AMERICAN HUMANE ASSOCIATION

TWENTY YEARS AFTER CAPTA:

A PORTRAIT OF THE CHILD PROTECTIVE SERVICES SYSTEM

MAY 27, 1994

Children's Division

63 Inverness Drive East • Englewood, CO 80112-5117 • 303-792-9900

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PROJECT STAFF:
KAREN J. FARESTAD, PH.D., PROJECT DIRECTOR
AMY WINTERFELD, J.D., PROJECT MANAGER
TRICIA ENGLAND, M.S.W.
PATRICIA SCHENE, PH.D.
ROBYN ALSOP, M.A.
WENDY WALSH
MICKEY SHUMAKER
LISA MRAZIK
TONI WELLER

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American Humane Association
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System Structure—what is it; how did it develop; who manages it?

A. System Structure—what is it; how did it develop; who manages it?

The public system of intervention in cases of child abuse and neglect known as child protective services (CPS) today generally resides in public departments of social services in states and counties throughout the United States. This current system of intervention, although not originating with the state mandatory reporting laws of the 1960s, was made more commonly recognizable and universally available by these statutes.

In many ways, our existing child protective service system has been amazingly successful in a relatively short period of time. Every state has reporting laws mandating professionals who work with children to report their suspicions of child neglect and abuse to universally available child protective services units. Upon receipt of this information, if deemed necessary, these units must "investigate" or "assess" the child's situation. Normally this process results in an "official report" which makes its way into a state-run information system. Official reports are then investigated, resulting in decisions to "substantiate" the report, to provide ongoing services, or to close the case after investigation. As a result of recent efforts to automate reporting data, states now collect more information about child protective services reports than at any other time in the development of the system.

However, we have little data about how well the system actually serves the children and families who are reported. This has become the subject of extensive examination and controversy. There are those who argue that no governmental agency should have the right to investigate parents, and still others who believe CPS is not doing enough to protect children from abuse and neglect. Definitional quandaries remain about what constitutes child abuse or child neglect and whether there can ever be agreement on definitions across communities. Many are concerned that our interventions are disrespectful of parents and lack the necessary cultural competence to understand and utilize the strengths of diverse communities. There is debate about the overall focus of our intervention—are the dual goals of child protection and family preservation compatible?

Some believe that child protective services should primarily be a quasi-law enforcement function—protecting "victims" and punishing "perpetrators." Others argue that child maltreatment emerges from a larger context of family problems

and advocate supporting parents through services rather than punishing them and placing their children in foster care. Almost everyone recognizes that we have not placed sufficient resources in CPS in terms of well-trained staff, manageable workloads, treatment and services, as well as resources for adequate supervision and effective accountability. The demands on the system, and the controversy it attracts, have become so intense that in 1990 the U.S. Advisory Board on Child Abuse and Neglect referred to child abuse as a "national emergency" requiring the "replacement of the existing child protection system" (U.S. Advisory Board, 1990).

Clearly, the child protective service system is in transition. It lacks both sufficient resources and the broad public and professional support that is necessary to effectively respond to the needs of neglected and abused children and their families. At this important crossroads in the evolution of the system, decisions to restructure must not be made in haste. They must instead be based on a thorough understanding of the background of the system, its current status and limitations, and a shared concern among the public and child advocates about what supports and interventions are essential for vulnerable children and families.

History of the Child Protective Services System

To understand the structure of child protective services in the United States today, one must first understand historically how the system developed. Throughout much of our history as a nation, the abuse and neglect of children was a private concern. Laws concerning parent-child relations were grounded in the philosophy that parents should be given autonomy in disciplining and controlling their minor children and that, in the interest of preserving family harmony, the state should not intrude into the parent-child relationship.

In colonial days, poverty was considered a sin and work the way to salvation. Children of the "unworthy poor" had to be saved from developing slothful ways, often by separating them from their parents through indenture or placement in institutions and foster homes (Costin, 1985). The legal base for early "child-saving" was the power of the township overseer of the poor and the doctrine of parens patrie on which American guardianship law rests. Public responsibility for the poor was placed in local towns following the Elizabethan Poor

Law of 1601. Parens patrie—the ruler's power to protect minors—came to be broadly interpreted in America as justification for governmental intervention into the parent-child relationship in an attempt to enforce parental duty or supply substitute care (Schene, 1991).

This attitude began to change in the late 19th century. Although it may be difficult to imagine from today's late 20th century perspective, the development of public concern and policy for dependent, abused and neglected children was largely at the initiative of private, non-profit agencies. In 1875, the first Society for the Prevention of Cruelty to Children (SPCC) was established in New York City after the much publicized case of Mary Ellen Wilson, a young child who was brutally treated by her caretaker. A concerned citizen, frustrated in attempts to get help for Mary Ellen from various public agencies in New York City, was able to convince the American Society for the Prevention of Cruelty to Animals (ASPCA) to provide assistance to the child as a member of the animal kingdom. As a result of their efforts, Mary Ellen was protected and legislation was enacted to protect children from abuse and neglect.

There were more than 250 SPCC's by the 1920s. Early leaders in the child protection field came almost exclusively from these private, secular agencies as opposed to religious or governmental groups. Although many viewed this as largely a "middle-class movement directed against lower class immigrant parents" (Costin, 1985), its impact was much broader. These organizations took an active role in protecting individual children and in advocating for better legislation and public sector commitments to safeguard children's interests. As public awareness grew through these efforts, children were less likely to be considered solely the "property" of their parents or the source of inexpensive labor (Kahn, Kamerman, McGowan, 1973).

The private child protective movement initially adopted a punitive, law enforcement emphasis. The New York SPCC "discovered" cases of child abuse and neglect by stationing agents in magistrate courts to investigate all cases involving children. They advised magistrates on the commitment of children; they were given police powers and could take custody of children pending the investigation. This law enforcement approach was gradually replaced in some regions by a broader focus on family casework and the need to maintain and enrich family life

through broad social supports. Child protection, initially isolated from the general child welfare movement, gradually became part of it.

To rehabilitate and reconstruct family life, many anti-cruelty societies expanded their protecting efforts beyond the individual child. The Pennsylvania society, for example, in association with other Philadelphia social agencies, was instrumental in forming a local children's bureau to consider the needs of any child in distress (McCrea, 1910). In the 19th century, however, only one state, Indiana, created a governmental body to perform the duties elsewhere performed by SPCC's. In 1899 a law was passed authorizing the appointment of a "board of children's guardians" in townships and counties (six persons appointed by the circuit court) to investigate alleged abuse and neglect, bring perpetrators to trial, oversee the children and place them in temporary homes (Folks, 1902).

Gradually, in the first half of this century, more public social services agencies in other states began to take on responsibility for delivering services to abused and neglected children and their families. The primary role for public social services did not come about arbitrarily. The experience of those who had been responding to abused and neglected children led to the commitment to help families rather than simply treat child maltreatment as a crime. The overall trend in public policy around child neglect and abuse throughout the 20th century has been, and still is, in the direction of providing social services so that families can ultimately be protected and effectively parent their children.

By the 1930s, many of the older humane societies no longer performed protective services for children, their functions being taken over by a variety of public and voluntary organizations such as juvenile courts, juvenile protective associations, family welfare societies, children's aid, and local welfare boards. Some SPCC's and humane societies merged with public welfare agencies so that in many of the newly formed government boards, personnel long associated with the SPCC tradition continued to carry out policy (Carstens, 1923). The growing acceptance by states, counties and municipalities of responsibility for child protection work symbolized a new era in the child welfare movement.

The Social Security Act of 1935 marked the first federal government venture into funding child welfare services. Title IV-A (ADC, later AFDC) specifically addressed the financial needs of children in families deprived of parental support.

Title IV-B (Child Welfare Services) encouraged states to develop, strengthen or expand preventive and protective services for vulnerable children by providing limited federal funding to states through formula grants. The major impact of Title IV-B was on the substitute care system—funds were available through IV-B to pay for foster care of children, but not available to provide supportive services to families with children at home.

A corresponding development of social casework methods in the 1930s and 1940s provided a major impetus for moving child protection from a law enforcement, punitive focus to a social service, rehabilitative one. "Aggressive casework," the use of outreach and case finding, found increasing favor in the 1950s. As a result, social workers recognized that casework methods could be applied to families who had not of their own free will sought out service (Antler and Antler, 1979).

In keeping with this philosophy, the decade of the 1960s was one of major development in our country's response to child maltreatment. Due to the efforts of child welfare professionals, along with the medical community's recognition and publicizing of the "battered child syndrome," reporting laws were passed in every state. These laws obligated professionals who work with children to report child abuse or neglect to local departments of social services and gave private citizens and family members a means to report their concerns and seek assistance as well. Largely due to these efforts, child abuse truly became an issue of national importance. Public welfare departments assumed a social service investigation function and a capacity to track families and perpetrators as they might "hospital-hop" or move from community to community.

Public Law 93-247, the Child Abuse Prevention and Treatment Act (CAPTA), was passed by Congress in 1974, and has been regularly revised and updated since then. CAPTA established the National Center for Child Abuse and Neglect as an agency within the federal Department of Health, Education and Welfare (currently the Department of Health and Human Services); provided about $60 million in federal funds to assist states, localities and nonprofits to develop programs and services for abused and neglected children and their families; and tied these federal funds to the presence of state laws establishing systems for the identification, reporting and response to child abuse and neglect. Additional federal

child welfare policy was set by passage of the Indian Child Welfare Act of 1978 which emphasized the role of Native American tribes and families in decision making around the protective needs and placement of their children and mandated state courts to preserve the integrity and unity of these families.

Through CAPTA, the federal government encouraged states to develop laws and policies based on national standards by requiring states to meet certain standards to be eligible for federal grants. It is generally agreed that the National Center on Child Abuse and Neglect has been effective in bringing about the adoption of state policies relative to reports of abuse and neglect as well as national awareness of the problem. What was not addressed in this legislation was the question of services to those children and families reported. The size of the state grants was too small to fund service programs beyond demonstration efforts or training resources for social service workers.

It was not until the enactment of PL 96-272, the Adoption Assistance and Child Welfare Act of 1980, however, that the federal government attempted to develop and implement a national child welfare policy. The 1980 Act ties federal foster care funding to the implementation of policies related to family preservation and permanency planning for children removed from their homes. Caseworkers and courts are now obligated to demonstrate and certify that "reasonable efforts" were made to preserve families (or that an emergency necessitates child removal) before children can be placed in foster care or made eligible for adoption (American Humane Association, 1992).

By October 1983, all states were to develop plans so that reasonable preventive efforts would be made for each child prior to out-of-home placement. Reasonable Efforts were also required to reunite children with their families if placement did occur, before pursuing an alternative stable home for the child. A major goal was a reduction in the large numbers of children drifting permanently in the foster care system. Fiscal incentives were included to help move the service emphasis away from foster care, including Medicaid coverage for adopted children with special needs. The new legislation clearly made "permanency planning" a national goal for dependent children and facilitated action at the state level.

Additionally, PL 96-272 mandates case review procedures to insure that there is a case plan for each child in foster care and that the plan is being followed.

However, since the mid-1980s the full implementation of PL 96-272 has been hindered by both the increasing numbers of children identified as abused and neglected and the serious limitations on service resources in most American communities. Only with the passage of the Family Preservation and Family Support Act in 1993 do we have the beginning of a federal resource and planning commitment to provide services to support and preserve families, not just to protect children.

Federal/State Legislation and Constraints on the System

The federal role in child protection remains an indirect one which is limited by the U. S. Constitution. Congress has authority to act only in certain subject matter areas that the Constitution specifies. Areas not specifically designated for federal action, including domestic relations and family law, are Constitutionally reserved for action by the states. To impact state policies for child protection, the federal government has used the approach of requiring states to meet certain programmatic criteria in order to receive federal funds for child welfare services. Since state participation in these federal programs is voluntary, the requirements imposed by Congress do not violate the Constitution. Most states choose to participate in these programs because of the large dollar amounts involved, and are therefore obligated to meet any concomitant federally imposed standards for services (Spar, 1992).

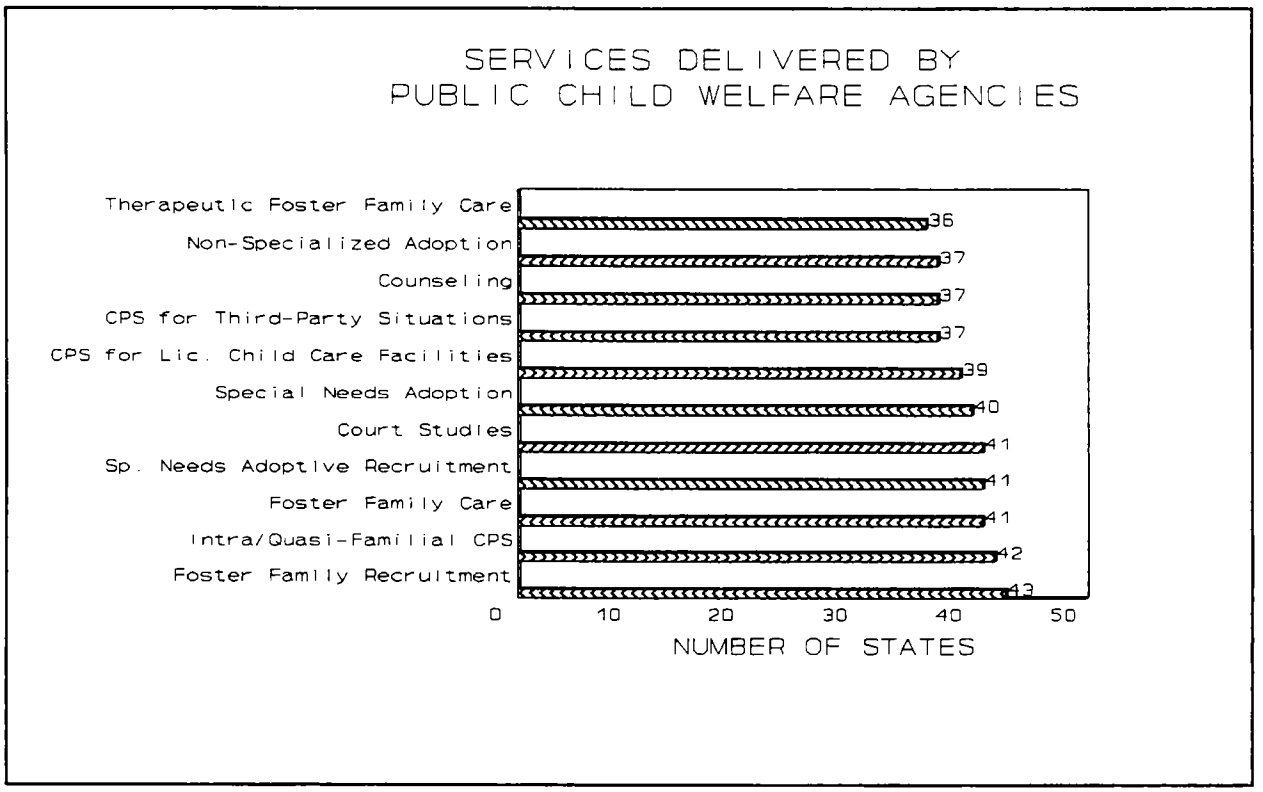
The result of this joint state/federal control is a system where state law is paramount, but where federal funding requirements have greatly influenced state and local practice. Each state has a law or laws defining child maltreatment, reporting responsibilities, and procedures for intervention as well as the overall purpose, focus, and organization of child protective services in the state. Another overlying framework for practice is imposed by the policy manuals of each state department of social services, and by local regulations which outline the policies and procedures for caseworkers to follow when they intervene in cases of abuse and neglect. Additionally, in many jurisdictions activists have brought lawsuits aimed at obtaining improved services for those impacted by the child protection system, resulting in further court imposed requirements for practice or for services

that will meet legislative policy mandates. The conglomeration of state law, federal funding legislation, and court imposed requirements has resulted in a body of policy so dense that practice in individual cases must respond to a complex web of requirements that, in many cases, hamstrings rather than facilitates services to individual families.

System Management Structure

Nor is the system managed by a single individual or agency. Although all 50 states and the District of Columbia provide the core services of intra- or quasi-familial child protective services, family foster care, and adoption services for special needs children; it is the public child welfare agency (as opposed to a contract provider, another division within the public human services agency, or other service provider) which delivers these services in a smaller proportion of states. In 42 states (82.4 percent) the public child welfare agency delivers intra- or quasi-familial services, and in at least 41 states (80.4 percent) it is that agency which also provides foster family care and recruitment services, prospective adoptive family recruitment services for special needs children, and court studies pertaining to dependency, abuse and neglect (American Public Welfare Association, 1990). In seventy to eighty percent of the states, public child welfare agencies also deliver the following services: adoption services for special needs children, child protective services for licensed child care facilities and third party situations, adoption services for domestic non-special needs children, counseling, and therapeutic/specialized family foster care (American Public Welfare Association, 1990). (See Figure A-1.)

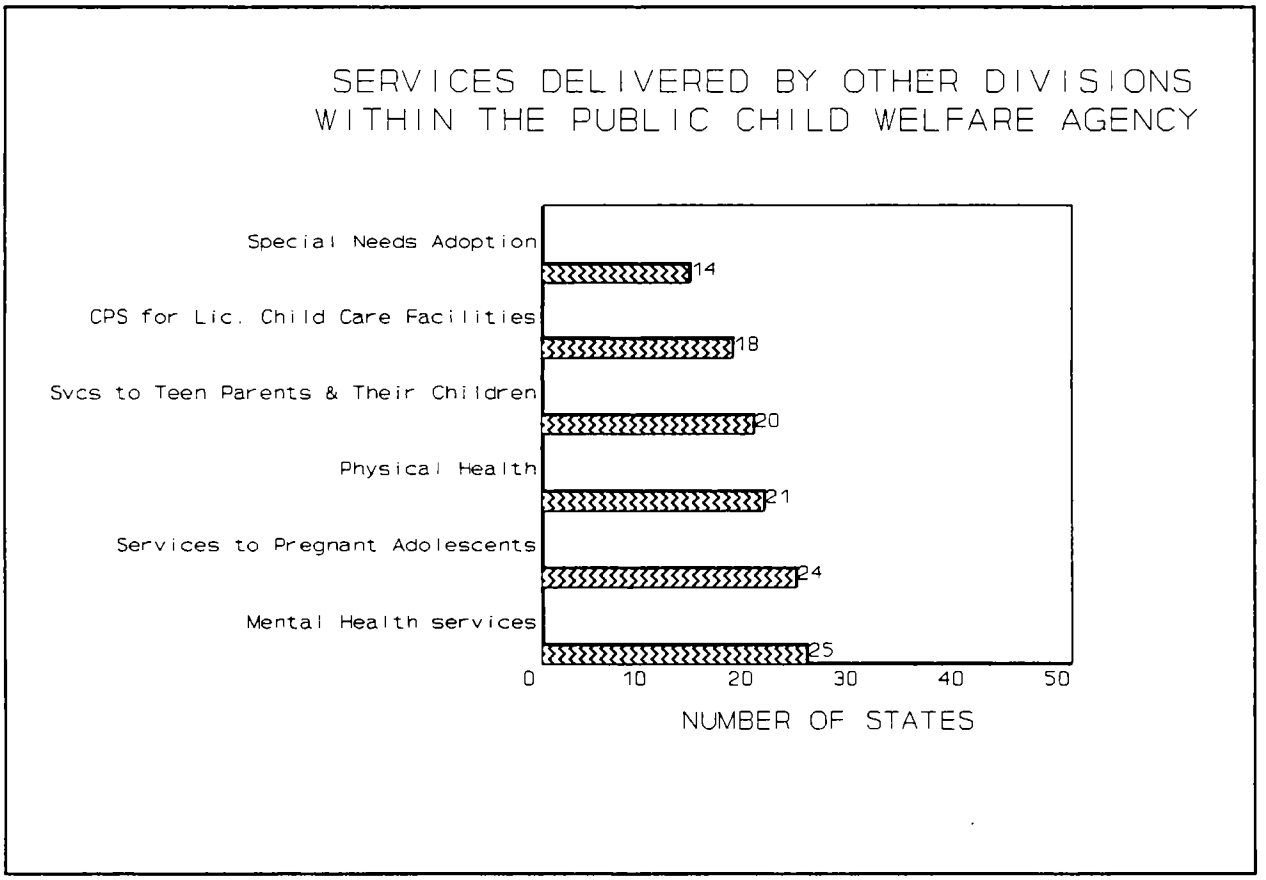
Figure A-1



American Public Welfare Association. (1990). Factbook.

Many additional services essential to the strengthening of families and protection of children are provided by divisions within public human services departments or by contract providers. For example, services related to parental and child alcohol and drug abuse (an area which has been singled out as a major contributor to the increasing number of reports) are delivered by the public child welfare agency in only a small number of states. States rely on other human services divisions, by and large, to provide alcohol, drug abuse and mental health counseling, and many state child protection agencies also rely on other divisions to provide child protective services for licensed child care facilities (See Figure A-2).

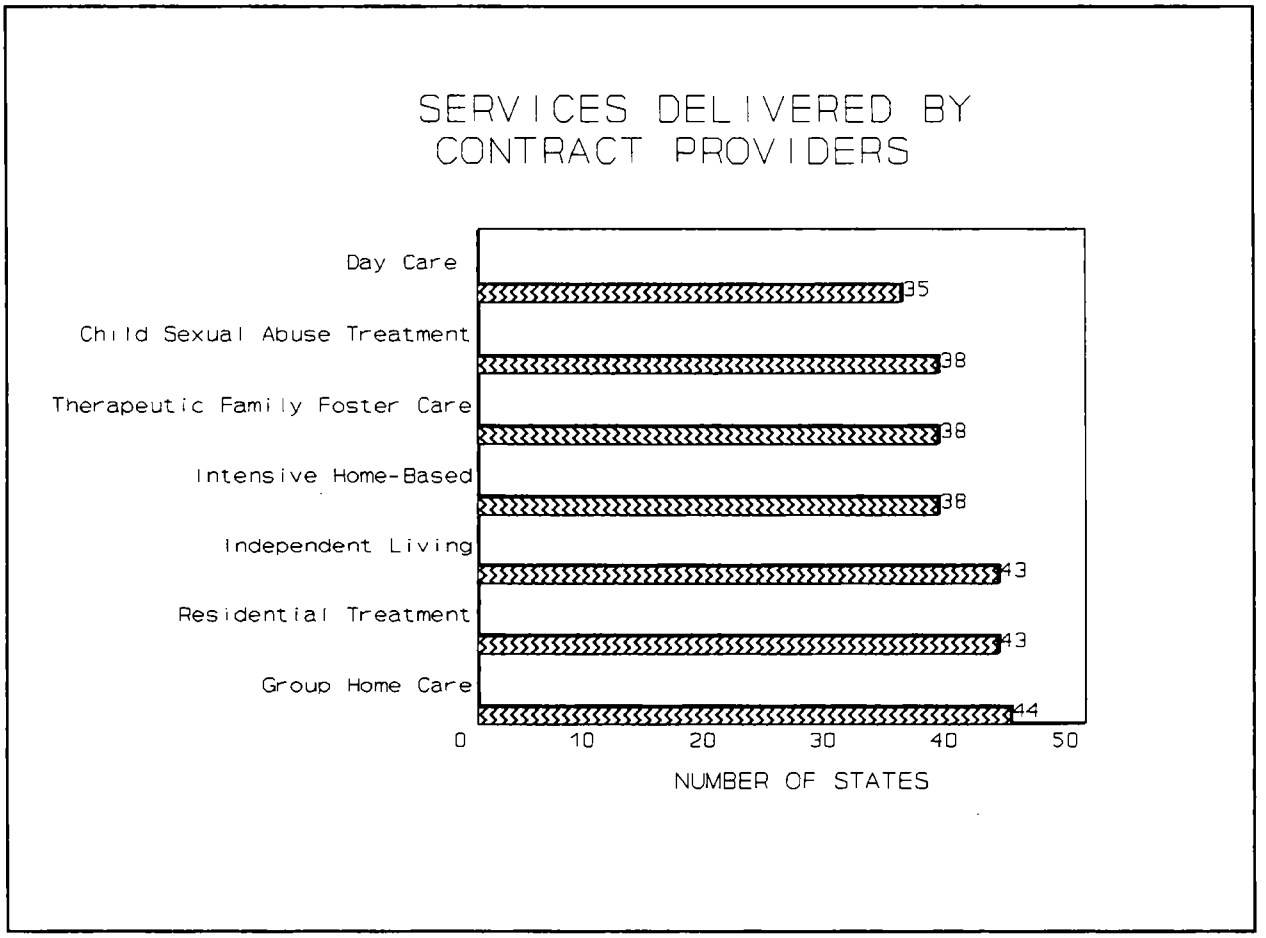
Figure A-2



American Public Welfare Association. (1990). Factbook.

Outside contract providers are relied on in at least 43 states to deliver group home care, residential treatment, and independent living services; and it is also common for agencies to use contract providers for intensive home-based services, therapeutic/specialized family foster care, and child sexual abuse treatment services (American Public Welfare Association, 1990). (See Figure A-3.)

Figure A-3



American Public Welfare Association. (1990). Factbook.

Preparation of CPS Staff

Delivery of services is also impacted by the structure states have established for training their child welfare staff. The complexity of this work, both in assessing the alleged incident of abuse or neglect and the risk to children, and in delivering services which are often involuntary to multi-problem families, necessitates a high level of skills, training and education. Yet the trend in hiring has been toward reducing the qualifications needed by caseworkers. Eleven of 43

states reporting such data indicate that one or more direct service positions within the agency do not require a college degree as an educational prerequisite (American Public Welfare Association, 1990). At the same time, due to the intense emotional demands of child protection work, high caseloads, low pay and low status, nearly 90 percent of state agencies have difficulty recruiting direct service workers for child protection responsibilities (American Public Welfare Association, 1990). These staffing trends have meant that training plays an increasingly critical role in preparing staff to intervene with families.

Unfortunately, some agencies have been slow to institute the type of competency-based training which best prepares workers in the field. In a 1990 survey, only 24 states reported providing mandatory *pre-service* training to direct service workers and only two-thirds of those states assessed the competency of trainees upon completion of the training program. Just 15 states provided *pre-service* training to supervisors. All fifty states do provide some type of *in-service* training, but the training is mandatory for direct services workers in just 35 of the states. Approximately 40 percent of the states assess staff competency following completion of *in-service* training. Requirements for the amount of training provided also vary tremendously from 20 hours (in Illinois, Missouri and South Carolina) to 140 hours (Arizona), with half of the states reporting 20 to 40 hours of mandatory *in-service* training (American Public Welfare Association, 1990).

Administration of training varies by state as well, with the majority of states utilizing a specific child welfare agency training unit to deliver *pre-service* training to workers, supervisors, and managers; but with most states turning to outside consultants for *in-service* training for all staff. Forty-four states reportedly coordinate their staff training with schools of social work (and federal Title IV-E funds provide incentive to do so). Other sources of training include umbrella training units for the entire agency, national training centers, community colleges, law enforcement, national or regional conferences, and teleconference participation (American Public Welfare Association, 1990).

Structure of Services

States also differ in how they administer the services they provide. Although a myriad of specific approaches exist, the three primary management methods are:

- services centrally managed and provided directly by the state (37 states),
- services state-supervised but provided by the counties (15 states), and
- direct provision or purchase of services by counties or local entities (4 states)[1].

To add to the management complexity, although in most cases one management system predominates, it is often also the case that state or local government has primary responsibility for particular programs or populations. The management approach that is utilized within a state often can be critical to the ability of agencies to gain the involvement and support of local communities in their efforts to reach vulnerable children and families (Robison, 1990).

In sum, today's child protection system is dominated by its responsibility for investigating allegations of child maltreatment and for providing care for children who cannot safely remain in their own homes. CPS has become mainly an investigation, not a service provision resource, and foster care has become the main intervention resource, even though only about 20 percent of children substantiated for abuse and neglect are placed out of the home. CPS does not effectively draw upon a larger array of community service resources, even for its open cases. There are relatively few resources available for improving family functioning, treating the multiple service needs of abused and neglected children, providing concrete assistance with housing, medical care, food and other

[1] Some states use a combined approach, which accounts for the total of 56 states.

necessities, and few ways for public social services to provide preventive or early intervention services to strengthen families before abuse or neglect takes hold.

In many respects the system still reflects its roots, in which practice developed separately in individual jurisdictions and under a wide variety of state and federal programs, rather than as one cohesive system of services for children and families. The result is a system still struggling to respond comprehensively to the needs of vulnerable children and families, and still without a unified policy and programmatic framework to do so.

Section B

Accessing the System/Reports—how do children and families enter the system?

B. Accessing the System/Reports—how do children and families enter the system?

A child or family's access to the child welfare system is often decided by a specific crisis event that precipitates state involvement in the family's life. Whatever that incident is—a report of child abuse or neglect, a disruptive act in the school or the community, the need for substance abuse treatment—it is typically the incident that determines which agency will handle the case. That agency then responds to the event, but not necessarily to the overall needs of the child and family. Indeed, the availability of a particular program, facility, or funding stream may determine what services a family will receive, rather than the family's specific needs (Robison, 1990).

For families who enter the child welfare system through child protective services, the interrelated needs of the child and family often either are not assessed or they are met with duplicative requirements for assessments by different child-serving agencies and the court system, with each assessment focused on the individual agency's target problem. Children with special needs or multiple problems may move from one agency to another without their needs being fully assessed or served. Open-ended funding streams help to create an incentive for out-of-home placement, even though that course may have drastic and emotionally harmful consequences for both children and families. A lack of flexibility by individual agencies to help the family deal comprehensively with its needs may mean that families become involved with several agencies, sometimes with each unaware of the other agencies' efforts. Understanding the whole picture is the key to creating better services for abused and neglected children and their families (Robison, 1990).

Screening Criteria/Definition for Report Acceptance

All fifty states currently have criteria designed to direct certain children and their families into the child protective services system. When a child and family meet these threshold requirements, they will be accepted into the system as a report of alleged abuse and/or neglect. The majority of states utilize three criteria to determine if a report will be referred for investigation:

1. the child must be under the age of 18;

2. the alleged perpetrator must be someone identified as either a parent, caretaker, guardian or someone responsible for the health and welfare of the child; and

3. there must be an allegation of abuse or neglect that constitutes evidence of harm or a risk or threat of harm to the child.

Additional criteria such as the availability of identifying information which will enable the child and perpetrator to be located, are outlined in several states[2] (see Appendix A). However, most states adhere to some form of the three basic criteria as outlined above. Many states also require a specific factual allegation that meets the statutory or policy definitions of abuse and/or neglect[3].

Six states[4] also indicate that other factors must be considered, such as severity of the abuse, age of the child, perpetrator's access to the child, recency of the incident or time between the alleged incident and the report, and the parent's willingness to protect the child. In Minnesota, the criteria specify that the report must contain information not previously received by the local agency.

To some extent, these criteria are aimed at screening out inappropriate reports so that the system can concentrate its resources on more effectively serving families and children with serious and legitimate child protection issues and can avoid unwarranted intrusion into the privacy of the family. Controversy has arisen, however, in defining what reports are "appropriate" for the system to serve and in developing truly effective and valid methods to identify those cases.

As more stringent screening criteria and more non-reportable conditions are identified, system resources do become more focused. A fallout of these efforts,

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[2] These additional criteria are utilized in Arizona, California, Colorado, Massachusetts, Minnesota, Utah, and Washington.

[3] These states are Arizona, Arkansas, Colorado, Delaware, Kentucky, North Carolina, Rhode Island, South Carolina, Texas, Virginia, Washington, Washington, D.C., and West Virginia.

[4] The six are California, Kansas, Maine, Michigan, South Dakota and Wisconsin.

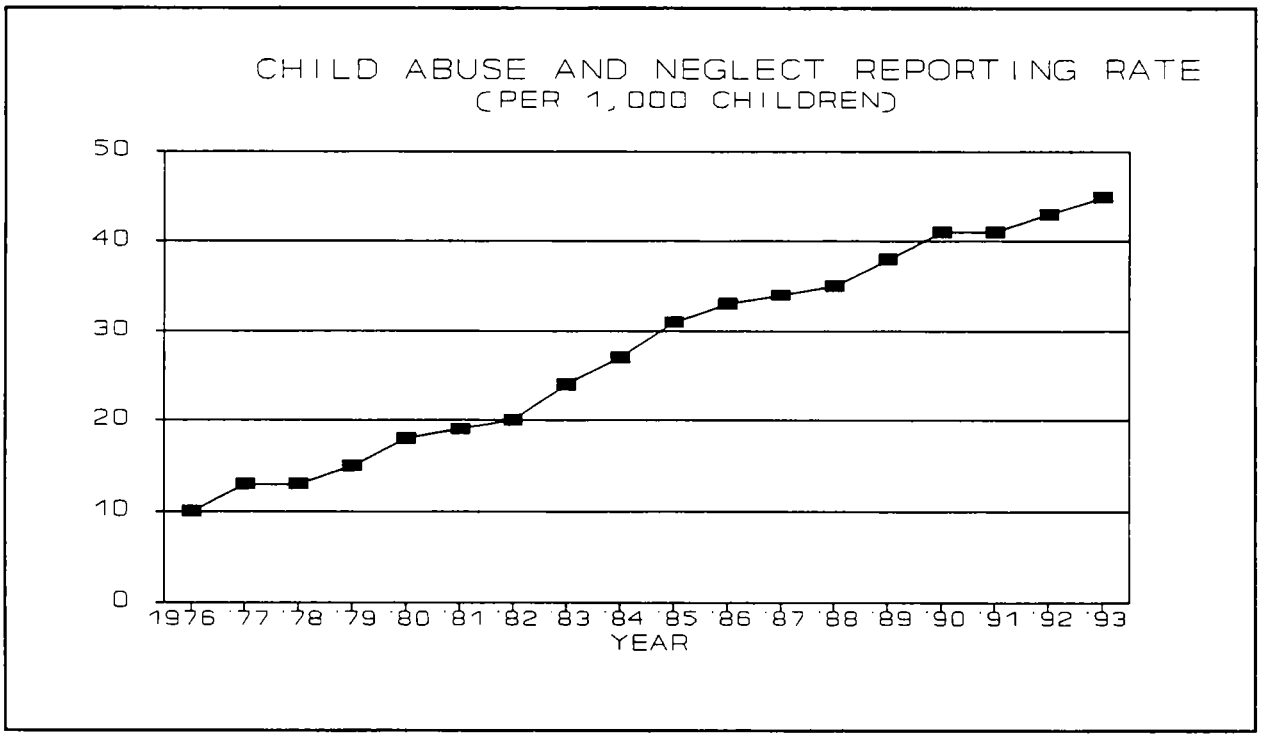
however, is that situations which are of real concern for the welfare of the children but which are not specific incidents or conditions of child abuse or neglect (e.g., substance abuse by parents or homelessness) may not be addressed by any system until the family's condition is more severe and intractable. Moreover, there is controversy among workers, administrators, and those who have researched screening policies as to whether low-risk cases can be effectively screened out at the time maltreatment is reported and prior to investigation (Wells, Fluke, et al., 1989; see also English, D. and Aubin, S. W., 1990).

Access to the child protection system, in short, is in most cases driven by policy constraints aimed at eliminating all but a defined set of child protection emergencies from the purview of the system, rather than by the goal of securing appropriate assistance for families at risk of abuse or neglect.

Current Report Numbers and Rate of Reporting

The year 1976 marked the first time that data were interpreted nationally on reports of child abuse and neglect made to state child protective service agencies. In that year, 669,000 children in the United States were reported for maltreatment (American Humane Association, 1978). This number represented a report rate of 10 children per 1,000 U.S. children. By 1993 the numbers had increased to an estimated 2,989,000 children reported nationally, representing a report rate of 45 children per 1,000 (McCurdy and Daro, 1994). These numbers represent an increase in reports from 1976 to 1993 of 347 percent. (See Figure B-1.)

Figure B-1



American Humane Association. (1976-1987). National Reporting Study; Daro & McCurdy. (1988, 1989, 1993) Annual fifty-state survey; NCCAN (1990, 1991, 1992) NCANDS Report.

Many systemic factors contributed to this significant increase in reports. As of 1967, all states had enacted mandatory reporting legislation. These laws, supported by public education on how to identify and report child maltreatment, led to greater public awareness of the problem and increased reporting (Sawyer and Maney, 1981). These years also saw changes in laws and policies regarding agency response to alleged child abuse that have affected the types of reports accepted for investigation, procedures used to investigate or assess reports and other agency actions. At the same time, agencies have made great strides in improving their information infrastructures. While significant improvements are still needed, public agencies today are much better able to document and retrieve information about the families entering the child protective services system.

Changes in the family and social environment also are cited as contributors to an increased incidence of child abuse and neglect. Factors cited anecdotally,

but widely accepted as contributing to maltreatment, include economic stress exhibited by higher numbers of families and children living in poverty, unemployment, and the barriers that low income presents in gaining access to child rearing resources. Another factor that has gained attention over the past several years is increased substance abuse among many parents, a problem which can severely limit parents' abilities to provide appropriate care for children. Much higher rates of teen pregnancy, compounded by the erosion of community and familial supports, also have made more children vulnerable.

While the nearly three million children reported as abused or neglected in 1993 is a staggering figure, this number represents only part of the problem. Alleged child abuse by third party perpetrators is typically handled by law enforcement agencies, and these children are not generally reflected in the national statistics. Military and Native American children are protected by separate Department of Defense or tribal systems, and their numbers are not always reflected in public agency reporting. Equally disturbing is the fact that many maltreated children never come to the attention of child protective services. The 1986 National Incidence Study revealed that only an estimated 35 percent of children known to be harmed during that year were actually investigated by child protective services (U.S. Department of Health and Human Services, 1988). This percentage translates into 1,424,400 children demonstrably endangered by abuse or neglect who did not come to the attention of public CPS.

Report Source

Every state has defined groups of individuals, usually professionals, who are mandated to report suspected child abuse and neglect to local or state child protective service agencies. From 1976 to 1982, these professionals accounted for approximately 50 percent of all reports made to agencies nationally (American Humane Association, 1984), with parents, other family members, neighbors and friends, and anonymous reporters accounting for most of the remainder of reports. Since 1982 the distribution of reporters has maintained a remarkable consistency, with 52 percent of all reports in 1992 initiated by professionals (National Center on Child Abuse and Neglect, 1994). Educators, law enforcement and criminal justice

personnel, and social service professionals consistently account for the greatest numbers of reports.

There is some evidence to suggest that agencies have granted mandated reporters greater credibility over time. For instance, fewer anonymous reports are substantiated, while reports made by mandated reporters are more often substantiated and opened for services than those from anonymous or non-professional report sources (Flango, 1988; American Humane Association, 1984, 1988).

Unfortunately, studies involving a broad range of professionals suggest that child protective agencies have been losing credibility with professional reporters. Numerous studies have shown that when professionals experience agency inaction or further family disruption as a result of reporting, their reporting behavior tends to diminish (Warner & Hansen, 1994; Tite, 1993; Zellman, 1991, 1990). Educating professionals on their legal responsibilities and on procedures for reporting, a common response for underreporting, does not address the fundamental distrust of the system's ability to intervene effectively.

Substantiation

States use different terms to denote substantiation (e.g., valid, indicated, substantiated, confirmed) and each state may assign a different meaning to these terms. For the most part, states use just two disposition categories (however named), distinguishing only substantiated cases from unsubstantiated ones.[5] In a substantial minority of states though, a third category is utilized to cover instances in which the report is possibly false or possibly true, but not clearly either.[6] Many states also further divide the substantiated category, but then combine these categories when calculating substantiation rates (Flango, 1991).

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[5] Twenty-seven states use this approach including: Arkansas, Delaware, Florida, Hawaii, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming.

[6] States using a intermediate category of this type include: Alaska, Alabama, Arizona, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Nebraska, New Hampshire, New Mexico, Oregon, Utah, Washington, D.C., Wisconsin.

Criteria for the amount of evidence or proof required to substantiate a report vary from state to state and are defined by law, policy, regulation or customary practice. The general standard for substantiation is either:

a) that available facts or circumstances would cause a reasonable person to believe that abuse or neglect had occurred; or

b) there is some credible evidence or a preponderance of evidence to indicate that abuse or neglect occurred.

Eighteen states[7] require some credible evidence to substantiate an allegation of abuse and/or neglect including "reason to believe/reasonable cause/reasonable relationship," "strong circumstantial evidence," or "probable cause." In eleven states and Puerto Rico, a case is substantiated when credible evidence exists, without qualification.[8] A preponderance of evidence is a requirement for substantiation in another eleven states and the District of Columbia.[9] The remaining six[10] states use a combination of either the caseworker's determination or individual judgment. Delaware requires a level of risk to be assessed in order to determine substantiation (Flango, 1991).

Studies have shown that the higher the level of evidence or standard of proof required to substantiate a case, the lower the rate of substantiation. In addition, states that use some form of risk assessment model have higher substantiation rates than states that do not use such tools (Flango, 1991).

Based on a compilation of statistics from the American Humane Association's National Reporting Study, the Annual Fifty State Survey of the

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[7] Alaska, Arizona, Arkansas, California, Idaho, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota.

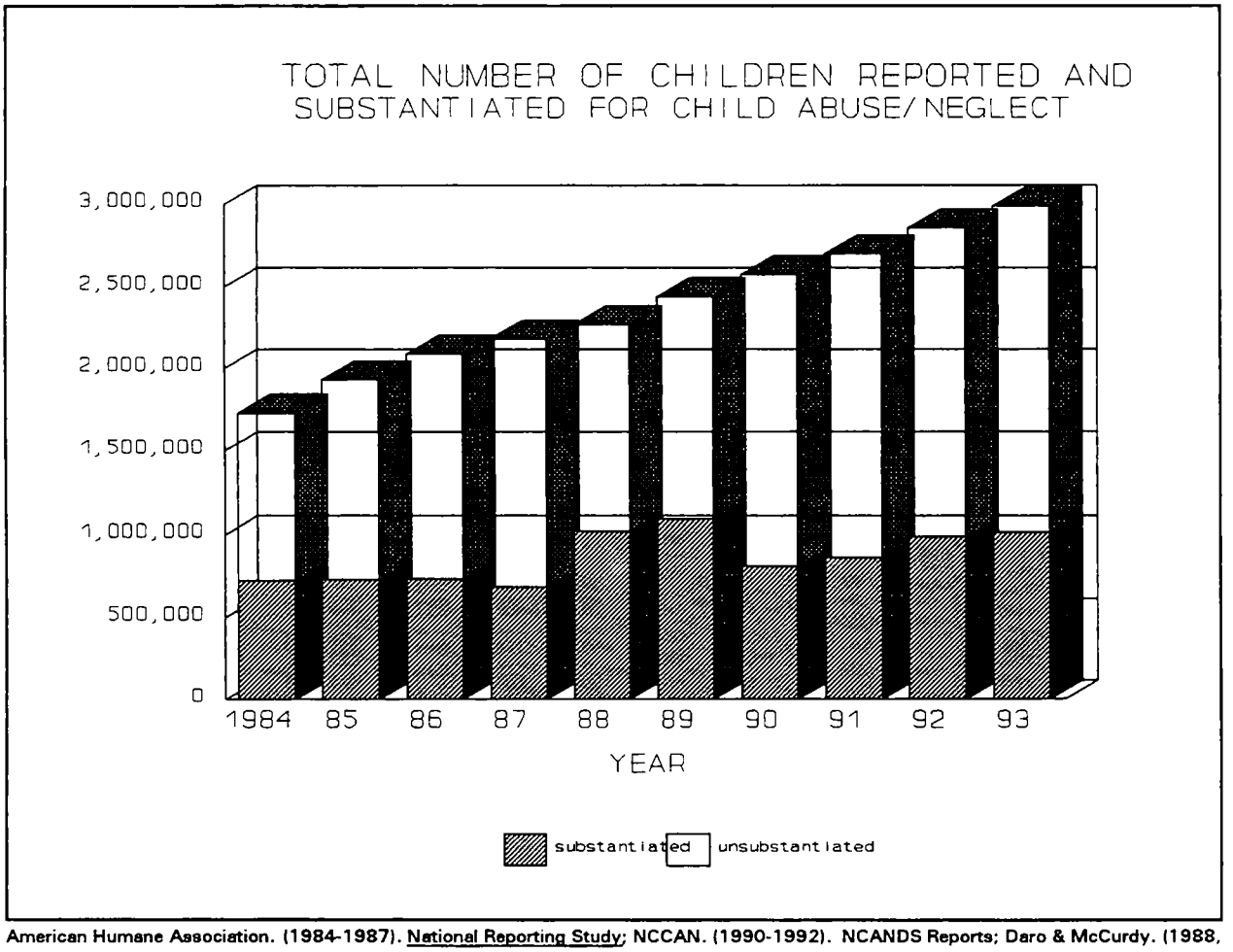
[8] Alabama, Colorado, Connecticut, Florida, Illinois, Maryland, Michigan, Nebraska, Nevada, Puerto Rico, Rhode Island, Utah.

[9] Georgia, Iowa, Kansas, New Jersey, Oklahoma, Pennsylvania, Texas, Vermont, Virginia, Washington, Washington, D.C., Wisconsin.

[10] Hawaii, Indiana, Minnesota, Mississippi, New Mexico, Ohio, Tennessee, West Virginia and Wyoming.

National Committee to Prevent Child Abuse (NCPCA) and the National Child Abuse and Neglect Data System (NCANDS) reports, the average percentage of child abuse and neglect reports substantiated nationally has hovered around 39 to 40 percent since 1978 (see Figure B-2)[11].

Figure B-2



American Humane Association. (1984-1987). National Reporting Study; NCCAN. (1990-1992). NCANDS Reports; Daro & McCurdy. (1988, 1989, 1993). Annual Fifty-State Survey.

[11] Prior to 1984, substantiation rates were based on total reports. From 1984-1993, substantiation rates are based on total children reported. Figure B-2 presents substantiation rates from 1984-1993, based on the total number of children reported. 1988 and 1989 figures are based on an average substantiation rate of 45 percent.

The National Incidence Study, in contrast, identified an increase in substantiation rates from 43 percent in 1980 to 53 percent in 1986 (U.S. Department of Health & Human Services, 1981, 1988).

Substantiation has always been a difficult issue to understand fully, as state definitions of what constitutes child abuse and neglect, criteria for substantiation and the resources to conduct in-depth investigations differ greatly, resulting in an extreme variation in the percentage of substantiated reports by state. These differences have ranged from as few as 8 percent to as many as 80 percent of reports substantiated by individual states. Because of these dramatic variations, substantiation rates must be interpreted with caution.

Substantiation rates are a lightning rod for criticism from those who believe that low substantiation rates provide evidence that CPS agencies intrude into the lives of families without adequate provocation (Besharov, 1988). Some also use these rates to argue that CPS staff are not adequately trained to perform their jobs or that the public has been inappropriately encouraged to report child abuse and neglect. Still others have suggested that an ideal substantiation rate, if such a thing were possible, should center around 50 percent to allow for reporting of legitimate suspicions of abuse without increasing risk to children (Flango, 1991).

Two critical questions may be framed regarding this debate. First, how willing are we as a society to accept some invasion of privacy to protect vulnerable children? The criminal justice system has shown that the public tends to accept invasions of privacy when the objective of intervention is public safety (Finkelhor, 1990). Although the American public strongly supports aggressive pursuit and arrest of alleged criminals, conviction rates are currently 55 percent for those accused of violent crimes. From a public policy standpoint, does this rate differ significantly from child maltreatment substantiation rates of 40 percent?

Secondly, what is the public mandate for action? The public has fairly clear expectations for criminal justice to identify and punish individuals who threaten the public safety. To a lesser extent, the public also assigns some value to criminal rehabilitation activities. In contrast, the public expects CPS to protect children from harm by identifying abusive situations and individuals, but is much more ambiguous about what the nature of intervention should be. Our philosophical shift in child protection, moving away from punishment of perpetrators and toward

providing family support, requires a more complex conclusion on the part of the public.

Regardless of which side of this debate one joins, it is difficult to argue that substantiation rates are not important. They serve as a barometer of the public's ability to identify suspected child abuse and neglect. More importantly, in some agencies substantiation functions as a gatekeeper, with services provided only to a portion of children and families involved in substantiated cases.

Section C

Children and Families in the System—who are they; what are they like; what do they need?

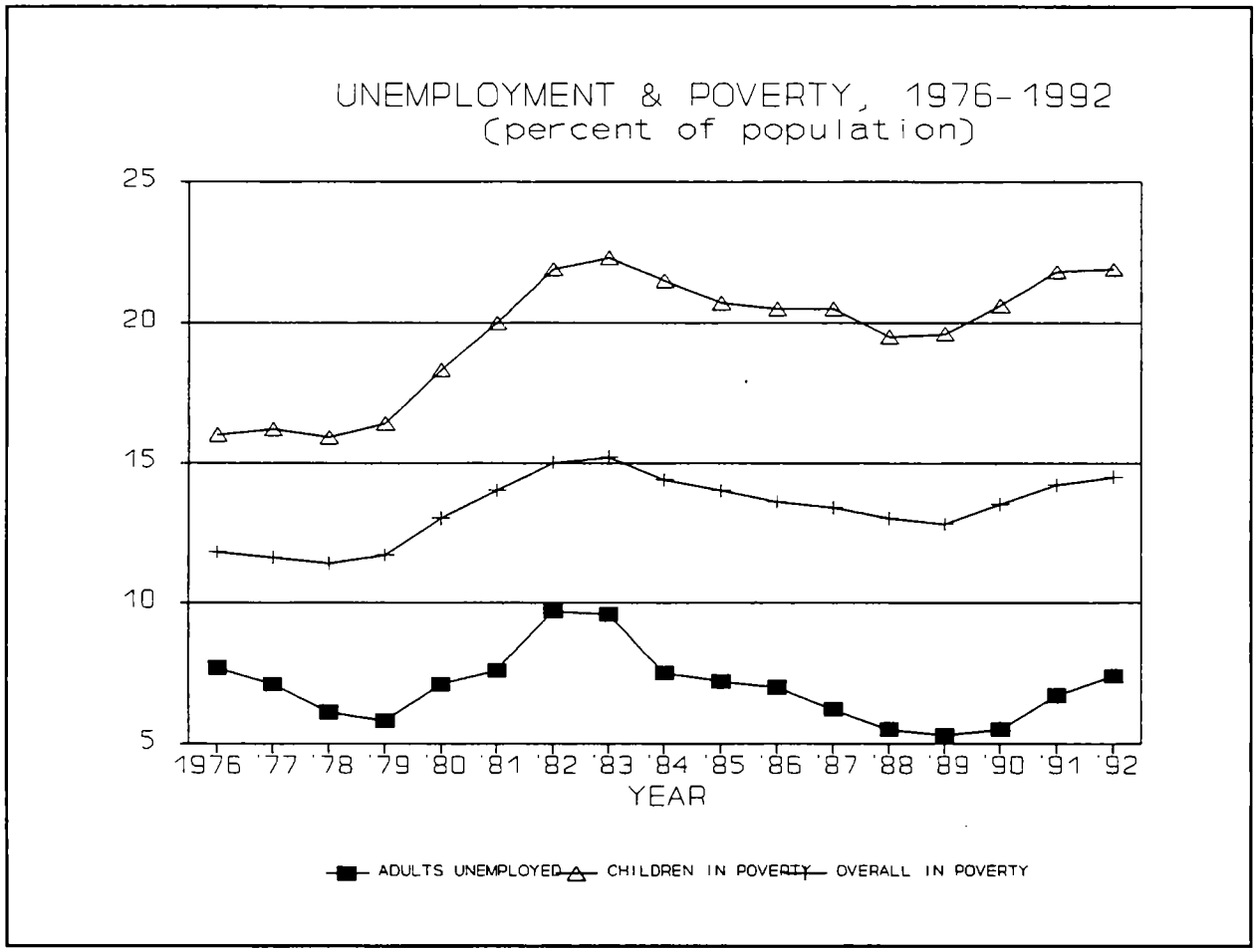
C. Children and Families in the System—who are they; what are they like; what do they need?

Families who become involved with the child protection system come from many different backgrounds and all walks of life. However, at the time that families are reported for abuse or neglect, they often are experiencing one or more stressors which increase the likelihood that they will maltreat their children. As we examine the characteristics of children and families involved in maltreatment, it is important to keep in mind that the factors discussed here are those to which child protective service agencies have selectively attended. There may be other no less critical factors operating in the lives of these families that have escaped our attention.

A composite profile of child victims known to the child protective services system reveals a seven and a half year old, Anglo girl, with a parent under the age of 36 who is a perpetrator of neglect. The identified neglect typically involves deprivation of necessities and/or inadequate supervision (American Humane Association, 1987). This profile has been relatively consistent over time.

The child welfare system historically evolved in response to the child-rearing difficulties encountered by a relatively well-defined group of poor, deprived families encountering unmanageable family crises (Antler, 1985). Numerous studies have demonstrated beyond question that this orientation persists as they repeatedly find poverty or economic deprivation to be the most common characteristic of CPS families (Pelton, 1989; Pecora, Whittaker & Maluccio, 1992). In 1980, the annual income of 43 percent of child protective service families was under $7,000, compared with 17 percent of the general population, and this trend continued at least into 1986 (U.S. Department of Health & Human Services, 1981; 1988). Other studies have shown similar relationships between economic deprivation and child maltreatment (Gil, 1970; American Humane Association, 1978-1988). Yet no national studies since 1986 have examined this issue, though they continue to cite anecdotal support for the impact of economic stress on families (McCurdy & Daro, 1994). (See Figure C-1.)

Figure C-1



Committee on Ways and Means. 1993 Green Book.

A brief review of recent annual state reports indicated that some states report caseworker-identified economic problems as a stress factor contributing to child maltreatment, but few states appear to make the link between child welfare and income maintenance systems or other proxies for poverty in order to corroborate this hypothesis with factual data. One state that obtains specific income information for CPS families reported in 1992 that 44.9 percent of families experiencing maltreatment had annual incomes below $12,000, while another 36.6 percent of reported families fell in the $12,000 to $25,000 range (Virginia Department of Social Services, 1993). These percentages compare with 10.2

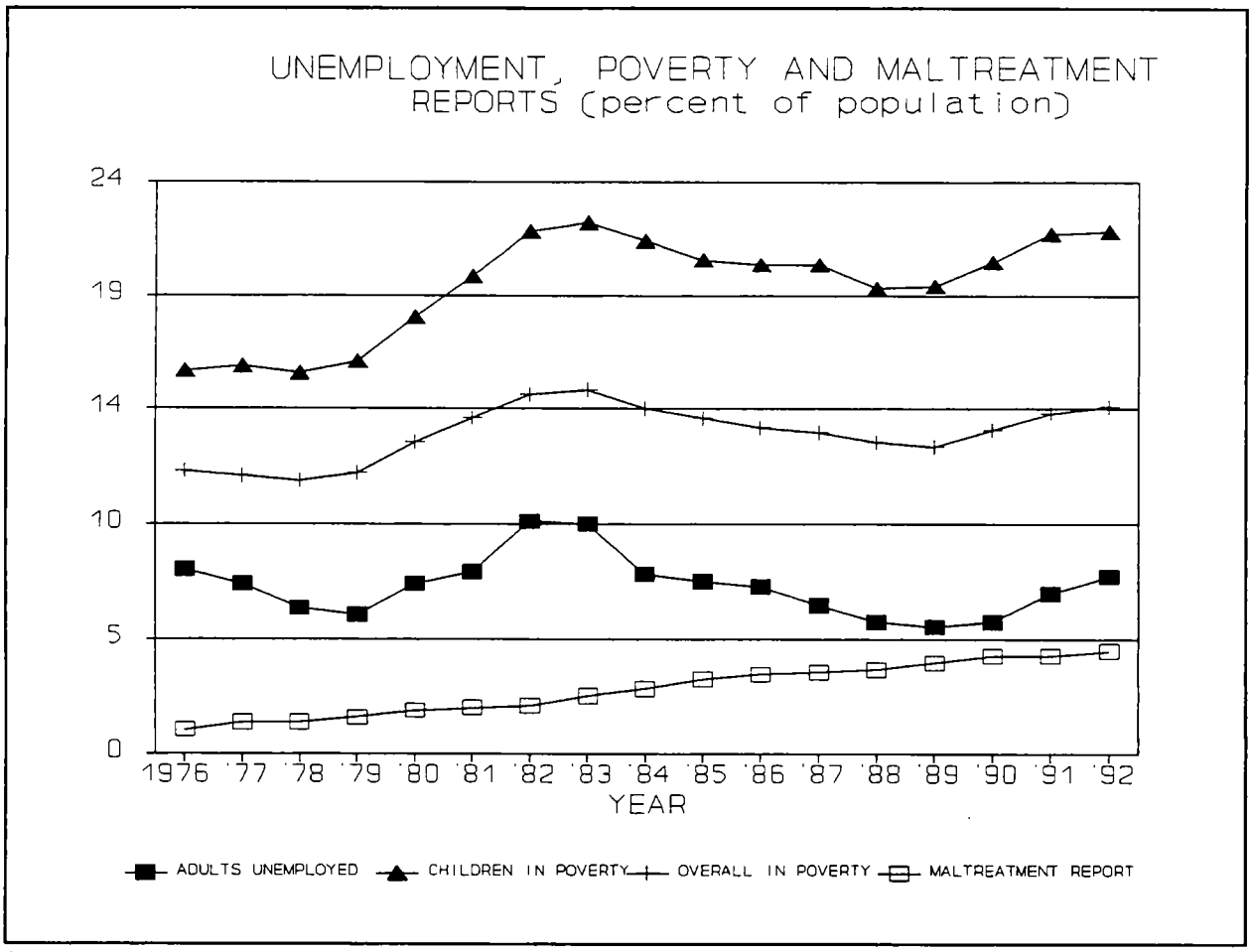
percent of the state's families who lived in poverty in 1989[12], and a median annual income of $33,328 for all families in the state (U.S. Department of Commerce, 1993).

Many children and families now enter the child protective system with more serious, complex problems due to living without the necessary familial and community supports in neighborhoods characterized by deprivation, substance abuse and violence. Children who come into out-of-home care are more likely to have been there before, and their home conditions are more likely to have deteriorated from those of the previous placement. A combination of stressors commonly identified in maltreating families includes unrealistic expectations of the children, parental substance abuse (with from 3 to 80 percent of cases identified as involving substance abuse in 1993), family problems or inability to cope with parenting responsibilities, inadequate housing, and immaturity or low self esteem (McCurdy & Daro, 1994; Missouri Division of Family Services, 1992; American Humane Association, 1987).

The picture of maltreating families that emerges from the available data is one of a younger, more economically and socially vulnerable population (see Figure C-2).

[12] Defined as an annual income of $9,885 for a family of three and $12,674 for a family of four.

Figure C-2



Committee on Ways and Means. 1993 Green Book; AHA (1976-1987). National Reporting Study; Daro & McCurdy. (1988-1989) NCPCA Annual Fifty-State Survey; NCCAN. (1990-1992). NCANDS Reports.

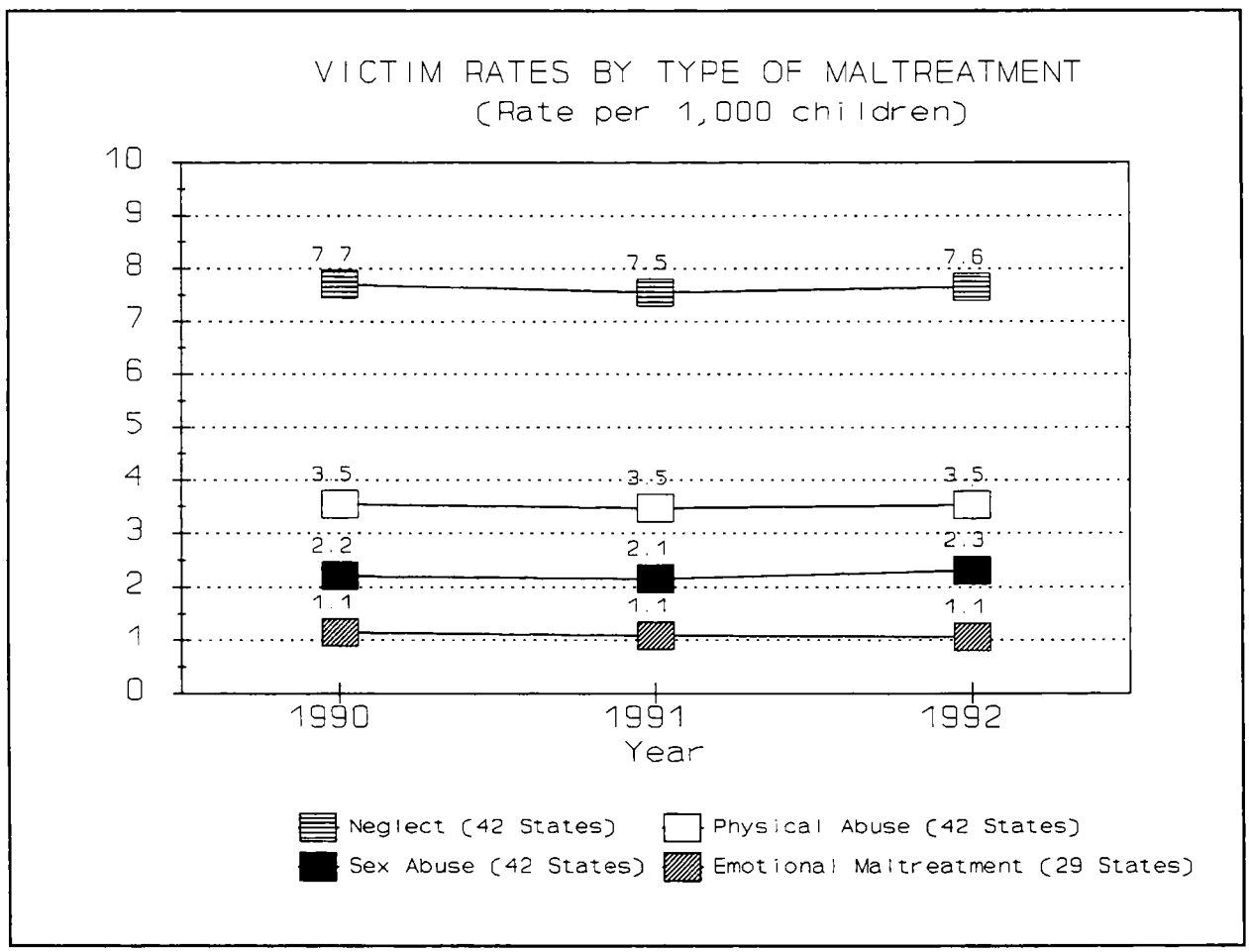
These are often families experiencing increased stresses in individual or family life, who lack knowledge or are unwilling or unable to easily access the kinds of community and family supports that could help to ameliorate their situations.

Maltreatment Types

Maltreatment substantiated by child protective service agencies is aggregated into five broad categories:

- physical abuse,
- sexual abuse,
- neglect,
- emotional maltreatment and
- other, a category which generally includes abandonment and dependency (see Figure C-3).

Figure C-3



Source: NCCAN. (1994). Child Maltreatment 1992.

Because of systemic changes and differences in data collection procedures between 1976 and 1993, the maltreatment data from these years may not be

directly comparable. One significant difference is the unit of measurement. Some studies categorize maltreatment type by children and others by reports. Because more than one child can be involved in a report, these separate categories tend to present different pictures of reporting activity.

An individual child may also experience more than one type of maltreatment. In these instances, some states choose to report only the most serious maltreatment while others report all that are present. This overlap can distort the picture of maltreatment. In addition, increased awareness of specific types of maltreatment, such as sexual abuse, leads to greater numbers of specific types of reports, thereby decreasing the percentage of maltreatment represented by other categories. Finally, the tightening of definitions on the characteristics of reports that are accepted for investigation has undoubtedly affected the portrayal of maltreatment. With these qualifiers in mind, a review of the patterns of reported maltreatment suggests some notable changes in the 18 years since data collection began.

In every year since national data collection began, the largest percentage of substantiated reports made to child protective service agencies has been characterized as neglect. Though neglect is consistently the leading form of identified and reported maltreatment, the percentage of all reports represented by neglect has shown a relatively steady downward trend, from a high of 86.4 percent in 1978 (American Humane Association, 1979) to a low of 44 percent in 1991 (National Center on Child Abuse and Neglect, 1993). Because of its chronic nature, neglect may take a lower priority than more acute forms of maltreatment. However, its cumulative effects can be devastating. Over the years, neglect has been a primary contributor to child maltreatment fatalities.

Definitions of neglect vary across states and generally refer to the "failure to provide needed, age-appropriate care" (National Center on Child Abuse and Neglect, 1993). The most frequently identified types of neglect are inadequate supervision and deprivation of necessities. Numerous studies have linked neglect to poverty and the resulting difficulty that resource-poor families may have in providing basic necessities such as food, clothing, medical care and nurturance for their children. For this reason it is interesting to note that, at the same time that the percentage of neglect reports has decreased, the numbers of children living in

poverty has increased from a rate of 16.0 in 1976 to a rate of 21.8 in 1991 (Committee on Ways and Means, 1993).

The next largest category of maltreatment consistently has been physical abuse. Substantiated physical abuse reports have shown a gradual increase from 15.9 percent of all reports in 1976 (American Humane Association, 1978) to 25 percent in 1993 (McCurdy & Daro, 1994). Physical abuse refers to "physical acts that caused or could have caused physical injury to a child" (National Center on Child Abuse and Neglect, 1993) and includes both minor and serious injuries.

Sexual abuse may well have received the most media and public attention in the past few years. For example, of the 414 requests for information received by the National Resource Center on Child Abuse and Neglect (at the American Humane Association) in the first quarter of 1994 (January through March), 239 were for general information about child abuse and neglect, 142 were specific to sexual abuse, 12 to emotional abuse, 11 to neglect, and 10 to physical abuse. The reasons for this attention are not entirely clear. We can speculate that the prevalence of sexual abuse across all socioeconomic strata and significant underreporting, combined with the demand by adult survivors for recognition and resources to treat the effects of their experiences, have intensified media interest and focused public attention on this issue. However, despite this attention, the numbers of substantiated sexual abuse reports are low compared to other types of maltreatment. While the percentage increased dramatically from 3.2 percent of all reports in 1976 to 15.7 percent of all reports by 1986, this percentage has stabilized since that time and stands at 15 percent of all reports in 1993 (McCurdy & Daro, 1994).

The majority of states (36) have defined a separate category of emotional maltreatment. A general definition of emotional maltreatment "refers to acts or omissions that caused, or could have caused, conduct, cognitive, affective, or other mental disorders, such as emotional neglect, psychological abuse, mental injury, etc." (National Center on Child Abuse and Neglect, 1993). Emotional maltreatment is often considered to be a component of any form of maltreatment, and a report solely alleging emotional maltreatment appears less likely to be investigated without some indication of a high level of severity. The percentage of substantiated reports characterized as emotional maltreatment has declined from

14.6 percent in 1976 to 4 percent in 1993, though in recent years it has ranged from 5 to 10 percent of all reports.

The fifth category of maltreatment type, "other," includes reports such as abandonment, educational neglect, and reports of an unspecified nature that are not included in the preceding categories. Between 1976 and 1993, this category has ranged from 4 to 10 percent of all reports.

Age of Victims

The average age of all child victims was 7.5 years in 1992, down slightly from 7.8 years in 1976 (National Center on Child Abuse and Neglect, 1994; American Humane Association, 1978). Younger children are considered to be much more vulnerable to abuse and neglect and are reported in greater numbers to CPS agencies. In 1992, 27 percent of substantiated child victims were three years of age or younger, with children under one year of age accounting for almost twice as many victims as any other age group (National Center on Child Abuse and Neglect, 1994). In particular, very young children are more likely to be the victims of neglect. Children under age one also represent 46 percent of child fatalities, and 86 percent of all child fatalities involve children under the age of five (McCurdy & Daro, 1994).

Race/Ethnicity of Victims

Anglo children comprise the greatest number of maltreatment victims. However, in relation to their numbers in the general population, Anglos have been underrepresented in child protective service populations since national data were first aggregated in 1976. The 1980 and 1990 census counts show that Anglo children constitute approximately 80 percent of the total child population. In contrast, Anglo children were 67.6 percent of all child victims in 1976, decreasing to 55.2 percent in 1992. At the same time, African American children have been overrepresented in the CPS system compared to their numbers in the general population, and the percentage of African American child victims is increasing. In 1976, these children were 21 percent of all child victims; by 1992 they

constituted almost 26 percent of all child victims. This is compared with an African American population of approximately 15 percent of the general population in 1980 and 1990 U.S. census counts.

It is more difficult to accurately identify the numbers of Hispanic children represented in CPS populations or to contrast them with the number of Hispanics in the general population. The difficulty hinges on how agencies define Hispanic. Some states define this group as a separate race and others, including the U.S. Census Bureau, define Hispanic as an ethnic group subset within each race category. For these reasons the child maltreatment reporting data and census data are not comparable. However, using the numbers as provided by individual states without regard to differences in definition, reporting studies have shown that Hispanic children made up 10.8 percent of all child victims in 1986 and 9.6 percent in 1992.

Several explanations have been offered for the overrepresentation of non-Anglo children and families in CPS populations. Some have proposed that the behavior of these families may be under greater public scrutiny, resulting in a greater likelihood of being reported. Others point out that the general relationship between socioeconomic status and race/ethnicity in this country means that families of color are more likely to have poverty-associated problems such as dangerous living environments, inadequate education, unemployment, and limited access to medical care, all factors that have been strongly correlated with child maltreatment (Pelton, 1989).

Gender of Victims

Boys and girls are equally vulnerable to child abuse and neglect. In 1976, both genders were equally represented among child victims (American Humane Association, 1986; National Center on Child Abuse and Neglect, 1994), while in 1992 the percentage of male victims had decreased slightly to 46 percent, and female victims had increased slightly to 53 percent (National Center on Child Abuse and Neglect, 1994). This is the reverse of the gender pattern of the general population where males constitute 51 percent and females, 49 percent of the total population under age 18 (Bureau of the Census, 1993).

With one notable exception, gender differences for substantiated victims by maltreatment type are minimal. There are slightly more male victims of physical abuse (51 percent), neglect (52 percent) and child fatalities (54 percent). Slightly more girls are victims of emotional maltreatment (53 percent), while significantly more girls (79 percent) are victims of sexual abuse. These gender distributions by maltreatment type have been consistent since 1986 (American Humane Association, 1988; National Center on Child Abuse and Neglect, 1994).

Fatalities

The number of child fatalities documented as deaths attributable to child abuse and neglect has been slowly climbing since 1986. In that year there were 1,014 child fatalities, increasing to 1,299 in 1993 (McCurdy & Daro, 1993, 1994). This means that more than three children are known to die every day as a result of child maltreatment, and there are likely to be more deaths that are misdiagnosed. Studies have shown that a portion of child deaths attributed to accidents, homicides or SIDS, upon further investigation, may actually be attributable to child maltreatment.

Children under the age of five are most vulnerable; in 1993, 86 percent of child fatality victims were under the age of five and 46 percent were under the age of one. In the same year, 55 percent of child fatalities resulted from physical abuse and 40 percent from physical neglect. Forty-two percent were known to the child protective service system either through an open CPS case at the time of death or through former involvement with the CPS agency (McCurdy & Daro, 1994).

Thirty-four states have now established death review committees that review the circumstances surrounding child deaths and strive to identify why child protection has failed and what system changes might prevent future deaths. The implementation of these teams does not appear to correlate with changes in the rate of child fatalities, though they may have prevented a more dramatic increase in fatalities.

Relationship of Perpetrator to Child Victim

As noted earlier, not all CPS agencies accept reports of third party abuse, referring these reports instead to law enforcement agencies, and their occurrence may not be counted in child maltreatment reporting data. By far the greatest amount of child maltreatment known to CPS agencies is perpetrated by parents or other relatives of the child victim. A composite profile of perpetrators from 1979 to 1982 revealed that parents[13] were perpetrators of maltreatment in 94 percent of substantiated cases. By 1992, the percentage of maltreatment perpetrated by parents had dropped to 78.8 percent, with other relatives accounting for 12 percent and unrelated perpetrators for 14.6 percent. The change in perpetrator patterns may reflect changes in family structure, increased discrimination regarding the legal relationship of the perpetrator and victim, increased public awareness of what constitutes appropriate adult-child interactions, and pressures on CPS agencies to respond to both intra-familial and extra-familial incidents of child maltreatment.

Other Characteristics of Maltreating Families and Children

The previous section has characterized child maltreatment primarily as viewed from within the child protective agency. Other sources of information such as developmental and clinical studies and intervention literature help to round out the picture of children and families at risk of child maltreatment.

Abusive and neglectful parents share a range of characteristics that distinguish them from non-maltreating parents. These parents tend to be immature and dependent and to engage in role reversal, that is seeking care from, rather than providing care for, their children. They tend to be socially isolated, partly due to inadequate social skills, and have great difficulty establishing trusting relationships. They have low self esteem and while they may seek pleasure in dramatic ways, they find it difficult to enjoy themselves. Maltreating parents typically have

[13] Of those defined as parents, 85 percent were biological parents and the remainder were either stepparents, adoptive parents or foster parents.

unrealistic expectations of their children, often due to poor role modeling from their own parents as well as a lack of knowledge about child development. They sometimes fear that they will spoil their children if they give them too much attention, so they teach with criticism rather than praise. They often find it difficult to empathize or to see situations from another's perspective. Finally, they tend to be disorganized, impulsive and action-oriented and find it difficult to accomplish tasks they set out to accomplish (American Humane Association, 1992).

Given this portrait, it is not difficult to understand that maltreating parents must be supported in their efforts to develop better parenting skills as they frequently do not have the skills and perseverance to seek and follow through with obtaining help. Several studies have shown that maltreating parents are more likely to follow through with referrals for concrete services related to shelter, food, clothing, health, and income and much less likely to follow through with counseling related services (Wolock, 1982; Pelton, 1989).

Children also enter the system with a range of needs that may not be identified or effectively addressed. The findings of a national clinical evaluation of a sample of abused children under age 13 showed their extensive needs (Daro, 1988):

- approximately 30 percent of the abused children had some type of cognitive or language disorder;
- approximately 14 percent of the abused children exhibited self-mutilative or other self-destructive behaviors;
- over half of the abused children had difficulty in school including poor attendance and misconduct;
- over 22 percent had learning disorders requiring special education service; and
- approximately 30 percent had chronic health problems.

Maltreated adolescents included in the study demonstrated an even wider range of problems and more severe disorders than the younger group.

We also know that the effects of child maltreatment can follow children into adulthood and be highly damaging both to the individual and to society. Studies have shown that victims of child maltreatment are 53 percent more likely to be arrested as juveniles, 38 percent more likely to be arrested as adults, and 38 percent more likely to be arrested for a violent crime (Widom, 1992). Recent studies also suggest that the long-term impact of childhood victimization may include among other outcomes, poor educational performance, health problems and low levels of achievement in adult life (American Public Welfare Association, 1988).

These short and long-term effects can be remediated, however. A child's personality and resiliency are the keys to lessening the impact of maltreatment on his or her life and development. Resiliency is defined as the capacity for successful adaptation despite adverse circumstances. Resilient children still carry the effects of maltreatment into their adult lives, yet they demonstrate an ability to recover from these experiences and to gain mastery in their lives (Rivkin and Hoopman, undated). Promoting resiliency by helping children to develop internal resources, external social support networks and a track record of mastery in various life tasks, should be the goal for protective services intervention.

The parent and child characteristics just discussed are not presented in order to label parents as guilty or unfit, but to provide a focus for CPS interventions. Clearly, these interventions must be designed to promote the factors that contribute to competent parenting and to help children develop the resiliency they need to bounce back from these potentially devastating experiences.

Section D

Interventions—what do we do for children and families? what are the scope and type of services we provide?

D. Interventions—what do we do for children and families? what are the scope and types of services we provide?

Describing in a systematic way what child protective services currently does for children and families is the most difficult part of painting a portrait of the system. As Kamerman and Kahn wrote in 1989, "A fully satisfactory, systematic picture of child and family services in the U.S. or of children in this system is impossible given the current status of terminology and data" (Kamerman & Kahn, 1989). While data collection efforts have improved over the last five years, there are still no comprehensive efforts to track cases through the system and link children and families who enter the system with services received, characteristics of providers, and outcomes in terms of child and family functioning, child safety, and family preservation.

Our knowledge of how the system intervenes with families is based, instead, on summary descriptive information about the types of services offered in states, the policy framework for substantiating and serving maltreatment cases, and limited anecdotal or research information about the success of particular programs and services. (The last category is discussed in more detail in the "community ownership" section of this report.)

Victims Removed from Home

Passage of the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) and the emergence of family preservation programs such as the Homebuilders model have oriented CPS systems toward providing services to retain children in their own homes whenever possible. Perhaps as a result, the percentage of substantiated child victims placed in out-of-home care has been about 20 percent since 1979 (American Humane Association, 1984; Daro, undated), though the actual number of children who are placed has increased. Those children who do not leave placement quickly are spending longer amounts of time in out-of-home care than in the past (Tatara, 1993). These longer stays have resulted in a backlog of children in out-of-home care as children enter care at a higher rate than they leave, thereby escalating the total numbers of children in care at any one time. A total of 224,000 children entered placement in 1991. When these

numbers were combined with children already in care, the total was 636,000 children living in out-of-home care (Daro, undated).

These disturbing numbers suggest that the system is falling behind in its efforts to achieve permanency for children. Factors thought to contribute to this trend include resources diverted to placement prevention rather than reunification efforts, increased severity of family problems which require longer term interventions, stiffer criteria for family reunification, and unrealistic expectations that the CPS system somehow can help its clients overcome difficult social problems such as poverty and its impact on families (Tatara, 1991).

Court Action Initiated

Between 1976 and 1986, court action, including filing for temporary custody, dependency and other civil actions, was initiated during investigation for 16 to 18 percent of all substantiated cases. In 1992, court action was initiated for approximately 89,000 child victims in 30 states (National Center on Child Abuse and Neglect, 1994). State agencies typically do not track criminal court filings so the relationship between CPS agency involvement and criminal prosecution for child maltreatment is not known. It is also not known to what extent court action is initiated after cases are opened for services.

Additional Services Provided to Substantiated Families

A review of child protective policies in the ten states which contain 80 percent of the U.S. child population[14] indicated that most of these states require additional service provision once a report of abuse or neglect is substantiated. In at least two states, policy also provides that services may be offered based upon the receipt of the report alone, even before an investigation.[15] Services beyond

[14] California, Florida, Georgia, Illinois, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas.

[15] See Georgia policy 2102.11a and Florida statute section 415.5021 et. seq., initiating a new two-track system not requiring investigations for service provision.

investigation are clearly required by policy once there has been a substantiated report in five states.[16]

The numbers of child victims and families that actually receive services is consistently undercounted nationally due to the retention of reporting and service data in separate information systems that often do not link with one another. It is, however, possible to construct a fairly accurate picture of general service activity to cases from intake through the conclusion of investigation, although this information is limited to cases of substantiated maltreatment. The percentage of substantiated cases that are opened for any type of ongoing service delivery appears to have increased from 33.3 percent in 1976 to a high of 78 percent in 1990 (American Humane Association, 1984; McCurdy & Daro, 1993). Our most recent statistics show that 70 percent of substantiated children received some type of services in 1993 (McCurdy & Daro, 1994). The services most frequently identified are out-of-home care, casework counseling and case management, and these services have been consistently identified over time.

Additional Services Provided to Screened-Out or Unsubstantiated Families

Some screened-out reports may involve families and children with service needs. However, agency response to reports that do not meet screening criteria for report acceptance varies. A review of ten states' CPS policies in this area found substantial variations in guidance. In three states[17] the handling of screened out reports is not addressed in policy, while two states[18] have policy stating that **all** reports are to be investigated, so no information is provided on how to handle screened-out cases.

In the remaining five states[19], policy indicates that inappropriate reports are to be referred to other child welfare or community services that may ameliorate the

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[16] California, Michigan, New Jersey, New York, Texas.

[17] California, Florida, Illinois.

[18] New York and Ohio.

[19] Georgia, Pennsylvania, Michigan, New Jersey, Texas.

child or family's situation. Texas policy requires workers to notify the reporter when cases are closed at intake and to provide information and referral assistance, as well as advise the reporter of potential indicators of the need to report again. Georgia workers are required to document why an initial assessment was not conducted and what alternative referral was provided. Two states[20] provide for or require supervisor discretion in decisions to provide CPS services or referral to other community-based resources.

Only four of the ten states reviewed have policies which indicate that information and referral services are provided to unsubstantiated families. In California, workers are to refer a child and/or family to other community agencies and resources if the investigation determines that child welfare services are not necessary. Illinois and New York policies are similar in that, even if the report is unfounded, the family may still be offered a variety of services if they are needed. Michigan is quite clear that unsubstantiated reports are to be "assessed for referral to Preventive Services or other community services" with the stipulation that parents are willing to accept other services. A case conference with staff must be held prior to the referral being made. While the remaining states do not have formal policies to guide the provision of information and referral services to unfounded cases, this is not to say that in practice referral does not occur.

While policy permits many states to provide services to unsubstantiated and voluntary cases, no national data exist on the numbers of these cases that actually receive services. However, research and anecdotal information suggest that the numbers are low, while policy suggests that children and families in these categories typically would be referred to other community agencies for services if needs are identified.

Which States Provide Services Beyond Investigation

In every state and the District of Columbia, three basic services are provided statewide: child protective services for intra- or quasi-family situations, family foster care, and adoption services for special needs children (American Public

[20] Michigan and New Jersey.

Welfare Association, 1990)[21]. It is not surprising that all states currently respond to intra-familial reports of abuse and neglect, since a reporting law is required under the Child Abuse Prevention and Treatment Act (CAPTA) to access those federal funds, nor that all states offer family foster care and special needs adoption assistance, services which they may fund on an open-ended basis through federal Title IV-E (funding is discussed in more detail below).

Forty-nine states and the District of Columbia also provide the services of licensed child care facilities, prospective adoptive family recruitment for special needs children, and services related to the Interstate Compact on the Placement of Children on a statewide basis. (Alaska provides these services at selected locations throughout the state.) As of 1990, more than forty states provided the following additional services to vulnerable children and families: court-related program services including home studies on dependency, abuse or neglect (49 states); adoption services for in-state non-special needs children (47); foster family recruitment services (47); counseling (45); participation in the Interstate Compact on Mental Health (45); child protective services for third-party perpetrator situations (44); mental health services (44); day care services (43); emergency shelter services (43); and physical health services (42) (American Public Welfare Association, 1990).

More specialized child protective/child welfare services, particularly those aimed at maintaining children in their own homes, tend to be less available or available only in selected locations in some states. In 1990, only 34 states provided some type of intensive, home-based services in some localities, and only 26 states provided respite care services, again in a limited number of localities (American Public Welfare Association, 1990). With passage of the Family Preservation and Support Act in 1993, it can be expected that these types of services will become more available as federal funding increases from $60 million directed at statewide planning efforts in 1994 to at least $255 million for family preservation and support service delivery by 1998.

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[21] The methodology utilized to collect this information was a survey of state child welfare agency administrators.

Other more specialized services which currently are less universally available on a statewide basis include: Independent Living Services for Youth Age 16 or Older (offered statewide in 35 states), residential treatment services (32 states), child sexual abuse services (30 states), therapeutic family foster care (29 states), group home care (29 states), homemaker services (27 states), alcohol abuse services for parents and children (25 states), and drug abuse services for parents (25 states) (American Public Welfare Association, 1990).

Inconsistencies in Practice

Identification of inconsistencies between policy and practice typically occurs in the context of special studies and compliance reviews. From the findings of these efforts, we know that inconsistencies are more the rule than the exception. Studies have shown inconsistencies between individuals as well as between policy and actual practice in several areas. These areas involve decisions about screening, risk assessment, opening a case for services, and decisions to place a child (Rossi, Schuerman and Budde, 1994; Pennsylvania Office of Children, Youth and Families, 1993; Wells, Fluke, Downing and Brown; 1989).

It is not surprising to find that practice decisions are often inconsistent with policy or administrative guidelines. Research has shown that, in practice, service decisions made by human services staff are influenced by individual factors such as values, education, skills, cognition and empathy and by organizational factors including workload, training, supervision, and agency policy and history (Kern, Baumann, McFadden & Law, 1993). Studies have also found that, when faced with ethical practice conflicts, workers give client needs equal weight to organizational requirements and search for creative ways to balance these sometimes competing interests (Walden, Wolock & Demone, 1990).

Attaining a level of consistency in agency policy and practice presents a constant challenge and can be addressed effectively only by the existence of adequate resources to attend to both individual and organizational factors.

Outcomes (Recidivism/Placement/Fatalities)

In 1990, the U. S. Advisory Board on Child Abuse and Neglect considered the question of what the system does for children and families and stated, "Research on the effectiveness of interventions for neglected children and their families is rudimentary" (U.S. Advisory Board on Child Abuse and Neglect, 1990). Child welfare agency-based evaluation and research has tended to focus on measuring program processes (e.g., timeframes, contacts, service counts) rather than consequences or outcomes for children and families. In recent years, trends toward outcome-based evaluations in the fields of education and health care have caught the attention of those in child welfare and sparked efforts to hold child welfare agencies accountable for client-focused outcomes. Increased public scrutiny of interventions with maltreated children and their families, and the development of clinical assessment instruments for use with child welfare populations have also contributed to the movement toward outcome-based evaluation. Most of these efforts to date have focused on issues of child safety as measured by recidivism and placement.

Recidivism

Because the goal of child protective services is to prevent additional harm to child victims, recidivism (defined as subsequent confirmed maltreatment) is thought to be a potential indicator of the agency's ability to meet its goal. The measurement of recidivism, however, presents many challenges to agencies and researchers alike, resulting in an extreme variation in recidivism rates. Recidivism studies have shown rates of 14 percent (Marks & McDonald, 1989), 38 percent (Baird, 1988) and 46 percent (Johnson & L'Esperance, 1984) among CPS populations, with subsequent incidents occurring most often within one year of an initial incident (Herrenkohl, et al., 1978).

Because of the chronic nature of child abuse and neglect, families screened into CPS are those where subsequent maltreatment is thought to be more likely to occur. If these screening decisions are based on valid factors, and other agency factors such as resources and staff skills are held constant, it would be logical to

expect an increase in recidivism rates with the tightening of screening criteria. However, so few agencies have conducted ongoing studies of recidivism that we are not really in a position to measure this effect. Of the few states whose annual reports present an analysis of recidivism trends, one showed a small increase from 14.2 percent in 1991 to 15.3 percent in 1993 (Pennsylvania Department of Public Welfare, 1994). California showed an increase from 28.8 percent in 1985 to 40.4 percent in 1989 (Hill, 1991). These are isolated examples which may or may not reflect broader trends.

Placement

Reduction in the numbers or duration of placements is an outcome considered most often by family preservation programs. While this outcome is child focused, it does not directly address or measure the long term success of system intervention for the child and family, and therefore may not be a useful client outcome measure. As mentioned above, the number of children entering placement has remained at about 20 percent of those substantiated for maltreatment. However, the speed with which a significant segment of children leave substitute care has decreased, resulting in an overall increase in the number of children in out-of-home care. We cannot say with certainty whether this is because children now enter care at a younger age on average, because they enter care with more severe problems, or because the system is truly failing to reach its stated outcome goal of achieving permanency for children more expeditiously.

Fatalities

Child fatality as an individual and system outcome has driven efforts by states to understand the characteristics of families and environments in which child fatalities occur and to initiate system changes that promote more effective identification and intervention into these volatile situations. Thirty-four states have established death review committees to investigate the circumstances surrounding child fatalities. Some of these states review only those child fatalities known to be related to child maltreatment while others review <u>all</u> child deaths, regardless of the

reason for death. In at least one state the committee's recommendations have led to a set of protocols and procedures for handling such cases, and also policy changes and training mandates for workers.

Several potential outcomes or impacts have been associated with the implementation of interagency child death review teams including improvements in interagency communication and management of cases; intervention efforts on behalf of the surviving, at-risk siblings of the child victim; identifying families who are at risk for potential severe or fatal abuse; providing interagency services to families who are considered high risk; improving the system's relationship with the media and its ability to use the media to educate the general public about child abuse prevention; and enhancing communications between states and counties within states regarding child deaths (Durfee, Gellert and Tilton-Durfee, 1992).

Developing Other Outcome Measures

At the Second Annual Roundtable on Outcome Measures in Child Welfare Services (American Humane Association, 1994), a matrix model was proposed as a developmental framework for tackling the issue of defining and measuring outcomes. One axis of the matrix represents target outcomes (child safety, child functioning, family functioning, family continuity/preservation) and the other axis represents the focus of intervention (child, family, community). As an example of the model's application, a community-focused intervention to impact family functioning could be indicated by a family functioning outcome defined as an "increase in the availability and adequacy of recreational services and community supports to encourage healthy family functioning" (American Humane Association, 1994, p.10).

Increased interest in outcome-based evaluation is driven by a concern to hold agencies accountable for the quality and effectiveness of services provided to families. However, given the significant gaps in what is known about interventions, the well recognized and documented resource limitations, and persistent staffing dilemmas, it will be essential to balance the interpretations of outcome studies with better information about service implementation. Otherwise, the system may err in concluding that a program is a failure, or worse yet, that family problems are intractable, when the failure may truly be one of program or service implementation.

Section E

Costs and Funding Sources—who pays how much for what?

E. Costs and Funding Sources—who pays how much for what?

In the 1990s, the child protective services system is funded by a fragmented array of local, state, federal, and private monies. Lack of coordination between funding sources surely affects the nature and outcome of services provided to children and families. Although there is an opportunity presented by the potential to draw funds from multiple sources, the current funding system also presents barriers to effective service delivery. These include the need to satisfy numerous differing information and documentation requirements, an uncoordinated and categorical approach to service delivery, funding geared only to "emergency" services, and lack of entitlement to a universal set of comprehensive services for vulnerable children and families (Farrow and Joe, 1992).

Federal Funding Streams

Currently, federal human services legislation has created more than 100 separate programs to deal with problems or needs of the nation's families in the areas of:

- public health,
- social services,
- mental health,
- juvenile justice,
- substance abuse,
- education,
- public assistance,
- housing and
- job training.

These funding streams, which were created to respond to specific human services needs, have remained categorical in nature and targeted to individuals with specific problems, with separate funding mechanisms, eligibility requirements, and accountability structures.

Historically, the concept that money and counseling go together ("not alms, but a friend") became a standard in the development of modern social work in this

country early in the 20th century. But by the time the Social Security Act was drafted in 1935, a debate had begun as to whether cash assistance to parents with children (now AFDC) should be administered by the Children's Bureau (created in 1912 to deal with child-related issues of data collection, child labor, investigations into the condition of children, and maternal and child health), or by the newly created Social Security Board (which also was charged with responding to the needs of the blind and aged). The Children's Bureau "lost" the contest, and cash assistance to families with children became a program managed by the Social Security Board (Kamerman and Kahn, 1989).

The separation of the legislative mandate and administrative responsibility for the child welfare and financial assistance programs in the 1935 Act created a dichotomy between the public child welfare system and financial assistance programs for families and children that remains to this day. In large measure, federal child welfare programs became focused on foster and institutional care, while the social services responsibilities of programs that continue primarily to provide income assistance for children and families have not been well developed. Even a specific 1962 legislative mandate to better coordinate child welfare services with Aid to Families With Dependent Children (AFDC), and passage of more flexible general social services funding under Title XX in 1975, did not result in better coordination of services (Kamerman and Kahn, 1989).

The 1960s and early 1970s saw a rapid growth in overall federal financing of social services provided by the states. The 1962 amendments to the Social Security Act legislated federal-state cost sharing for social services aimed at reducing or preventing welfare dependency. Between 1967 and 1972 federal expenditures grew from $281.6 million to $1.7 billion, a 504 percent increase! (Burt and Pittman, 1985). By the mid-1970s, federal dollars accounted for about half of the total public spending on child welfare services. A cap was placed on federal social service expenditures in 1972 due to the enormous increases—a doubling of expenditures in one year (1971-1972) from $741 million to $1.7 billion (Burt and Pittman, 1985). This cap made it even more difficult for states to develop and use services to children as an alternative to foster care.

Congress made a major effort in 1975 to improve state services to families, and to reduce current and future dependency, through passage of another

amendment to the Social Security Act—Title XX. States were given increased authority, responsibility and flexibility in choosing the array of social services to be provided with federal financial participation (75 percent federal share; 25 percent state share), although the $2.5 billion cap on social service expenditures enacted in 1972 remained in effect, thus limiting opportunity for program development. Title XX supplied approximately 30 percent of the budget for state child welfare services by 1982, compared to 52 percent from state, local and private sources. Children's services received on average about one half of the Title XX dollars, yet, when the decade of the 1970s closed, nearly three-fourths of all child welfare monies were devoted to foster care (Burt and Pittman, 1985).

The categorical nature of current federal programs makes it almost impossible to approach families holistically, drawing upon the most appropriate combination of program services. Furthermore, community-based resources, both public and private, often do not fit precisely into the categorical system (many are developed to fill gaps in community service needs) and thus are not easily integrated into the mix of services offered to children and families by public departments of social services.

It is beyond the scope of this paper to discuss all of the federal funding streams that serve vulnerable children and families, but even among those services which are focused primarily on the needs of at-risk children, there is a lack of coordination. The child welfare system and child protective services system are typically viewed as distinct and separate entities. Federal funding mechanisms reinforce this distinction by channeling funds to coordinate policy around child abuse and neglect programs through the Child Abuse Prevention and Treatment Act (CAPTA), while maintaining the largest federal funding streams for child welfare services under Titles IV-B, IV-E and XX of the Social Security Act.

In addition, states utilize funds for emergency services under Title IV-A, and numerous other federal grants to deliver services to at-risk children and families. Some of these additional federal funding sources (those directed specifically to child abuse prevention and treatment will be discussed in more detail below) include:

- Title XIX - Medicaid,
- Child Abuse and Neglect Basic Grants and "Baby Doe" grants,
- Child Abuse and Neglect Discretionary Grants,
- Child Care and Development Block Grants,
- Children's Justice Grants, and
- Alcohol, Drug Abuse and Mental Health Grants.

Title IV-B

Title IV-B of the Social Security Act is the federal funding mechanism directed specifically to providing child welfare services for the purposes of:

- placement prevention and family reunification;
- family preservation and family support programs;
- child protection and abuse prevention; and
- maintenance of foster placements, adoption assistance payments, and work-related child day care. (The last three areas are limited to the level funded under IV-B in 1979.)

Under Title IV-B, Congress has permanently authorized a federal match of 75 percent to states for services in the above categories that address the welfare of children. There are no income eligibility requirements for service recipients, but funding under IV-B for these direct services is capped at the level annually appropriated by Congress.

Since FY 1990, Title IV-B funding has been authorized at $325 million annually (exclusive of the new Family Preservation and Support Program which will add approximately $1 billion over five years beginning in FY 1994), but actual appropriations have never reached the full amount authorized. For FY 1993, for example, the total appropriation was $294.6 million.

Each state is allocated a share of authorized IV-B funds based on its under-21 population and per capita income. (A state-by-state listing of allocations for recent years follows in Table E-1.)

TABLE E-1
TITLE IV-B CHILD WELFARE SERVICES: STATE-BY-STATE ALLOCATIONS

[In thousands of dollars]

	Fiscal years			
	1986 actual	1991 actual	1992 actual	1993 appropriation
Alabama	4,208	5,634	5,432	5,798
Alaska	267	561	614	675
Arizona	2,807	4,307	4,418	4,781
Arkansas	2,504	3,369	3,273	3,496
California	17,789	26,520	27,289	30,049
Colorado	2,470	3,482	3,558	3,845
Connecticut	1,838	2,123	1,942	2,066
Delaware	529	716	717	764
District of Columbia	339	469	431	448
Florida	7,944	11,771	11,773	12,946
Georgia	5,810	8,002	7,737	8,386
Hawaii	639	1,247	1,180	1,281
Idaho	1,194	1,576	1,581	1,734
Illinois	8,815	11,488	11,338	12,157
Indiana	5,012	6,677	6,709	7,115
Iowa	2,572	3,223	3,364	3,566
Kansas	1,911	2,779	2,885	3,083
Kentucky	3,149	4,934	4,883	5,192
Louisiana	4,635	6,368	6,350	6,750
Maine	1,182	1,477	1,443	1,533
Maryland	3,151	4,074	3,924	4,256
Massachusetts	2,755	4,498	4,336	4,567
Michigan	7,916	10,047	10,196	10,860
Minnesota	3,483	4,537	4,753	5,093
Mississippi	3,140	4,244	4,177	4,438
Missouri	4,403	5,654	5,798	6,218
Montana	874	1,125	1,136	1,212
Nebraska	1,458	2,087	1,996	2,137
New Hampshire	756	498	1,028	1,078
Nevada	711	1,123	1,170	1,326
New Jersey	4,756	5,412	4,936	5,308
New Mexico	1,586	2,282	2,291	2,493
New York	12,123	15,245	14,490	15,530
North Carolina	5,948	7,916	7,771	8,326
North Dakota	670	908	942	983
Ohio	9,027	12,196	12,283	13,053
Oklahoma	2,966	4,114	4,144	4,428
Oregon	2,311	3,162	3,283	3,576
Pennsylvania	9,297	12,011	11,905	12,650
Rhode Island	799	1,032	1,025	1,070
South Carolina	3,578	4,876	4,747	5,101
South Dakota	794	1,015	1,038	1,107
Tennessee	4,497	6,137	5,933	6,329
Texas	14,219	21,476	21,845	23,688
Utah	2,325	3,192	3,196	3,478
Vermont	574	717	713	750
Virginia	4,494	5,905	5,891	6,322
Washington	3,331	4,968	5,169	5,668
West Virginia	1,975	2,519	2,454	2,565
Wisconsin	4,150	5,442	5,639	6,033
Wyoming	197	689	703	751

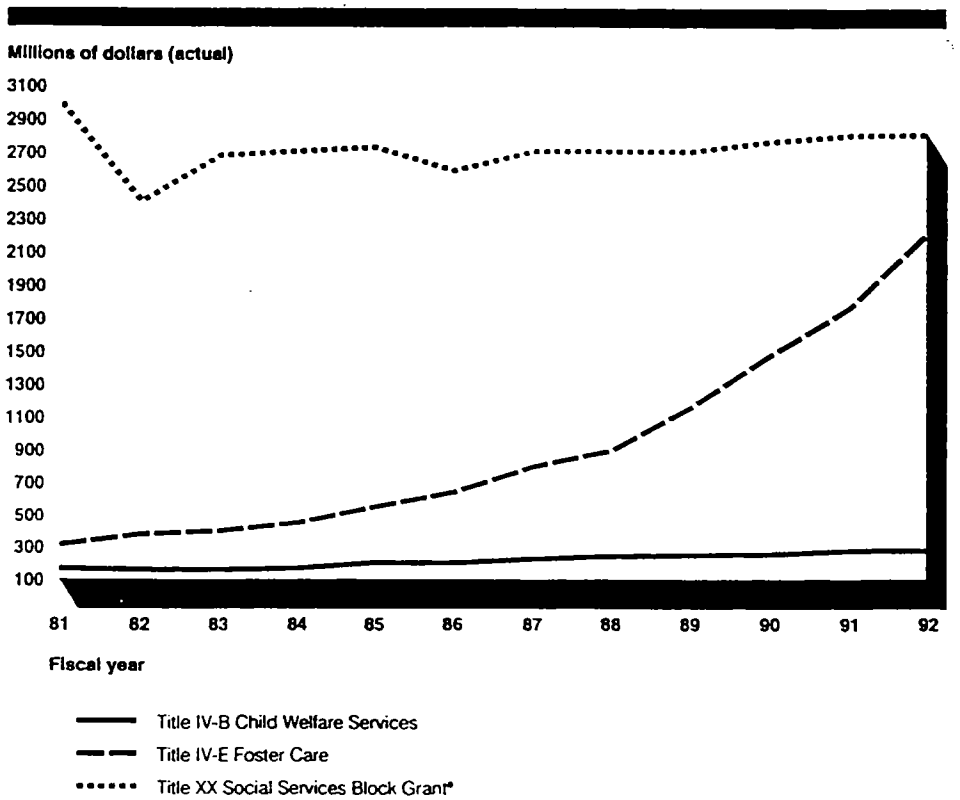
Source: Committee on Ways & Means, U.S. House of Representatives (1993). Overview of entitlement programs: 1993 Green Book, pp. 889-890.

According to the government's own report "because of minimal reporting requirements under the [IV-B] program, there are no reliable national or state-by-state data on the exact number of children served, their characteristics, or the services provided" (Committee on Ways and Means, 1993). An analysis by the American Public Welfare Association for FY 1990 found that states planned to spend 44 percent of their IV-B funds for preventive and supportive services including child protection, 21 percent for administration and management, 17 percent for foster care services, 11 percent for foster care maintenance, 4 percent for adoption activities, less than 1 percent for training and staff development, and the remainder (2 percent) for other child welfare activities (American Public Welfare Association, 1990). Funds for child welfare research and demonstration projects are also authorized under Title IV-B, and a total of $10.2 million was appropriated for grants and contracts to carry out these activities in FY 1992 (Spar, 1992).

With passage of the Adoption Assistance and Child Welfare Act (Public Law 96-272) in 1980, states were also permitted to transfer unexpended foster care IV-E funds to direct IV-B child welfare services. Thirty-one states used this mechanism to transfer $32.6 million from IV-E to IV-B in 1983. Over the past decade, however, growing foster care caseloads have meant that there has been little or no surplus of foster care funds. In 1991, only two states transferred $0.9 million, and by 1992 no funds were transferred. Thus, although in recent years (between 1981 and 1992) funding for Title IV-B child welfare services grew by 67 percent, it has not kept up with open-ended entitlement spending for foster care under Title IV-E. The ratio of IV-E expenditures to IV-B appropriations was two to one in 1981; but by 1992, expenditures for IV-E foster care outpaced the appropriation for IV-B direct and preventive services by a ratio of eight to one. (See Figure E-2 on the following page.)

Figure E-2

Federal Funding for Foster Care Outstripped Funding for Services



[a]Represents total Social Services Block Grant amounts; portion spent on child welfare services is unknown.

Source: United States General Accounting Office. (1993). Foster care: Services to prevent out-of-home placements are limited by funding barriers. (GAO/HRD-93-76)

Title IV-E

Title IV-E of the Social Security Act is another large source of federal funds for child welfare services. Under IV-E, funds are directed to foster care, adoption assistance, and the independent living program for children over age 16. The IV-E foster care program provides maintenance payments for basic food and shelter for AFDC-eligible children placed in out-of-home care settings, as well as administrative and placement assistance, and training. Because foster care moneys are provided on an open-ended entitlement basis, foster care costs have

burgeoned as the number and severity of child protective services cases has increased. In addition, in order to access these open-ended funds, states have become much more administratively adept at tracking children who are eligible for IV-E foster care funds and reporting the maximum amount of eligible services.

Between FY 1982 and FY 1992, the number of children in AFDC foster care more than doubled from 93,000 to 222,315, and foster care costs funded by Title IV-E increased 616 percent from 1981 to 1992. Total national IV-E foster care expenditures (including maintenance, administration, and training) were $2.209 billion in 1992, and the Congressional Budget Office projects that by 1998 they will total $3.913 billion[22] (Committee on Ways and Means, 1993). These costs are separate and distinct from substitute care expenditures for children who are not IV-E eligible because of higher income levels, but may receive substitute care services with federal Title XX funds.

An important policy setting function of Title IV-E enacted in 1980 in Public Law 96-272 is that, in order to receive its full share of IV-E funds, every state must meet certain federal requirements to prevent children from languishing for extended periods in foster care. Currently, all states have certified their own initial compliance with these IV-E permanency planning requirements and the federal government reviews states' actual compliance.

Thus, in spite of the protections introduced into the law in the Adoption Assistance and Child Welfare Act in 1980, federal funding continues, in large measure, to be utilized by states as an virtually unlimited means to finance substitute care for AFDC-eligible children rather than for the delivery of other appropriate services. In addition to the fact that direct services funds under Titles IV-B and XX are capped, federal policy discourages innovation because of the lack of a waiver provision in Title IV-E which would permit states to use funds from that program to demonstrate and rigorously evaluate alternative methods of providing services that will preserve families (United States General Accounting Office, 1993).

The combination of growing eligible caseloads and an open-ended entitlement to IV-E funds has therefore encouraged state agencies to remove

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[22] California, at $418.78 million, and New York, at $675.20 million, account for almost half of the 1992 expenditures according to a 1993 report by the General Accounting Office.

children, even in light of express provisions for "reasonable efforts" to prevent foster care placements. [Experts also attribute the growing foster care caseload and higher foster care costs to the generally higher cost of substitute care compared to in-home services, the rise in illegal drug use especially among young mothers in inner city areas, the AIDS epidemic, and the increased number of homeless families (McCurdy & Daro, 1993).] When one of the largest federal funding streams (IV-E) simply may not be used for placement prevention and family reunification services, it is not surprising that fiscal imperatives rather than policy directives are driving the system. This can be seen on a state by state basis in Table E-3 on the following page, which details foster care expenditures, especially in comparison to the amounts expended under Title IV-B for direct services (see Table E-1 and Figure E-2).

Title XX

The Social Security Act's Title XX Social Services Block Grant is a capped entitlement providing 100 percent federal funds to states (based on population) that can be used at their discretion for a wide array of social services aimed at children, families, adults, and the elderly. In 1992, a total of $2.8 billion was appropriated for all services under Title XX, but there is no complete data on the amount actually spent on services for abused and neglected children.

Two sources do give an approximation of how Title XX funds are spent for both children and adults. First, states are required to file pre-expenditure reports with the Department of Health and Human Services (HHS), including information about the types of activities to be funded and who will be served. Based on a summary of pre-expenditure reports for the years 1983 through 1992 prepared by HHS, the services states most frequently planned to provide were:

- day care for children of working parents (not specifically reserved for child protective services cases),
- home-based services,
- protective services for children,
- adoption services,
- social support services, and
- specialized services for the disabled (Committee on Ways and Means, 1993).

TABLE E-3
FEDERAL FOSTER CARE EXPENDITURES UNDER TITLE IV-E, FISCAL YEAR 1992

[In thousands of dollars]

State	Maintenance payments	Child placement services & administration	Training	Total
Alabama	$ 1.45	$ 3.02	$ 0.06	$ 4.53
Alaska	2.06	2.73	--.08	4.71
Arizona	6.22	8.59	.53	15.34
Arkansas	1.61	3.17	.97	5.75
California	213.77	193.63	11.38	418.78
Colorado	5.89	12.07	.94	18.90
Connecticut	4.78	9.47	.85	15.10
Delaware	.43	0.81	.07	1.31
District of Columbia	2.51	3.94	.12	6.57
Florida	13.89	23.51	3.43	40.83
Georgia	8.46	14.94	1.44	24.84
Hawaii	.47	1.50	.05	2.02
Idaho	.49	.83	.01	1.33
Illinois	58.43	31.45	5.01	94.89
Indiana	10.21	10.97	.00	21.18
Iowa	5.98	5.94	.37	12.29
Kansas	8.21	8.23	.29	16.73
Kentucky	14.21	16.53	4.45	35.19
Louisiana	14.43	10.61	.82	25.86
Maine	5.90	.27	.72	6.89
Maryland	25.00	18.60	1.90	45.50
Massachusetts	29.64	15.54	.00	45.18
Michigan	50.14	50.00	3.38	103.52
Minnesota	14.50	11.24	3.08	28.82
Mississippi	1.49	1.71	.32	3.52
Missouri	15.72	22.06	1.90	39.68
Montana	2.47	.40	--.02	2.85
Nebraska	4.96	2.39	1.36	8.71
Nevada	.96	1.15	.07	2.18
New Hampshire	2.99	3.42	.04	6.45
New Jersey	10.49	10.62	.22	21.33
New Mexico	3.14	2.83	.90	6.87
New York	399.54	261.60	14.06	675.20
North Carolina	8.51	2.53	.07	11.11
North Dakota	2.16	1.44	.23	3.83
Ohio	37.01	35.02	3.18	75.21
Oklahoma	2.80	2.59	.54	5.93
Oregon	7.58	10.18	.10	17.86
Pennsylvania	96.70	42.03	5.00	143.73
Rhode Island	2.87	3.45	.07	6.39
South Carolina	4.82	5.86	.37	11.05
South Dakota	.93	.82	.10	1.85
Tennessee	9.42	7.18	.83	17.43
Texas	36.04	29.10	1.21	66.35
Utah	2.64	2.14	.15	4.93
Vermont	3.90	2.36	.08	6.34
Virginia	3.59	6.81	1.44	11.84
Washington	9.24	11.17	.46	20.87
West Virginia	3.23	1.57	.09	4.89
Wisconsin	19.53	16.52	.00	36.05
Wyoming	.72	.57	.01	1.30

Source: Committee on Ways & Means, U.S. House of Representatives (1993). Overview of entitlement programs: 1993 Green Book, pp. 893-894

In addition, the Voluntary Cooperative Information System of the American Public Welfare Association in 1986 collected data from 37 states which showed that five services accounted for over half of the services provided under Title XX, measured by recipient counts. Those services were:

- protective services for children (15 percent),
- information and referral services (13 percent),
- child day care services (13 percent),
- counseling services (7 percent), and
- homemaker/home management/chore services (6 percent).

Table E-4, which follows, summarizes Title XX Social Services Block Grant Allocations by State, for the years 1991 and 1993, with an estimate of allocations for 1994. (See Figure E-2 for a comparison of the relative amounts expended on all three major federal funding streams, Titles IV-B, IV-E, and XX.)

Even though Title XX is a major source of federal funding for direct child welfare services provided by states, the funding level for this program actually dropped by six percent between 1981 and 1982. Again, it is not known how much of the Title XX funds are expended by states for children's services, as these grants also support services for adults, the elderly and disabled. In three states (CA, MI, NY) that collectively accounted for 54 percent of federal foster care costs in 1991, Title XX moneys were spent mainly on services other than child welfare programs. New York spent 76 percent and Michigan 52 percent of their respective Title XX allocations primarily on day care for children, services for the elderly, and homemaking assistance to families. California did not use any of its Title XX moneys for child welfare services, but spent them for in-home supportive services for the aged, blind, and disabled (United States General Accounting Office, 1993).

TABLE E-4
TITLE XX EXPENDITURES

[In thousands of dollars]

	Fiscal years			
	1989	1991	1993	1994 estimate
Total	$2,700.0	$2,800.0	$2,800.0	$2,800.0
Alabama	45.1	46.5	46.2	45.1
Alaska	5.9	5.9	6.2	6.3
Arizona	36.5	39.9	41.0	41.4
Arkansas	26.4	27.1	28.3	26.2
California	300.5	320.7	333.2	335.4
Colorado	36.4	37.4	38.9	37.3
Connecticut	35.5	36.6	38.8	36.3
Delaware	7.1	7.5	7.5	7.5
District of Columbia	7.0	7.0	6.8	6.6
Florida	130.0	139.7	144.8	146.6
Georgia	68.0	71.8	72.5	73.1
Hawaii	11.8	12.4	12.4	12.5
Idaho	11.2	11.4	11.3	11.5
Illinois	128.7	131.6	128.0	127.4
Indiana	61.3	62.9	62.1	61.9
Iowa	31.8	32.1	31.1	30.9
Kansas	27.4	28.3	27.7	27.5
Kentucky	41.5	42.2	41.3	41.0
Louisiana	50.1	49.9	47.2	46.9
Maine	13.1	13.7	13.7	13.6
Maryland	49.7	52.4	53.5	53.7
Massachusetts	65.0	66.7	67.4	66.2
Michigan	101.9	104.7	104.1	103.4
Minnesota	46.9	48.8	49.0	48.9
Mississippi	29.2	29.7	28.8	26.6
Missouri	56.4	58.2	57.3	57.0
Montana	9.1	9.1	8.9	8.9
Nebraska	17.8	18.1	17.7	17.6
New Hampshire	11.4	12.3	12.4	12.2
Nevada	10.7	11.9	13.5	14.2
New Jersey	84.9	87.5	86.5	85.7
New Mexico	16.5	17.1	17.0	17.1
New York	198.0	202.9	201.4	199.4
North Carolina	70.5	73.5	74.2	74.4
North Dakota	7.6	7.6	7.2	7.0
Ohio	119.8	123.0	121.4	120.8
Oklahoma	36.8	36.7	35.2	35.1
Oregon	30.1	31.3	31.8	32.3
Pennsylvania	132.4	135.9	133.0	132.1
Rhode Island	10.9	11.2	11.2	11.1
South Carolina	37.6	39.3	39.0	39.3
South Dakota	7.9	8.1	7.8	7.8
Tennessee	53.5	55.4	54.6	54.7
Texas	185.8	190.7	190.2	191.5
Utah	18.5	19.1	19.3	19.5
Vermont	6.0	6.3	6.3	6.3
Virginia	64.5	68.1	69.3	69.4
Washington	49.7	52.6	54.5	55.4
West Virginia	21.4	21.3	20.1	19.9
Wisconsin	53.5	55.0	54.8	54.7
Wyoming	5.6	5.4	5.1	5.1

Source: Committee on Ways & Means, U.S. House of Representatives (1993). Overview of entitlement programs: 1993 Green Book, pp. 872-873

Title IV-A

Title IV-A of the Social Security Act is designed specifically to meet the emergency needs of low income children and their families. (Many families receiving these funds are AFDC-eligible, but at the option of each state, they need not meet such an eligibility requirement.) This funding stream is an open-ended entitlement (with services for each client limited to a maximum duration of 90 days). States have recently shown a growing interest in utilizing these funds for child protective and child welfare services by defining children and families as in need of "emergency services" when reported for child abuse or neglect, because of the risk that a child may be removed from the home.

To access these funds, states must file an emergency assistance plan detailing what constitutes a covered emergency, what kind of assistance will be provided (e.g., shelter care), and the kinds of services that will be provided (e.g. case management, counseling). As of 1992, only North Dakota, Missouri, Tennessee, and Michigan were operating approved IV-A emergency assistance plans, and the state of Texas had planned to do so. The ability of states to tailor a plan that meets their specific needs under waiver provisions that are present in this Title (unlike IV-E), made this an attractive funding option for states to pursue. However, it seems likely that a funding limitation may be imposed (American Humane Association, 1993; United States General Accounting Office, 1993).

Additional Federal Funding

The Child Abuse Prevention and Treatment Act (CAPTA) is one of the best known federal enactments dealing with child abuse and neglect. In spite of its name, the Act is not the largest federal funding source for programs and services in this area. In 1992, appropriations under CAPTA totalled just $60 million for a variety of grant programs aimed at increasing the ability of states to respond effectively to victims of child maltreatment through services, administration, and research initiatives.

CAPTA is important, however, for the policy direction and resource commitment it establishes. The Act created the National Center on Child Abuse

and Neglect, established a national information clearinghouse for disseminating information on effective programs in the field, and authorized the U.S. Advisory Board on Child Abuse and Neglect, as well as an interagency coordinating task force for federal activities and a commission on child deaths. Grants to states under CAPTA encourage them to develop and expand programs addressing specific aspects of abuse or neglect, and, perhaps most importantly, require states to have in place laws regarding the reporting of child abuse and neglect in order to receive grant funds. A new program added to CAPTA in 1989 authorized grants to localities for emergency protective services for children of substance abusers.

One of the largest additional funding sources for child welfare services is the Medicaid program authorized by Title XIX of the Social Security Act, and its child-specific component, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. All states must extend Medicaid benefits to the categorically needy including, among others, anyone receiving AFDC, as well as pregnant women and children up to age 6 with incomes up to 133 percent of the poverty level, and children age 6 to 19 born after September 30, 1983, with incomes up to 100 percent of the poverty level.

Medicaid eligible children must be provided with EPSDT screenings at intervals which meet reasonable standards of medical and dental practice. Treatment needs identified during either a periodic or inter-periodic screen will also be covered by Medicaid for virtually all services for which such funds are available.[23] States have become increasingly competent at training service providers to administratively report interim visits that uncover needed eligible treatments as interperiodic screens.

Additional federal funding streams that are directed specifically to funding programs or services that will help to ameliorate child abuse or neglect include:

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[23] This could include treatment needs related to child abuse or neglect, such as inpatient or outpatient hospital care, laboratory and x-ray services, physicians' services, federally qualified health center and rural health clinic services, home health services, physical and speech therapy, services of psychologists, pediatric nurse practitioner services, and many others if specified in the Department of Health and Human Services' procedures or recognized by state law.

- Child Abuse and Neglect Basic Grants, which are awarded to states by the National Center on Child Abuse and Neglect (NCCAN) for assistance in developing, strengthening and carrying out improvements to child protective services agencies and programs;

- Child Abuse and Neglect Discretionary Grants, also awarded by NCCAN, but directed to support research on the causes, prevention and treatment of abuse and neglect; and

- Child Abuse and Neglect Prevention Grants (known also as Challenge Grants), which until recently were the only federal funding stream dedicated solely to prevention efforts and which are awarded to states based upon state funding made available for prevention (primarily through Children's Trust Funds now in place in every state).

State Funding

In 1990, the American Public Welfare Association reported that, nationwide, states and localities funded about 57 percent of child welfare services costs. Under law, child welfare is primarily a state law concern, but historically child protective services evolved haphazardly in many states with much of the direction provided by private child protection societies, and out-of-home care provided by private religious or ethnic associations. By requiring states to adhere to certain standards if they wish to receive federal funds, federal legislative mandates have imposed some uniform requirements on states, but there is still a great deal of variety in the manner in which states fund and administer child welfare programs.

Although mandated services are often driven by federal policy standards, when federal funding is lacking, state and local governments must augment services with their own funds. A 1993 federal study which concentrated on California, Michigan, and New York found that these states were increasingly responsible for their own growing child welfare costs at the same time that budget constraints forced them to balance many other competing demands.

In California in 1992, for example, state and county funds paid for 64 percent of child welfare services, while 4 percent of services were funded by federal IV-B moneys and 32 percent by other federal sources (primarily IV-E funds for administrative cost reimbursement). In Michigan, the state's share of foster care costs not eligible for IV-E moneys grew 30 percent from 1983 to 1991, while the counties' share of these costs increased 144 percent.

As mentioned above, every state also now has a Children's Trust Fund, dedicated solely to providing moneys for preventive services. Many states have developed innovative mechanisms for contributing to the trust funds, such as fees imposed on marriage licenses.

Local and Private Funding

Local governments and private foundations are also a source of funds for programs serving at-risk children and their families. Although foundation grants must be applied for individually, they have the advantage of permitting communities to customize funds to needed uses without legislative constraints. The flexibility of foundation funding has made the impact of a relatively smaller amount of dollars greater, by allowing communities to begin or build upon innovative programs and services. Foundations which historically have had a special interest in supporting child welfare services projects include:

- Carnegie Corporation of New York,
- Casey Family Foundation,
- Edna McConnell Clark Foundation,
- The Ford Foundation,
- Kellogg Foundation,
- Northwest Area Foundation,
- The Pew Charitable Trusts, and
- The Robert Wood Johnson Foundation.

Some local governments have also found creative ways to raise and utilize funding for child welfare services through a concept known as Children's Services Councils. This idea (which is discussed more fully in the next chapter) provides specific dedicated local tax funds, as approved by local voters, to fund community children's services.

Costs/Benefits Analysis

AHA has calculated the current estimated cost of providing basic child protective services. This projection is derived from unit of service costing data obtained from four Ohio counties in 1987, and similar data from the state of Texas for 1989 (Fluke, Edwards, et.al., 1989)[24]. These figures were adjusted for 1993 using the percentage change in the cost of living index (Fluke, Edwards, et. al., 1989). A weighted average per unit cost for 1993 was then constructed based on the numbers of reports for each jurisdiction. Unit costs were then applied to national estimates of children reported, substantiated and served by CPS agencies in 1993 (McCurdy & Daro, 1994). This approach produces a conservative estimate of the costs of providing CPS investigation and in-home services as shown in Table E-5:

Table E-5

1993 Costs of Selected CPS Services

Type of Service	Unit Cost	National Cost
Investigation	$813	$1.7 billion
In-home services	$2,702	$1.2 billion

[24] These jurisdictions were chosen based on the availability of unit cost data obtained from studies conducted by the American Humane Association.

Based on the Ohio and Texas studies, the cost to conduct a single investigation in 1993 averaged $813 nationally. The estimated aggregate costs to conduct all investigations nationally was $1.7 billion. In contrast, the per case cost to provide in-home services averaged $2,702, about three times the unit cost of an investigation. However, fewer in-home services were provided, resulting in an aggregate cost for all in-home services of $1.2 billion. To provide some perspective on this cost, the $1.7 billion spent to investigate reports of child maltreatment represents less than half of the annual amount spent by the United States on foreign military aid to the Near East and South Asia (U.S. Department of Commerce, 1993).

In addition to the costs of direct investigatory and child protective services, the costs of maltreatment to our society include such impacts as increased amounts spent on health care, in-patient mental health treatment for abused children and juveniles, other juvenile placement facilities, and family preservation services provided in an attempt to stabilize families to prevent out-of-home placement. Researchers have also estimated these costs utilizing additional data sources.

In the health care arena, costs may include a doctor or emergency room visit, care for chronic health problems, or family or group therapy to treat emotional problems. It is estimated that the annual cost for hospitalization alone of children with serious physical injuries due to maltreatment is $792,162,400.[25] The cost of providing lay person counseling to abused children and their families for one year is estimated at $814,756,800[26] (National Committee to Prevent Child Abuse, 1994).

Out-of-home care costs are not limited to foster care (which is estimated to have a total cost of $1,908,000 annually). Other substitute care costs resulting

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[25] This estimate is based on 143,300 children reported with serious physical injuries due to abuse in 1990, assuming a hospital stay of 4.3 days (average hospital stay for children with bone fractures), and an estimated average one week hospitalization cost of $9,000. Not included are injuries requiring more than a five day stay, costs incurred in attempting to save children who were fatally abused, long-term impairment due to head injuries, emergency room care, long-term therapeutic care, and institutionalization.

[26] This figure is based on an estimated cost per family for lay person counseling of $2,860, assuming that one in five abuse victims received these services of 1,424,400 confirmed cases of abuse from the 1988 National Incidence study (U.S. Department of Health and Human Services, 1988).

from abuse and neglect of children whose welfare has been seriously endangered include placement of juveniles in specialized service facilities (estimated at $1,945,356,200 annually) and placements of maltreated children or adolescents in in-patient mental health facilities (estimated at $2,848,800,000 annually). Family preservation services are estimated to cost an additional $192,500,000 annually (McCart and Heller, 1993), a figure that will likely increase with the new federal initiative in this area.

Aggregating these additional costs of remediating the effects of maltreatment reveals a figure of approximately $8.5 billion annually which is spent beyond the cost of conducting child protective services investigations and providing in-home child protective services (National Committee to Prevent Child Abuse, 1994). This figure is a conservative estimate of the costs related to child abuse and neglect in our society, however, it does not include items such as:

- long-term impairment,
- lost productivity and loss of future earnings,
- special education services,
- drug and alcohol treatment,
- cost of juvenile court proceedings,
- potential welfare dependency, and
- family reunification services.

All of the above are more difficult to quantify (Daro, 1988)[27].

Several researchers have analyzed the costs of treating child abuse and neglect versus the cost of prevention, arriving at the conclusion that prevention and early intervention cost less than waiting until family problems become more intractable. An extensive study of a home visitor program in Elmira, New York was conducted by Dr. David Olds and colleagues. Olds' study addressed many issues related to the costs/benefits of a home visitor program for pregnant women and new mothers. Program costs for the sample as a whole were $3,171 per

[27] Daro (1988) has attempted to quantify some of these costs and estimates them on an annual basis as: special education/rehabilitation ($7 million), juvenile court and detention ($14.8 million), loss of future earnings ($658 million to $1.3 billion), and long-term foster care ($646 million).

family and $3,017 for the low-income families (in 1980 dollars). For low income families, 96 percent of the program's costs were recovered in two years after the program ended. Program benefits for the entire four-year evaluation period included savings of $1,708 per family for the sample as a whole and $3,013 for the low-income families (Olds, et. al., 1988).

Similar studies have been conducted focusing on early intervention programs and their associated benefits and cost savings. In a 1985 study conducted by Victoria Seitz, low-income first-time parents received home visits, health care services, and day care services. After ten years, these parents reported higher education levels and greater financial independence than similar families who had not been offered services. Better school performance for the child who participated in the program was also achieved, compared to the control group (Seitz, 1985). A separate longitudinal study conducted at the University of Syracuse in the 1970s showed that associated juvenile justice costs can also be reduced by early intervention. In the Syracuse study, 108 low-income families received access to a full spectrum of educational, nutrition, health and safety, and human services resources through home visits. All families had annual incomes under $5,000, and mothers with an average age of 18, less than a high school education, and no work or semiskilled work history. Eighty-five percent of participants were single parents. Ten years after children left the program, it was found that 6 percent of participating children had a history of juvenile delinquency compared to 22 percent of the control group. Total costs for adjudicating juvenile cases for program participants was $12,111 compared to $107,192 for the control group (National Committee to Prevent Child Abuse, 1994).

In sum, we can say with confidence that the costs to our society of child abuse and neglect are enormous, even looking only at those that we can currently quantify with some degree of accuracy. When we consider that many of the long-term costs of child maltreatment cannot be accurately measured, but make serious demands on the whole community over a period of years, the dimensions of the maltreatment crisis become truly staggering. Clearly, we must develop the tools and resources that services providers and communities need in order to effectively respond to protect children and strengthen families.

Section F

Community Ownership—who cares about the success or failure of the system? who are the key partners to ensuring its success?

F. Community Ownership—who cares about the success or failure of the system? who are the key partners to ensuring its success?

There is a growing consensus that our current mode of responding to the problems of children and their families is not adequate. Families have multiple needs that are not met by single systems. When families must seek services from unconnected systems, they experience fragmented services and access barriers. The child protective services system in particular has faced dramatic changes in the past two decades, moving from a fledgling service component of a broader child welfare system to a system that is staggering under a burgeoning caseload and increasingly complex family problems.

Different systems have come to recognize that they share the same clients. The systems have developed duplicative services while gaps remain, leaving some children and families without needed resources. The present service system is inadequate, uncoordinated and in some cases inaccessible and ineffective (American Humane Association, 1993).

Consensus Elements of an Effective Community System of Care

Communities are the place where the needs of families and the availability or lack of service resources converge. As the U.S. Advisory Board on Child Abuse and Neglect has stated:

> No society can safely ignore its communities and neighborhoods, for these constitute the environment which will mold its children and their growth toward adulthood. Research indicates that the quality of life in neighborhoods plays a significant role in determining the incidence of child abuse and neglect. (U. S. Advisory Board on Child Abuse and Neglect, 1990).

Any attempt to better serve vulnerable children and families must be grounded in building supports from the community level up.

A series of recent reports have called for the development of an integrated, community based, system of care. The American Humane Association, and many others, have worked to identify common elements of diverse audiences' visions for this system and have found that there is remarkable consensus regarding the essential characteristics of this system. Services offered within this system must be:

- based upon a shared vision,
- child centered and family focused,
- neighborhood and community based,
- culturally respectful,
- offered early and focused on family need,
- built on family strengths,
- seamless and flexible, and
- easily accessible and non-stigmatizing.

As envisioned, this community-based system of care would be based on cultural and familial strengths. This system would emphasize prevention and early intervention and would have flexible funds to meet unique family needs. Services would be provided in a way and at a location that is comfortable and easily accessible. This system would be grounded in the philosophy that children are best nurtured within their own homes, families, and communities (whenever they can safely remain there), and that we are better able to facilitate access by troubled families to services that draw upon community and cultural strengths. This system must recognize that families have a range of needs, from prevention and early intervention to remediation through family support and treatment. The overall goal would be to better serve children and families earlier and thus save taxpayer dollars (American Humane Association, 1993).

The objectives of an integrated community system would be to improve access; improve quality and effectiveness; and reduce long-term service costs. However, designing the integrated community system requires thinking outside the current single system paradigm and consideration of other systems of support including, for example:

- income assistance,
- health care,
- mental health services,
- juvenile justice,
- youth services, and
- education and housing.

Common Elements of Successful Community Programs

It is also important to consider the array of services which are offered to more effectively respond to vulnerable children and families. Issues of system design and service provision must focus on both the **type** of services offered and the **manner** in which services are provided. An array of supportive and protective services must be available in every community.

While it is not possible to generalize a set of elements that all successful community programs have in common, the following attributes have been identified as contributing to the success of community programs:

1. There is universal availability of services to all in the community, not a stigmatized approach.

2. Services are offered on a voluntary basis whenever possible.

3. Services are offered in the home, where there is complete access to the parent(s) and child(ren); or at a convenient location within the community that families can reach by available transportation.

4. Services are intensive when so needed—available on a 24-hour basis.

5. Services are provided for as long a period of time as necessary.

6. Services are tailored to meet a family's specific needs.

7. Services are comprehensive (e.g., substance abuse treatment, job training if needed) and offer practical supports in child development (e.g., WIC, transportation to other services as needed).

8. A creative and culturally sensitive approach to outreach is used.

9. The service provider focuses on building a trusting relationship with the family, and on building social supports for the family and child(ren), (this is an important "bottom line" common denominator for success).

10. The program maintains close ties for the family to the health care system and, if necessary, increases support services.

11. The program insures that workers receive intensive ongoing training and supervision.

12. Supervisors ensure that workers have a reasonable workload so as to be able to do their job effectively.

13. The program is well integrated into the rest of the community (Donnelly, 1993).

Examples of effective integration of community services have typically been found at the individual program level. In order to better understand factors which contribute to successful community collaboration and integration, the American Humane Association recently identified ten programs which have frequently been cited as successful examples of integrated community services and which embrace most or all of the above key attributes defined above (American Humane Association, 1993). The American Humane Association then conducted a brief telephone survey of leaders of these organizations. The leaders identified the following issues as important in achieving more effective community collaboration

(American Humane Association, unpublished, 1993; a brief summary can be found in Appendix B describing each of the surveyed programs):

- *Resource mobilization.* Collaboration and integration are more likely to be achieved when there is a **crisis**, bringing diverse interests together to solve a common problem, when **funding is provided** and when **individuals who trust each other arrive at a common vision.**

- *Leadership.* In the community arena, **one person can make a difference.** Program representatives frequently reported that a single individual played a significant role in pushing an agenda and bringing together other key players.

- *Broad commitment.* **Top management and front line staff** are both needed to implement integrative efforts. Although programs reported that the initiative can originate from either the bottom up or the top down, both are ultimately needed to overcome barriers.

- *Shared risks and benefits.* Integration is more easily achieved when players have **joint obligations** and therefore share in risk and gain.

- *Measuring outcomes.* The capacity to **measure change**, based on an objective assessment of the experience builds support for further change.

Examples of Effective Community Programs

The following section provides a more detailed discussion of specific program or project examples which illustrate effective efforts to build community partnerships and, when known, discusses strategies to develop bridges across systems.

Hawaii's Healthy Start Program

One of the best known programs for the prevention of child abuse and neglect is Hawaii's Healthy Start Program. Originally begun through the efforts of individual community agencies, the program has since been extended by legislation to serve targeted communities throughout the state of Hawaii and serves as a model for the Healthy Families America nationwide prevention program.

Healthy Start, which is aimed at families with children from ages zero to five, begins with the identification of at-risk newborns and the immediate provision of home visitor services on a voluntary basis to those families identified as at-risk for abuse or neglect. The program is a cooperative public-private partnership coordinated by the state's Department of Health, Maternal and Child Health Branch (not by the child protective services agency). Initially, Maternal and Child Health worked with seven private agencies to provide overall program administration, while private hospitals and family support agencies were responsible for direct service provision at 11 sites statewide.

Program staff conduct a daily review of births at hospitals serving targeted areas in the state to identify potential clients. If risk indicators are present at the initial review by the program's Early Identification Worker, a more structured interview is conducted using the Family Stress Checklist instrument. Mothers sign a consent for the release of information in conjunction with the interview. If, during a more intensive interview, a family is determined to be at risk, a referral is made to a Healthy Start or Family Support program. In addition, the Early Identification Worker notifies the mother's physician of the referral and may make other referrals as needed for community services such as public health nursing, rent assistance, or substance abuse treatment.

An important component of the program is that the Family Support Worker to whom the referral is directed makes an immediate contact with the family while the mother and child are still in the hospital. Workers believe this is crucial to building a trusting relationship with the family, and families are more likely to accept services if they are offered at a naturally non-stigmatized point such as childbirth when many families need or accept assistance.

Program administrators report that Healthy Start has enjoyed a wide measure of success in the prevention of child abuse and neglect. In a three-year demonstration of the program, there was a 100 percent non-abuse and a 98 percent non-neglect outcome. In the long term, the program is expected to result in no abuse or neglect for 95 percent of the children served by the program for at least one year, and to reduce the downstream social costs of abuse and neglect. A more complete comprehensive evaluation of the program is currently being conducted by the National Committee to Prevent Child Abuse.

Another measure of success has been the degree of interagency cooperation achieved. In negotiating agreements with hospitals to allow for initial family contacts, the project staff has consciously involved both the nursing and social services programs at the hospitals. As a result, the program is seen as reducing the burden on hospital social workers by screening all but the more serious cases from their workloads, and as reducing legal and morale concerns among nursing staff by ensuring that high risk infants receive needed services. In addition, Healthy Start has drawn upon established family support programs in the state and enlisted them in prevention efforts (American Humane Association, 1991).

Family Centers/Family Resource Schools

In Connecticut, strong support from the state level was responsible for the Connecticut Family Resource Center initiative. The purpose of the Connecticut initiative is to provide comprehensive school-based family support and education services. Initially, the program was piloted in specific rural, urban and suburban locations chosen more on political grounds than on the basis of a supportive local climate. Experience, however, proved that comprehensive local linkages required commitment to the state-initiated program from local leaders like the head of the Board of Education, the directors of the Department of Social Services and the United Way, representatives of the teachers' union, as well as an advisory group of parents who used the centers.

Legislation co-authored by the state's Departments of Education and Human Resources, the Bush Center for Child Development and Social Policy at Yale University, and Connecticut's Permanent Commission on the Status of Women,

passed the Connecticut General Assembly in 1988 and resulted in a six-month demonstration program at three sites around the state, which was increased to a $500,000 program in fiscal year 1989.

The Family Resource Centers use local schools, in cooperation with existing community-based family and child services agencies as access points for four basic categories of preventive and fundamental child development services that are useful to all families in the community. The four service components provided are:

- child-care—full time for preschoolers, and before and after school for elementary age children;

- parent education training, including:
  - home visiting,
  - toy and resource libraries,
  - child development education classes and
  - GED preparation;

- support and training for family daycare providers, the state's major source of infant care; and

- teen pregnancy prevention through positive youth development activities for young people up to age 18.

Programs are modeled after Edward Zigler's Schools of the 21st Century concept (Melaville and Blank, 1991).

Children's Services Council

One community that has successfully built a full range of community-supported services for children and families is Pinellas County, Florida. Since 1949, the county has had a funding mechanism for children's services that is both non-categorical and consistent in providing funds for community services for children. The Juvenile Welfare Board of Pinellas County, as it is called, is in its

45th year of providing preventive, supportive and treatment services that are accessible to all and funded by a county ad valorem property tax. The Board (or Children's Services Council as it is referred to in other Florida counties that have adopted the system) consists of local officials and child advocates who act as needs assessor and grants source, determining the broad needs of children and distributing funds to programs evaluated and deemed worthy. Total revenues in Pinellas County for 1989 for the Juvenile Welfare Board amounted to $15 million.

In the late 1980s, other Florida counties created Children's Services Councils after the Florida Legislature made it possible to create county-wide special independent taxing districts to provide child welfare services. In counties where these districts have gained voter approval, the ad valorem tax reaches all property but is typically limited to one-half mill, on average a $15 to $50 annual tax bill on a $100,000 home. This mechanism eliminates children competing with adult agencies for local funds and encourages children's programs to be cost-efficient, productive and responsive to the local community Council's assessment of county needs for children's services (American Humane Association, 1991).

Strategies for a Targeted Community Approach

As we search for effective methods to intervene in communities, a logical first step is finding the means to identify at-risk communities. One approach has been offered by the Annie E. Casey Foundation, which has identified the dimensions that characterize "distressed communities" (Annie E. Casey Foundation, 1994). These dimensions include high levels (i.e., one standard deviation above the mean) of poverty, female-headed families, high school dropouts, unemployment, and reliance on welfare. Communities that have at least four of these five problem indicators are considered "severely distressed neighborhoods." Using this definition, the Casey Foundation identified 3.9 million children living in severely distressed neighborhoods, located in every state except one, often living in either inner city or rural communities, and disproportionately children of non-Anglo race or ethnicity.

Healthy Families America has utilized a similar approach to identify communities at risk for child abuse and neglect. These are useful models, and

there are many easily accessible sources of data that can be used to identify distressed or at risk communities. As we design our interventions we must be careful to maintain a dual focus on the attributes of the system that contribute to the problem as well as the characteristics of the families themselves.

Challenges for the Community System of Care

The capacity of communities to take on supports to vulnerable children and families is an issue of great importance in any discussion of narrowing public interventions on their behalf, when the concomitant expectation is that less severe service needs will be met by the community system of support. Communities do not now have such systems and there are relatively few inducements to facilitate such coordination. Furthermore, no mechanisms of accountability currently exist at the community level for monitoring the effectiveness of such interventions. Significant legislative efforts have recently been enacted at the federal level which contain language requiring the development of community based planning processes, cross system linkages and other methods of encouraging the integration of services at the community level. Defining expectations that such integration occur is an important first step, however, successful experiences are typically at the **program**, not the community level. Significant work is still required to build an adequate community infra-structure to accommodate such expectations.

This process could be informed by a limited analysis of other related reform initiatives, including efforts to de-institutionalize the chronically mentally ill; the development of supports for the severely physically disabled; and increasing utilization of community correction strategies for minimal risk offenders. This process would enhance our understanding of major system reform in areas which impact on community based service delivery. Each of these experiences, and the associated policy considerations, would be of value in considering a reform agenda for child protective services.

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Appendix A

Criteria for Acceptance of Reports of Abuse and/or Neglect

CRITERIA FOR ACCEPTANCE OF REPORTS OF ABUSE AND/OR NEGLECT

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
ALABAMA	X	•NOT SPECIFIED	X	
ALASKA	X	X	X	
ARIZONA	X	X	•SPECIFIC ALLEGATION MUST BE MADE	•MUST HAVE SUFFICIENT IDENTIFYING INFORMATION TO FIND CHILD
ARKANSAS	X	•MUST BE 10 YRS OR OLDER	X	•MUST BE A SPECIFIC INCIDENT IDENTIFIED
CALIFORNIA		X	•SPECIFIC ALLEGATION MUST BE MADE	•CHILD CAN BE LOCATED •OTHER FACTORS SUCH AS AGE OF CHILD, PERPETRATOR ACCESS, FAMILY FACTORS, ETC.
COLORADO	X	X	X	•MUST BE SPECIFIC ALLEGATIONS OF KNOWN OR SUSPECTED INCIDENT •MUST BE SPECIFIC INFORMATION TO LOCATE ALLEGED VICTIM
CONNECTICUT	X		X	
DELAWARE	X	X	•MUST MEET STATUTORY DEFINITIONS OF ABUSE AND/OR NEGLECT	
DISTRICT OF COLUMBIA	X	X	•MUST MEET DEFINITION OF ABUSE AND NEGLECT AS OUTLINED IN D.C.CODE	

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
FLORIDA	X	X	X	•IF CHILD IS UNDER 18 AND IS MARRIED, MUST HAVE CHILD'S PERMISSION TO INVESTIGATE
GEORGIA	X	X	X	•MAY ALSO INVESTIGATE CASES RE: UNBORN CHILD (EACH CASE IS SPECIFIC)
GUAM	X	X	X	•ALLEGED INCIDENT MUST HAVE OCCURRED WITHIN PAST MONTH AND IS CONTINUING
HAWAII	X	X	X	
IDAHO	X	X	X	
ILLINOIS	X	X	X	
INDIANA	X	X	X	
IOWA	X	X	X	•ALLEGATIONS MUST FALL WITHIN THE DEFINITION OF ABUSE AND NEGLECT
KANSAS				•MUST BE ENOUGH INFORMATION TO BELIEVE A CHILD IS IN IMMEDIATE DANGER BY VIRTUE OF THE CHILD'S AGE, LOCATION, SERIOUSNESS OF INJURY, PERPETRATOR'S ACCESS TO CHILD
KENTUCKY	X	X	•MUST MEET STATUTORY DEFINITION OF ABUSE/NEGLECT/DIFFERENT CRITERIA FOR EACH TYPE OF SPECIFIED HARM.	

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
LOUISIANA	X	•INCLUDES NON-CUSTODIAL PARENT	X	•MUST HAVE CAUSE TO BELIEVE THE CONDITIONS OF CHILD PRESENTS SUBSTANTIAL RISK TO CHILD'S HEALTH & WELFARE
MAINE	X	X	X	•MUST ALSO FACTOR IN OTHER CRITERIA SUCH AS AGE OF CHILD, TYPE OF ABUSE
MASSACHUSETTS	X	X	X	•MUST ALSO CONSIDER AMOUNT OF TIME BETWEEN INCIDENT & REPORT •ALSO NEED IDENTIFYING INFORMATION ON CHILD AND PERPETRATOR
MARYLAND	•NOT SPECIFIED	X	•SPECIFICS DIFFER BY TYPE OF ABUSE	
MICHIGAN	X	X	X	•HARM MUST BE NON-ACCIDENTAL OR RESULT OF NEGLIGENCE BY CARETAKER •RECENCY OF INCIDENT •PERPETRATOR ACCESS TO CHILD •PARENT'S WILLINGNESS TO PROTECT CHILD

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
MINNESOTA	X	X	•MUST AGREE WITH STATUTORY DEFINITION OF ABUSE AND NEGLECT	•ALLEGATION MUST CONSTITUTE MALTREATMENT •MUST BE SUFFICIENT IDENTIFYING INFO TO CONDUCT INVESTIGATION •REPORT MUST CONTAIN INFO NOT PREVIOUSLY RECEIVED BY LOCAL AGENCY
MISSOURI	X	X	•LISTING OF TYPES OF HARM, MUST MEET STATUTORY DEFINITIONS	•CRITERIA FOR ACCEPTANCE OF REPORTS SHOULD BE CONSISTENT BETWEEN THE CENTRAL REGISTRY AND THE LOCAL OFFICE
MISSISSIPPI	X	X	•SPECIFIC LISTING OF CRITERIA THAT MUST BE GATHERED AT INTAKE IN ORDER TO CONSTITUTE HARM	•THIS CRITERIA IS SPELLED OUT IN POLICY AS TO WHAT IS NOT AN APPROPRIATE REPORT.
MONTANA	•NOT SPECIFIED	X	X	•FOUND IN STATUTE NOT IN POLICY
NEBRASKA	•UNDER AGE 17	•OR SOMEONE KNOWN TO THE FAMILY WHO HAS POTENTIAL OR READY ACCESS TO THE CHILD	X	

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
NEW HAMPSHIRE	•NOT SPECIFIED	X	•SPECIFIC CRITERIA FOR TYPE OF ABUSE DEFINED IN POLICY	
NEW JERSEY	X	X	•SPECIFIC CRITERIA FOR TYPE OF ABUSE DEFINED IN POLICY	
NEW MEXICO	X	•OR INDIAN CUSTODIAN	•SCREENS BY DEGREE OF RISK TO CHILD	•EMERGENCY - OCCURRING NOW •CLEAR THREAT •MODERATE RISK
NORTH CAROLINA	X	X	•INFLICTS OR ALLOWS TO BE INFLICTED	•AS DEFINED IN STATUTE
NORTH DAKOTA	X	X	X	•IN STATUTORY DEFINITIONS OF ABUSED CHILD, NOT FOUND IN POLICY
NEW YORK		X	•SPECIFICS ON TYPE OF ABUSE ARE OUTLINED	•NO INFO ON AGE OF CHILD
OHIO	•OR UNDER AGE 21 IF PHYSICAL/ MENTAL DISABILITY	•NOT SPECIFIED	X	
OKLAHOMA	X	X	X	•POLICY SAYS TO INVESTIGATE ALL REPORTS THEN SAYS •INTRAFAMILIAL REPORTS ONLY •INVESTIGATE 3RD PARTY PERP (TEACHER/COACH) IF PARENT REFUSES TO PROTECT

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
OREGON	•NOT SPECIFIED	X	X	•POLICY SAYS ALL REPORTS RECEIVED ARE EVALUATED
PENNSYLVANIA				•NO CRITERIA STATED IN POLICY
PUERTO RICO	X	X	X	•IN STATUTE, NOT POLICY
RHODE ISLAND	X	X	X	•IN DEFINITIONS SECTION IN POLICY •ENCOMPASSES BOTH ACTS & OMISSIONS •RESPONSE PRIORITIES DIFFER PER CASE
SOUTH CAROLINA				•ALL REPORTS MUST BE SCREENED TO SEE IF THEY MEET STATUTORY DEFINITION OF ABUSE OR NEGLECT
SOUTH DAKOTA				•SCREENER EVALUATES ALL FACTORS TO DETERMINE IF REPORT IS APPROPRIATE THEN DETERMINES PRIORITY OF RESPONSE (EMERGENCY VS. NON-EMERGENCY)
TENNESSEE	•PHYSICAL, NEGLECT, EMOTIONAL ABUSE •UNDER AGE 13 FOR ALL SEXUAL ABUSE	•NOT SPECIFIED •SPECIFIED FOR SEXUAL ABUSE CASES ONLY	X X	

STATE	AGE OF CHILD <18 YEARS	PERPETRATOR MUST BE IDENTIFIED AS PARENT,CARETAKER OR PERSON RESPONSIBLE FOR CHILD'S HEALTH AND WELFARE	THERE IS EVIDENCE OF HARM OR CONTINUED RISK OF HARM	OTHER CRITERIA NECESSARY
TEXAS	•ONLY IF CHILD IS NOT/HAS NOT BEEN MARRIED	X	X	•AS OUTLINED IN STATUTORY DEFINITIONS OF ABUSE/NEGLECT
UTAH	X	•NOT SPECIFIED	•SPECIFIC ALLEGATIONS MUST BE DEFINED	•TIME OF OCCURRENCE OF INCIDENT MAKES IT POSSIBLE FOR INVESTIGATION TO TAKE PLACE •VICTIM CAN BE LOCATED
VERMONT	X	X •IF SEXUAL ABUSE, ANY ACCESS TO THE CHILD	X	•ONLY INVESTIGATE CURRENT ALLEGATIONS WITHIN PREVIOUS 3 MONTHS (EXCEPT FOR SEXUAL ABUSE)
VIRGINIA	X	X	X	•CRITERIA AS OUTLINED IN POLICY DEFINITIONS •AGENCY MUST BE AGENCY OF JURISDICTION FOR THE CASE
WASHINGTON	X	•OR 3RD PARTY AND PARENT WON'T PROTECT	X	•ALLEGATION MUST MEET DEFINITION OF ABUSE/NEGLECT •MUST BE ABLE TO LOCATE THE CHILD
WEST VIRGINIA	X	X	X	•ALLEGATION MUST MEET STATUTORY DEFINITIONS OF ABUSE/NEGLECT
WISCONSIN				•LONG LISTING OF CHILD, FAMILY, INCIDENT, RISK FACTORS TO BE CONSIDERED
WYOMING	X	X	X	•AS OUTLINED IN STATUTES

AMERICAN HUMANE ASSOCIATION
CHILDREN'S DIVISION

SURVEY OF PROGRAMS
(October 1993)

1. **CARING COMMUNITIES PROJECT**

Children and Youth Services
Missouri Department of Mental Health
Ms. Jan Carter, Program Coordinator
1706 East Elm Street, P.O. Box 687
Jefferson City, MO 65101
(314) 751-4122
(314) 526-4561 fax

Organizational Setting: School based.

Operation Date: 1988

Population Served: Communities around the schools.

Major Services:

It is a collaborative effort between the Department of Social Services, Mental Health, Health, Elementary and Secondary Education to provide family-centered prevention services aimed at keeping troubled children in school and in their own homes and communities. Services include after school latchkey programs; adult basic education; substance abuse prevention activities; on-site early and periodic screening diagnosis and treatment (EPSDT) and child health services; income and food assistance; cooperative day treatment.

Participating groups: Danforth Foundation, Department of Social Services, Mental Health, Health and Elementary and Secondary Education.

2. **CHESTER E. DEWEY COMMUNITY SCHOOL PROJECT #14**

Ms. Merrilyn Parks, Coordinator
200 University Avenue
Rochester, NY 14605
(716) 454-7960

Organizational Setting: School based.

Operation Date: 1987

Population Served: Families and children within the school community.

Major Service:

Build school/community collaborations, promote instructional change and year-round schooling, and organize schools as sites for access to a wide range of social, cultural, health, recreation, and other services for children, their families, and other community adults.

Participating groups: Department of Social Services, school principal, the Lewis Street Neighborhood Center, YMCA, Girl and Boy Scouts, the University of Rochester, the Center for Educational Development, Grove Place, Xerox, Eastman Kodak, IBM, St. Luke and St. Simon Church.

3. **CONNECTICUT FAMILY RESOURCE CENTERS**

Department of Human Resources
Bureau of Planning and Program Development
Mr. Paul Vivian, Program Manager
1049 Asylum Avenue
Harford, CT 06105
(203) 566-8048

Organizational Setting: School based.

Operation Date: 1988

Population Served: Children and families in communities surrounding selected participating schools.

Major Services:

Year-round child care [full-time for preschoolers, before and after school care up to 6th grade; parent education (new parents invited to participate in home visiting, resource libraries, child development education classes)]; GED classes for parents of preschoolers in full-time care; support and training for family daycare providers (states main source of infant care); teen pregnancy prevention, child development specialists in cooperations with existing community-based child and family service agencies.

Participating groups: Connecticut General Assembly, Connecticut's Permanent Commission on the Status of Women, the Bush Center for Child Development and Social Policy at Yale University, and the State Departments of Education and Human Resources.

4. **FAMILIES FIRST**

Family Preservation Initiative
Office of Children and Youth Services
Ms. Susan Kelly, Program Coordinator
235 S. Grand Avenue, Suite 411
P.O. Box 30037
Lansing, MI 48909
(517) 373-3465

Organizational Setting: State administered.

Operation Date: 1988

Population Served: Families at risk referred by CPS or other social services.

Major Services:

Counseling, concrete services, referrals; intensive crisis intervention (family preservation) therapists who also provide parent education, case management and whatever it takes to get family life stabilized.

Participating groups: Department of Social Services, the Juvenile Courts, and Mental Health Boards.

5. **FLOYD COUNTY YOUTH SERVICES COALITION**

St. Paul's Parish House
Mr. Ralph Thumas, Project Director
1015 E. Main Street
New Albany, IN 47150
(812) 944-2972

Organizational Setting: Housed as different projects within different facilities and agencies.

Operation Date: 1986

Population Served: At risk youth and families.

Major Services:

Coalition has committees--networking, advocacy, long-range planning--which work to identify needs and resources, design short and long term strategies to maximize resources, and to generate new avenues of support for youth and families in an effort to coordinate community services for youth.

Have conducted key information study to determine perception of service providers about needs of clients and utilized United Way's Allocation Needs Assessment, a home-based field study.

Participating groups: Lilly Endowment, Chamber of Commerce, Juvenile Justice Centers, social services agencies, and local churches.

6. **FRANKLIN McKINLEY SCHOOL DISTRICT**

C/O Ms. Dolores Ballesteros
Superintendent
Desert Sands Unified School District
87879 Highway 111
Indio, CA 92201
(619) 775-3500

Organizational Setting: School based.

Operation Date: 1988

Population Served: "Wholistic" community focus.

Major Services:

It is a "one stop shopping" concept for wholistic services for children and families. The public agencies involved in the collaboration include: the San Jose City Hospital that runs the Health Clinic, Santa Clara Dental Association runs the Dental Clinic, the San Jose State University and Community College operate the "Si Se Puede" tutoring and outreach project. Other services that are housed in the facility include the Narvaez Mental Health Center, Probation Office, Community Affairs Office, Home Schooling Center, Head Start Teacher Training Center, Children's Discovery Center, PTA Clothes Closet, The Technology Center and the Video Production Center.

7. **KENTUCKY INTEGRATED DELIVERY SYSTEM (KIDS)**

Department of Education
Ms. Karen Schmalzbauer, Consultant
School Community Resource Branch
1732 Capitol Plaza Tower
500 Mero Street
Frankfort, KY 40601
(502) 565-6117
(502) 564-6952 fax

Organizational Setting: School based.

Operation Date: 1988

Population Served: At risk children and families.

Major Services:

Joint venture between the State Department of Education and Governor's Cabinet of Human Resources (Departments of Social Services, Health, Mental Health and Mental Retardation, and Employment) to help local agencies coordinate existing services and make services available at school sites. By 1990, 14 local joint ventures were underway to develop formal agreements; create multi-agency case conference teams; develop confidentiality procedures and sharing recommendations with parents; train school and agency staff on purpose of collaboration and operation of case conference teams; locate designated service staff at school sites.

8. **NEW BEGINNINGS**

San Diego City Schools
Ms. Jeanne Jehl, Administrator on Special Assignment
4100 Normal Street, Room 2220
San Diego, CA 92103-2682
(619) 293-8371
(619) 293-8267 fax

Organizational Setting: School based.

Operation Date: 1988

Population Served: Began with high poverty neighborhood around elementary school; families with children ages 5-12 years attending the designated school.

Major Services:

High level representation from health, probation, social services, juvenile court, court administrators, city manager's office, housing commission, school superintendent, chancellor of community college district. The collaboration has two goals. One is to improve services and to demonstrate innovations for improved services, and the other is to foster institutional change in the agency partners. It began with a feasibility study involving family interviews, focus groups with line workers, and data from case management services.

Participating groups: City and County of San Diego, San Diego City Schools, the San Diego Community College District, San Diego Housing Commission, University of California San Diego School of Medicine, Children's Hospital and Health Center, and the IBM Corporation.

9. **YOUTH ADVOCATES**

Mr. Bruce Fisher, Executive Director
285 12th Avenue
San Francisco, CA 94118
(415) 668-2622

Organizational Setting: Private.

Operation Date: 1967

Population Served: Runaway and homeless youth, ages 11 to 17, and their families.

Major Services:

Youth Advocates operate Huckleberry House, Cole Street Youth Clinic, Nine Grove Lane and Marin Outreach and Counseling. They provide a wide variety of services that include crisis shelter, medical assistance, information and referral, individual/family/group counseling, HIV prevention and education, drug and alcohol abuse prevention education, educational assistance, and short-term residential care.

Participating groups: San Francisco and Marin counties, outstation staff from the San Francisco Probation, Public Health and Social Services Departments. Also participating is the UC San Francisco's Division of Adolescent Medicine.

10. **YOUTH FUTURES AUTHORITY**

Mr. Otis S. Johnson, Executive Director
128 Habersham Street
Savannah, GA 31404
(912) 651-6810
(912) 651-6814 fax

Organizational Setting: School based.

Operation Date: 1987

Population Served: At risk youth.

Major Services:

The mission is to develop a comprehensive plan for private and public agencies to deal with youth problems, help implement the plan, and contract with agencies to provide direct services under the plan. The Youth Futures Authority would fund a variety of programs in four middle schools and four high schools. The goals were significant reductions in youth unemployment, teen pregnancy, the dropout rate, and the proportion of students in the lowest quartile on achievement tests. Services include case management, tutoring labs, counseling; afterschool and summer activities; summer jobs; a high-school health clinic, and a teenage pregnancy program with day care, nursing, and social services for teen mothers enrolled in educational institutions.

Participating agencies: Annie E. Casey Foundation, the local United Way, the City of Savannah, the County of Chatham, Chamber of Commerce, the Department of Health, the school system, business groups and human service agencies.