# STATE PLAN FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT

## FY 1990/91
## FY 1991/92

Children's Trust Fund Board
P.O. Box 30026
Lansing, MI

# TABLE OF CONTENTS

# CHILDREN'S TRUST FUND FOR THE PREVENTION OF CHILD ABUSE

Board Members:

Joe Crump, UFCW Local 951, Chairperson
Dave Berns
Lisa D'Aunno, J.D.
C. Cameron Dean
Father William Easton
Diane Emling
Gayle Holtan, B.S.N., M.P.A.
Barbara Hower, M.S.
Johnnie Hunter
Margaret A. Posch
F/Lt. Jack Shepherd
Le Anne Silvey
Betty Tableman, M.P.A.
Elnora Strahan Vader
Cora Visscher

Staff:

David C. Mills, Executive Director
Lorraine White, Secretary

# 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 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 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 (Act 250 of the Public Acts of 1982). 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 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 8 and 9). 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 seven such funding cycles, awarding approximately 200 grants for a total of $2,916,160 or an average of $416,594 per year. The grants have funded five types of prevention programs covering neglect, abuse and sexual abuse (for detailed information regarding neglect, abuse and sexual abuse, please see pages 13 through 27):

a. Programs that provide neighborhood-based centers available for short-term respite care 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. Innovative programs for children and adolescents directed at the prevention of sexual abuse.

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

e. Parenting and related skills training and support groups.

**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 69 designated councils representing 76 of Michigan's 83 counties.

Funding to councils is provided on a formula basis. See Section IV Procedures. A total of $1,392,658 or an average of $198,951 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 88/89 was $189,114, and has totaled $1,026,320 for the last seven years.

3. Sources of Financial Support.

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

a. Tax Check-Off: Table 1 provides a summary of money collected from tax check-offs since the creation of the Children's Trust Fund:

## Table 1.

### INCOME TAX CHECK OFF TRENDS

| | FY 1982/83 | FY 1983/84 | FY 1984/95 | FY 1985/86 | FY 1986/87 | FY 1987/88 | FY 1988/89 |
|---|---|---|---|---|---|---|---|
| Total Tax Collections | $664,913.00 | $612,219.61 | 698,219.73 | $1,040,161.00 | $1,220,161.00 | $926,909.00 | $740,176.00 |
| Tax Returns Submitted | 3,770,000 | 3,889,000 | 3,976,000 | 4,110,000 | 4,286,000 | 4,352,000 | 4,436,000 |
| Tax Returns With Refunds | 2,904,000 | 3,020,000 | 2,981,000 | 3,074,000 | 3,377,000 | 3,018,000 | 3,171,000 |
| Returns with Children's Trust Fund Check-Offs | 199,000 | 196,192 | 227,943 | 183,690 | 197,245 | 155,618 | 115,088 |
| Percent of Returns With Refunds That Had Children's Trust Fund Check Offs | 6.85% | 6.50% | 7.65% | 5.91% | 5.95% | 3.09% | 3.63% |
| Average Amount Per Return | $3.34 | $3.12 | $3.03 | $5.54 | $5.90 | $5.95 | $6.24 |

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.

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. Totals from direct donations are:

| | |
|---|---|
| 1982/83 | $ 3,676.00 |
| 1983/84 | 13,958.00 |
| 1984/85 | 32,706.00 |
| 1985/86 | 103,996.00 |
| 1986/87 | 90,000.00 |
| 1987/88 | 120,000.00 |
| 1988/89 | 120,000.00 |
| Total | $484,336.00 |

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. Interest earnings have been:

| | |
|---|---|
| 1982/83 | $ 19,012.50 |
| 1983/84 | 77,353.23 |
| 1984/85 | 96,531.64 |
| 1985/86 | 114,980.00 |
| 1986/87 | 170,000.00 |
| 1987/88 | 218,000.00 |
| 1988/89 | 225,000.00 |
| Total | $920,876.73 |

d. State Department Support: Four state departments represented on the Children's Trust Fund Board have donated $100,000 to date to assist with the funding of monitoring grants.

e. 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.

Five million each was appropriated for FY's 1986 and 1987. Michigan received $156,545 in 1986, $496,192 in 1987, $496,000 in 1988, and $198,000 in 1989, for a total of $1,346,737.

Table 2 summarizes the total sources of spendable support made available for the Children's Trust Fund.

Table 2

CHILDREN'S TRUST FUND INCOME BY YEAR

| | FY 1982/83 | FY 1983/84 | FY 1984/85 | FY 1985/86 | FY 1986/87 | FY 1987/88 | FY 1988/89 |
|---|---|---|---|---|---|---|---|
| Tax Check-Off (one-half of collections) | $332,456.50 | $306,109.80 | $349,109.86 | $520,080.00 | $610,080.00 | $ 479,505 | $374,434 |
| Direct Donations | 3,676.86 | 13,950.44 | 57,705.93 | 88,996.00 | 70,000.00 | 120,000 | 120,000 |
| Interest | 19,012.50 | 77,353.23 | 81,530.64 | 114,980.00 | 170,000.00 | 218,000 | 225,000 |
| State Department Support | — | 15,000.00 | 20,000.00 | 15,000.00 | 20,000.00 | 25,000 | 25,000 |
| Challenge Grant | 0 | 0 | 0 | 156,535.00 | 496,192.00 | 496,000 | 198,000 |
| Legislative Appropriation for Public Awareness | | | | 500,000.00 | | | |
| Total | $355,145.86 | $412,413.47 | $508,346.43 | $1,306,605.00 | $1,296,272.00 | $1,338,505 | $924,434 |

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 1991 and 1992.

The State Plan is designed for:

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

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

3. Indicating 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.

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

- Annual Report - 1989.
- Direct Service Program Summaries - 1990/91.
- Direct Service Program Summaries - 1990/91. (available December, 1990)
- CTF Program Evaluation Report.

# 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. Treatment 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 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.

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 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.

The purpose of primary and secondary prevention is two fold: (1) to avoid a breakdown in parent/child interaction through modifying environmental conditions, interpersonal behaviors, and life coping skills, or (2) to provide parent and child support, child protection, and parent and child information to vulnerable children. 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 are incorporated within the community's service structure, are ongoing, and reach a substantial portion of the target population.

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. (See appendix A for more information concerning this issue.)

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 (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 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 reported cases that are either substantiated or unsubstantiated, there are a number of reports which are neither 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 cases of sexual abuse which occur in institutional or group settings where the perpetrator is not a family member.

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

1. Overall Statistics

a. Statewide Incidence

For October 1, 1988 through September 30, 1989, Children's Protective Services in the Michigan Department of Social Services received 48,970 complaints alleging child abuse or neglect.

Of these 48,970 complaints, 16,159 were found to be substantiated* after investigation. The 16,159 substantiated cases involved 38,612 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% (Dr. Ray Helfer).

b. Type of Abuse and Neglect

The victims experienced abuse and neglect as follows (unduplicated reporting by DSS-Protective Services 1988/89 figures):

| | | |
|---|---|---|
| 1. | Physical neglect | 39% |
| 2. | Social neglect | 25% |
| 3. | Physical injury | 21% |
| 4. | Sexual abuse | 12% |
| 5. | Abandonment | 4% |
| 6. | Congenital drug addiction | 1% |
| 7. | Other neglect** | 1% |

c. Trends

Trends since 1980 are reported in Table 3. The number of substantiated victims of sexual abuse has approximately doubled in this seven 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,

*The remaining 32,811 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.

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

## Table 3.

## MICHIGAN TRENDS

| Fiscal Year | Number of Victims Substantiated* | | | 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 | 25,669 | 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 | 3,518 | 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 |
| Change, 1980 to 1989 | -5% | -11% | +87% | | |

*Unduplicated count.
**Cases, not victims.

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 may also account for these increases and decreases.

d. County Incidence

The distribution of abuse and neglect throughout Michigan in 1986-87 is reported in Table 4. 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 41.4 in Clare County to 4.2 in Houghton County and Livingston 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.).

TABLE 4.
NUMBER OF ABUSED/NEGLECTED CHILDREN BY COUNTY AND CATEGORY OF ABUSE/NEGLECT
CHILDREN'S PROTECTIVE SERVICES SUBSTANTIATED CASES 10/88 - 10/89

| County | Child Population | Total* Abuse/ Neglect | Rate Per 1000 | Physical Injury | Sexual Abuse | Misc. | Physical Neglect | Social Neglect | Abandonment |
|---|---|---|---|---|---|---|---|---|---|
| Alcona | 2,639 | 17 | 6.4 | 4 | 1 | 0 | 1 | 11 | 0 |
| Alger | 2,777 | 20 | 7.2 | 2 | 7 | 0 | 0 | 11 | 0 |
| Allegan | 29,846 | 374 | 12.5 | 66 | 106 | 8 | 101 | 108 | 7 |
| Alpena | 9,309 | 117 | 12.6 | 14 | 8 | 4 | 33 | 58 | 0 |
| Antrim | 5,098 | 51 | 10.0 | 12 | 10 | 0 | 15 | 11 | 3 |
| Arenac | 4,746 | 28 | 5.9 | 6 | 5 | 0 | 6 | 13 | 0 |
| Baraga | 2,505 | 32 | 12.8 | 8 | 8 | 0 | 17 | 1 | 0 |
| Barry | 15,360 | 168 | 10.9 | 33 | 16 | 2 | 93 | 23 | 7 |
| Bay | 35,049 | 365 | 10.4 | 74 | 66 | 5 | 177 | 74 | 6 |
| Benzie | 3,367 | 30 | 8.9 | 3 | 1 | 1 | 13 | 11 | 1 |
| Berrien | 51,050 | 789 | 15.5 | 235 | 93 | 10 | 224 | 222 | 38 |
| Branch | 12,329 | 174 | 14.2 | 53 | 32 | 0 | 49 | 53 | 3 |
| Calhoun | 39,017 | 1017 | 26.0 | 160 | 56 | 18 | 396 | 383 | 23 |
| Cass | 14,855 | 192 | 12.9 | 30 | 46 | 4 | 81 | 30 | 4 |
| Charlevoix | 6,433 | 64 | 9.9 | 9 | 5 | 0 | 12 | 44 | 2 |
| Cheboygan | 6,487 | 99 | 15.3 | 15 | 27 | 0 | 26 | 37 | 0 |
| Chippewa | 8,435 | 105 | 12.4 | 13 | 17 | 5 | 56 | 22 | 0 |
| Clare | 7,494 | 310 | 41.4 | 48 | 30 | 1 | 96 | 143 | 2 |
| Clinton | 19,384 | 89 | 4.6 | 13 | 15 | 1 | 47 | 13 | 4 |
| Crawford | 3,374 | 90 | 26.7 | 14 | 17 | 7 | 22 | 40 | 1 |
| Delta | 11,846 | 82 | 6.9 | 10 | 9 | 1 | 43 | 17 | 2 |
| Dickinson | 7,252 | 58 | 8.0 | 15 | 7 | 5 | 26 | 5 | 0 |
| Eaton | 29,333 | 143 | 4.9 | 44 | 33 | 1 | 45 | 20 | 4 |
| Emmet | 7,423 | 152 | 20.5 | 22 | 19 | 6 | 56 | 52 | 0 |
| Genesee | 136,188 | 1463 | 10.7 | 354 | 207 | 62 | 505 | 349 | 43 |
| Gladwin | 6,813 | 116 | 17.0 | 25 | 17 | 1 | 37 | 46 | 1 |
| Gogebic | 4,572 | 42 | 9.2 | 4 | 5 | 0 | 25 | 8 | 0 |
| Grand Traverse | 19,090 | 106 | 5.6 | 26 | 31 | 3 | 18 | 30 | 1 |
| Gratiot | 12,379 | 95 | 7.7 | 26 | 29 | 3 | 33 | 5 | 1 |
| Hillsdale | 13,467 | 169 | 12.5 | 63 | 20 | 4 | 52 | 32 | 2 |
| Houghton | 9,483 | 40 | 4.2 | 1 | 6 | 0 | 10 | 19 | 4 |
| Huron | 11,207 | 70 | 6.2 | 5 | 9 | 0 | 19 | 37 | 0 |
| Ingham | 78,821 | 659 | 8.4 | 178 | 79 | 22 | 272 | 136 | 11 |
| Ionia | 18,545 | 83 | 4.5 | 27 | 11 | 3 | 28 | 20 | 1 |
| Iosco | 8,729 | 83 | 9.5 | 14 | 8 | 0 | 31 | 28 | 2 |
| Iron | 3,308 | 109 | 33.0 | 10 | 9 | 0 | 46 | 47 | 0 |
| Isabella | 15,470 | 164 | 10.6 | 20 | 44 | 7 | 50 | 54 | 0 |
| Jackson | 43,898 | 462 | 10.5 | 100 | 88 | 1 | 176 | 75 | 28 |
| Kalamazoo | 61,750 | 698 | 11.3 | 138 | 96 | 13 | 142 | 294 | 22 |
| Kalkaska | 4,136 | 59 | 14.3 | 13 | 18 | 0 | 17 | 8 | 3 |
| Kent | 151,959 | 918 | 6.0 | 214 | 113 | 25 | 391 | 159 | 23 |
| Keweenaw | 417 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |

| County | Child Population | Total* Abuse/ Neglect | Rate Per 1000 | Physical Injury | Sexual Abuse | Misc. | Physical Neglect | Social Neglect | Abandonment |
|---|---|---|---|---|---|---|---|---|---|
| Lake | 2,296 | 48 | 20.9 | 13 | 2 | 4 | 9 | 20 | 0 |
| Lapeer | 25,588 | 160 | 6.3 | 42 | 19 | 2 | 67 | 39 | 4 |
| Leelanau | 4,380 | 21 | 4.8 | 4 | 6 | 0 | 2 | 2 | 7 |
| Lenawee | 28,553 | 372 | 13.0 | 72 | 107 | 6 | 100 | 130 | 4 |
| Livingston | 37,376 | 158 | 4.2 | 58 | 36 | 2 | 19 | 41 | 6 |
| Luce | 1,588 | 40 | 25.2 | 9 | 2 | 4 | 16 | 4 | 6 |
| Mackinac | 2,982 | 38 | 12.7 | 17 | 5 | 0 | 3 | 7 | 6 |
| Macomb | 201,160 | 1176 | 5.8 | 295 | 141 | 47 | 388 | 310 | 25 |
| Manistee | 6,095 | 56 | 9.2 | 6 | 6 | 2 | 9 | 31 | 2 |
| Marquette | 20,233 | 153 | 7.6 | 36 | 15 | 3 | 37 | 59 | 3 |
| Mason | 7,629 | 78 | 10.2 | 21 | 23 | 2 | 21 | 9 | 2 |
| Mecosta | 10,349 | 86 | 8.3 | 16 | 27 | 1 | 27 | 5 | 11 |
| Menominee | 8,156 | 54 | 6.6 | 11 | 7 | 0 | 15 | 22 | 0 |
| Midland | 23,964 | 254 | 10.6 | 65 | 40 | 7 | 72 | 97 | 3 |
| Missaukee | 3,922 | 38 | 9.7 | 10 | 11 | 0 | 1 | 15 | 1 |
| Monroe | 45,062 | 246 | 5.5 | 51 | 32 | 11 | 99 | 54 | 8 |
| Montcalm | 16,902 | 131 | 7.8 | 38 | 41 | 0 | 38 | 10 | 4 |
| Montmorency | 2,331 | 19 | 8.2 | 9 | 1 | 0 | 2 | 7 | 0 |
| Muskegon | 50,520 | 551 | 10.9 | 117 | 71 | 9 | 186 | 180 | 8 |
| Newaygo | 12,861 | 181 | 14.1 | 30 | 26 | 6 | 25 | 96 | 1 |
| Oakland | 296,888 | 2017 | 6.8 | 377 | 247 | 81 | 803 | 528 | 50 |
| Oceana | 7,559 | 129 | 17.1 | 28 | 29 | 2 | 49 | 21 | 0 |
| Ogemaw | 5,765 | 108 | 18.7 | 11 | 13 | 3 | 27 | 52 | 2 |
| Ontonagon | 2,519 | 16 | 6.4 | 6 | 2 | 0 | 5 | 4 | 0 |
| Osceola | 6,849 | 93 | 13.6 | 25 | 20 | 1 | 22 | 31 | 1 |
| Oscoda | 2,098 | 24 | 11.4 | 6 | 1 | 3 | 5 | 5 | 4 |
| Otsego | 5,476 | 41 | 7.5 | 2 | 3 | 0 | 3 | 33 | 0 |
| Ottawa | 58,692 | 341 | 5.8 | 82 | 30 | 1 | 87 | 157 | 0 |
| Presque Isle | 4,140 | 27 | 7.0 | 4 | 6 | 0 | 1 | 18 | 0 |
| Roscommon | 4,593 | 128 | 27.9 | 19 | 6 | 6 | 26 | 89 | 3 |
| Saginaw | 69,134 | 731 | 10.6 | 89 | 43 | 10 | 257 | 342 | 9 |
| St. Clair | 46,467 | 445 | 9.6 | 109 | 83 | 2 | 155 | 116 | 6 |
| St. Joseph | 19,202 | 234 | 12.2 | 49 | 52 | 6 | 92 | 25 | 14 |
| Sanilac | 13,228 | 118 | 8.9 | 28 | 15 | 2 | 46 | 33 | 3 |
| Schoolcraft | 2,361 | 25 | 10.6 | 4 | 2 | 0 | 6 | 13 | 0 |
| Shiawassee | 23,676 | 234 | 9.9 | 52 | 29 | 4 | 86 | 64 | 8 |
| Tuscola | 18,339 | 157 | 8.6 | 44 | 20 | 11 | 58 | 29 | 10 |
| VanBuren | 22,495 | 414 | 18.4 | 111 | 85 | 9 | 106 | 114 | 5 |
| Washtenaw | 69,342 | 408 | 5.9 | 124 | 51 | 19 | 80 | 81 | 56 |
| Wayne | 644,803 | 6387 | 9.9 | 1240 | 361 | 236 | 3658 | 677 | 398 |
| Wexford | 8,434 | 102 | 12.1 | 7 | 5 | 2 | 10 | 81 | 2 |
| STATE TOTAL** | 2,779,677 | 25,943 | 9.3 | 5,458 | 3,145 | 727 | 10,205 | 6,400 | 921 |

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

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 1988-89 in Michigan, 68% of children in substantiated cases--17,526 children--experienced neglect. The type of neglect was identified as follows:

| | |
|---|---|
| physical neglect: | 10,205 |
| social neglect: | 6,400 |
| abandonment: | 921 |

c. Demographics

(1) Age

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

(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).

---

***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.

TABLE 5

AGE AND SEX OF VICTIMS

| | MALE | | | | FEMALE | | | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | Abuse | Neglect | Abuse/ Neglect | Total | Abuse | Neglect | Abuse/ Neglect | Total | Abuse | Neglect | Abuse/ Neglect | Total |
| 1 | 265 | 1036 | 31 | 1332 | 254 | 992 | 32 | 1278 | 519 | 2028 | 63 | 2610 |
| 1 | 101 | 743 | 24 | 868 | 111 | 636 | 15 | 762 | 212 | 1379 | 39 | 1630 |
| 2 | 141 | 675 | 20 | 836 | 216 | 564 | 21 | 801 | 357 | 1239 | 41 | 1637 |
| 3 | 189 | 615 | 27 | 831 | 242 | 544 | 32 | 818 | 431 | 1159 | 59 | 1649 |
| 4 | 224 | 582 | 19 | 825 | 265 | 498 | 24 | 787 | 489 | 1080 | 43 | 1612 |
| 5 | 217 | 566 | 25 | 809 | 250 | 566 | 23 | 839 | 467 | 1132 | 49 | 1648 |
| 6 | 199 | 530 | 31 | 760 | 265 | 518 | 21 | 804 | 464 | 1048 | 52 | 1566 |
| 7 | 211 | 512 | 21 | 744 | 247 | 492 | 25 | 764 | 458 | 1004 | 46 | 1508 |
| 8 | 187 | 498 | 20 | 705 | 269 | 466 | 22 | 757 | 456 | 964 | 42 | 1462 |
| 9 | 213 | 439 | 27 | 679 | 255 | 385 | 41 | 681 | 468 | 824 | 68 | 1360 |
| 10 | 180 | 422 | 23 | 625 | 261 | 408 | 20 | 689 | 441 | 830 | 43 | 1314 |
| 11 | 191 | 431 | 28 | 650 | 258 | 377 | 34 | 669 | 449 | 808 | 62 | 1319 |
| 12 | 192 | 330 | 21 | 543 | 336 | 341 | 22 | 699 | 528 | 671 | 43 | 1242 |
| 13 | 178 | 341 | 25 | 544 | 403 | 412 | 39 | 854 | 581 | 753 | 64 | 1398 |
| 14 | 167 | 302 | 31 | 500 | 457 | 422 | 50 | 929 | 624 | 724 | 81 | 1429 |
| 15 | 119 | 234 | 19 | 372 | 402 | 397 | 40 | 839 | 521 | 631 | 59 | 1211 |
| 16 | 113 | 181 | 10 | 304 | 324 | 327 | 40 | 691 | 437 | 508 | 50 | 995 |
| 17 | 40 | 64 | 0 | 104 | 133 | 109 | 9 | 251 | 173 | 173 | 9 | 355 |
| State Total | 3127 | 8501 | 403 | 12031 | 4948 | 8454 | 510 | 13912 | 8075 | 16955 | 913 | 25943 |

(3) Socio-economic Status

Families reported for neglect and abuse are disproportionately less educated and poor (Gil, 1970; American Humane Association, 1980; Bergdorf, 1981).

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 socio-economic 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 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). 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. Possible Intervention

(1) Infancy

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

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

(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) besides the mother.

Actions which might be undertaken include:

1) School-based adolescent parent programs.

2) Parent support home visit services.

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

4) Adequate provisions for daycare for working mothers.

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

6) 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:

1) Developmental daycare.

2) Before and after school (latch key) programs: Adequate provisions for summer daycare for working mothers; before- and after-school programs.

3) Parenting education.

4) 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.0.).

These nonaccidental physical injuries are inflicted by parents, siblings, babysitters, 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 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 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. Nationally 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 6.

Table 6.

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

| Type of 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.

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 1988/89, the Michigan Department of Social Services substantiated physical injury to 5,458 children. The National Family Violence surveys thus suggest 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

(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.

(2) Sex

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

(3) Socio-economic status

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

(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.

d. Possible Interventions

(1) Infancy

Programming to prevent physical injury during infancy include:

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

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

2) Actions to discourage closely spaced births.

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

4) Actions to increase social networks.

5) Actions to reduce violence between parents.

6) Drop-in centers for respite care.

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

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

2) 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.

(e) Actions to improve consumer products and environmental safety.

e. Limitations in Knowledge About Interventions.

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 and neglect. 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.

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 and neglectful 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; Mitchell, 1988). 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:

(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 (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. Halpern (1984) indicate 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 the sexual exploitation of a child for the gratification of the perpetrator or another person (Children's Trust Fund promulgated rules).

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 12% of substantiated protective service cases of abuse and neglect in Michigan affecting 3,145 children. As indicated previously, this does not include statistics on the number of cases of sexual abuse in out of home care. 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., Veiver & Tharinger, 1986; Brown & Finkelhor, 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

(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. Possible 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 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.

(2) 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.

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

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

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

e. Limitations and Knowledge.

With respect to sexual abuse prevention programs, the research remains inconclusive as to whether direct instruction changes children's attitudes and behaviors with regard to the prevention of sexual abuse and even less evidence that preventive knowledge minimizes a child's risk for maltreatment.

Of those studies recently 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, Plummer, 1984; Conte et al., 1985; Swan et al., 1985; Collins, 1986). 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 (1985) 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; Nelson et al., 1986).

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.

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.

a. Outline for Special Considerations

(1) The vulnerable parent

(a) Alcoholic. See b below.

(b) Other substance abuser.

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

(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 d below.

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

b. The Vulnerable Parent: Substance Abuse (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 (Famularo, Stone, Barnum, and Wharton, 1986; Behling, 1979; Black and Mayer, 1981). 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 & Mayer, 1978). 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.

Alcoholic mothers are 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, 1985). Alcoholic parents were more likely to harm their children when they were 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. Finkelhor (1986) suggests that alcohol acts as a physiological disinhibitor making it easier for sexual abuse to occur. Alcohol allows the perpetrator to ignore social taboos against sexually abusing children.

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 (National Committee for Prevention of Child Abuse (NCPCA), 1989). 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 (Chasaff, 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. 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.

It is believed that the number of drug related abuse cases is much higher than reported. The Washington Post (Green, 1989), reported "Social workers making their rounds, police on drug raids, and concerned neighbors are increasingly finding these children by accident." Another national concern is the number of children abused before their birth. A survey of hospitals report 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). Chasnoff (cited in Besharov, 1989) suggests that as many as 375,000 infants per year are affected prenatally by substance abusing mothers. Besharov suggests that 1 to 2 percent of all live births, or 30,000 to 50,000 children, were fetally exposed to crack cocaine.

These infants are not only hard to care for because of drug-engendered sensitivities, but are at risk for neglect and abuse in homes where drug abusing parents are emotionally and physically unavailable.

c. The Vulnerable Parent: Developmentally Disabled.

Developmentally disabled (mentally retarded) parents and their children fall into a highly vulnerable high 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 continuing 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 (Gil, 1971, Garbarino & Crouter, 1978, Watkins & Bradbord, 1983; 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, et. al., 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 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 (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. 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. 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. The existing data base.
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.

2. 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 documenting a validated service model.

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

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

The Children's Trust Fund is presently underwriting an experimental research study comparing the effectiveness of services for first-time parents who receive a perinatal coaching program and a group of parents who receive no programmatic services. The research is investigating 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

Results of this study will be available January, 1991. If you are interested in receiving a summary of the results, please contact the office.

3. 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.

4. 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.

Additionally, 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.

5. In order to give direction to grant applicants, the Children's Trust Fund Board will, annually, through the issuance of a request for proposals (RFP), set priorities and specific parameters for each funding category.

6. 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 its 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,
- 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 facilitte 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 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 an support for professional or paraprofessional and volunteer workers,
- have provisions for facilitating access to needed health and social services.

C. Prevention Programs Process.

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(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 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.

# 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 74 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 need assessments in a proactive strategy of identifying a priority issue or population 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 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 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

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

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

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

d. Foster fund raising to Children's Trust Fund and local councils.

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

f. Run local education and training programs.

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

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).

2. Annual Prevention Plan and Budget

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. Additionally, then all designated local council are required to submit quarterly progress reports. Councils receiving $4,000 or more per year are also required to submit quarterly financial reports.

## V. POLICY, LEGISLATIVE AND INTERAGENCY ACTIVITIES

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.

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.

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.

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.

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

# VI. APPENDICES

# APPENDIX A

## 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 above. 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 in 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% |
| 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

## Survey of Formerly Funded Programs

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| **NEIGHBORHOOD BASED FAMILY RESOURCE CENTERS** | | | | | | |
| Child Abuse Prevention Services | Mt. Hope Family Growth Center - Seed Money | 1983 | 3 | YES | | Various sources, including: Capital Area United Way, Ingham County, Office for Children, fund raising. |
| Grand Rapids Child Guidance Clinic | Neighborhood Drop-In Center | 1985 | 4 | YES | | United Way, Investment income, Contributions, Dept. of Social Services. |
| Mt. Carmel Mercy Hospital | Neighborhood Parent Center | 1985 | 2 | YES | | |
| Center for Urban Studies, Wayne State University | Sault Ste. Marie, Chippewa Ct. Youth Program | 1985 | 1 | NO | Lack of Funds | |
| Livingston Council for the Prevention of Child Abuse and Neglect | Parents Place | 1986 | 1 | NO | Recent reports indicate that program closed because of poor management. | |
| Oakland Family Services | Summer Camp for Parents and Children | 1988 | 1 | NO | Lack of Funds | |
| Community Family and Children Services | Neighborhood Based Family Center | 1985 | 2 | NO | Lack of Funds | |

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| | | PREGNANCY/NEWBORN PROGRAMS | | | | |
| AuSable Valley CMH | | 1983 | 2 | YES | | DMH |
| Catholic Social Services | Perinatal Coaching | 1985 | 2 | YES | | United Way, Catholic Services Appeal dollars. |
| Family and Children's Services of Calhoun County | Pregnancy Newborn Program | 1987 | 1 | YES | | Michigan DMH Grant/10% match by Family and Children's Services: United Way. |
| Sparrow Hospital | | 1984 | 1 | YES | | Unknown. |
| Gratiot County Child Advocacy | Perinatal Coaching/ Bubbylonian Encounter | 1983 | 3 | YES | | 80% from United Way, the rest is agency monies. |
| Kalamazoo Child Guidance Clinic | Early Intervention Program | 1984 | 1 | YES | | Matching dollars is a continual problem - community resources drying up. |
| Mason County Community Mental Health | | 1986 | 1 | NO | Never got word on renewal - no money. | |
| N.W. Michigan Child Guidance Clinic, Inc. | Positive Parenting Project | 1988 | 1 | YES | Adaptation of training to compliment teen parenting training already provided to clients - net result of improved program. | United Way |
| Institute for Family and Child Study | NICU Perinatal Coaching | 1984 | 3 | NO | Unknown | |
| Oakland Family Services | Perinatal Coaching | 1984 | 3 | YES | | |

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| **PREGNANCY/NEWBORN PROGRAMS (continued)** | | | | | | |
| Visiting Nurses Corp. | CAN Care/Parenting Education | 1987 | 2 | NO | Poor program design, lack of resources. Became expendable with the reorganization of hospital. | |
| Benzie Teenage Parent Program | Perinatal Coaching | 1984 | 3 | NO | Unknown | |

## SEXUAL ABUSE PREVENTION PROGRAMS

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| Alpena-Montmorency-Alcona I.S.D. | S.A.P. Program | 1983 | 2 | YES | | Inkind |
| Alpha Theatre Project | Bubbylonian Encounter/ No Easy Answers | 1984 | 1 | YES | | Schools, service clubs, fund raisers, Michigan Council for Arts. |
| The Corner Health Center | Sexual Abuse Prevention Play | 1984 | 2 | NO | Lack of interest from schools. | |
| Family Neighborhood Services | Out Wayne County Bubbylonian Project | 1987 | 1 | YES | | The schools pay for the performances. |
| Hillsdale County Council | Bubbylonian Encounter | 1985 | 1 | NO | Contractual problems with author of Bubbylonian Encounter. | |
| Iosco County D.S.S. | "Little Bear" | 1985 | 1 | YES | | Donations from Service Groups. |
| Kalkaska County Child Advocacy Committee | Bubbylonian Encounter | 1987 | 2 | YES | | Local grants/donations and schools. |
| Lake County Child Protection Council | Lake County P-CAN | 1985 | 1 | YES | | None. |
| Manistee-Mason District H.D. | | 1987 | 1 | YES | Materials which were developed are supplied to area schools when requested. Inservice relevant to the materials provided upon request. | |

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| | | SEXUAL ABUSE PREVENTION PROGRAMS (continued) | | | | |
| Montcalm Area I.S.D. | Bubbylonian Encounter | 1986 | 1 | YES | | Community Mental Health-We Care For Kids Council. |
| Oakland Co. Youth Assistance Advisory | Prevention of Sexual Abuse-Prevention | 1987 | 1 | YES | | Charge schools for services. |
| Ottawa Community Coord. Child Care | I Tell: Empowering Children with Special Needs | 1989 | 1 | YES | | Local SCAN Council |
| S.A.F.E. Place | Bubbylonian Encounter | 1987 | 1 | YES | | Battle Creek Junior League Adventist Hospital, School fees. |
| Saginaw Co. Sexual Assault Center | Happy Bear | 1986 | 1 | YES | | C.A.N. Council, Junior League of Saginaw, and United Way. |
| St. Joseph Co. C.A.N. Council | Sexual Abuse Prevention | 1984 | 3 | YES | | Local CAN Prev. Council, donations and grants. |
| Women's Center | SAFE | 1986 | 1 | NO | Lack of sufficient funding - local support insufficient. | |
| Women's Center | How to Say NO! | 1987 | 1 | NO | Lack of sufficient funding - local support insufficient. | |
| YWCA of Greater Flint | Domestic Violence/ Sexual Assault Ed. Pro. | 1986 | 1 | YES | | United Way, Community Donations, and Grants. |

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| **SEXUAL ABUSE PREVENTION PROGRAMS (continued)** | | | | | | |
| Detroit Urban League | Bubbylonian Encounter | 1988 | 1 | YES | | Participating schools pay for the program. |
| Isabella County Sexual Assault Task Force | Teen Sexual Abuse Prevention Program | 1984 | 2 | NO | Program closed because of poor management. | |
| Macomb Intermediate School District | Bubbylonian Encounter | 1985 | 2 | NO | Unknown. | |
| Michigan Big Brothers/ Big Sisters | Prevention Program Training | 1984 | 1 | NO | Only one year program. | |

## LATCHKEY PROGRAMS

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| East Jordan Family Health Center | | 1985 | 2 | NO | | |
| Gaylord Community Schools | Latch Key Program | 1985 | 2 | YES | | Participant fees. |
| Tri-Cities Learning Center | Kiddie Carousel-Latch Key Program | 1986 | 2 | NO | The public schools in this community opened their doors before and after school; our doing the same would be redundant. | |
| MiSaBa Council of Camp Fire, Inc. | I Can Do It! | 1986 | 1 | YES | | United Way of Midland County |
| Shepherd Child Care Center | | 1987 | 2 | YES | | Parents |
| Sterling Area Health Project | Latchkey Program | 1986 | 1 | NO | Low attendance; inadequate time to build service. | |
| Center for Urban Studies, Wayne State Univ. | Edmundson After School Program | 1985 | 1 | YES | | Self-supporting. |
| YMCA of the Blue Water Area | Latchkey Program - "Prime Time" | 1983 | 3 | YES | | Self-funded and United Way |
| Ontonagon Area Community Schools | Latchkey | 1987 | 2 | NO | Low enrollment, lack of interest. | |

## PARENTING EDUCATION AND SUPPORT PROGRAMS

| Agency | Program Name | First Year of CTF Funds | Total Years Funded | Presently Operating? | Reasons if Not Operating | Current Source of Funding |
|---|---|---|---|---|---|---|
| Comprehensive Youth Services | Search of Family Excellence (PSTSG) | 1987 | 1 | NO | Terminated In January, 1988. Person in care of grant left - new director did not have time to carry it out. | |
| The Family Center, Inc. | Parent Nurturing Program | 1987 | 1 | NO | Grant was not renewed. Lack of funding. | None. |
| Ionia County Health Department | Parent Nurturing Program | 1986 | 1 | YES | The program was discontinued in its previous format due to the cancellation of funding. However, we have attempted to continue CTF activities in a less formal curriculum. | Local appropriations and State allocations. |
| Midland-Gladwin CMH Services | Group for Teenaged Parents | 1988 | 1 | YES | | St. John's Episcopal Church, First Baptist Church, M-6 CMH-Parent Education Program |
| Pontiac General Hospital | Parenting Sharing | 1988 | 1 | YES | Parenting Programs continue to operate through funds provided by Pontiac General Hospital. | Pontiac General Hospital |
| Center for Urban Studies - Wayne State University | ACCESS | 1986 | 2 | NO | No more funding. | |

# SUMMARY

## Survey of Formerly Funded Programs

| Name of Priority | Subtotal | Total Still in Operation | Percentage of Programs Still Operating |
|---|---|---|---|
| Neighborhood Based Family Resource Centers | 7 | 3 | 43% |
| Pregnancy/Newborn Programs | 12 | 8 | 67% |
| Sexual Abuse Prevention Programs | 22 | 15 | 68% |
| Latchkey Programs | 9 | 5 | 56% |
| Parenting Education and Support Programs | 6 | 3 | 50% |

## APPENDIX C

Bibliography.


Affholter, D., D. Connell, and M. Nauta. (1983) "Evaluation on the Child and Family Resource Program: Early Evidence of Parent-Child Interaction Effects." Evaluation Review. 7:1, pp. 65-79.

Badger, E. (1981) "Effects of a Parent Education Program on Teenage Mothers and Their Offspring," in K. G. Scott, T. Field, and E. Robertson (eds.), Teenage Parents and Their Offspring, New York: Grune & Stratton.

Behling, D.W. (1979) "Alcohol Abuse as Encountered in 51 Instances of Reported Child Abuse." Clinical Pediatrics. 18(2): 87-91.

Bergdorf, K. (1981), Recognition and Reporting of Child Maltreatment: Findings from the National Study of the Incidence and Severity of Child Abuse and Neglect. Washington D.C.; National Center and Child Abuse and Neglect.

Besharov, D. (1989). The Children of Crack. We will Protect Them. Public Welfare, 47, 6-12.

Black, R. and Mayer, J. (1978) An Investigation of the Relationship Between Substance Abuse and Child Abuse and Neglect. Final Report submitted to the National Center on Child Abuse and Neglect, ACYF, DHEW.

Black, R. and Mayer, J. (1981) Parents with Special Problems: Alcoholism and Opiate Addition. In H. Kempe and R. Helfer (Eds.), The Battered Child, Chicago University Press.

Borkin, J., and L. Frank. (January/February 1986) "Sexual Abuse Prevention for Preschoolers: A Pilot Program." Child Welfare. 65:1.

Brown, A. and Finkelhor, D. (1986). Impact of Child Sexual Abuse: A Review of the Research. Psychological Bulletin, 99, 66-77.

Caruso, G.A. (1984) Optimum Growth Project. Updated Program Description. South County Mental Health Center, Delray Beach, Florida, February.

Chasnoff, I. (1987). Perinatal Effects of Cocaine, Contemporary OB/GYN, May, 163-179.

Christoziv, C. and Toteva, S. (1989). Abuse and Neglect of Children Brought Up in Families with an Alcoholic Father in Bulgaria. Child Abuse and Neglect, 13, 153-155.

Collins, J. (June 1986). Child Sexual Abuse Prevention Materials: Evaluation Report. Report submitted to the U.S. Department of Health and Human Services, Office of Human Development Services, Administration of Children, Youth and Families.

Conte, J., C. Rosen, L. Saperstein, and R. Shermack. (1985) "An Evaluation of a Program to Prevent the Sexual Victimization of Young Children." Child Abuse and Neglect. 9:3, pp. 329-334.

Daro, D. (1988) Confronting Child Abuse: Research for Effective Program Design. New York: The Free Press.

Dickie, J., and S. Gerber. (1980) "Training in Social Competence: The Effects on Mothers, Fathers and Infants." Child Development. 51, pp. 1248-1251.

Downer, A. (1984) "Evaluation of Talking About Touching." Unpublished manuscript (Author, P.O. Box 15190, Seattle, WA 98115).

Field, T., S. Widmayer, S. Stringer, and E. Ignatoff. (1980) "Teenage, Lower-Class, Black Mothers and Their Preterm Infants: An Intervention and Developmental Follow-Up," Child Development. 5, pp. 426-436.

Finkelhor, D. (1986). A Sourcebook on Child Sexual Abuse. California: Sage Publications.

Flanzer, J. (1979) "Alcohol-Abusing Parents and Their Battered Adolescents." In F. Seixas (Ed.), Currents in Alcoholism. Vol. VII. New York: Grune and Stratton, pp. 529-538.

Gabinet, L. (1979). "Prevention of Child Abuse and Neglect in an Inner-City Population: II. The Program and the Results." Child Abuse and Neglect. 3:3/4, pp. 809-817.

Garbarino, J. (1987). Children's Response to a Sexual Abuse Prevention Program; A Study of the Spiderman Comic, Child Abuse and Neglect, II, 153-148.

Gil, D. G. (1970) Violence Against Children: Physical Child Abuse in the United States. Cambridge, MA: Harvard University Press.

Gray, E. (1983). Final Report: Collaborative Research of Community and Minority Group Action to Prevent Child Abuse and Neglect. Vol. 1: Perinatal Interventions. Chicago: National Committee for Prevention of Child Abuse.

Gray, J. D., C. A. Cutler, J. G. Dean & C. H. Kempe. (1977) "Prediction and Prevention of Child Abuse and Neglect." Child Abuse and Neglect. 1, pp. 45-58.

Green, Slacum, The Crack Legacy/Children in Distress. The Washington Post, September 10, 1989.

Gutelius, M., A. Kirsch, S. MacDonald, M. Brooks and T. McErlean. (1977) "Controlled Study of Child Health Supervision: Behavior Results;" Pediatrics. 60, pp. 294-304.

Halpern, R. (January 1984) "Lack of Effects for Home-Based Early Interventions? Some Possible Explanations." American Journal of Orthopsychiatry. 54:1, pp. 33-42.

Hindeman, M. (1977) "Child Abuse and Neglect: The Alcohol Connection." Alcohol and Research World. 1(3): 2-6.

Larson, C. (1980) "Efficacy of Prenatal and Postpartum Home Visits on Child Health and Development." Pediatrics. 66, pp. 191-197.

Levant, F., and G. Doyle. (January 1983) "An Evaluation of a Parent Education Program for Fathers of School-Aged Children." Family Relations. 32, pp. 29-37.

Love, J., M. Nauta, C. Coelen, K. Hewett, and R. Ruopp. (1976) National Home Start Evaluation: Final Report, Findings and Implications. Ypsilanti, MI: High Scope Educational Research Foundation.

Mayer, J. and Black, R. (1977) "The Relationship Between Alcoholism and Child Abuse and Neglect." In: F. Seixas (Ed.), Currents in Alcoholism. Vol. II. New York: Grune and Stratton. pp. 429-445.

McAnarney, E., K. Roghmann, B. Adams, R. Tatlebaum, C. Kash, M. Coulter, M. Plume, and E. Charney. (February 1978) "Obstetric, Neonatal, and Psychosocial Outcome of Pregnant Adolescents." Pediatrics. 61:2.

McGuire, J., and B. Gottlieb. (1979) "Social Support Among New Parents: An Experimental Study in Primary Prevention." Journal of Clinical Child Psychology. 8, pp. 111-116.

O'Connor, S., P. Vietze, K. Sherrod, H. Sandler, and W. Altemeier. (1980) "Reduced Incidence of Parenting Inadequacy Following Rooming-In." Pediatrics. 66, pp. 176-182.

Ozintz, E. The Littlest Victims. Chicago Tribune, October 6, 1988.

Olds, D., R. Chamberlin, and R. Tatlebaum. (1986) "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation." Pediatrics. 78, pp. 65-78.

Olson, L. and Holmes, W. (1983), Youth at Risk. Adolescents and Maltreatment. Boston, MA; Center for Applied Social Research.

Pelton, L. H. (1978) "Child Abuse and Neglect: The Myth of Classlessness." American Journal of Orthopsychiatry. 48, pp. 608-617.

Plummer, C. (1984) "Research Prevention: What School Programs Teach Children." Unpublished manuscript (Author, P.O. Box 421, Kalamazoo, MI 49005).

Polit, D. (January-February 1987) "Routes to Self-Sufficiency: Teenage Mothers and Employment." Children Today. pp. 6-11.

Powell, D. (March 1986) "Parent Education and Support Programs." Young Children. pp. 47-53.

Seitz, V., L. Rosenbaum, and N. Apfel. (1985) "Effects of Family Support Intervention: A Ten-Year Follow-Up." Child Development. 56, pp. 376-391.

Swan, H., A. Press, and S. Briggs. (July-August 1985) "Child Sexual Abuse Prevention: Does It Work?" Child Welfare. 64:4, pp. 395-405.

Travers, J., M. Nauta, and N. Irwin. (1982) The Effects of a Social Program: Final Report of the Child and Family Resource Program's Infant and Toddler Component. Cambridge, M.A.: ABT Associates.

Viever, E. and Tharinger, D. (1986). Child Sexual Abuse: A Review and Intervention Framework for the School Psychologist. Journal of School Psychology, 24, 293-311.

Wandersman, A., L. Wandersman, and S. Kahn. (1980) "Stress and Social Support in the Transition to Parenthood." Journal of Community Psychology. 8, pp. 332-342.

Wisconsin Department of Health and Social Services. Bureau for Children, Youth and Families. (1982) Child Abuse Reports in Counties of High Unemployment. Unpublished Report: Madison.

Woodside, M. (1988). Research on Children of Alcoholics: Past and Future. British Journal of Addiction, 83, 785-792.

**Children's Trust Fund**
**For The Prevention of Child Abuse**
**North Ottawa Tower, Third Floor**
**611 West Ottawa**
**P.O. Box 30026**
**Lansing, Michigan 48909**