It is a very critical service for CES. Good follow-through may prevent repeated crises and repeated needs for service by the family and child.

COST EFFECTIVENESS OF NASHVILLE'S CES PROGRAM

The Nashville CES program demonstrated that the cost of the new system is less than the fragmented system which formerly operated. While the cost to the DHS increased, the cost to local government for institutional care was considerably decreased. This is shown in the following table:

TOTAL NASHVILLE CES COSTS

(\$000)

Program Component	<u>Program</u> 1972-3	<u>Year</u> 1973-4	Total
Department of Human Services	95,000	131,000	226,000
Juvenile Court	89,000	70,000	159,000
Richland Village	29,000	31,000	60,000
<hr/>			
Total	213,000	232,000	445,000
Less			
Richland Village Savings	244,000 ^a	269,000 ^b	513,000
Net Costs	(31,000)	(37,000)	(68,000)

^a17,001 days of care @ \$14.36 in 1972-3 costs

^b17,001 days of care @ \$15.82 in 1973-4 costs

This does not reflect the savings to Juvenile Court and the Police Department for the time saved in processing necessary neglect/dependent cases. The net savings to local government has been used to reduce the bond indebtedness of the construction of Richland Village. The foster care appropriation by local government to DHS has been increased by \$25,000 for fiscal 1974.



CHAPTER VI

COOPERATIVE PLANNING WITH GOVERNMENT

Development of a CES system in most communities will be a unique experience in working with both public and private social agencies and with local and state government officials. It involves local councilmen and state legislators as well as county and city managers and other representatives of the Mayor's Office. It is a rewarding experience from which mutual respect may grow.

How does a social agency or a committee with social welfare concerns generate interest and commitment from government officials? How do you "educate" local and state lawmakers to the needs of children and families? How do you secure their assistance in bringing about changes in the law which are needed to provide protection? How do you get permissive legislative support for appropriation of local or state funds to support programs?

These and many other questions were raised by persons during the past few months when the concept of CES was presented at Children's Bureau Regional Conferences throughout the country and at the National Working Conference on CES. There are no easy answers for these questions. Each community must find the answers which work best for them. Once agencies in a community learn how to work together to support a system which cuts across private as well as local and State governmental lines, strength necessary for good social programming increases. When the system is threatened, these agencies can pull together and have an impact on both administrative and funding decisions which will affect the future of the system.

This has been demonstrated in Nashville. When demonstration funding from Children's Bureau of HEW ceased, the agencies within the system gathered sufficient support from the power structure to influence continuation of the system through the State government. This required assistance from both local and State legislators. The fact that the program had been successful and had been well publicized had considerable influence on government officials and legislators who were in a position to further the program. Once new programs are established, constant vigilance concerning problems which threaten their continuation must be maintained. New issues will often arise which can threaten a system and destroy it.

ROLE OF THE SOCIAL WORK PROFESSIONAL

The social services field in general has received many harsh words in recent years. Some have been deserved. Some, however, have grown out of widespread misinformation, misunderstandings, and miscommunications. Reporters, politicians, and the public at large find the work of social agencies complicated and confusing. "Welfare" becomes an easy target for the uninformed. Social service programs, including those designed to sustain children and families, have become hidden beneath the negative reactions to financial assistance programs. The professionals in the field have to accept some of the blame for public ambivalence, and for the related confusion: failure to speak out, hiding behind professional jargon, unwillingness to become involved, and apparent inability to claim public credit for many deserved successes have led to the public's misunderstanding of social services.

This public ambivalence has clearly affected the politics of human services. Elected political leaders, responding to confusing communica-

tions and unapprised of true facts, are crippled in their efforts to alleviate perceived problems. Social workers have lived under the fear that trying to educate politicians could be interpreted as a violation of the Hatch Act and of civil service regulations. As a result, new programs have either died aborning, failed to secure proper input in their planning stages from practicing professionals, or have met with suspicion and resistance when introduced to the legislative process.

This pattern dooms any field to eternal starvation unless it is broken. Social services work in particular, due to the intricacy of the environment in which it is carried out, requires that professionals get their facts together, organize their activities, and enter directly into education and persuasion campaigns. A part of the responsibility of each person in social services is to inform citizens of the problem related to providing service. We must also make them aware of the successful operation of programs. Agency policy should be such that you can level with citizen's groups with objective documentation as to the success or lack of success of programs.

All of us in the social services must become more knowledgeable of the actual cost to administer certain programs. We are not expected to become fiscal experts but we need to be knowledgeable enough to intelligently interpret cost factors.

The following section seeks to provide help in tailoring the message--and the medium--to the intended audiences. Elected officials, appointive administrators, elected legislators, and the public at large all need good, reliable, professional information in order to perform their respective roles in "doing good," as we presume they are motivated to do. The professional server needs simply to take the time to arm himself with clear,

concise, persuasive information, to make appointments, and to go and talk on a face-to-face basis to the legislator or official whose support is needed.

Suggestions for Communicating with the Political System

1. Elected public officials, both public administrators and legislators (local, state, and federal), are basically persons concerned with the problems of their constituency, though perhaps on different levels. Efforts to communicate with these men and women are usually worth the effort. Social workers should not become so awed by the positions of public officials that they hesitate to communicate with them. Dedicated, concerned public administrators and lawmakers have made it clear that they want to understand what is needed. They cannot know unless they receive adequate information. Many have related that they seldom receive letters from their constituency. When they do (even three or four), they feel this is a command. Also, most communications received are negative, coming from those who are against certain legislation, rather than positive in support of new or amended legislation.
2. Legislators (at least most) are easily reached by phone or by letter. Most will welcome a visit to their office to discuss genuine concerns. Some will welcome an invitation to homes of constituents, particularly local councilmen or state representatives. They welcome visits of interested persons to the assemblies, whether they be local council meetings or state legislative meetings. The presence of concerned persons tells them of the interest and willingness to invest time and

effort for worthwhile programs. Few interested citizens or professionals attend these meetings. When they do attend, it is for a special cause and usually there is a large crowd. Many have never "darkened the door" of local or state legislative meetings and would not even know where to go. It is time to find out! Also, it is time to show interest in other matters, in addition to social service issues, which are before legislative bodies. Social workers and citizens need to broaden their understanding of governmental programs. This kind of effort can have real impact.

3. When matters of concern are discussed with public officials, accurate facts and figures must be provided. No legislator can support or draw up legislation unless he has documentation of need and cost. He must be able to support his position with his fellow legislators. If needed information is provided or assistance is offered to obtain what is needed, the response to requests is more likely to be a positive one. Written materials, such as fact sheets or brief and clearly written explanations of problems or programs, are always welcome.

4. Illustrations

- a. The experience in Nashville has been that by using all of the above, DHS has been able on two different occasions to maintain or increase the foster care budget on the local level when it was in serious jeopardy. This was accomplished by working with local councilmen to help them understand the need for foster family homes, the reasons children come into care, and the cost of care. Fact sheets were prepared and distributed,

not only to councilmen, but to agencies and other influential citizens. Letters were written to each councilman expressing concern for the children in foster care and the effect a cut in funds would have on the children. A request was made and granted for a discussion of the matter with the Health and Welfare Committee of the council. Many interested individuals contacted their councilman and attended the council meetings.

b. On the state level, several legislative actions have occurred because of the interest and concern stimulated in a number of legislators. This occurred as the result of publicity about the CES program and through contacts with legislators made by people in the community. Since the beginning of CES, the following legislation has been passed:

1. New child abuse law, April, 1973. This law conforms to the new Federal Child Abuse Act.
2. Protective legislation for caretakers and homemakers assigned on an emergency basis (the Juvenile Court Judge assisted in drafting this amendment because of his concern). (See Appendix A)
3. State appropriated funds for continuation of emergency shelter for adolescents and families to replace the loss of Title IV-A funds.
4. Amendment of the state law which deleted the prohibition of overtime pay for state employees.
5. Senate Joint Resolution, number 28, directing the Tennessee Department of Human Services to develop

a twenty-four-hour per day child protection service program for the state, April, 1973. (See Appendix A)

6. Senate Joint Resolution, number 24, directing the Tennessee Department of Human Services to prepare a survey of the need for services to children and their families for each county and to survey the services available in each county, April, 1973.

(See Appendix A)

There is no intent to indicate that social work professionals or the committee alone achieved this. They were able to stimulate interest among others in the community who were willing to assist. The Council of Community Services and the Junior League have representatives who attend legislative hearings regularly. These persons are actively involved in communicating with legislators, interpreting needs to the legislators, and offering feedback to the community groups they represent. Other members of various volunteer groups, agency boards, etc., have actively assisted in working with legislators.

5. One of the most effective means of helping state legislators learn about social services and acquiring their support can be accomplished as was done in the following experience:

The University of Tennessee School of Social Work assigned a social-work student to a State Senator as a legislative aide. They chose a senator who was conservative, concerned about human problems, and who was well respected among his colleagues. This was done during the first year

of the CES demonstration project. This student had been in protective services, had worked with many of the child abuse referrals, and understood the need for emergency services. During the year as an administrative aide, the student was able to provide the kind of information to the Senator which helped him understand both the plight of children in crisis, their need for better protective legislation, and their need for emergency services to both protect and provide preventive services.

This Senator has continued to have social-work students serve as legislative aides and has continued to try to understand problems and needs of people. As a result, he has sponsored or cosponsored numerous pieces of legislation dealing with neglect and child abuse, state appropriations for social service programs, protective legislation for the elderly, and others. He now serves on the advisory committee for the National Center on CES and has been supportive of the Center's efforts.

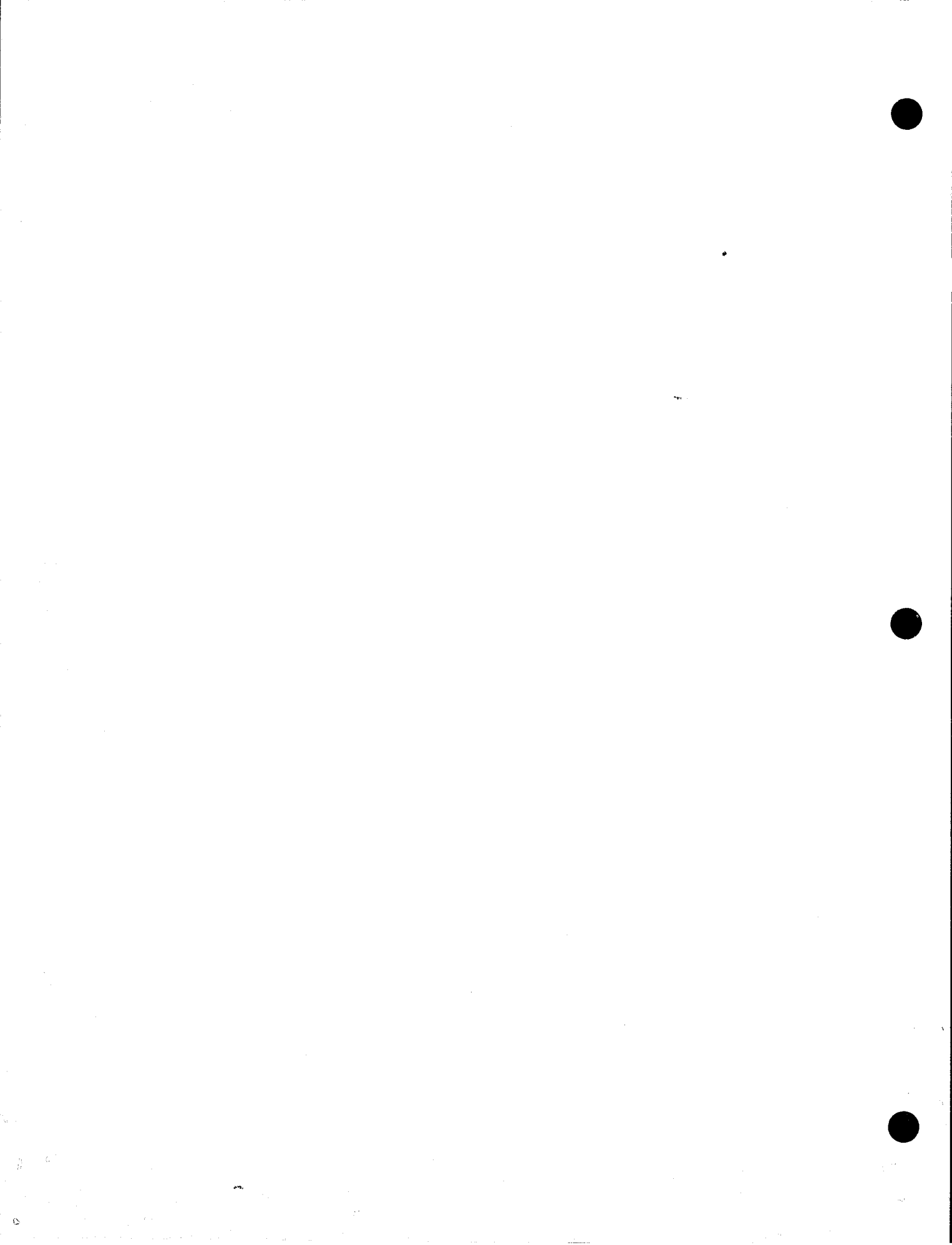
This is one excellent way of achieving input where it can be most effective. Care must be taken in choice of students assigned and the legislators to whom they are assigned to insure a positive effect.

Summary

There are many other ways in which input into the political system can occur. Many persons reading this material will have found ways more effective than those mentioned. The way which seems most effective for

the individual or community should be used.

If social service personnel are to have any impact on program development and funding of social service programs, ways must be found of communicating clearly. Individual responsibility must be taken for doing all that is possible to educate those persons in our political system who can effect social service programs. Finally, social service personnel must be willing to look objectively at the present system, to work and plan together, and to be open to making changes if this will provide the kind of services needed. This kind of individual commitment will be required if establishment of systems of Comprehensive Emergency Services to children in crisis is to occur.



CHAPTER VII

SOME SPECIAL CONCERNS

Many problems were encountered in the formation of the CES system in Metropolitan Nashville just as many problems continue as other communities set out to develop CES. In adapting CES to the various communities, there are some outstanding problem areas which need to be addressed.

DEVELOPMENT OF CES IN RURAL AREAS

Above all, one must be prepared to work within the present life and culture of a rural community. This cannot be done coercively by outsiders or intrusively by the established power source from the outside. An approach can only come in the form of an offer or explanation of CES as a service option. A prelude to this would be a question directed to the community regarding its needs and most "felt discomforts".

All through rural communities one finds small settlements or villages, varying from a few houses and a combination general store, post office, and gas station to a larger town with several stores. Many particularly small rural communities are trading centers for the area around them. In some areas there are landlords who should be involved in the development as such individuals still control large tracts of land and have much influence over many families, as with the coal mining towns of the Appalachian Regions or the sharecroppers of the deep South. This should be a first point to consider in assessment. Who has the greatest influence over the community or area to be served? How much conflict exists between landowners and the dwellers who are to benefit by a CES system?

If the owners of a particular geographical area have active control or interest in their large landholdings, they should be directly contacted for input into any planning both in the developing and operationalizing of CES. If they have delegated control of care of their holdings to others, these persons must be identified and taken into consideration during planning stages. The main purpose in any of these early contacts is to identify and capitalize upon a power source as the level of involvement of such communities is often determined by a sanction by this power source.

It is necessary to examine the hierarchy of influence that is exerted upon a community. It is accepted that certain roles must be enacted within any system of influence, i.e. political system. The manner in which these roles are carried out allows a greater likelihood of variance between communities. In an urban community the likelihood is that these roles will be carried out by larger numbers of individuals but also enacted in a more formally defined and recognizable manner. The rural community conversely will, as might be expected, involve fewer individuals. What might be unknown is that their interrelationship will probably be more subtle and have a higher likelihood that single individuals will fulfill more than one role.

In planning for effective programming general density of the area, its accessibility both physically and in communication need to be ascertained. The proximity of the area to an urban center is also a major consideration.

To mobilize a small city or a community around an effective service delivery system is at best a challenge. This poses even greater problems in a remote area where small scattered communities will reflect varying

values, traditions, and life styles so varied, in fact, that it is difficult to immediately identify commonalities or what binds them together.

The leadership within such areas must identify power sources and generate the necessary interest in CES. Stimulation then first takes the form of educating the populus to need and calling for cohesiveness as common goals and purpose evolve. On the other hand, CES will offer to some more organized rural areas a means for moving directly into a reorganization for a more effective, timely response to any family or child in crisis.

The key factors related to the application of CES to the rural community are as follows:

1. The need for a Comprehensive Emergency Service system in a rural community is just as great for each individual child; however, the problem situations may not be as great.

2. The process for the establishment of CES must incorporate factors unique to the given area. Paramount among the considerations will be such things as the traditions and lifestyles of the area. This will be a major consideration in identifying power sources and identifying the present non system for delivery of service and how effective it is.

3. Another major factor is the appropriate identification of informal resources already operating.

4. Identification of the community's human service network that can become a part of CES such as mental health, hospitals, etc.

5. The interdependency of the rural community to nearby urban centers will offer the potential for the development of more resources.

As a note of caution, however, planners must ever be aware of the prevailing

attitude of most of families toward the institutions in the urban center. Unless the prevailing attitude is one of receptiveness, little will be gained unless there is equal participation. There must evolve a trust of the institutions where there is suspicion.

6. A good public education campaign is necessary to stimulate interest in the problems related to children and their families in crisis. This, too, becomes important to the casefinding effort. The visibility of CES in a rural area is a problem in that it is difficult to publicize the service due to the fact that population is spread out. Also, suspiciousness and lack of trust of institutions can be a prohibiting factor and one which you might have to counteract through public education.

Special Attention for Minority Children

Where there are high concentrations of cultural and ethnic minorities in a given community, this must be considered when planning for CES. Minorities need to have input into the planning so service components and elements are designed to meet the specific needs of that group.

There are language barriers between the service provider and his client on so many human service agencies, but an even greater problem relates to the lack of understanding and acceptance of certain customs, traditions, etc., of cultural minorities by the dominant culture. Generally, minority children are at greater risk in our society and represent a disproportionate number of those children coming into placement. This can be attributed to several factors. The minority group family is at high risk while he is also less likely to trust the traditional agencies. The only service offered or available is generally provided with little understanding or regard as to this individual's

differences. In so doing, the family feels even more alienated from his source of help. This becomes a vicious cycle.

Native Americans residing on reservations, perhaps, represent an even better example of a group who represent a unique situation. They are subject to the civil codes as well as tribal law. There are varying cultural differences from one reservation to another. There is little effort being made to either design programs to accommodate these differences by the dominate culture nor is there a willingness to provide the Native American with resources to be completely self reliant so he can design, implement, and operate the human service programs to meet his own needs.

The Native American is again caught in the throes of a kind of cultural conflict which puts his family at extreme high risk. The plight of off-reservation Indians is often no better. Again, due to the discriminatory practices of our society, he is more subject to difficulties which will threaten the intactness of his family such as job insecurity and the resultant economic instability.

There is a higher percentage of Indian children in placement. The involvement of Native Americans in the planning of their own CES systems is essential. In those communities where groups of reservation Indians live, CES components must be staffed with this in mind by hiring Native Americans to staff the various components.

Special Needs of Adolescent

The adolescent represents another high risk group in that the turmoil related to being caught between childhood and adulthood makes one more susceptible to problems which are likely to bring him to the attention of a social or law enforcement agency. The trend traditionally has been toward wholesale institutionalization of any adolescent in trouble, often

for offense which would not be illegal for adults. There has been little consideration for the youth's "side of the story". Almost as if a possession of his parents, his fate is often determined by them. Too often, instead of social agencies providing alternatives in situations where adolescents are in conflict with parents, they have simply furthered the estrangement by relying solely upon court action to bring the child into the custody for a placement which is generally inappropriate. Too often this is the first and only alternative.

Juvenile courts have become dumping grounds for problem older children who should rightfully receive service from a social agency. For those cities who have forced the responsibility upon the social service agency, they have responded simply by placing such rebellious youth in foster homes or group homes which are often unable to manage their acting out behavior. This is often the beginning of a reinforcement of the estrangement between adolescent and parents which can never be reversed.

Unless social service agencies begin to do planning for service which offers alternatives for the adolescent, they will continue to do more harm than good. Written agreements with crisis hotlines with specially designed advertising which is appealing to youth is one way of having adolescents gain entry to a CES system. The staff needs special training to equip them with the skills necessary to quickly assess and work toward maintaining the adolescent in his own home or, where indicated, an appropriate short-term placement. Such skills must include gaining sufficient trust by the adolescent that he is willing to work toward improving the situation while also being able to offer parents some problem-solving alternatives. Immediate crisis intervention aimed toward

mediating the conflict between parent and child with an offer of quick follow-through of good quality directed toward solving the underlying difficulty is essential. This overall process must be directed toward offering to families a means of readily available support during a particularly vulnerable period.

DECISIONS IN SUSPECTED CHILD ABUSE CASES

Reports of child abuse will constitute one of the highest priorities for CES in that the detection and identification of child abuse may save the lives of some children. However, to uncover a child abuse situation without providing immediate, consistent, and ongoing service is not only criminal but is also extremely dangerous to this highly vulnerable child. One of the great myths is that the initial contact constitutes a warning to the parent and that he will not harm the child if he knows he is under surveillance. If parents with abuse problems had such excellent control, the abuse would not have occurred in the first place. The increased anxiety which can occur if there is no immediate help can be unbearable, thus creating an increasingly dangerous situation for the child. Immediate follow-through is imperative!

Parents who have abuse problems can place tremendous demands on CES intake and outreach staff. Staff must be available to these parents at all times, either through a neighborhood based center or a centralized office. They must be able to assess when the parent is anxious and help this parent begin to trust other adults. Mistakes in the initial decision regarding the validity of an abuse situation can be serious; therefore, training and skill in assessment is vital. The intake worker is always responsible for keen observations and skillful assessments that will



CONTINUED

1 OF 3

ultimately result in a differential diagnosis and plan for protecting the children and helping the parents.

Child abuse, however, is a multifaceted problem involving several disciplines. CES staff cannot function in isolation in making determinations about child abuse and whether the child must be placed or can safely remain at home and what services are needed. Child abuse situations often evoke a great deal of feeling even on the part of professionals. Doctors, police officers, news photographers, homicide investigators, relatives, and curious onlookers create a scene that, at its best, is not conducive to any constructive action. There is generally a great deal of interrogation of the parents and often outright harassment.

Out of feelings of frustration, physicians frequently lash out at parents in an accusatory manner. Police officers seek evidence as to whether a crime has been committed. News reporters want a story for the morning paper. All are aghast that this could happen. Each has his own version of what punishment would be sufficient for the parents.

Often, no one knows where to begin or how to proceed. The physician calls the police because a child had been "assaulted" by his parents, and it is his understanding that this is a matter for the police. Often, the homicide investigator is there because the police officers' directive is to have homicide in on cases involving assault on a child.

The intake worker's ability to focus on his responsibilities in this atmosphere becomes confused and exceedingly difficult. He must tactfully deal with the frustrated and angry physicians. He must subtly intercede, to prevent further harassment of the parents. He must patiently wait for the police and homicide investigative officers to complete their interrogation without interfering. Often, the most he might do is offer

suggestions to law enforcement personnel to help preserve the parents' feelings as persons. By the time the worker gets to talk with the parents some several hours later, if they are not arrested, their defenses make it almost impossible to get anything other than distorted information. The atmosphere for beginning positive and constructive action has been lost.

Basic planning is necessary to see that hospitals, physicians, police officers, etc. know the legal definition of child abuse in their state. They must also know the mandates regarding reporting. Hospitals need to set up protocols for the management of child abuse cases that clearly designate the person responsible for reporting and coordinating.

The assessment of child abuse situations should never be left solely to the emergency intake or follow-through staff. A multidisciplinary team who also has affiliation with the coordinating committee must assist not only in the assessment but recommendations for treatment and follow-through.

This expert consultation maximizes the potential success of each situation as it allows for collective decision making which is generally more accurate.

If state reporting laws prohibit direct referrals to the department or agency which houses CES, all efforts should be made to change them. The provision of emergency service to parents with abuse problems and the protection of the child is clearly a CES responsibility.

Many state statutes define the abusing parent as a criminal, and therefore, the roles of law enforcement and that of social service agencies are often unclear but tightly interwoven. Also, the problems which are sure to arise, due to the philosophic differences between law enforcement and social service, can best be ameliorated by having law enforcement involved from the beginning.

The administrative staff of CES has the responsibility for providing leadership to mobilize the community to develop effective, diversified programs for the treatment of child abuse. This includes making the community aware of the extent of the problem and current knowledge regarding identification and treatment. The community's attitude about punishing the parents can give way to concern and commitment to the development of programs for the prevention of abuse.

There are surely other special situations in your community which will warrant consideration as you plan a CES system, perhaps a high concentration of migrant farm laborers or a concentration of military dependents. These families often lack many of the naturally built-in family supports. Plan with this part of the population involved.

CHAPTER VIII

PROBLEMS RELATED TO ADMINISTRATIVE AND SUPERVISORY SUPPORT

STAFF AND/OR AGENCY RESISTANCE TO PROGRAM CHANGES

Bureaucracies set up for service delivery are tradition bound. Such agencies are resistant to change, even when their methods of service delivery are obsolete and ineffective. Often, top level administrators with program responsibility have long since lost touch with the actual service delivery process and consumer needs. This poses problems in the development and maintenance of viable programs. Staff at local levels, seeing and feeling the needs of children and their families on a daily basis, are usually ready to push for and demand resolution of many of the problems inherent in changing and developing new programs.

Staff on all levels in the primary agencies must be involved in the planning from the beginning. Everyone's input must be encouraged. This does not suggest that staff providing direct service should assume or usurp the responsibility of program planners. But the further removed program planners are from the problem(s) of children and their families, the more difficult it is for them to develop programs which realistically meet their needs. Involvement of consumers, the community, as well as all levels of staff is important for effective planning of CES systems.

All staff members need to know how the changes resulting from the initiation of a CES system will affect them. How will their present duties and responsibilities be altered? Program administrators must never make the mistake of completely bypassing staff on the assumption that this is too time consuming. Many very effective human service programs have

faltered early in their development because of the resistance of local planners and service providers. Frequently, program evaluations have revealed that little has been accomplished because too much administrative time and energy has been directed toward trying to deal with resistance.

To assure the development of CES with the least amount of resistance, both the staff of the primary agencies and the community must be helped to understand the need for such change. The value of CES, both its human and cost benefits, is the central issue. Administrators must be made aware of the benefits in a clear, concise manner. This is particularly true when the system is a part of a large multi-function social service agency. The services can falter unless administrative staff at all levels fully understand the CES concept, its importance to children and families, and how it relates to other child welfare services within the agency and the community. Administrative support is essential in resolving problems that arise within the agency, whether at the local level or between the local office and district or state level staff.

ADMINISTRATIVE STRUCTURE

The minimal administrative staff for a CES system includes a coordinator for the system and a supervisor for each basic component. If the agency is small with a low workload, it is possible that one person can supervise several components, assuming that person has the necessary skills and there is sufficient supplemental staff to assist.

The coordinator's function relates to coordination of the basic components, coordination of CES with other services within the primary agency, and most importantly, coordination of CES with other agencies upon whom the system is dependent; such as law enforcement, medical

facilities, and the court. To accomplish this kind of coordination, there must be a strong tie between the coordinator and the coordinating committee. The coordinator will be the link between the operational level of the system and its coordinating and monitoring mechanism, the committee.

The coordinator's other major function is to work in the areas of advocacy and community education. He must constantly aim toward creating a community awareness of the plight of the child in crisis. He must also develop a climate in which citizens will refer and one which promotes self referrals. As gaps in service are uncovered, the committee must be made aware of these gaps in order to plan for services to meet the needs. This is an ongoing process.

SUPERVISORY ROLE

Supervisory staff share this responsibility with the coordinator. They are the ones to help interpret needs. They have a more direct responsibility for the ongoing evaluation of the system and are usually the first to uncover trends. This is one of the secondary functions of the immediate supervisor of each component, with the primary function being to supervise the staff. This supervision is demanding and requires being on call beyond the usual 8:00 to 4:30 workday.

The very nature of the work assignments in Comprehensive Emergency Services requires accessibility to supervision on a request basis. This is not to say that there should not be planned conferences and staff meetings to help the worker plan and organize his work. These conferences, whether individual or group, may not differ greatly from conferences in any other social agency situation. Emergency service workers, however,

cannot be restricted to a specified conference time and be expected to operate on their own on weekends and at night. The demands made on emergency service workers to make decisions daily which involve the lives of children, and the risk sometimes involved, make it mandatory that supportive supervision be available whenever needed. This kind of supervision goes beyond that which is ordinarily provided in social work agencies. Without supervision which provides for understanding, and which allows a worker to express his feelings and concerns over the stressful situations he encounters, good emergency service workers will be lost to the program. Emotional support is essential for the best trained worker. As the emergency service staff becomes more experienced, they require less supervisory time on individual case situations. Still, supervision of the emergency intake service is an enormous responsibility and must be available on a planned twenty-four-hour basis.

The supervisor must permit experienced staff the freedom to operate independently and trust them to exercise sound judgment. This is a basic element for good supervision in any social agency. This trust will free the workers to learn to make decisions, to grow, and to learn when to depend on their own judgment. Until this degree of competence and skill is attained, they will rely on the supervisor when critical decisions must be made which could jeopardize a child or his family. Through this process the emergency intake worker as well as other CES staff will learn to function independently.

CES staff must have training not only in the detection and treatment of abuse, but also in making quick, accurate assessments. Even the best training may not equip the human spirit to deal with the reality of

child abuse on a daily basis. The supervisory staff of CES must stay carefully attuned to the needs and temperament of the workers. Supervisors must watch for trouble signs: Is a staff member becoming overwhelmed? Why? Does he need to be relieved? Has the workload become unduly heavy or overloaded with highly charged situations? Intake workers who exhibit symptoms indicative of the above will not be able to relate as empathetically as required and may cease to function effectively.

The supervisor, like the conductor of an orchestra, must recognize problems which affect the total functioning of the system, as well as the interaction within any one or more sections. Even more important, problems which affect the job performance of individual staff members must be quickly noted by the supervisor if there is to be an effective work unit.

The supervisory position requires a person who is able to make definitive decisions quickly. Often, the CES staff has little information upon which to base decisions and may not have the means available for gathering additional information. This gives the supervisor the responsibility for acting on limited information. There is some risk in this, but having helped the staff person exhaust everything available to him at the moment, a decision must be made. It often must be made then and 'not tomorrow'.

The CES staff is constantly confronted with hostility, human suffering, and potential danger as well as apathy and lack of motivation on the part of the families. As advocates, they are confronted with unresponsiveness, callousness, punitiveness, lack of understanding, and benign neglect even on the part of many of society's institutions designed to serve children and their families. The demands on the staff can be overwhelming.

Therefore, the supports and rewards must be commensurate, including strong emotional support from supervisors. There must be support, an opportunity for growth on the job, and recognition for staff on all levels.

The supervisory staff of the various CES components must be highly flexible, confident individuals who have the necessary knowledge and experience in child welfare services to help plan, develop, and direct the system. Once the system is operational, they must be willing and able to give much of their time and energy to maintain their component as a viable entity.

Decisions regarding the staffing pattern are an important aspect of the supervisor's work. He must be mindful of workloads. Drastic increases over a period of time would be indicative of the need for additional staff. He must prepare his request to administration for staff increases by including statistics on workloads, workload distribution, and any information helping justify the request.

He must constantly monitor the system for delays or gaps in the provision of service. He must see that his service is coordinated with all others within the system and with the supportive services in the community.

These skills are required in addition to attending the needs of the staff and dealing with morale. Good supervision includes setting the tone for the unit of work. The most perplexing problems confronting the supervisory staff often relates to areas such as personality clashes between staff members, conflict, motivation, and morale.

CES staff must have a high level of maturity. They will hopefully have joined the staff with some motivation other than the salary. It is then incumbent upon the supervisor to develop and maintain this motivation

to produce a work environment that maximizes the potential of each staff member, forging the result into a smoothly operating work unit. This is a difficult task.

Ingredients essential to good supervision include such personal attributes and skills as:

1. flexibility
2. sensitivity and awareness to the needs of the staff
3. ability to discern problems affecting the job performance of individuals
4. ability to regularly monitor and detect breakdowns in the effectiveness of the work unit as a whole
5. willingness to be accessible and give of one's self beyond regular working hours
6. ability to be directive without being excessively controlling
7. ability to organize and plan effective service delivery
8. ability to motivate others
9. ability to train, as the supervisory staff will have ongoing training responsibility



CHAPTER IX

EMERGENCY INTAKE

INTRODUCTION

For the CES system to operate in a comprehensive way and serve families and children to its maximum capacity, it must be well coordinated. The basic components of the system must join together to provide a network of preventive and protective services. The twenty-four-hour emergency intake is the component which provides the central mechanism necessary for coordination. It is through the emergency intake service that a child or family enters the CES system and other components of service become available. The emergency intake is the main thrust for the system and its components.⁴

PURPOSE AND PHILOSOPHY

Emergency intake utilizes an answering service to respond to calls twenty-four hours a day, seven days a week, with workers on duty at all times to respond and take immediate action in regard to crises involving children and their families. Typical kinds of problems that are likely to come to the attention of the emergency intake service and which can be readily identified as needing immediate attention are:

1. children alone, lacking proper supervision
2. mother ill, needs to go to hospital; needs someone to care for children
3. child suspected of being abused

⁴The intake and other service units may be a part of the protective service or any other unit in the agency. Always, strong linkage with ongoing services is essential.

4. parents being taken to jail; children alone
5. child seriously ill, needs help getting emergency treatment;
no responsible person available
6. older youth, in conflict with parents and requesting temporary
placement; includes runaways in some instances
7. child left in department store or public place alone
8. child wandering streets alone

The intake worker is the decision maker in the field at night and on weekends, directing and/or coordinating the activities related to a crisis situation. In critical or unusual situations he must be able to consult with a supervisor on call. Even though supervision by telephone is available, most persons who work nights quickly develop the ability to make dependent decisions as they become more reliant upon the combination of good training and experience. For this reason, well-planned training is essential for the worker assigned to emergency intake as well as continued in-service training.

Emergency intake must have the capability for screening and responding to emergency situations on a twenty-four-hour basis. Among the possible combinations for this component are a commercial answering service to screen calls with workers rotating on call both day and night. Their duty is to respond to any crisis which affects a child and his family.

The service the intake worker provides for the child and his family extends through the resolution of the crisis. For some families there will not be a need for continuation of service beyond a short period of crisis. For instance, if a single parent contracts a sudden illness requiring brief hospitalization, there may be no one to care for the

children. CES provides that emergency care until the parent is able to return home and resume full responsibility for the children. For other families, outreach and follow-through will provide service which continues for a period far beyond the crisis situation.

SPECIFIC SERVICES

Emergency intake must be capable to do the following:

1. receive calls twenty-four hours per day
2. screen calls that can safely be referred to sources of help the next morning
3. screen for emergencies needing immediate contact and service
4. refer emergencies needing immediate attention to a trained intake worker for
 - a. additional screening
 - b. immediate contact and assessment
 - c. provision of immediate services as the need is determined by that emergency intake worker
5. make immediate connection with the outreach worker for help to the parent the next day and for further planning for the child.

The twenty-four-hour emergency intake provides an immediate response by means of a trained worker whose primary purpose is to maintain a child in his own home during a family crisis and to assist the family with a wide range of services. Emergency intake must have available all the other components of CES. This will enable the child to remain at home safely while efforts are made to rally the necessary supportive services to strengthen the home. In some instances, he may arrange for the entire family to reside in a family shelter while further plans are worked out with them. When it is in the child's best interest, the emergency intake

worker must remove the child. He may place the child in an emergency foster family home or, if he is older and it seems indicated, in an emergency shelter for adolescents. Always, the ability of the intake worker to reach out immediately to provide services needed by the parents and child is most important. It is through the intake worker that essential services are made available to the family in a time of crisis.

This centralized intake, to be completely effective, must serve all children in crises for it is essential to more effective planning that there be a centralized entry point. This is not to say that some systems will not provide service on a decentralized or neighborhood basis and in some instances they will be responsible for their own intake by already established procedure. Somehow, there will have to be some effort to centralize the information gathered.

There needs, also, to be some consideration given to the special needs of adolescents when planning and implementing emergency intake. The emergency number must be publicized so as to attract adolescents in trouble. Personnel must be trained to identify and assess situations involving troubled adolescents. Such must be done before they are categorized and labeled deviant or delinquent which seems to be the traditional route as a prerequisite for service.

The adolescent is often alienated and suspicious of adults. He is less willing to trust any formalized social service. Therefore, someone needs to concentrate on unique ways of advertising the service in a convincing manner to adolescents.

Not only should the intake be designed with adolescents in mind, but each of the components must be designed with this part of population's unique needs in mind.

PROCEDURE FOR TWENTY-FOUR-HOUR EMERGENCY INTAKE

There are three optional twenty-four-hour emergency intake models, any one of which may be adapted for use in the community. Each model has built in the capability of screening and responding effectively and each is geared to provide the same quality of service. A community's size and its density of population will determine the number of emergencies and the staff necessary to respond to such emergencies.

Model I: The first model relates to the operation of emergency intake in a large metropolitan area which requires a different level of staff scheduling from that of a remote rural area. A commercial answering service with a specified number of intake workers rotating on call twenty-four hours per day should be adequate for most communities. The answering service worker receives calls after regular working hours. There is some preliminary screening of situations required to determine if emergencies exist. Appropriate referrals are transmitted to the intake worker on call. The intake worker, through telephone calls and field visits, gathers additional information which may aid in determining the nature of the problem, its severity, and if children may be in danger.

In this model the emergency intake worker is on intake duty during normal working hours at his desk one day per week where he receives calls directly. He then is "on call" one night per week where he receives calls through the answering service at home or by beeper. If he determines that the call needs field assessment, the worker goes out to talk with the child, the source of the referral, and others who can give pertinent information and assistance.

Non-emergency situations are either referred to outreach and follow-through or to other appropriate agencies as indicated.

This kind of twenty-four-hour coverage is effective and fairly inexpensive. It can operate in large metropolitan areas with calls going into a central switchboard with emergencies referred to a neighborhood-based emergency intake worker. This allows for decentralized or neighborhood-based service delivery.

In smaller cities the referrals can be handled by one intake worker and one caretaker designated on call for specified nights and weekends. In communities with twenty-four-hour "hot lines" for suicide prevention, reporting child abuse, etc., it is possible to work out plans for these services to provide, in addition, adequate services for receiving and screening calls for CES. Always, training and supervision are necessary.

Model II: The spatial distance to be covered in some areas of the country and the sparse population require a different procedure for emergency intake coverage.

Most calls regarding any kind of emergency to include family/child crisis situations are referred to the local law enforcement. A cooperative arrangement is between law enforcement and CES which will entail referring a child crisis directly to a designated staff person on call who can be reached by a beeper or phone. The beepers give staff greater freedom as they have a thirty-mile range. This is important in areas where a limited number of staff provide coverage.

A note of caution regarding the use of law enforcement for screening--there must be the necessary training of law enforcement to

perform in this capacity. They must be oriented to a humane response geared toward a helping philosophy. Even with the training for an appropriate response, anyone making use of law enforcement must realize that there will continue to be a reluctance on the part of some to refer to a law enforcement agency. This is especially true of self referrals of child abuse situations who know they will continue to run the risk of punitive action upon detection.

With this in mind, another consideration for a rural area is the switchboard of a local hospital for referrals. Even where the hospital is some distance away, a toll-free number which is highly publicized can become the resource used by the community for reporting. To get the target population to make use of the emergency number will take time, especially in a rural area. A public awareness campaign will require some innovation on the part of everyone to come up with what will be most effective.

There will likely be only a few referrals each week in a sparsely populated area. Therefore, two or three staff persons may be designed to cover intake after hours along with supportive staff operating on a similar on-call schedule.

The differential use of staff for some components will certainly be advantageous for some communities and each community should certainly look at its informal resources. The importance is that there must be a system and that it have the capability. For instance, if a church wants to volunteer to provide the caretaker component, such should certainly be encouraged as long as the plan calls for sufficient training of the volunteers and a formalized operating procedure.

Model III: The third model consists of workers stationed in a central location or in a neighborhood center to receive calls, screen them, and respond appropriately. Trained social workers being physically present to receive calls insures accurate and immediate evaluation of each call. Such an operation is more costly which is prohibitive for many agencies. As calls are received by these workers and determined to be emergencies, a field assessment is made. In communities where this is now being done, at least two persons are physically present in the office at all times. A combination of this and the first model consists of a centrally located trained social worker who screens calls and refers appropriate emergencies to intake workers on call, could best be utilized in very large metropolitan areas.

These models are described as suggestions. Each community must take a look at what it has available and utilize this in the development of CES. Communities must also organize and staff in accordance with their individual needs, which will be determined largely by the size and character of the community. The essentials for a CES system are twenty-four-hour coverage for screening intake and the capability for responding immediately.

INTAKE PROCESS

At no point can there be a break in the pattern of service delivery, once service is initiated. There should be immediate identification of problems and assessment of the total situation. The initial assessment is often done with little information other than what can be gathered from the children involved, relatives, neighbors, and the complainant. All of these can be important sources of information. Much can be gathered from

the complainant prior to any other contact with the child or his family. The complainant usually knows a great deal about the family or he would not feel the necessity to make a complaint. Of course, there are a few situations where nothing is known of the family, such as in cases of abandonment.

Even in the largest cities where there is the greatest capacity for isolation, there is always a clue or a lead to information about a family. People do not live in complete isolation. There are some minimal contacts essential to everyone's life. These are with the school, doctor, or health facilities, landlord or mortgage holders, employers, or financial assistance agencies. In our highly technical society man is greatly dependent upon records and statistics about people. For most any situation of children coming to the attention of CES, these are potential sources of additional information about a family. CES workers must be concerned about confidentiality and its importance when working with children and their families in crisis. It is of no less importance than in any other area of social or human services. The staff of CES is caught between the need to know as much as necessary to make decisions about the children and the family's basic right to privacy. Each staff person must be taught the fine art of eliciting pertinent information without divulging any information of importance to others who do not have the right to know. They must know when to share what information and with whom.

Aside from any others, the parent is the primary source of information, and the initial contact must always include the parent if possible. CES personnel use contacts with other sources only when the parent or others related to the child are not available, i.e., in situations where the child has been deserted or left unsupervised for an extended period of time.

Having contacted the family, the most important tasks include:

1. quickly clarifying the role of CES staff
2. creating a positive, helpful environment, enabling the worker to engage the family members in constructive problem identification
3. sorting out relevant problems for the purpose of setting priorities
4. involving the family in arranging for immediate care for the child
5. making commitments to problem solving
6. assigning specific responsibility for problem solving by both family and staff
7. setting time limits for completion of certain aspects of the problem solving
8. reaching agreements concerning continuation of the relationship
9. reviewing progress and setting new goals

Initially, the emergency intake worker and, later, the outreach person is the catalyst in this process.

STAFFING

As CES systems are developed, many will be housed in the state and local social service programs. This poses a potential problem with staffing. Such agencies across the nation are plagued by many problems, such as excessive workloads and untrained staff, which have unjustly earned them the reputation of being unresponsive to the clientele they are mandated to serve.

The prevailing attitude of indifference and the lack of national support for development of human resources has been further compounded by the shortage of trained and experienced personnel in the field of child

welfare. Constant staff turnover and a large cutback in training stipends have caused many urban areas to be short of knowledgeable staff. These problems are not new to administrators of child welfare agencies. They represent a reality that must be dealt with when considering some of the problems that will arise in the development of CES systems.

Qualifications

If emergency intake workers are available with graduate training in social work, this will be a distinct advantage. Workers with bachelor degrees plus in-service training can become skillful in this role. Other special skills that grow out of experience in agencies providing child welfare services are invaluable. Persons coming into CES systems with such experience are certainly equipped to be trained to do the job, even without an MSW degree.

Some essential skills that a person must have or needs to develop through effective in-service training are:

1. feeling and concern for parents and the ability to project this
2. expertise in interviewing to ascertain certain factual and descriptive information
3. competence in making quick and accurate assessments
4. skill in dealing with potentially volatile situations
5. ability to tactfully and effectively deal with both lay and professional people while in the middle of an emotionally charged situation
6. ability to be frank, persuasive, supportive, and empathetic

Factors Affecting Workloads

Aside from these and other basic skills, another primary consideration is the level of staffing that is needed. The number of staff persons

needed will be determined by various factors. The total population to be served and the rate of intake will determine the size of workloads. Projections can be based on workload sizes in an effective protective service program.

As all emergency intake assessments must be immediate, though tentative, leeway in coverage is necessary. The anticipated rate of increase in intake, as a new CES system is promoted, should be taken into account. As the telephone number is advertised, intake will increase. In Metropolitan Nashville the number of referrals of children increased by 92% within two and a half years.

Increases in the rate of intake will relate to other factors, some predictable, some unpredictable. For example, the rate of intake is higher each year during certain months. In Nashville this was the months of March and August. This may be predicted after trends can be observed and documented.

The other factor is the extent of community education. This includes promotional activities geared toward informing the public of their responsibility to report cases of neglect and abuse. Success in educating the public brings about increased demands on the service due to greater awareness which stimulates more frequent reporting.

The most outstanding example of the effects of publicity on intake rates is the experience in Florida with a statewide WATS line for reporting child abuse. The extensive statewide publicity campaign resulted in dramatic increases in the reporting of neglect and abuse. Furthermore, it is the opinion of program personnel that the number of reported cases in Florida is representative of the actual incidence nationwide. If this is true, the potential for uncovering children in

crisis is phenomenal.

Emergency intake workers' workloads must be carefully guarded. It has been noted that they cannot effectively handle more than 18-20 families at a given time. The size of such families and the complexity of the problem situation will be another factor to consider when determining that this is even a manageable workload.

Certain kinds of situations will be far more time consuming for the intake worker even though their severity is not so great, such as with the family without shelter. This is generally also the family with no resources; therefore, the amount of time and "leg work" is unbelievable. However, once given sufficient support, this family might not need the intense ongoing follow-through required by some.

Sufficient staff is of paramount importance to avoid burn-out that is so much of a problem in this kind of human service delivery. Staff must have the satisfaction of manageable workload and a high degree of flexibility in the assignment of work taking into consideration the above factors.

OVERTIME

The method for providing twenty-four-hour coverage and the rate of compensation for staff providing such coverage must be well planned. In some cities protective service intake will already have staff manning "hot lines" on a twenty-four-hour schedule or on an on-call basis. Any system may be used, as long as the CES criteria for twenty-four-hour intake is met. However, the rate of compensation for staff must be given primary consideration.

In some states the Civil Service regulations will place limitations on the rate of compensation for overtime. If such regulations do not allow

for adequate compensation of CES staff for overtime, the regulations must be altered. There should be an immediate review of the existing regulations and an early decision regarding what must be done.

Regarding emergency homemakers, some agencies will have to decide between full-time homemakers and hourly-wage homemakers. Again, the advantages and disadvantages of each must be considered on an individual agency basis. What is available and what can be adapted will be the primary factors to be considered.

CHAPTER X

OUTREACH AND FOLLOW-THROUGH

INTRODUCTION

Outreach and follow-through provides immediate casework assistance to children and families in crisis and continues follow-through and supervision beyond the crisis stage in helping families cope with their immediate problems and in finding longer-term solutions.

Those developing CES systems can learn from problems of protective services. Caught between two disciplines and essentially shut out of both, protective service staff too often have been left to rely upon their own ingenuity to fulfill their mission. Protective services have traditionally enjoyed the distinction of providing a service that was caught in an evolutionary process, moving from its law enforcement focus to its social work frame of reference.

Those individuals who have worked with neglected and abused children have for years "enjoyed" this unique position as the stepchild of the social work profession. Also, protective service staff could not align themselves with law enforcement due to its philosophy which is most often diametrically opposed to the social service objective of working with families, not punishing them.

It is important to give proper consideration to the need for social work staff trained to "reach out" to families on the brink of disaster. Some problems are compounded due to social pressures which do not permit families to admit to having certain kinds of problems. Therefore, rather than be labeled a failure, many families reach the brink of total breakdown

before reaching the attention of some social agency.

Preventive services at best have been ill-defined, often poorly managed, and not made visible by administrators of human service agencies. Families are often shifted from one agency to another because their problem is not severe enough or does not fit into the eligibility requirements of a given agency. Services to families in a given locality are often so fragmented and ill-coordinated that families do not get the service they need.

Outreach must become just that--reaching out or extending service to a family, as opposed to the traditional concept of intake where families must come to ask for help. Traditionally, service has been offered to families in child protection. However, it has been offered in an atmosphere of punitiveness and not with any positive reaching out. The essence of CES is its outreach. There has been much controversy in social work around reaching out. The reasons, as offered by the professions, for not doing so range from the belief that an individual or family that is not ready for help cannot make use of the services being offered or that reaching out robs people of their rights of self determination. Their reasoning fails to take into consideration people who have repeatedly sought help but have not been successful or people who do not know of resources which aid in solving problems. To assume that a family does not want help and cannot make use of the help may not be at all true.

PURPOSE AND PHILOSOPHY

Social work has long recognized certain basic values as being vital to a helping relationship. These are respect for the client, his right to self determination, and sanctity of the casework relationship. "Commit-

ment, openness, and trust are ingredients which facilitate an effective client-worker relationship."⁵ These are essential for outreach to be effective. As we develop CES systems, these ingredients, along with high visibility, become the key to success with outreach and follow-through service with families. Many families who have learned through experience not to trust and who are fearful of rejection must have the necessary service extended to them through outreach. The emergency caseworker must extend his offer of help with commitment and openness and accept the initial burden for continuation of that relationship. Often, the precipitating behavior is just that--a cry for help.

The caseworker must initiate help that is not sought. One of the best examples of this is the model for therapeutic intervention with parents with abuse problems. There are very few parents coming to any service agency to admit they have an abuse problem and few, if any, are knowledgeable enough of self to say, "I believe I am potentially abusive. Would you help me?"

If service is offered immediately in a crisis situation in a non-threatening manner by persons with both the expertise and commitment to provide some help to the family, the chances of having the family reject the offer of service are very low. Also, when the person is involved in identifying his own problems, he is likely to be motivated to solve these problems.

The emergency intake worker and the caretaker begin this process. They provide the initial impression that is carried throughout the service

⁵ Allen Pincus and Anne Minahan. Social Work Practice: Model and Method. (Itasca, Illinois, 1973), p. 40.

delivery process and is to be the overriding feature in all components. This should be the image of a helping person who extends himself in a constructive, helping relationship where the child and his family are offered the widest possible range of service options. The atmosphere is one where CES extends but does not impose help except where absolutely necessary for the protection of the child.

The weakest component of the Metropolitan Nashville system was its outreach and follow-through unit. This service was provided by an existing protective service unit which was expanded by one worker to accommodate the additional load. Because this unit was never completely incorporated into the system, there continued to exist basic philosophic differences and continued confusion regarding procedure. This invariably hampered the work flow and deterred emergency intake workers from transferring case situations. As they continued to provide ongoing service past the "crisis stage", workloads mounted to the critical point.

Outreach and follow-through is an essential component of the CES system. This component must be clearly defined in terms of its role and responsibility. It must become a viable part of comprehensive emergency service rather than merely a supportive or supplemental service.

TRANSFER TO OUTREACH

Various decisions must be made regarding the initiation of follow-through. Is the point of transfer to be immediately following the first remedial action and on the following workday? If this is to be standard procedure, conferences and immediate follow-through by the outreach unit is imperative.

Example: The emergency intake worker assigns a caretaker to provide supervision for children found alone at 10:00 p.m. The most immediate problem is "children without supervision". The assignment of the caretaker provides the remedial action. The emergency intake worker's responsibility that night goes one step further in that he exhausts all possible efforts to locate the parent or responsible relative to supervise the children.

Having failed to locate either parents or relatives and having assigned the caretaker, the emergency intake worker has no further responsibility until the next day. So far, however, little information is available about the family other than that obtained from the complainant, the children, neighbors, friends, the landlord, and personal observations. There has not been any face-to-face contact with the family.

The neighbors say that the children often play in the hallway late at night when no one is at home. The landlord has heard other tenants complain that the youngsters create a disturbance and play with matches in the hallways late at night. The complainant, a neighbor, makes the same allegations but adds that she has had to rescue one child from a crib when the two older children set the apartment afire while there alone. She has seen as much of this as she can "stand" and wants the authorities to do something.

The apartment is in shambles with dirty clothes and stale food on the floor throughout. The children appear hungry and are poorly clad. There is no food in the apartment, and they have eaten only cold cereal and water. None of the children are old enough to know how long their mother has been gone. They were watching cartoons when

she went to the grocery store, and she has not returned.

This example would illustrate that much can be gathered during this brief encounter about the circumstances of the family even though there has been no contact with the parent. Is it best at this point for the emergency intake worker to transfer responsibility to another worker for immediate next-day follow-through with the family and children? Would it be better for the emergency intake worker to complete the initial assessment and plan before transfer? The disadvantage in expecting the emergency intake worker to carry through remedial action to a point of resolution is the demand on his time and energy to do intensive work on the next day after having worked during the night. He may also have answered more than one call.

To transfer the case to the outreach worker the following morning would require a written report of the work done by the emergency intake worker--including the complaint, observations of the children and the apartment, any collateral contacts, efforts to locate the mother, and the assignment of the caretaker (including the time and the name of the person assigned). As soon as possible, the following day there should be a conference including the intake worker, emergency homemaker, outreach worker, and supervisors.

The outreach worker, accompanied initially by the emergency intake worker, must act that same day to relieve the caretaker and assign the emergency homemaker. The information which has been made available must be used to locate the parents.

Several undesirable features to this plan are possible:

1. The initial thrust by the emergency intake worker can be lost

since it is most difficult for a new person to enter at this point with the same interest.

2. It can be difficult for a second person to initiate court action since the emergency intake worker has most of the evidence and is the most likely person to file a neglect petition if necessary.
3. It can be confusing and difficult for the child to have another person introduced at a crucial point. This must be carefully handled.

This entire process should be geared to avoid any break in service delivery. There should be a conference with the emergency homemaker and the supervisor the following morning. This should include a sharing of the available information about the situation and the children. If an emergency homemaker is assigned, the caretaker may be able to offer important information that individualizes the children; for instance, one child may be withdrawn, one may have enuresis, and one may seem especially troubled. She may also share practical information about such things as food or supplies that are needed. The caretaker may then be relieved of the assignment by the homemaker. It is very important that the children be introduced to the homemaker and that the caretaker have sufficient overlap with the homemaker to avoid making the children feel more insecure.

The outreach worker then picks up where the intake worker left off the night before and intensifies efforts to locate the mother and/or suitable relatives. If relatives are located the worker must ascertain their willingness and suitability to provide temporary supervision. Arrangements are then initiated for relatives to care for the child, if this is possible. If, for some reason, there are no relatives and the parent does not return, the worker begins a plan to place the children. This is only after a

reasonable period of waiting with no word as to the parents' whereabouts. If the parents return, and in most situations this does happen the following day, the process at this point entails thorough assessment of the situation with the parents and some agreements for problem solving. The outreach worker ideally wants an early tentative agreement from the parents as to what aspects of the problems will be dealt with and what is expected of the service. This is the beginning of an ongoing relationship directed toward solving the family's problems.

CONTINUITY OF SERVICE

Outreach and follow-through as one of the service components must be tied into the system in the same way as all other components with referral and/or transfer procedures. Once the family is referred to this component, there is responsibility for the staff to provide the same level of service to insure continuity. Often, supervision is needed for a long period of time to enable the family to sustain the gains which have been made. The outreach and follow-through worker should also be able to make referrals to other resources or agencies for the family as the need is identified.

Any number of community resources might provide the needed service; however, there must be frequent conferences to assure continuation of the necessary service. Community agencies must feel some commitment to the family. As situations are assessed through multidisciplinary conferences, all agencies identified as a potential resource need to have input into that assessment and agree to be a part of the service plan for that family. Referrals from outreach and follow-through staff to such agencies with a mere hope for approval for service is not sufficient.

It causes too much break in the delivery and creates too much room for loss of momentum. There is also the problem of having tentatively promised the family some service that is not forthcoming. To have a family appear at an agency only to be told they do not qualify is most disheartening and can result in feelings that they are being shuffled from one agency to another with no hope for relief to their situation.

Follow-through staff must not simply refer and forget. As long as the person has some problem for which CES has responsibility, there needs to be involvement by this staff. This involvement might be planned conferences including all involved agencies to review the progress and update planning.

Procedure could include planned periodic telephone contacts with the agency involved to discuss the progress. At any point the agency is no longer able or willing to follow a family, a part of the agreement must include notifying CES if there is still a question of the safety of the child. Outreach and follow-through staff must be prepared to again pick up on such situations and see that the family receives the needed service to a point of termination.

Record keeping must be such that recidivism can be readily documented. Repeat cases must be flagged. A high level of recidivism serves as a warning of breakdowns in the system. Each case or groups of situations must be analyzed for problem areas which might give a clue to breakdowns resulting in recidivism.

Many families are subject to recurrent crises which occur at periodic intervals despite the success of the original intervention. In some instances, the support systems just are not available to sustain such families nor

are they able to function independently. That such families have progressed beyond a suspicion of social agencies and a willingness to ask for help when faced with a new crisis is in itself a positive sign. This as a factor must be considered when analyzing recidivism.

Generally, procedures must allow for a degree of coordination which makes for the greatest continuity of service delivery. This minimizes the recidivism. CES staff is always responsible for the continuation of service as needed even in other agencies.

CHAPTER XI

EMERGENCY NEIGHBORHOOD CRISIS CENTERS

INTRODUCTION

Emergency neighborhood crisis centers are multifunctional, community-based centers designed to identify families in crisis or impending crisis situations. Such centers provide emergency services to community residents with primary emphasis on prevention and early detection of families in crisis. Neighborhood crisis centers provide another viable service delivery component of CES to be used in areas where decentralization is imperative for accessibility and visibility. Those centers make it possible for a community to participate in planning and coordinating the service delivery.

PURPOSE AND PHILOSOPHY

The concept of neighborhood-based social service dates back to the beginning of the social work profession. The original settlements brought the service provider to the clientele. These decentralized offices often became administrative nightmares for the parent agency, but were a most effective method of service delivery since they were so accessible to the consumer.

Whether such centers are effective or not will be determined by several factors.

1. Their purpose must be clearly stated to the community so that available services are used appropriately.
2. The location of such a facility greatly affects the degree to which it is used.

3. The acceptance of services offered is dependent to some degree on how well the services are publicized.
4. The selection, skill, and training of staff is an important factor, particularly when the center serves a minority cultural group.

The location of crisis centers in those neighborhoods with the highest incidence of crisis and/or potential crisis situations is very important. In determining the location, it is necessary to take a look at such factors as the geographic distribution of protective service referrals, the highest concentration of child population, etc. As an area is selected, it is also important to take into consideration city planning which might cause large shifts in population, such as ongoing urban renewal programs. Any urban renewal program can completely change the composition and character of a neighborhood.

The physical facilities need to be informal, yet comfortable. The warmth generated in an informal atmosphere can help many families feel more positive toward the service in general.

An even greater factor is the selection, training, and supervision of staff for the crisis centers. As much as possible, staff should be recruited from the neighborhood, thus eliminating some problems which can grow out of a failure to understand the character of the neighborhood. In large cities where various ethnic groups are represented, an understanding of the language, tradition, customs, etc., is an extremely important prerequisite. This understanding is necessary in gaining the trust essential for establishing and maintaining a helping relationship. Another more practical consideration is that staff who are indigenous to

the area will know better the problems within the community, the resources available, and the means to gain access to such resources.

Such selected staff can be trained in such areas as interviewing, assessing situations quickly, and helping families make use of the available resources.

Neighborhood residents must be informed about the function of the crisis centers, including who can be helped and what kind of help is available. For this process of outreach to be truly effective, there must be staff designated to inform residents of the services. The use of mass media to publicize the center's telephone number and briefly describe the services available can be effective. Having door-to-door contacts for the distribution of informational leaflets is a way of insuring a much greater coverage of the entire area served. Such an effort also creates a more favorable atmosphere for trust in that the center staff came into the neighborhood offering help.

The publication and distribution of informational material should be in the language common to the neighborhood. Neighborhood crisis centers will depend on self referrals and second-party referrals directly to the center, either by drop in or telephone. Referrals may also come from a centralized answering service which receives, screens, and refers calls to the emergency intake worker who is attached to the crisis center. Multi-disciplinary consultation which will identify high-risk families becomes another referral source.

SPECIFIC SERVICES

In large metropolitan areas, service delivery through neighborhood-based centers is imperative. However, even smaller communities will find

this concept beneficial in areas of high frequency of reported dependency, neglect, and abuse. The neighborhood crisis center serves a twofold purpose. It provides immediate access to emergency services in neighborhoods most in need and aids communities in identifying areas in which problems and gaps in service delivery occur.

The neighborhood centers must have the capability of responding on a twenty-four-hour basis to all emergency situations due to some family crisis. All of the essential CES components must be accessible, including emergency intake and outreach workers, foster family homes, etc. There must be a uniform follow-through and continuity of service to families. Advocacy is very much a function of this staff since the close proximity of the persons involved gives the staff a firmer grasp of the prevailing problems of the neighborhood.

A city may not initially be able to open neighborhood crisis centers that will meet the specific needs of individual neighborhoods. However, as such needs are identified, there must be enough flexibility to make it possible to add service components. Neighborhood crisis centers should not supplant the function of other social service agencies. However, this can become a problem and planners should be aware of it. Even at best, neighborhood crisis centers cannot be all things to all people. Due to their visibility, they can be erroneously identified as all-purpose "social service potpourri".

To avoid this image, such centers should clearly publicize their service objective as related to relieving families with children in crisis. However, such centers cannot work with human problems in isolation, and there will be many situations brought to the attention of the

crisis center that will not relate to children but to older family members, such as a grandmother in need of service. This is a logical consequence of gaining the trust of the neighborhood. People will bring to the center many problems because they trust the staff of the center to be able to help with them. The credibility of neighborhood centers will suffer if the centers are advertised as being unlimited in scope.

For this reason, it is imperative that neighborhood crisis center staff develop expertise in referring some problems to other community resources. If such resources are unresponsive, this can create another problem. As indicated by the experiences of the Westside Children's Service, "A major objective of the Westside Children's Service dealt with a provision of a 'bridge' to appropriate delivery systems..., often the problem was to find a referring agency whose orientation and work philosophy was similar to that of the project in emphasizing immediate acceptance for help."⁶

Many social agencies are and will remain tradition bound and more intent on screening out people than making service easily accessible. It becomes the function of planners for CES to become advocates, when appropriate, for families and to develop good working relationships with other agencies in the community to expedite referrals that are inappropriate for CES.

Crisis centers should not be envisioned by neighborhood residents as an ongoing resource for financial assistance. The socioeconomic conditions of certain neighborhoods are such that there will be heavy demands placed on the crisis centers for tangible services. These must be

⁶The West Side Children's Services Project, Grant No. OCD-CB 58 (Child and Family Services, Buffalo, New York, 1974).

provided through an emergency fund or petty cash to sustain families on a temporary basis until they can get to an ongoing resource. Emergency funds can go for a deposit and one month's rent, food stamps, or transportation to work until the family receives money from elsewhere. Such a fund is essential. It should be enough to adequately meet the needs and the direct service staff should have flexibility in the use of the fund. Rules and regulations governing the use of petty cash are essential for responsible fiscal accountability. However, rigid rules which make it impossible for staff to utilize the fund can seriously hamper the effectiveness of the center.

Other tangibles which might be necessary include a supply of nonperishable food and children's clothing, especially disposable diapers and canned or powdered formula. Storage space and security may become a problem. An arrangement for an account with local merchants can also take care of some small emergency needs such as medicines and nonfood items. This includes cleaning supplies, which are essential to the maintenance of a household, but cannot be purchased with food stamps.

USE OF CONSULTATION TEAMS

Community-based consultation teams can serve functions both preventive and protective. Such teams are a primary means for the early detection of families in a pre-crisis stage. Schools, hospitals, social service agencies, mental health facilities, etc. all know certain families whose children are considered to be high risk. These are families who have limited resources available and are poorly equipped to cope with the rigors of normal day-to-day survival. This can be the family where one or

both parents are mentally ill, alcoholic, or addicted to drugs.

It could also be the native American family who has recently left a reservation for a large metropolitan area or the southern, rural, black family recently moved to a large city. These are high-risk families who, even under ideal circumstances, are subject to complete breakdown requiring separation of children.

All social agencies and/or institutions must become aware of the signals indicating serious family deterioration. Some agencies and institutions see many children and their families regularly. The school system, for instance, has closer contact with children over a longer period of time than any other institution, and school personnel must learn to identify the early signs of crisis situations which may endanger children and threaten family breakdown. A multidisciplinary consultation team then becomes the mechanism for facilitating early intervention.

This team approach serves to facilitate the following:

1. multidisciplinary concensus regarding an assessment of the problems
2. planning for the most effective intervention in the pre-crisis phase
3. early referral to appropriate resources for intervention
4. evaluation of the effectiveness of intervention
5. ongoing multidisciplinary consultation to maximize the success of intervention by making available to the primary intervener the input of various disciplines
6. planning, mobilizing, and coordinating resources to make a greater impact on families

This team approach provides for coordination of processes for early identification of potential crisis situations and plans for intervention and

follow-through to include the use of either CES components or other appropriate community resources. Identifying, reaching out, and providing supportive and/or supplemental services to families in a pre-crisis stage can prevent the total breakdown of many families.

As these professionals representing various disciplines come together, they should work toward identifying potential crisis situations and share in planning solutions for the problems facing each family.

CHAPTER XII

EMERGENCY SHELTER FOR FAMILIES

INTRODUCTION

An emergency shelter for families is a facility that provides temporary shelter for families who have lost their homes for any reason, or whose home situations are so inadequate that they are compelled to leave on an emergency basis.

This component of service may be provided by an agency other than a department of social services. In Metro Nashville it was provided by the Salvation Army and was a component added after the initial CES program began. No matter which agency provides the service, there must be carefully developed procedures for coordination so the service is available when needed.

The actual physical facility may be a leased apartment house which is furnished. It may be space allocated by the Salvation Army to house transient individuals which is converted into a facility for families. The nature of the facility is not as important as the quality of service provided the family. The facility needs to provide clean, spacious, comfortable, and safe shelter for a family. Adequate space for the anticipated number of families will avoid unnecessary placement of children. Casework service may be provided by the intake and outreach workers, or the shelter program may have social work staff with the training to assist displaced families with relocation. If the worker is to be someone other than the intake or outreach worker, there needs to be very close coordination to assure continuity of service.

The major emphasis is on a complete assessment of the family's problems and remediation of the problem related to shelter as well as any related social problems which jeopardize the intact family. The goal is to restore the family to an acceptable degree of stability and independence.

PURPOSE AND PHILOSOPHY

The emergency shelter for families program is based on the philosophy that the situation of displaced families can be improved by providing social services and remedial programs for all members of the family. It is designed to provide the least amount of disruption to the family. This program provides a number of desired services for families.

Room and Board (for up to 14 days)

An emergency shelter program would not have to work with a fourteen-day deadline; however, the experience of the program in Metropolitan Nashville has been that a deadline is important for the motivation of the workers and the family. Furthermore, they have found that it often takes a full fourteen days or more to locate adequate housing and resources for families with low incomes.

Family Problem and Needs Assessment

There are multiple problems and needs involved in emergency shelter, and a worker located at the shelter facility is in a unique position for fully assessing the needs and problems of each family.

Social Services Assistance

This is usually in the form of referrals and coordination between agencies and the family. Other agencies are frequently contacted for assistance with ongoing financial resources, training or employment, housing, clothing, medical and legal needs, etc. Due to the involvement

of many supportive agencies in most situations, it is necessary for the emergency shelter worker to act as a coordinator and to follow through on results.

Relocation Assistance

A large part of the emergency shelter worker's time is spent trying to locate adequate housing for families. This is often very difficult due to limited incomes, large families, earlier evictions, a scarcity of public housing, and special needs of clients, e.g., lack of transportation.

Transportation Services

Transportation services are determined and furnished according to the needs of each family. Some of the needs for transportation involve: getting children to and from school (an attempt is made to maintain regular school attendance of children who are enrolled in local schools while they reside in the family shelter); trying to locate housing; and getting parents to and from other agencies when necessary. A van of some type is useful to transporting large families and for moving household goods.

Family Counseling Services

The counseling services offered by the emergency shelter staff will be limited somewhat by their training and abilities. There is often need for counseling involving dealing with child rearing, employment, financial, emotional, drinking, and other family problems. If the emergency shelter worker does not feel capable of performing needed counseling services, he will be able to recognize the problems and refer them to the outreach worker or an appropriate person or agency.

Follow-through

As in any other emergency situation, follow-through services become an essential part of working with displaced families. For some families

only short-term follow-through will be required as the strengths of the family will be such that they will be able to function with minimal assistance. For most families needing emergency shelter, long-term follow-through will be required to assist the family to a degree of stability and independence. These families will require ongoing social services over an extended period and will need to be referred to other supportive agencies.

Outreach and follow-through to these families will be similar to those provided other families as the problems are similar. Still, more lower socioeconomic families will need this service and will, therefore, require many tangible services. However, the related problems impacting on the family are very much the same.

CRITERIA FOR SERVICE

In the Metropolitan Nashville-Davidson County CES Program a financial eligibility determination was required in accordance with pre-established criterion due to funding of the family shelter program through the Title IV-A funding. There are tremendous shortcomings with this eligibility and it is not recommended for other systems. No components of the CES system should have an income eligibility requirement. The criteria should relate solely to the definition for an emergency affecting children and their families as previously defined.

STAFF AND JOB DESCRIPTION

Staff Director

The staff director should have a master's degree in social work, and/or extensive social work, casework, and administrative experience in working with low income residents and communities. Further, he must

be able to: assess family situations; give leadership in working problem situations toward satisfactory conclusions; supervise and administer a team of social service staff and perform as a liaison between agency personnel, other social service agencies, and the community at large.

The staff director is responsible for the supervision of all social service staff, the maintenance of all records pertinent to families enrolled in the shelter program, the evaluation of all staff in their area of assignment, and other duties as assigned. If time allows, the director may also want or need to share some of the direct service with the social workers. In some family shelter programs, supervision will be the CES coordinator's responsibility. This will be true in smaller communities where a full-time director is not feasible. The CES coordinator may also direct all the activities of the family shelter.

Social Service Worker

At minimum, the social service worker(s) should have a B.A. degree in sociology, psychology, or a related behavioral science area, and/or extensive experience and skills in interviewing, record keeping, assessing problems quickly and accurately, and other activities related to working with families who have problems of an emergency nature. The responsibilities of the social service worker(s) include: the maintenance of files on the families assigned to him; assessments of family problems and needs; the development of plans of action for quickly alleviating problem situations and promoting the adjustment of families during and following displacement and coordination between agencies when necessary; and planning follow-through activities including coordination with other CES staff.

Casework Assistant

The casework assistant(s) should have at least two years of college studies, and/or extensive experience in social service work with low income families and communities, and knowledge of social service agencies and assistance resources in the community. He must be able to drive and have in his possession a valid chauffeur's license. The casework assistant(s) should provide transportation necessary to help families meet their needs, make home visits, and assist in follow-through activities, make referrals when appropriate, and perform other tasks as assigned.

Resident Manager

The resident manager(s) should be a highschool graduate of high moral character, and have the emotional stability needed to perform effectively under stress and duress. He should also be able to deal effectively with emotionally upset clients, to relate well with all people, to supervise the non-social services activities of the shelter, and to report relevant information to the director or social service worker(s).

The resident manager is responsible for the daily living routine, and the health and welfare of the shelter participants. He maintains a twenty-four-hour residence at the shelter, and insures that it is adequately maintained and supervised at all times. He supervises the cook and maintenance staff of the shelter, and performs other tasks as requested by the director.

It has been the experience of the Nashville Emergency Shelter for Families that a couple, i.e., husband and wife, seems to work out best for the resident manager position. There are several reasons for this.

First, it helps to have a responsible woman available for some situations, and a responsible man is more appropriate for others. Another reason is that the husband and wife can take turns relieving one another of responsibilities. Another recommendation in relation to the resident manager position is that an assistant or substitute should be available for days off, vacations, and emergency situations. A husband and wife team as resident managers can relieve one another of responsibilities, but they will also require a substitute for times that they need to spend together away from their jobs.

Cook

The cook must have the ability to prepare well-balanced, appetizing meals for all shelter resident clients. He must be able to use all kitchen equipment, and to maintain the area in a sanitary manner at all times. He should have a neat, healthy personal appearance, a valid health card, and evidence of a recent physical examination. The cook's duties include: the preparation and serving of three meals per day for shelter participants and perhaps a snack for younger children living at the shelter; washing all dishes and utensils used in performing this task; and other duties may be requested by the resident manager.

FACILITIES

Family Rooms

It is preferable to have facilities which allow for the entire family to remain together in a reasonable amount of privacy. Particularly during a time of crisis, most families want to be together for support.

The Nashville Emergency Shelter for Families is located at the Salvation Army Social Service and Welfare Center, and this is also used as

a transient lodge. Because the building was not originally designed for families, there are several drawbacks; one being that husbands must sleep separately from their wives and children. This problem is usually handled adequately by most families, but a few have chosen to sleep in cars rather than to be separated. It is recommended that communities consider apartments for families, located perhaps in public housing, or provide mobile housing units.

Dining Room and Kitchen

Three balanced meals should be served in family style to families residing in the shelter at specified times each day. Most families who are admitted to the shelter have very little, if any money for food; and those who do have some money usually need to save it for obtaining housing.

Lounge and Recreation Facilities

Over a two-week period families need to be able to move about beyond their rooms. They will spend much of their time looking for housing, employment, and so on, but generally there are also many slack periods. Therefore, it is important that a lounge and some recreational facilities be available. The lounge might have some form of entertainment, such as a television, books, magazines, and games, as well as being a place for visiting. It would also be very desirable to have a playground and/or day care facility readily available. The parents must go out to search for shelter. This often requires long hours of sitting and waiting so it is more convenient to have provisions for the children while the parents are absent.

Laundry Room

Again, many families will have no money, and washing and drying facilities are helpful for sanitary purposes.

Storage Space

Some families will have household goods, and will need a place to store them until they find a home.

Supplies

It is recommended that emergency family shelter programs have the following supplies readily available: towels, sheets, blankets, soap, laundry detergent, diapers, baby formula, hygienic supplies (such as feminine napkins, deodorant, and combs), and a first aid kit. In addition, it would also be helpful if clean clothes and shoes, and some funds for small necessary purchases are easily accessible. Finally, a small refrigerator in the shelter residents' lounge for items such as baby's milk can prevent some problems related to the kitchen.

SOCIAL SERVICES PROCESS

When the family is referred by the emergency intake worker, he should share information regarding the family with family shelter staff. Once the family arrives at the shelter, additional information will be needed and obtained from the family.

Intake Interview

The purpose of the intake interview is to obtain some basic information about a family who is being admitted to the emergency shelter for families program. This information is needed to give the social service worker an idea of the problems and needs involved in a case. Moreover, the intake interview is a time when the worker can explain the program to new clients.

Assessment of Needs and Problems

An assessment of needs and problems is based upon information obtained from the family agencies and other sources that may have knowledge about a family. In addition, the emergency shelter for families workers are in an excellent position to observe shelter residents, and can use this firsthand information to better understand them.

Development of a Plan of Action

A plan of action should be based upon the assessment of problems and needs, and a sound knowledge of available resources. Plans should be made with the knowledge and consent of the family whenever possible. In fact, independence should be encouraged by helping families to help themselves as much as is feasible.

Social Services Assistance--Implementing the Plan of Action

1. Referrals are one of the most common activities of the social service worker. Families coming to the emergency shelter have multiple needs and problems, and will almost always require the services of many different agencies.
2. Coordination of services with other agencies is an important function of the emergency shelter for families social worker because these families have multiple problems and needs. Coordination of services is necessary to prevent duplication of efforts, to insure that necessary services are performed, and to increase the efficiency and effectiveness of the various agencies and services that are involved in the case. In addition, since the emergency shelter for families social workers are

subjected to a two-week deadline for gathering the basic necessities for clients to live, it is often necessary for the workers to initiate action, and to express the urgency of situations to other agencies. Finally, it is vitally important that the outreach worker follow the family during their stay even if they do not have major responsibility. This is done through conferences and progress reports. This is necessary for a coordination of efforts, and should aid the worker in providing necessary outreach and follow-through. Because of the many agencies involved, coordination will be a problem. The dependence on other agencies for much of what is required for relocation of the family also poses a great problem. Many families come to the family shelter without minimal resources, i.e., no job, no household furnishings, etc. Some very basic tangible long-range services, such as low-rent housing, food stamps, and public assistance, must be provided to begin to relocate many families. Good working agreements with such agencies will be extremely important in assisting displaced families quickly and efficiently.

SPECIALIZED RESIDENTIAL PROGRAMS

Whereas emergency shelter for families programs have as a minimal service shelter for families who have no home, there are residential treatment programs for entire families beginning across the country. The purpose for such programs is to provide a therapeutic milieu for parents and children in high-risk situations. This is an alternative to separation. Such programs serve a twofold purpose; an opportunity to observe the mother and child interact in a protected environment and early intervention to prevent

further deterioration of this relationship. It has both preventive and protective aspects. The parents learn new ways of dealing with problems related to care of their children while receiving the encouragement and support of a protective environment.

One fairly unique residential treatment program for families is The Native American Community House (NACH). Located in the south end of Seattle and operated by the Seattle Indian Center, NACH is the first urban native American program of its kind in the country. The program operates an apartment complex where qualified staff and residents live and work together to solve the problems which threaten to break up the family. NACH believes that most families can learn to handle their difficulties and remain together if they have a strong will to stay together. Each family must agree to stay in the program for at least three months.

CHAPTER XIII

EMERGENCY CARETAKERS

INTRODUCTION

Emergency caretaker service is a supportive child welfare service. It consists of carefully selected and trained personnel who go into homes as assigned by an emergency intake worker to provide responsible adult care and supervision for children in crisis.

The emergency caretaker program began in 1966 in Buffalo, New York with the emergency parent program of the Children's Aid Society for the Prevention of Cruelty to Children.

This component provides the emergency intake worker with another option for responding to child emergencies. By using the emergency caretaker, the child remains at home thus preventing unnecessary precipitous placement.

PURPOSE AND PHILOSOPHY

The field of child protection has long recognized the need to have a temporary caretaker for children who are found deserted or whose parents are temporarily incapacitated. Many children who are placed during nights and weekends would not have to be placed if optional service were available. The child can remain at home safely, in an environment that is familiar and feels secure. The service is short-term. The caretaker is relieved the next working day when the parent or relative returns or when a homemaker is assigned. This temporary service also allows time for an orderly placement, if placement is indicated.

Again, as with all components, the basic assumption is that a child should remain with his parents in his own home if he can do so safely. It is also felt that the natural family may be enabled to reassume adequate care with the support of various child welfare services as indicated. The wider range of options for the various needs of children and families insures a more effective service. Emergency caretakers, while involved for only a brief time, are important precisely because that period is so crucial.

STAFFING AND RECRUITMENT

The recruitment of caretakers can pose problems because the job is normally only part-time employment for most of this staff. Recruitment of personnel who want only part-time employment or personnel with full-time employment in related fields who will accept the position of caretaker should be considered.

The latter category has certain advantages in that the staff comes with certain pertinent training and experience. They may know how to relate to families with problems and know something about child development and human behavior.

Health aides, social work assistants, as well as school of social work students may have a good knowledge base and the necessary practical experience. While orientation and training for this kind of personnel does not require the same degree of complexity, as for social work staff, it is important that they have sufficient training. It should not be assumed merely because they have been trained in other related employment that the training was adequate.

There is the possibility that in some cities volunteers can be used as caretakers. The SCAN⁷ Programs have provided a precedence for the effective use of trained volunteers, as lay therapists, with child neglect and abuse situations. Persons who volunteer their time may do so in exchange for the experience and the payment of transportation plus incidentals would be sufficient compensation. It is possible that in some cities trained volunteers can be used effectively. For example, one agency used graduate law students, and others have used husbands and wives of students.

Recruitment of caretakers from areas with the highest reported incidence of child abuse or neglect is important, especially in large urban areas where most resources will likely operate better on a neighborhood level. Caretakers need to be immediately accessible; therefore, it is necessary that they be within a short driving distance of any assignment. Recruiting and hiring from neighborhoods where centers are located not only makes the caretaker a more familiar figure, but also makes it probable that the caretaker will be equipped with necessary knowledge about the character of the neighborhood and its sub-cultures. The more familiar a caretaker is with the neighborhood, the easier it is to obtain acceptance by the children and the family. Even though it may be impossible to recruit enough caretakers to cover all possible ethnic and/or religious groupings, this should be a consideration.

In areas where there are high concentrations of different ethnic groups, a part of the training of caretakers should definitely include an effort to increase awareness and acceptance of various racial, religious, and ethnic

⁷ SCAN (Suspected Child Abuse and Neglect) programs, making use of trained lay therapist, have been established in Spokane, Washington and Little Rock, Arkansas.

differences including language, diet, religious taboos, etc.

Aside from this, the criteria for selection should cover certain other factors:

Age

The age of the caretaker is not of great importance except as one considers the general health and vitality of the person. Managing a household and a large group of rowdy and often undisciplined youngsters can be exhausting for the person who is not in the best of health.

Formal Education

Formal education as a criterion should not be so rigid as to reject those individuals who otherwise qualify. The caretaker must have sufficient language and writing skills to complete simple reports, to write down observations, and to complete requisitions for pay. Communicative skills should be adequate for the caretaker to relate to the parents and children.

Other

Far more important factors are the ability to make accurate and meaningful observations and the emotional stability to remain calm under stressful situations.

The caretaker must be a reliable person who can function independently and be able to assume total responsibility for a household and a group of children. This includes the ability to cause things to progress smoothly with the least amount of disruption to the children. They must also have sufficient judgment to know when to call upon the emergency worker. The emergency intake worker assumes responsibility for support of the caretaker for the duration of an assignment.

Personal Attributes of Caretaker

The caretaker must have a genuine respect for people of all socio-economic and/or racial levels. She must like children and be able to relate to many different kinds of children, some of whom will not fit the image of what "children should be like"--loving, dependent, and respectful of adult authority.

Young children who have been left alone for long periods of time may survive only because they are cared for by an older member of the sibling group who assumes the role of parenting. Children who have lived for long periods of time without adult supervision may resent an adult imposing certain restrictions, setting up rules, etc. Very young children, who have been free to leave the house when they want to and go where they want to go, become very belligerent and difficult to manage if someone moves in and immediately sets up rules and regulations to govern their behavior.

The caretaker must have some understanding of how to handle such problems. Most caretakers, hopefully, will have had successful experience with child rearing and will have some experience in dealing with these kinds of problems.

Practical training experience on how to handle various situations that are certain to occur will prevent much agony for the caretaker. The primary consideration as staff is recruited is that they must have patience, tolerance, and a basic love for children. This is a necessary prerequisite. It is also necessary that this person be eager to learn and to incorporate new ideas. This is important as training for caretakers must be a continuous process.

Training

Caretakers become a part of the remedial process at a crucial time, so staff should be carefully trained to handle these assignments. The emergency caretaker is often the first member of the CES staff the parent will encounter. The ability to handle hostility, to impress on the parent that there exists a desire to understand and help with the parents' problems as well as with the children, is important. The tone of this initial encounter is critical to the ongoing relationship. It will insure the beginning of a positive, constructive relationship for the family. The emergency caretaker, being far more than a trained babysitter, is the key to the beginning of a helping relationship. Staff for caretaker service must be selected and trained with this in mind.

Caretakers must have training in broad and specific areas. They must have thorough knowledge of the resources of supplemental and/or supportive agencies. They need to have certain procedures clearly spelled out in writing, so that these procedures may be used for reference on an ongoing basis. It is especially important that caretakers fully understand what to do in relation to accidents, injuries, and/or serious illnesses of a child in their care. Also, procedures for reporting to the emergency intake worker the arrival of parents or the violent and/or irrational behavior of a parent are necessary.

Caretakers must be equipped with some basic knowledge of human behavior. The content of this training should be as simple as possible and should deal with basic material on understanding normal and abnormal human behavior. Caretakers need information regarding the philosophy of CES, as well as other child welfare services, to correctly interpret

the role of caretaker within the community and, more importantly, relative to the parent.

Caretakers must become skillful observers both of child/adult behavior as well as of the family's environment. There must be an awareness of how important it is to report observations since caretakers are often key sources of information as intake workers formulate assessments and make decisions about the children. This role must not be confused with "spying on the family or meddling". Caretakers must make observations as professional members of the team. These observations will assist intake workers with an early, accurate impression of the children, the home, and the quality of care available to children in that home.

Simplified teaching materials for child development meet the requirement for a better understanding of the stages of children's physical and emotional development. Most caretakers will come with some experience from having observed children in their own families but may not have the knowledge base for understanding and applying this to other children.

Scheduling for caretakers should assure coverage at all times. The schedule, itself, should be made available to all personnel of CES. The number of caretakers needed for coverage will be greater if the plan is to rotate caretakers on an eight-hour "on call" schedule as opposed to a twelve-hour schedule. The most important thing is to have a sufficient number of caretakers on call for some designated, hourly schedule during which time a person would be available for assignment as requested by the emergency intake worker. It is also important that, after the caretaker is assigned, she be available to remain on the assignment until the next

working day. This means that the full weekend should be covered by one caretaker if at all possible. This minimizes the number of people to whom the child must relate. Example: If a caretaker is assigned at 7:00 p.m. on Saturday, hopefully the scheduling would be flexible enough that she could remain on the assignment until the homemaker arrived on Monday morning. This certainly requires some flexibility.

Personnel should be selected with this in mind. The caretaker position will at best provide very limited compensation in the form of a retainer (such as \$20.00 or \$25.00 per week). In addition, staff should be paid no less than the minimum hourly wage plus transportation for the hours on an assignment. This could represent supplemental income to those who may have other income from employment, social security, student stipends, etc.

SPECIFIC SERVICES PROVIDED

The emergency caretaker performs essentially the same task as the homemaker. She cleans house, bathes and feeds children, etc. Her role differs only in that she is assigned mostly nights and weekends to hold the family together until other relief is available or an alternate plan is made.

In most case situations, the parents are temporarily absent. In some situations, however, a parent is in the home but is incapacitated and unable to function. This may be due to sudden illnesses requiring complete bed rest or an impending mental breakdown during which the relief provided by the caretaker holds the situation together until the parent can be evaluated or hospitalized.

The caretaker will enter many situations where there are not even basic supplies such as cooking utensils, food, or a place to sleep. It is therefore imperative that each caretaker be sufficiently equipped to be self sustaining. We have included at the end of this chapter a supply and equipment list essential for the caretaker.

The caretaker must see that the children are comfortable and that their basic needs are met. Her primary responsibility is to safeguard the child and attempt to provide a secure environment. The physical environment is her secondary concern. She must clean the dwelling well enough that it is not a hazard, but she should not become preoccupied with this chore. If the physical conditions of the home are hazardous, some other alternative should be considered, as in homes with no plumbing or with no heat in the winter.

The judgment as to the feasibility of assignments is the responsibility of the intake worker. The relationship between the intake worker and the caretaker becomes a binding one with the intake worker depending on the caretaker for certain vital observations. The caretaker in turn must depend on the intake worker for certain judgments such as what may or may not be a safe and suitable situation for assignment of a caretaker.

This interdependence must be detailed and in writing to govern assignments. A battery telephone or other communication system will insure necessary communication. Caretakers will need certain supplies, and the following is a suggested list:

1. blankets
2. food
3. cooking equipment
4. rechargeable flashlight
5. first-aid kit
6. disposable diapers
7. aluminum folding cot
8. battery telephone
9. items of clothing
10. appointment card
11. petty cash

CHAPTER XIV

EMERGENCY HOMEMAKERS

INTRODUCTION

Emergency homemakers are assigned to provide twenty-four-hour service to children and their families, primarily for the purpose of maintaining children in their own homes until parents are able to resume responsibility. Homemakers services are also used when parental functioning can be improved by teaching parents more effective ways of caring for children and maintaining their homes.

Emergency homemakers do not differ greatly from teaching homemakers as far as task, role, and responsibility except that the emphasis is primarily on emergencies. The emergency homemaker is available for assignment to a home on a twenty-four-hour basis, seven days a week, while the teaching homemaker is normally assigned during weekdays.

Basically, the emergency homemaker service is supplemental and is designed to provide trained, experienced persons who are able to function in a team with the emergency intake or outreach worker. Emergency homemakers are called upon to relieve the parent who cannot carry out his parental responsibilities. Whenever the parent is in the home, teaching becomes an integral part of the homemaker's responsibility.

While case situations requiring emergency homemakers are varied, many involve parents who are temporarily absent due to illness or desertion. In these instances the emergency homemaker may be called on to help the family remain in the home. The caretaker is relieved when the homemaker is assigned. If an emergency occurs during the day, the emergency homemaker is often assigned directly to the family where she

remains for several weeks. This allows the caseworker sufficient time to make long-range plans for the children.

The homemaker extends the service offered initially at night or on weekends by the caretaker. As the caretaker is relieved the following morning, the specific nature of the assignment will be determined by whether the parent is present or not and the nature of the problems in the home.

PURPOSE AND PHILOSOPHY

The emergency homemaker is often a preferred option because the child can be maintained in the home with his family. The primary objective, as with all components, is the preservation of the family. The initial assumption is that the family can be strengthened. The homemaker is useful in situations in which the parents are unable to carry out their responsibilities due to such circumstances as physical or mental illness, death, or desertion. The homemaker's involvement allows the child to remain in familiar surroundings until the parent returns or until relatives have been found who can provide substitute care. In situations where neither becomes available and the child must be placed, the emergency homemaker buys time for planning and offers the child some security by helping him prepare for the placement, thus minimizing the traumatic effects of placement for the child.

The emergency homemaker helps to safeguard the child against further emotional or physical damage. In families which have been under extreme interpersonal or environmental stress, parents are often unable to carry out even basic parenting responsibilities. In helping the family through this period the homemaker also helps to identify and maximize the potential strengths of the parents.

SPECIFIC SERVICES PROVIDED

The nature of the problem will greatly determine the specific tasks of the emergency and teaching homemaker. During the briefing conference which precedes an assignment, the emergency intake worker or outreach worker will have identified certain problem areas for immediate consideration. Other problems may become apparent after arriving at the home and conferring with the caretaker. These early specific tasks will generally relate to maintaining the equilibrium of the family. They include reassuring children whose mother has been unexpectedly hospitalized or reassuring an abusive mother who is caught in the dilemma of both needing to be mothered and being required to mother.

A better sense of the specific tasks may be derived from a number of typical case situations. These do not represent all of the possible assignments but may give an idea of the wide and effective utilization that can be made of the emergency homemaker.

Parent Temporarily Out of the Home Due to Desertion

In situations of temporary desertion, the emergency homemaker is often preceded by a caretaker who has not only identified problems but also strengths within the family structure. This includes such things as which child has certain attachments to others within a sibling group, which children carry out certain parenting responsibilities (as is often the case where children have been chronically neglected), which child seems more upset as indicated by what kind of behavior, what is the maturation level of individual children. This process of individualizing family members and identifying problems will continue throughout the contact. It will, therefore, be the task of all CES personnel to become skillful observers of behavior and situations. The pooled information

of the caretaker and the emergency intake worker will facilitate the homemaker's assignment, will make for an easier overall adjustment for the children, and will facilitate the decision-making process regarding what plan is best for the children and the family.

The intake worker must have a healthy regard for the observations of the caretaker and homemaker. Even though responsibility for assessment of the situation rests with the intake worker, she and her supervisor need to listen, and translate these observations into accurate assessments. One of the distinct advantages of CES is evident here where the demands, more often than not, do not allow time for long and complicated assessments before taking action.

The emergency homemaker becomes a substitute parent in such situations and carries out the responsibilities of the parent in relationship to children and the household. This includes cooking meals, washing clothes, cleaning house, and attending the children's emotional, physical, and emotional needs. It may also include taking children to clinics, driving them to and from school, and helping them with homework. Older children may need encouraging to assume appropriate responsibilities or to be relieved of burdens, to be allowed to be children again.

The full responsibility for a group of children, some of whom are probably severely maladjusted, is a heavy workload. On twenty-four-hour assignments, the homemaker should have temporary relief on a planned basis.

Parent Temporarily Out of the Home Due to Illness

In case of illness of a parent, the emergency homemaker's assignment will extend some time beyond the parent's return to the home. She remains until the parent is able to resume care of the children. In some cases of

extended illness or death of a parent, as in cases of desertion, she has a responsibility to prepare the children to accept a new person or placement. When one parent is in the home but the other is absent, the emergency homemaker's responsibilities are much the same, but will probably not include staying in the home on a full-time basis. Where mothers have died or deserted, fathers often request placement of the children so as not to lose their jobs and personal belongings. The emergency homemaker is then an invaluable resource, enabling the children to remain at home. This bridges the gap until relatives come to take over, until day care is located, or until some other orderly placement can be worked out. Many fathers can manage even younger children alone after working hours once child care is worked out or once they accomplish certain unfamiliar tasks such as doing girl's hair or bathing and changing a baby. Some fathers, with support and encouragement, become adept in the operation of a household and the management of a job and children. The homemaker is often the one who helps the father make this transition and learn these skills.

Suspected Child Abuse

Case situations where the child is suspected of having been physically abused often require the assignment of emergency homemakers as:

1. an early alternative to placement of the child
2. a parent surrogate who supports the mother and frees her to parent
3. an observer of the parent/child interaction

She provides valuable information that will assist the intake worker in his decision regarding the validity of the abuse and its impact on the child.

Homemakers represent a tremendous resource to CES because they can offer both immediate therapeutic intervention and skilled observations. According to some current theories, the emergency homemaker may be easily trained to act as a "lay therapist", thereby maintaining the child at home until longer-term, therapeutic resources can be introduced.

The specific tasks of the homemaker in child abuse situations include:

1. helping the mother with the child, both to relieve her of the pressures of full parenting and for the purpose of modeling alternative behavior
2. helping to relieve environmental stress, thus eliminating the triggering mechanism for repeated incidents of abuse
3. encouraging the parent to rely upon the homemaker and to no longer lean so heavily on the child, hopefully making the child less vulnerable
4. encouraging the parent to learn to trust which may encourage other positive interpersonal relationships
5. cultivating self esteem by identifying strengths and providing positive experiences for the parent
6. providing some feedback for realistic expectations of the child in accordance with his age and level of maturation
7. offering the child an environment that is free of inappropriate adult responses

No one should be left with the impression that the duration of the emergency homemaker assignment will be sufficient time to accomplish all that needs to be done with families that have child abuse problems. This

will be just a beginning, but this beginning sets the stage for successful long-term intervention.

Failure to Thrive

These children represent a sizable proportion of those in the high-risk category. With proper management, the problem may be solved. With no intervention, the client may be subject to death or the lifelong consequences of early nutritional and maternal deprivation.

The emergency homemaker's responsibility is to ensure the proper feeding and nurturing of the children and to assist in the diagnosis of the child's problems. In situations where the parent is suspected of being too disturbed or too intellectually limited to care for the child, the homemaker has a further responsibility to assist the physician, public health nurse, etc., in determining the parent's capacity for filling a parental role. Mentally retarded parents are often able to grasp basic skills and, with ongoing support, are able to function adequately. The process is simply one of showing them how, step by step, and over and over again, until the desired behavior is incorporated. This requires immense patience and skill.

Some research would suggest that failure to thrive is the forerunner of abuse. From practical experience, most experienced child protection workers have learned to regard failure to thrive as a clear indicator that a mother/infant relationship is on a downhill course. The intervention of CES and the emergency homemaker can reverse this course and spare the children the lifelong liabilities this problem brings.

These case situations have pointed out some guidelines for the effective utilization of emergency homemakers. The Nashville CES system's experience in working with cases of suspected abuse and failure to thrive demonstrates the success of using emergency homemakers. There are only a few situations where failure to thrive has required placement after the assignment of a homemaker and only a minimal number of incidents of later abuses. The benefits can be graphic and rewarding, as when a child who was terribly deprived is gradually transformed into a hale and hearty child. Getting the mother "turned on" to parenting is difficult, but well worth the time and energy.

RECRUITMENT OF EMERGENCY HOMEMAKERS

Recruitment of emergency homemakers can present some problems due to the demands of the job. Availability for twenty-four-hour assignments requires persons who are free of personal responsibility.

There are various considerations that must be made when hiring. Any problems the prospective homemaker may encounter in meeting the needs of her own family is one of these. Many of the attributes the emergency caretakers need are also desirable here. The person's attitude and understanding toward the role of homemaker is another factor of great importance. The homemaker should be a skillful person who will perform a vital role to help families. A homemaker needs to know she is critical to the team's success and is not to be relegated to the position of maid or housekeeper.

Resources for recruitment are job training programs, employment security, manpower, and concentrated employment programs. Techniques include leaflets distributed in designated areas, free public spot announcements, and newspaper ads.

The qualifications for emergency homemakers should include only those criteria directly related to getting the job done. Since the qualifications for homemaker are almost identical to those of caretaker, refer to those qualifications stated in Chapter XIII, page 139.

Workloads for the emergency homemakers should normally consist of one family per homemaker. In such situations, she is needed early morning and late evenings but has many chores to do throughout the day. Teaching homemakers, in contrast, may serve more than one family at a time, providing services for a few hours per day to more than one family, or serving on alternate days.

It is highly recommended that the scheduling for emergency homemakers be such that there is always one homemaker available as a backup person in case illness or personal problems require the primary homemaker to leave an assignment.

Scheduling and assigning of cases will be the primary responsibility of the emergency homemaker supervisor. In her absence the supervisor of the emergency service and/or project coordinator might assign homemakers. Assignments are to be made in accordance with the availability of staff. However, consideration should always be given to the particular expertise of the individual homemaker. An effort should also be made to balance assignments so as not to overburden any one homemaker.

OTHER PROCEDURAL CONSIDERATIONS

1. Information regarding the physical condition of the home is important, especially in twenty-four-hour cases. The homemaker needs to know if there are any food or cleaning supplies available so as to arrange to take the needed supplies or to request petty cash as needed.

2. If there is some question regarding the current status of utility bills (e.g., possible discontinuance of service), this should be clarified with the parent when available. In situations where bills must be paid, the intake worker will plan with the parent to delegate this responsibility to the homemaker if no one else is available. Homemakers might have difficulty in purchasing food stamps. Therefore, if the parent is participating in the food stamp program and stamps must be purchased while a parent is hospitalized, the worker should plan for this.
3. In many situations, relatives arrive to offer help after a homemaker is assigned. The homemaker should refer such relatives to the caseworker and should not relinquish any responsibility or make alterations in the schedule without consulting the supervisor.
4. Temporary relief should be provided so that the homemaker can be included in planning conferences and staff meetings. This input is vital for decisions regarding plans for the family in crisis.

CHAPTER XV

EMERGENCY FOSTER FAMILY HOMES

INTRODUCTION

Emergency foster family homes provide up to fifteen days of care for children who cannot be maintained in their own homes. These homes are designed to minimize the emotional shock of removal of children from their families by providing them with a home environment as an alternative to institutional placement.

Emergency foster families provide an alternative which must be available at any hour. Emergency foster parents must be selected for their willingness to accept any child in any condition. This is a very demanding responsibility; therefore, these parents must be prepared for the stress and strain. They need to receive adequate training and they must be adequately compensated. The CES system must also allow for maximum support to the emergency foster parents, such as relief on a planned basis and provisions for personal emergencies such as illness.

PURPOSE AND PHILOSOPHY

Foster family services is the child welfare service which provides: (1) social work and other services for parents and children⁸ and (2) family living in the community for children whose natural family cannot care for them, either temporarily or for an extended period of time. Foster family service begins when the question of separating the child from the family arises. It ends when the child is back home, or in a relative's home.

⁸ "Children" includes youth to the age of legal majority.

is placed for adoption, is placed in a more appropriate facility, or reaches legal majority.

Emergency foster family homes serve those children requiring placement because they cannot be maintained in their own home. An emergency foster family is decided upon as the alternative only after careful consideration of all factors, including what is most suitable and appropriate for the needs of the individual child.

An assessment of the family crisis and the decision to place a child in an emergency foster family home must often be made without all of the information needed. An emergency placement is usually made with primary consideration given to the immediate safety of the child. The parent is either unable or unwilling to provide a safe environment for the child in his own home. Some circumstances precipitating emergency placements include:

1. incidents of abuse
2. situations in which children are found unsupervised where it is unsafe for the assignment of a caretaker
3. cases in which parents have been arrested and have not been able to make bond
4. situations involving older children requesting placement due to severe conflict with their parents
5. situations in which there are medical emergencies and the parents either refuse or they are not available to give consent

While the entire emphasis of CES is to provide a range of alternatives to placement, this does not negate the need for placement in some situations. Emergency service staff must function as a team in considering input from all available sources to arrive at the decision for

placement. For the child whose parents are traveling through the city and who are apprehended by the police, there is no alternative to placement until suitable relatives arrive for the child. The decision to place this child is a relatively simple one involving only such things as the child's age, what preparation must be given, and what is the most appropriate emergency foster family home for that child.

The decision regarding placement of a child who has been abused is far more complex and relies upon input from professional disciplines and various supportive services. Again, the emergency intake worker must know what sources of input to seek, obtain all pertinent information needed, and coordinate all outside disciplines as well as other CES components. This is necessary to formulate a decision regarding the feasibility of placement. This decision should include the parent as often as possible.

Once the decision is made to place the child, the emergency intake worker sets out to initiate with the responsible parent, guardian, etc. a plan for the child and his family. This plan should include short and long-term objectives which are in keeping with the child's best interest.

From this point all effort is directed toward meeting objectives which aim at either reuniting the child with his natural parents, relatives, etc. or continuing the child in care for a determined time-limited period. Work must begin immediately for a planned placement.

RECRUITMENT OF EMERGENCY FOSTER FAMILY HOME

The recruitment of emergency foster family homes becomes a full-time responsibility in large agencies. In small agencies where staff has multiple responsibilities, the recruitment program should be planned and organized to

generate sufficient homes as needed.

The recruitment of emergency foster family homes can become the responsibility of the staff recruiting other foster homes. As all prospective foster parents go through the selection process, the need for foster parents to provide emergency homes should be discussed. Realistic information regarding the differences and the demands of emergency care should be covered.

A well-planned, ongoing publicity campaign (no matter how good initially) is something that will need to be revised frequently. The methods that have been tried and proved to be effective will be continued while those that are not productive must be revised or discarded.

The effective recruitment and maintenance of emergency foster family homes must begin with an assessment of the need for foster family services for the entire community. This includes identifying areas of potential placements based on the rate of reporting of family crises. Such an assessment should include information regarding children with special problems or the special needs of a given community because of ethnic or racial differences. The recruitment and approval of emergency homes in neighborhoods is directed toward solving some of the problems which might grow out of ethnic and racial differences. Emergency foster families located in the community or neighborhood from which most crises are reported should be the primary aim of the recruitment effort.

Such a plan also provides a more accessible placement resource for the emergency intake worker. But more importantly, the child at least remains in family surroundings, eliminating the need to adjust to a totally alien environment.

Recruitment will require much involvement of the community and other foster families. Present foster families become an invaluable resource for both formal and informal contacts. There should be input by the foster parents' association and citizen committees regarding effective publicity. Often, an emergency foster parent is able to give a far more convincing though realistic portrayal of their role than could a staff person.

STANDARDS FOR EMERGENCY FOSTER HOME SERVICE

The requirements of foster parent families relative to age, health, income, and the physical facilities of their home should meet the recommended basic standards for foster family service systems.

Providing foster family care for children on an emergency basis is very demanding. Foster parents must be available to receive children at any hour with little warning. For that reason, foster parents must be selected with age, stamina, and flexibility as a matter of primary consideration. The age and condition of the children is another factor which places unusual demands upon emergency foster parents. Children coming into care on an emergency basis are likely to present any number of physical and/or emotional problems which require much time and effort. A severely battered child who is in a cast when placed in an emergency home requires much attention as does the child who is emotionally disturbed. The number of children placed in each home is also a factor to be considered when planning for emergency foster care.

An emergency foster family home will not be an appropriate placement for some children who must be placed. At all times, the emergency intake worker or the outreach worker must be aware of this. Children who are too disturbed to relate in a family setting, older adolescents, or children

who are so unsupervised they cannot adjust to adult authority should not be placed in emergency foster homes.

Adolescents often request a group home or shelter placement. As much as possible, the request of the adolescent should be given consideration. There are many problems related to the placement of adolescents, some of which can be eliminated or at least minimized if the adolescent is involved at all times in his own placement.

The numbers and ages of children coming into care will place greater demands on the emergency home space from time to time. Therefore, provisions for any increased space must be planned.

In considering how many children will go into each home, some consideration needs to be given to the foster parent's abilities with children of differing ages. Most emergency homes will likely be asked to agree to accept children of all ages but, invariably, some emergency parents are better with some ages than others, and this should be considered when placing the children.

If most children taken into care are of the same age during a given period, this can create a problem also. For instance, when all the children taken into care in a given month are infants, support and relief of the emergency foster mother will be needed. It will be very difficult to operate emergency foster homes without a system for relief. Homemakers are one resource for providing this relief on a planned basis.

COORDINATION

Coordination between the emergency foster family homes and other components of CES is both important and complex.

Overall coordination and monitoring of the entire system is necessary

to avoid unnecessary placement of children. As any component becomes critically understaffed or has breakdowns in service delivery, more children will require placement. There should also be data gathering and ongoing statistics kept on children in placement. The system for monitoring should include keeping accurate records of the following:

1. total number of children placed in emergency foster family homes
2. number of children placed directly in planned foster family homes
3. children being maintained in their own homes but who are potentials for placement
4. children who have special needs (retarded, physically handicapped, etc.)
5. the date each child is placed and the date he is moved from care
6. the plan for this child, where he is going, and when
7. number of children in each emergency foster home, their ages, sex, and any special needs
8. total number of all foster family homes, group homes, etc. with estimated capacity of each
9. work load of the staff who recruit, evaluate, approve, and supervise these emergency foster family homes

This list could go on, but these are the essentials. The monitoring should include how designated staff is to gather, compile, and keep this information updated.

Frequent conferences between the staff supervising emergency foster homes and other CES staff are essential. These begin with that first conference for planning the child's placement and the objectives. Conferences must be conducted on a planned basis at scheduled periods to evaluate and update the plans.

Someone should be designated to flag children who have not moved by the anticipated period. This person, who would also be responsible for the statistics, must have the authority to call a conference at any time regarding the individual child or children. This person also becomes a resource person for placement in that they have available to them information about all placement resources.

Keeping accurate records of the number of children in each emergency foster home at all times is important. Emergency intake workers must be informed each day of the number of vacancies available in emergency foster homes and the name and location of these homes. This can be done by providing all emergency services staff a listing of emergency foster family homes. As vacancies occur and are reported, the list is constantly updated. At the end of each day, emergency intake is given this updated listing.

STAFFING

There must be sufficient casework staff to supervise the emergency foster homes. They must be readily available to assist emergency foster parents as problems arise and to see to each child's needs. Attending to medical problems of children coming into care demands much staff time. Many of the children will have health problems requiring special medical care which is given in addition to the routine physicals required for placement. Arranging for this care can be time consuming. Many diagnostic examinations are necessary and must be completed to determine a plan for the child. Psychiatric evaluations or a complete neurological workup can be a part of the information necessary to determine the extent of the damage done to a child.

The training of the emergency service caseworkers and that of the emergency foster parents must be thorough. They must have some knowledge of child development and human behavior. It is of great importance that they understand the characteristics of normal adjustment for each developmental period. It is of equal importance that this staff have a healthy concept of self and be aware of their own biases, eccentricities, etc. They also need to have a good attitude about the agency, a thorough knowledge of the philosophy and purpose of foster family services, and an understanding of preventive and protective services.

Problems

Coordination is one of the major problems likely to arise. Many other problems are likely to occur both in the operation of the homes or with individual and/or groups of children. Severe conflict between the foster parent and the child because of ethnic, cultural, and/or religious differences can create a crisis in a home and must be dealt with as a serious and realistic problem for both child and foster parent.

A child who has been chronically neglected and whose socialization is so retarded that he knows nothing of using eating utensils, for example, can become both a challenge and a frustration for a foster parent. Foster parents must have support and ongoing assistance with interpretation to deal with this kind of behavior.

Training

The emergency foster parents must have the time to participate in overall planning and training for the development of foster family services. They should be an integral part of this planning as they can be valuable

resources due to their experiences with children. They should be involved in training, both as participants and as leaders. Joint training sessions for emergency caseworkers and foster parents can be beneficial to both.

CHAPTER XVI

EMERGENCY SHELTER FOR ADOLESCENTS

INTRODUCTION

Emergency shelter for adolescents provides residential substitute placement for older youths with special problems which cannot be handled in their own homes or in foster family homes and who should not be placed in juvenile detention. A program of emergency shelter for adolescents strengthens a comprehensive emergency services system by reaching out with immediacy to the adolescent in crisis.

In Metropolitan Nashville, Richland Village is the facility providing residential placement for older youth. Prior to CES, Richland Village provided emergency shelter care for children of all ages. The number of children under six years of age coming to the facility was so large that the need for program expansion to serve adolescents was not feasible. With the development of CES and provision of alternatives for children in crisis, particularly children under six, Richland Village was enabled to restructure its services. With initiation of the CES system and prior joint planning between agencies, Richland Village obtained Title IV-A and LEAA funding to implement a two-week emergency shelter program and a long-term treatment program for adolescents.

This kind of programming allows for flexibility necessary for adolescents coming into the emergency shelter program who may be in need of long-term placement. If, after careful assessment, it is determined that treatment is needed, the adolescent can be transferred to this program within the same facility.

PURPOSE AND PHILOSOPHY

Under "ordinary" circumstances, adolescence is a critical period of transition for the adolescent and his family. The onset of a crisis situation may intensify an already strained relationship and add to the vulnerability of both. Recognizing this, emergency shelter for adolescents is designed to meet their needs whether the crisis is due to family conflict, behavior which threatens them with juvenile detention, emotional disturbance, etc.

The significance of peer group relations, the struggle for and fear of independence, interests in the opposite sex, onset of pubescence, and various expectations are a few factors with which the adolescent must cope. The adolescent is expansive in mood and temperament one day, comfortable with parents and siblings, enjoying home surroundings. But, he can be withdrawn, uncommunicative, and depressed on the next day. To the adolescent, parental figures may be alternately intelligent and perceptive, but, then, incapable of understanding, and too strict. The struggle for a sense of identity, the need to look toward the future while tied to the past, peer group pressure, drug experimentation or continued use are but a few factors which place the adolescent in what seems, at the time, an impossible situation.

Adolescence is a difficult period, even under conditions characterized by warmth and love with a good home environment and parents whose relationships are good and who carry their parental roles and responsibilities realistically. Even these conditions can be negated by forces outside the abilities of parents and adolescents to manage comfortably. They can be exacerbated, for example, by family breakdown spanning a continuum of crises from severe illness, to loss of income,

to death. When family relationships are poor, when there has been inadequate parenting, abusiveness, and neglect, the family will be ill-prepared to cope with even the normal problems of adolescence. These and other factors can be catalysts which propel the family and the adolescent into a crisis situation requiring emergency services. Such services are especially important when the need for substitute emergency placement for the adolescent arises.

SPECIFIC SERVICES PROVIDED

Emergency shelter for adolescents provides services designed to meet the special needs of this age group. The adolescent's willingness to accept help, the immediate casework intervention given in the crisis situation, and the ongoing supportive service offered, contributes to the effectiveness of the shelter program. The advantages are closely meshed with the purpose and philosophy of the service. They are:

1. Provision of a physical setup which operates within clearly delineated boundaries. Several cottages on one campus, or group homes in the community, under supervision of house-parents can be conducive to experiences in group living and manageability.
2. Opportunities for dilution of emotional parent-child relationships, provided through contact with parental figures.
3. Opportunities to interact with a variety of adult figures. Representation of different disciplines in staff composition offers the youth a choice in adult-child relationships that may be more comfortable for him.
4. Acceptance, which the adolescent can gain within such a setting which is operated with a tolerant, but not permissive, atmosphere.

5. Accessibility to treatment through contact with the personnel offering therapy. This may be facilitated by the youth's residence at the treatment institution.

Referrals for emergency shelter should be screened and made by the emergency intake unit of the CES system and accepted with the same degree of immediacy that exists throughout the Comprehensive Emergency Services system. Effectiveness can be achieved when staff of the participating agencies in the system have established good, cooperative working relationships so that matters of procedure are not complicating factors.

Even when the crisis situation requiring emergency shelter for adolescents is severe for the parent and the youth, residential placement allows for a "cooling off" period and an opportunity for all persons involved to reorganize their thinking as to how best to restore harmony within the family. The emergency shelter program is meaningful to the youth where it avoids needless court proceedings and hearings, including debates over placement. Both adolescents and parents can correctly assume that disposition will be made as quickly as possible.

Because of the specified time limit, staff members are required to move quickly to coordinate services to insure that no delay is allowed in disposition of the case. The youth may perceive this as a positive experience and gain some preparation for future planning, which could include movement, after the limited time period, into more intensified treatment, into foster family placement, toward returning home, etc.

Adolescents placed in an emergency shelter program should participate in individual counseling if this seems necessary and the problem can be dealt with during a specified time period. Staff members should not provoke presentation of problems which cannot possibly be handled during the

emergency shelter period, but should refer the youth to an appropriate resource.

Group experiences should be available and active participation strongly encouraged. Within any period of emergency placement, planning should be such that an orientation group is continually accessible and attendance should be compulsory. Further planning should allow adolescents to discuss practical problems sharing information and listening to their peers who have also come into emergency shelter. Learning activities include classes in arts and crafts and participation in recreational activities. The adolescent should be free to receive visitors under supervision.

Although this is usually a new and strange situation which can cause anxiety, depression, and "acting out" behaviors, the entire program should be geared to counter the emotional upheavals which can occur in a group placement.

The adolescent can receive the benefits of counseling services, learning and recreational experiences, as well as basic life-sustaining services, without undue outside stimulation that could create a further problem or add to the one that precipitated the admission.

CRITERIA FOR SERVICE

Once a CES system is established, it can be expected that many adolescents will come to its attention. It is important to establish early the criteria for determining which youths can be served by CES and which cannot. Many adolescents charged with delinquent acts should be served by the appropriate mechanism within the legal system. If CES attempts to undertake service to this group, it can become overburdened and be unable to serve those adolescents for whom it is designed. It

is not always easy to determine who should be served, as the question of delinquency is sometimes unclear. The decision should be emergency shelter care when there is a question.

Often, the precipitating event that brings an adolescent to the attention of the emergency intake is brought about by parent-child conflicts manifested in "acting-out" behavior such as:

1. truancy from school, poor school record, educational deficiencies
2. experimentation with drugs or use of drugs, experimentation and use of alcohol
3. running away or refusing to stay with parents
4. poor self-control, i.e., fighting, abusiveness toward parents, wandering, inappropriate speech or actions
5. hostile acts towards parents or other persons in authority
6. conflict with adults over value judgements

The intensity of the parent-child conflict was shown graphically by the findings in a study of adolescents who were called to the attention of the CES system over a five-month period. It was found that these adolescents expressed severe problems in communicating with their parents. The situations had become intolerable and the majority of these adolescents came to the court requesting placement since they wanted to leave home. Some described being physically abused; but after thorough assessment of the situation there may have been a single episode which had precipitated the youth leaving home, with no history of habitual physical or real emotional abuse. There had been serious communication problems which became more outstanding as the youth reached adolescence and began to exert his independence.

The parent, on the other hand, felt a loss of control, fear of no longer being able to manage the child's behavior, and that the youth

would "turn bad". This, in most instances, was a gross exaggeration on the part of both. The youth feared the parent and the parent was confused and frustrated with the youth's efforts toward independence.

Parents are as deeply involved with the adolescent's own struggle to successfully complete this period in their lives as is the adolescent. For this reason, consideration must be given to the parent's problems since they affect the adolescent and plans for the future. Such problems may include:

1. personal problems such as mental or physical illness;
2. poor parenting practices such as poor limit-setting behavior or confusion about one's role as a parent;
3. inadequate or excessive financial resources, and poor utilization of resources.

Since emergency shelter is for a limited time, decisions must be made for the future of the adolescent. Should he return home? If not, what are the alternatives for placement? Whatever the decision, both the parents and the adolescent should be involved in the decision-making process, whenever possible. Referral to a family service or mental health agency for counseling may be indicated and may be a prerequisite for the adolescent's return home.

If a decision is made to place the adolescent in a treatment program (if one is available), involvement of the adolescent, his parents, and the staff in the treatment process should be a stated expectation and responsibility. This should be agreed upon by all concerned to provide the most effective treatment for the adolescent.



APPENDIX A

AMENDMENT TO TENNESSEE CODE ANNOTATED - SECTION 37-230 (b)

ENACTED APRIL 1972.

. . . . "When prior to the filing of the petition, it appears to the court that a child is in need of the immediate protection of the court, the court may, in its discretion, hold the child, release the child to its parents, a suitable relative, a suitable person approved by the department of public welfare pending further investigation for a period not to exceed seven (7) days, including Saturday and Sunday; provided, however, that in no case shall the court hold a child longer than seven (7) days unless a petition is filed within the seven (7) day period. In lieu of any disposition of the child authorized by the preceding sentence, the court may in its discretion authorize a representative of the Department of Public Welfare to remain in the child's home with the child until a parent, legal guardian, or relative of the child enters the home and expresses a willingness and apparent ability to resume permanent charge of the child or in the case of a relative to assume charge of the child until a parent or legal guardian enters the home and expresses such willingness and apparent ability."

SENATE JOINT RESOLUTION NO. 24

By Henry

A RESOLUTION directing the Department of Public Welfare to prepare a survey of the needs for services to children and their families for each county and to survey the services available in each County.

WHEREAS, The Senate Commission on Child Neglect, Dependency and Abuse was unable to obtain an adequate picture of the range of needs across the State for services for children and had considerable difficulty in finding a complete picture of the services available for children and their families; and

WHEREAS, An inventory of services available for children and their families and an inventory of service needs would be invaluable to state and local government and private agencies in planning the most effective possible use of public and private funds in the interests of young people and their families;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE EIGHTY-EIGHTH GENERAL ASSEMBLY OF THE STATE OF TENNESSEE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the Department of Public Welfare is requested to prepare, with full assistance of the Inter-Departmental Committee on Child Development, the Developmental Disabilities Council, and all state and local government agencies serving children and their families, a county by county survey of the needs for services to children and their families such as emergency shelter homes, foster homes, community child care courses, employment programs, planned parenthood programs and other such programs, and a detailed inventory of the services available in each county for children and their families.

BE IT FURTHER RESOLVED, That the Department of Public Welfare in preparing this study shall make a detailed assessment of the extent to which all state agencies and institutions engaged in service to children are in fact meeting needs and of the programmatic, personnel, equipment, and physical facility requirements of the agencies and institutions to meet the needs identified under the preceding paragraph which are within the scope of their responsibilities.

BE IT FURTHER RESOLVED, That all private agencies serving children are requested and urged to cooperate fully with the Department in the conduct of this study.

BE IT FURTHER RESOLVED, That such additional funds as may be necessary to the Department of Public Welfare to carry out the direction of this resolution shall be appropriated under the General Appropriations Act section appropriating funds for "additional duties and responsibilities" of existing departments in a sum sufficient to pay all expenses of the study up to a maximum of fifty thousand dollars.

BE IT FURTHER RESOLVED, That the Department of Public Welfare submit its report in compliance with this resolution to the members of the General Assembly by January 1, 1974 and shall provide copies of the report to appropriate child serving agencies in each county for their use in development and improvement of child serving programs in their counties and towns.

ADOPTED: May 2, 1973



CONTINUED

2 OF 3

SENATE JOINT RESOLUTION NO. 28

by Henry

A RESOLUTION requesting the Department of Public Welfare to develop a 24-hour-a-day child protective service program for the state.

WHEREAS, The Senate Commission on Child Neglect, Dependency and Abuse received persistent reports with respect to the need for child protective services on a 24-hour-a-day basis in order to provide adequate protection for victims of brutality, abuse and neglect; and

WHEREAS, The Tennessee Department of Public Welfare has an experimental 24-hour-a-day protective service program operating in Davidson County; and

WHEREAS, The Senate Commission on Child Neglect, Dependency and Abuse concluded that such a program could contribute greatly to the protection of children who are the victims of brutality, on a twenty-four hour-a-day basis for all children in Tennessee;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE EIGHTY-EIGHTH GENERAL ASSEMBLY OF THE STATE OF TENNESSEE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the Tennessee Department of Public Welfare is urged to continue its experiment in Davidson County, to evaluate its experience with this 24-hour-a-day program intensively, to develop proposals for making such service available throughout the State with such local variation as may be desirable, and to report to the General Assembly no later than January 1, 1974, with its recommendations and plans with respect to the provision of such services thereafter to the extent that its experience and studies show that it is feasible and desirable.

APPENDIX B

The following list includes the major forms designed specifically for use in the Comprehensive Emergency Service project in Metropolitan Nashville-Davidson County. Samples of the forms are provided along with a description of the purpose of each form and who uses it. Staff should be familiar with all the forms and, specifically, with those related to his function. These sample forms may be helpful to individual departments of social services as they develop the forms they need.

- Order of Reference. The Order of Reference is completed by the emergency intake worker on call to obtain identifying information from the complainant. This form is used as a face sheet for the Investigative Report form.
- Investigative Report. The emergency intake worker completes this form when he is investigating a complaint or referral. It provides space for a description of the content of follow-up contacts, as well as assessment and description of the case.
- Emergency Service Statistical Sheet. This form is completed by the emergency intake worker and provides needed data which can be used in interpreting the program, its size, use of components, etc. Over a period of time this information can be helpful in determining which components of CES need to be increased or decreased in size, and can help in determining staffing patterns.
- Schedule for Intake. The Schedule for Intake is an administrative form which illustrates the schedule and rotation of the emergency intake staff. It is shared with the answering service on a monthly basis. Any alterations or substitutions are reported verbally to the answering service.
- Child Placement Contract I. This contract is an administrative form used by the department in order to pay the foster parent's retainer salary. It is a contract which is signed by the department and newly approved foster family parents.
- Emergency Caretaker Contract. This contract is an administrative form signed by the department and the newly approved emergency caretaker. It lists the responsibility of both caretaker and the department.
- Caretaker Schedule. This is an administrative form which illustrates the schedule and rotation of the emergency caretaker staff.
- Homemaker Schedule. This is an administrative form which illustrates the schedule and rotation of the emergency homemaker staff.

- Homemaker Referral. The emergency worker completes this form when he is requesting emergency homemaker services for one of his clients.
- Agreement for Assignment of Homemakers. This form was created at the request of the emergency homemakers. It is signed by the client who is receiving the service. It provides the homemaker with some protection in that it gives authority to the homemaker for being present in the client's home as well as permission to transport the client's children.
- Homemaker's Day Sheet. The homemaker fills out this form on a daily basis. The space provided for observations is very important and often indicates progress that has been made in the client's home.
- Homemaker Progress Report. This reporting form is completed on a regular basis by the homemaker and indicates progress that she had made with a client.
- Homemaker Evaluation Report. Upon termination of a case, the homemaker completes this form.

ORDER OF REFERENCE
PROTECTIVE SERVICE REFERRAL FORM

ASSIGNED TO: _____ DAVIDSON COUNTY D.P.W.
A.M.
INTAKE DATE: _____ TIME: _____ P.M. INTAKE WORKER: _____

MOTHER: _____ RACE: _____

ADDRESS: _____ JUVENILE COURT WORKER: _____

PHONE NUMBER: _____ HEARING DATE, IF SET: _____

FATHER: _____ COMPLAINANT: _____

ADDRESS: _____ ADDRESS: _____

PHONE NUMBER: _____ PHONE NUMBER: _____

MARITAL STATUS: _____ RELATIONSHIP: _____

FULL NAMES AND AGES OF CHILDREN, AND SEX, IF KNOWN AND BIRTH DATES:

REASON FOR REFERRAL OR NATURE OF COMPLAINT: _____

RELATIVES WHO MAY BE CONTACTED	ADDRESS	PHONE NUMBER
_____	_____	_____
_____	_____	_____

CHILDREN REMOVED: YES: ___ NO: ___ RECEIVES P.A.: YES: ___ NO: ___

TYPE OF PLACEMENT: _____

EMPLOYMENT:

FATHER: _____

PHONE HRS. INCOME

MOTHER: _____

PHONE HRS. INCOME

OTHER AGENCY INVOLVEMENT: _____

CHECKED V.I.: _____

CURRENT OR PREVIOUS CASE (# & WORKER)

IF NECESSARY PLEASE CONTINUE ON REVERSE OF THIS SHEET





EMERGENCY SERVICE STATISTICAL SHEET

CASE NAME: _____ DATE REFERRED: _____

CASE NUMBER: _____ CASE SITUATION: _____

INTAKE WORKER: _____ TIME REC'D _____ A.M.
 _____ P.M.

Case Referred by:

- Juvenile Court
- Law Enforcement
- Relative
- Non-Relative
- Social Agency
Specify: _____
- Hospital _____
- School _____
- Other _____

- Case Assigned to E. Intake Worker
- Case Referred at Intake
 - a. Outreach & Follow-up
 - b. Service Unit (CWS)
 - c. Other Agency
Specify: _____
- Date Referred: _____
- Case Closed after Initial Service
- Case Transferred or Closed Before
4 wks. ___ 6 wks. ___ 8 wks. ___ Longer ___

Petition Files Yes No

Petitioner _____

Child Placed Yes No

Placement Recourse

- a. Emergency F. H.
Specify: _____
- b. Richland Village (Emergency Shelter for Adolescents)
- c. Relative
Specify: _____
- d. Other
Specify: _____

Emergency Caretaker Assigned

Emergency Homemaker Needed

Reason not Assigned _____

Teaching Homemaker Assigned

Date Homemaker Assigned _____

Date Terminated _____

Caretaker Assigned:

Yes No

Time Assigned _____

Time Relieved _____

Family went to Emergency Shelter

Yes

No

Used Emergency Funds

Emergency Funds Needed but not used

Used Other
Specify: _____



DAVIDSON COUNTY CES DEMONSTRATION & RESEARCH PROJECT
 TENNESSEE DEPARTMENT OF PUBLIC WELFARE

SCHEDULE FOR INTAKE

DATE _____

	DAY	NIGHT
SUNDAY		OVERTON
MONDAY	FRAZIER	ADGENT
TUESDAY	NORMAN	FRAZIER
WEDNESDAY	YORK	NORMAN
THURSDAY	OVERTON	YORK
FRIDAY	ADGENT	

Schedule for Weekends on Call -- 5:00 p.m. Friday 'til 5:00 p.m. Sunday.

- 1st weekend of each month _____
- 2nd weekend of each month _____
- 3rd weekend of each month _____
- 4th weekend of each month _____
- 5th weekend of each month _____

On call Assignments will follow in sequential order --therefore, in those months with only 4 weekends, the order would change --so it will be necessary to post weekends at the beginning of each month.

Each worker will have a "Back-up", or a person who may be called at night in case of an unusually heavy load requiring two people. Back-ups will also relieve during the day when the worker on call must be in the field. Back-ups are not required to be on call, but may be contacted if needed.

PRIMARY PERSON	BACK-UP PERSON
ADGENT	YORK
NORMAN	FRAZIER
OVERTON	NORMAN
FRAZIER	ADGENT
YORK	OVERTON



CHILD PLACEMENT CONTRACT

Between

THE TENNESSEE DEPARTMENT OF PUBLIC WELFARE

And

FOSTER PARENTS APPROVED TO PROVIDE EMERGENCY CARE

Following your application, offering your home as an emergency foster home for a child in the care of the Tennessee Department of Public Welfare, an authorized representative of the _____ County Office has discussed with you the service which you are prepared to offer, the responsibilities of foster parents, of this Department, and the child's relationship with his natural family. We have confidence in your ability to meet the needs of children and in your willingness to cooperate with this Department throughout the period a child will be in your care.

RESPONSIBILITY OF FOSTER PARENTS

We, _____ and _____
(name of foster father) (name of foster mother)

Foster Home Number: _____,
(Street address, City, State, Zip Code)

as foster parents understand and agree that:

1. We are responsible to the Davidson County Office, Tennessee Department of Public Welfare, for the child's care, health, education (if the child is of school age), and training during the period the child remains in our home. We agree to discuss all matter pertaining to the child's welfare with the caseworker.
2. Under no circumstances will we allow anyone other than an authorized representative of the Department to remove, either temporarily or permanently, the child from the foster home.
3. In case of illness or accident requiring the care of a physician, we agree to notify the county office immediately. We understand, however, that we are expected to use our own judgement in calling a doctor first in case of an emergency. In case of serious illness of any member of our family, we agree to notify the county office.
4. We agree to respect the confidentiality of information which has been given us concerning this child to enable us to understand and meet the child's needs. We agree to notify immediately the caseworker of any inquiries about the identity of the child.
5. We agree not to permit the child to leave our home for visits or to take the child outside this locality without prior approval of the Department. We agree to discuss with the caseworker in advance any plans regarding a change in our place of residence.

6. We agree not to accept any other adults or children as continuing members of our household while the Department has a child placed in our care without first consulting with the county office and receiving its approval.
7. We agree not to incur any expenses, with the exception of emergency medical service, without prior approval of the county office.
8. We agree to consider the child as a member of the family, and to provide care and training as we would for a child in our family.
9. We understand that this child is not available for adoption, and we agree that we will not attempt to adopt, file a petition to adopt or to take any steps whatsoever leading to the adoption of the child.
10. Should we desire to adopt a child through the Department we understand it will be necessary to file a written application with the county office and have our home studied and approved as an adoptive home.
11. We agree that the Department has the right to remove this child from our home at any time. We also agree to notify the county office when removal of the child is at our request, giving the county office sufficient time to make other plans should we find that for any reason we cannot keep the child or properly care for him.
12. We agree to accept children on a temporary basis while serving as emergency foster parents for the Department.
13. We agree to accept in our home on an emergency basis at any given time as many as five children within the age range of infancy through six years.

THE DEPARTMENT'S RESPONSIBILITY

The Department of Public Welfare through its undersigned representative, agrees:

1. To pay you a base salary of \$150.00 per month to offer your home for emergency shelter care and to pay you our regular board rate for each child placed in your home.
2. To provide suitable clothing for the child, when not included in the boarding care rate, as planned between the foster mother and the caseworker.
3. To provide payment for medical and dental care of the child.
4. To provide payment for other special needs, not included in the boarding care rate, in keeping with the Departmental policies and planning between the foster mother and the caseworker.
5. To consult regularly with the foster parents regarding the child's health, development, and planning for the child's welfare.

6. To advise the foster parents in advance of plans for the removal of the child unless some unforeseen situation arises beyond the worker's control.
7. To plan for contacts between the child and his natural relatives when indicated with due regard for all parties concerned.
8. To give prompt attention to the foster parents' request for removal of the child if they can no longer provide care. Consultation regarding problems will be given to prevent unnecessary replacements when possible.

TERMINATION OF CONTRACT

We understand this contract can be made void by giving the Davidson County Office of the Tennessee Department of Public Welfare a thirty day written notice requesting the termination of the contract and the removal of any foster children in our care placed at the request of the agency.

The Tennessee Department of Public Welfare reserves the right to terminate the contract at its discretion following a discussion with the above-named foster parents as to the reasons of this action. Whenever possible a thirty day notice shall be given the foster parents of our intentions.

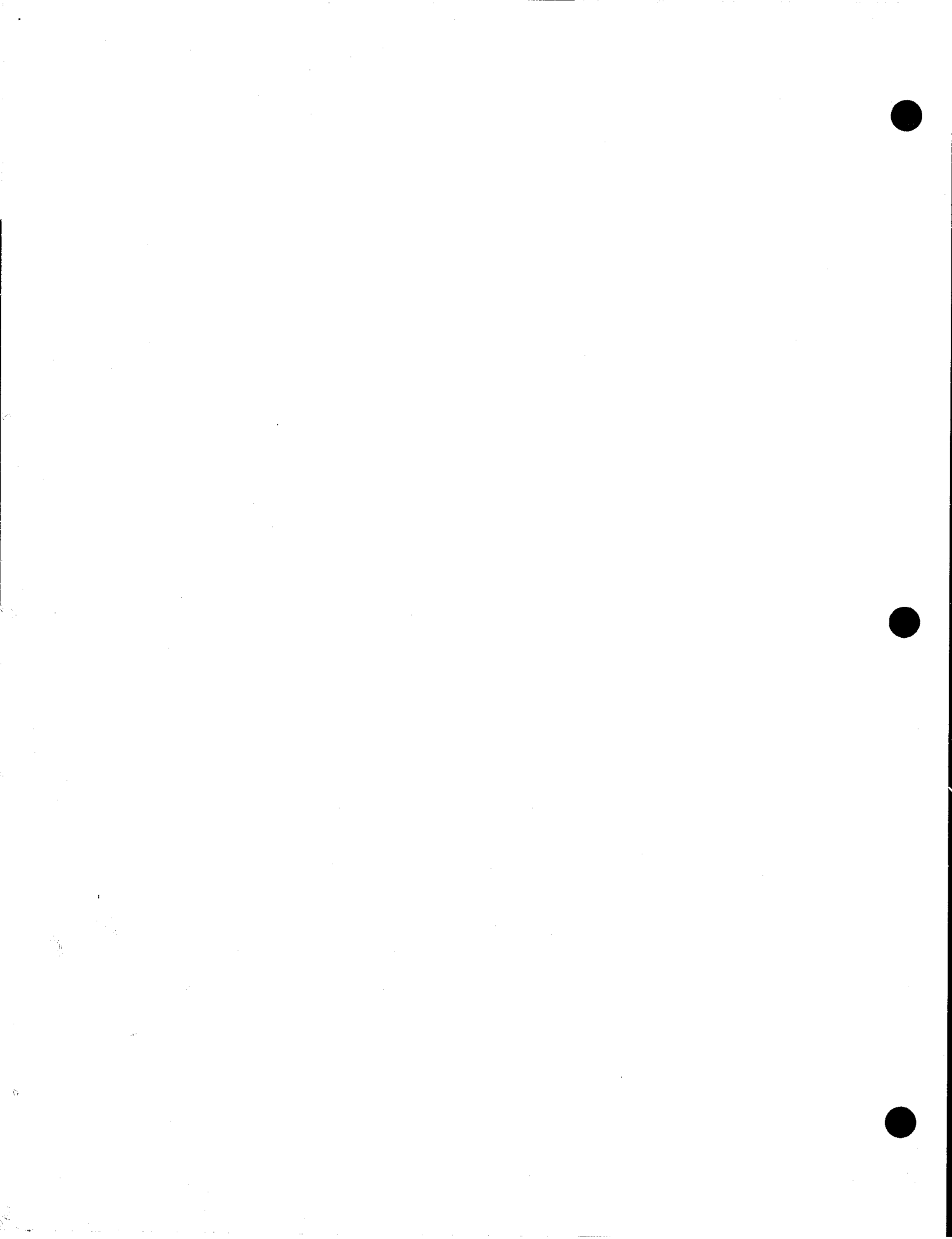
Entered into this the _____ day of _____, 19_____.

(Foster Father's signature)	(Worker's signature)	(Home phone number)
-----------------------------	----------------------	---------------------

(Foster Mother's signature)	(Name of supervisor)	(Home phone number)
-----------------------------	----------------------	---------------------

(Office phone number)	(Street address)
-----------------------	------------------

(City)	(County)	(State)	(Zip Code)
--------	----------	---------	------------



CONTRACT BETWEEN

THE TENNESSEE DEPARTMENT OF PUBLIC WELFARE
(DAVIDSON COUNTY CES DEMONSTRATION AND RESEARCH PROJECT)
EMERGENCY CARETAKERS APPROVED TO PROVIDE EMERGENCY SUPERVISION

RESPONSIBILITY OF CARETAKERS

Caretakers are responsible to the Davidson County Office of the Tennessee Department of Public Welfare being under the Supervision of the Supervisor of the Emergency Intake Service.

I agree to the following conditions:

- (1) I agree to be available from _____ to _____ 7 days per week:
every _____ and _____ week per month for the primary purpose of providing care and supervision of children in the absence of parents and/or responsible relatives.
- (2) While on assignment, I agree to the following conditions:
 - A. Under no circumstances will I allow anyone other than an authorized representative of DPW remove the children from the home while in my care.
 - B. I agree to notify the Emergency Intake Worker immediately if the parents, relatives, or anyone comes to the home, or in case of any change in the situation such as illness or an accident involving a child.
 - C. I agree to respect the confidentiality of all information regarding case situations.
 - D. I agree to remain on duty until the caseworker, his supervisor, or some other designated official of the Emergency Intake Service relieves me of duty.

THE DEPARTMENT'S RESPONSIBILITY

- (1) The Department agrees to pay a retainer of \$65.00 per month and \$1.75 per hour while on duty plus mileage at the rate of 9¢ per mile to and from an assignment as well as while on duty.
- (2) The Department agrees to have a case worker available at all times to instruct the caretaker, be consulted in case of an emergency or to relieve the caretaker when indicated.
- (3) The Department agrees to schedule the caretaker to work only during the hours to which both have agreed; however, in case it becomes necessary and the caretaker is agreeable he may work during other hours.

Caretakers will continue to be retained until notified that their services will no longer be needed.

Date retained _____

Caretaker's Name _____

Caretaker's Address _____

Telephone Number _____

City

County

State

Zip Code

Davidson County CES Demonstration and Research Project
Tennessee Department of Public Welfare

CARETAKER SCHEDULE

	Day 7 a.m.-7 p.m.	Night 7 p.m.-7 a.m.
1st week of month	Kirby	Ewing
2nd week of month	Thompson	McDaniel
3rd week of month	Kirby	Ewing
4th week of month	Thompson	McDaniel

HOMEMAKER SCHEDULE*

	On Call	Back Up
June 1-8	Kirby	Blann
June 8-15	Jones	Graham
June 15-22	Dunn	Jones
June 22-29	Blann	Elliott
June 29-July 6	Cooke	Moore
July 6-13	Brown	Dunn
July 13-20	Elliott	Kirby
July 20-27	Hall	Brown
July 27-Aug. 3	Moore	Cooke
Aug 3-10	Graham	Hall
Aug. 10-17	Kirby	Blann
Aug 17-24	Jones	Graham
Aug. 24-31	Blann	Cooke

*On call assignments start and end at 4:30 each Friday.



HOMEMAKER REFERRAL

Date: _____

Homemaker's Name: _____

Case Name: _____ Caseworker: _____

Case Number: _____ Supervisor: _____

Address: _____

Date for Service Requested: _____

Date for Service to Terminate: _____

HOUSEHOLD MEMBERS (Names, birthdates, sex)	Type of Case
_____	_____ Emergency
_____	_____ Teaching

Primary Problems	Approximate Length of Service
_____ dependent-neglect	_____ 1-3 days, 24 hours
_____ abandonment	_____ 4-5 days, 24 hours
_____ mental and/or emotional illness	_____ 2 weeks, 24 hours
_____ behavior problems	_____ 1-5 days, daily
_____ alcoholism	_____ weeks
_____ one parent family	_____ 2 weeks, daily
_____ abuse	_____ 3 weeks, daily
_____ hospitalization	Other _____

Housing

_____ House	_____ electricity
_____ Apartment	_____ telephone
_____ Washer	_____ cleaning supplies
_____ Water	_____ adequate food supply

_____ will petty cash be needed

Goal Expectation of Homemaker

1. _____
2. _____
3. _____
4. _____

Goal Expectation of Family

1. _____
2. _____
3. _____
4. _____

AGREEMENT FOR ASSIGNMENT OF HOMEMAKERS

(I) (WE) _____ have agreed to have a Homemaker placed in the home for the purpose of providing emergency care and supervision of my children. During my temporary absence, this person, as a representative of the Tennessee Department of Public Welfare, has my permission to act in this capacity.

The Homemaker has my permission to transport my child by automobile during her assignment in my home.

Parents Name: Mother _____

Father _____

Responsible Relative _____

Date: _____



HOMEMAKER'S DAY SHEET
PROTECTIVE SERVICE PROJECT

DATE	FAMILY NAME & ADDRESS	ARRIVAL TIME	DEPARTURE TIME	SPEEDOMETER READING	TYPE OF SERVICE	WORKER: _____ OBSERVATIONS





HOMEMAKER, PROGRESS REPORT

DATE: _____

HOMEMAKER'S NAME: _____

CASE NAME: _____

ADDRESS: _____

DATE ASSIGNED TO CASE: _____

CASEWORKER'S NAME: _____

ACCEPTANCE OF FAMILY TO HOMEMAKER

_____ EXCELLENT _____ FAIR
_____ GOOD _____ POOR _____ REJECTION

CONDITION OF HOME

_____ GOOD _____ NEEDS CLEANING SUPPLIES
_____ FAIR _____ NEEDS CLOTHING
_____ POOR _____ NEEDS FOOD SUPPLIED
_____ OTHER _____

MAJOR ACCOMPLISHMENTS WITH FAMILY

1. _____
2. _____
3. _____
4. _____

AREAS WHICH NEED IMPORVEMENT (special problems)

1. _____
2. _____
3. _____
4. _____

HOMEMAKER RECOMMENDATIONS FOR CONTINUING NEEDS OF FAMILY

1. _____
2. _____
3. _____
4. _____
5. _____

HOMEMAKER EVALUATION REPORT

DATE: _____

HOMEMAKER'S NAME: _____

CASE NAME: _____

ADDRESS: _____

CASEWORKERS NAME: _____

DATE CASE ASSIGNED: _____ TERMINATION DATE: _____

FAMILY ACCEPTANCE OF HOMEMAKER

_____	Excellent	_____	Poor
_____	Good	_____	Rejected
_____	Fair		

MAJOR GOALS ACCOMPLISHED

1. _____
2. _____
3. _____
4. _____

MAJOR GOALS NOT ACCOMPLISHED

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PROBLEMS PREVENTING SUCCESS

1. _____
2. _____
3. _____
4. _____
5. _____

COMMENTS:

APPENDIX C

NATIONAL CENTER FOR CES

Following the successful demonstration of CES in Nashville, it was determined by the Children's Bureau that the concept should be disseminated to other communities so that similar systems could be developed throughout the country. HEW Office of Child Development contracted with the Urban Observatory of Nashville to develop the National Center for CES.

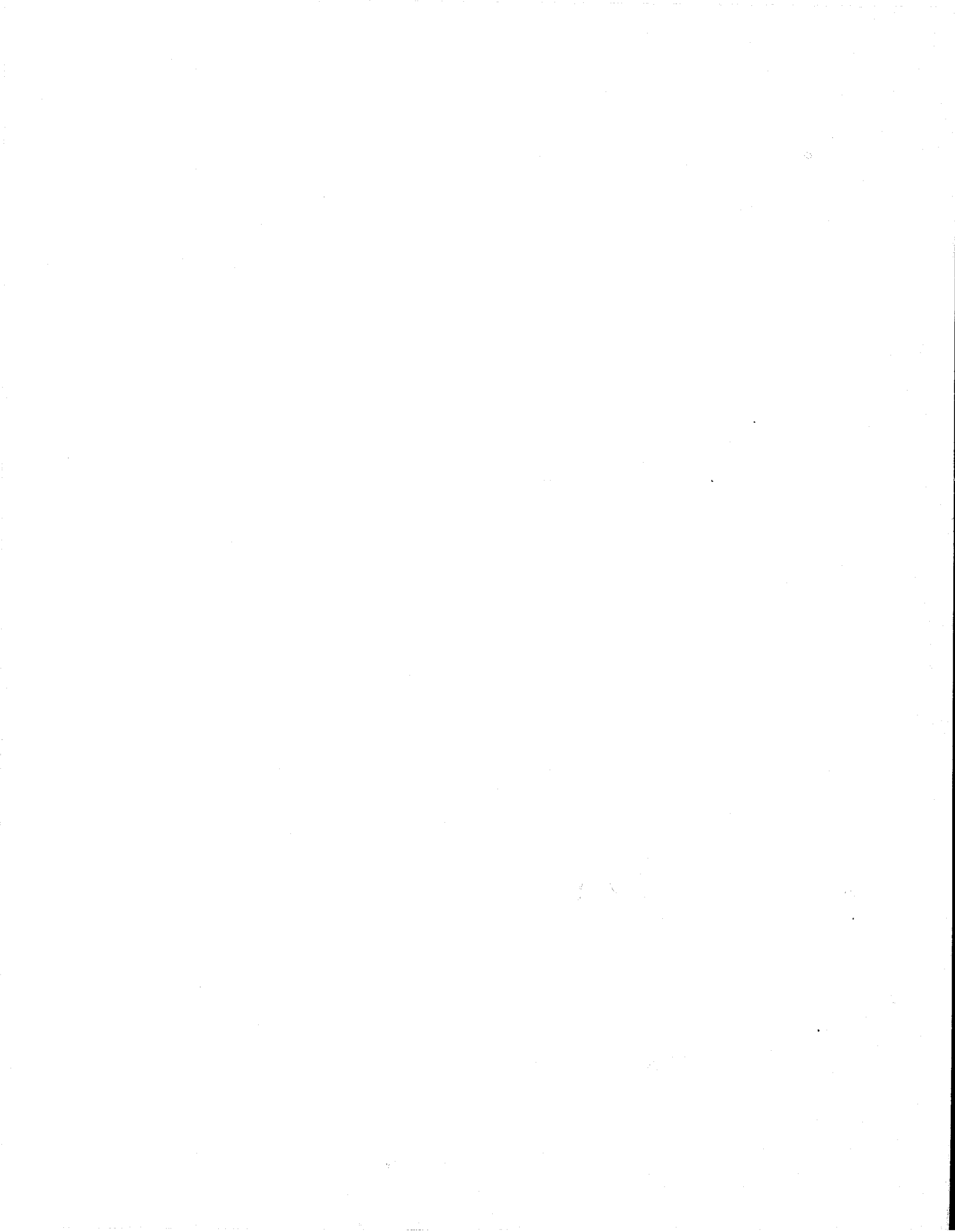
The Urban Observatory, a nonprofit research organization, assisted in research for the initial neglect/dependent study and for the CES demonstration project in Nashville. It is not connected with the Tennessee Department of Public Welfare. There is, however, an agreement for cooperation between DPW and the Urban Observatory for planned site visits, sharing of information, etc.

The National Center for CES was established in Nashville, Tennessee, July 1974, and is available to help communities develop similar programs. In order to accomplish this, the Urban Observatory hired as Director and Assistant Director of the National Center for CES two persons who had been directly involved in the development of the original proposal and in the administration of the program. It also established an Advisory Committee to assist in accomplishing its goals. Many of the members of this Advisory Committee were a part of the committee which worked together to develop the CES system in Nashville. The professional staff of the Center is prepared to share those organizational and managerial skills which are necessary to plan and implement a coordinated system of CES with other communities.

The National Center has a continuing commitment to prepare and disseminate materials relevant to the planning, establishment, and operation

of a CBS system. With the help of professional media consultants, the Center is developing both printed and audio-visual materials. Some are particularly useful in engendering community support and in generating community referrals.

Having hosted a national working conference in Nashville, October 1974, to review written and audio-visual materials, the staff of the Center conducted ten Regional workshops throughout the country, between January and May, 1975. Additionally, the Center is responding to a large number of requests for information, technical assistance, and consultation throughout the present year. Therefore, interested individuals should feel free to contact the Center for further information and assistance.



END