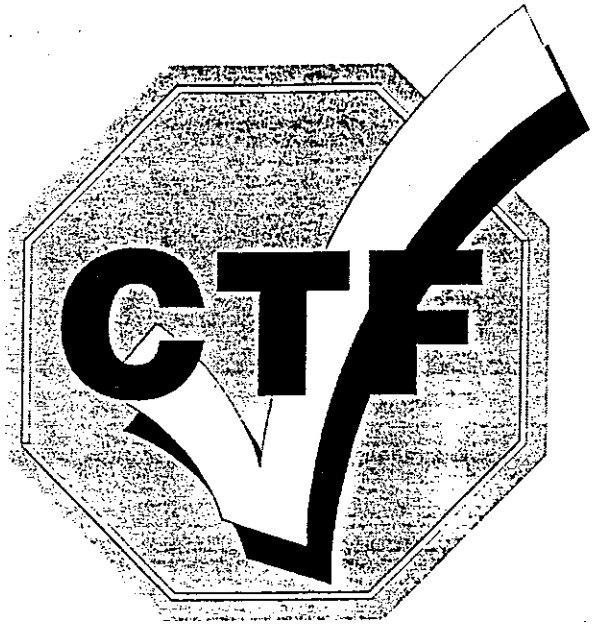
Check To Protect Our Kids



THE CHILDREN'S TRUST FUND

STATE PLAN FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT

FY 1994/95
FY 1995/96

Children's Trust Fund Board
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Executive Summary

This report is an update of the FY1992/93 and 1993/94 State Plan. Similar to the previous report, this document will outline the history, philosophy, policy, goals and activities of the State Child Abuse and Neglect Prevention Board, hereafter referred to as the Michigan Children's Trust Fund (MCTF) since its inception in 1982. It will also update the available information on child abuse and neglect, including the identification of risk factors and evaluation of prevention efforts.

The MCTF is a nonprofit organization which procures funds from a state-wide income tax checkoff, private donations, state department support, and fundraisers. MCTF monies are channeled primarily into grants to local councils and direct service prevention projects. Because MCTF relies heavily on donated funds, it can only do as much as contributions allow. Sections III and IV outline the bases on which MCTF funds are distributed. Local councils are composed of community volunteers representing various local agencies (as specified in section IV, B). These councils receive formula funding which may be used in their efforts to educate their communities about child abuse and neglect prevention, the MCTF, and support local prevention projects. Funds to direct service prevention projects are allotted on a competitive basis through a Request for Proposals (RFP). Grants are based on project merit, relevance to MCTF priority areas, and factors related to geographical distribution. To date, two RFPs have been issued in FY1993/94.

During previous years, MCTF awarded grants with a focus in five priority areas: Neighborhood Based Family Resource Centers, Pregnancy/Newborn programs, Sexual Abuse Prevention programs, Latchkey programs, and Parent Skills Training and Support programs. Within the last four years, CTF has moved from awarding grants in these five priority areas to two: Pregnancy/ Newborn programs and Parent Skills Training and Support groups. This change has come about for a number of reasons. Child sexual abuse prevention programming has been discontinued due to the inclusion of sexual abuse prevention information in the Michigan Model of health and sex education. The Children's Trust Fund supported the Michigan Model and was involved in the curriculum development of the sexual abuse prevention materials. Latchkey programming has been discontinued because local school districts have become more active in supporting before and after school programs in communities throughout the state. Neighborhood based family resource centers have been discontinued as a discrete grant priority, but many of the aspects of these programs have been absorbed in the two remaining priority areas.

The emphasis on Pregnancy/Newborn programs reflects a movement towards both early intervention and a home visitor intervention model. Pregnancy/Newborn programs typically involve a home visitor as an integral part of the program. Home visitor programs have become increasingly popular, both nationally and locally, especially with populations of parents who are difficult to reach in other ways. In a home visitor program, a volunteer, indigenous, experienced mother is selected, trained, and supervised in the delivery of a program providing information, skills training, and support to expectant or new parents. The program is delivered in frequent (often weekly) meetings that take place in the parents' home. The home visitor serves as a teacher, a model, and a source of support for the new parents.

The choice of MCTF to focus on these two priorities was based upon ten years of experience funding prevention programs in Michigan, as well as careful consideration of national experience. Both of these priority areas have been documented to be successful ways to reduce risk of child abuse and neglect. In the coming years we will continue to monitor the success of the programs we fund and are committed to adjusting our funding priorities according to the lessons we learn from this monitoring.

This year's State Plan contains new information in the following areas:

- Section I contains updated information on MCTF income and distribution of funds;
- Section II contains updated information on types of abuse, including appropriate definitions, national and state incidence rates, and discussion of risk factors, particularly parental substance abuse;
- Section III includes a discussion of the outcomes from a research project conducted by MCTF which focused on a parent aide home visitor intervention funded by MCTF. A brief outline of current MCTF research projects is also provided;
- Section IV outlines information for local councils designation and evaluation based on the revised Designation Agreement for FY 1992/93;
- Appendix A contains updated information from the 1993 survey of formerly funded MCTF programs;
- Appendix B gives a breakdown of rates of abuse and neglect, donations to MCTF, and MCTF, distributions by county during fiscal year 1992/93.

I. INTRODUCTION

A. The State Plan

Act No. 150, P.A. 1982, Section 6(b) specifies that the Children's Trust Fund Board shall "biennially...develop a state plan for the distribution of funds from the trust fund. In developing the plan the state board shall review already existing prevention programs. The plan shall assure that an equal opportunity exists for establishment of prevention programs and receipt of trust fund money among all geographic areas in this state."

This State Plan has been developed in response to that mandate as a document which will assist the Children's Trust Fund Board in carrying out its mission for the fiscal years 1992 and 1993.

The State Plan is designed to:

1. Summarize what is known about child abuse and neglect and its prevention.

2. Establish a framework for activities of the Children's Trust Fund Board and Local Councils.

3. Indicate the course of direction the Children's Trust Fund Board will take with respect to allocation of funds and other activities.

B. The Children's Trust Fund to Prevent Child Abuse and Neglect

1. History.

In the early 80's Dr. Ray Helfer, a pioneer in the field of child abuse and neglect prevention, recognized the need for a permanent source of funding for child abuse and neglect prevention services. Most of the funds available, both then and now, are for intervention after abuse has occurred.

Dr. Helfer conceived the idea of a Children's Trust Fund as a means of underwriting services directed at the conditions associated with child abuse and neglect and promoting positive family interaction. The idea was to establish an income tax check-off. Monies raised would be divided in half -- one-half being immediately available and one-half placed in a permanent trust account. By doing this, the trust account could at some point become a self-sustaining source of funding and eliminate the need for yearly fund raising.

In 1982 Representatives Debbie Stabenow and Curtis Hertel translated Dr. Helfer's idea into legislation. In September of 1982 three bills were passed by the legislature and signed into law by the Governor. The three pieces of legislation (Acts 250, 211, and 249 of the Public Acts of 1982): (1) authorized the State Treasurer to place a line on the state income tax form which allows taxpayers who are receiving a refund to donate a portion of the refund, (2) provided that half of the refund donations each year would go into a trust fund, and that the income tax check-off would cease when the fund reached $20 million, and (3) established a 15 member Board to administer the fund. The first legislative act (Act 250) also outlined the purpose and function of the Board and the trust fund.

The program established by these Acts is commonly known as the Children's Trust Fund for the Prevention of Child Abuse. The Governor appoints 10 of the members of Children's Trust Fund including the chairperson. The other five members are appointed one each by the state departments of education, mental health, public

health, social services, and state police. Initial appointments to the Board were made in late 1982 and in February 1983 the Board held its first meeting.

The enabling legislation establishes both the purpose of the trust fund and priorities for funding. The Board is authorized to disburse funds for the following purposes which are listed in order of priority for expenditure:

a. Development or operation of a prevention program by a private, non-profit or public organization.

b. Activity by local councils to prevent child abuse and neglect.

c. Administration.

2. How Children's Trust Fund Money is Spent.

Prevention program grants: The Children's Trust Fund Board uses a competitive approach to selecting recipients for prevention program grants. The Children's Trust Fund Board will consider grants which address primary (i.e., general population) and secondary (i.e., at risk population) prevention only (for definitions of what constitute primary and secondary prevention, please see pages 9 and 10). The process involves a Request for Proposals prepared yearly by the Board which describes the type of programs that will be funded during that year and the process of applying for funds. Private and public agencies then submit the required material and the Children's Trust Fund Board selects the best projects for funding within the limits of the dollars available.

To date, the Children's Trust Fund Board has gone through 13 such funding cycles, awarding approximately 366 direct service grants and Local Council grants ranging from 7 our first year, to 19 in FY 1992/93. A total of $7,392,566 or an average of $739,256 per year has been awarded. The grants have funded five types of prevention programs covering neglect, and physical and sexual abuse (for detailed information regarding neglect, and physical and sexual abuse, please see pages 12 through 29):

a. Programs that provide neighborhood-based centers available for short-term child care as respite for parents.

b. Programs that address pregnancy and/or the newborn period to facilitate parent-infant interaction and sensitivity to the infant's capabilities and needs.

c. Programs for children and adolescents directed at the prevention of sexual abuse.

d. Programs for before and after school child care (latch key) which provide supervision and enhancement of life coping skills.

e. Parenting and related skills training and support groups.

As part of the monitoring of prevention program grants, the Children's Trust Fund conducts an annual survey of previously funded programs. Overall, 40% of formerly funded CTF programs are still in operation (see appendix A). This is consistent with the previous survey. Latch-key Programs were the most likely to still be in operation, and Parent Education and Support Programs were least likely to still be in operation, although no statistically significant differences were found based on priority area. Programs funded for 4 or more years were significantly more likely to still be in

operation. Those programs which are still operating reported receiving funding from numerous sources, most commonly user fees, United Way funding, and direct donations. While most programs were unable to specify why their program had been discontinued, the data indicate that lack of funding was most often responsible.

Local Council Grants: Local councils are community organizations that coordinate local efforts to prevent child abuse and neglect. Local councils may apply to the Children's Trust Fund Board for designation. Designation means that the organization meets the requirements set forth in the enabling legislation and is eligible for Children's Trust Fund funding.

To date there are 70 designated councils representing 78 of Michigan's 83 counties.

Funding to councils is provided on a formula basis as described in Section IV, page 34. A total of $2,359,583 or an average of $235,958 per year has been paid to local councils through this formula method. Local councils also received $75,000 in grants prior to this formula funding being developed in 1985.

Administration: Administration, which includes the expenses of the Board and staffing has been kept to a minimum in compliance with the legislation. The administrative budget for FY 92/93 was $199,400, and has totaled $1,690,404 for the last eleven years.

Table 1 summarizes the total expenditures of the Children's Trust Fund by fiscal year. Appendix B gives a breakdown of allocations to Local Councils and direct service grants during Fiscal Year 1992/93.

TABLE 1

CHILDREN'S TRUST FUND
EXPENDITURES THROUGH FISCAL YEAR 1992/1993

Fiscal Year	Trust Account	Direct Services	Local Councils	Administration	Advertising	Totals
FY 1982/83	$332,456	$0	$0	$36,682	$0	$369,138
FY 1983/84	$306,110	$273,040	$91,498	$115,000	$25,000	$810,648
FY 1984/85	$349,109	$242,538	$150,000	$120,000	$50,000	$911,647
FY 1985/86	$520,081	$307,998	$170,000	$174,139	$50,000	$1,222,218
FY 1986/87	$610,328	$550,000	$230,000	$190,000	$500,000	$2,080,328
FY 1987/88	$479,505	$769,027	$335,193	$201,385	$75,891	$1,861,001
FY 1988/89	$370,088	$773,557	$415,967	$189,114	$104,599	$1,853,325
FY 1989/90	$428,807	$574,545	$281,470	$141,935	$74,000	$1,500,757
FY 1990/91	$485,769	$454,128	$337,506	$218,260	$65,821	$1,561,4
FY 1991/92	$438,103	$385,224	$231,773	$204,716	$60,000	$1,319,816
FY 1992/93	$461,509	$292,638	$292,581	$199,400	$30,000	$1,276,128

3. Sources of Financial Support.

Financial support for the Children's Trust Fund has come from five sources as outlined below and as summarized in Table 2.

TABLE 2

CHILDREN'S TRUST FUND INCOME BY YEAR

Fiscal Year	Tax Check-Off (one-half of collections)	Direct Donations	Interest	State Dept. Support	Challenge Grant	Legislative Appropriation for Public Awareness	Total
FY 1982/83	$332,456	$3,676	$19,012	$0	$0	$0	$355,144.00
FY 1983/84	$306,110	$13,950	$77,353	$15,000	$0	$0	$412,413.00
FY 1984/85	$349,109	$57,705	$81,530	$20,000	$0	$0	$508,344.00
FY 1985/86	$520,081	$88,996	$114,980	$15,000	$0	$500,000	$1,239,057.00
FY 1986/87	$610,328	$70,000	$170,000	$20,000	$156,545	$0	$1,026,873.00
FY 1987/88	$479,505	$120,000	$218,000	$25,000	$496,192	$0	$1,338,697.00
FY 1988/89	$370,088	$120,000	$225,000	$25,000	$496,680	$0	$1,236,768.00
FY 1989/90	$428,807	$86,591	$278,119	$10,000	$190,459	$0	$993,976.00
FY 1990/91	$485,769	$48,000	$280,000	$5,000	$253,334	$0	$1,072,103.00
FY 1991/92	$438,103	$123,834	$309,968	$0	$154,119	$0	$1,026,024
FY 1992/93	461,509	$436,965	$321,812	$0	$	$0	$1,220,286

a. Tax Check-Off: Table 3 provides a summary of money collected from tax check-offs since the creation of the Children's Trust Fund. It should be noted that the number of returns with CTF check-offs decreased and the average donation increased during FY1992/93. This trend is due to a change in the minimum donation from $5 to $10.

TABLE 3

INCOME TAX CHECK OFF TRENDS					
Fiscal Year	Total Tax Collections	Tax Returns Submitted	Returns with CTF Check-Offs	Percent of Returns with Refunds that had CTF Check Offs	Average Amount per Return
1982/83	$664,913	3,770,000	199,000	6.85%	$3.34
1983/84	$612,220	3,889,000	196,192	6.50%	$3.12
1984/85	$698,219	3,976,000	227,943	7.65%	$3.03
1985/86	$1,040,161	4,110,000	183,690	5.91%	$5.54
1986/87	$1,220,657	4,286,000	197,245	5.9%	$5.90
1987/88	$959,010	4,352,000	155,618	3.09%	$5.95
1988/89	$740,176	4,436,000	115,088	2.59%	$6.24
1989/90	$857,614	4,363,000	122,107	2.7%	$6.99
1990/91	$971,539	4,383,000	140,027	3.1%	$6.87
1991/92	$876,206	4,651,000	128,800	2.7%	$6.80
1992/93	$923,018	4,576,000	86,430	2.0%	$10.67

b. Direct Donations: The Children's Trust Fund is able to receive direct donations. These donations have come from individuals, memorial gifts, and organized fund raisers like the Magic Ride for Kids. A significant increase is noted in direct donations from FY1992/93 due to the success of a radio fundraiser in the Grand Rapids Community. Donations for this event totaled over $300,000. Totals from direct donations are listed here in Table 4.

TABLE 4

Childen's Trust Fund Direct Donations			
1982/83	$3,676	1988/89	$136,102
1983/84	$28,950	1989/90	$77,517
1984/85	$77,705	1990/91	$52,790
1985/86	$103,996	1991/92	$123,834
1986/87	$90,000	1992/93	$436,965
1987/88	$113,953	**TOTAL**	**$1,245,488**

c. Interest: One half of all monies collected through the tax check off are deposited in the permanent trust fund which is an interest bearing account and are summarizedhere in Table 5.

TABLE 5

Trust Fund Account Interest Earnings			
1982/83	$19,012	1988/89	$263,904
1983/84	$77,353	1989/90	$278,119
1984/85	$81,530	1990/91	$292,334
1985/86	$114,980	1991/92	$309,968
1986/87	$170,000	1992/93	$321,812
1987/88	$218,000	TOTAL	$2,147,012

d. State Department Support: Four state departments represented on the Children's Trust Fund Board have donated over $105,000 to date to assist with the funding of monitoring grants. The Department of Education donated $5,000 in FY 1991/92; however, no State department funding was made available in FY 1992/93.

e. Federal grants: In 1985 Congress passed the CTF Challenge Grant Act. The act provides federal match to states who develop a children's trust fund and have funds committed to prevention programs. Michigan allocations, since 1986, are reflected in Table 6.

TABLE 6

Michigan Children's Trust Fund Challenge Grant Allocations			
1986/87	$156,545	1990/91	$253,334
1987/88	$496,192	1991/92	$154,119
1988/89	$496,680	1992/93	$163,474
1989/90	$190,459	TOTAL	$1,910,803

f. Legislative Appropriations: Recognizing that too many residents of our state were unaware of the Children's Trust Fund (CTF) and its purposes, the Children's Trust Fund Board conducted an extensive advertising campaign in FY 1986/87 to increase public awareness and understanding. This effort was funded by a $500,000 appropriation requested by Governor Blanchard and passed by the legislature.

C. Reports available from the Children's Trust Fund Office.

- Annual Report - 1992/93.
- Direct Service Program Summaries - 1991/92.
- Direct Service Program Summaries - 1992/93.
- Direct Service Program Summaries - 1993/94

II. CURRENT THINKING ABOUT THE PREVENTION OF CHILD ABUSE AND NEGLECT

A. Approach to the State Plan.

1. Definition of Prevention.

Study and service in the field of child abuse, as in many others--health, social work, safety--is placing increased emphasis on prevention. The reasons are the same across all fields: the alternative course, waiting until problems have become acute and children are abused and neglected, is too costly in terms of child and family well-being, and in the financial costs of treating acute problems. Treatment is the most expensive form of intervention and costly in the rate and consequences of failure. Caldwell (1992) found in the State of Michigan that long and short term costs associated with the treatment of child abuse and inadequate prenatal care were over 823 million dollars per year. On the other hand, the costs of providing home visitor services to every family in the state following the birth of their first child would total only 58 million dollars.

Prevention is generally thought of as taking measures to keep a certain phenomenon from happening. Prevention can take place at either of two different points in time: before the phenomenon has ever occurred or before it has occurred but in the context of certain warning signals. Prevention in child abuse refers to those efforts aimed at positively influencing adults and children before abuse or neglect occurs.

The Children's Trust Fund for the Prevention of Abuse and Neglect has as its mission primary and secondary prevention of child abuse and neglect.

Primary prevention or general population services may be directed at influencing societal forces which impact on parents and children or at accomplishing an environmental modification (such as requiring infant car seats or installing child-safe caps on medicine containers). Primary prevention or general population services may be providing education through the media or may be direct services which are made available to all individuals (such as immunizations or instruction in the schools or the maternity unit). The cost per person of these efforts is usually quite low.

The major components of primary prevention are:

- It is offered to all members of a general population.
- It seeks to promote wellness.
- The per person cost is usually low.

Secondary prevention refers to those supportive and intervention services offered adults and children who are considered, because of their life situation or personal characteristics, to be "at risk". While substantiated child abuse or neglect has not taken place, the probability for abuse or neglect is assumed to be greater than in the general population. The major components of secondary prevention are:

- It is offered to a predefined group of families or individuals.
- It is voluntary.
- It may be more problem-focused than primary prevention.
- It seeks to prevent future parenting problems by focusing on particular stresses, the prevention of family dysfunction, and the promotion of wellness.

The purpose of primary and secondary prevention as undertaken by CTF is twofold:

(1) to avoid a breakdown in parent/child interaction through modifying environmental conditions, interpersonal behaviors, and life coping skills, and (2) to provide parent and child support, child protection, and parent and child information. Prevention programs are defined in the Children's Trust Fund enabling legislation as a system of direct provision of child abuse and neglect prevention services to a child, parent or guardian (Act No. 250, P.A. 1982, Sec. 2.(f)). Such programs often lead to incorporation of services into the community's service structure, are ongoing, and reach a substantial portion of the target population, as specified by grantees.

A major consideration in the formulation of programs is whether they will be targeted at general populations (primary prevention) or at populations defined in terms of some element of risk derived from epidemiological studies (secondary prevention). The National Mental Health Association, for example, states that any "activity deserving to be described as prevention should generally include...an identified population at risk for that condition" and reserves the term health promotion for what have been described here as primary prevention activities. The Children's Trust Fund Board determines program by program whether general populations or at risk populations will be addressed.

2. Organization of Material.

This document conceptualizes the problem of child abuse and neglect using the traditional categories of neglect, physical and sexual abuse and looking at readily available data. To begin strategizing regarding prevention of child abuse and neglect it is necessary to consider the unique conditions and circumstances of each category as well as their commonalties.

3. Limitations of Data.

The actual extent of abuse and neglect is unknown. Most statistics are based on reports of abuse and neglect made to Children's Protective Services units of the state Departments of Social Services which are the agencies charged with investigating these reports and protecting the children involved. Yet, the National Study of Incidence and Severity of Child Abuse and Neglect (1982) revealed that two thirds of the cases known to community professionals who were not employed by state Children's Protective Services went unreported.

Reportedly, older victims are less likely than younger victims to be reported to CPS agencies (Ards and Harrell, 1993); however, the second National Incidence and Prevalence Study of Child Abuse and Neglect indicates that physical abuse, for instance, is substantially higher in the five oldest age groups.

In addition studies based on parental self-reports of family violence (Straus, Gelles and Steinmetz, 1980) and studies based on self-reports of sexual exploitation (Finkelhor, 1984) indicate (as summarized in the National Study cited above) an incidence much higher than identified in the official reports to Children's Protective Services. Self-report data is not available for Michigan.

An important distinction exists between incidence and prevalence rates. Incidence is the number or percent of new cases within a specific population over a given period of time, usually one year. Prevalence is the total number or percent of children currently in a population who have experienced abuse or neglect. Helfer (1984) has estimated that in any given year approximately 1.25 to 1.50 percent of U.S. children are suspected of being abused or neglected (incidence), while as many as 22% of children (studies have ranged from 16% - 30%) will experience abuse and neglect in their first 18 years of life (prevalence). While most reporting is based on incidence, it

should be emphasized that incidence data does not adequately reflect the extent of the problem.

Specific to Michigan, there are a number of limitations to the state data:

a. Substantiated cases may not represent all cases in which child abuse and neglect has occurred. Michigan statistics differentiate between substantiated and unsubstantiated complaints. Children's Protective Services is required by law to commence an investigation of every report of suspected in-home child abuse and neglect within 24 hours. State Police may also be enlisted in joint investigations with Protective Services, or given primary responsibility for the investigation. If there is sufficient evidence to make an arrest, State Police have jurisdiction in this realm. It is not required that the perpetrator be in-home for a police investigation to be conducted.

   Protective Services is required to make a face-to-face contact before an investigation is completed. Within 21 days, Protective Services must decide whether there is sufficient evidence to "substantiate" abuse and neglect, i.e., credible evidence to believe abuse or neglect is occurring or has occurred. This, of course, involves not only varying county criteria for substantiation but also professional judgment of line and supervisory staff (which varies despite required training), as well as the amount of resources the department can devote to investigation, the ability of the worker to locate the family, and the quality of the information provided by the reporting persons.

b. In addition to the reported complaints that are either substantiated or unsubstantiated, there are a number of complaints which are rejected as inappropriate for Children's Protective Services investigation at the time the complaint is received or after CPS has conducted a preliminary investigation. Complaints or reports are rejected for various reasons including: allegation does not represent an instance of child abuse or neglect; it is a police matter; case was discounted after collateral contacts; there was insufficient information or risk level identified.

c. It is also important to note that complaints of abuse and neglect reflect community values about what constitutes abuse and neglect, public awareness of the problem, and public faith in the community agency's ability to make a difference. While it is important to be aware of these reporting issues, there are certainly general trends in the statistical picture of child maltreatment which may be useful for child abuse prevention planning. Some of these statistics are reported in the plan.

B. Statistical Analysis by Type of Child Maltreatment

I. Overall Statistics

a. Statewide Incidence

   During calendar year 1993, Children's Protective Services in the Michigan Department of Social Services received 118,097 complaints alleging child abuse or neglect.

   Of these, about 53,302 complaints received a full investigation. 11,484 were

found to be substantiated* after investigation. The 11,484 substantiated cases involved over 20,282 children. This represents a substantiated incidence of 1% of the child population annually. Because of limitations on reporting previously cited, the actual incidence could be considerably higher.

b. Type of Abuse and Neglect

TABLE 7

1992/93 Types of Abuse and Neglect	
1. Physical Neglect	43%
2. Social Neglect	22%
3. Physical Injury	22%
4. Sexual Abuse	11%
5. Abandonment	4%
6. Congenital Drug Addiction	1%
7. Other Neglect**	1%
** Inappropriate use of funds; unlicensed home; improper guardian. (Due to rounding, percentages may not total 100%.)	

The overall FY 1992/93 rae of abuse and neglect can be categorized according to type of maltreatment as follows in Table 7 (unduplicated reporting by DSS Protective Services). Terms are defined on pages 13 through 22.

c. Trends

Review of state statistical trends, as seen in Table 8, reveals a declining rate of substantiation of child abuse and neglect in the context of a declining children's population and an increasing number of reported cases of child abuse and neglect.

*The remaining 41,818 reports included unsubstantiated cases due to inability to locate, lack of evidence and insufficient allegation to investigate.

TABLE 8

Child Abuse and Neglect Statistical Trends			
	1980	**1990**	**Change**
Child Population	2,753,121	2,458,765	294,356
	1990	**1993**	**Change**
No. of Complaints	100,000	118,097	18,097 (18%)
Substantiated Cases	16,328	11,484	4,844 Decline
Rate of Substantiation	30.6%	21.4%	30% Decline

A comparison of 1980 and 1990 census data reveals that the number of individuals under 18 years of age has declined by 294,356. State demographers suggest this trend may be due to a number of factors including lower fertility rates and a decline in the number of births due to either the "baby boomer" population reaching post child-bearing age and/or a migration of the working-age population during the recession in the early 1980's. In addition, statistics suggest that the decreased substantiation rate has occurred during a time when Child Protective Services is receiving an increasing number of complaints of child abuse and neglect. The data reveal an 18% increase (e.g., 1990--100,000 complaints; 1993--118,097 complaints) in the number of complaints over the course of the previous three years.

While the number of children in the state of Michigan has declined and the number of reported complaints of child abuse and neglect has increased, the number of substantiated cases of child abuse and neglect has actually decreased. Reportedly, 30.6% of reported cases of child abuse and neglect were substantiated in 1990, while in 1993 only 21.4% of reported cases were deemed to be substantiated. This represents a 30% decline over a three year period when, in prior years the rate of substantiation had remained relatively stable. Although procedures for reporting and substantiating child abuse and neglect vary from state to state; the national average for both reporting and substantiation has remained unchanged over the past year (National Committee to Prevent Child Abuse, 1994). A more standardized means of comparing national and state rates of substantiation might be to consider how many children per 1000 are substantiated as victims of child maltreatment. In this context, 15 out of every 1000 U.S. children were substantiated victims of child abuse or neglect, while in the State of Michigan, during the same time period, 7.9 children per 1000 were identified as victims.

A number of potential explanations have been provided for these trends; however, none of them are considered to be definitive. Protective Services reports that a perpetrator notification procedure was implemented in August of 1992, prior to the noted decline in the rate of substantiation. This procedure stipulates that suspected perpetrators must be notified, offered a hearing, and placed on a central registry which may have resulted in a system which has become more cautious in substantiating. In addition, the substantiation rate also dropped subsequent to the introduction of the Families First program. This program offers alternatives for providing services to families who are experiencing interpersonal violence and may have resulted in families being

diverted through the system prior to a case of abuse or neglect being substantiated. Other explanations could include a higher threshold for considering a case of abuse as substantiated, an increase in family violence, or a child protective system that has reached maximum capacity. Furthermore, any number of these factors could be interacting in conjunction to produce the observed trends.

Trends for overall and type of abuse for substantiated cases are reported in Table 9. The number of substantiated victims of sexual abuse approximately doubled up until 1989. Since that time, a downward trend has been emerging which indicates a 33% decline in the number of substantiated victims of sexual abuse. Substantiated physical injury and neglect cases combined have decreased by 51% since 1980. Speculations on these trends suggest that increased awareness and recognition of the problem has led to increased reporting of sexual abuse, while the reduction in neglect cases may reflect improvements in providing assistance to families before evictions, energy shut-offs, and food emergencies. However, changes in investigation practices, community tolerance, and extent of legal documentation required for substantiation may also account for a portion of these increases and decreases.

Table 9

MICHIGAN TRENDS IN SUBSTANTIATED CASES

Children's Protective Services
Fiscal Years 1980/81 through 1992/93

Fiscal Year	Number of Victims in Substantiated Cases*			Protective Services Field Staff	**Reported Cases Investigated
	Total	Physical Injury and Neglect	Sexual Abuse		
1980	27,308	25,625	1,683	N/A	N/A
1981	26,669	23,949	1,720	N/A	34,688
1982	25,625	23,935	1,690	472	36,729
1983	26,474	24,444	2,030	444	38,364
1984	26,241	23,313	2,928	475	40,210
1985	26,376	22,858	3,418	535	42,982
1986	28,571	24,546	4,025	516	49,367
1987	25,570	22,113	3,457	552	49,392
1988	25,316	22,201	3,115	531	47,934
1989	25,943	22,798	3,145	543	48,970
1990	25,774	15,858	2,689	492	50,997
1991	26,366	16,328	2,553	517	49,074
1992	25,931	16,537	2,570	494	51,601
1993	20,282	12,640	2,111	541	53,302
Change, 1980 to 1993					
	-25.7%	-51%	+25%		
Change, 1981 to 1993					
					+54%
Change, 1982 to 1993					
				+5%	
Change, 1992 to 1993					
	-21.7%	-23.5%	-18%	+10%	+3.3%

* Unduplicated Count.
** Cases, not victims.

d. County Incidence

The distribution of abuse and neglect throughout Michigan in FY 1992-93 is reported in Appendix D. These figures must be considered with extreme

caution because of differential levels of community awareness and reporting. They may also reflect variations between counties in community prevention activities and court practices. Rates per 1,000 children ranged from 26.5 in Antrim County to .5 in Schoolcraft County.

2. Neglect

a. Definition

Neglect is defined as harm to a child's health or welfare by a person responsible for the child's health or welfare (i.e., parent or guardian) which occurs through negligent treatment, including the failure to provide adequate food, clothing, shelter, medical care and adult supervision (Michigan Act 250 of 1982, Section 2 and act 238 of 1975, Section 2(d)).

For the purposes of management information, the State of Michigan divides neglect data into two groups: actions inherently detrimental to the child's body (physical) or actions inherently detrimental to the child's social and/or emotional well being (social). If there is more than one type of neglect for any one victim, then only the most severe is coded into state statistics.

Physical neglect includes malnutrition, exposure to elements, locking in or out, and medical neglect. *Social neglect* includes emotional neglect, emotional abuse, failure to thrive,* lack of supervision, and conditions leading to dependency.

b. Extent

According to the 1993 Annual Fifty State Survey completed by The National Committee to Prevent Child Abuse, neglect represents the most common type of reported and substantiated maltreatment. For the United States as a whole, 47% of children in substantiated cases are categorized as neglected.

In 1992/93 in Michigan, 69% of children in substantiated cases--13,414 children--experienced neglect. The type of neglect was identified as follows in Table 10:

TABLE 10

1992/93 Victims of Neglect	
Physical Neglect	8,362
Social Neglect	4,288
Abandonment	764

*Failure to thrive is defined as failure to gain weight and/or grow in height; it can also be defined as any infant (generally less than one year of age) who fails to grow (in weight and/or height) and develop (in personal-social-adaptive, language, gross motor or fine motor areas) as compared to pre-established standards over a period of time (generally a few weeks).

c. Demographics

(i) Age

Reports of deprivation of necessities (i.e., neglect) are clearly more prevalent in younger (birth to age 5) children and decreases with age (see Appendix E). National studies indicate that emotional and educational neglect increase with age. Emotional abuse peaks between the ages of 12 and 17.

(ii) Sex

When all forms of abuse and neglect are considered across age groups, incidence does not vary between boys and girls. There is more documentation of physical, educational and emotional neglect among boys than girls during all ages with the exception of physical neglect during adolescence (12-17).

(iii) Socio-economic Status

Families reported for neglect and abuse are disproportionately less educated and poor (Gil, 1970; American Humane Association, 1980; Bergdorf, 1981). Findings from the National Incidence Study (1987) revealed substantially higher rates of maltreatment in all categories among families whose income was less than $15,000 as compared to those earning $15,000 or more.

While differences in public scrutiny and the biases of reporting could account for this finding, some researchers indicate that such a conclusion appears unwarranted in view of the stability of the socio-economic pattern as reporting increases (Pelton, 1978). Furthermore, a strong association of social class and incidence of child abuse and neglect is observed which could be the result of stresses inherent in impoverished living conditions.

Low socio-economic status families are more likely to suffer from the effects of unemployment, economic problems, unwanted children, illness and other stress-producing events and conditions (National Study of Incidence, 1981). In addition, they are more likely to be linked with public social service systems that report child abuse and neglect. By definition, many aspects of neglect are directly linked to income given that a lack of resources (e.g., heat and hot water) may be reason to substantiate neglect.

(iv) Race

With respect to race, it is worth emphasizing that affluent whites and blacks have equal numbers of substantiated cases and, overall, low rates of child abuse and neglect. In lower income families, the overall incidence rates for white children are substantially higher than those for black children. For low income black families, substantiated cases involve primarily neglect with a relatively low incidence of physical abuse. This may be related to lack of resources, as discussed above.

d. Possible Interventions

Programming to prevent neglect includes the following facets:

* Actions to reduce poverty, or provide an adequate level of income maintenance for families on public assistance or to reduce homelessness.

* Actions to provide adult support and assistance to immature, isolated and cognitively limited parents and children.

  This programming is targeted at preventing the effects of lack of knowledge, immaturity, unrealistic expectations and low cognitive functioning. It is also designed to facilitate stable adult support since research is clear that outcomes are better for children living in a household where there is a stable adult (female or male) besides the mother. Actions which might be undertaken include:

  a) School-based adolescent parent programs.

  b) Home visitor programs to build strong families.

  c) Center-based programs which enroll mother and infant.

  d) Adequate provisions for daycare for working mothers.

  e) Foster care homes which will take both the adolescent mother and her baby.

  f) Residential living arrangements for a group of adolescents and their infants.

* Actions to assure adult supervision, adequate stimulation for development and growth and a healthy emotional environment. These programs include:

  a) Developmental daycare.

  b) Parenting education.

  c) Home Visitor programs.

  d) Life coping skills training.

  e) Before and after school (latch key) programs and summer daycare for working mothers.

3. Physical Abuse

   a. Definition

   Physical abuse is defined as harm or threatened harm to a child's health or welfare by a person responsible for the child's health or welfare which occurs by nonaccidental injury or maltreatment (Michigan Public Act 250 of 1982, Section 2(b) and Act 238 of 1975, Section 2(c)). These nonaccidental physical injuries are inflicted by parents, babysitters, or other caregivers.

   The extent of the injuries would be rated as mild (a few bruises, welts, scratches or cuts), moderate (numerous bruises, minor burns, or a single fracture), or severe (large burn, central nervous system injury, abdominal injury,

multiple fractures, any life threatening abuse including in the extreme, death). The severity of injury does not always correspond to the severity of the family problem, e.g., one episode of shaking a newborn can lead to permanent central nervous damage or death. Poisonings are included in the category of physical abuse.

b. Extent

While reported and substantiated physical injury is a low level occurrence, physical violence toward children is a relatively widespread phenomenon. National Family Violence surveys conducted in 1975 and 1985 have documented the extent to which children age 3 to 17 in intact households experienced parent to child violence during the past year. While the overall extent to which parents at least once acted violently in one of the ways documented has remained constant, there has been a marked decline in the percent of parents in intact households using measures defined as severe violence. Overall and individual types of abuse can be viewed in Table 11.

TABLE 11

PARENT TO CHILD VIOLENCE: A COMPARISON OF RATES IN 1975 AND 1985		
	1975	1985
Overall Violence	63.0%	62.0%
Severe Violence	14.0%	10.7%
Very Severe Violence	3.6%	1.9%
	Percent of households using at least once during past year	
Type of Violence	**1975 (N = 1,146)**	**1985 (N = 1,488)**
1. Slapped or spanked	58.2	54.9
2. Pushed/grabbed/shoved	31.8	30.7
3. Throw something	5.4	2.7
4. Hit or tried to kit with something	13.4	9.7
5. Kicked/bit/hit with fist	3.2	1.5
6. Beat up	1.3	0.6
7. Threatened with gun/knife	0.1	0.2
8. Used gun or knife	0.1	0.2

Severe violence is defined as items 4-8; very severe violence is defined as items 5-8 above.

From a national probability sample which covered households with two caretakers and at least one child aged 3 to 17. Information was obtained on one parent and one child per household. R. J. Gelles and M. A. Straus. Is Violence Toward Children Increasing? A comparison of 1975 and 1985 National Survey Rates. Paper presented at the Seventh National Conference of Child Abuse and Neglect, Chicago, Illinois, November 11, 1985.

The index of very severe violence is used to estimate the actual extent of physical injury to children. At 1.9% of 1980 population figures, this estimate would mean that almost 8,000 children in Michigan experienced physical injury. According to NCPCA (1994), physical abuse constitutes a significantly greater percentage of reported cases than substantiated cases. In 1992/93, the Michigan Department of Social Services substantiated physical injury to 4,278 children. The National Family Violence surveys suggests that an additional 2,500 children in Michigan in intact households, experienced very severe violence which was not officially substantiated as physical abuse.

c. Demographics

(i) Age

National data indicate that physical injury increases with age, peaking between the ages of 12 and 17. However, fatalities are higher among younger children, whereas moderate injuries are more prevalent among older children (National Incidence Study, 1987).

Michigan data show rates for abuse somewhat consistent across all age groups; although, abuse appears to increase disproportionately for females as they approach adolescence. See Appendix E.

(ii) Sex

National data indicate that physical abuse is higher in boys from birth to 5 years.

(iii) Socio-economic status

See discussion under Neglect, Section 2.C.3.

(iv) Race

Rates of physical injury are high in low income white families. Rates of physical injury are low in low income black families. Rates of physical injury are low in high income families regardless of race.

(v) Family Composition

The National Incidence Study (1987) found that rates of physical abuse and neglect were higher in families with four or more children.

d. Possible Interventions

Programming to prevent physical injury include:

Actions to reduce life stresses, e.g.,

a) Actions to reduce poverty, or to provide an adequate level of income maintenance for families on public assistance.

b) Actions to discourage closely spaced births.

c) Actions to teach life coping or stress management training skills.

d) Actions to increase social networks.

e) Actions to reduce violence between parents.

f) Actions to provide parenting information and skills.

g) Action to facilitate acquisition of life coping skills by children.

h) Actions to reduce the societal condoning of violence in media presentations and institutional practices.

i) Actions to improve consumer products and environmental safety.

j) Drop-in centers for respite care.

Actions to facilitate bonding/attachment and to provide parenting information and skills, e.g.,

a) Hospital practices and procedures to facilitate bonding and knowledge of infant's capacities and needs.

b) Parent-infant support and intervention services to facilitate bonding/attachment, and improve parenting practices.

- Home-visitor programs. See Appendix C for further information.
- Center-based programs.

e. Research on Parent Interventions

With regard to interventions directed at parents, the research literature suggests that programs supporting parent-infant bonding and the development of specific parenting skills such as discipline methods, basic child care, and infant stimulation; child development education; familiarity with local support services; and linkages to other new parents in the community address a number of interpersonal and situational difficulties which are thought to be precursors to abusive behavior. In her review of the effects of prevention programming, Daro (1988) notes that comprehensive programs which have incorporated several of these strategies through intensive weekly contact with participants over a period of one to three years generally have been found to produce the most positive gains.

Specifically, the positive effects cited by Daro included:

- improved mother-infant bonding and maternal capacity to respond to the child's emotional needs (Dickie and Gerber, 1980; Field et al., 1980; O'Connor et al., 1980; Affholter et al., 1983; Beckwith, 1988);

- demonstrated ability to care for the child's physical and developmental needs (Love et al., 1976; Gutelius et al. 1977; Gabinet, 1979; Field et al., 1980; Larson, 1980; Travers et al., 1982; Gray, 1983; Olds et al., 1986);

- fewer subsequent pregnancies (McAnarney et al., 1978; Badger et al., 1981; Olds et al., 1986);

- more consistent use of health care services and job training opportunities (Powell, 1986);

- lower welfare use, higher school completion rates, and higher employment rates (Gutelius et al., 1977; Seitz et al., 1985; Powell, 1986; Polit, 1987).

In identifying the types of parents most likely to benefit from these educational and supportive services, several researchers have noted particular success with adolescent, relatively poor mothers (Badger, 1981; Olds et al., 1986), and with mothers who felt confident in their lives prior to enrolling in the program (Powell, 1986). Others have observed less positive gains when the client

population included a sizable percentage of middle-class parents (McGuire and Gottlieb, 1979; Wandersman et al., 1980; Levant and Doyle, 1983).

For those studies which have demonstrated the direct effects of certain interventions on reducing child maltreatment we cite the following four studies:

(l) Parenting disturbances requiring hospitalization of the infant during the first two years of life were 9 times more frequent among low income first-time mothers who received routine minimal contact with their infants vs. rooming-in with them at the point of birth (O'Connor, 1977).

(2) Infants in high risk families receiving weekly home visits experienced no injuries serious enough to require hospitalization in the first two years of life compared to 20% in the control group (Gray, Cutler, Dean and Kempe, 1977).

(3) The Optimum Growth Project, providing home visits and continuing contact over the first five years to high risk families, found 14 times more episodes of abuse/neglect/foster care in the control group (Caruso, 1984).

(4) In probably the most extensive empirical study conducted to date David Olds and his colleagues showed that participation in an intensive service model does reduce the incidence of child abuse and neglect. The first-time mothers who participated in this study were randomly assigned to one of four groups in which the most intensive level of services involved regular pre- and postnatal home visits by a nurse practitioner. Those who received the most intensive intervention had a significantly lower incidence of reported child abuse over the two-year postbirth study period. While 19% of the comparison group at greatest risk for maltreatment (i.e., poor, unmarried teens) were reported for abuse or neglect, only 4% of their nurse-visited counterparts were reported. In addition, those infants whose mothers received ongoing nurse home visits had fewer accidents and were less likely to require emergency room care. The mothers also reported less frequent need to punish or restrict their children (Olds et al., 1986).

Despite the positive results reported above, it is apparent that there continues to be a need to document the immediate and long-term impacts of these prevention strategies. As a cautionary note, practitioners need to be cognizant of the fact that their intervention may not be as successful as their theories and assumptions indicate; however, Donnelly (1992) reports that a 1991 survey by the National Committee for the Prevention of Child Abuse found that 86% of respondents endorsed offering home visits and other supportive services to first time parents. On the other hand, Halpern (1984) indicates that even the most intensive home-based interventions accounted for only 10% of the variation in participant outcomes. Other factors such as economic insecurity, limited access to services, maternal educational levels, and parental psychopathology were more powerful predictors of success or failure.

4. Sexual Abuse

a. Definition

Sexual abuse is engaging in sexual contact, sexual penetration, or the sexual exploitation of a child for the gratification of the perpetrator or another person

(Act 250, Section 2(b), and Act 238 of 1975, Section 2(c)).

Sexual exploitation is allowing, permitting, or encouraging a child to engage in prostitution; or allowing, permitting, encouraging, or engaging in the photographing, filming, or depicting of a child engaged in a listed sexual act as defined in section 145c of Act No. 328 of the Public Acts of 1931.

b. Extent

For the United States as a whole, 15% (NCPCA, 1994) of children in substantiated cases are categorized as sexually abused. While the rate of actual abuse remains unknown, national surveys indicate that as many as 27% of women and 16% of men have experienced sexual abuse by the time they reach adulthood (Los Angeles Times Poll cited in Finkelhor, 1987).

Sexual abuse is involved in 10% of substantiated protective service cases of abuse and neglect in Michigan affecting 2,111 children. As indicated previously, this does not include statistics on the number of cases of sexual abuse in out-of-home care. Sexual abuse is substantiated in approximately 50 group settings annually.

Surveys of adults suggest that one in four girls and one in six boys experience some form of sexual exploitation by age 18 (Finkelhor, 1985). This would suggest an annual incidence in Michigan of 50,000. There is a serious attempt in current research efforts to determine the short and long term effects of this exploitation of children. A number of people report that there may indeed be short and long term effects of sexual abuse (e.g., Brown & Finkelhor, 1986; Veiver & Tharinger, 1986). Emotional effects of sexual abuse include feelings of guilt, fear, depression, anger, and hostility. Behavioral effects of sexual abuse include: persistent inappropriate sexual behavior with self, peers, or younger children, regressive behaviors, "detailed and precocious understanding of sexual behaviors," sleep problems, inadequate peer relations, overly acting out or compliant, school problems, running away from home, suicidal, and, in girls, extraordinary fear of men and overly seductive behavior. Long term effects may include lack of basic trust, low self-esteem, depression, and self destructive behaviors.

c. Demographics

(i) Age

Sexual abuse increases with age and peaks between ages 9 and 12 (Finkelhor, 1987). Although, some data suggests that sexual abuse prevalence increases from 0.36 per 1,000 children 0-2 years old, to 2.41 per 1,000 children in the 3-5 year age range and remains relatively stable through adolescence.

(ii) Sex

Girls of all ages experience more sexual abuse than boys of all ages (National Incidence Study, 1987). However, this discrepancy in rates of abuse may be exaggerated by the fact that boys tend not to disclose sexual abuse (Finkelhor, et al, 1990).

(iii) Characteristics

Father-daughter incest accounts for less than a third of all sexual abuse. A high percentage of sexual abuse occurs with someone who is known to the child. Children who are particularly vulnerable to sexual abuse are those who are living with stepfathers or foster parents; or in families where the mother is unavailable or incapacitated or the parental relationship is conflictual (Finklehor, 1987). Children who are developmentally disabled or in isolated rural settings are also vulnerable.

Perpetrators are predominantly male (95 percent in abuse of girls, 80 percent in abuse of boys; Finkelhor, 1984). A regression analysis of the Second National Incidence and Prevalence Study of Child Abuse and Neglect suggests that sexual abuse is more likely for Whites than Blacks, for girls than boys regardless of family income, and for children residing in urban areas than for children residing in rural areas (Cappellari, Eckenrode, and Powers, 1993).

d. Possible Interventions

* Actions to prevent sexual abuse have been directed primarily at installing programs in schools and other group settings which inform children about appropriate and inappropriate touching, saying "no," and reporting to an adult as means of minimizing victimization. These programs have included dramatic or puppet presentations, films, books, and special curricula.

  In addition to Children's Trust Fund funded projects, this area has been a major focus of activity for local councils.

  The Michigan Model for Comprehensive School Health Education provides another opportunity. This program is unique to Michigan and is an interagency gubernatorial initiative to install health education in every Michigan elementary classroom by 1991; it includes a personal safety lesson at every grade level.

* Actions to prevent sexual abuse can be directed at parents that would better equip them to talk with their children regarding sexual issues and that would assist them in identifying and responding to questionable situations.

* Actions to prevent sexual abuse can be targeted at altering the social sanctions which perpetuate sexual abuse.

* Actions to prevent sexual abuse can be directed at young parents who have experienced sexual abuse in terms of protection of their own children.

* Actions to prevent sexual abuse can be directed at staffing issues and parental oversight in group child care programs and recreation programs.

5. Limitations and Knowledge.

A literature review commissioned by the Children's Trust Fund Board found a limited number of prospective longitudinal evaluations which document the actual effects of preventive interventions on the incidence of child abuse. However, the research that is available does provide information on several short-term outcomes as well as information which may contribute to successful program implementation. Daro

(1988) points out that this research provides:

Repeated documentation of initial and very positive service outcomes in terms of enhanced parenting skills and more positive parent-child interactions in cases of physical abuse.

With respect to sexual abuse prevention programs, the research remains inconclusive as to whether direct instruction changes children's attitudes and behaviors and even less evidence that preventive knowledge minimizes a child's risk for maltreatment. However, of those studies conducted, several have noted that children who receive sexual assault prevention instruction demonstrate an increase in knowledge regarding various safety rules and are more aware of the local support system available to them if they have been or are abused (Downer, 1984; Conte et al., 1985; Swan et al., 1985; Collins, 1986; Conte and Fogarty, 1990; Kohl, 1993). Other studies have noted significantly lower knowledge gains on the part of young children (Borkin and Franks, 1986; Conte et al., 1985).

Several studies have noted that a significant percentage of children are familiar with many of the basic safety concepts presented in these classes prior to receiving formal instruction (Plummer, 1984; Swan et al., 1985; Collins, 1986). Daro (1988) suggests that this finding may indicate that many of the safety rules taught in these programs, as well as a basic awareness of the existence of child abuse, may be far more familiar to children today than at the time these programs were initially designed. In addition, at least two studies have indicated the need for sexual abuse prevention programs to focus more on skill-building as it relates to the children's ability to apply the techniques they have been taught (Downer, 1984).

Finally, while at least two studies suggest that these programs may produce unintended fears and/or uncertainties in children (Swan et al., 1985; Garbarino, 1987), no consistent evidence of this has been forthcoming. Overall, there is no information on the long-term effect on the incidence of sexual abuse nor on the positive or negative developmental consequences for children.

6. Special Considerations

In addition to the information provided above, there are special considerations which need to be taken in account, such as the vulnerable parent, the vulnerable child and the vulnerable situation which are more closely defined below. This analysis is particularly important because it can lay the groundwork for targeting special prevention initiatives.

a. Outline for Special Considerations

(I) The vulnerable parent

(a) Alcoholic. See b below.

(b) Other substance abuser. See b below.

(c) Mentally retarded and low functioning. See c below.

(d) Mentally ill.

(e) Adolescent/single parent.

(f) Highly stressed parents.

(2) The vulnerable child

(a) Low birth weight.

(b) Developmentally disabled.

(c) Drug addicted at birth. See b below.

(3) The vulnerable situation

(a) Unemployment and poverty. See d below.

(b) Societal condoning of violent behavior or the inappropriate sexualizing of children.

b. The Vulnerable Parent: Substance Abuse

Drug Abuse

In their Annual Fifty State Survey, NCPCA (1994) reported that the majority of States cited substance abuse as a major presenting problem of families on their caseloads. Not only does there seem to be a relationship between alcohol abuse and child abuse, but there is an increasing awareness of the relationship between drug abuse, specifically crack and cocaine, and child abuse (NCPCA, 1989). Drug abusing parents experience a number of situational and personality problems which increase the likelihood of child abuse and neglect. Use of illicit drugs often leads to the diversion of time and resources away from the family and parental involvement in illegal activities which increase the risk of incarceration and disruption of the family unit. Drug intoxication may cause parents to behave violently, become paranoid, or lessen constraints about injuring, molesting or neglecting their children (Famularo, et al., 1986). Studies of families with drug abusing parents have found higher rates of physical illness among both children and parents. Bays (1990) estimates that 90% of drug abusers experience mental, emotional, or personality disorders which further impair their parenting abilities.

Mothers who are drug addicted are more likely than fathers to be poor, to be single parents, or to have a partner with alcohol or drug problems (Robin-Vergeer 1990). Children of addicted mothers are more often poisoned by drugs, due to adults letting them try it, being exposed to second hand smoke, or breast feeding from a drug using mother (Bays, 1990).

In the United States the number of individuals who abuse alcohol and cocaine continues to increase. There are more than 5 million regular users of cocaine, and 10 million adult alcoholics (Chasnoff, 1987). Woodside (1988) estimates that with over 6 million children of alcoholics and a large number of children who have drug abusing parents, the total number of children under the age of 18 directly affected by substance abusing parents is more likely between 9 and 10 million. According to NCPCA (1989), state child welfare offices indicate that substance abuse is a factor from as low as 20% to as high as 90% of the child abuse cases reported. Considering a national figure of abuse, it is estimated that 675,000 children are seriously abused by caretakers who abuse alcohol or drugs (NCPCA, 1989). A conservative estimate would suggest that 1 out of every 13.3 children with a parent who abuse alcohol or drugs is seriously abused each year.

Another national concern is the number of infants exposed to drugs before their birth. A survey of hospitals reported that as high as 27% to as low as .4% of all pregnant women seen were substance users (Besharov, 1989). Ten percent of all babies are exposed to illegal drugs that the mothers took while they were pregnant, according to a survey completed by the National Institute of Drug Abuse (Ogintz, 1988). More recently, Chasnoff (1992) estimates that at least 11% of pregnant women in the United States use substances during pregnancy, and that more than 300,000 infants per year are born to crack/cocaine abusing mothers.

Drug-exposed infants are not only hard to care for because of drug-engendered sensitivities; they tend to be physically immature, have more medical problems, and may be more temperamental than other babies (Bays, 1990). These factors tend to interfere with mother-infant bonding. Older drug and alcohol-affected children are more likely to be hyperactive, developmentally delayed, have conduct disorder, or have learning problems which increase parents' frustration and the risk for abuse. They are also at risk for neglect and abuse in homes where drug abusing parents are emotionally and physically unavailable.

Alcoholism

An abundance of research links heavy drinking and alcoholism with child abuse, although there is no agreement among studies on incidence rates (Behling, 1979; Black and Mayer, 1981; Famularo, Stone, Barnum, and Wharton, 1986). Studies have indicated that 69% of abusing families have at least one alcoholic parent (Behling, 1979). Again, depending on the study, between 25% and 84% of abusing parents have misused alcohol (Leonard and Jacob, 1988). A number of situational characteristics and personality factors are found in common between alcoholic and child abusing families: issues of low self-esteem, dependency-independency conflicts, low frustration tolerance, confusion of sociosexual and parental roles, depression, immaturity, and impulsivity (Hindeman, 1977; Mayer & Black, 1977; Christozov and Toteva, 1989).

The greater the parental abuse of alcohol, the greater the battering or neglect of adolescent children (Flanzer, 1979). Persons who report being frequently drunk are more abusive than those who seldom drink or those who are consistently drunk. In a controlled study of cases of physical abuse, sexual abuse, or neglect which resulted in court ordered removal of children from the home, Famularo, et al. (1986) found an over representation of alcoholic parents. The court involved families were more likely to have met the diagnosis for alcoholism at some point during their life, and were more likely to have experienced major depression.

Studies show that alcoholic mothers are more likely than alcoholic fathers to abuse their children. Mothers report being more abusive toward their children across all social classes and at each level of alcohol abuse (National Survey of Family Violence, Coleman & Strauss, 1985). Alcoholic parents are more likely to harm their children when they are not in treatment (Black & Mayer, 1981).

There appears to be a high incidence of alcoholism among fathers reported for sexual abuse (50% to 71%) as well as serious illness and undiagnosed alcoholism in the mothers. A study conducted by Finkelhor and Williams (cited in Vanderbilt, 1992) found that 33% of sexually abusive fathers reported being under the influence of alcohol at the time of the abuse; 10% reported that they

had been using drugs. Finkelhor (1986) suggests that alcohol acts as a physiological disinhibitor making it easier for sexual abuse to occur and allowing social taboos to be ignored.

In 1991, the U.S. Department of Health and Human Services announced a nationwide competition to design and evaluate model interventions to assist children living in substance abusing households. A progress report on one such program (Blau, Whewell, Gullotia, and Bloom, 1994) suggests that a comprehensive approach in the context of a responsive human service delivery system is most efficacious including community based respite care, physical health care, drug and alcohol treatment, job training, and prevention/education services.

c. The Vulnerable Parent: Developmentally Disabled.

Developmentally disabled (primarily mentally retarded) parents and their children fall into a highly vulnerable, at-risk population requiring early intervention. Neglect and developmental delay are more characteristic in this population than physical abuse. Families at particular risk are those without a functioning supportive kinship network. Experience in this field suggests that establishing a long term, supportive relationship and enhancing child care skills is essential to effective services for this population.

d. The Vulnerable Situation: Unemployment and Poverty

Physical injury and social neglect are related to stress and isolation of caregivers while physical neglect is, in significant aspects, a function of absence of resources. The relationship between the incidence of abuse and neglect and the socio-economic status of the family has been previously noted and is well documented (Olsen and Holmes, 1983). We wish here to emphasize the vulnerable situations created by high levels of unemployment and poverty.

Statistical analyses have indicated a high correlation between rates of abuse and neglect and the unemployment rate (Steinberg, Catalano, and Dooley, 1981). Reports from state agencies during the recent recession added to the evidence that the incidence of child abuse increases as a function of unemployment. In Michigan, during 1981, when the rate of unemployment was 15%, abuse increased by 9% (National Committee for Prevention of Child Abuse, 1984).

There has been a 31% increase since 1979 in the number of children living in poverty. This increase is a function of unemployment in intact families as well as an increase in female-headed households resulting from single parenthood and divorce, combined with the level of unemployment and depressed wages for women. Reductions in the level of public assistance, WIC, food stamps and other social welfare support have disproportionately affected children and families. The 1994 National Kids Count Data Book indicates that in 1991 one in every five (20%) children lived below the poverty line which represents only a slight improvement from the 20.5% recorded in 1985. A long term review of this data suggests this negligible improvement represents a plateau rather than a trend, since the rate has steadily remained around the current rate since 1980. In 1991, 20.5% of Michigan's children were considered to live in poverty. The high proportion of children living in poverty (20% of all children, 50% of black children) constitutes a major risk for abuse and neglect (Children's Defense Fund).

III. PREVENTION PROJECTS

After reviewing the material previously outlined, the Children's Trust Fund Board made determinations concerning its activities with respect to future state plan development, prevention projects, local councils and policy, legislature and liaison activities.

A. State Plan Development

1. The Children's Trust Fund Board will continue analyses of county figures and other data.

2. In future state plans, the Children's Trust Fund Board will further explore income and other relationships to neglect and abuse in Michigan.

3. The Children's Trust Fund Board will keep an updated review of the literature on child abuse and neglect. Special risk factors including information on the vulnerable parent, the vulnerable child and the vulnerable situation will be further explored in terms of their relation to the incidence of abuse and neglect.

4. In the future State Plans, findings regarding the effectiveness of home visitor interventions will be further explored.

B. Prevention Projects

Under Section 9 of Act 250, P.A. 1982, the Children's Trust Fund Board is authorized to allocate funds to development of community services designed to prevent child abuse and neglect. The Children's Trust Fund Board has made the following determinations with respect to direct service projects.

1. Legislative Intent

Section 9 of the Children's Trust Fund enabling legislation established the funding of prevention programs as the first priority for expenditures of Children's Trust Fund monies by stating:

> The state board may authorize the disbursement of available money from the trust fund, upon legislative appropriations, for exclusively the following purposes, which are listed in the order of preference for expenditure:
>
> To fund a private nonprofit or public organization in the development or operation of a prevention program.

2. Request for Proposal Process

The Children's Trust Fund Board has implemented the funding of prevention programs by means of a Request for Proposal (RFP) process. The process is as follows:

a. Children's Trust Fund Board, with input from local councils, establishes priorities for funding.

b. A Request for Proposals is issued which describes the priorities for funding, explains the Children's Trust Fund, outlines the grant application process and provides for a pre-application.

c. The applicant sends the pre-application for review to the local council representing the county of application. This review is a requirement set forth in Section 9(I)(i) of Act No. 250, P.A. 1982.

This subparagraph does not apply if a local council does not exist for the geographic area to be served by the program or it is a multicounty or statewide program.

d. The applicant sends pre-applications that are approved by the local councils to the Children's Trust Fund Board for review.

e. Children's Trust Fund Board reviews pre-applications and selects those which are requested to submit full applications.

f. Full applications are reviewed by the Children's Trust Fund Board and selections made in terms of programmatic criteria, and funds available for distribution.

3. Criteria for awarding direct service grants:

The Children's Trust Fund Board will take into consideration the following aspects in making its final decision on projects:

a. Approval of the local council (required by law).
b. Knowledge of the program type, derived from previous research and experience.
c. Merit of the application.
d. Priority rating of the local council, where one exists.
e. Distribution among project types.
f. Distribution among geographic areas.

4. Scope and evaluation of the Children's Trust Fund direct service grants.

The Children's Trust Fund Board has categorized three levels of direct service projects which may be funded. Evaluation measures appropriate to each category have been specified. Projects will be identified according to level in contractual documents.

Level I: The project is seen primarily as a means of supporting direct services at the local level.

Evaluation measures will cover:

(1) Contractual performance.
(2) Consumer satisfaction.
(3) Feedback on service objectives.
(4) Cost analysis.

Level 2: In addition to the direct service provided, the project is seen as making a significant contribution toward knowledge in the field.

Evaluation measures under Level 2 will cover items (1) to (4) above and

(5) Analysis of experience, which permits a redefinition of Children's Trust Fund Board parameters for this type of project.

Level 3: The project is seen as documenting a validated service model.

Evaluation measures under Level 3 will cover items (I) to (5) above, and

(6) An evaluation design which provides for comparison with an unserved group.

The Children's Trust Fund has previously underwritten a two-year experimental research study at a Detroit perinatal coaching program. The study compared the effectiveness of services for 30 first-time parents who received a perinatal coaching program and the outcomes for a group of 34 parents who received no programmatic services. The intervention was implemented by volunteer parent aides (women who had experience with the parenting process and had raised their own children). The program began in the third trimester and lasted up until the baby's first birthday. The research investigated issues such as:

The intensity of services the parents receive.
The methods used to recruit parents.
The methods by which the coaches deliver services.
What is the effect of services on the following outcomes:

- social support
- parenting skills and knowledge
- development of the child
- mother/child interactions
- parental stress
- pregnancy outcomes
- self-esteem
- child abuse and neglect

Findings from this research study supported the parent aide intervention model in that social support was found to positively influence the mothers' perceived levels of parenting stress. Additionally, mothers in the intervention group provided more appropriate play materials for their children in the home environment at 6 months post-birth than control group mothers (Brookins, 1991). If you are interested in receiving a more detailed summary copy of the results of this study, please contact the CTF office.

Currently, research is being conducted through a prevention program and research grant to determine the effects of a one-on-one mentoring program for teen mothers. The program focuses specifically on improving social support, parenting skills and knowledge, parental stress, self-esteem and feelings of self-sufficiency, and decreasing outcomes of child abuse and neglect. The research component will be ongoing for the duration of the grant and will provide comparative data on mothers who received mentoring and those who did not.

5. Time lines for funding direct service grants.

The Children's Trust Fund Board will fund projects for various time lines. Grants will be identified as:

a. Seed Money - Grants so identified will be limited to one year of funding.

b. Subsidy - Grants so identified will be eligible for, but not guaranteed, funding in the subsequent year. The basis for determining whether or not to fund the project in the subsequent year will be a review of performance in accordance with the contractual obligation under the grant agreement and analysis of available dollars. A project being identified as a subsidy grant does not obligate

the Board to fund it for more than one year.

c. Declining Funding - Grants so identified will be eligible for, but not guaranteed, a total of two to four years funding. The basis for determining whether or not to fund the project in subsequent years will be a review of performance in accordance with the contractual obligation under the grant agreement and an analysis of available dollars. A full application for succeeding years will not be required from the grantee. The amount of funding shall decline each year according to the following schedule:

First Year - amount awarded by the Board
Second Year - 50%-75% of first year award
Third Year - 25%-50% of first year award
Fourth year - 25% of first year award.

6. Collaboration with other state agencies.

The Children's Trust Fund Board will also facilitate prevention projects through further collaboration with other state agencies by:

a. Being aware of what other agencies are doing and what their funding criteria are.
b. Recommending projects to other agencies for continuation grants.
c. Encouraging joint Children's Trust Fund and state agency funding.
d. Developing a contractual mechanism for multiple agency collaborative funding.
e. Encouraging other agencies to implement systemic prevention programs.

7. In order to give direction to grant applicants, the Children's Trust Fund Board will set priorities and specific parameters for each funding category, through the issuance of a request for proposals (RFP), during each year in which grants are to be awarded.

8. Specifications for Projects Funded

a. Parenting and Related Skills Training and Support Groups programs designed to educate and provide peer support for parents in the areas of child development, child care skills, life coping skills, stress management, and general advocacy and support. This priority also includes those programs that support respite child care as a component of their parent support services.

Parenting and related skills training and support groups should:

- provide for a time limited training experience using established training materials,
- encourage on-going self-help groups,
- have an active recruitment process which includes outreach,
- make provisions, if necessary, for transportation and child care,
- provide a welcoming, comfortable, non-academic environment,
- target and be accessible to high risk neighborhood or high risk groups in the community (i.e., teenage parents, referrals from health department visiting nurses, etc.),

- provide opportunities for unstructured time to assist in the development of social skills,
- include child development instruction which focuses on realistic expectations,
- have a strong component relating to awareness of community resources,
- include a stress management component which, among other things, focuses on methods for handling anger,
- provide respite care for children and support activities for parents,
- have an active recruitment process including direct person-to-person contact to attract the target population.
- show strong evidence of support from potential referral sources,
- make provisions for referral to needed services,
- meet requirements of the Department of Social Services as appropriate for licensure,
- have explicit provisions for training paraprofessionals and volunteer aides,
- have explicit ongoing provisions for supervision and support of aides.

b. Pregnancy/Newborn programs which address pregnancy and/or the newborn period to facilitate parent-infant interaction and sensitivity to the infant's capabilities and needs. Priority will be given to programs that target high risk families.

Pregnancy/Newborn Programs should:

- have a systematic recruitment process to attract parents and have links to local health care services,
- show strong evidence of support from the local medical community including hospitals, clinics, doctor's offices, etc.,
- serve or make explicit provisions for service to high risk families,
- show evidence of a strong training procedure for service providers,
- provide adequate supervision and support for service providers,
- have provisions for facilitating access to needed health and social services.

IV. LOCAL COUNCILS

Section 10, Act 250, P.A. 1982 sets forth the conditions under which Children's Trust Fund monies are made available to local councils. This section also establishes the conditions which local councils must meet in order to be designated as a Children's Trust Fund council.

A. CTF Goals for Local Councils

The Children's Trust Fund Board has made the following determinations with respect to councils:

1. The Children's Trust Fund Board is committed to a long term goal of having every county in the state represented by a designated council. Currently 78 of the state's 83 counties are represented. (The specific goal for the next year is to increase by 5 the number of counties represented). This goal will be addressed by providing technical assistance to groups interested in becoming a council and by continuing to make formula funding available to any group that becomes designated.

2. The Children's Trust Fund Board provides technical assistance for local councils or groups wishing to become designated local councils. The Children's Trust Fund Board will also support existing local councils by providing technical assistance.

   Technical assistance will be provided by Children's Trust Fund Board and staff through written communication, telephone contact and on site visits, and workshops. Workshops deal with such matters as prevention plans, needs assessment, grant application reviews, publicity, fund raising and other matters of interest to both local councils and the Children's Trust Fund. The Children's Trust Fund is currently seeking foundation support for expanded technical assistance to local councils.

3. Local councils are seen by the Children's Trust Fund Board as an essential ingredient in the development of child abuse and neglect prevention programs. Because of this the Children's Trust Fund Board will continue to network with local councils in the development and implementation of policy, procedures, priorities and strategies. This networking will include sharing information to and from councils, seeking input from councils on the Board's funding priorities, and encouraging local councils to participate in all Children's Trust Fund activities.

4. Local councils also provide coordination of prevention services within the county(ies) they represent. For funding purposes this coordination involves the councils' review of all applications for Children's Trust Fund funding. An application not reviewed and approved by the appropriate local council will not be considered for funding by the Children's Trust Fund Board. Applications for multi-county programs or from counties without a local council do not require local council approval.

5. The Children's Trust Fund Board recommends that councils review the data in this state plan and utilize it as one component in their prevention plan and grant reviews. Further, the Children's Trust Fund Board encourages local councils to use this data and their needs assessments in a proactive strategy of identifying priority issues or populations, and developing appropriate projects.

B. Designation of Local Councils

1. Criteria

The Children's Trust Fund enabling legislation, Act 250 of the Public Acts of 1982,

establishes the criteria which organizations must meet to become a Children's Trust Fund designated council:

a. Has as its primary purpose the development and facilitation of a collaborative community prevention program in a specific geographical area. The prevention program shall utilize trained volunteers and existing community resources wherever practicable.

b. Is administered by a board of directors composed of at least sixteen (16) people with an equal number of members from the following two groups:

(1) A representative from each of the following local agencies: the county department of social services, the department of public health, the department of mental health, the probate court, the office of the prosecuting attorney, a local law enforcement agency, a school district, and a number of private, local agencies that provide treatment or prevention services for abused and neglected children and their parents or guardians.

The number of private agencies to be represented on the local council shall be designated in the bylaws of the local council by the remaining members.

(2) Elected representatives: The elected members shall represent the demographic composition of the community served, as far as practicable.

c. Does not provide direct services (to clients) except on a demonstration project basis, or as a facilitator of interagency projects.

d. Demonstrates a willingness and ability to provide prevention program models and consultation to organizations and communities regarding prevention program development and maintenance.

e. Demonstrate an ability to match, through money or in-kind services, 50% of the amount of any trust fund money received. The amount and types of in-kind services are subject to the approval of the state board.

f. Other criteria the state board deems appropriate.

2. Application Procedures

Groups wishing to apply for designation status are required to submit an application. The application is reviewed by the local council committee of the Board. If the application does not meet all requirements, committee members and staff work with the applicant to achieve compliance. When the committee feels the applicant meets all requirements, they recommend approval to the Board as a whole.

3. Ongoing Performance Expectations

Once approved, a Children's Trust Fund designated local council is required to perform the following tasks:

a. Complete and submit to CTF annually a plan for implementing prevention efforts in their area. This plan shall include an assessment of community need.

b. Act as a clearinghouse to review and approve applications for grants from CTF.

c. Assist in the monitoring and evaluation of prevention programs funded by CTF in their area.

d. Submit quarterly program reports on a schedule and format established by CTF staff.

e. Run local education and training programs.

f. Foster fundraising to CTF and local councils.

g. Provide input to the CTF Board on establishment of prevention program priorities.

h. Provide assistance to prevention projects in their area in developing match and on-going funding.

i. Provide prevention program models and consultation to organizations and communities regarding prevention program development and maintenance.

j. Maintain financial records in accordance with generally accepted accounting practices and allow access by CTF to such records at reasonable times.

k. Provide CTF staff with copies of bylaws, incorporation papers, and a current list of board members.

C. Funding of Local Councils

1. Allocation of Funds

The Children's Trust Fund Board provides funding to assist local councils in the performance of these tasks. Each fiscal year the Children's Trust Fund Board allocates a sum of monies for local councils. This money is then distributed to the councils based on the following formula:

> Each council will receive $1,000 for each county or part of a county that the council has been approved to represent. In addition each council will receive the same percent of the remaining funds as the percent of total donations to the Children's Trust Fund received from their county(ies).

For the Fiscal Year 1992/93 distribution of funds to Local Councils, see Appendix A.

2. Annual Prevention Plan and Budget

a. Councils are expected to submit an annual prevention plan which details proposed expenditures of these monies. This plan must be reviewed and approved by the local council committee before funds can be released.

b. Additionally, then all designated local council are required to submit quarterly progress reports regarding their prevention plan.

c. Councils receiving $4,000 or more per year are also required to submit quarterly financial reports. Councils receiving less than $4,000 per year are required to submit a year-end expenditure report.

V. POLICY, LEGISLATIVE AND INTERAGENCY ACTIVITIES

Under Section 7, Act 250, P.A. 1982, the Children's Trust Fund Board may make recommendations to the Governor and the legislature concerning "state programs, statutes, policies, budgets, and standards which will reduce the problem of child abuse and neglect, improve coordination among state agencies that provide prevention services, and improve the condition of children and parents or guardians who are in need of prevention program services."

The Children's Trust Fund Board will carry out this activity in accordance with the following determinations:

1. The Children's Trust Fund Board role in reviewing and commenting on public policy recommendations and reports.

   The Children's Trust Fund Board will review and comment on public policy recommendations and reports in areas consistent with the Board's priorities and policies.

With respect to policy, legislative and advocacy activities, the Children's Trust Fund Board has made the following determinations:

   (1) Activities are limited to issues involving primary and secondary prevention.

   (2) In the area of parent/infant programs, the Children's Trust Fund Board will advocate for primary prevention activities which provide information and support to all parents as a part of family-centered maternity care.

2. The Children's Trust Fund Board role in relation to pending legislation.

   The Children's Trust Fund Board will:

   a. Support other children's advocacy groups in areas consistent with the Board's priorities and policies.

   b. Review selected legislative bills in accordance with the following two considerations:

      (1) Does the proposed legislation relate to child abuse prevention and the Board's priorities.

      (2) Are there political implications in the Board's taking a position.

3. The Children's Trust Fund Board role with respect to various state departments and prevention implications of program, statutes, policies, budgets and standards.

   The composition of the Children's Trust Fund Board, with representatives from five state departments, provides an opportunity for the Children's Trust Fund Board to be familiar with state department activities with prevention implications.

   a. The Children's Trust Fund Board may make suggestions concerning departmental issues consistent with Board priorities.

   b. The Children's Trust Fund Board may convene agencies around issues consistent with the Board's priorities.

4. The Children's Trust Fund Board's role with respect to the Governor and the legislature.

   The Children's Trust Fund Board will:

   a. Provide an annual report.

   b. Develop an active liaison.

   c. Communicate Children's Trust Fund Board positions as appropriate.

   d. Provide data on prevention projects funded in each legislative district.

VI. APPENDICES

SUMMARY

STATISTICS OF ALL FORMERLY FUNDED PROGRAMS			
Name of Priority	**Subtotal**	**Total Still in Operation**	**Percentage of Programs Still Operating**
Neighborhood Based family Resource Centers	18	9	50%
Pregnancy/Newborn Programs	25	9	36%
Sexual Abuse Prevention Programs	29	11	38%
Latchkey Programs	15	8	53%
Parenting Education and Support Programs	26	8	31%
Total Programs Still Operating: -45 **Total Programs Not Operating: 68** **Total Percentage of Programs Still Operating: 40%**			

APPENDIX B

County Rates of Abuse/Neglect, CTF Donations and Allocations							
County	Rates of Abuse/	1993 Check Off Donations		1993 CTF Award			Percent of Total CTF
		Amount	% of Total	Local Council*	Direct Service Grants		
Alcona	7.9	$368	.047	$1,120	$0	1,120	0.16
Alger	3.6	$557	.06	N/A	$0	0	0
Allegan	6.9	$5,591	.714	$2,829	$0	2,829	0.40
Alpena	7.8	$1,847	.236	$1,604	$0	1,604	0.23
Antrim	26.5	$1,372	.175	$1,449	$0	1,449	0.20
Arenac	24.6	$940	.12	$1,307	$0	1,307	0.18
Baraga/ Houghton/ Keweenaw	5.1*	$3,639	.465	$4,190	$14,000	18,190	2.56
Barry	7.0	$4,048	.517	$2,324	$0	2,324	0.33
Bay	5.2	$8,111	1.036	$3,653	$0	3,653	0.51
Benzie	7.1	$1,502	.192	$1,491	$9,200	10,691	1.50
Berrien	15.9	$8,562	1.09	$3,800	$0	3,800	0.53
Branch	14.1	$2,888	.369	$1,945	$0	1,945	0.27
Calhoun	11.6	$8,774	1.12	$3,870	$0	3,870	0.54
Cass	10.9	$2,403	.30	$1,786	$9,500	11,286	1.59
Charlevoix/ Emmet	9.3*	$5,271	.67	$3,724	$0	3,724	0.52
Cheboygan	19.5	$1,392	.178	$1,455	$0	1,455	0.20
Chippewa	12.1	$2,225	.284	$1,728	$0	1,728	0.24
Clare	21.6	$2,285	.292	$1,747	$0	1,747	0.25
Clinton	3.0	$3,977	.508	$2,301	$15,155	17,456	2.45
Crawford/ Roscommon	13.3*	$2,615	.334	$2,855	$750	3,605	0.51
Delta	7.6	$2,165	.277	$1,708	$8,550	10,258	1.44
Dickinson	4.7	$1,401	.16	N/A	$0	0	0
Eaton	4.6	$6,438	.822	$3,106	$9,994	13,100	1.84
Genesee	9.3	$32,994	4.215	$11,791	$46,850	58,641	8.24
Gladwin	17.2	$1,133	.145	$1,371	$0	1,371	0.19
Gogebic	5.5	$895	.114	$1,293	$0	1,293	0.18

County Rates of Abuse/Neglect, CTF Donations and Allocations							
County	Rates of Abuse/	1993 Check Off Donations		1993 CTF Award			Percent c Total CT
		Amount	% of Total	Local Council*	Direct Service Grants		
Grand Traverse/ Kalkaska/ Leelanau	10.4*	$9,530	1.217	$6,117	$0	6,117	0.86
Gratiot	4.1	$1,889	.241	$1,618	$0	1,618	0.23
Hillsdale	14.2	$2,075	.265	$1,679	$0	1,679	0.24
Huron	8.9	$1,982	.253	$1,648	$0	1,648	0.23
Ingham	8.6	$44,741	5.716	$15,633	$55,450	71,083	9.98
Ionia	8.7	$4,365	.558	$2,428	$0	2,428	0.34
Iosco	8.3	$1,185	.151	$1,388	$7,913	9,301	1.31
Iron	3.4	$415	.053	$1,136	$0	1,136	0.16
Isabella	7.1	$3,432	.438	$2,122	$7,500	9,622	1.35
Jackson	7.2	$11,372	1.45	$4,719	$0	4,719	0.66
Kalamazoo	14.6	$27,287	3.486	$9,924	$0	9,924	1.39
Kent	5.7	$49,149	6.279	$17,074	$32,424	49,498	6.
Lake	24.6	$240	.03	N/A	$0	0	0
Lapeer	7.9	$4,978	.636	$2,628	$0	2,628	0.37
Lenawee	10.3	$6,269	.801	$3,050	$0	3,050	0.43
Livingston	2.3	$10,503	1.342	$4,435	$0	4,435	0.62
Luce	21.1	$387	.049	$1,127	$0	1,127	0.16
Mackinac	18.4	$619	(.08)	$1,202	$0	1,202	0.17
Macomb	5.2	$64,960	8.30	$22,245	$5,000	27,245	3.83
Manistee	4.7	$1,226	.16	$1,401	$0	1,401	0.20
Marquette	6.7	$4,971	.64	$2,626	$0	2,626	0.37
Mason	10.3	$2,081	.27	$1,681	$0	1,681	0.24
Mecosta/ Osceola	5.8*	$3,483	.45	$3,139	$0	3,139	0.44
Menominee	7.0	$1,093	.14	$1,357	$0	1,357	0.19
Midland	7.1	$5,310	.68	$2,737	$3,160	5,897	0.83
Missaukee/ Wexford	9.9*	$2,180	.28	$2,712	$0	2,712	0.
Monroe	2.9	$7,117	.91	$3,328	$0	3,328	0.47
Montcalm	5.2	$3,865	.49	$2,264	$0	2,264	0.32

County Rates of Abuse/Neglect, CTF Donations and Allocations							
County	Rates of Abuse/	1993 Check Off Donations		1993 CTF Award			Percent o Total CTF
		Amount	% of Total	Local Council*	Direct Service Grants		
Montmorency/ Oscoda	7.9*	$767	.10	$2,251	$0	2,251	0.32
Muskegon	8.0	$9,719	1.24	$4,179	$4,500	8,679	1.22
Newaygo	14.9	$1,583	.20	$1,518	$0	1,518	0.21
Oakland	4.4	$118,461	15.13	$39,743	$26,463	66,206	9.30
Oceana	10.7	$1,231	.16	$1,403	$0	1,403	0.20
Ogemaw	20.1	$642	.08	$1,210	$0	1,210	0.17
Ontonagon	11.4	$537	.07	$1,176	$0	1,176	0.17
Otsego	7.4	$1,810	.23	$1,592	$0	1,592	0.22
Ottawa	4.2	$11,996	1.53	$4,923	$0	4,923	0.69
Presque Isle	5.7	$599	.07	N/A	$0	0	0
Saginaw	11.3	$13,115	1.68	$5,289	$0	5,289	0.74
St. Clair	7.6	$10,914	1.39	$4,569	$19,940	24,509	3.44
St. Joseph	10.0	$4,949	.63	$2,619	$7,188	9,807	1.38
Sanilac	4.7	$3,165	.40	$2,035	$7,200	9,235	1.30
Schoolcraft	.5	$248	.03	N/A	$0	0	0
Shiawassee	4.7	$6,087	.78	$2,991	$0	2,991	0.42
Tuscola	5.3	$2,323	.30	$1,760	$0	1,760	0.25
Van Buren	14.4	$4,920	.63	$2,609	$0	2,609	0.37
Washtenaw	4.1	$43,700	5.58	$15,292	$22,500	37,792	5.31
Wayne (Mayor's Task Force	9.6*	$66,908	8.55	$22,882	$36,500	59,382	8.34
Wayne (Out Wayne)	---	$92,027	11.76	$31,098	$27,182	58,280	8.19
TOTALS		$785,798	100	$335,004	$376,919	$711,923	100

*Multiple county average.

APPENDIX C

PARENT/INFANT HOME VISIT SERVICES.

Parent-infant home visit support and intervention services have developed under various auspices titles. Home visit models may be called "perinatal coaching," "infant mental health services, "parent aides" or "volunteer friends." Services may use professional, para-professional or volunteer staffing. Services provided include various combinations of the following components:

- Support and intervention during pregnancy.
- Support during delivery.
- Provision of information in the hospital concerning newborn capabilities.
- Support and intervention generally during the first year of life.
- Facilitation of parent-infant attachment and interaction.
- Developmental guidance on child care and infant development.
- Facilitation of health care and access to needed resources.
- Encouragement of responsible decision making, family formation and life planning.
- Resolution of conflictual situations.

In implementing parent/infant programs targeted at pregnant women or newborns, two issues relate to the population selected, i.e., (1) whether service will be provided to families with firstborn only or to families for all birth orders, and (2) whether service will be provided to all families or only to families identified on the basis of risk factors.

These issues become important for intensive ongoing support and intervention services, where there ar significant costs to providing the service in terms of cash outlay, time recruitment and training). They irrelevant to the provision of information, education and facilitation of bonding which can be incorporat into ongoing hospital service routines and which should be available to all parents.

Firstborn vs. all birth orders.

The choice is often made to serve families with firstborn children only with intensive support and intervention services on the premise that it is easier to work with families without older children and th first-time mothers have less information and more unrealistic expectations, etc.

Limiting services to families of firstborn ignores the extent to which abuse and neglect occur when a woman has several closely spaced young children or has one of more young children and is again pregnant (Schwartz and Schwartz. 1977).

GENERAL POPULATION VERSUS AT RISK POPULATION.

A decision to provide services to all families with newborns is generally made on one of two premises: (1) that families at risk for
abuse and neglect cannot be identified, and (2) that identification involves judgmental labeling. Finally, decision to provide services to all families assumes a level of resources not realistic under current conditions, with the distinct possibility that limited resources will be expended in improving the quality life for families who will do reasonably well while overlooking those in more problematic life situations. Attitudinal surveys show a wide propensity for abuse and thus do not identify the small percentage of parents who will actually abuse.

However, either systematic observation of behavior in the hospital and informed clinical judgment can identify between 10% and 20% of parents with atypical patterns of interaction with their infants and li stress are indicative of risk (ref. published studies of screening procedures in Denver, Colorado; Kalamazoo, Michigan, etc.).

Clinical or systematic observations of parent-infant interaction are carried out as an integral part o the maternity unit and are no more intrusive than assessment of physical status. Nor need the offer of services be judgmental; a statement that having a new infant is stressful does not in itself communicat prediction that the parent is a potential abuser.

COMPARISON OF DECISION TO SERVE ALL FAMILIES VERSUS PRIMARY AND SECONDARY PREVENTION AT RISK FAMILIES FOR PARENT/INFANT PROGRAMS TARGETED AT FAMILIES WITH NEWBORNS		
	All Families	**At Risk Families**
Services provided to:	All mothers/infants as specified and within capacity of program	Mothers/infants as identified on basis of risk criteria and within capacity of program
Percent of population expected to serve:	100%	Maximum of 20%
Labeling Implications:	No labeling since service is provided to everyone	No labeling if application of risk criteria is unobtrusive and service is not presented as "you are selected because you are at risk"
Likelihood of reaching target	High ratio of low risk to high risk families (est. 20 to 1) Theory: 100% of entire population is reached and accepts service Practice: limitation of resources and orientation toward everybody may mean bypassing more difficult and poor families with highest risk for abuse	Fewer low risk families served (est. 5 to 1) Some high risk families will be missed by risk criteria

APPENDIX D

NUMBER OF ABUSE/NEGLECTED CHILDREN BY COUNTY AND CATEGORY OF ABUSE/NEGLECT

Children's Protective Services Substantiated Cases 10/92 - 19/93

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Misc.	Physical Neglect	Social Neglect	Abandon-ment
Alcona	2,142	17	7.9	5	2	0	6	4	0
Alger	2,240	8	3.6	1	0	2	2	3	0
Allegan	26,865	185	6.9	59	39	5	36	63	7
Alpena	8,066	63	7.8	9	4	0	27	23	0
Antrim	4,677	124	26.5	12	19	3	14	92	0
Arenac	3,990	98	24.6	10	2	6	52	28	0
Baraga	2,106	15	7.1	3	1	0	10	1	0
Barry	13,989	98	7.0	24	15	0	31	25	4
Bay	29,379	154	5.2	36	25	4	74	31	3
Benzie	2,956	21	7.1	3	2	2	11	3	0
Berien	43,519	692	15.9	182	49	23	192	255	27
Branch	11,567	153	14.1	50	30	0	65	18	0
Calhoun	36,193	419	11.6	98	40	11	239	42	6
Cass	13,365	146	10.9	18	26	6	15	83	0
Charlevoix	5,792	34	5.9	5	7	0	6	19	2
Cheboygan	5,605	109	19.5	15	17	6	23	57	0
Chippewa	8,080	98	12.1	27	7	0	42	27	4
Clare	6,535	141	21.6	33	12	3	21	80	1
Clinton	16,652	50	3.0	10	9	2	21	10	0
Crawford	3,201	43	13.4	12	6	0	18	6	0
Delta	10,174	77	7.6	16	12	4	29	17	1
Dickinson	6,972	33	4.7	15	7	0	9	1	1
Eaton	25,629	118	4.6	40	24	3	23	19	1

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Misc.	Physical Neglect	Social Neglect	Abandon-ment
Emmet	6,677	85	12.7	19	13	0	36	19	2
Genesee	120,663	1,121	9.3	307	152	21	461	149	53
Gladwin	5,762	99	17.2	31	16	1	38	17	4
Gogebic	4,031	22	5.5	5	1	1	12	3	0
Grand Traverse	17,412	104	6.0	29	13	0	22	35	8
Gratiot	10,578	43	4.1	7	8	0	12	13	5
Hillsdale	12,256	174	14.2	0	26	0	90	19	1
Houghton	7,942	22	2.8	2	3	0	16	1	0
Huron	9,377	83	8.9	7	10	0	31	27	8
Ingham	68,365	586	8.6	170	59	9	231	132	9
Ionia	16,104	140	8.7	54	17	3	42	40	2
Iosco	7,964	66	8.3	12	7	7	25	14	1
Iron	2,930	10	3.4	3	2	2	0	3	0
Isabella	12,526	89	7.1	11	30	1	40	11	1
Jackson	38,567	278	7.2	77	52	3	110	32	11
Kalamazoo	54,473	795	14.6	153	83	10	187	358	15
Kalkaska	3,954	80	20.2	14	15	4	20	23	3
Kent	141,576	800	5.7	219	104	22	390	60	11
Keweenaw	339	2	5.4	2	0	0	0	0	0
Lake	2,155	53	24.6	9	12	2	25	5	2
Lapeer	22,109	175	7.9	33	18	3	66	58	0
Leelanau	4,310	21	4.9	1	2	0	4	10	4
Lenawee	25,778	265	10.3	68	44	3	123	51	0
Livingston	33,132	75	2.3	33	16	0	0	28	4
Luce	1,568	33	21.1	5	2	0	15	16	0

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Misc.	Physical Neglect	Social Neglect	Abandon-ment
Mackinac	2,766	52	18.4	6	7	0	31	7	3
Macomb	171,653	886	5.2	248	84	19	291	273	33
Manistee	5,101	24	4.7	5	8	0	5	6	1
Marquette	18,399	124	6.7	54	10	5	46	6	4
Mason	6,711	9	10.3	36	16	1	9	8	0
Mecosta	8,183	45	5.5	14	9	1	10	11	0
Menominee	6,589	46	7.0	21	10	3	8	3	2
Midland	20,708	146	7.1	44	13	1	50	53	2
Missaukee	3,603	30	8.3	7	5	0	7	12	2
Monroe	38,244	111	2.9	19	22	0	53	17	3
Montcalm	15,201	79	5.2	16	16	0	43	3	2
Montmorency	2,100	13	6.2	4	2	0	8	0	0
Muskegon	44,664	357	8.0	96	41	3	145	61	24
Newaygo	11,292	168	14.9	35	29	7	29	77	1
Oakland	268,58	1,181	4.4	229	152	55	429	304	55
Oceana	6,642	71	10.7	21	8	1	21	22	0
Ogemaw	4,925	99	20.1	13	13	2	33	36	2
Ontonagon	2,109	24	11.4	1	3	3	3	14	0
Osceola	5,973	36	6.0	8	16	0	2	9	2
Oscoda	1,886	18	9.5	3	0	0	8	3	4
Otsego	5,118	38	7.4	14	2	0	18	3	1
Ottawa	55,078	229	4.2	62	49	2	43	71	12
Presque Isle	3,503	20	5.7	1	5	0	0	15	0
Roscommon	4,173	55	13.2	9	3	0	11	32	3
Saginaw	59,577	672	11	67	49	14	146	419	8

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Misc.	Physical Neglect	Social Neglect	Abandon-ment
St. Clair	40,411	306	7.6	49	54	3	101	99	12
St. Joseph	16,978	170	10.0	40	33	0	82	19	5
Sanilac	11,293	64	4.7	24	11	1	19	6	6
Schoolcraft	2,130	1	.5	0	0	0	0	1	0
Shiawassee	19,935	93	4.7	31	27	2	25	11	4
Tuscola	15,826	84	5.3	7	21	5	21	37	2
Van Buren	20,396	288	14.4	72	42	7	109	61	7
Washtenaw	61,096	248	4.1	72	20	12	78	31	39
Wayne	570,637	5464	9.6	912	256	155	3,488	503	320
Wexford	7,565	87	11.5	17	15	5	27	24	0
STATE TOTAL**	**2,458,765**	**19,522**	**7.9**	**4,278**	**2,111**	**47**	**8,362**	**4,288**	**764**

* Unduplicated count. Also includes inappropriate use of funds, unlicensed home/improper guardian, and congenital drug addiction.
** Does not include Keewenaw County

APPENDIX E

AGE AND SEX OF VICTIMS
Children's Protective Services 10/92 - 9/93

	MALE				FEMALE				TOTAL			
	Abuse	Neglect	Abuse/ Neglect	Total	Abuse	Neglect	Abuse/ Neglect	Total	Abuse/ Neglect	Neglect	Abuse/ Neglect	Total
<1	214	919	32	1165	170	853	26	1049	384	1772	58	2214
1	92	614	18	724	86	575	22	683	178	1189	40	1407
2	127	531	16	674	160	554	22	736	287	1085	38	1410
3	137	526	21	684	191	458	13	662	328	984	34	1346
4	156	404	15	575	186	408	29	623	342	812	44	1198
5	162	379	16	557	168	359	24	551	330	738	40	1108
6	133	374	16	523	189	377	31	597	322	751	47	1120
7	140	391	18	549	172	314	20	506	312	705	38	1055
8	154	331	20	505	187	306	18	511	341	637	38	1016
9	156	324	15	495	176	290	21	487	332	614	36	982
10	146	287	17	450	189	238	23	450	335	525	40	900
11	137	273	12	422	186	273	33	492	323	546	45	914
12	175	275	16	466	214	276	31	521	389	551	47	987
13	138	241	13	392	308	290	9	647	446	531	62	1039
14	140	225	12	377	291	251	40	582	431	476	52	959
15	120	186	11	317	311	267	49	627	431	453	60	944
16	73	124	5	202	201	207	30	438	274	331	35	640
17	25	79	3	107	92	76	8	176	117	155	11	283
>17	0	0	0	0	0	0	0	0	0	0	0	0
State Total	2425	6483	276	9184	3477	6372	489	10338	5902	12855	765	19522

APPENDIX F
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