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Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-1977. Volume X. A Guide for Planning and Implementing

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This guide describes the process of planning and implementing child abuse and neglect service programs. It begins with a description of the planning process and the essential elements of a well-functioning community-wide child abuse and neglect service system. The steps involved in conducting a community needs assessment are presented as well as the kinds of problems typically encountered in setting up a new program. Methods for identifying project goals and examples of realistic goals are presented. Alternative program designs are described as are alternative treatment strategies a program may wish to provide. Methods for monitoring case management practices, client progress and project resource allocation are discussed and sample case record and program record instruments are supplied. The guide concludes with a discussion of ways to ensure cooperative working relationships with other community agencies and among program staff and ways to avoid worker burnout, as well as summary comments about how to enhance the likelihood of establishing an effective program.

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The ideas presented here are those of Berkeley Planning Associates staff and not necessarily the opinions of the federal government.

PREFACE

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

We wish to thank the many people who helped us develop and produce this manual. The directors and staff of the eleven demonstration projects shared with us their experiences in implementing new programs in the child abuse and neglect field, experiences which have become the basis of many discussions in the document. The director and staff members of the Extended Family Center in San Francisco, a former Children's Bureau child abuse demonstration service program, also offered many insights into the dynamics of setting up a new program. Elsa TenBroeck, Elizabeth Davoren, and Eli Newberger, consultants to Berkeley Planning Associates, provided valuable suggestions for and criticisms of this document.

The federal personnel responsible for the demonstration projects also provided valuable input. We particularly wish to thank our own project officers from the National Center for Health Services Research -- Arne Anderson, Feather Hair Davis and Gerald Sparer -- for their support and input. Their support for this particular document helped ensure that the evaluation findings would be disseminated in a form which would assist local communities in facing and dealing with the problems of abuse and neglect.

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INTRODUCTION

Instances of child abuse and neglect can occur in any community and in any kind of family. While studies have found that certain personal and social conditions tend to enhance the likelihood of abusive or neglectful treatment, no family or community can consider itself above the problem or "out of danger." Despite this inability to successfully anticipate all instances of abuse or neglect, a community can develop a service system which provides both a treatment program for those families experiencing problems of abuse or neglect and a support system for those parents feeling pressured, isolated, and confused.

Berkeley Planning Associates (BPA) has developed this manual as a guide for those planning to develop such a community-based program. While our primary purpose has been to assist community planners in establishing a child abuse and neglect project, the following information and guidelines will also be useful to those planning other kinds of community-based social service or health programs. A sound planning process, which includes a thorough assessment of your community's needs, a carefully designed program model, and a comprehensive treatment strategy, is a vital element in developing and maintaining an effective and efficient community service, regardless of its purpose. The manual reflects the experiences of many community child abuse and neglect programs and service systems across the country, and its recommendations are rooted in the successes and failures of these programs.

The authors imagine this document will be useful to community planners in a number of different ways. First, it can help you determine the service needs within your community and guide you in establishing appropriate and meaningful program goals and objectives. Second, the manual outlines a wide range of models and specific treatment strategies which your program might adopt, thereby offering guidance in the design of your program. Third, performance standards of case management and treatment and methods for monitoring treatment services and program resource expenditures are presented as issues of concern to program managers. Finally, the manual highlights the key practices you need to adopt to ensure your program's effectiveness. Methods for working with community agencies and groups, as well as methods for avoiding worker "burnout," are carefully developed.

Although child abuse and neglect are by no means new problems, until recently there have been very few programs that dealt specifically with them. Little is known about the causes of child abuse and neglect, about which treatment services are most effective, about what kinds of workers should provide services, and about how they should be trained. The field is still very young. Since this manual has been developed at a time when knowledge is limited, it is not the final word on what programs should be like. Rather, it presents issues and questions you should consider prior to designing your programs.

The potential of death or severe impairment to a child in many abusive or neglectful situations presents a set of problems no community can afford to ignore. Sooner or later the issue, which lies dormant in many cases, will come to present itself to the community as a crisis in need of resolution. Despite the uncertainty surrounding the effectiveness of different treatment strategies, it is clear that a viable community service network can be one of the best defenses against this painful issue. It is the authors' hope that this manual will encourage communities to deal with the issue of child abuse and neglect before the lack of services results in an avoidable tragedy.

PART I

PLANNING

Before you rent an office or hire a staff, it is important to spend some time thinking about the planning process itself. Many of the pitfalls and difficulties waiting for those intent on beginning a new community-based service can be avoided, or at least their impact minimized, by thinking through the overall process you will follow in establishing your service. The process outlined in Chapter 1 is one often applied to the development of social service programs and should be helpful in organizing the tasks necessary in designing and implementing your particular program. The chapter first outlines a model of a well-functioning child abuse/neglect community-wide system against which you can measure your community's current system. Chapter 2 identifies some of the most common problems those establishing a new service might encounter and offers suggestions on how to most effectively deal with them.

Chapter 1:

Planning for Programs and Services Your Community Needs

Developing a local child abuse and neglect service program is a challenging and time-consuming task. For those who have not organized a local service before, the number of decisions and the vast array of options open to you may be confusing and frustrating. Simple decisions can quickly develop into complicated problems when you are faced with unanticipated responses to a selected course of action. The purpose of this manual is to provide, in a compact format, assistance to those who may soon begin planning their own child abuse and neglect service project, be they city officials, hospital administrators or concerned community residents. The following chapters will outline the major steps involved in planning, implementing, and operating a program, as well as point out some of the options to consider and pitfalls to avoid.

The first major problem in program implementation, however, is the need for program developers to decide where and how to begin. What kinds of programs or services are needed most in a given community? How can such needs be identified? What are the elements of planning a new program, the steps required, and the importance of each step? While this initial chapter cannot provide an exhaustive review of different planning methods, it sets forth the basic and essential elements of program planning, providing you with a skeleton outline on how to proceed. Rather than initially framing your planning in terms of your specific needs, it is more useful to first think about what ideally you would want your system to look like. You can then compare this ideal with the realities of your situation and plan accordingly. Thus, before discussing the planning process, six essential elements of a well-functioning community-wide child abuse and neglect system have been outlined. This discussion, or an adaptation of it, can be used as the basis on which to develop your specific planning approach.

Elements of the Ideal System

While there is no single "right way" to meet the service needs of abusive and neglectful parents and their children, certain program elements and community-wide operational policies have been found useful in treating these clients. The six elements outlined below, while not the only conditions that programs should strive toward, are considered critical to establishing a well-functioning community system and an effective program.

(1) Community Coordination Mechanisms: A first step in creating a well-functioning community-wide system is the establishment of a community-wide coordinating body which takes responsibility for eliminating the fragmentation, isolation, duplication and inefficiency inevitable when services operate in a vacuum. This body will also provide a forum for

communication and, eventually, service planning. While membership in this body can range from volunteers to political appointees, its most important characteristic is simply that it includes representatives from community agencies directly involved with or concerned about child abuse and neglect. Minimally, this includes protective services, police and/or sheriff's departments, the juvenile courts, the schools, the local hospitals treating children, private service agencies, and community representatives.

In addition to cooperating through participation on this central council, individual agencies need to establish specific, written coordinating agreements. Agreed-upon relationships between any two agencies for reporting or referring cases, for service provision or for input into case decisions need to be known and understood by more than high-ranking officials. Line workers within each agency need to understand how they too can relate to or depend upon another agency. The formalization of agreements, usually by putting them into writing, forces careful articulation of what is being agreed to and serves as a record for new personnel.

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

(3) Centralized Reporting System: Twenty-four hour centralized reporting and response systems are a third element of a well-functioning system. Many states realize the importance of having the capacity to immediately intervene in family situations on the child's behalf with appropriate investigative procedures and service provisions. These states already require the existence of a 24-hour reporting system. Whether your system is state-wide or local, it is important for local residents and professionals to know that the system responds quickly to emergencies and that knowledgeable personnel are providing immediate intervention.

Numerous problems currently besetting communities, including "lost" cases, duplication of functions, and case "tracking" (i.e., reporting a case to one agency results in a certain set of actions, perhaps strictly criminal,

while reporting the same case to another agency results in different actions, perhaps strictly therapeutic) could be reduced or eliminated through a centralization of reporting to a single agency. Even if state laws designate two agencies to receive reports, the problems can be minimized by requiring that copies of all reports received by one agency be forwarded to the other agency for information purposes. It is then incumbent upon both agencies to coordinate the investigative and treatment planning activities pursued for individual cases.

(4) Varied Service Package: Because problems of child abuse and neglect are interactive between parents and children, and because the predisposing family problems triggering the maltreatment are different for different families, a variety of treatment options for both parents and children needs to be made available for optimum effectiveness. A full complement of treatment services would include: individual and group services; supportive and advocacy services as well as therapeutic and educational ones; crisis or emergency and long-term treatment; day services as well as residential care; and professionally provided services as well as self-help endeavors.

In addition to providing services after the maltreatment has occurred, service projects are increasingly providing prevention services. Primary prevention is defined as those activities aimed at eliminating the situations and behaviors often cited as responsible for child maltreatment. These include adequate curriculum for school age children about the responsibilities of adulthood; sensible and early sex education; and family life and parenting education which includes introductions to problems of child abuse. Secondary preventive services are those activities which intervene at a point in a family's situation when abuse or neglect is imminent. These services include prenatal or hospital screening programs, 24-hour crisis counseling hotlines, and parenting classes for families encountering difficulties and frustrations with their children.

(5) Quality Case Management: The ways in which each case of child abuse and neglect is handled by individual service providers may well be the largest single determinant of the overall community system's effectiveness. Although definitive quality standards are difficult to specify, there are numerous practices, procedures and methods most professionals in the field consider to be "good practices." By employing minimum case management standards, projects would help ensure:

- prompt response to all reports;
- carefully planned decisions concerning service provision, preferably with interdisciplinary input;
- initial assignment of clients to the most appropriate agency and staff member within agencies;
- appropriate services at the required level of intensity for all clients;

- necessary referrals to other service providers;
- clear termination criteria; and
- necessary follow-up for all terminated clients.

(6) Community Education and Public Awareness: The more informed professional staff of all agencies in a community are about the dynamics of abuse and neglect and about the way their community system functions, the better the treatment abused and neglected children and their parents receive. Because of the high turnover rates in many of the professions dealing with abuse and neglect, and because knowledge about maltreatment is continually being advanced, it is important for training to be an ongoing process. And it is important for such training to reach all relevant professional groups and classes of workers involved in the detection, treatment or legal aspects of child abuse.

Another integral component of an adequate child abuse and neglect system is the education of community citizens, so that they understand the dynamics of child abuse and neglect and the system which is in operation for receiving reports and providing treatment.

A Model for Program Planning

Planning may be defined as an effort to identify those areas in which a system or a program falls short of that which is desired to develop and implement services and programs which will reduce the gap between what is and what is wanted. Your particular community may already have a well-functioning system into which your project can be easily incorporated. On the other hand, your community may have none of the ongoing conditions cited above, making the attainment of the ideal state far more problematic. In either case, the details and scope of your project can only be determined by working through a planning process in which the specific strengths and weaknesses of your community are unveiled and debated. Figure 1.1 depicts the principal steps in a program planning process.

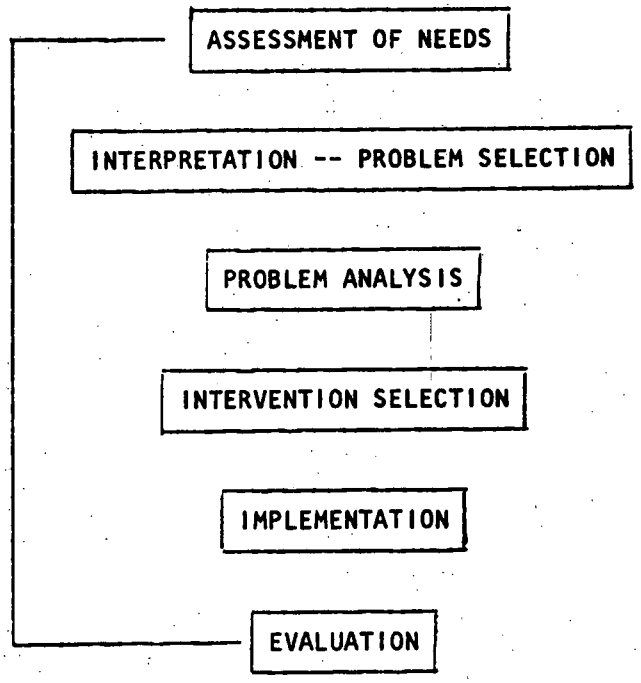
The first step typically taken in planning a new program is a Needs Assessment or the compilation of opinions and information necessary to determine the status quo and identify the problems or unmet needs in relation to what is desired. In this sense, a needs assessment is like a signal system which, on the basis of information collected, suggests or flags where interventions ought to be made. What gaps or duplications exist within the system? Where is the system inefficient? Where is the handling of cases, the provision of services, or the recruitment of workers getting bogged down? Are professionals or the general public lacking in knowledge or expertise about the problem under consideration?

General rules for conducting a needs assessment are as follows: (a) to think comprehensively (to be concerned with all systems that might influence the situation of concern); (b) to think prospectively (to be concerned not just with the past and the current situation, but also with the probable future); and (c) to involve many different perspectives (to include those representing different disciplines and agencies). In addition to providing

insights into areas of appropriate intervention, the assessment will also provide a basis for ultimately evaluating the appropriateness and effectiveness of the intervention selected.

Figure 1.1

STEPS IN THE PLANNING PROCESS*



The second step in program planning is Interpretation or Problem Selection. Having identified the range of existing problems, one must then decide which will be the area of focus. Since no one program can generally expect to attack all problems, it is best to develop specific criteria by which to judge the importance of the various problems. The criteria should reflect the values and concerns of those who can affect, or are affected by, the situation.

Having identified the principal problem(s), the third planning step is Problem Analysis, that is, analyzing the problem in terms of alternative intervention points. A given problem will have numerous possible solutions. A useful approach to problem analysis is to identify all of the "inputs and outputs," or causes and effects, of the problem. By assessing all of the

*As outlined by Henrik Blum in Planning for Health, Human Sciences Press, New York, 1974.

different precursors to and consequences of the problem, areas of possible intervention will present themselves. In addition, the analyst will gain an understanding of how pressing the problem actually is, that is, whether the consequences are negative enough to merit intervention. Figure 1.2 is an example of a problem analysis. The problem analyzed is the frequent duplication of investigation. Protective services, the police, the local children's hospital and the public health department all simultaneously, but not jointly, investigate the circumstances surrounding the same reported physical abuse case. As the figure indicates, primary precursors to this problem include: a vague reporting law; lack of communication among agencies; protection of turf by each agency; and divergent purposes in conducting the investigation. Some of the primary consequences of this problem include: animosity between agencies; wasted resources; and unnecessary confusion and conflict for the client. By studying both the primary causes and effects, and the secondary ones, possible areas of intervention become apparent, including: (1) the establishment of a community-wide multidisciplinary diagnostic team or coordinating council to enhance communication between agencies; (2) reformation or more precise interpretation of the state reporting law; (3) establishment of formal agreements between agencies to conduct joint investigations where possible.

After identifying alternative interventions, the next step in the planning process is Intervention Selection. The costs and benefits of each alternative should be considered in selecting the most appropriate interventions. How much would it cost to implement a particular intervention? How many dollars are needed? How much effort must be diverted from other activities? How long will the intervention take? What are the benefits of a particular intervention? What additional problems are avoided by intervening at a particular point? By comparing the costs and benefits of alternatives, one intervention or a combination of several will appear as the most desirable.

Program planning, by our definition, includes the actual implementation of the selected intervention(s). While you may not be directly responsible for the program implementation, you do have a responsibility for ensuring that the ideas generated are capable of being translated into action.

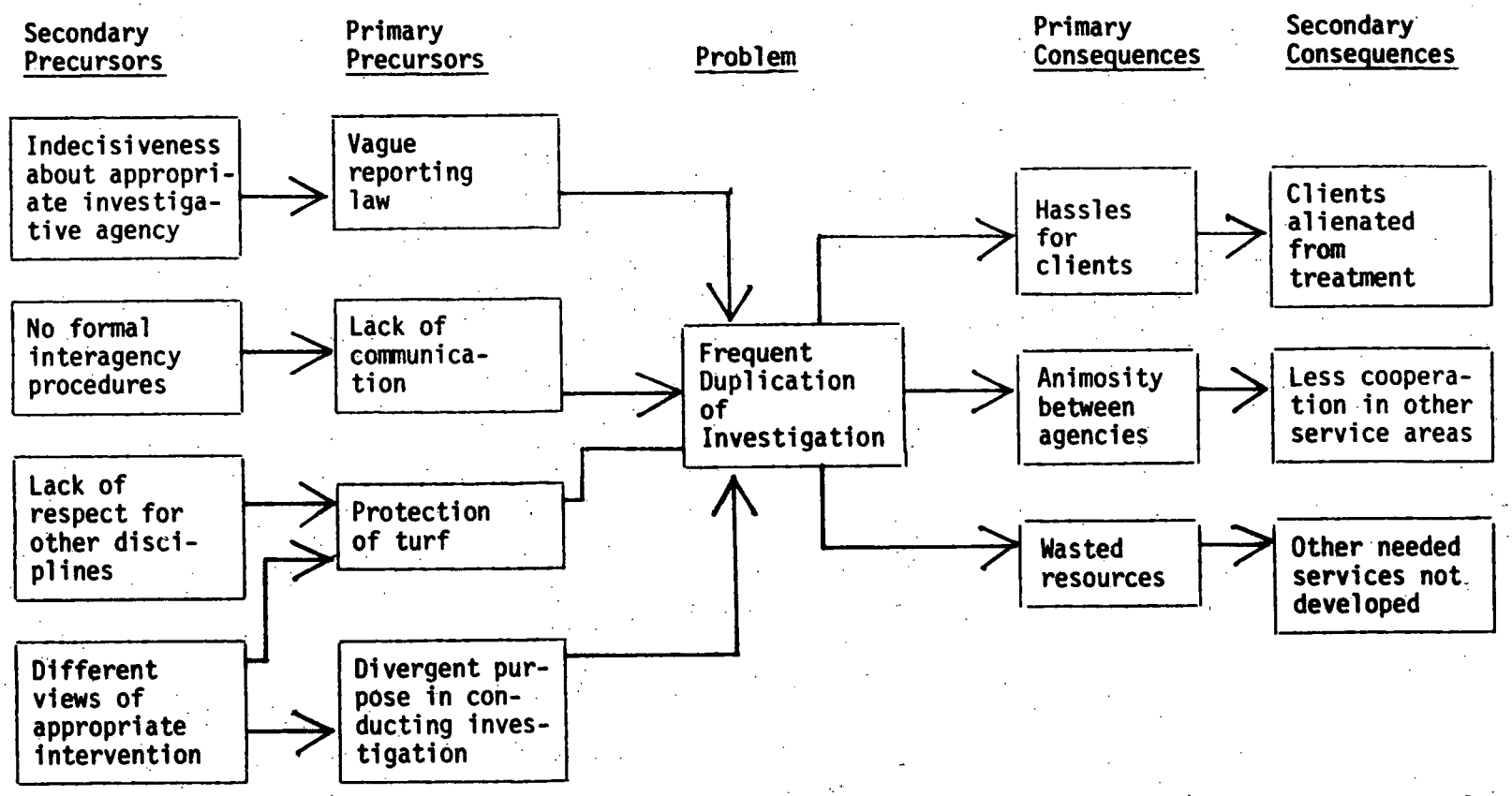
Finally, Evaluation is an integral part of program planning. Evaluation requires collecting and interpreting information to make judgments about the value or worth of an intervention or program. It is a tool for understanding impact, that is, the extent to which the selected interventions were effective in bringing about the desired changes and thus eliminating or reducing the identified problems.

Working Within a Political Context

The planning process is a political one and as such must take place within the context of a community's political environment. Ignoring political issues invariably results in unsuccessful planning. The astute planner will try to keep abreast of what is happening in the community, while touching base with power centers, potential funding sources, and others who will be important in later stages of program implementation. The key is

Figure 1.2

EXAMPLE OF A PROBLEM ANALYSIS



letting people know what you are planning, soliciting their ideas, and being aware of the interests of others while working with them to help ensure a program's success.

You can become familiar with your community's dynamics by reading relevant documents such as the local daily newspaper or the minutes of local governmental bodies' meetings, as well as by keeping in contact with those who are active in the community. Among the obvious agencies to contact are the local protective services department, the children's hospital, the police and/or sheriff's department, the public health department, the juvenile court, day care programs, the mayor's office, as well as United Way and other local funding groups. In addition, for the past several years, each region of the country has had a federally funded Regional Child Abuse and Neglect Resource Center, and an Office of Child Development designee within the regional Health, Education, and Welfare Department. Such groups and individuals can be particularly useful in keeping you informed of other local child abuse and neglect activities.

Keeping abreast of what is happening state-wide and nationally is important. Many national and regional organizations currently publish newsletters that can assist in this effort. Perhaps most important, however, is letting others in the community know what you are planning. Because of the emotional nature of the problem, and the high level of social concern, program planners will not find it difficult to attract a number of political supports. In order to develop that support, however, word must go out about your plans. Effective public relations and real efforts to contact and work with the appropriate people are invaluable.

Chapter 2:

Implementing a New or Expanded Program

While the model and planning process outlined in the previous chapter appears to lay out a clear road toward program development, the picture is somewhat deceptive. As one goes about establishing a local child abuse/neglect service project, the pieces of the puzzle will most likely not fit together as nicely as our model indicates. Funding problems, management problems, problems relating to the community, and general start-up problems that plague all new programs will require immediate and swift attention if they are to be kept under control. The purpose of this chapter is to acquaint those interested in establishing a local service project with the types of problems others have encountered in implementing similar programs. This chapter is not a set formula for success; however, by being sensitive to the pitfalls outlined below, you will greatly enhance the likelihood of developing a well-functioning project, one that will prove to be an asset to your clients and your community.

Locating and Using Resources

Your quest for resources should begin among those agencies in your community already providing services. Not all new services which you might have identified as necessary will require a large infusion of new resources. Many service components might be developed within the framework of an existing agency with minimal staff re-assignment. Other services might be provided through a cooperative venture among several agencies. By pooling resources, your community service network might find ways to reduce duplication of services, thereby freeing resources for application to new service areas. Finally, before you look toward new resources, a careful review of your community's volunteer potential should be made. Many very successful programs have been operated on a shoestring, through the judicious use of volunteer staff time, donated office space, and donated equipment and supplies.

After having carefully reviewed your existing resources, you might well find that you still need additional funding to fully implement your program objectives. If this is the case, you clearly will have to cultivate new resources. While this might well be a time-consuming and frustrating task, there are a variety of potential resources, both public and private. For example, many federal programs and private foundations provide projects with start-up money, often called "seed money" or developmental funds. The amount of this funding is usually small and will most likely require some sort of matching funds in order to meet all initial operation costs. In addition, these grants tend to be limited to a short time period, usually six months to a year. While very useful for a program's initial development, start-up funds should not be viewed as a long-term funding source for your project.

Once established, you should immediately begin looking for supplemental or continuation funds. These "program operation" funds, usually of an ongoing nature, can be derived from federal or state service monies, such as Title XX (typically reimbursement for services, not necessarily operating funds) and Title IV-B, Maternal and Child Health funds. "The Foundation Directory," issued by the Foundation Center of New York City, lists numerous national and local foundations which also provide such funding. In addition, you should pay close attention to possible local government funding sources, such as revenue sharing and LEAA grants. Local private agencies, such as churches, the United Way, and other concerned citizen and business groups, should also be contacted as possible funding sources.

Determining which of the possible programs, foundations and organizations to approach for funds and developing the program plans and proposals most likely to receive favorable consideration are obviously necessary endeavors. There are numerous publications, manuals, and information systems that catalog available public and private programs and foundation grants. While some of these are prohibitively expensive to purchase (the grant information systems may run to $500 per year), most are available for review at any large library or university. Other child abuse and neglect funding information may be available from sources such as the Federal Catalogue of Domestic Assistance. Additional sources of information related to program funding and proposal writing are listed in Appendix B.

One of the key points to remember when assessing the feasibility of funding is to be thorough but realistic. Be certain not to overlook possible funding sources, even if unusual, but do not waste time or resources approaching highly unlikely sources. For example, no matter how worthwhile the project, a proposal for continuation funds will not be funded by a foundation whose express purpose is to provide start-up money. Another key point is the importance of considering both public and private funds. While public money is often necessary and desirable for start-up, a plan to ensure continued funding should be developed early. Local funding is often easier to obtain in small communities with active community groups and organizations, while large urban areas may need to rely more on public funds, even though there is tremendous competition for these funds.

The final point is the importance of understanding the politics of your area, as well as the politics operating at the state and federal level. In developing a broad base of support for your program, the local political structure, the mayor's office or city council, as well as the people and organizations who most influence local policy should be consulted. Letters of support or actual testimony from these sources will often make the difference between the success or failure of receiving most funding. In general, seeking and obtaining outside funds is not a substitute for community support and local financing. The surest way to maintain your program will be by maintaining local enthusiasm.

Start-Up Problems

The start-up phase of a program, locating and equipping facilities, hiring and training staff and readying the program for receiving clients, takes most new programs from three to six months. Expansion of an existing agency may require less time, since facilities and some staff will already be available. Whether your program will be new or simply an expansion, it will most likely encounter a number of very predictable problems.

First, it is very difficult to find prospective staff members with any experience working in child abuse and neglect. A well-publicized job opening, given current economic conditions, will likely bring numerous applicants with good social service experience or promising educational backgrounds. However, those responding will most likely be lacking specific experience or training in abuse or neglect. Programs have found that while such new staff members will require more initial training on issues about abuse and neglect, the lack of specific experience seems to make little difference in the ultimate performance of staff or of the program.

Second, it has been difficult to find packaged training materials for new staff members.* Setting up your own training program will most likely require a search of existing literature, selecting books, articles and audio-visual materials which best suit your program's needs. Since no one method of staff training has been proven to be more effective than any other, it is probably best for your training scheme to be eclectic and as comprehensive as possible. In this respect, it is best to think of training as not only a start-up activity but also as a continuing activity.

Third, finding an appropriate facility for your program may pose great difficulties. You will want space convenient to other key agencies and clients and one which provides a warm "home-like" setting. Zoning laws, licensing and other codes, prohibitive rents, landlord reluctance to rent to service programs, and the general unavailability of space will make finding such a facility difficult. Perseverance is probably the key to finding a suitable location, coupled with the utilization of many different realtors, key contacts in the community, and even newspaper ads. It will be a rare program that finds and refurbishes space in a week or two.

Fourth, the actual translation of a program proposal into an ongoing operation poses difficulties. Proposals are often overambitious and unrealistic given a program's actual resources and the realities of the existing community system. Problems are exacerbated if the Program Director was not among the proposal writers or if agnecies with which the program must cooperate were not included in developing the proposal. Excluding anyone who will be instrumental in implementing program activities from the initial planning can create difficulties in interpreting what the program is supposed to be doing and why. Resentment might also build because of the initial exclusion. As a result, you should anticipate that plans will be modified to take into

*New sets of materials are now becoming available from the federal government's National Center on Child Abuse and Neglect.

account the realities of resource availability and the ideas of those not included in the initial planning.

Management Problems

The management problems experienced by new child abuse and neglect programs fall into three categories: management of cases; management of staff; and management of resources, especially time.

The problem most often encountered in managing cases is the lack of case supervision or consultation. Few programs provide for a staff member(s) whose primary responsibility is to monitor case handling. Even if supervisory staff are available, they often do not fully understand the nature of "case supervision." Without careful monitoring and review of what is happening to cases, clients drop out, fail to get the services prescribed for them, or are kept in the caseload for an unnecessarily long time. Other issues related to case management are more fully discussed in Chapter 7.

The primary staff management problem experienced by child abuse and neglect programs is turnover or "burnout." Working with child abuse and neglect cases exacts emotional and physical energy from staff. When a program is new, staff strain tends to be even greater. Assigning staff members diverse responsibilities, including training and coordination with other agencies, and building time into the job for necessary rest and recuperation, can reduce these problems. Other examples of preventing burnout are outlined in Chapter 10.

With regard to management of time, the issue confronted most frequently by new programs is avoiding spending too much time on general management and not enough on direct services. There is a tendency in new programs, particularly those which utilize collegial forms of decision making, to spend a great deal of time in staff meetings, reviewing procedures, planning activities and airing staff members' concerns. Such meetings are not only beneficial but also essential. However, the program manager must take care to limit time spent in such sessions so that staff members have sufficient time to undertake direct services.

Problems Related to Service Delivery

It is not possible for a new program to anticipate every eventuality. Many of the details related to client services will need to be worked out after a program is under way. However, there are some problems encountered by most new programs which the program manager can be aware of from the outset.

First, new programs, particularly those housed within private agencies, seem to have difficulty establishing referral linkages. Existing agencies might be initially reluctant to refer cases to your program. Once referrals do start, however, many will be inappropriate and, if unscheduled, the total number may overwhelm your program. Thus, you should take care in identifying possible referral sources and in educating each source about your program's capacity and the kinds of cases you plan to serve. You may wish to implement

your referral system in stages to avoid overloading your staff. Initially, referral linkages could be worked out with the key public agencies in the community such as the local law enforcement agencies, protective services, the local children's hospital, and the schools. As cases are received from these sources, the treatment program could be implemented. Once the treatment program is operational, your referral network can then be expanded.

A second problem with which new programs struggle is defining the kinds of cases to accept. Even after the program has developed criteria for accepting cases, referrals will come in which do not fit those criteria but which the program will be inclined to accept for fear that these cases will not receive services elsewhere. Programs have two options: to take all cases, although this diverts energy from those cases earmarked for services, or, if necessary, develop services in other agencies where these cases can be referred.

Third, new programs often encounter problems in organizing client flow. Particularly troublesome are working out criteria for termination, determining if the criteria have been met, and actually terminating cases. It is often easier for a worker to hold onto a case than to declare that "we've done all we can" and suffer the separation anxiety of termination. However, if a program fails to terminate cases, caseloads will grow to unmanageable proportions.

Fourth, certain treatment services present more serious implementation difficulties than others. It is difficult to establish a system for handling emergencies on a 24-hour basis which does not divert case workers from other work. It is hard to ensure that clients receive prescribed services from other agencies without the caseworker allocating time to take the client for treatment. It is not wise, at least for new cases, to leave it entirely up to a client to make his or her way to an unfamiliar location for a counseling session. Another difficult service is providing multidisciplinary team reviews for every case in the program's caseload. While programs may find it relatively easy to bring together a multidisciplinary team, it is not easy for a team to do a thorough job on more than a few cases at a meeting. Thus, a program with a team will likely have to select only certain cases for this special treatment. Finally, while many programs have little difficulty in obtaining some donated services, such as consultants' time on a diagnostic team, other services, particularly expensive ones such as psychological testing of children, are very difficult to obtain in this way. As a general rule, you should not count on having expensive services donated.

Finally, and perhaps most importantly, most programs encounter great difficulty in reaching certain clients. Child abusers and neglectors are often initially very resistant to services and unable to accept help. This will most likely be true for a certain number of your cases. Repeated home visits, even though no one may answer the door, numerous phone calls and other attempts to make contact with prospective clients, coupled with early efforts to provide the client with concrete advocacy and support services, are essential to overcome this resistance. Staff must learn to cope with their own frustrations in working with resistant cases in order to make the breakthroughs which help clients accept necessary services.

Problems in Relating to the Community

No child abuse and neglect service program can exist in isolation from the rest of the community child welfare service system. Many aspects of relating to the community system, however, can cause problems for new programs.

First, new program staff members are generally anxious to spread the word about their activities. The desire to give talks, issue press releases and do radio and TV spots on the part of staff members certainly should not be discouraged. There is, however, a potential pitfall in overemphasizing these activities too early in the implementation of your program. As mentioned earlier, the program may be swamped with referrals and requests for services before it is ready to provide them. While it is necessary to inform agencies of your program's activities, you should wait until your program is ready to offer services before launching extensive publicity campaigns. Even then, community and professional education, particularly describing program activities, should be kept to a minimum until the program is well underway.

Second, many new programs experience difficulty in gaining acceptance from established agencies, especially if these agencies were not included in initial planning. It will take you some time to gain trust and respect from outsiders. This confidence will only come once you have demonstrated what you can do. If you promise more than can be delivered, if you do not follow through completely on referrals, and if you behave in contradiction to existing professional standards, trust and respect may never come.

Third, not only do new programs encounter difficulties in establishing formal working "contracts" with other agencies, problems may also arise in putting those contracts into operation. Once another agency has formally agreed to work with you, the onus will be on your program to make sure that the agreement is brought to fruition.

Fourth, new programs, once underway, often find themselves inundated with requests for information, visits, and speeches. Because of the heightened interest in child abuse and neglect, and the general paucity of information, project staff members are immediately earmarked as "experts" and numerous demands are placed on their time. A program can deal with these demands by assigning a particular day of the week as the time for visitors; sharing responsibilities for speaking at community meetings among all staff members; producing a brochure about its activities which responds to most requests for information, thereby reducing the need for individualized responses. Following such practices will increase your project's ability to deal with community requests without crippling your ability to provide services.

Finally, new programs will soon discover, if they did not during the planning stages, that there is a dearth of certain services in the community, notably day care, emergency shelter and foster care for children. While you may choose to fill these service gaps with your program, you may also wish to consider assisting other agencies in providing the missing services.

Regardless of the approach you take, it is important to remember that your goal is to provide your clients with comprehensive services. This can be done either directly or through participation in a well-functioning community-wide system.

PART II

DESIGNING

Having taken the initial steps in conceptualizing your program, you now need to reach out into the community and determine local needs. Once local needs have been established, specific program goals, service models, and treatment strategies can then be adopted. The purpose of this section is to guide those interested in establishing local child abuse/neglect projects through the planning maze. Each of the following four chapters emphasizes critical areas to consider in each planning step, as well as the problems one can expect to encounter along the way. In short, the section provides a realistic approach to follow in developing your own service.

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Chapter 3:

Assessing What Kind of Programs Your Community Needs

Conducting an assessment to determine the treatment services, professional and community education endeavors, and coordination activities needed in a community is the obvious first step in developing an adequate service delivery system. Although this should precede the development of all new programs, often it is skipped or done casually. While the problems most in need of correction may appear self-evident, this should not automatically be assumed. The most visible problems are often problems program planners want to see resolved due to political pressure, bias, or previous experience. More important problems in the system might well be overlooked or hidden due to ignorance or fear of complications. Considering the complexity of the child abuse/neglect issue and the sensitive nature of any service perceived as interfering with the private family, the serious issues in need of attention might fall into this latter category. A thorough needs assessment can help uncover some of the less obvious problems and direct your program down a useful path.

This chapter clarifies the reasons for conducting a needs assessment prior to implementing a new program, identifies the types of information that could be included in such an assessment, and outlines a method for conducting an assessment.

Purpose of a Needs Assessment

The reasons for undertaking a comprehensive study of the community and its current services before suggesting a new program in the child abuse/neglect field include:

- determining the adequacy of the current abuse/neglect service delivery system, in part by identifying gaps or duplications in available services;
- ensuring new or modified activities address community needs on a priority basis, i.e., solving the most important problems first;
- ensuring plans are not made in the absence of critical information which may later affect the program's implementation;
- increasing the coordination and cooperation of the entire community system by involving other pertinent agencies and staffs early in the planning process; and

- providing baseline information that might be used later to evaluate the effectiveness of subsequent changes in the system.

Conducting an Actual Needs Assessment

Various methods have been developed for the purpose of teasing out information relevant to the establishment of a community-based child abuse/neglect program. Although many of these systems have been developed for use in other social and health problem areas, they are useful for a child abuse/neglect program and their adoption can save time and error for those conducting their first needs assessment.

The following discussion provides guidelines for structuring a needs assessment. Although the outline may be made more appropriate to the individual requirements of specific programs, it contains the essential steps those conducting a needs assessment will want to include. While the steps are listed in a rather linear fashion, the needs of your particular program might require you to proceed in a slightly different manner or repeat some of the steps several times. A needs assessment is one part of a dynamic planning process in which stages interact continuously.

The steps in the assessment include: identify the key community agencies and individuals; determine what information to collect; obtain copies of existing information; develop instruments for collecting additional information; collect the data; analyze the collected information and determine community needs; and develop plans for periodic reassessment.

(1) Identify Key Agencies and Individuals: Many community agencies and programs deal with abused and neglected children or their parents. Many of these, such as the local Juvenile Justice Court, Protective Service agency, police, hospitals, child welfare and foster care agencies, and schools, should be involved in the planning and execution of the needs assessment. In addition to these agencies, other groups and individuals who may see people with child abuse and neglect problems should also be included in the community inventory system.* Community groups and individuals who are knowledgeable about child abuse and neglect and community services in general should also be identified. These might include governmental officials, health and welfare planning agencies, civic group leaders, clergymen, funding agencies, and other private citizens involved with community problems. Input from former or current clients might provide useful perceptions about the adequacy of the existing system. While it may not be possible to survey every agency and program in the initial needs assessment data collection, all of them should be identified early and included in the ongoing review of the community system.

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*Examples include day care agencies, Head Start programs, handicapped children's agencies, child guidance centers, Community Mental Health Centers, drug and alcohol abuse programs, public health nurses, private physicians, district attorneys, marriage and family counseling services, and churches.

(2) Determine What Information to Collect: Determining what information to collect from each of the agencies and individuals identified above is a critical step. Each participant in the assessment should identify the critical issues as they, or their agencies, perceive them. The entire group can then determine what information would be needed to address these central concerns. You may require information that is both quantitative, such as the number of abuse/neglect cases seen each year by each agency and the average monthly caseload per worker, and qualitative, such as the workers' perceptions of the service quality. Information should be detailed and specific enough to highlight the system's strengths and weaknesses and provide insights into possible solutions to identified shortcomings. It should not be so detailed that the assessment becomes an extensive research undertaking, burdensome to all involved.

Appendix A provides a listing of the kinds of questions that should be answered by a thorough needs assessment. Some of the areas listed may be more or less important for your particular community, and the collection of information should be modified accordingly.

(3) Obtain Copies of Existing Information: Most likely, some of the information identified in Step 2 has already been collected by existing agencies. Available data sources which could be scanned for relevant information include annual social service department reports; census data; and state or local Central Registry reports, if they exist. This information should be assembled and reviewed before developing any new data collection methods. Even if the existing information is in a slightly different format from what is desired, or is somewhat out-of-date, it is preferable to use these data as is, and to concentrate on researching information that is currently available.

(4) Develop Needed Data Collection Instruments: With knowledge of what data already exist, you can now design data collection instruments to obtain the additional information needed. These should be short, easy-to-understand materials that specify what information is desired. Individual questionnaires or check lists may be required for different agencies, depending on the functions the agencies perform and the extent of their knowledge. Some questions, however, will probably be relevant for all agencies and individuals, and should be asked of all agencies. For example, most key individuals and agencies will have an opinion on the problems of the existing child abuse/neglect system.

(5) Collect the Data: Actual data collection can take many forms. Interviews with representatives of key agencies may be used to gather information about the number of staff members working in the agency, the way in which they function with respect to child abuse and neglect cases, and their perceptions of the adequacy of the system. These personal interviews elicit more comprehensive and integrated information because they permit additional questioning about unclear statements. Some factual information may also be collected through other means. In the interest of time, however, we would not recommend mail surveys. Such surveys often require a longer time for information to be received and may entail many

calls or written reminders to agencies before they are completed and returned. If the agency being surveyed does not have the desired service statistics readily available, a viable means of data collection is to conduct a search of their records, or at least a sample of records. Abstracting 100 records, selected at random, can provide useful indications about the types of cases served by the agency. Clearly, if such a record search is to be done, confidentiality of cases must carefully be preserved. In addition to individual interviews and record searches, a method of gathering information from many people quickly and easily is to schedule a meeting where the views of various people can be expressed on each issue. This is particularly useful for obtaining information from civic leaders, government officials, community residents, and clients. Care should be taken to structure these meetings to ensure that the entire range of issues and questions is addressed and everyone has an opportunity to participate.

(6) Analyze the Data: Once the required information has been collected, it must be analyzed by either the original planning group or, if no planning group has been established, by some group that represents various agencies, programs, and community groups. It is very likely that the information will be incomplete and some items will be of questionable validity. The different perceptions of agency representation and conflicting data items will need to be reconciled, and interpretations as to the meaning of all the collected information will have to be made in light of other known facts about the community. Value judgments will be a necessary part of this type of analysis. As the information collected will demonstrate, different people will have varying opinions about what should be considered a "problem." Consequently, it is necessary to include as many different viewpoints as possible in the analysis process in order to arrive at a consensus truly representative of community thinking.

There are various problem-solving techniques that are often used with large groups of people to enable them to focus their attention on the pertinent issues and resolve their differences of opinion in a mutually satisfactory way. The Nominal Group Process, described in Chapter 4, is one such device. It permits all group members to voice their opinions, to enter into directed discussion about various alternatives, and to develop a priority listing of concerns.

Once the information gathered has been studied, problems or needs identified should be prioritized and analyzed, as discussed in Chapter 1. Intervention points can then be identified, the most cost-effective solutions chosen, and a plan for action developed. At this point, feedback should be provided to all participants in the process, including a summary of the information collected and the action plan(s) chosen. This step is often overlooked and may engender negative feelings on the part of some individuals or agencies. No one should feel s/he has contributed to the study but never saw its outcome or participated in the decision making. Later coordination of the system could depend on the positive relationships developed during the needs assessment and subsequent planning process.

(7) Develop Periodic Reassessment Plan: A needs assessment is not a one-shot undertaking. It is necessary to reevaluate the system periodically to determine whether the proposed solutions have been implemented, and, if so, how successful they have been. It is also important to identify any new problems that have arisen since the last study. One method of accomplishing this is to indicate methods for ongoing collection of data on key indicators from relevant agencies. These data can be analyzed to detect problems at any early stage. The identified problems can then be discussed by agency representatives and solutions developed.

Some Cautions and Reminders

A needs assessment is often overlooked by those planning to implement a child abuse/neglect project or program. As a result, programs that do not respond to the real needs of the community, or that duplicate existing services, may be developed, making the system less coordinated than before.

Although the needs assessment will take some time to develop, it should never be allowed to balloon into a major research endeavor. The purpose is to gather as much useful information as is needed in a short period of time. If the study drags on too long, the information will be out of date and much less useful for planning purposes, and enthusiasm for implementing a program may have waned. In order to prevent the needs assessment from becoming a costly, time-consuming study, some compromises may need to be made. Where needed data do not exist, or exist only in case records that would need to be individually reviewed, inexpensive alternatives should be considered. For example, estimates made by agency staff might be sufficient or a sample of records could be reviewed to obtain estimates. Flexibility in the level of detail sought should be stressed. Other time- and cost-saving measures include: having volunteers or students conduct parts of the study; relying on already-developed survey instruments, if possible; and gathering information from group meetings, rather than individual interviews.

Some community agencies may resist a needs assessment because they consider it threatening. It should be stressed that the purpose of the study is not to "evaluate" any agency's performance, but to help identify problems that all concerned can begin to solve. Early consultation with agencies, a sensitivity to the internal pressures of these agencies, a non-threatening approach by the study group and interviewers, and the provision of feedback to those who have participated should help to break down any resistance to the needs assessment.

Chapter 4:

Program Goals

Once you know what the community needs, a specific program can begin to take shape. Based on the information gathered in your needs assessment, a series of program goals, or targets, can be developed. These goals constitute your program's central core, around which specific service components are built. After determining the program's goals, other aspects of the service delivery package, such as treatment modalities, staffing patterns, and budgeting procedures, can be developed or refined. This chapter begins by explaining what is meant by goals and then describes various methods for identifying and measuring goals. Clear, precise and realistic goal statements are a critical first step in successfully transforming your program into action.

What Are Goals?

There is a long-standing debate among social scientists over the definition of and differences between goals and objectives. Some would argue the two terms are synonymous, while others always differentiate the two. For purposes of this discussion, the following definitions are used: goals are those specific outcomes the program can expect to achieve by the end of a particular time period; and objectives are the more specific targets that lead to goal accomplishment. In addition to these divisions, a project may also specify missions or "global goals" which represent the project's long-range expectations. While such comprehensive statements are likely to be part of most program planning, the design of the service delivery system will be best guided by carefully stated program goals.

One of the functions of establishing program goals, therefore, is to assist in the construction of the entire system. In order for goals to provide this function effectively, the following guidelines should be kept in mind.

- Goals should address the real needs of the community and the clients and not merely reflect the preferences of the program's staff, Board, and sponsors. Those involved in program management and goal determination must be open to the opinions and needs of those they serve.

- The list of goals should be realistically attainable, reflecting the size of the budget and staff. This will most certainly mean establishing priorities among a long list of possible goals, all of which may represent legitimate needs of the community.

- A program should define goals that cover important components of a program package and avoid goals that are trivial or procedural. For example, a goal of "setting up regular staff meetings" would generally be too narrow in focus to be considered an acceptable program goal.

- Goals should be clearly stated so that everyone can readily understand what is to be achieved. It is difficult to determine the meaning of the following statement: "to utilize strategies for determining modalities for prevention of dysfunctioning in families which exhibit characteristics identified as possible causes for abuse." The idea could be more clearly stated in this manner: "to identify effective treatment services for potential child abusers."

- Finally, goals should be stated in such a way that progress toward achieving them can be measured for evaluation and monitoring purposes. "To do well in delivering community services" is not an appropriate goal statement because there is no measurable reference point for the word "well." Table 4.1 at the end of this chapter lists examples of goals and objectives for a child abuse program.

Formulating goals is important for at least three reasons. First, goals provide the program with direction. Because it is impossible to do everything, articulation of goals forces management to choose among competing demands and assists in determining whether resources are being allocated in accordance with the desired outcomes. Second, goals make the intent of the program clear to the community. In most cases, the members of the staff, people in the community, and the funding source(s) all have perceptions of the program's function. The process of defining goals can make potential conflicts among the various interests apparent, and having a statement of goals can provide a program with a base from which to contend with the pressures of competing interests. Moreover, the process itself provides a method of identifying those individuals or agencies having differences of opinion so that program staff can work closely with them to reconcile the points of view. Finally, continuously thinking and rethinking about goals and measures of those goals provides a standard of performance against which evaluation can take place. Because internal evaluation is critical if a program is interested in delivering useful services, measuring goal achievement can and should be a primary concern.

How to Select Program Goals

There are several ways to select goals. An individual, such as the program planner, can take sole responsibility for determining goals, based on his or her understanding of the community. While this is efficient, it presents numerous hazards, including bias, incomplete knowledge, and lack of consensus. Of course, a person could elicit more information and suggestions for goals from the community by means of interviews with

representative laypeople and professionals. This step involves the community but allows for no interaction and information sharing among the various community actors. Consequently, consensus building on goals is lacking. Furthermore, the biases of the interviewer can color the interpretations of collected opinions. Choosing goals using a group of knowledgeable people, such as representatives of other community agencies, an Advisory Board if the program has one, potential or actual clients, or the staff as a whole, allows for a cross-section of ideas. However, this method also has its drawbacks. Holding free-form discussions allows certain individuals to dominate, particularly people with high status or leadership positions. In addition, minority opinions are often unexpressed; energy is expended on competing for the floor instead of on listening to the ideas of others; discussions tend to digress from the issue; and, in the end, the real decisions are hastily made.

The disadvantages of decision making in a group setting can be mitigated by means of a structured group technique, such as the Nominal Group Process. This process ensures a representative choice of goals, as well as agreement by a majority of people present. The Nominal Group Process, developed by Andre Delbecq and others over a ten-year period, seeks to increase creativity and effectiveness in group idea generation for the purpose of planning and evaluation. The process as used for goal articulation begins by asking individuals in the group what they think the goals of the program should be. Each member of the group writes down his/her responses during a 10-15 minute silent period. This is followed by a round-robin discussion in which all ideas are shared with the group, deliberated upon, and then voted on, in terms of their importance or appropriateness. As a result, the group selects what it believes to be the best of many possible goals, while avoiding the pitfalls of unstructured group interaction.*

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*In the Nominal Group Process, the silent period itself is tension-producing and, as such, idea-producing. It allows time to reflect and think while encouraging all members of the group to participate. The method supports the generation of minority ideas; avoids hidden agendas; makes each participant work and contribute; gives each a sense of responsibility for the group's success; fosters creativity as well as interaction; and allows personal concerns to be aired. It is especially useful in a heterogeneous group since it does not permit any one person or point of view to dominate. Because the silent period is followed by the sharing of all ideas prior to their discussion, all members are assured that their ideas will be heard. In the discussion which follows, the benefits of group interaction, feedback and information-sharing are realized. Group members have a chance to question each other's ideas and clarify them. The group interchange is structured only by the time allotted for discussion and by the voting session, which gives the people another chance to express their views.

Goals Reassessment

Although a program should continually strive to meet its initial goals, issues will often arise in the program's first year that make original goals unattainable. Confronted by the constraints of the "real world," the agency may soon realize that it cannot accomplish as much as was hoped. Budget limitations, the skills and interests of the staff hired, and the realities of pursuing certain activities will call for goal reassessment. Therefore, it is to be expected that the program emphases will shift somewhat during the first year, and you should not be alarmed if this proves true for your program.

Because of this tendency, program management and staff should periodically rethink the program's direction and the feasibility of accomplishing certain goals. At the end of the first year, a structured reassessment should take place, again using a group technique such as the Nominal Group Process. This reclarification of direction is essential for guiding the program toward accomplishing well conceptualized, feasible goals. As goals are met, or as experience changes expectations, goals can and should be reformulated throughout the life of a program.

Goal Measurement

One way for a program to evaluate its progress is to determine how well its goals are being met. In order to do so, indicators or specifications of program activity toward goal attainment must be developed. Indicators for each goal should be determined at the beginning of program operation as they will clarify the implications of selecting particular goals, both in terms of work activities necessary to achieve the goals and in terms of the type of evaluation and monitoring required to carry out a goals assessment. Measures must then be developed to specify the data needed in order to know how well the goals are being carried out. Table 4.1 shows the types of indicators and measures that could be applied to some sample goal statements. Some reflect actions necessary to accomplish the goals; others are outcomes that suggest goal achievement.

Because a goal achievement assessment should always be community and program specific, it is necessary to choose indicators that are particular to the locale and agency. It is also important to get input from both the staff and management involved in actually carrying out the steps necessary to accomplish the goals.

In a very small program, progress toward goals could be monitored on a part-time basis. However, in a larger agency it may be necessary to have a full-time evaluator for determining an evaluation design, developing instruments for collecting program data, and analyzing the data.

Goal Accomplishment

Based on the experiences of several child abuse/neglect programs, certain commonalities exist in those programs found most successful in reaching their stated goals. New programs could maximize their chances

for goal accomplishment by incorporating the following attributes whenever possible and wherever practical:

- sponsorship by an ongoing agency with a history in the community;
- identification by the community as an agency central in the local child abuse system;
- from the outset, the sponsoring agency imparts authority which comes from being one of the community's primary social service providers;
- coordination with the community's service delivery system;
- a remaining involvement in the ongoing management by those instrumental in developing the original program design;
- consistently strong administrative leadership;
- flexible program management, responding to situations and needs as they arise;
- clear staff role differentiation, but all staff sharing responsibility for the various program activities;
- stable caseloads over time eliminating crisis level case overloads;
- management concerns of the program's director include planning and evaluation; and
- low staff turnover.

Table 4.1

SAMPLE GOALS, OBJECTIVES, INDICATORS AND MEASURES

Program Goal	Objectives	Indicators	Measures
To increase the medical community's awareness of suspected abuse and the services available.	• To provide education to the county's private physicians.	1) Participation of medical community in project's professional education programs.	a. Number of meetings held with hospital physicians, nurses and social service staffs. b. Number of informational packets distributed to medical personnel. c. Number of courses/presentations given.
	• To provide education to hospital-based nurses.		
	• To contact and seek coordination agreements with the Department of Public Health and County Hospital.	2) Inclusion of medical personnel in the program's activities.	a. Number of medical personnel invited to sit on the Advisory Board. b. Number of medical personnel participating on the program's multidisciplinary review team.
		3) Increase in referrals to the program from the medical community.	a. The comparative proportion of all referrals to the program that come from the medical community in the years before and since the program's educational efforts began.
		4) Awareness by the medical community of the abuse services available.	a. Percentage of medical personnel who were contacted by the program who can correctly identify the services available.
Program Goal			
To identify the most effective treatments for abused and neglected children.	• To provide a range of treatment modalities for children.	1) Designing a plan to assess the effectiveness of treatment strategies.	a. Develop method for assessment of the child on entering the program. b. Selecting the control group. c. Procedures to reassess the child over time.
	• To get all abused/neglected children of families in the caseload into treatment.	2) Implementation of the design.	a. Number of children assessed on entering the program. b. Number of completed records on the results of assessment and reassessment, together with the amount and type of treatment provided.
	• To systematically study the results of different treatment.	3) Awareness of the most effective strategies of treatment.	a. Analysis of the treatments that proved most effective for those children in the program.
		4) Use of the results of the assessment/evaluation.	a. Alteration of the program's treatment services as a result of the effectiveness study. b. Distribution of the results to others in the field.

Chapter 5:

Program Design

The exact form of your local child abuse and neglect program will depend on a number of factors, some of which you will control and some of which will be predetermined. Since no particular service has been shown convincingly, through systematic research, to be the most or least effective, you should seek to provide services which will be most effective for your particular situation. The kind of program you will develop will depend, in part, upon state and local laws, the needs of your community, and the limits of your resources, both financial as well as human. The purpose of this chapter is twofold. First, guidelines are presented for pinpointing the specific circumstances which will influence the design of the program. Second, five alternative organizational models and staffing patterns for child abuse and neglect service programs are explored.

Program Dimensions

Programs can vary along several dimensions. The unique demands of your individual service situation will mold your

- organizational context,
- resources,
- program components,
- treatment strategies,
- staff,
- decision making process,
- service size,
- target population,
- location, and
- service availability.

Program developers should carefully consider each area in designing their programs, giving special attention to situations which will limit their options. Brief discussions of each area follow. A simple check list of key questions to consider is presented in Figure 5.1.

(1) Organizational Context: Child abuse and neglect service programs are found in a variety of contexts. Some have found the local public protective services agency to be an effective home base. On the other hand, programs have been housed successfully in hospitals and private social services agencies. Other equally viable, but less frequently used, agencies

Table 5.1

CHECK LIST FOR GUIDING PROGRAM DESIGN

Organizational Context

- Agency location
- Other agencies with which you will interact

Resources

- Amount of resources (dollars and human)
- Source of resources
- Resource duration

Program Components

- Service areas mandated by program goals
- Specific services anticipated

Treatment Strategies

- Direct services
- Referral services
- Staff perspectives
- Treatment process anticipated

Staff

- Number of staff (part-time/full-time; paid/volunteer)
- Specific staff skills; strengths and weaknesses

Decision Making Process

- Chain of command
- Communication and feedback in networks

Size

- Financial resources
- Anticipated client load

Target Population

- Characteristics of perceived target client population
- Criteria for selecting specific clients from total target population

Location

- Number of actual locations for service
- Number and location of other community services
- Nature and extent of local community resources

Availability of program

- Hours service will operate
- Days service will operate
- Location and extent of back-up services

include schools, public health departments, day care centers, juvenile courts, and mental health centers. While most programs are housed in a single agency, some have found it more advantageous to be supported by two or more agencies. In short, a variety of agency locations exist, and one should be sensitive to the advantages and disadvantages of all possibilities.

(2) Resources: Existing programs have successfully utilized resources from a variety of federal, state, and local government sources as well as grants from private foundations and other private groups. Some programs have chosen to make extensive use of volunteer services and a variety of donated items (such as transportation and child care) as a way of bolstering their budgets. Other programs have sought lump sum donations, while still others have sought service donations from local professionals in the medical, legal, and social service fields. In gathering your resources, it is most important to consider whether any funding source will place restrictions on your program or present cash flow problems. Resources should be sought to complement your service needs, and services should be designed to make the best use of your resources.

(3) Program Components: Once a program has articulated its priorities by establishing specific goals, it has also, to a large extent, selected the general service categories it will pursue. Each of the specific services you decide to provide will most likely fall into one of the following broad categories:

- direct treatment services for parents;
- direct treatment services for children;
- direct treatment services for families;
- supportive and advocacy services;
- coordination of services for individual clients;
- preventive activities;
- professional and community education;
- consultation and technical assistance for other professionals;
- activities directed toward changing child abuse legislation and policy; and
- coordination of the community child abuse and neglect system.

For those programs pursuing more than one of the above activities, there are many possible mixes. Program planners should keep in mind that emphasis on any one activity will have both positive and negative implications. For example, staff members who spend most of their energy providing services to adult clients within the program may overlook problems of other

agencies dealing with the same clients which could "undo" the benefits of treatment. At the same time, a strong emphasis on treatment may produce a staff that can effectively advise other professionals.

(4) Treatment Strategies: A wide range of alternatives for treatment services exists and each has been proven successful in certain situations. As discussed in the next chapter, you, as a program planner, will need to examine each alternative carefully in light of the options existing within your program design and the needs of your community.

(5) Staff: Because of the nature of child abuse and neglect problems, many different skills and disciplines have been successfully utilized in dealing with this problem. Persons working in child abuse and neglect programs include social workers, community educators, teachers, lay therapist/parent aides (a layperson trained on the job to provide supportive services), logistic aides (a layperson trained on the job to follow through with advocacy services), homemakers, nurses, nurse practitioners, pediatricians, lawyers, psychologists, and psychiatrists. The final composition of a program's staff will depend on the specific services provided and the program's own philosophy about what skills are most essential. In addition to the professions listed above, some programs employ former abusers or neglectors as counselors. Organizationally, a program will want to have a director and/or coordinator, a bookkeeper/office manager, a secretary, some number of treatment workers, and a casework supervisor. Programs do not necessarily need to depend on professional staff for all its treatment workers. Many programs have successfully trained lay persons to work with clients. Besides filling identified staff and consultant positions, a program should consider establishing or using:

- an advisory committee (which may or may not have decision making authority, but which can help the program think through decisions and give the program leverage in the community);
- a multidisciplinary review team (which may review cases at intake or periodically during treatment and which should truly be multidisciplinary, having at least three different disciplines, and preferably more, represented on it); and
- a researcher or evaluator to document what the program is doing and to give the program feedback on its progress.

(6) Decision Making Process: Although the decision making body will be determined, in part, by its agency location, there are many variations. Decision making can be formal or informal; hierarchical, collegial, or collaborative; participatory or non-participatory. Many of our observations of child abuse/neglect programs suggest that the particular form of decision making adopted by a program will not greatly influence program effectiveness. What will influence the success of a program is how well the decision making is carried out. What is important is that human needs are kept foremost, and that all participants feel their opinions are heard and valued.

(7) Size: Although the actual number of dollars available to a program need not determine the scope of possible activities, the number of dollars coupled with human resources (paid staff and volunteers) will. The size of your budget and the cost of your planned services will clearly influence the number of clients you can hope to reach. For example, if a program is planning to offer a very expensive service, such as residential care, its per-client costs will run quite high. If, on the other hand, a program establishes a 24-hour hotline, with its relatively low per-client cost, as the primary service, many more people can be reached for the same overall cost. A program should probably plan on serving a minimum of 20-25 families at a time to be at all efficient. Although there are no guidelines for maximum caseload size, many people recommend that no one worker be responsible for more than 20-25 families.

(8) Target Population: Programs that are required or choose to serve all appropriate referred cases have substantially different problems from those that serve only a select number of clients. In an unrestricted program, the caseloads will probably be much larger, the types of cases will be more varied, and the numbers of referrals may vary from month to month. Consequently, careful planning will be needed to avoid confusion and service disruption. Programs that choose to serve a select population must carefully define their selection criteria and inform potential referral sources accordingly. Such criteria may be "first come, first served," only abuse or only neglect cases, or select cases. Some programs choose cases with certain identifiable characteristics, such as living in a specified community, being free from drug abuse, or only single mothers. The types of clients one will accept obviously affects what services are needed and thus should influence the service package. If a program cannot explain why its clients particularly need its services or why services it has decided not to deliver are of lower priority than services being delivered, there are legitimate grounds for suspecting that program planning and design have not been sensitive to the needs of the target population.

(9) Location: Although very few child abuse and neglect programs have chosen to operate from more than one office, this tactic may be beneficial to programs serving an expansive geographic area. Many programs, originally part of a large public agency, have located in a separate building to escape an office atmosphere and create a space more amenable to service delivery. Such a space often takes on the characteristics of a home, with lounging areas and the like. If a program has a choice of location, access to public transportation and to other agencies should be given high priority.

(10) Availability of Program: Some programs are open only during daytime hours; others provide services throughout the day and into the evening, particularly for clients who work; still others are available 24 hours a day. Whether or not program staff are available to clients on a 24-hour basis, the clients will require 24-hour coverage since crises often occur after hours. Consequently, programs not providing 24-hour coverage should arrange for this service through some other community

agency. Delivering 24-hour coverage requires consideration of staff assignments, an over-time compensation policy and, most importantly, adequate management of the 24-hour coverage to avoid worker burnout.

Prototypes of Child Abuse and Neglect Service Programs

This section presents the most common models for child abuse and neglect services. The five include a protective service model, hospital model, private service agency model, volunteer model, and coordination model. Some variation of the protective services model exists in every community, as mandated by the specific state's law.

Protective Services Model

In most communities, the Protective Services unit of the public social services agency has been a primary service provider for abusive and neglectful families. Traditionally, these units have offered counseling and advocacy services to clients through professionally trained social workers. Recently, some Protective Service departments have revamped their programs. Staffs have been expanded to include homemakers, nurses, psychotherapists, and lawyers. With the additional skills represented by these disciplines, plus an emphasis on purchasing or contracting for services from other agencies, more and varied services are offered. Counseling and advocacy services, however, have remained primary. Although such programs still handle all reported cases of abuse and neglect in the community, caseload sizes for individual workers have been reduced, allowing for more intensive, as well as more varied, service offerings.

This model has several advantages. First, the agency is legally mandated to investigate and treat abuse and neglect cases, and thus begins with legitimacy, authority, and credibility in the community. Second, the agency has a permanent source of funds. There are, however, several disadvantages. The program must abide by civil service rules and regulations which can be somewhat restrictive, and the program must compete within the agency for money, attention, and control. In addition, clients are often resistant to receiving services if they are provided under the auspices of the "welfare department" or are seen as formal extensions of local law enforcement agencies.

A variation of the Protective Services model is to have two units within the program, one focusing on intake/investigation and the other on treatment. The benefits of this approach are that the investigation and diagnosis can be much more thorough; the investigation worker, who bears a certain stigma in the client's mind, is separate from the treatment worker; and the treatment can be more directed, since treatment workers do not also have to concentrate on intake. However, there are some very real problems with this approach. First, the chances of the intake workers burning out are great. Intake/investigation in many ways is the most exhausting phase of treatment, and these workers never have a chance to relate to any clients for an extended period of time. This often denies them the positive aspects of working with abusive and neglectful parents. Second, unless a very smooth

transition is worked out between the intake and treatment units, treatment workers may have to repeat many of the intake investigative steps to make sure they understand the case and that clients receive the services they need. Finally, the client may suffer by having to establish a rapport with more than one worker.

Hospital Model

Some hospitals, primarily children's hospitals, have initiated or sponsored child abuse and neglect programs. These programs, typically linked with the hospital's social service department, focus on identifying and diagnosing cases. They provide special training for all hospital staff, particularly doctors and nurses who work in the emergency room and outpatient department. The program staff is on-call to assist in diagnosing suspected cases, reporting the case to the appropriate agencies, and coordinating treatment services for families with other community agencies. A trauma team, composed of program and hospital staff, is typically included in the diagnosis of the most severe cases, if not for all of the cases. A few programs also provide their own treatment services, including group therapy and child care.

The hospital model has a number of advantages. The program has financial support from the hospital and access to hospital services, particularly medical care for the abused or neglected child and parents. The credibility of the hospital gives the program important leverage in the community, while also ensuring some physician participation. The physician can be of great value as a consultant, without carrying the full burden of the management of cases. However, in such a program the medical viewpoint can prevail, with the emphasis exclusively on diagnosis to the detriment of treatment. The focus of the program will likely be on physical abuse. Social workers and others may be forced to take a back seat to the doctors. Additionally, a hospital can easily become isolated from the community, unless it maintains communication with the local protective services agency and other local service providers.

Private Service Agency Model

The private service agency model is most often a small center, with a limited caseload of 20-40 families. Treatment services such as group therapy, individual counseling, 24-hour hotline counseling, and often day care are provided on the premises. These centers focus on the family as a unit and the program facility is selected and decorated to reflect more of a homelike than office atmosphere. These programs are very selective in identifying and accepting cases. Two distinct variations of this model exist: (1) a residential program, and (2) a program that concentrates more on education and coordination than on direct services.

The benefits of such a program are limited red tape, flexibility in meeting clients' needs, and minimization of stigma, maintaining anonymity when necessary. On the negative side, the program will initially lack

legitimacy in the community and may have difficulty securing interagency linkages. Funding sources are usually unstable, making it difficult to retain highly skilled staff on a long term basis.

Volunteer Model

There have been several programs that operate almost exclusively through volunteers. The volunteers may or may not include former child abusers and neglectors. These programs are primarily concerned with treatment, although large numbers of requests come to them for training and education. Three services commonly offered include: lay therapy or parent aide counseling (laypersons, trained on the job, assigned to 1-3 families to provide friendship and support); Parents Anonymous (small therapy groups run by and for abusive or neglectful parents); and 24-hour hotline counseling. Operating with small budgets and only occasionally with a paid director, these programs typically function independently from other community agencies. As such, they are bound only by their own rules and policies. Often they can more easily offer services to clients that reflect the clients' expressed needs in a non-stigmatizing way. The unit cost of services is substantially lower than other programs, and clients find it quite easy to relate to the "non-professional" service provided. While volunteers may be the most enthusiastic of workers, the turnover rate is likely to be higher than that of paid staff. A second drawback is that volunteers, by virtue of their lack of training, may be unable to diagnose cases of abuse or neglect and are often unprepared to work with the most severe cases of abuse or neglect. And, volunteers will not have as much acceptance or legitimacy from other providers as professionals will. When the primarily volunteer staff is supplemented with a professional casework supervisor, these problems can be eliminated.

Coordination Model

Some agencies, primarily public but in some instances private, have adopted a coordination model. Under such a model, the agency takes primary case management responsibility for clients, but services are provided, often on a purchase-of-service basis, by other community agencies. Such an arrangement allows the agency staff more time to generate service providers in the community and to ensure that clients are handled efficiently and effectively. A variation of this model places case management responsibility with an outside agency, freeing the public agency to devote all its time to developing a more coordinated set of services.

Chapter 6:

Treatment Strategies for Programs

Many different services exist for abusive and neglectful parents and their families. At present, there is little empirical data indicating which treatment services are most effective for different people.* In addition, many different schools of thought, as to the causes of abuse and neglect and the most appropriate treatments, surround the delivery of services. Overall, the focus of these different schools of thought, and the literature in general, is on the abusive or neglectful parent, and what his or her needs are, rather than on the child who is maltreated.

First, there are those who take a criminal justice approach, arguing that parents who abuse or neglect should be prosecuted, and minimally the child should be protected by removal from the home into foster care. In contrast to this once prevalent and now diminishing approach, others argue for trying to keep the family together during treatment. Those who take a psychiatric approach explain abusive and neglectful behavior as a result of internal conflicts, low self-esteem, and other weaknesses of the parent. This group advocates psychotherapy, most often individual rather than group.

Others discuss abuse and neglect in terms of socioeconomic aspects in which behavior is explained by environmental circumstances. The stress of poverty and other social problems is seen as a primary cause of child maltreatment. Consequently, individual counseling and supportive services that help break the poverty cycle are advocated both for parents and their families.

The group dynamics approach attributes the abuse or neglect problem to the breakdown of the extended family and increased feelings of alienation and isolation experienced by many people in modern society, particularly those in urban areas. The suggested intervention is to provide people to talk to and to lean on -- Parents Anonymous, group therapy,

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*The authors have recently completed a three-year study of the relative impacts of different services on over 1700 abusive and neglectful parents served by 11 demonstration programs. The findings may not be generalizable to all programs, given the unique aspects of those programs. However, in that study it was found that supplementing treatment offerings with the services of a layperson who can interact as a friend frequently with the parent and lay self-help groups, such as Parents Anonymous, increase the overall effectiveness of treatment. In addition, it was found that most clients will need treatment for at least six months.

other forms of group activity, lay therapy counseling, or foster grandparents. Family-oriented treatment including day care is also advocated.

Those taking an anthropological approach base their arguments on the premise that certain racial and ethnic groups have traditional socialization patterns that include forms of discipline outsiders might regard as harsh, abusive, or unnecessary. This approach stresses that the intervention, which may be one of many forms of therapy, must be tailored to the characteristics of the particular ethnic or racial group in question. Treatment, according to this approach, should help parents understand the reasonable limits of their culturally-based forms of discipline, instead of attempting to eliminate the discipline.

Finally, the educational approach suggests that the parents lack an understanding of child development, nutrition, health care, or homemaking skills that are causally related to abuse and neglect. Homemaking, parent education, and child management classes are advocated by those subscribing to this model.

It may be that each of these approaches is germane to understanding the dynamics of abuse and neglect for some kinds of families or situations. Abusive and neglectful behaviors are not simple phenomena. Nor, despite the similarities in outcome (e.g., a bruise, a broken bone), are the behaviors explained by a universal theory covering all abusers and neglectors. Much must be taken into account in understanding abusive and neglectful behavior and the most appropriate service approaches. Therefore, we do not advocate any one particular approach. Rather, the purpose of this chapter is to identify the range of treatments that a program might offer to parents, children, and families, and to suggest some of the critical issues to consider in planning for these services.

Dimensions of Services

The mixes of treatment services offered vary greatly from program to program. This variation reflects not only the differing orientation of program staffs toward the abuse and neglect problem, but also the different objectives of programs, the kinds of agencies in which programs are housed, the kinds of clients the program intends to serve, the skills of the staff, the program's resources, and the needs of the community. A program should address the following questions, which are similar to those addressed in selecting a program model, in planning its own treatment service options.

- Will the program take primary responsibility for management of the case, or just provide services for cases being managed by another agency?
- Will the program be housed in a public or private agency? How will this influence the kinds of clients to receive services and the services that will be offered?

key staff members. In this way, the program helps assure that clients get needed services from other agencies with whom the client may be at a disadvantage. At the same time, it helps those agencies become more responsive to the needs of abusive and neglectful clients. Advocacy services may include the following:

- Income and employment assistance: Activities here vary from helping a client to obtain welfare; to enroll in job training, vocational rehabilitation, or education that will lead to job improvement; or to deal with money management within the home.

- Housing assistance: The worker may assist the client in securing better housing or in making his/her present dwelling more livable.

- Health and well-being assistance: Medical, dental, or optometric care, family planning counseling, or homemaking services that furnish instructional assistance in nutrition, hygiene, and other health-related matters may be provided.

- Legal assistance: Here, workers may pave the way for clients to deal with the courts or police on a variety of legal problems.

In addition to these advocacy services, supportive services such as the following may be offered:

- Transportation: The client may be provided with transportation to and from service appointments, and for other daily activities such as shopping.

- Child care: Workers may arrange for child care or even babysit themselves, in order to give the client free time to participate in services or handle other daily needs. Child care can also provide a respite from the demands of child-rearing, often reducing the stress associated with child abuse and neglect.

- Waiting with client: A worker may sit with a client while s/he waits for a doctor's appointment, a court hearing, or other services, and at that time assist the client with procedures, as well as providing support.

- Homemaking: A client may receive assistance with cleaning, meal planning, cooking, and the like, thereby alleviating certain household stresses and pressures.

- Emergency funds: Small allotments of money may be given to clients to reduce the stress of financial crisis.

- Will the program be housed in an educational, medical, legal, social service, mental health, public health, or other type of agency? How will this influence treatment offerings?

- Will the program provide services to all appropriately referred cases or to just a limited number?

- Will the program provide services for whole families, only adults, or only children?

- Will the program treat preventive as well as actual cases?

- Will the program treat physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, medical neglect, or combinations of these?

- What other criteria will the program use to decide who will receive services?

- Will the treatment be short (3-6 months) or long (1-2 years)?

- What kinds of staff members will the program have: professional, lay, paid, volunteer, a mix?

- What will be the program's resources (e.g., large or small budget, lots of space or no space, cars)?

Treatment Options

A variety of treatment options are presented below. While each option is treated as a distinct service, the benefits of one type of service often occur in conjunction with another. For example, individual counseling can be given while a worker is transporting a client. In practice, services are most often offered in combinations. The listing below is certainly not exhaustive; it reflects what many child abuse and neglect programs are currently offering. The services fall into four main categories: supportive and advocacy services; treatment services for adults; treatment services for children; and treatment services for families. A fifth type of service, in the form of client participation, is also presented.

Supportive and Advocacy Services: Supportive and advocacy services are most often important in gaining the client's initial trust and may also provide the basis of services throughout treatment. They can be directed at a number of the client's situational problems, such as lack of food or poor housing. In order to promote effective delivery of these services, the program must develop expertise in how other community agencies function (e.g., the juvenile court, the welfare department, the housing department) and must establish good working relationships with their

Treatment Services for Adults: These services focus on providing the client an opportunity to work through particular behavioral, situational, or attitudinal problems in settings that foster support and friendship. They vary depending on whether the service is for an individual or a group, on the degree of formality of the service, and on the range of skills required of the service provider. These services include:

- Individual counseling: Individual counseling includes a range of one-to-one interventions aimed at improving the client's social behavior and situation. Usually the counseling involves discussions between the worker and the client about the client's situation and problems and the possibility of change or improvement. Advocacy and supportive services are often used as back-up for this counseling. The counseling may be broadly based, touching on a number of social, psychological, or economic issues, or focused on specific issues, such as the child abuse or neglect situation.

- Individual therapy: Individual therapy is distinct from individual counseling in that it is more structured, requires a different set of skills from the service provider, and tends to be more focused. The therapist, most often a trained psychologist, psychiatrist, or social worker, meets with a client, usually for one-hour sessions once or twice a week. Using a psychological or social-psychological orientation, the therapist helps the client better understand his or her problems. Such a service requires a receptivity on the part of the client and a commitment to work on his or her problem.

- Parent aide or lay therapist counseling: Counseling provided for clients by laypersons is a relatively new, very economical, and exciting approach to services. A layperson, typically a volunteer who is trained on the job, is matched with a client (on occasion, two or three clients) to provide support, empathy, and friendship to that person. This special counselor visits with the client, and helps with household and other responsibilities. In general, this service provides the client with someone to share concerns. The success of such treatment lies in the selection and training of appropriate persons to do the counseling, and the support and supervision given to them on a continuing basis.

- Couples counseling: Often the problems experienced by a client are directly related to relations with a spouse or mate, indicating a need for couples counseling. Akin to individual counseling in terms of the support provided, the counselor meets with married couples or two adults living together to help them talk through their difficulties with each other and their children.

- Group therapy: Group therapy, a widely used approach to treatment, is a series of meetings run by a skilled leader for about 6-10 clients. Through the use of a variety of group techniques, clients talk over and, ideally, begin to come to terms with their problems. The sessions tend to be open-ended, dealing with a wide variety of issues, although more structured techniques, such as Transactional Analysis or Gestalt Therapy, may be employed. Group therapy can help the client understand that his or her problem is not unique, but is shared by others, and concurrently gives the client an opportunity to develop social bonds. In some cases, group therapy is used to focus on problems of special groups, such as alcoholics or drug abusers.

- Child management and education classes: Child management or parent education classes, which may have nothing more in common with "classroom courses" than the fact that they meet at specified intervals, are a series of group sessions devoted to child development, parenting, and family relations. A detailed curriculum may or may not be specified in advance; discussions may or may not replace a lecture format; children may or may not be included. The most common format used in child abuse/neglect programs is a directed but informal approach in which small groups of parents try to learn new positive behaviors, drawing on their own experiences as well as the experiences of others in the group. Programs have found it beneficial to have someone knowledgeable about parent-child relations and child development lead such a group. Parents occasionally bring their children to the sessions to provide a more direct learning experience.

- 24-hour hotline counseling: Many programs have a telephone line that a client can call at any time, day or night, to reach out for help and receive therapeutic assistance, or at least be assured of reaching a patient listener. Calls may be limited to the program's identified client group, or may be open to anyone in need; calls may or may not be anonymous. A smoothly operating hotline requires careful planning and in most cases participation by most, if not all, of the treatment staff. Staff members having hotline duties are given special tutoring in listening skills.

- Crisis intervention: Crisis intervention, which implies emergency, non-scheduled meetings with a client at times when the client is in crisis, may overlap in content, although not in concept, with many of the above-mentioned services. A worker may be providing regular counseling or therapy to a client during office hours, but crisis intervention requires the worker additionally be on-call and capable of intervening, day or night. As such, crisis

intervention requires careful planning to provide 24-hour coverage, if desired, without disrupting workers' other responsibilities to clients. Crisis intervention for adults may be provided in the context of a community's Comprehensive Emergency Services 24-Hour System.*

Treatment Services for Children: Historically, treatment services in the child abuse/neglect field have been directed to the adult. With the exception of foster home placements and medical services, both of which are essential in certain situations, the child has been overlooked. In an effort to help the child overcome some of the residual effects of abuse or neglect, and to reduce the likelihood that the child will become an abusive or neglecting parent, programs are increasingly developing specific treatment services for the child to complement or be used instead of foster care and medical care. In many instances, these services are beneficial to the parent as well. Included among these services for children are the following:

- Therapeutic day care/child development sessions: A therapeutic day care program, called child development by some programs, is typically provided five days a week for 4-8 hours a day. In addition to supervised care for the child during the daytime, special activities to deal with the child's developmental, psychological, and emotional or motor problems are provided. This therapeutic approach to day care allows for individualized treatment for children in a group setting. Like day care in general, programs providing therapeutic day care must ensure not only that licensing and other relevant regulations are met, but that the necessary supervision, space, equipment, toys, and supplies are available.

- Day care: The basic day care program is oriented toward providing the child with organized play and other activities during the day in a group setting. The emphasis is less on the needs of individual children and more on providing all children with a safe, enriching environment.

- Crisis intervention: Crisis intervention, which implies emergency, non-scheduled interactions with a child, may include the provision of services to the child in the home or, if necessary, by removing the child from the home at any time of day or night. Such intervention

*The Comprehensive Emergency Services 24-Hour System, developed in Nashville, Tennessee, is a program which involves a coordinated comprehensive child welfare service provided on a 24-hour basis. It is available to all families and seeks to prevent unnecessary separation of children from their families during crisis. Materials describing this system in detail are listed in the bibliography.

may be provided in the context of a community's Comprehensive Emergency Services 24-Hour System.

- Crisis nursery: A crisis nursery is a place to which a child may be brought at any time, day or night, and left for short periods of time when a parent is undergoing a crisis or simply feels in danger of taking out frustration on the child. The nursery itself may be in a home or on a program's premises. Careful attention must be given to ensuring that the nursery actually provides 24-hour coverage. One danger in operating a crisis nursery is that it may be used as a long-term placement center rather than as temporary care.

- Residential care: Residential care implies longer-term, non-emergency day and night care of children. Therapeutically oriented services for individual children may be included in this treatment, and parents may be involved in the residential center's daytime activities. Because of the care's 24-hour nature, the requirements for a workable center, including staff, facilities, and materials, are much more extensive than those of a day care program.

- Individual therapy: The types of individual therapy provided to a child depend very much on his or her age and needs. Play therapy, using play equipment to promote the child's self-expression, and individual therapy, one-to-one counseling by a child psychologist, psychiatrist, or other trained worker, are more often appropriate once a child has reached pre-school age. Other forms of specialized therapy, such as speech or physical therapy, may commence at an earlier age.

Treatment Services to Families: Besides supportive and advocacy services, which tend to benefit the whole family, and the range of crisis intervention services provided under a Comprehensive Emergency Services 24-Hour System, very few programs provide treatment services for the family as a unit. Such treatment services are, perhaps, more difficult, both logistically and because the individual problems are compounded in this setting. However, the benefits are probably as great as those generated by individualized services. Examples of family services include the following:

- Residential care: Some programs provide residential care for both parents and their children. Such care is usually temporary (2-3 months). Many of the other treatment services for adults and children are provided within the residential setting. Like residential care for children, such care is very expensive and requires extensive planning and monitoring.

- Family counseling or therapy: Like couples counseling, family counseling may be provided for most or all members of a family when the relationships and dynamics among them are a problem. At times, the counseling may be provided for individual family members and at times for the family as a group.

Client Participation: Clients are often the victims of an isolated and alienating life. While services such as group therapy help to create situations in which clients can form bonds with other people, client participation in various activities is a more direct approach to helping the clients reduce their alienation and possibly enhance their self-esteem. Examples of these include:

- Parents Anonymous: Parents Anonymous, which is similar to group therapy, is a series of group sessions complemented by other activities, run by and for abusive or neglectful parents. Although such groups ideally have one or two resource persons who act as sponsors and attend the group meetings, Parents Anonymous is very clearly oriented toward having the parents organize and help themselves.

- Parent consultants: Some programs use "rehabilitated" clients as treatment workers. Such parent counselors provide important and often overlooked perspectives on the needs of clients, while benefiting themselves from direct involvement in service delivery.

- Child abuse/neglect councils or other organized child abuse/neglect activities: Many communities are now developing child abuse/neglect councils or child abuse/neglect activities such as Speakers Bureaus or legislation committees. Encouraging clients to participate in such groups can be therapeutic for both the client and other group members. Participation may include actually helping to organize and manage the group activities, giving speeches, or helping to operate a hotline.

Examples of Treatment Program Mixes

There are many possible combinations of services that would result in viable programs. It may be true that certain services cluster more naturally than others (play therapy can easily be incorporated into a day care program; certain advocacy services follow naturally from individual counseling), but this should not negate your desire to test innovative mixes. As mentioned, little is currently known about which services are most effective for given clients. Early, large-scale treatment evaluations in the field do suggest that many treatment programs are more effective when lay therapy and/or self-help services are offered in conjunction with

other services.* However, while suggestive, these early studies cannot be regarded as conclusive. Therefore, it is to the field's advantage for programs to try new strategies and to assess how well they work. To give you a feel for the mixes that are possible, the following examples describe five programs that mix services in very different ways.

Program A is an independent center, providing services on a daily basis to families referred by various local agencies. Group therapy and individual counseling are provided weekly for parents and the Center operates a 24-hour hotline for its clients. Two day care programs are operated for children, one for infants and one for pre-schoolers. The pre-school program focuses on the specialized problems of the child. Parent consultants are included as part of the treatment staff, and a Parent Advisory Board, composed of interested adult clients, has input into major program decisions.

Program B serves only adult clients referred to them by the local Protective Services unit, which maintains primary responsibility for the management of the case. Clients attend child management classes or group therapy sessions, or both, on a weekly basis, and may receive the supportive services of a parent aide or lay therapist.

Program C is housed within a Protective Services Department. This special child abuse unit provides adults with individual counseling, complemented by advocacy services, particularly those related to income and housing. Clients' children who have not been placed in foster homes are referred to day care programs whenever possible.

Program D is a residential facility for parents and children. Parents are helped with homemaking skills -- meal planning, cooking, money management -- as well as provided with individual and group therapy. Workers provide direct assistance to mothers in caring for their children, particularly around meal time. The program, affiliated with a hospital, provides comprehensive medical services for the entire family. Families stay in the residential facility for three months, after which time they receive services on an "outpatient" basis.

Program E offers as its primary service 24-hour hotline counseling. Anyone may call the program, anonymously or not, and receive support. When necessary, the program also provides home visits, advocacy and respite care for children. It is staffed primarily by volunteers.

Some Comments and Cautions

Most clients go through a series of stages during treatment. To some extent, these stages dictate what services can most effectively be offered. Initially, and for some time after intake and diagnosis, the client is

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*Evaluation, National Joint OCD/SRS Demonstration Program in Child Abuse and Neglect, Berkeley Planning Associates, 1974-1977.

probably in the most resistant phase. Supportive and advocacy services are most successful at this stage, since the client is not likely to be ready to accept more therapeutic services. Concrete actions that directly affect the client's life, such as help in finding new housing or a day care center, go a long way not only toward improving the client's life, but also in developing the client's responsiveness to other services. Once the client is interested in the program, more therapeutically or educationally oriented services, either individually or in groups, are appropriate. During this receptive phase, the client should be prepared for the final phase of treatment termination. Termination, which means the reduction or cessation of services to the client, can be the most traumatic phase unless the client is prepared well in advance. Preparation includes reducing the dependence of the client on the service provider(s) and services.

It is not easy to implement any treatment program. Regardless of the amount of careful planning prior to the initiation of service delivery, unanticipated problems and situations will arise once services commence. Thus, a hasty change of plans when initial problems occur should be avoided. Once a set of treatment services has been decided upon, it would be well to work with the mix for some time (six months to a year) before deciding that the mix is inappropriate.

PART III

OPERATING

Careful planning is not only central to establishing a well-functioning child abuse/neglect service project but also central to operating an effective and efficient system. Throughout the project's life, complete records as to individual client progress, the distribution and effectiveness of services, and the project's operational costs will help projects keep track of their human and financial resources as well as their overall impact on clients. Such record keeping will provide early indications of a flaw in the system, allowing you to alter goals, program structure, or treatment strategies before substantial damage is done to a client or to the overall system. The following three chapters discuss the ongoing operations of case management, service monitoring, and cost monitoring and offer suggested practices in each area.

Chapter 7:

Case Management

Case management is best understood as a series of interconnected steps that frame the agency/worker/client relationship. In a child abuse and neglect agency, case management includes all the phases of service delivery, beginning with intake and diagnosis, through development of a treatment plan, management of service delivery, case termination, and follow-up. This process is graphically illustrated in Figure 7.1. Successful case management means continuity of service provision, rational decision making regarding treatment design, and execution and coordination among all service providers. Effective client participation, timeliness in moving clients through the process, and maintenance of an informative and useful case record are also vital to an efficient and effective client treatment. In this chapter we will review some of these essential practices which case workers as well as agency administrators might adopt to improve case management. The chapter concludes with a suggested evaluation of the case management process which you can apply to the process operating within your program.

Suggested Case Management Practices

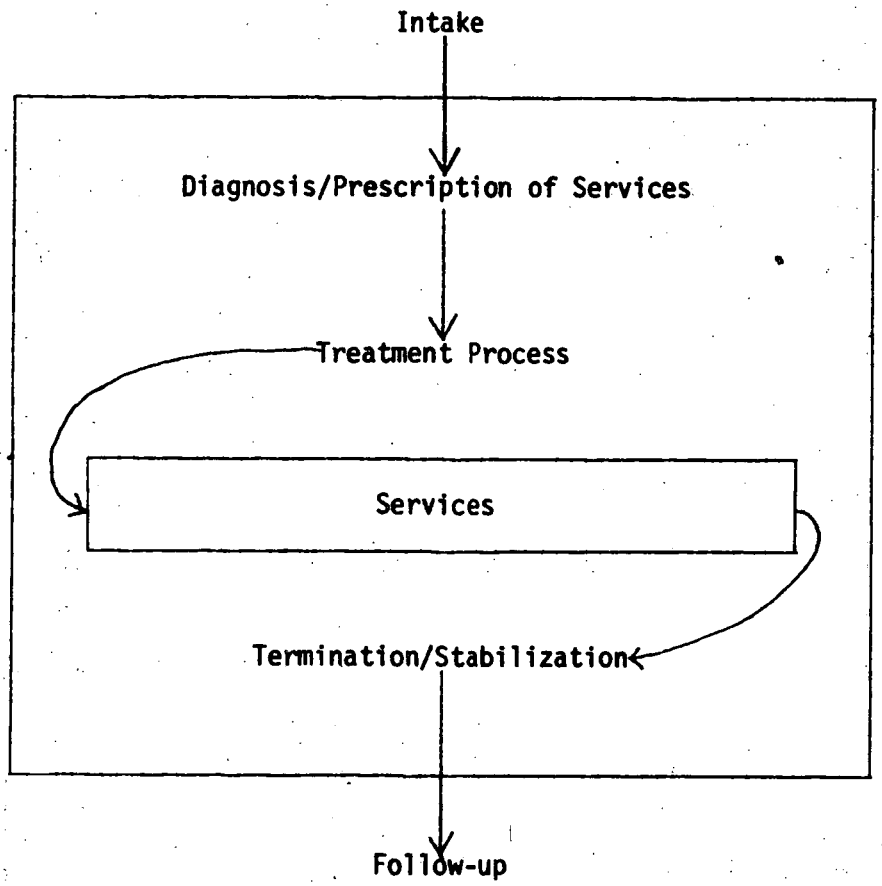
While there are many aspects to case management, those experienced in serving child abuse/neglect clients have suggested that the following case handling practices are essential for quality case management. It is important to remember that these practices reflect the ideal situation and need to be applied to the demands of your specific program. As such, some will appear more useful than others and some will be easier to adopt than others. All, however, should be considered desired management targets.

(1) Immediate Response: Child maltreatment cases need prompt response. Case managers who respond to incoming reports of crisis with a sense of urgency set the tone for all future interactions with the client. The expectation is that emergencies receive immediate response, while other prospective clients are contacted within 2-3 days. While inadequate referral information often makes tracking down reported cases difficult, it is critical abuse/neglect agencies maintain systematic response mechanisms. When all clients cannot be contacted immediately, criteria must be applied to quickly get in touch with those most in need.

(2) Obtaining Further Case Background: Good case management includes establishing lines of communication with other agencies and institutions reporting suspected cases. While complete background information is important for thorough intake, ongoing communication sets up linkages which serve

Figure 7.1

THE CASE MANAGEMENT PROCESS



to build trust and confidence between reporting services and the abuse/neglect agencies. Whether or not the reporting agency maintains a service association with the client in question, this linkage can be useful for future cases. Formal interagency agreements around case management encourage workers to open up and maintain communication, thereby strengthening service delivery.

(3) Develop Client-Centered Treatment Plan: Acceptable case management practices for abuse/neglect cases involve development of an individualized treatment plan for each client. Rather than non-specific service schedules based on cursory assessment, certain minimum information is necessary before a client-centered plan can be established. Setting up realistic treatment plans and agreements with clients most often requires at least two, if not more, contacts prior to a decision. This is not to suggest that services should not be provided before finalizing the treatment plan. Clearly, in emergency situations service provisions should not be delayed. However, long term, mutually agreed upon treatment requires time for a completed assessment and engagement of the client in a working relationship.

(4) Promptness in Treating the Client: Timely initiation of treatment services is critical to establishing a positive working relationship with the client and to protecting the child. If children are still in the home, it is dangerous to open a case for investigation and management and then delay or provide no treatment. If there are waiting lists or no services are available, then it is incumbent on the agency responsible for case management to provide some alternatives and actively seek implementation of new services.

(5) Use of Multidisciplinary Team Review: A multidisciplinary review team serves as a formal means for introducing a range of perspectives on diagnosis and treatment planning. These reviews are important for case management because a sole worker or even a single agency staff cannot be expected to know all there is about managing many of these complex cases. In addition, presenting cases to a multidisciplinary team encourages workers to thoroughly prepare their treatment plans and/or reassess their clients' progress. Because workers who do not use multidisciplinary review are missing helpful assistance and opportunities to explore other avenues of case management, it is suggested that efforts be made to make review teams more accessible and attractive to workers.

(6) Use of Case Conferences (Staffings): While other review practices, such as multidisciplinary teams or consultants, might be employed, it is important that client flowthrough be monitored. Case conferences are an effective mechanism for periodical reviews of a client's use of services and resources. They also provide an important support structure for workers, allowing for internal quality review of worker performance. Many workers are frustrated by the lack of input regarding their case handling and important decisions on such aspects as child placement and court action; case conferences can provide the necessary support.

(7) Use of Outside Consultants: Working with child abusing families is very challenging and difficult. Deciding to remove a child from his or her home; diagnosing the client, family, and home environment; and sorting through various treatment options often require special expertise and an outside perspective. A worker who effectively uses outside consultation indicates his or her awareness of the periodic need to turn to experts for assistance. For this reason, case managers need access to a range of consultants -- such as lawyers, doctors, psychologists, and other social workers -- to assist in sensitive problem solving. Despite limited budgets, agencies should make every effort to arrange for a panel of outside consultants and workers should be encouraged to use these resources.

(8) Referral for Services to Outside Agencies/Individuals: Many clients present multiproblems requiring assistance with financial, housing, mental health, and child care needs. Usually a single agency does not provide a full package of services, necessitating a coordinated approach among various agencies. Case managers must expect to arrange or help clients shop around for services provided elsewhere. The extent to which clients receive services from other agencies or individuals is one indicator of how well the client is being served by the program and the case manager.

(9) Communication with Outside Service Providers: Merely arranging for other services is not sufficient. A comprehensive treatment approach, covering all the client's needs, requires that there be ongoing communication among all providers serving the same client. Communication among those jointly serving a client is crucial in assuring continuity of care and in decreasing service duplication. Unless strongly fostered by formal coordination agreements, however, interagency communication unfortunately tends to be limited.

(10) Active Client Participation in Treatment Decisions: In working with clients, case managers, although a symbol of authority, try to motivate and encourage clients to respond to treatment intervention. In this context, workers often find it difficult to involve clients and elicit their participation. Client participation in their own treatment planning, however, might well be the prime motivating factor for them to accomplish their treatment goals. When clients have voiced their own needs and directed the development of their own treatment plans, they have a greater investment in working on these goals and are more likely to take responsibility for their success.

(11) Frequent Contact between Case Manager and Client: Frequency of case manager contact with a client is determined by the treatment plan, involving the degree to which the client needs to be supervised and the length of the treatment process. Actual case manager-client contact, however, is constrained by demands placed on the worker from other clients and administrative duties. With abuse and neglect cases, where the potential for crisis is high, routine interaction between client and case manager must be established and continued. Maintaining frequent contact with the client suggests that the case manager is monitoring the client's progress in a systematic manner. Case managers should seek ways to maximize ongoing contact with the client and supervisors should encourage regular meetings between client and worker.

(12) Longer Time in Treatment: Before placing a case into treatment, you should review it carefully, determining if ongoing supervision is really necessary. It is wasteful of both the client's and the case worker's time to set up a treatment plan only to have the case terminated in a few weeks. While the actual time in treatment would be expected to vary depending on the client characteristics, most child maltreatment cases need six or seven months of services before they are considered ready for termination. Short-term cases placed in a complex treatment program tend to be hastily handled, without rational, systematic procedures and practices. Referral to another agency is perhaps more appropriate for these cases. Such referrals also allow your case workers to focus on the more serious cases.

(13) Follow-up Contacts After Termination: The case management process does not end with case termination. Following-up after case closure, either by making a personal contact with the client or by contacting another agency still working with the client, is an important aspect of quality case management. Follow-up contacts with abuse/neglect cases can prevent new crises that might provoke reincidence. Many agencies, while exhibiting strong case management practices for open cases, are remiss in urging workers to make contact within a short period of time after termination. Such contact should be encouraged by the agency. It is the easiest, most efficient way to assure that no new problems have emerged which require further intervention.

Agency Level Supports for Quality Case Management

Agency administrators can also adapt measures to provide a foundation for good case management performance. Three key factors are:

(1) Continuity Between Intake and Ongoing Treatment: The field is currently divided on the advisability of intake units. Some argue that abuse and neglect cases need intake by specialized workers. They feel it is critical to distinguish between the investigatory role of an intake worker and the ongoing, supporting role of a treatment worker. However, others believe that a good worker can and should assume both intake and treatment responsibilities to ensure uninterrupted services and a sense of continuity with the client. The critical service feature from this perspective is continuity, which is most often effectively achieved when the same person handles intake and ongoing treatment. If intake units are staffed by experienced and well-trained people, and if the transfer of the client can be done smoothly, then the adverse effects of separate intake units are mitigated.

(2) Limited Turnover of Primary Case Managers: To ensure continuity of services, minimal transferring of clients from one case manager to another is advisable. The obvious exceptions to this are when the client and the worker are unable to establish a working relationship and when continued worker involvement with the client is interfering with treatment objectives. These major disruptions can be reduced in number by careful initial matching of workers and clients. Treatment supervisors and program administrators need to be sensitive to the case worker's feelings about a

client and his or her general work environment. Such sensitivity will allow administrators to offer assistance and support to case workers, thereby preventing burnout and subsequent resignation, the primary cause of case manager turnover.

(3) Smaller Caseloads: Within the confines of an agency's setting, administrators must actively seek to keep workers' caseloads at a manageable size, giving them time to carry out the essential steps of case management. Abuse/neglect cases demand more attention than welfare or other types of protective services cases. Consequently, smaller workloads (closer to 20 than 30 or 40) can positively affect the quality of performance by individual workers.

Evaluating the Adequacy of Case Management

Two complementary activities are necessary in order to determine whether an agency's case management practices are satisfactory. In addition to reviewing specific cases, administrators must review overall program procedures and policies that serve to enhance or detract from case management. The following is a checklist of questions which will help to assess if an agency is supporting implementation of good case management.

On intake:

- Have criteria been developed for determining which cases to accept?
- Are there agreements with other agencies regarding coordination of the investigation of incoming reports?

On diagnosis/prescription of services:

- Are the forms that workers are required to complete consistent with the information necessary for case decision making?
- Are consultants and/or a multidisciplinary review team available to workers for use in diagnosis and treatment planning?

On the treatment process:

- Does the agency have standards for minimum frequency of contact with clients?
- Are there standards for the format and scheduling of periodic case conferences?

On termination:

- Are there criteria for determining the timing and procedures for case termination?

On follow-up:

- Have policies and procedures been put in place for monitoring a client after termination?

On continuity/coordination:

- Have all means been taken to ensure minimal staff turnover?
- Are there methods for both formal and informal internal communication among staff?
- Have agreements with outside agencies been made to support referral for services?

On client participation:

- Has the agency specified procedures for client involvement in treatment plan decision making and execution?

On program ethics:

- Does the agency have provisions for confidentiality of records?
- Is informed consent obtained from all clients for treatment of children, for disclosing case information, and for obtaining information from other agencies?

On program priorities:

- Is there a standard for a minimum caseload size and is it followed?
- Does the program have a means for self-evaluating the quality of the case management process?
- Is staff time monitored to determine whether or not a disproportionate amount of time is spent on record keeping and general management rather than on client-related service provision?

It is crucial that actual cases also be reviewed in order to definitively determine the state of an agency's case management practices. A sample of cases should be selected (or all, if the agency is small) and abstracted. No case management assessment should depend solely on the workers' written records. Although a readable and useful case record

is one factor in quality case management, it cannot capture the gamut of the case management process. Therefore, it is recommended that queries regarding case handling be obtained both from the written record and from an interview with the primary case manager.

A suggested form for use in self-evaluation of case management is presented in Form 7.1. The first section, which determines facts of case handling, can be applied separately by people who are trained in the use of the instrument, but who are not necessarily experts in the provision of service delivery to clients. The information resulting from the data collection can then be compared to case management standards which either come from the field at large or have been developed earlier within the agency. Comparison of actual practice to norms or standards, such as those presented in this chapter, allows an agency to detect if there are areas in which practice deviates sufficiently to cause alarm. The entire form, which also includes a section for rating various aspects of case management, should be used by those experienced in abuse/neglect case management, as they are the ones who can be expected to best make peer judgments on the quality of performance.

Form 7.1

CASE REVIEW GUIDELINE

Client I.D. Number_____

Date of Review _____

Reviewer Name_____

Case is Terminated_____ Active _____

Primary Case Worker Name_____

Intake and Plan

1. Date initial referral received: _____
2. Date of first contact with client (any type): _____
3. Time between initial referral and first in-person contact with client:_____
4. Number of contacts with client prior to decision on treatment plan:_____

Treatment Process

5. Time between first contact with client and provision of first treatment service by project:_____
6. Have there been multidisciplinary team (MDT) reviews of this case?
7. How many times have outside consultants, other than MDT, been used on the management (not treatment) of this case?
8. Have there been case conferences or staffings of this case?
9. Approximate frequency of contact by case manager with client while in treatment:_____

Coordination of Case Information

10. Was there contact with the agency or individual who referred client to project?

11. Did this case manager do the intake on this case?

12. After intake, how many case managers have there been for this client?

13. (If more than one case manager): Why has there been more than one case manager?

14. How many people in this project (other than case manager) have provided direct treatment to this client?

15. Have any agencies (or individuals) outside of the project provided direct treatment to this client (while the client was in the project's caseload)?

16. How many contacts have there been, with other agencies or individuals from whom client received services, to discuss client's status and progress?

17. Which, if any, family members of the client have been involved in direct treatment at the project?

Termination and Follow-Up

18. Date case terminated (or stabilized):_____

19. How many follow-up contacts have there been with the client after case was closed (or stabilized)?

20. How many follow-up contacts have there been with other agencies working with the client after case was closed/stabilized?

Case Assessment by Manager

21. What is the case manager's assessment of the difficulty involved in handling this case, compared to other cases in the project's caseload?

22. What is the case manager's assessment of the degree to which the client is interested in treatment?

23. What is the case manager's assessment of the degree to which the client was responsive in treatment?

Record Contact

24. Is the following information adequately included in the record?

- circumstances of abuse/neglect incident
- family stress conditions
- interaction between child and client
- client's functioning on characteristics associated with abuse/neglect (self-esteem, attitude toward child, expression of anger, etc.)
- child's mental and physical health, and development status
- goals of treatment for the client
- the treatment plan
- client's progress during treatment
- services received by client

25. Reviewer Assessment of the Case: Based on interviews with case workers and review of the case records, what has been the quality of the agency's case management procedures (very poor, adequate, very good)?

- intake -- timing
- intake -- thoroughness
- intake -- helping approach
- record of critical information
- knowledge of critical information
- planfulness in case handling
- frequency of case manager's contact with client during treatment

- reassessment of case during treatment
- coordination of information from all providers
- goals: understandable, feasible, being worked on
- client opportunity to participate in case decisions
- if case terminated: appropriateness of decision to maintain case
- follow-up after termination
- supervision of case manager on the case
- rate the overall management of this case

Chapter 8:

Monitoring Treatment Activities

For many social workers, paperwork is their greatest headache. Certainly not all people dislike paperwork; some find it a welcome relief from working with clients. Others find record keeping helpful in objectively reflecting on their work. Whether one enjoys paperwork or finds it an anathema, social workers tend to agree that there should be less, rather than more, assigned. On the other hand, administrators and other management personnel view paperwork as an important source of information and statistics for validating program needs and activities. As a result, they tend to favor more record keeping, designing forms to meet their informational needs. Because administrators need different information than social workers normally collect, excessive paperwork requirements and a fragmented approach to record keeping often emerge within an agency's operations.

While workers tend to belabor paperwork duties, records do serve many valuable functions. They can serve as a coordinative mechanism for gathering and maintaining information relevant to clients, workers, and the agency. Records provide information on the client and his/her relationship with the case worker and other service providers involved in the case. They are a means for monitoring the client's progress and a method for supervisors to review the quality of their staff's work. Proper documentation for legal and other proceedings is maintained and a permanent record provides information needed by program administrators when evaluating the effectiveness of agency services. Records collected by the staff of a child abuse/neglect service project should strive to maximize these functions and minimize the case worker's "paperwork" burden. The remainder of this chapter discusses the kind and extent of the data those operating a child abuse/neglect program should maintain in order to maximize benefits for their system.

Information to be Maintained on Clients

Some form of case record should be maintained on every client served.* Several programs in the child abuse and neglect field currently maintain records on families rather than individuals. There are advantages to this approach if the program is truly serving the family as a unit. In such instances, the case worker is looking for changes in the family instead of

*In maintaining records on clients, programs must pay very careful attention to issues of privacy and confidentiality. While courts may have the right to subpoena client records, appropriate safeguards must be maintained to ensure that information about clients is available only to authorized individuals.

changes in the individual members of the family. However, family records do not always allow for careful monitoring of individual progress. For this reason, it is best for most programs to maintain complete information on each member of the family directly being served by the program in addition to its family overview records. In this way, individual progress and changes can be monitored without losing the total family picture.

Because records provide a coordinative link, it is advisable that there be one central location for case records. Workers' process notes, evaluation information, multidisciplinary and case conference reviews, a record of services received, medical records, and other relevant information need to be assembled in one place.

The information maintained on clients will vary from one program to another, depending on a program's own objectives as well as its responsibilities to other agencies. Still, there are certain types of information, discussed later in this section, that are minimum essentials. Maintenance of this minimum information will assist the primary worker in understanding the client's needs and how those needs are being met. It is not sufficient for the worker to carry this information in his or her head. Written information will ensure that (1) all other workers on a given case will know what is happening on that case; (2) if there is worker turnover, new workers will have access to critical information needed for continuity of services; and (3) the program has proper documentation for legal and other proceedings, and for service evaluations.

Historically, at least in the social work field, information on clients has been maintained in the form of narratives, written dialogues of what occurs on every contact with a client. Narratives are very time consuming, and often difficult to use for reference, but they are not without value. When designing case record formats, programs should attempt to incorporate some narrative reports to cover the minimum information requirements outlined below. At the same time, programs should be identifying ways of recording other information in summary formats, or at least more graphically, to facilitate reference and review.

Minimum information to be maintained on adult clients: The case record should include certain background or demographic information on the case as well as a case history. This information will be useful in designing the initial service plan and for reference at later points in the treatment process. Form 8.1 is a sample intake form that might be used to record this information. This form should be tailored to suit a program's special needs, keeping in mind other forms a program may be required to complete.

In addition to the background statement, the case record should also include a specification of treatment goals and the treatment plan developed in conjunction with these goals. Such goals and treatment plans should be reviewed periodically and changes in them or progress toward them recorded.

Form 8.2 provides an example of how goals and treatment plans might be recorded. This form could be completed at intake and at regular intervals thereafter. The specific categories used in a form such as this can vary, depending on the types of clients seen by the program and their range of problems. (This particular list reflects the characteristics that, according to the child abuse and neglect literature, are thought to be related to the potential for abuse or neglect.) A section for recording information on recurrence of abuse or continuing neglectful behaviors could also be included in this form.

The case record should also include information on the services the client is receiving, from both the program and other community agencies. Workers may want to maintain daily or weekly logs on their clients. Recording such information will help the treatment worker be aware of what is happening to the client. Form 8.3 is a sample service summary, on which daily or weekly logs could be tallied by months both by type and by frequency. Programs may wish to use brief narratives to accompany this summary information.

Finally, information relating to termination and any follow-up contacts with the client after termination should be recorded in the case record. Included with this information should be a report on what was accomplished during treatment, the reasons for termination, and specific plans for either follow-up by the program or referral to other agencies. In addition, each follow-up contact with the client should be noted in the record, with comments on the client's progress.

Minimum information to be maintained on children: Certain background and case history information should be included in the child's record. Form 8.4 is an example of what might be included on an intake form. Depending on the focus of the program, the detail of the case history can be expanded or reduced.

The case record should also include information regarding the primary problems that are to be the focus of treatment, treatment goals, and the treatment plan. Problems can be recorded within general areas of child development such as physical characteristics and growth patterns, socialization skills and behavior, cognitive and language development, motor skills development, and interaction patterns. As tests are administered, results should be recorded. Form 8.5 is an example of the format in which this information could be maintained. Information on recurrence of abuse and neglect can also be recorded.

The case record should include information on the type and frequency of the services the child is receiving. A summary format, such as that depicted by Form 8.6, is suggested, but narratives accompanying these data could be helpful.

Finally, the case record should include information relating to termination and any follow-up contacts with the child. The record should show what was accomplished during treatment, the reasons for termination, and specific plans for either follow-up by the program or referral to other

agencies. Also, each follow-up contact with the child after termination should be noted in the record, with comments on the child's progress.

Some Comments and Cautions

Besides the information specified above, there are many events, observations, and comments that programs will find essential for inclusion in a case record. We have attempted to specify the minimum needs, which would take a minimum of the workers' time to record, and which are easy for a program to analyze. Beyond this minimum, program goals and requirements should dictate what is necessary and useful. The case record should be viewed primarily as a tool for workers to meet client needs. Many programs will be completing forms on clients to meet local, state, and federal requirements.

The information contained in the forms suggested in this manual summarize the situation of the child and the parents, as well as the program's activities to help them. Such a summary can provide a quick overview of each case without forcing someone to read through a bulky case history to find salient or important information. The information in these forms can also be used to evaluate the effectiveness of the program, the progress of a treatment plan, and the performance of individual workers. If these forms are used, an effort should be made to avoid duplicating other existing forms. If other forms must be filled out for reimbursement purposes, a Central Registry, or various other social service information systems, an attempt should be made to devise one uniform form to comply with all these requirements; usually the information is similar, if not identical.

Form 8.1

ADULT CLIENT INTAKE FORM

1. Client's Name:_____

   Address:_____

   Home phone:_____

   Office phone:_____

2. Mate's name:_____

3. Date Report Received: ___/___/___ (mo / day / yr)

4. Source of Referral:

   Name:_____

   Agency:_____

   Phone number:_____

5. Reason(s) for Referral (brief description of incidents prompting the report):

6. Case Status:

___ Abuse established	___ Neglect established
___ Strong indication of abuse	___ Strong indication of neglect
___ Weak indication of abuse	___ Weak indication of neglect
___ Indication of potential abuse	___ Indication of potential neglect

7. Severity of Case:

For Abuse	For Neglect
___ Death due to abuse	___ Death due to neglect
___ Severely injured	___ Severely neglected
___ Moderately injured	___ Moderately neglected
___ Mildly injured	___ Mildly neglected
___ Emotional abuse	___ Emotional neglect
___ Sexual abuse	___ Failure to thrive
___ Potential abuse	___ Potential neglect

8. Person(s) identified as responsible for abuse/neglect (check all that apply):

   ___ Mother
   ___ Mother substitute
   ___ Father
   ___ Father substitute
   ___ Other (specify)_____
   ___ Unknown

9. Previous record/evidence of abuse/neglect by perpetrator(s) (check all that apply):

   ___ Record/evidence of abuse
   ___ Record/evidence of neglect
   ___ No record/evidence of abuse and neglect

   Briefly describe the previous incident(s):

10. Legal actions taken to date (check all that apply):

    ___ Case reported to legally mandated agency(ies)
    ___ Court hearing held
    ___ Court supervision, child at home
    ___ Child removed from home temporarily (1 day to 2 weeks)
    ___ Child placed in foster or other longer term care
    ___ Child removed from home permanently
    ___ Criminal action against abuser/neglector
    ___ Other (specify)_____

11. Other agencies interested in case:

    Name_____
    Agency_____
    Phone number_____
    Explain_____

    Name_____
    Agency_____
    Phone number_____
    Explain_____

    Name_____
    Agency_____
    Phone number_____
    Explain_____

HOUSEHOLD CHARACTERISTICS

12. Date of birth and sex of children in family

Child involved in abuse/neglect:

Name	Date of Birth	Sex	Custody Status
	/ /		
	/ /		
	/ /		

Other children in family:

	/ /		
	/ /		
	/ /		

13. Adult household member(s) (enter the number of individuals in each category in the appropriate space):

___ Natural mother
___ Mother substitute
___ Natural father
___ Father substitute
___ Grandparent
___ Other relative
___ Other(s)

14. Approximate ages of parent(s)/parent substitute(s):

___ Mother/mother substitute
___ Father/father substitute

15. Marital status of parent(s)/parent substitute(s):

___ Legal marriage
___ Consensual union
___ Never married
___ Divorced/separated
___ Widow/widower
___ Marriage partner temporarily absent
___ Marriage partner permanently absent
___ Unknown

16. Level of education completed:

Mother/ substitute	Father/ substitute	
		No high school degree
		High school degree
		Some college/vocational training
		College graduate
		Post graduate

17. Ethnicity/race of parent(s)/parent substitute(s):

Mother/ substitute	Father/ substitute	
		Caucasian
		Black
		Spanish surname
		American Indian
		Other (specify)_____

18. Estimated yearly family gross income:

From employment $_____
From public assistance _____
From other sources _____
Total $_____

19. Employment of adult household members:

Name	Occupation	Employment Status

CLIENT'S NEEDS

20. Primary problems of client which help explain the actual or potential abuse/neglect situation (check all that apply):

___ Marital problems
___ Job related difficulties
___ Alcoholism
___ Drugs
___ Health problem (physical)
___ Mental health problem
___ New baby in home
___ Argument/physical fight
___ Financial difficulties
___ Mental retardation of parent
___ Pregnancy
___ Heavy continuous child care responsibility
___ Physical abuse of spouse
___ Recent relocation
___ Overcrowded housing
___ History of abuse as child
___ Normal method of discipline
___ Social isolation
___ Other (specify)
_____

21. Elaborate on client's particular problems:

Form 8.2

ADULT CLIENT'S GOALS OF TREATMENT AND TREATMENT PLAN

PROBLEM AREA	GOAL(S)	SERVICES PLANNED	SERVICE PROVIDER(S)
General Health:			
Personal Habits (drugs, alcoholism):			
Stress From Living Situation:			
Housekeeping:			
Child Care:			
Sense of Child as Person:			
Behavior Toward Child:			
Awareness of Child Development:			
Isolation:			
Ability to Talk Out Problems:			
Reactions to Crisis Situations:			
Way Anger is Expressed:			
Sense of Independence:			
Understanding of Self:			
Self-Esteem:			
Other:			

Form 8.3

SERVICES PROVIDED TO ADULT CLIENT

Client's Name_____

NOTE: Be sure to record amount of service provided, using units specified under specific service (e.g., number of hours, number of sessions, etc.). "Project" = services provided to client by the project and "Other" = services received by the client from another agency.

SERVICE CATEGORIES Month →	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other
Psychological or other testing (no. times)												
Case Review by Diagnostic Team (no. times)												
Social Work Counseling (no. contacts)												
Parent Aide/Lay Therapist Counseling (no. contacts)												
Individual Therapy (no. hours provided)												
Group Therapy (no. sessions attended)												
Parents Anonymous (no. sessions attended)												
Couples Counseling (no. hours provided)												
Family Counseling (no. hours provided)												
Alcohol Counseling (no. times)												
Drug Counseling (no. times)												
Weight Counseling (no. times)												
Family Planning Counseling (no. hours provided)												
24-Hour Hotline (no. of calls)												
Crisis Intervention (no. contacts)												
Child Management Classes (no. sessions attended)												
Job Training (no. sessions attended)												
Homemaking (no. times)												
Medical Care (no. visits)												
Residential Care for Child (no. nights)												
Day Care (no. visits)												
Crisis Nursery (no. visits)												
Welfare Assistance (Yes or No)												
Auxiliary Services: babysitting (no. times)												
Auxiliary Services: transportation (no. rides)												
Emergency Funds (no. dollars)												
Other (specify)												

Form 8.4

CHILD INTAKE FORM

Name_____

Address_____

Phone_____

Parents_____
Mother

_____
Father

Date Report Received ___/___/___
mo day yr

Date of Birth ___/___/___
mo day yr

With whom is child living?_____

Who has legal custody of child?_____

_____

School & District_____

CASE HISTORY

Description of injury/neglect:

Explanation of how it occurred:

Severity of Case:

For Abuse	For Neglect
___ Death due to abuse	___ Death due to neglect
___ Severely injured	___ Severely neglected
___ Moderately injured	___ Moderately neglected
___ Mildly injured	___ Mildly neglected
___ Emotional abuse	___ Emotional neglect
___ Sexual abuse	___ Failure to thrive
___ Potential abuse	___ Potential neglect

Legal actions taken to date: (check all that apply)

___ Case reported to legally mandated agency(ies)
___ Court hearing held
___ Court supervision, child at home
___ Child removed from home temporarily (1 day to 2 weeks)
___ Child placed in foster or other longer term care
___ Child removed from home permanently
___ Criminal action against abuser/neglector
___ Other (specify)_____

Sex:

___ Male ___ Female

Ethnicity/Race:

___ White ___ Black ___ Spanish surname
___ American Indian ___ Other (specify)_____

Special Characteristics of Child:

___ Premature
___ Mentally retarded
___ Product of multiple birth
___ Emotionally disturbed
___ Adopted/foster child
___ Unwanted pregnancy
___ Unliked child

Previous record/evidence of abuse/neglect: (check all that apply)

___ Record/evidence of abuse
___ Record/evidence of neglect
___ No record/evidence of abuse and neglect

Explain:

Form 8.5

CHILD'S GOALS OF TREATMENT AND TREATMENT PLAN

AREA	PROBLEMS NOTED	GOALS	SERVICES PLANNED	SERVICE PROVIDER(S)
Physical Characteristics and Growth Patterns	Exam results:			
Socialization Skills and Behavior	Test results:			
Cognitive/ Language Development	Test results:			
Motor Skill Development	Test results:			
Interaction Patterns with Parents/Other Family Members				

Form 8.6

SERVICES PROVIDED TO CHILD BY PROGRAM OR OTHER AGENCY

Child's Name_____

NOTE: Be sure to record amount of service provided using units specified under specific service (e.g., no. hours, no. sessions, etc.)

SERVICE CATEGORIES — Month →	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other
Day Care (no. hours)												
Therapeutic Day Care (no. hours)												
Play Therapy (no. sessions)												
Individual Therapy (no. sessions)												
Medical Care (no. times)												
Psychological Testing (no. tests)												
Speech or other Specialized Therapy (no. sessions) SPECIFY TYPE_____												
Foster Care (no. days)												
Residential Care (no. days)												
Crisis Nursery (no. days)												
Other (specify) _____												
Other (specify) _____												
Other (specify) _____												

Chapter 9:

Monitoring Program Resources

Program managers should know how the program's funds are being spent, how staff members are spending their time, and the total and unit costs of different program activities. In addition, the program manager should be aware of how resource allocations have changed over time and whether or not there are less expensive ways of carrying out the program's activities. Detailed cost information can help increase program efficiency, improve staff assignments, ensure priority areas are receiving resources, and plan future activities more effectively and efficiently. This chapter serves two purposes. First, it presents a method for monitoring costs by services. Second, it includes cost estimates for certain service combinations and illustrates how those starting a local child abuse/neglect project can use the data as guidelines in establishing specific treatment strategies.

Determining Costs by Program Category

In traditional cost accounting, program dollars are accounted for by line items such as rent, telephone, salaries, durable equipment, and purchased services. Although this method for cost accounting provides information on how money is spent in terms of the overall program, and is often necessary for administrative purposes, it does not provide information on discrete program activities. It also does not tell a manager how staff members are spending their time nor does it take account of the program's donated resources. In resource accounting by program activity, all of a program's resources, whether paid for or donated, are considered in terms of specific, discrete program activities. This approach forces a program to account for all of its resources in a functional manner.

Very simply, resource accounting by program activity consists of the following steps:

- identifying all discrete program activities;
- identifying all resources;
- determining the time period to be covered;
- determining personnel time allocations by program activities;
- determining non-personnel resource allocations by program activities;
- determining purchased service allocations by program activities;

- calculating expenditures by program activities; and
- determining how many units of each service were provided and dividing to obtain the unit cost of each service.

These steps, elaborated below, do not require much time, nor any special set of skills. They easily merge with any overall accounting system you adopt for your project.

(1) Identifying All Discrete Program Activities: A program's discrete activities include specific services such as group therapy or community education and activities that provide necessary support for services, such as general management and staff training. Tasks that produce services, such as writing letters or talking on the telephone, do not fall into this category because they are not unique to any particular service. The activities you list should be clearly distinguishable from each other.

Because every program will have its own unique set of services, no master list can be developed which would allow each program to check the appropriate service categories. Table 9.1, however, does present a list which illustrates the range of activities which might be found in a local child abuse/neglect project.

(2) Identifying All Resources: All of the program's resources, whether paid for or donated, should be compiled into a single file. Some of these resources may be dollars from federal, state, or local agencies while other resources will be personnel, paid or volunteer, regular or part-time, consultant or advisory. Finally, program resources may include donated items such as reduced rent or office equipment. It is important to distinguish donated from paid-for resources and, where possible, to estimate the value of donated resources.

(3) Determining the Time Period to Be Covered: Before breaking down your resources by program activities, you need to determine what time period the resource accounting will cover. Although any time period can be chosen, it is generally best to use one-month periods. This will probably correspond to the program's current accounting procedures and will be long enough to allow for monitoring of the full array of program activities. Ideally, one would undertake the resource accounting every month as a routine part of program management. However, it is generally sufficient to conduct this more detailed accounting once per quarter.

(4) Determining Personnel Time Allocations: The fourth step involves determining how each staff member spent his or her time during the accounting time period, in relation to program activities. The salary or imputed salary can then be distributed accordingly. It is important to do this for every person who regularly contributes to the program, whether paid or not. For those not paid by the program, estimates of what they would have been paid (what their time was worth) should be made.

Table 9.1

POSSIBLE CHILD ABUSE AND NEGLECT SERVICE PROGRAM ACTIVITIES

Project Operations:	Staff development and training Program planning General management Rest and recuperation
Community Activities:	Prevention Community education Professional education Coordination Legislation and policy Technical assistance and consultation
General Casework Activities:	Outreach Intake and initial diagnosis Case management and ongoing case review Court case activities Multidisciplinary team case reviews Follow-up
Treatment Services to Parents:	Crisis intervention during intake Individual counseling Parent aide/lay therapist counseling Couples counseling Family counseling Alcohol, drug, and weight counseling 24-hour hotline counseling Crisis intervention Individual therapy Group therapy Parents Anonymous Parent education classes
Treatment Services to Children:	Day care Residential care Child development program Play therapy Special child therapy Crisis nursery
Treatment Services to Families:	Residential care Family therapy
Support Services to Families:	Homemaking Medical care Babysitting/child care Transportation Emergency funds Psychological and other testing Family planning counseling Advocacy with legal problems Advocacy with income/employment problems Advocacy with housing problems

The easiest way to determine personnel resource allocations is to have each person working on the program keep track of his or her time on a daily basis, as suggested by Form 9.1. At the end of the given time period, tally how many hours a given individual worked on the different program activities. Then allocate the person's hourly salary and fringe benefits or imputed salary among program activities, as indicated by the proportions of time. If overtime is paid, the extra payments should be allocated to the proper activity. Tally the allocations for all personnel for each activity to establish total personnel expenditures.

The information collected on how staff members spend their time is beneficial to program managers and staff members, even if dollar values are not ascribed to it. One can sum the number of hours all staff members spent on each of the different program activities to determine how the staff as a group allocate their time. Or, one can group staff members according to their different roles (for example, regular staff, volunteer, consultants) and determine how these different groups contribute to the program.

(5) Determining Non-Personnel Resource Allocations: All non-personnel resources also need to be allocated to specific program activities. Identify all non-personnel expenditures, rent, telephone, printing, and durable equipment (such as office furniture) and record how much was spent on each (or if the item was donated, how much it was worth) in the manner indicated by Form 9.2. Then estimate how each expenditure should be allocated across program activities. For example:

> If $200 were spent during the month on printing and 50% of the printing was for community education activities, 30% for research instruments, and the remainder for client forms, allocate $100 to Community Education, $60 to Research, and $40 to Case Management.
>
> If $800 were spent on rent during the month and the office space is equally occupied by the day care program, the case workers, and administrative and research staff, allocate $200 to Day Care, $200 to Case Management, $200 to General Administration and $200 to Research.

These non-personnel expenditures will probably be a small portion of the total budget. Therefore, while accuracy is important, precision in allocating these costs is not essential. Instead, allocations should be made to the nearest 5-10%. Once all of these non-personnel expenditures have been allocated, expenditures can be summed to determine the total non-personnel expenditure for the given activity.

(6) Determining Purchased Service Allocations: It is quite possible that your project will not see the need to purchase services from outside sources. You may prefer to deliver the service directly to your client or refer the client to an appropriate agency. If, however, you do decide to purchase services, such as homemaking, day care, or actual direct treatment, the cost of such purchases will need to be allocated to one of your discrete program activities.

(7) Calculating Expenditures by Activities: Having allocated all costs by program activity, you can now determine the total expenditures for each different program activity. This is done simply by summing the calculated expenditures determined for personnel, non-personnel, and purchased services for each activity. This will result in important management information on how all program resources were utilized during the time period and what different program activities cost. A program manager may wish to convert these data into percents rather than raw dollar figures, allowing for easier comparisons over time.

(8) Determining Unit Costs of Services: In addition to understanding what it is costing a program to offer various services, a program manager will want to know what the unit costs of different services are. For example, how much does it cost to provide one day of day care to one child? Or, what does one case review by the multidisciplinary team cost?

There will be several program activities for which it will be inappropriate to determine unit cost. General management and research are two obvious examples. However, it is possible and desirable to determine unit costs for all direct services to clients. By studying changes in unit costs over time, the program manager can determine the efficiencies within the program. For example, assuming that the quality of the service remains unchanged, if the unit cost of a service declines over time as the number of clients using the service increases, a program is said to have "service economies." In other words, the program can increase its service provision to clients without significantly increasing its costs or reducing service quality.

In order to calculate unit cost it is necessary to determine how many units of a given service were offered during the time period and divide that number into the service's total cost. Form 9.3 suggests a format for doing this and possible unit measures. Information on units of service provided may be maintained on individual cases using a form such as Form 8.3 presented in Chapter 8.

While the above accounting procedure is useful for comparing the costs and effectiveness of different service strategies, its primary use is in program planning. Not only does the process produce cost data against which individual programs can assess their own efficiency, it also provides the basis for designing a program's structure and budget. In the remainder of this chapter, the following issues are briefly discussed: (a) determining the allocation of project resources; (b) methods to enhance project economy and efficiency; and (c) the costs associated with alternative treatment models.

Determining the Allocation of Project Resources

Program planners can assume that most programs will utilize about 40% of their budgets on overhead functions including staff development and training, program planning and review, and general management. An additional 10% or more will be used for general case management and case

review (including record keeping). If these indirect costs are incorporated into the costs of other program activities, it can be expected that most direct service programs, once operational, will spend about 75% of their budget on direct client service activities and an additional 25% on community-oriented activities. In starting a program, you should expect some shifts in your budget allocations during the first six months. New programs have been found to initially spend a substantially greater proportion of their budget on general case management functions (i.e., implementing a system for case management) and proportionately less time on community activities.

Methods to Enhance Project Economy and Efficiency

There are a number of things cost-conscious planners and program managers can do to maximize the value of each program dollar. First, because of the current public concern about and commitment to problems of child abuse and neglect, programs can encourage volunteer participation in service delivery. Carefully cultivating this resource might expand your program's budget by at least 10%. Second, the unit costs of group-oriented services are lower than individual services and the differences have been found more dramatic as higher volumes of group services are offered. Thus, cost-conscious program planners and managers might consider building more group services into their program designs. Finally, a program's management and organizational features can be designed to enhance efficiency. Examples of this include larger staff sizes, smaller caseload sizes, fewer supervisory positions, and greater job clarity.

The Costs of Alternative Treatment Models

Most likely, no two services provided by a child abuse/neglect project will have identical unit costs. Maintaining a residential treatment facility is clearly more costly than providing a 24-hour telephone hotline. In developing its treatment strategy, a project will have to consider the costs of individual services, compiling a package which meets client needs within existing budget limitations. To assist in this process, cost estimates were developed for various services, based on the experiences of existing child abuse/neglect projects. These figures are presented in Table 9.2.

As discussed in Chapter 5, a child abuse/neglect project can adopt any of a number of program models depending on the needs of its potential clients, the size of its budget, and the resources and limitations of the local community. For the purpose of demonstrating cost differences, treatment strategies and cost estimates for five different program models were developed. The models include an individual counseling project, a lay therapy project, a group treatment project, a children's program, and family treatment project.

In all of the models, it was assumed the following basic services were provided: intake and initial diagnosis; case management and regular review; crisis intervention; multidisciplinary team case reviews; court case activities; and follow-up. In a caseload of 100 clients, it can be assumed

Table 9.2

ESTIMATED ANNUAL COST PER CLIENT TO DELIVER SERVICES*
AND ANNUAL VOLUMES OF UNITS

Service	Annual units/clients		Approx. annual cost/client
Intake and initial diagnosis	Intake process	Over 2 mo.	$ 160
Multidisciplinary team case review	Reviews	2	110
Crisis intervention	Contacts	26	360
Court case activities	Cases	Over 3 mo.	380
Individual counseling	Contact hours	52	770
Individual therapy	Contacts	52	1,110
Parent aide/lay therapy counseling	Contact hours	52	380
Couples counseling	Contacts	52	880
Family counseling	Contacts	52	1,560
Alcohol or drug counseling	Person sessions	52	390
24-hour hotline	Calls	78	590
Group therapy	Person sessions	52	550
Parents Anonymous	Person sessions	52	300
Parent education classes	Person sessions	20	190
Day care	Child sessions	260	2,020
Residential care	Child days	90	3,400
Child development program	Child sessions	260	5,600
Play therapy	Child sessions	104	1,230
Special child therapy	Contacts	52	2,800
Crisis nursery	Child days	14	500
Homemaking	Contacts	30	680
Babysitting/child care	Child hours	104	370
Transportation/waiting	Rides	104	900
Psychological and other testing	Person tests	2	75
Follow-up	Person follow-ups	2	50

*Cost per client estimates include indirect costs such as general management, staff development and training, and case management and regular review.

that all clients will receive intake and initial diagnosis over a two-month period, ongoing case management, semi-weekly crisis intervention contacts after intake, and two follow-up contacts. Approximately 25% of a program's caseload would receive two multidisciplinary team reviews and about 10% would require court case intervention extending over three months. This basic service package would require an annual budget of roughly $60,000. While this basic model lacks any "ongoing treatment or therapeutic services," it is a close approximation of that offered in many of our public protective service agencies. Table 9.3 displays the annual costs associated with these basic services, as well as the budget supplement for each additional service provided by the model project.

The INDIVIDUAL COUNSELING MODEL would supplement the basic service package with a weekly counseling contact for each client, as shown in Figure 9.1. The annual cost of this model is close to $137,000 for 100 clients, or $1,370 per client. In contrast, the LAY THERAPY MODEL, substituting a weekly lay therapy contact for the individual counseling contact and including a weekly Parents Anonymous session for about a quarter of the caseload, would require an annual budget of roughly $105,500, or only $1,055 per client. Following the philosophy underpinning the lay therapy concept of providing more frequent contact with the client for longer duration, the weekly contacts could double in the lay therapy model and raise the annual program cost to $143,000, closely approximating the Individual Counseling Model.

The GROUP TREATMENT MODEL would augment the basic service package with group therapy once a week for half of the clients, a series of parent education classes for all clients, and weekly individual counseling for about a quarter of the clients. Such a treatment program would require an annual budget of roughly $127,000, or $1,270 per client.

A model CHILDREN'S PROGRAM would add to the basic services a daily child development program for an average of one child in each client family and special child therapy once a week for about 10% of them. This amounts to an extremely costly program model at $650,000 per year, or $6,500 per child. The FAMILY TREATMENT MODEL supplements the children's program with weekly individual counseling for one parent and weekly sessions of either family counseling or group therapy. The annual budget for such a program would exceed $800,000, or $8,000 per family.

In addition to the basic treatment models proposed, several ancillary services, such as babysitting, transportation, and psychological tests, may be offered to a subset of a project's clients. If one assumes that 25% of the 100 client caseload in each of the treatment models would receive these services, the annual budgets would increase by approximately $34,000. The impact of providing daily day care sessions for at least one child in each family escalates the program costs by approximately $2,000 per child, or $200,000.

Since the unit cost figures used to calculate the preceding estimates included the overhead expenses of project operations and case management,

Table 9.3

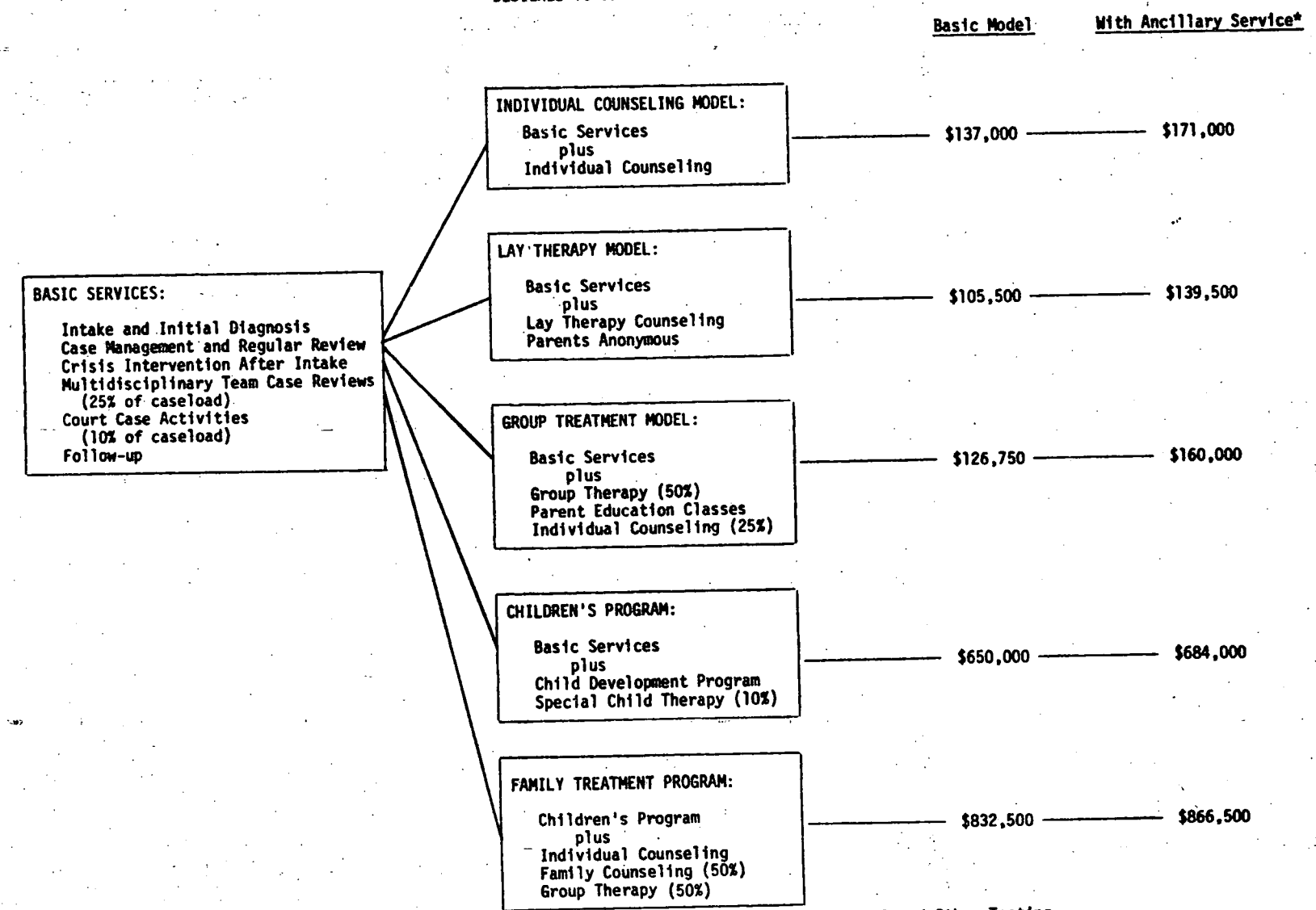
ESTIMATED ANNUAL SERVICE STRATEGY COSTS

		Annual Cost for 100 Clients
Basic Services:	Intake and Initial Diagnosis Case Management and Regular Review Crisis Intervention After Intake Multidisciplinary Team Case Reviews (25% of caseload) Court Case Activities (10% of caseload) Follow-up	$ 60,000

If supplemented with:	Then, add to annual costs:
Individual Counseling	$ 77,000
Parent Aide or Lay Therapy Counseling	28,000
Parents Anonymous (25%)	7,500
Group Therapy (50%)	55,000
Parent Education Classes	20,000
Child Development Program	560,000
Special Child Therapy (10%)	30,000
Family Counseling (50%)	78,000
Babysitting (25%)	9,000
Transportation (25%)	23,000
Psychological Testing (25%)	2,000
Day Care	200,000

Figure 9.1

ESTIMATED PROGRAM COSTS OF THREE ALTERNATIVE SERVICE MODELS
DESIGNED TO SERVE 100 CLIENTS



*Ancillary services include Babysitting/Child Care, Transportation/Waiting, and Psychological and Other Testing.

the annual budgets already include indirect costs. Most projects, however, also will provide substantial community activities; in fact, 25% of an average program budget is typically expended on prevention, community and professional education, coordination, and legislation and policy activities. These services are essential for ensuring adequate interface between a project and the rest of the community. If one assumes, therefore, that the budget estimates provided in Figure 9.1 comprise 75% of the total annual budget, the costs of the different models would range from less than $200,000 to well over a million dollars a year.

A further cost consideration in estimating budgets for alternative treatment strategies is that of the sponsorship under which the program functions. Analyses have revealed that several services delivered within Child Protective Services agencies are substantially more costly per unit than when delivered in other agency settings. On average, if a service program is housed in a Protective Services department rather than a private agency, the service costs should be increased by a factor of about 10%. In addition, projects should also consider inflation rates and local wage and price scales when estimating current and future costs.

Form 9.1

TIME ALLOCATION

Instructions

1. For the selected components on which you spend time, please enter the number of hours spent each day.
2. The hours need not sum to any particular total and should not include any part of lunch, time off, etc.
3. This form should be filled by or for all persons who work in any regular capacity directly for the program.

Day of Month →	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Community and Professional Education																
Coordination																
Technical Assistance and Consultation																
Program Planning and Development																
General Management																
Project Research																
Staff Development and Training																
Direct Services to Clients: Intake and Initial Diagnosis																
Case Management and Regular Review																
Court Case Activities																
Psychological and Other Testing																
Multidisciplinary Team Case Review																
Individual Counseling																
Couples Counseling																
24-Hour Hotline Counseling																
Group Therapy																
Parent Education Classes																
Crisis Intervention																
Day Care																
Crisis Nursery																
Homemaking																
Medical Care																
Babysitting/ Child Care																
Transportation/ Waiting																

Form 9.2

NON-PERSONNEL EXPENDITURES

Instructions

1. Enter all non-personnel expenditures for the month.
2. Determine how each was utilized in relation to program activities.

Item →										
Payment This Month →										
	%	$	%	$	%	$	%	$	%	$
Community & Professional Education										
Coordination										
Technical Assistance & Consultation										
Program Planning & Development										
General Management										
Project Research										
Staff Development & Training										
Direct Services to Clients: Intake & Initial Diagnosis										
Case Management & Regular Review										
Multidisciplinary Team Case Review										
Individual Counseling										
24-Hour Hotline Counseling										
Group Therapy										
Parent Education Classes										
Crisis Intervention										
Day Care										
Crisis Nursery										
Homemaking										
Medical Care										
Babysitting/Child Care										
Transportation/Waiting										

Form 9.3

COSTS OF UNITS OF PROJECT SERVICES

Instructions

1. For each selected service provided by the project, indicate total quantity provided this month.
2. Divide number of units into total cost of service to determine unit cost.

SERVICE	UNITS	QUANTITY	COST PER UNIT
Intake & Initial Diagnosis	Intakes		
Case Management & Regular Review	Avg. Caseload This Mo.		
Court-Case Activities	Cases		
Psychological & Other Testing	Person Tests		
Multidisciplinary Team Case Review	Reviews		
Individual Counseling	Contacts		
Couples Counseling	Contacts		
Family Counseling	Contacts		
24-Hour Hotline Counseling	Calls		
Group Therapy	Person Sessions		
Parent Education Classes	Person Sessions		
Crisis Intervention	Contacts		
Day Care	Child Sessions		
Crisis Nursery	Child Days		
Homemaking	Contacts		
Medical Care	Visits		
Babysitting/Child Care	Child Hours		
Transportation/Waiting	Rides		

PART IV

MAINTAINING

The long-term effectiveness of your project will depend on your maintaining a sound system, both internally and externally. Within your agency, worker opinions, management processes, organizational structure and community environment will all interact in ways which can be supportive or destructive to your staff. Avoiding worker "burnout," one of the most common dilemmas facing child abuse and neglect service projects, can be accomplished by following clear and well-developed procedures in each of these areas. These procedures are outlined in Chapter 10. Maintaining close ties with other local agencies concerned with child abuse is also critical for a well-functioning program. Procedures for working with the rest of the community are discussed in Chapter 11. The final chapter of this manual summarizes all of the recommendations made in previous chapters, weaving in results from a three-year evaluation of the 11 federally funded child abuse and neglect demonstration projects. As stated frequently throughout this manual, the critical principles governing the design and development of your project come first from your own community. The practices suggested here are meant only as guidelines, not as hard and fast rules.

Chapter 10:

Avoiding Worker Burnout

Once you have established a program which reflects the needs of your community in its goals and objectives and effectively serves its target population through an effective and efficient service delivery system, you will be faced with the difficult task of maintaining it. Start-up problems and case management difficulties will give way to several new dilemmas as the novelty of your program fades away. Throughout the life of your program, worker "burnout" must continuously be avoided. Allowing this condition to develop within your program most certainly will cripple your ability to adequately serve those in need. As with most of the difficulties discussed earlier, worker burnout has warning signs which indicate a need for intervention long before the problem becomes dangerous to your overall operations. This chapter identifies some of these early warning signs and offers suggestions on how to structure your project so as to avoid serious complications.

The Cost and Causes of Worker Burnout

"Burnout" is a major problem in social service fields affecting workers' mental health, quality of service delivery, and overall agency performance. Workers afflicted with "burnout" develop a cynicism regarding the meaning and purpose of their work with clients and are no longer sure that the time and energy needed to solve human problems is worth the effort. Human costs associated with burnout are many and varied. Clients of burned-out workers are likely to receive less service and to be depersonalized. Burned-out workers suffer physical and emotional ills such as flu, viruses, depression, apathy, and cynicism. Workers who have burned out often terminate their jobs, forcing agencies to spend scarce resources and time recruiting and selecting new staff. During this period, fellow workers must carry extra caseload responsibilities, further short-shrifting the clients.

Any work environment includes at least four major components:

- Worker characteristics: the variations that exist among workers, in motivation, attitudes, education, age, personal interests, experience and skills;
- Management processes: the integrative functions that blend human characteristics and organizational structure into an effective and efficient working agency;
- Organizational structure: the framework for operating within an agency and the blueprint describing how personnel are arranged in relation to each other and to the task;

- Community environment: the context in which the agency is located, community values, goals, attitudes, as well as the number and amount of community resources allocated to social services.

While burnout is the result of the interrelationship of worker, management, and organizational factors, there are specific conditions in each that are thought to lead to burnout. In the following section these aspects of program operation and their implications for prevention of burnout are examined.

Worker Characteristics and Burnout

The field of child abuse and neglect demands certain kinds of behavior and attitudes. Workers must be able to deal with their feelings about child abuse and be able to accept parents who abuse their children. Because children may be in danger 24 hours a day and the parents often resistant to treatment, the job requires 24-hour coverage, patience, perseverance and aggressiveness. Because child abuse clients often need help with a wide range of services, the worker must be interested in working with many different disciplines and agencies and demonstrate assertiveness in seeking needed services for clients. In order to find a person with these characteristics, it is important to specifically define the behavior, attitudes and personal skills required for the job. Such clarity will reduce the incidence of job incompatibility, a contributing factor in worker burnout.

Unrealistic expectations about what can be accomplished to help clients can also lead to burnout. This is especially true in the area of child abuse and neglect. A young and inexperienced worker may well become dissatisfied and alienated from his or her job when clients are found to repeat an abusive act or fail to regularly attend treatment sessions. A social worker, trained to define problems with a psychoanalytic framework or trained in various other theories of human behavior which emphasize therapeutic techniques, may be embittered to discover that the agency cannot afford "one-to-one" therapy. Even when clients are offered therapy, progress is often slow, another discouraging fact to workers with high expectations. Contrary to what social workers expect, rather than provide treatment, most agencies concentrate on meeting their clients' needs for advocacy services. These efforts require skills and interests quite different from therapy and the outcome is not always as personally satisfying. Unfortunately, if these unrealistic expectations are not dealt with during the recruitment and hiring process, workers quickly become disillusioned.

Differences in individual job needs, expectations, growth needs, and job interests suggest that the recruitment and selection process in agencies is one opportunity to prevent burnout. Job responsibilities should be clearly specified. Potential applicants should be screened to determine whether their personality needs and job interests are compatible with the job demands. Potential employees should be given a job orientation that includes exposure to clients and job duties. Since staff training and opportunities for growth are so important in preventing burnout, these must be provided on an ongoing basis, but should be directly related to the job and employees' individual interests. Agencies should also provide

programs for potential supervisors and administrators so that when they are promoted they are more prepared for the change in role expectations and have chosen a job role that is personally suitable.

Program Management and Burnout

In addition to the influence worker characteristics have on worker burnout, the way in which a program is managed also contributes to worker attitudes and worker performance. Research has shown areas of management related to burnout are: project leadership, communication, supervision, job design and work environment. Problems within each of these dimensions which might lead to burnout are outlined below.

(1) Leadership: Program leadership and the extent to which support and structure is provided are prime factors in preventing burnout. The most successful directors are those who provide direction and also validate workers by soliciting and incorporating their input into decisions related to project operation.

There are several reasons for leadership problems existing in social agencies. Many administrators are promoted into a leadership position because they have been outstanding supervisors, therapists, or are experts in the specialty area. Some, either because of personal disposition or personal problems, are unable to cope with the responsibilities. Another important reason for leadership difficulties is that most program managers are not trained for their new position and consequently are forced to learn on the job. Unfortunately, many report that they are unable to rely on their immediate supervisors for support, direction or consultation.

Selection criteria of program leaders should include both a knowledge of the specialty field and administrative skills. Training in administration and planning should be provided before individuals are promoted to the job. Equally important, there should be an in-house structure providing ongoing consultation and training, so that administrators can continue to develop leadership abilities.

(2) Communication: Inadequate communication within an agency causes many problems for workers. When information and feedback are not circulated among all staff members, workers feel unproductive and unappreciated. In many agencies, workers turn to other workers to vent their anger and gain some needed support. Consequently, problems fester and grow out of proportion as workers congregate in each other's offices venting their most recent frustrations.

While it is not easy to make specific recommendations for improving communication, general guidelines can be offered. These include:

- regularly scheduled staff meetings should be held;
- program management should specify channels of communication;

- all people should be involved in discussions that directly affect them;
- individuals must take personal responsibility for resolving conflicts with other workers;
- any communication about third parties that excludes their participation should be discouraged;
- there should be a feedback structure for regularly evaluating the communication habits of the agency.

Some projects find periodic staff meetings designated to deal with personnel problems helpful; others believe that one-to-one confrontation is best; and others bring in facilitators and consultants to remedy communication problems. Because communication is a very important factor associated with burnout and is a critical ingredient in agency performance, it is most important that you establish a communication system that functions at an optimal level for your project.

(3) Supervision: Good supervision is crucial to workers' performance and satisfaction. Workers expect a supervisor to know what they do, to hold them accountable for the quality of work, and to give feedback about work performance. Good supervision is imperative in the child abuse and neglect field given the crucial decisions workers are required to make each day. Removing a child from a home, taking a mother to court, struggling with sexual abuse cases are extremely troublesome decisions. In these situations a worker needs to proceed carefully and to share the decision making process with a more objective party or parties. Supervisors can and should provide such support.

Often, however, this type of support and encouragement is not provided. Some supervisors are those "burned out workers" who were promoted into the supervisor's position from direct service. In other cases, supervisors are workers who have demonstrated exceptional ability as caseworkers, but who have not had a model of good supervision and do not know the ingredients of supervision. More importantly, supervisors rarely receive training in supervision prior or subsequent to the promotion. Many supervisors report that support, direction and feedback on their performance is rarely provided on an ongoing, consistent basis.

Supervision requires unique skills and caseworkers need training and consultation in the performance of their duties. This training can be provided by a training program within or outside the agency, e.g., a supervisor in one project, feeling inadequate as a supervisor, purchased supervision from a private consultant and saw immediate benefits from his efforts. Supervisors' training should focus on the development of skills in advocacy, community resource development, communication, and case monitoring accountability and support.

(4) Job Design: Research indicates that job design is another important factor in worker satisfaction and performance. A successful job design includes variety, opportunities to be innovative and creative, job autonomy, and results that show that the work is meaningful.

Clearly, not all social work jobs include these job characteristics. Many of the social workers who burn out tend to have a narrowly defined task and feel stuck in a confining casework job. Some workers need and want opportunities to develop skills in training, education, community organizing and group work. When those needs are not met, workers become dissatisfied. In programs where workers are given a variety of job opportunities, higher job satisfaction is found. Public speaking engagements can provide workers with positive feedback about their accomplishments, creating renewed enthusiasm in working with clients. A good job design and opportunities to develop innovative activities with clients can compensate for deficiencies in other work environment areas and conditions.

In work with abuse and neglect families, some workers do not perceive that they are successful or that their efforts have been meaningful. Such feelings often lead to burnout. The intake job is a classic example where this problem occurs. Intake workers complete investigations, begin tentative treatment planning, and then refer their clients to other workers. Because they rarely hear what has happened with the client, they are unable to attribute meaning to their work activity. Improving the communication among all workers involved in a case can minimize this negative impact.

Allowing workers to perform their duties within a flexible schedule can also reduce the chances of burnout. This is a tricky concept, however, in that a worker's schedule must also fit the project's overall organizational need. In a job as personally demanding as working with abuse and neglect, it is important that workers be given permission to work in their own style and the freedom to take appropriate measures to nurture and revitalize themselves. Careful management and monitoring of the entire staff is essential in ensuring flexibility, so one worker does not overburden other staff members or reduce service effectiveness for clients.

(5) Work Environment: An orderly, efficient work environment, clearly defined rules and expectations, and a limited amount of work pressure in the agency can all work to reduce burnout. Research suggests that the impact of workload is modified when the work environment has an efficient, planful atmosphere, specific rules and policies, and minimal job pressure.

Many social workers conplain that their jobs consist of one crisis after another. Under such conditions workers cannot see that they have accomplished anything and do not feel that their efforts have been meaningful. In order to have an efficient, planful work environment, the management and workers must specify goals for the program and workers must develop prioritized treatment goals for clients; plans to accomplish these goals can then be specified. As a result, case records and other management information systems can be designed to give feedback and information relevant to goal attainment and goal status. These efforts give workers and project management a sense of control and provide direct feedback on accomplishments.

Organizational Structure and Burnout

Bureaucratic structures are intended as an efficient method for producing a product, under defined work conditions, where the production process is known, understood and controllable; all conditions in the production process are specified and follow a known sequence. In contrast, there is a high degree of uncertainty in working with child abuse and neglect delivery services. There is wide variation among workers, clients, and the kinds of problems presented to the agency. In situations of uncertainty, structures need to be flexible, responsive and fluid. In highly formalized, centralized organizations, workers cannot respond quickly and efficiently to emergency situations, thereby exaggerating the crisis situation and taking undue amounts of time from other clients.

In addition to causing delays and creating stress for the workers, highly centralized and formalized organizations can also have a negative influence on the quality of program management. In highly formalized agencies, jobs are designed to fit the organization's purposes and to control unintended variation, and are less relevant to the individual's style and work habits. Consequently, workers feel locked into rigid jobs, report a need for greater autonomy and resent their inability to work with clients using their own work habits. In highly centralized organizations, communication is more likely to be delayed. Decision making is often layers removed from the workers and personnel input is rarely solicited. There are delays before organizational changes are communicated to workers; and because workers do not share in decision making, these official decisions seem irrelevant and inappropriate for present job conditions.

The impact that these structural problems have on workers' performance and burnout cannot be underestimated. Innovation and experimentation are required to test out a variety of alternative organizational structures that can deal with the highly variable task of service delivery and that are also compatible with professional values of autonomy and comply with realistic requirements for accountability and conformity.

Environment and Burnout

The fourth area that can contribute to worker burnout is the community environment -- both the community's values and beliefs about abuse and neglect clients and the amount and kind of resources available to assist clients. To date there is no systematic research that shows a relationship between burnout and community values and resources. There are, however, indications that program conflicts with the parent agency, a lack of community support and coordination in working with clients, and a dearth of resources to adequately serve clients' needs can contribute to worker burnout.

Disagreements, or conflicts with the parent agency, either because of a perceived disparity in resources between the project and other agency departments or because of disagreements about the program's functions and role, make the workers' jobs more difficult. Workers feel unsupported and often have trouble getting services for their clients from other agency

departments. These conflicts divert worker energy away from clients and their problems, as workers become involved in internal program squabbling.

Another frequent source of worker discouragement is the lack of community support and cooperation from other social agencies for their program. In many communities the police, the courts, hospitals and other community agencies have a low opinion of child protection workers. They do not refer clients to the agency and often do not work with the program in serving mutual clients. The lack of community support and the absence of a coordinated community approach tend to isolate workers and further frustrate those who are already trying to cope with other systems' dysfunctioning within their own programs. Workers also become discouraged when the community lacks sufficient resources to effectively help their clients.

In order to ensure your community environment will be supportive, you must establish relationships with other community agencies that foster positive opinions about your program and its function, setting in motion a coordinated network of services. While developing community networks is a function of each worker's job, it is also outside the control of any one person. Consequently, agency administrators must set a priority on maintaining healthy positive working agreements with community agencies. If a community network approach is used there will be improved services, more efficient use of resources, and reduced worker burnout. Finally, agencies working together, through a coordinated system, provide a united approach to the development of new services and recruitment of monies from local, state, and federal levels that can solve the problem of no resources and enhance the worker's effectiveness with clients.

Chapter II:

Activities in the Community

An effective program must be continually active in the community. Reaching those people who can benefit from your services will require an ongoing outreach program not only to the community at large but also to other social services agencies within your area. No agency can effectively serve its target population if it functions in isolation. Although establishing a community education program and a cooperative network with other agencies are difficult tasks, they are essential to maintaining a well-functioning child abuse and neglect project.

The purpose of this chapter is to clarify the need for relationships with other community agencies and the community at large, and to identify appropriate coordination and educational activities in the community. There are no established guidelines for delineating the "one right way" to carry out community education or coordination. You will need to develop your own priorities and approach based on your program's goals and the community in which it operates.

Community and Professional Education

There are several reasons for devoting some program resources to community and professional education. Presentations on the dynamics of abuse and neglect and its treatment can change community attitudes toward those problems and encourage those who recognize an abuse or neglect situation, in themselves or others, to seek assistance where it is available. Where needed services are not available, educational efforts can create awareness of such gaps. Presentations to professional groups, including physicians, nurses, teachers, police, court personnel, social workers and others likely to deal with abuse and neglect situations, will increase the knowledge and skills of those currently working with abusive and neglectful families. They will also be instrumental in reaching those professionals who have little knowledge of abuse and neglect, who may have been reluctant to get involved, or who have been working in isolation from the mainstream of service provision.

Because one program cannot meet every community education need, it is important to identify the purpose of these educational activities and the specific groups they are designed to reach. In some community education endeavors, the emphasis will be specifically on an explanation of the program, perhaps even on recruiting volunteers. Others will provide a broader discussion of abuse and neglect, its causes, approaches to treatment, and legal responsibilities for people identifying suspected cases. A community education program for which the purposes and target groups have been

planned in advance is far more likely to serve the program's and community's needs than an unsystematic program based on simply responding to requests as they are received. This is especially true in designing an effective professional education program, since the most important groups to reach may be those who have not yet had any exposure to identification and treatment of abuse and neglect, or groups that are not aware of the range of agencies and services available to address the problem. Most important, careful planning of this educational component will reduce susceptibility to the common problem of expending great effort on public relations and education activities before developing the program's readiness for the subsequent increase in client referrals.

In staffing educational presentations, many programs have found it valuable to give all staff members some responsibility, since the range of staff perspective and expertise (social workers, physicians, psychologists, nurses, homemakers, lay therapists) can be used. In addition, participation by all staff members in community and professional education enhances their sense of responsibility and commitment, and helps them to develop professionally.

A valuable adjunct to educational presentations is a method for evaluating the presentations. The purpose of such an evaluation is to determine whether the goals of the presentation have been achieved and if the audience found the subject matter useful -- for example, whether the audience's knowledge about child abuse and neglect has increased, or more positive attitudes have been promoted. A simple questionnaire can be tailored to the audience and material presented to provide this evaluative feedback at the end of the presentation.

Coordination

The purpose of coordination is to develop a service network in which the various agencies' roles and relationships are clear, and to provide the best system for helping families by avoiding overlapping functions and ensuring that all important services are available in the community. Coordination at the agency level is necessary to establish each agency's responsibility for the different functions in service delivery -- identification, investigation, treatment planning, treatment, and follow-up. In addition, coordination at the individual case level is important when more than one agency is working with a client. It is essential in this situation to coordinate information on the client's needs, progress, and the services being provided to avoid duplication and provide the best service for the client.

A well-coordinated system in a community can be difficult to achieve, since agencies usually have established procedures and may have differing perspectives or approaches to handling abuse and neglect. Another agency, particularly a new program, can be viewed by existing agencies either as a needed complement to services they provide or as an "interloper," duplicating or threatening their role. Therefore, early coordination efforts should be part of developing any new program. This is one of the primary purposes of the needs assessment, discussed earlier in Chapter 3. When the

needs assessment is undertaken, the input of existing agencies can concurrently be incorporated into the development of the planned program. Working relationships, which are mutually beneficial and based on the perspectives of both agencies, can then be initiated.

Once such communication channels have been established, agencies can jointly determine what coordination procedures are necessary and beneficial. Areas for consideration include:

- referral procedures among agencies;
- the types of cases to be accepted by each;
- the roles the agencies will play in investigating cases, providing various types of treatment, and in day-to-day management of the case;
- procedures for sharing information on the diagnosis and progress of cases with which more than one agency is working.

A written agreement may have value in establishing interagency procedures. A sample of such an agreement is provided in Table 11.1. Actual agreements between agencies will vary depending on the kind and extent of responsibility to which all parties agree.

Effective interagency coordination is often enhanced by agencies' participation on each other's Advisory Boards, by staff sharing agreements, or by interagency contracts or purchase-of-service agreements. All of these increase the agencies' knowledge of each other's activities and provide mutual support to fulfill agency and client needs.

Coordination on individual cases with which two or more agencies are involved may be less formal, but it is integral to effective case management. Often, coordination on cases is established through the informal contacts that workers in agencies establish with each other. Consequently, formal procedures are not always needed. Informal contact should not be relied on as a method for sharing information on joint clients, however, if it is not likely to occur spontaneously. In such cases, developing prepared forms for interagency progress reports and information sharing on cases can be valuable. Establishing a routine for inviting the primary worker on a case from other agencies to attend all case conferences is another way of ensuring adequate coordination on joint cases. While these types of procedures are fundamental to an individual worker's effective case management, they can be facilitated by good working relationships at the agency level. Conversely, poor working relationships can hamper even the best worker's achievement of needed coordination on cases that involve other agencies.

Continuing Needs Assessment

An ongoing assessment of your community needs is a vital part of effective coordination. In order to keep abreast of problems in the community service delivery system and to work effectively with other agencies

Table 11.1

SAMPLE COOPERATIVE WORKING AGREEMENT -- DIVISION OF SOCIAL SERVICES (a state agency) AND THE CHILD CENTER (a voluntary agency)

The Division of Social Services (DSS) is mandated by law to investigate reported cases of child abuse and neglect; to report such cases to the Central Registry; and to offer protective social services to families referred for possible or actual child abuse.

The Child Center provides specialized treatment services to abused or potentially abused children and their families.

1. Suspected or possible abuse cases referred to the Child Center will in turn be referred to DSS.
2. The DSS worker will handle referral as any other abuse referral, i.e., making a home visit, providing a written report to the court and Central Registry within 90 days.
3. Following the home visit by the DSS worker, a meeting will be set up between DSS and the Child Center on those cases that the Child Center is considering for intake.
4. The Child Center worker and the DSS worker will work together in formulating an effective treatment plan.
5. The DSS worker will continue the investigation and attempt to motivate the client to seek services offered by the Child Center.
6. The DSS worker will provide the Child Center with any pertinent information.
7. The Child Center will provide the DSS with a copy of the treatment plan and regular feedback on progress, including a written summary at least every other month.
8. The DSS worker will monitor the family progress through information received from the Child Center while the family is in treatment.

to alleviate these problems, you need to continually monitor the key indicators identified in your initial needs assessment.

The difficulties you encounter in your initial assessment will most likely exist in your ongoing efforts. Part of your coordination and community education program should be encouraging community agencies to maintain the data needed to continually evaluate the community's ability to serve cases of abuse and neglect. Of particular importance is regular feedback on the number of cases being identified each year by each principal agency, the sources of cases identified, the proportion of cases that are investigated and substantiated, and the proportion of cases actually receiving services. The Central Registry may be the best unit for maintaining this information, and coordination and education efforts can be aimed at ensuring that:

- all pertinent agencies and professionals use the Registry;
- the reporting form contains all the important items of information; and
- the results are reported back to user agencies.

Where there is no Central Registry, or it is not the best center for handling this information, some other approach should be developed. Perhaps a Child Coordinating Committee, with representatives from all agencies and a small staff to collect and organize the necessary data could be established. Alternatively, the health and welfare planning agency in the community may be suited to this task. Whatever the form, adequate data for continuing needs assessment depends on commitment from all agencies to tabulate the essential items in a uniform manner.

Chapter 12:

Elements of a Successful Project: A Summary

The preceding chapters have followed the development of a community child abuse and neglect service project from design to implementation. As you plan your own project, it is important to remember that the problems you encounter will be unique to your situation and will be defined by your community context. This manual has attempted to minimize the negative impact of these problems by citing the most common difficulties new social service projects face and offering some methods for effectively dealing with them.

The first chapter presented six essential elements of a well-functioning community-wide child abuse and neglect service network, thereby constructing a model system against which you could compare your community. This chapter combines the organizational and service practices recommended in the preceding chapters into elements of a well-functioning child abuse and neglect service program. As with the discussion presented in Chapter 1, this is an ideal model, one which may or may not be possible for you to achieve. These recommendations are the results of four years evaluating demonstration child abuse and neglect service projects and the communities in which they reside. Several of the recommendations are sound operational procedures (i.e., smaller caseloads, clear lines of communication, etc.) which will clearly enhance your program's effectiveness. Others, such as seeing a client weekly, are norms or standards which you may find beneficial to vary. The recommendations presented in this chapter reflect some of the current, best judgments and knowledge about child abuse and neglect service delivery; they are not, however, conclusive. You should not shy away from approaches different from those presented here, if you feel they would better address the critical issues within your community. In establishing and operating your project, your eventual success will be determined not by how well you match the ideal but, rather, by how well you meet the needs of your clients and your community.

Program Organization and Management

Many aspects of how your program is managed will depend upon its size, its location and its primary goals and objectives. However, the experiences of the demonstration projects suggest that programs are more likely to be successful if certain conditions exist.

First, while larger communities can certainly effectively utilize the services of child abuse and neglect treatment programs housed in hospitals and private social service agencies, a program is more likely to have an easier time implementing its activities and operating effectively in a community if it is housed within (or has very strong ties with) a public

protective services agency. The legitimacy and respect required for receiving and making referrals, for working with law enforcement officials and the courts, and for coordinating efforts with other professionals are much more likely to be present if a program has a protective services base. The position of the program is additionally enhanced if the program's parent or host agency (e.g., social services) is well-educated about the program's purpose and activities.

A program's staff should reflect a variety of disciplines and should include lay as well as professional workers. Both of these practices enhance management and treatment effectiveness. Volunteers, in particular, can help enrich a program both by expanding the perspectives present on the staff as well as by greatly expanding its resources. Staff continuity is important, particularly in leadership positions. For newer programs, with turnover in administrative positions, selecting new administrators from the existing staff helps immeasurably in ensuring continuity. Just as it takes a new program about six months to become operational, it takes a program with a new director from the outside almost six months to undergo the transition. Child abuse and neglect programs simply cannot afford such "down time." In addition, a division in responsibilities between the person who manages a project (the director) and the person who oversees the project's treatment program (a treatment services coordinator) is important for making sure that both overall program planning and individual case planning get the direction they need.

A new program needs a strong Advisory Board, composed of individuals who have influence in the community and who will advocate for the program. Such an Advisory Board should be actively involved in program planning for at least the first two years of a program's operation.

Of the many elements of program organization and management, the following appear most important in avoiding or reducing worker burnout and thus enhancing project performance:

Organizational structure

- reasonable caseload size, allowing adequate coverage of all clients;
- formalized procedures and policies with flexible rule monitoring to allow workers to adjust their schedules to client needs and personal preference;
- worker participation in decision making regarding their jobs and program operations;
- minimal accountability procedures that are directly applicable to the workers' job and improved service provision.

Recruitment and selection process

- job activities and expectations clearly stated;
- realistic exposure to job and clients prior to employment;
- careful matching of workers' interests, personal job expectations and skills with the job demands, expectations and characteristics.

Leadership

- neither passive nor authoritarian;
- provides support and structure for workers;
- conveys a sense of trust in staff.

Communication

- consists of formal channels of communication;
- assures that all relevant information is transmitted directly to all staff in a timely, appropriate manner;
- conflicts are directly handled by individual staff, or facilitated by a concerned third party in a timely fashion.

Supervision (consultation)

- provides monitoring of work quality;
- gives direct feedback to workers on their performance;
- provides support;
- facilitates workers' jobs by assisting with development of resources and service delivery networks in the community;
- provides advocacy on behalf of the clients and workers within the agency.

Job design

- provides variety of work tasks;
- provides opportunities to develop and participate in innovative and creative treatment programs;

- offers job autonomy;
- provides a sense of accomplishment and achievement;
- allows avenues of personal development and actualization.

Work environment

- program goals, policies, and procedures are clearly specified;
- client treatment goals are developed and prioritized;
- plans to accomplish treatment goals are specified;
- case records and information systems give direct feedback on client progress and goal status;
- work pressure and crisis orientation is minimized.

Child abuse and neglect programs can anticipate that approximately 40% of the program budget will be consumed by overhead operations, including staff training and development, program planning and general management. While these activities are crucial to a well-functioning program, not much more than this proportion of the budget should be spent on them, and over time program management should seek to reduce costs in this area. In addition, a program should plan on allocating about 10% of its budget on those community-oriented activities that enhance interagency communication and coordination and result in a better trained and educated community.

Treating Abusive and Neglectful Parents

Child abuse and neglect are different phenomena in many ways; the overt or covert acts associated with them, as well as the characteristics of the maltreatments, differ. However, research in the field suggests that many aspects of treatment can, and perhaps should, be the same. In planning for treatment services, a program should not be too concerned about developing different mixes of services for different types of clients. Client characteristics, and even case management practices, have less to do with treatment effectiveness than does the type of service offered.

A program that is likely to be successful with clients (and success might well mean that only half of the clients served improve, such that reincidence of abuse or neglect after termination is unlikely); would reflect the following:

- Range of Services Offered: A full range of treatment services, including therapeutic, educational, advocacy and supportive services, to meet all of a client's needs, are available to the program's clients, through either direct provision by the program staff or on a referral basis.

- Focus of Service Model: The focus of the service model offered is on the use of lay treatment workers (lay therapists or parent aides) and the use of self-help groups (Parents Anonymous), but group services (group therapy, parent education classes) are also stressed, as is the use of individual counseling as the basis for case management.

- Service Prescription: The types of services offered do not necessarily vary by clients' characteristics but rather by needs. Intense, immediate treatment intervention is available for the more serious maltreaters, and 24-hour crisis intervention is available for all clients throughout treatment.

- Amount of Service Offered: Clients receive more than one or two different types of services, are in treatment for at least six months, and are seen by service providers on a weekly basis at least during the first six months of treatment.

Experience in the field suggests that service packages which are supplemented with lay therapy and self-help groups, such as Parents Anonymous, are both most effective and cost-effective. Clients who manifest certain needs (for money, for medical care, for alcohol counseling) should receive advocacy or supportive services designed to meet these needs, in addition to regular treatment services. Such ancillary services include 24-hour availability for crisis intervention, not because crisis intervention directly influences outcome, but because helping clients through crisis is a precursor to helping them improve. Likewise, the use of multidisciplinary teams is important in helping workers learn how to identify client needs.

While a focus on lay services is important, it is useful to keep in mind that clients receiving lay services in the demonstration projects were more likely to be reported with severe reincidence while in treatment. This suggests a need for careful case management and supervision by professionally trained workers, particularly during the early stages of treatment. Improvement in treatment cannot be measured by reincidence in treatment. Despite reincidence, a client may still benefit from services received. Measurement of success comes from changes in a client's behavior over time, and the true test of a treatment's impact is in establishing a reduced propensity to abuse at the end of treatment.

In order for treatment programs to function well, communication among client and service provider and among all service providers working with a given family is essential. While it appears most important for a program to provide services to both parents and children, this is not an easy treatment approach. Parent and children's workers often have a difficult time coordinating their efforts. Parents may feel ambivalent about the attention their children are getting in treatment, both because of the perception that this reduces workers' focus on the parents and it reduces the

parents' focus on the children. Programs that seek to work with both parents and children must organize both case management and treatment services so that they positively impact on the family, but not at the expense of the adult or the child.

Treating Abused and Neglected Children

Children who have been abused and neglected have a number of emotional, developmental and psycho-social delays or deficits as a result of (or minimally related to) the abuse or neglect sustained, and the generally deprived environments in which they are growing up. They have specific problems in numerous functional areas such as physical growth and development, socialization skills and behavior, interaction patterns with family members, and cognitive, language and motor skill development.

In order to begin to remedy these deficits in a meaningful way, child abuse and neglect programs need to make available, either directly or by contract or referral, specific therapeutic services for children in addition to services for parents. Although most existing high quality programs for children with general emotional or developmental delays would probably provide an adequate setting for dealing with these children's problems, some specific considerations related to the abused or neglected child's background and situation should be considered in developing therapeutic services for them. These considerations include:

- Breadth of Problems: Abused and neglected children exhibit problems in a wide range of areas, not only developmentally related areas such as language and motor skills, but also in the more emotionally related areas of socialization skills with adults and peers and interaction patterns with family members. Almost as many of these problems are considered to be "severe" as they are "mild." Programs must be able to provide, therefore, a variety of interventions in order to deal effectively with the different types of problems they are likely to encounter among the children they are serving.

- Specific Behaviors: Although the breadth of problems is wide, there are some common behavioral characteristics which are likely to influence service provision and effectiveness. These include an overly aggressive or apathetic posture, extreme anxiety and hypervigilance (which are likely to depress the child's scores on standardized tests), an inability to relate to either adults or peers in any acceptable manner, and a very poor relationship with their parents. This last aspect may preclude enlisting much support in the therapeutic process from the parents.

- Coordination of Parent and Child Interventions: Because many of the problems exhibited by the children are a result of their environmental situation, particularly their relationship with their parent(s), treating either the parent(s) or the child alone is unlikely to be effective. Although separate service strategies are required for each, coordination between those service providers working with the child and those working with the parent(s), such that each understands what the other is attempting to accomplish, is most important.

Providing the types of services required to help ameliorate the problems which abused and neglected children exhibit is costly and time consuming. However, it seems most apparent that child abuse and neglect treatment programs must work with these children, both because the serious nature of the problems they sustain as a result of the abuse and neglect jeopardize their chances for a healthy childhood, and because, as a preventive measure, early treatment of these children's problems may well reduce the likelihood of their becoming a burden on society -- perhaps as abusive parents -- when they grow up.

Case Management

While case management practices will vary out of necessity across clients, experience suggests that programs are more likely to be successful if they adhere to the following:

- Time Between Report and First Client Contact: Intake workers intervene immediately if a report is considered an emergency and within a few days for all other reports to ensure adequate protection of the child and to detect family crises.

- Number of Contacts (following the first contact) Prior to Decision on Treatment Plan: At least three to five meetings are held with a client, after the first contact, before a treatment plan is developed to ensure that a thorough assessment of client needs is conducted.

- Amount of Time Between First Contact and Delivery of First Treatment Service: Even though the treatment plan is not finalized, provision of treatment services begins within one week of the first contact with the client (if they do not begin during the first contact) to help alleviate immediate, pressing crises.

- Use of Multidisciplinary Team Reviews: Multidisciplinary team reviews are used for the more serious or complex cases at intake and at some other point in the treatment process. Every case manager presents at least one of his or her cases to such a team every

six months. The use of such teams can greatly enhance a worker's knowledge about how to best handle future cases, and thus is an important educational tool.

- Use of Case Conferences (staffings): Progress on every case is reviewed in a meeting of two or more workers once every three months, including at the time of termination.

- Use of Outside Consultants: Consultants representing different disciplines are used by case managers, particularly for input on the more complex or serious cases, to ensure that interdisciplinary perspectives are taken into account.

- Responsibility for Intake: Intakes are conducted by more experienced workers.

- Continuity of Case Manager: When possible, the manager of a case remains the same throughout the treatment process to avoid disruption in service delivery.

- Communication with Other Service Providers: Case managers maintain ongoing communication with all other service providers working with a given case to keep abreast of client progress.

- Contacts with the Reporting Source: The reporting source is contacted to gather available background information on the case and to discuss the client's progress, not only to reduce duplication of efforts but also to build trust and confidence between reporting agencies and child abuse/neglect programs.

- Client Participation: Clients are involved in the development of their own treatment plans and review of progress.

- Frequency of Contact Between Client and Case Manager: Case managers see clients frequently enough (once a week during the early stages of treatment, once or twice a month once the case has stabilized) to assess progress and the appropriateness of the treatment plan.

- Length of Time in Treatment: Cases are in treatment for at least six months, but rarely for two years. Clients are terminated according to specified criteria, tied to client treatment goals; clients are referred to other services at termination if necessary.

- Follow-Up Contacts: Follow-up contacts are conducted with every terminated case within two months from the time of termination with the explicit purpose of determining whether or not additional services are required.

- Case Records: Case records, adequately describing the client's problems, the treatment plan, the services provided and progress, are maintained on every client, not only to assist treatment workers in case review but also to ensure continuity should there be turnover in treatment workers or the case manager. Workers are trained in how to maintain and use case records to assess client progress.

- Qualifications of Case Manager: Case managers, as distinct from treatment workers, have extensive training in this area.

- Caseload Size: Caseload sizes are kept small, well under 25 when possible, for professionally trained workers; fewer than four for lay or part-time workers.

Of these norms or standards, compliance with the following are considered more important in terms of overall quality case management by experts in the field: short time between report and first contact with client; contacting reporting source for further background information; greater frequency of contact with the case; greater length of time in treatment; use of multidisciplinary team reviews; use of outside consultants; smaller worker caseload sizes; and use of follow-up contacts after termination. Of these factors, the two most clearly associated with client outcome by the end of treatment are greater length of time in treatment and smaller caseload sizes. While many aspects of case management are not directly tied to treatment outcome, good case management practices are important in helping to ensure clients get to the services they need, when they need them. Good case management practices also enhance project efficiency.

The Community Context

It appears that child abuse and neglect service programs are more likely to be successful if they operate within the context of a community-wide child abuse and neglect system with the following characteristics:

- Community Coordination Mechanisms: The community has a community-wide coordinating body for child abuse and neglect, with representation from all those agencies in the community that are or should be concerned with child abuse and neglect (minimally including protective services, the juvenile court, the police and/or sheriff's department, the schools, the local hospital(s) treating children, and private service agencies). This

group takes responsibility for eliminating the fragmentation, isolation, duplication and inefficiency in the community's child abuse and neglect system. Specific, formal coordinating agreements exist between all key agencies in the community system.

- Interdisciplinary Input: Interdisciplinary input (including legal, medical, social service, psychological and educational) is present at all stages in the treatment process (from intake and initial diagnosis through treatment and termination). In addition to having expanded agency staff to include several different disciplines, having hired consultants to work with agency staff, and generally having staff from different agencies work together, the community has a multidisciplinary review team available to review some, if not all, identified cases of abuse and neglect.

- Centralized Reporting System: A 24-hour reporting and response system exists in a central location, implying that reports can be made on a 24-hour basis; follow-up on reports is immediate and handled by one agency to avoid duplication.

- Service Availability: A full range of therapeutic, educational, advocacy and supportive services are available to both actual and potential physical and emotional abusers and neglectors and their children. The services of both lay and professional providers are utilized, as are client-operated services.

- Quality Case Management: There is adherence to minimum standards of case management in all agencies in the system including: prompt response to all reports; planful decision-making concerning service provision with interdisciplinary input; prompt assignment of clients to the agency or service provider best able to provide necessary services; receipt by clients of the appropriate services at the required level of intensity according to their needs; referral to other service providers when necessary with follow-up to make sure the client gets there; termination of clients according to established criteria; and follow-up on all terminated clients to see if they are in need of further services.

- Community Education and Public Awareness: Training and education is provided on an ongoing basis to all relevant professional groups or classes of workers who are involved in the detection, treatment or legal

aspects of child abuse. All key agencies in the system take responsibility to provide educational presentations on child abuse and neglect to all community and civic groups who request it and, additionally, to seek out and provide education to those public groups needing but not requesting it.

Of those essential elements of a well-functioning child abuse and neglect system, community service programs appear to be best able to impact on the following through a variety of community-oriented activities: increased awareness of and knowledge about child abuse and neglect on the part of professionals and the general public; increased availability of a comprehensive range of services available to abusive/neglectful families; increased centralization and coordination of the receipt of reports and the conduct of investigations; and improved management of cases.

Conclusion

In conclusion, it would appear that child abuse and neglect services are maximized if:

- They are closely affiliated with or housed within public, protective services agencies.
- The program participates cooperatively with law enforcement, local schools, hospitals and private social service agencies in the community in the identification and treatment of abuse and neglect, as well as the education and training of professionals and the general public.
- The program has strong, supportive leadership, a variety of disciplines on the staff, decentralized decision making, clearly specified rules but allowance for flexibility of the rules as clients' needs dictate.
- The program stresses certain aspects of case management including prompt, planful handling of cases, frequent contact with cases, small caseload sizes, coordination with other service providers, and use of multidisciplinary review teams and consultant input for the more complex or serious cases.
- The program utilizes more highly trained, experienced workers as case managers, but stresses the use of lay services (lay therapy) or self-help services (Parents Anonymous) in its treatment offerings, as well as 24-hour availability.

- Careful supervision is available to lay workers, particularly during the first few months they are working with a case.

- Therapeutic treatment services are provided to the abused or neglected child.

Even the more successful child abuse and neglect service programs should not expect to be completely effective with their clients. To successfully treat half of one's clients, so that they need not become protective service clients in the future, appears to be a norm for the field.

APPENDIX A

Questions to be Addressed in a Community Needs Assessment

A. Community Demographic Information

1. What are the geographic boundaries of the community or service area (e.g., city, county, other)?
2. What is the population breakdown by age groups?
3. What are the basic socioeconomic data by census tract or other small geographic area (e.g., income, employment, housing, family size, welfare assistance)?
4. What are the urban-rural characteristics of the community (e.g., population density, economic base)?
5. Are there concentrations of special populations (e.g., Indians, military personnel, ethnic groups)?

B. Community Resources Currently Available

1. How many agencies or individuals in the community system provide some service to abusive/neglectful families and who are they?*
2. What proportion of time is spent by these individuals specifically on abuse/neglect problems?
3. What functions do these individuals perform in the community system?

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*The following should be considered: Protective Services and other child welfare agencies; courts; police; schools/Head Start/day care; child guidance/development clinics; hospitals; clinics; private physicians; public health nurses; foster care placement agencies; public and private adoption agencies; community mental health centers; family/marriage counseling centers; drug/alcohol abuse programs; other public/private service programs; social service departments; community health planning agencies; and central fund raising agencies such as United Way.

C. Comprehensiveness of Services Available

1. What preventive services are available to deal with child abuse/neglect (e.g., child management classes, pre-natal screening, family life education classes for teenagers)?
2. What outreach activities (e.g., maternity ward monitoring, presentations to high-risk groups) are there?
3. What community and professional education and training activities have been undertaken?
4. Is there a 24-hour reporting or crisis telephone line? If so, are staff on duty or on-call 24 hours a day?
5. Is there timely investigation of reports or complaints? By which agencies?
6. What services are available and accessible for parents (e.g., individual and group counseling, lay therapist or parent aide support, couples counseling, Parents Anonymous groups)?
7. What services are available and accessible for children (e.g., psychological and other testing, day care, crisis nurseries, residential and foster care, child/play therapy)?
8. What services are available and accessible to families (e.g., crisis intervention, family counseling, housing, legal and welfare assistance, transportation)?
9. Are the following functions performed by agencies in the community: identification, investigation, treatment planning, treatment services, referral to other agencies, placement, follow-up?

D. Availability of Services

1. Approximately how many abuse/neglect clients receive the services listed in "C" above?
2. Are services provided in a format convenient for clients (e.g., hours of service, transportation provided if required, central location of services)?
3. Are services provided in a manner consistent with a "helping" or "therapeutic" philosophy, i.e., non-punitive and non-stigmatizing atmosphere?

4. Are services available in sufficient quantity to meet the needs of all the people requiring services? Are there long waiting lists, larger caseloads than desirable per worker, or restrictions on who can be served?
5. Are services well-publicized?
6. Are clients aware that services are readily "available"?

E. Coordination and Functioning of Service System

1. What agencies should be coordinating efforts?
2. What methods exist to ensure coordination among agencies in matters of education, reporting of cases, treatment planning, legal activities, treatment, referral of cases and placement?
3. Is there a central agency in the community handling abuse and neglect?
4. Is there an inter-agency abuse/neglect task force or committee?
5. Is there a multidisciplinary team for evaluation and treatment planning?
6. Have procedures and agreements for coordination between agencies been developed?
7. Are there "gaps" in the system such that one or more of the functions is not being performed (e.g., referral between agencies does not occur)?
8. Is there duplication among agencies where two or more agencies perform the same function with respect to an individual client (e.g., two or more agencies investigate the same case)?
9. Are there points in the system where a client can be "lost" (e.g., a case is identified but never referred for treatment)?
10. If two or more agencies are providing services to the same client, is there a system for sharing information about the case?
11. Is there any central record keeping system in operation? What information is available from this system?
12. Are there any bottlenecks in the system (e.g., many more cases are reported than can be investigated)?

F. Effectiveness of the Service System

1. How many reports of abuse/neglect are received by all agencies in the community; is this number increasing? How does this number compare with national reporting rates or reporting rates for similar communities? What percent are repeat cases?
2. Is the number of reports from previously non-reporting sources increasing?
3. What proportion of reported cases receive an investigation?
4. What proportion of substantiated cases receive some services from community agencies?
5. How many abused/neglected children are removed from their homes? Returned home? How long does a child usually remain in foster care?
6. How many agencies perform some follow-up on the majority of their terminated cases?
7. What are the basic problems of the system as perceived by service providers?
8. What are the basic problems of the system as perceived by clients (or former clients)?
9. Are community residents and professionals aware of the problem of child abuse/neglect and the resources available to deal with it?

G. Costs of the Community System

1. What are the overall community expenditures for child abuse and neglect (including staff salaries, administrative support, promotional activities)?
2. What is the cost per client served?
3. What are the most and least costly services currently provided?
4. How do these cost figures compare with those of similar communities?
5. How do these cost figures compare with the amount of money spent on other social services in the community?

H. Funding Sources

1. What additional funding sources are available to the community (including public, private, federal, state, and local sources)?

2. What are the limitations on increased funds?
3. Are there non-monetary resources available (volunteers, civic groups, churches, other service providers) who could become involved with the child abuse/neglect problem?

APPENDIX B

Relevant Documents for Community Planners

The following books and reports will provide you with valuable additional information and clarification specifically related to topics covered in this manual. The authors hope that you will take advantage of these sources in developing your service.

Listing of Major BPA Evaluation Reports and Papers in the Child Abuse Field

In the course of BPA's three-year evaluation of the eleven demonstration projects, several reports and papers were developed. These reports, listed below, expand on many of the issues presented in this manual and are available through the National Center for Health Services Research, Health Resources Administration, Department of Health, Education and Welfare.

Reports

(1) Comparative Descriptions of Projects Report; December 1977.

(2) Historical Case Studies of the Eleven Demonstration Projects; December 1977.

(3) Cost Analysis Report; December 1977.

(4) Community Systems Impact Report; December 1977.

(5) Adult Client Impact Report; December 1977.

(6) Child Impact Report; December 1977.

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

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

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

(10) Program Management and Worker Burnout Report, December 1977.

Papers

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

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

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

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

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

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

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

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

General Child Abuse and Neglect

Many more books, reports, and articles on all facets of the child abuse and neglect problem have been prepared than can be presented in this document. The following publications outline many of these works.

Child Neglect, An Annotated Bibiography. Prepared by the Regional Institute of Social Welfare Research, University of Georgia, for the Social and Rehabilitation Service of the Department of Health, Education and Welfare (1975): The bibliography, dealing primarily

with neglect, is divided into sections covering general works, prevention, identification, etiology, treatment, and sequellae; entries under each heading are fully described.

Hurt, Maure. Child Abuse and Neglect, a Report on the Status of the Research. Prepared for the Office of Child Development, Department of Health, Education and Welfare, DHEW Publication (OHD) 74-20 (1974): This report contains both descriptions of the recently completed and ongoing research in child abuse and neglect, and an annotated bibliography. The research study descriptions are compiled under the categories of: (1) characteristics of abuse and neglect, (2) reporting, recording and diagnosis, and (3) remediation and the family.

Polansky, Norman; Hally, Carolyn; and Polansky, Nancy. Child Neglect: State of Knowledge. Prepared under a grant from the Social and Rehabilitation Service of the Department of Health, Education and Welfare to the Regional Institute of Social Welfare, Research, University of Georgia (1974): The authors explore what is currently known about child neglect, the definition and prevalence of the problem, its etiology and identification and the prevention and treatment services most widely used to combat the problem.

Existing Child Abuse and Neglect Services

A Directory of Child Abuse Services and Programs. The National Center for Child Abuse and Neglect, Washington, D.C. (1976): This directory, which is to be periodically updated, presents a listing of over 1500 child abuse services by DHEW region. Entries include locations, contacts, purposes, services provided and a brief program description.

Child Protective Services, a National Survey. Prepared by staff of the American Humane Association, Children's Division (Denver) under a grant from the Child Welfare Foundation of the American Legion (1967).

Planning

Blum, Henrik L. and Associates. Health Planning. Comprehensive Health Planning Unit, School of Public Health, University of California, Berkeley (1969).

Delbecq, Andre L. and Van de Ven, Andrew. "A Group Process Model of Problem Identification and Program Planning." Journal of Applied Behavioral Science,

Vol. 7, No. 4 (1971): This paper describes the history of the Nominal Group Process, the procedures involved in applying the technique and its usefulness in various group settings to promote consensual decision making.

Hargraves, W.A.; Attkinnson, C.C.; Siegel, L.M.; McIntyre, M.H.; and Sorensen, J.F. Resource Materials for Community Mental Health Program Evaluation, Part II: Needs Assessment and Planning: This second of four resource books emphasizes the importance of the needs assessment phase of planning, provides useful guidance in the development and design of such studies and analyzes the adequacy of commonly available data and information.

Identifying Funding Sources/Proposal Writing

Lewis, Marianna O. (ed.) The Foundation Directory. Irvington, New York, Columbia University Press (1975): The basic work on foundations, listing those foundations that have made in excess of $25,000 in a year, or who possess $500,000 plus in assets. Contains information on programs, personnel, and financial data.

Wilson, W., and Wilson, B. Grant Information System. Scottsdale, Arizona, Onyx Press (1975): A regularly updated, easy to use volume that groups grant programs by funding area (e.g., Health Field).

Executive Office of the President, Office of Management and Budget. 1974 Catalog of Federal Domestic Assistance. Washington, D.C., U.S. Government Printing Office: This annual publication dealing with all federal funding programs is particularly useful when attempting to identify potential federal funding sources.

Hall, M. Developing Skills in Proposal Writing. Corvallis, Oregon, Continuing Education Publication (1972).

Urgo, Lewis A., and Corcoran, Robert J. A Manual for Obtaining Foundation Grants. Boston, Massachusetts, Robert J. Corcoran Company (1971): Focuses specifically on approaching foundations. Contains examples of forms and formats which might be adapted when writing grant proposals.

Program Goals

Mager, Robert F. Goal Analysis. Fearon Publishers/ Lear Siegler, Inc., Belmont, California (1972): This book describes a process for clarifying goal statements, generating performance indicators for established goals, and plotting performance results to monitor goal achievement.

Protective Services

A Guide for State and Local Departments on the Delivery of Protective Services to Abused and Neglected Children and Their Families. U.S. Department of Health, Education and Welfare, Social and Rehabilitation Services (1976): This guide, developed by Community Research Applications, Inc., under contract to Social and Rehabilitation Services, presents state and local administrators in public welfare and social service departments with ideas for developing a responsive and comprehensive protective services program.

Comprehensive Emergency Services

Comprehensive Emergency Services, U.S. Department of Health, Education and Welfare, Office of Child Development (1974): This, and several related publications, explains the Comprehensive Emergency Services System, developed by the National Center for Comprehensive Emergency Services to Children in Crisis in Nashville, Tennessee, designed to care for children in crisis due to family or community abuse or neglect.

Special Services for Children

Cohen, Donald, and Brandegee, Ada. Serving Pre-School Children. U.S. Department of Health, Education and Welfare, Office of Child Development, DHEW Publication No. (OHD) 74-1057 (1974): One of a series of booklets on day care, this handbook explores numerous issues related to developing day care programs for preschoolers, including program administration, budgeting, licensing, facilities, curricula, staffing, and the provision of health/nutritional services. There is a comprehensive overview of the pre-school child's development and descriptions of exemplary centers.

Day Care Evaluation Manual. Prepared by staff of the Council for Community Services in Metropolitan Chicago for the Office of Child Development. Publication No. 7502 (1974): This very extensive manual presents the rationale for the evaluation of day care services and describes the procedures and processes of applying the evaluation system outlined in the manual. Twenty-seven separate evaluation questionnaires, mostly in check-list form, covering every aspect of day care program administration, physical facilities, staff, licensing, and services are included in the manual.

Standards for Foster Family Services Systems with Guidelines for Implementation Specifically Related to Public Agencies. American Public Welfare Association, Washington, D.C. (1975): This easy-to-read report presents both basic and optimum standards for foster care agencies in areas such as legislation, facilities and equipment, standard development, rights of children and parents, community education, staff, case records, recruitments of foster families, volunteer services, evaluation services and many other important foster care related topics.

Evaluation

Clinic Self-Evaluation Manual for the Determination and Improvement of Clinic Efficiency. Prepared by Neil Sims, M.D., the Johns Hopkins University School of Medicine and Health Systems, Department of Westinghouse Electric Corporation for the Department of Health, Education and Welfare, Maternal and Child Health Services (revised 1971): This comprehensive, indexed manual provides guidelines and sample formats which allow clinic directors to evaluate the efficient utilization of facilities and manpower, and the effectiveness of services and appears easily adaptable to most direct service programs. The manual deals with documenting clinic objectives, administration procedures, resource expenditures, client flow analysis, work sampling (quality), and the interpretation and utilization of study results.

Suchman, Edward A. Evaluative Research: Principles and Practice in Public Service and Social Action Programs. New York, Russell Sage Foundation (1967): A classic volume on evaluation research with emphasis on the health and medical care fields.

Weiss, Carol H. (ed.) Evaluating Action Programs: Readings in Social Action and Education. Boston, Allyn and Bacon, Inc. (1972): A well-organized volume of practical articles dealing with evaluation.

Other Federal Publications of Interest

Model Child Protective Services Act with Commentary (September 1977).

Report of the U.S. Department of Health, Education and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, the Child Abuse Prevention and Treatment Act (August 1975).

Working with Abusive Parents from a Psychiatric Point of View, DHEW (OHD) 75-70.

(The) Diagnostic Process and Treatment Programs, DHEW (OHD) 75-69.

The Problem and Its Management -- Volume 1: An Overview of the Problem, DHEW (OHD) 75-30073.

The Problem and Its Management -- Volume 2: The Roles and Responsibilities of Professionals, DHEW (OHD) 75-30074.

The Problem and Its Management -- Volume 3: The Community Team: An Approach to Case Management and Prevention, DHEW (OHD) 75-30075.

Federally Funded Child Abuse and Neglect Projects, 1975 DHEW (OHD) 76-30076.

Child Abuse and Neglect Reports (Quarterly Pub.) DHEW (OHD) 76-30086.

U.S. Department of Health, Education and Welfare Activities on Child Abuse and Neglect, DHEW (OHD) 76-30004.

Child Abuse and Neglect Prevention and Treatment Program, 45CFR Subtitle B, Part 1340, Federal Register, Vol. 39, No. 245, December 19, 1974.

Child Abuse Projects Funded December 1974.

Children Today, May-June, 1975, DHEW (OHD) 75-14.

Comprehensive Emergency Services: A System Designed to Care for Children in Crisis, DHEW (OHD) 75-8.

(The) Extended Family Center, "A Home Away From Home" for Abused Children and Their Parents. Reprinted from Children Today, March-April 1974, Vol. 3, No. 2 (2-6).

Public Law 93-247.

Research, Demonstration, and Evaluation Studies on "Child Abuse and Neglect." The Intradepartmental Committee on Child Abuse and Neglect, Fiscal Year 1974, DHEW (OHD) 75-77.