CTF CHILDREN'S TRUST FUND

For the Prevention of Child Abuse

STATE PLAN FY 86/87

CHILDREN'S TRUST FUND FOR THE PREVENTION OF CHILD ABUSE

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I. INTRODUCTION

A. 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 treatment after abuse has occurred.

Dr. Helfer conceived the idea of a Children's Trust Fund as a means for 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 trust account. By doing this, the trust account could become a self-sustaining source of funding and eliminate the need for yearly fundraising.

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 (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. This third legislative act also outlined the purpose and function of the Board and the trust fund.

The 15 member board, officially named the State Child Abuse and Neglect Prevention Board is known as the Children's Trust Fund Board to Prevent Child Abuse (referred to as Children's Trust Fund Board in this State Plan). The Governor appoints 10 of the members 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 preference 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 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 for 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 three such funding cycles, awarding 58 grants for a total of $730,524. The grants have funded four types of prevention programs:

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

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. Innovative programs for children and adolescents directed at the prevention of sexual abuse. Priority this year will be given to programs for preschool and secondary school aged children.

d. Programs for latch-key (after school) children which provide supervision and enhancement of life coping skills.

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. See Section IV Procedures.

To date there are 65 designated councils representing 65 of Michigan's 83 counties.

Funding to councils is provided on a formula basis. See Section IV Procedures. A total of $300,000 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.

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 85/86 is $145,000.

3. Sources of Financial Support.

Financial support for the Children's Trust Fund comes from four sources as outlined below.

a. Tax Check-Off: The following is a summary of money collected from tax check-offs since the creation of the Children's Trust Fund:

	Tax Year 1982	1983	1984
Total Collections Amount	$664,913.00	$612,219.61	$698,219.73
Tax Returns Submitted	3,770,000	3,889,000	3,976,000
Tax Returns with Refunds	2,904,000	3,020,000	2,981,000
Returns with Children's Trust Fund Check-Offs	199,000	196,192	227,943
Percent of Returns with Refunds That Had Children's Trust Fund Check-Offs	6.85%	6.50%	7.65%
Average Amount Per Return	$3.34	$3.12	$3.03

b. Direct Donations: The Children's Trust Fund is able to receive direct donations. These donations have come from individuals, memorial gifts, and organized fundraisers like the Magic Ride for Kids. Totals from direct donations are:

1982/83	$ 3,676.86
1983/84	13,958.44
1984/85	57,705.93
Total	$75,341.23

c. Interest: One half of all monies collected through the tax check off are deposited in an interest bearing account. Interest earnings have been:

1982/83	$ 19,012.50
1983/84	77,353.23
1984/85	81,530.64
Total	$177,896.37

d. State Department Support: Four state departments represented on t Children's Trust Fund Board have donated $35,000 to the Children's Trust Fund for sup, mental staffing.

To summarize, these sources of financial support have made available the following for the Children's Trust Fund Board activities previously outlined:

	1982/83	1983/84	1984/85
Tax Check-off (one-half of collections)	$332,456.50	$306,109.80	$349,109.86
Direct Donations	3,676.86	13,950.44	57,705.93
Interest	19,012.50	77,353.23	81,530.64
State Department Support	---	15,000.00	20,000.00
Total	$355,145.86	$412,413.47	$508,346.43

B. 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 as a document which will assist the Children's Trust Fund Board in carrying out its mission for the fiscal years 1986 and 1987.

It is designed:

1. To establish a frame work for the Children's Trust Fund Board and local councils.

2. To summarize what is known about child abuse and neglect and its prevention.

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

This state plan is not intended to be all-inclusive. While the state plan should never become a voluminous document, the material contained herein will be elaborated and expanded in future years.

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 — treatment — is too costly. It is the most expensive form of intervention and costly in the rate and consequences of failure. The treatment of many social and environmental problems is often a case of too little service, given too late, with too low success rates.

Prevention is generally thought of as taking measures to keep a certain phenomenon from happening. Prevention intervention can take place at either of two different points in time: before the phenomenon has ever occurred; 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.

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 information through the media or may be direct services which are made available to all individuals (such as immunizations or instruction in the maternity unit).

The major components of primary prevention are:

- It is offered to all members of a general population.
- It seeks to promote wellness.
- The benefit is clear.
- The cost is low.

Secondary prevention refers to those supportive and intervention services offered adults and children who are considered, because of their life situation, to be "at risk." While substantiated child abuse or neglect has not taken place, the probability for abuse or neglect is much 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 as well as the promotion of wellness.

Treatment, sometimes referred to as tertiary prevention, refers to the services offered to families or individuals after child abuse or neglect has occurred. The intervention seeks to prevent future incidents of abuse or neglect on the part of the parents or to prevent repetition of abusive or neglectful behavior by the next generation. The key elements of treatment are:

- It is offered to parents or individuals who have been identified as abusive or neglectful.
- It is often not voluntary in that there may be legal or societal coercion to seek help.
- It focuses on the abusive or neglectful behavior of the parents or individuals.

The Children's Trust Fund for the Prevention of Abuse and Neglect sets as its mission prevention of the first two types: primary and secondary prevention of child abuse and neglect.

Treatment or tertiary prevention is beyond the scope and intent of the Children's Trust Fund legislation. Such efforts are addressed by State Departments of Social Services and Mental Health, as well as numerous private agencies. Therefore, this State Plan will discuss primary and secondary, but not tertiary, prevention issues.

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 will determine program by program whether general populations or at risk populations will be addressed. (See p. 22, IIIB6)

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 commonalities. Interventions are presented by age categories.

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.

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 an incidence much higher than identified in the official reports to Children's Protective Services, as summarized in the National Study cited above. Self-report data is not available for Michigan.

An important distinction exists between incidence and prevalence rates. Incidence is the number of new cases within a specific population over a given period of time, usually one year. Prevalence is the total number 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 in any given year (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 be underreported. Michigan statistics differentiate between substantiated and unsubstantiated cases. Children's Protective Services is required by law to investigate every report of suspected child abuse and neglect within 24 hours, including a face-to-face contact within 72 hours. Within 7 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 substantiated and unsubstantiated cases, there are an unknown number of reports which are not formally recorded nor investigated.

c. It is also important to note that reports of abuse and neglect depend on community values about what constitutes abuse and neglect, public awareness of the problem, and public faith in the community agencies' ability to make a difference.

d. Reports of more than one type of child maltreatment are counted only under one category.

e. Department of Social Services figures do not include all cases of sexual abuse which occur in institutional or group settings. Inasmuch as some children in these situations who have been abused will not be involved in investigations.

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.

4. Limitations of Existing Knowledge.

A literature review commissioned by the Children's Trust Fund Board found few prospective longitudinal evaluations which document the actual effects of interventions on the incidence of child abuse and neglect.* Most evaluations take into account short term changes in attitudes and behavior which have been shown to be correlated with the presence or absence of abuse and neglect.

Present intervention efforts directed at parents and infants are designed to modify interactional patterns, skills and life conditions which have been shown to be correlated with the presence or absence of child abuse and neglect. This health promotion model and intervention activities are shared with other programming for parents and infants directed at physical health, mental health and cognitive development objectives.

With respect to sexual abuse prevention programs, the evaluation of current initiatives, such as Bubbylonian Encounter, has been on identified increases in short-term knowledge and increase in voluntary acknowledgment of sexual abuse. 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.

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*We can, however, cite the following: (1) 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 infant vs. rooming-in (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 (National Mental Health Association, Rowland Award, 1979).

B. Analysis by Category

1. Overall Statistics.

a. Statewide Incidence

For October 1, 1984 through September 30, 1985, Children's Protection Services in the Michigan Department of Social Services received 42,982 complaints alleging child abuse or neglect.

Of these 42,982 complaints, 16,615 were found to be substantiated* after investigation. The 16,615 substantiated cases involved 26,376 children. This represents a substantiated incidence of 1% of the child population annually. Because of limitations on reporting previously cited, the actual incidence (unknown) could be considerably higher. The number of children who experienced abuse and neglect sometime during their childhood (i.e., prevalence) has been estimated as high as 22% (Helfer letter).

b. Type of Abuse and Neglect

The victims experienced abuse and neglect as follows (unduplicated reporting by DSS-Protective Services 1984-85 figures):

1. Physical neglect	34%
2. Social neglect	29%
3. Physical injury	21%
4. Sexual abuse	13%
5. Abandonment	3%
6. Congenital drug addiction	1%
7. Other neglect**	1%

c. Trends

Trends since 1980 are reported in Table 1. Number of substantiated victims of sexual abuse have more than doubled in this five year period, while substantiated physical injury and neglect cases combined have decreased by 11%. 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.

d. County Incidence

The distribution of abuse and neglect throughout Michigan in 1984-85 is reported in Table 2. 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 1000 children ranged from 39.03 in Clare County to 1.52 in Baraga County.

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*The remaining 26,367 reports included unsubstantiated cases due to inability to locate, lack of evidence and insufficient allegation to investigate, as well as multiple complaints on the same family. See also discussion under II.A.3.

**Inappropriate use of funds; unlicensed home; improper guardian.

Table 1.
MICHIGAN TRENDS, 1980 — 1985

Fiscal Year	Number of Victims Substantiated* Total	Physical Injury and Neglect	Sexual Abuse	Protective Services Field Staff
1980	27,308	25,625	1,683	N/A
1981	25,669	23,949	1,720	N/A
1982	25,625	23,935	1,690	472
1983	26,474	24,444	2,030	444
1984	26,241	23,313	2,928	475
1985	26,376	22,858	3,518	535
Change, 1980 to 1985	-4%	-11%	+109%	

*Unduplicated count.

Table 2. NUMBER OF ABUSED/NEGLECTED CHILDREN BY COUNTY AND CATEGORY OF ABUSE/NEGLECT
CHILDREN'S PROTECTIVE SERVICES SUBSTANTIATED CASES 10/84-9/85

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Congenital Drug Addiction	Physical Neglect	Social Neglect	Abandonment
Alcona	2,541	16	6.3	2	0	0	0	14	0
Alger	2,779	15	5.4	1	8	0	0	0	6
Allegan	26,093	262	10.04	57	60	2	106	42	6
Alpena	9,950	130	13.07	14	11	0	48	61	2
Antrim	4,764	102	21.41	17	20	0	38	30	3
Arenac	4,510	40	8.87	5	7	0	5	23	0
Baraga	2,627	4	1.52	0	1	0	3	0	0
Barry	14,402	149	10.35	16	14	0	71	34	2
Bay	36,632	358	9.77	60	61	2	143	121	2
Benzie	3,230	43	13.31	4	11	2	7	19	0
Berrien	52,681	943	17.9	206	165	1	246	341	26
Branch	12,051	182	15.1	31	60	3	34	57	1
Calhoun	40,895	661	16.16	118	59	4	199	295	8
Cass	15,206	155	10.19	27	43	1	57	26	5
Charlevoix	5,991	108	18.03	10	15	0	32	45	4
Cheboygan	6,297	58	9.21	7	17	1	4	29	2
Chippewa	8,026	121	15.08	17	10	0	68	33	0
Clare	6,892	269	39.03	45	23	2	130	64	1
Clinton	19,264	125	6.49	27	26	4	10	57	2
Crawford	2,913	41	14.07	6	17	0	13	6	1
Delta	12,160	144	11.84	17	40	1	72	14	0
Dickinson	6,847	82	11.98	13	18	0	37	14	0
Eaton	27,863	206	7.39	49	38	0	55	67	2
Emmet	6,717	85	12.65	16	8	0	43	20	2
Genesee	144,817	1,255	8.66	278	139	14	467	371	58
Gladwin	5,883	95	16.15	24	22	0	25	21	0
Gogebic	4,838	51	10.54	6	3	0	24	17	1
Grand Traverse	16,112	176	10.92	33	27	0	44	72	1
Gratiot	12,622	119	9.43	26	35	3	46	23	0
Hillsdale	12,767	202	15.82	34	26	0	92	54	0
Houghton	8,688	72	8.29	14	5	0	11	38	5
Huron	11,070	132	11.92	14	22	3	16	77	2
Ingham	72,174	673	9.32	165	127	7	170	207	13
Ionia	16,488	159	9.64	43	15	1	64	32	6
Iosco	8,120	108	13.3	33	12	0	41	18	0
Iron	3,222	99	30.73	11	5	0	43	40	0
Isabella	13,410	141	10.51	27	31	3	35	38	2
Jackson	44,126	483	10.95	121	92	1	135	110	26
Kalamazoo	56,736	497	8.76	105	76	0	113	191	13
Kalkaska	3,586	41	11.43	11	6	0	19	5	0
Kent	131,473	768	5.84	151	121	6	276	198	11
Keweenaw	406	no report							

County	Child Population	Total* Abuse/ Neglect	Rate Per 1000	Physical Injury	Sexual Abuse	Congenital Drug Addiction	Physical Neglect	Social Neglect	Abandonment
Lake	2,058	50	24.3	12	6	0	7	25	0
Lapeer	24,991	241	9.64	36	54	0	76	74	8
Leelanau	3,994	19	4.76	8	5	0	3	3	0
Lenawee	28,165	445	15.8	123	72	1	92	195	4
Livingston	34,475	164	4.76	41	33	10	45	26	9
Luce	1,942	37	19.05	5	6	0	15	9	0
Mackinac	3,042	73	24	5	3	0	19	44	2
Macomb	207,459	1,128	5.44	292	152	3	260	395	30
Manistee	6,420	82	12.77	4	17	0	13	48	1
Marquette	20,780	190	9.14	32	46	0	43	63	2
Mason	7,368	70	9.5	14	25	0	23	4	2
Mecosta	8,630	137	15.88	18	35	1	43	42	4
Menominee	7,894	75	9.5	1	6	0	3	55	7
Midland	23,693	215	9.07	43	36	1	73	74	1
Missaukee	3,226	34	10.54	3	3	0	18	8	0
Monroe	44,881	201	4.48	56	22	2	76	38	11
Montcalm	15,087	165	10.94	40	16	0	66	35	7
Montmorency	2,074	46	22.18	12	3	0	17	6	4
Muskegon	48,438	735	15.17	119	113	3	264	212	13
Newaygo	11,017	210	19.06	40	31	0	41	89	6
Oakland	289,910	2,524	8.71	558	272	29	971	665	62
Oceana	7,124	130	18.25	16	49	0	31	26	7
Ogemaw	4,782	167	34.92	19	31	0	18	94	8
Ontonagon	2,975	30	10.08	5	11	0	6	11	0
Osceola	6,016	56	9.31	12	2	0	36	6	0
Oscoda	1,924	38	19.75	4	3	0	10	8	1
Otsego	4,907	51	10.39	8	2	0	15	23	0
Ottawa	50,071	487	9.73	119	61	3	181	148	5
Presque Isle	4,248	33	7.77	3	5	0	14	9	0
Roscommon	3,996	62	15.51	5	6	0	9	28	14
Saginaw	74,267	966	13.01	133	89	5	333	432	12
St. Clair	44,181	391	8.85	106	47	4	125	94	26
St. Joseph	17,185	257	14.95	74	37	2	130	13	6
Sanilac	12,745	116	9.1	39	14	2	37	32	0
Schoolcraft	2,530	46	18.18	7	4	0	24	10	0
Shiawassee	24,000	220	9.17	56	59	12	40	48	6
Tuscola	19,033	144	7.57	18	23	0	65	36	2
Van Buren	21,146	595	28.14	111	145	0	132	217	1
Washtenaw	64,188	404	6.3	105	62	19	102	106	10
Wayne	683,609	5,853	8.56	1,419	399	58	2,500	1,201	293
Wexford	7,668	119	15.51	12	17	0	16	80	1
STATE TOTAL**	2,749,602	26,376	9.59	5,594	3,518	216	9,034	7,656	778

*Unduplicated count. Also includes inappropriate use of funds (108) and unlicensed home/improper guardian (294).
**Does not include Keewenaw 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 2.1.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*, educational neglect, lack of supervision, and conditions leading to dependency.

b. Extent

For the United States as a whole, 61% of children in substantiated cases are categorized as neglected.

In 1984-85 in Michigan, 67% of children in substantiated cases — 17,468 children — experienced neglect. The type of neglect was identified as follows:

physical neglect:	9034
social neglect:	7656
abandonment:	778
other neglect:	402

c. Demographics

(1) Age

Deprivation of necessities is clearly more prevalent in younger (birth to age 5) children and decreases with age (see Table 3). National studies indicate that emotional and education neglect increase with age. Emotional abuse peaks between the ages of 12 and 17.

*Failure to thrive is defined as failure to gain weight and/or grow in height and can 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).

As a neglectful behavior, failure to thrive involves underfeeding; the resultant caloric deprivation causes over 50 percent of cases of failure to grow (underweight) in infancy. Non-abusive causes of failure to grow include medical illness and related causes (30 percent) or a feeding error on the parents' part (20 percent). In addition, three percent or more of all children are short but well nourished.

(2) Sex

When all forms of abuse and neglect are considered across age groups, incidence does not vary between boys and girls. Boys in general experience more physical, educational and emotional neglect than girls during all ages excluding physical neglect during adolescence (12-17).

(3) Socio-economic Status

Families reported for neglect and abuse are disproportionately less educated and poor (Gil, 1970; American Humane Association, 1980).

While differences in public scrutiny and the biases of reporting could account for this finding, such a conclusion appears unwarranted in view of the stability of the socioeconomic pattern as reporting increases and the association of the highest degrees of neglect and of the most severe injuries with the poorest families (Pelton, 1978). The strong association of social class and incidence of child abuse and neglect appears to be the result

Table 3.
INCIDENCE OF ABUSE AND NEGLECT* BY AGE AND SEX, MICHIGAN 1983

	Age of Victim			
Sex and Type	3	3 to 5	6 to 11	12 to 17
Male				
Population	214,572	204,410	411,794	575,721
Abuse	2.17	3.01	2.69	1.44
Neglect	10.54	8.36	7.35	3.51
Abuse/Neglect	0.31	0.29	0.22	0.16
Total	13.03	11.66	10.26	5.11
Female				
Population	205,377	195,056	393,387	551,669
Abuse	2.15	3.91	3.53	3.78
Neglect	10.39	8.07	6.78	4.36
Abuse/Neglect	0.26	0.32	0.36	0.34
Total	12.80	12.30	10.66	8.47
Total				
Population	419,949	399,466	805,181	1,127,390
Abuse	2.16	3.45	3.10	2.58
Neglect	10.47	8.20	7.02	4.13
Abuse/Neglect	0.29	0.31	0.29	0.25
Total	12.92	11.98	10.45	6.75

*Entries are rates per 1000 children in age group. Rates for abuse include both physical and sexual abuse.

of stresses inherent in impoverished living conditions. Low socioeconomic 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). By definition, many aspects of neglect are directly linked to income.

(4) Race

With respect to race, it is worth emphasizing that affluent whites and blacks have equal and 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.

(5) Geographic

According to the National Study of Incidence (1981), educational neglect is higher in urban counties and emotional neglect is highest in suburban counties.

d. Intervention

(1) Infancy

Programming to prevent neglect during infancy at this time has two facets:

a) Actions to reduce poverty, or to provide an adequate level of income maintenance for families on public assistance (see Section 5.c., p.24).

b) Actions to provide adult support and assistance to immature, isolated and cognitively limited parents and their infants.

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) beside the mother.

Actions which might be undertaken include:

(i) Change in legal requirements for public assistance so that single adolescent mothers are not encouraged to leave their family of origin.

(ii) School-based adolescent parent programs.

(iii) Parent support home visit services.

(iv) Center-based programs which enroll mother and infant.

(v) Adequate provisions for daycare for working mothers.

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

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

(2) Childhood

Programming to prevent neglect during childhood at this time has two facets:

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

b) Actions to assure adult supervision, adequate stimulation for development and growth and a healthy emotional environment.

These programs include:

(i) Developmental daycare.

(ii) Latchkey programs: Adequate provisions for summer daycare for working mothers; before- and after-school programs.

(iii) Parenting education.

(iv) Life coping skills training.

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 2.1.b.).

These non-accidental physical injuries are inflicted by parents, siblings, baby sitters, or other caregivers.

The extent of the injuries would be rated as mild (a few bruises, welts, scratches, cuts, or scars), 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 or in the extreme death). The severity of injury does not always correspond to the severity of the family problem, i.e., one episode of shaking in a newborn can lead to permanent central nervous damage or death.

Poisonings and congenital drug addictions 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 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 (unduplicated count):

	1975	1985
Overall violence	63.0%	62.0%
Severe violence	14.0%	10.7%
Very severe violence	3.6%	1.9%

For details on individual types of violence and definitions, see Table 4, page 16.

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.

In 1984-85, the Department of Social Services substantiated physical injury to 5,594 children. (In addition, there were 216 infants born with congenital drug addiction.) The National Family Violence surveys thus suggest that an additional 2,000 children in Michigan in intact households experienced very severe violence which was not officially substantiated as physical abuse.

c. Demographics

(1) Age

National data indicates that physical injury increases with age, peaking between the ages of 12 and 17.

Michigan data shows rates for abuse somewhat consistent across all age groups. See Table 3, p. 12.

(2) Sex

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

(3) Socioeconomic status

See discussion under Neglect, Section 2. C. 3. p. 12.

(4) 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.

Table 4.
PARENT TO CHILD VIOLENCE: A COMPARISON OF RATES IN 1975 AND 1985

Type Violence	Percent of households using at least once during past year 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 hit 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 age 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.

d. Interventions

(1) Infancy

Programming to prevent physical injury during infancy include:

a) Actions to reduce life stresses, e.g.,

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

(ii) Actions to discourage closely spaced births.

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

(iv) Actions to increase social networks.

(v) Actions to reduce violence between parents.

(vi) Drop-in centers for respite care.

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

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

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

- Home-visit programs. See Appendix B for further information.
- Center-based programs.

(2) Childhood and Adolescence

Programming to prevent physical injury during childhood and adolescence has been directed at

a) Actions to reduce life stresses of parents.

b) Actions to provide parenting information and skills.

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

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

4. Sexual Abuse

a. Definition

Sexual abuse is the sexual exploitation of a child for the gratification of the perpetrator or another person.

Sexual exploitation is the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, are unable to give informed consent to, or that violates the social taboos of family roles (Schechter and Roberage).

b. Extent

For the United States as a whole, 6% of children in substantiated cases are categorized as sexually abused.

Sexual abuse is involved in 13% of substantiated cases of abuse and neglect in Michigan affecting 3518 children. As indicated previously, this does not include all known instances of children abused in group settings. 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. While it is generally agreed that sexual abuse is considerably underreported, this estimate probably includes some measure of incidents that would be unreportable under statutory intent and not subject to investigation.

c. Demographics

(1) Age

Sexual abuse increases with age and peaks between ages 12 and 17.

(2) Sex

Girls of all ages experience more sexual abuse than boys of all ages.

(3) 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 incapacitated. 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).

d. Interventions

(1) 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.

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, an interagency gubernatorial initiative to install health education in every Michigan elementary classroom, includes a personal safety lesson at every grade level.

(2) Actions to prevent sexual abuse can be directed toward 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.

(3) Actions to prevent sexual abuse can be targeted toward altering the social sanctions which perpetuate sexual abuse.

5. Special Considerations

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

Because of the time constraints in developing this state plan, these special considerations are outlined, with fuller discussion provided for only two.

a. Outline of Special Considerations

(1) The vulnerable parent

a) Alcoholic. See b below.

b) Other substance abuser.

c) Mentally retarded.

d) Mentally ill.

e) Adolescent/single parent.

(2) The vulnerable child

a) Low birth weight.

b) Developmentally disabled.

(3) The vulnerable situation

a) Unemployment and poverty. See C below.

b) Societal condoning of pornography and violence.

b. The Vulnerable Parent: Alcoholics (Rosseff, Henderson, Blume, 1985)

An abundance of research links heavy drinking and alcoholism with child abuse, although there is no agreement among studies on incidence rates. Studies have indicated that 69% of abusing families have at least one alcoholic parent (Behling); on the other hand, only 27% of alcoholic parents were found to abuse or neglect their children (Black & Meyer). 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; Meyer & Black).

The greater the parental abuse of alcohol, the greater the battering or neglect of adolescent children (Flanzer). Persons who report being frequently drunk are more abusive than those who seldom drink or those who are consistently drunk.

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

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.

c. 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 socioeconomic status of the family has been previously noted and is well documented (Gil, 1971, Garbarino & Crouter, 1978, Watkins & Bradbord, 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, et. al., 1981). Reports from state agencies during the recent recession added to the evidence that the incidence of child abuse increases as function of unemployment. In Michigan, during 1981, when the rate of unemployment was 15%, abuse increased by 9% (Wisconsin Health and Social Services, 1982; 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 the 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 high proportion of children living in poverty (22% of all children, 50% of black children) constitutes a major risk for abuse and neglect.

III. IMPLICATIONS FOR CHILDREN'S TRUST FUND BOARD ACTIVITY

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. No determinations were made for this state plan with respect to educational, informational and public awareness activities or financing.

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 ethnic relationships to neglect and abuse in Michigan.

3. In future state plans, the Children's Trust Fund Board will fully develop conceptualizations relating to the incidence of abuse and neglect and special considerations relating to the vulnerable parent, the vulnerable child and the vulnerable situation.

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. 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 1

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 establishing a validated service model.

Evaluation should measure under Level 3 will cover items (1) to (5) above, and

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

2. Research projects.

As resources available to the Board increase beyond the present level, the Children's Trust Fund Board will consider a specific assignment of funds to undertake research projects.

3. Time lines for funding direct service projects.

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

a. One-time seed money to pay for the establishment of a service, but not ongoing operation.

b. More than one year subsidy for the basic underwriting of service costs.

c. Declining funding, moving from 100% the first year to 0% over a period of time specified in advance.

The Children's Trust Fund Board will establish parameters by category as to whether direct service projects can be

a. Ongoing funding.

(1) Where initial concepts are expanded.

(2) Where alternative sources have been sought and are not available.

b. Longer term demonstration projects.

c. Sustaining a model as a base for training and technical assistance in replications.

4. Considerations in making direct service project decisions.

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

a. Approval of the local council (required by law).

b. The existing data base.

c. Merit of the application.

d. Priority rating of the local council.

e. Distribution among project types.

f. Distribution among geographic areas.

5. Collaboration with other state agencies.

The Children's Trust Fund Board will further collaborate 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.

Because of the apparent interrelationship between alcoholism and both physical injury and sexual abuse, the Children's Trust Fund Board will explore the feasibility of collaborative prevention projects with the Office of Substance Abuse Services.

6. Primary prevention versus secondary prevention activities.

Previous discussion indicated that the Children's Trust Fund Board would determine for each type of programming whether efforts would be directed toward primary prevention (i.e. general population) activities or secondary prevention (i.e. at risk population) activities.

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

(1) Projects to prevent sexual abuse will be primary prevention, directed at all children in organized settings.

(2) Projects directed at latchkey children will be secondary prevention, in terms of the general definition of latchkey children as an at risk population. Priority will be given to projects involving latchkey children living in high risk neighborhoods.

(3) Projects providing short-term respite care through neighborhood-based drop-in centers will be secondary prevention via location in neighborhoods with a high incidence of child abuse and neglect. Service will be provided without any qualifying requirement.

(4) In projects providing parent/infant services, priority will be given to secondary prevention activities, i.e. services directed at pregnant women, families with newborns, and families with older infants where life circumstances or behavior suggest poor attachment and nurturing. (See also discussion in Appendix A).

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.

C. 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.

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 65 of the states 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.

   Starting in 1986 the Children's Trust Board will be providing technical assistance through workshops for local councils or groups wishing to become designated local councils. These workshops will 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.

2. 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, telelphone contact and on site visits.

3. Local councils are seen by the Children's Trust Fund 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 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.

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.

D. Policy, Legislative and Liaison 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.

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.

   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 (legislative mandate, objectives, budget, status).

   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 annual report.

   b. Develop an active liaison.

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

IV. PROCEDURES

A. Designation of Local Councils

1. Criteria

The Children's Trust Fund enabling legislation 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 an equal number of members from the following two groups:

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.

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

c. Does not provide direct services 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.

2. Application Procedures

Agencies 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 local council is expected to perform the following tasks:

a. Facilitate a collaborative community prevention program in a specific geographical area. The prevention program shall utilize trained volunteers and existing community resources wherever practicable.

b. Provide Children's Trust Fund Board with review and comments on grant applications.

c. Participate, when invited by Children's Trust Fund, in monitoring funded projects in relationship to the process component of the evaluation.

d. Run local education and training programs.

e. Foster fundraising to Children's Trust Fund and local councils.

f. Provide input to Board on establishment of prevention program priorities.

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

B. Funding of Local Councils

1. Allocation of Funds

In order to assist local councils in the performance of these seven tasks the Board provides funding. 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 they have been approved to represent. In addition each council will receive a percent of the remaining funds equal to the percent of total donations to the Children's Trust Fund received from their county(s).

2. Annual Prevention Plan and Budget

Councils are expected to submit an annual prevention plan which details expenditures of these monies. This plan must be reviewed and approved by the local council committee before funds can be released. Then the designated local council is required to submit quarterly progress reports.

C. Prevention Programs

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:

a. 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 lists the priorities for funding, explains the Children's Trust Fund, outlines the grant application process and provides for a preapplication.

c. The preapplication is sent for review to the local council representing the county of application. This review is a requirement set forth in Section 9(1)(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.

d. Preapplications that are approved by the local councils are sent to the Children's Trust Fund Board for review.

e. Children's Trust Fund Board reviews preapplications and selects those who 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, priorities, geographic distribution, and funds available for distribution.

APPENDIX A

Home visit services.

Parent-infant home visit support and intervention services have developed under various auspices and 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 firstborns 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 are significant costs to providing the service (in terms of cash outlay, time recruitment and training). They are irrelevant to the provision of information, education and facilitation of bonding which can be incorporated into ongoing hospital service routines and which should be available to all parents.

Firstborns 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 that first-time mothers have less information and more unrealistic expectations, etc.

Limiting services to families of firstborns ignores the extent to which abuse and neglect occur when a woman has several closely spaced young children or has one or 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. 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 life stress are indicative of risk (ref. published studies of screening procedures in Denver, Colorado; Kamamazoo, Michigan, etc.).

Clinical or systematic observations of parent-infant interaction are carried out as an integral part of care in 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 communicate a prediction that the parent is a potential abuser.

Finally, a 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 on improving the quality of life for families who will do reasonable well while overlooking those in more problematic life situations.

Table 5.
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 specified and identified on basis of risk criteria.
Percent of population expected to serve	100%	Maximum of 20%
Cost implications	Extensive.	More limited.
Labeling implications	No labeling since service 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).	Fewer low risk families served (est. 5 to 1).
	Theory: 100% of entire population is reached and accepts service.	Some high risk families will be missed by risk criteria.
	Practice: limitation of resources and orientation toward everybody may mean by passing more difficult families.	

APPENDIX B

Paramaters for Projects

Drop-In Center

The drop-in center should be located adjacent to or accessible to a high-risk neighborhood.

The drop-in center should provide respite care for children and support activities for parents.

The drop-in center should have an active recruitment process to attract the target population.

The drop-in center should make provisions for referral to needed services.

The drop-in center should meet requirements of the Department of Social Services as appropriate for licensure.

Parent Aides

The program should have explicit provisions for training aides.

The program should have explicit on-going provisions for supervision and support of aides.

Pregnancy/Infancy Programs

The program should have a systematic recruitment process.

The program should have provisions for facilitating access to needed health and social services.

The program should serve or make explicit provisions for service to high risk families.

Services for Latch-Key Children

Service programs should be available five days per week during the school year.

There should be activities to enhance coping capabilities and social development.

There should be evidence of cooperation with the school.

Service programs should be in or near the school.

The program should meet requirements of the Department of Social Services as appropriate for licensure.

Prevention of Sexual Abuse

A. **Curriculum development and/or implementation for children**

Evidence that plans have been reviewed with the regional coordinator for the Michigan Model for Comprehensive School Health Education, so that the project is either coordinated with Michigan Model programming or in schools in which the Michigan Model is not being implemented.

Commitment of schools (or other agency) must be evidenced in letters of participation.

Indicate whether school perceives this effort as part of health and safety programming.

Training of all school (or agency) staff involved with children including teachers, administrators, and auxiliary staff. Training to include appropriate responses to disclosure, anxiety, etc.

Parent training should be included but not mandatory for participation of children.

Audio-visual, written and orally presented materials must meet community standards and there must be a mechanism for assuring this.

Curriculum must be developmentally appropriate. (Newly developed materials should have input of educators, sexual abuse prevention professionals.)

Presentations to children must be followed with a time for discussion, processing of information and/or follow-up. Showing of films or distribution of written material without interpersonal processing is inappropriate.

A referral system must be identified and in place prior to presentations.

Use of volunteers should be maximized.

The project should include a plan for maintaining training of staff and children as an ongoing service component.

B. **Community awareness, including training for parents**

Community standards must be assessed and identified.

Purpose of efforts and expected outcomes should be clearly stated (increased funding and resources, skills training so that adults can respond to crisis, increased recognition by community that sexual abuse is a problem, support of school programming, etc.).

The target groups should be clearly described and related to purpose (community awareness should usually be broad based to include a wide variety of audiences including parents, service groups, churches, etc.).

Sexual abuse should be defined specifically.

Accurate data must be used.

Prevention strategies should be identified for both individuals and for the community.

Audio-visual material should be related to purpose and have follow-up time for processing.

Community awareness efforts should be a part of an overall community plan to prevent sexual abuse (even if next steps are not yet ready for implementation).

Community awareness campaign should utilize broad community support and several agencies (it is inappropriate for outsiders or consultants to conduct community awareness independently).

Methods should be able to be used again as part of an ongoing awareness and prevention plan.

Support should be identified which indicates that ongoing support and involvement is in place.

C. **Secondary School Program**

Curriculum should include material directed at potential offenders, i.e. discussion sanctioned and nonsanctioned behaviors.

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Or Your Local Council

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 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 who 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, priorities, geographic distribution, and funds available for distribution.

APPENDICES

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B. Parent/Infant Home Visit Services.

Parent-infant home visit support and intervention services have developed under various auspices and 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 firstborns 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 are significant costs to providing the service (in terms of cash outlay, time recruitment and training). They are irrelevant to the provision of information, education and facilitation of bonding which can be incorporated into ongoing hospital service routines and which should be available to all parents.

Firstborns 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 that first-time mothers have less information and more unrealistic expectations, etc.

Limiting services to families of firstborns ignores the extent to which abuse and neglect occur when a woman has several closely spaced young children or has one or 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. 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 life 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 of care in 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 communicate a prediction that the parent is a potential abuser.

Finally, a 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 on improving the quality of life for families who will do reasonable well while overlooking those in more problematic life situations.

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 specified and identified on basis of risk criteria
Percent of population expected to serve	100%	Maximum of 20%
Cost implications	Extensive.	More limited.
Labeling implications	No labeling since service 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 by passing more difficult families.	Fewer low risk families served (est. 5 to 1). Some high risk families will be missed by risk criteria.

C. Parameters for Children's Trust Fund Grants.

1. **Neighborhood Based Family Resource Centers** should:

   - be located in or accessible to a high-risk neighborhood.
   - 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 a parental component (i.e., parent education classes, parent support groups, etc.).
   - have explicit provisions for training paraprofessional and volunteer aides.
   - have explicit on-going provisions for supervision and support of aides.
   - consider providing transportation for families to and from the center.

2. **Pregnancy/Newborn Programs** should:

   - have a systematic recruitment process to attract parents and is linked 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 professional or paraprofessional and volunteer workers.
   - provide adequate supervision and support for professional or paraprofessional and volunteer workers.
   - have provisions for facilitating access to needed health and social services.

3. **Prevention of Sexual Abuse Programs** should:

   - be community-based.
   - show evidence of access to the targeted population.
   - use an established model where one exists.

4. **Latch Key and School Age Child Care Programs.**

Applications will only be accepted from Title I schools for programs located in a school building. The Children's Trust Fund will not fund "phone-a-friend" or summer latch key programs. **All latch key programs must be licensed by the Department of Social Services.**

Latch key programs should:

- be available five days per week during the school year.
- provide age appropriate activities to enhance coping capabilities and social development.
- provide services at least 1 hour before and 2½ hours after school.
- show strong evidence of support and cooperation with the individual schools and school district.
- have explicit ongoing provisions for supervision and support of staff.
- have explicit provisions for training paraprofessional and volunteer aides.

5. **Parenting and Related Skills Training and Support Groups.**

- provides 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 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.

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