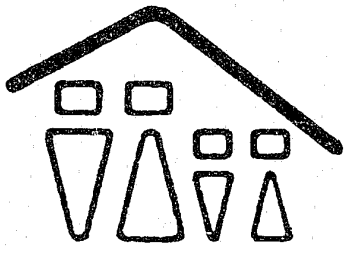
CHILD ABUSE AND NEGLECT IN NEW JERSEY:

ESTIMATING THE INCIDENCE PER COUNTY

PROJECTING TREATMENT NEEDS

DESCRIPTIONS OF MODEL TREATMENT PROGRAMS



HELP PREVENT CHILD ABUSE

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH AND FAMILY SERVICES
BUREAU OF RESEARCH, PLANNING AND
PROGRAM DEVELOPMENT
TRENTON, NEW JERSEY

April, 1977 (Revised)

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PREFATORY NOTE

This report on Child Abuse and Neglect in New Jersey: A Guide for Communities and Provider Agencies was first published by the Bureau of Research, Planning and Program Development in August, 1974. Some of the data embodied in that report have since become outdated; some of the programs it proposed have since been at least partially implemented; and significant legislation has been enacted. This updated and revised version of the report retains the format and oftentimes the language of the original report.

The purpose of this paper is to:

*demonstrate the need for protective service programming by comparing the incidence of abuse and neglect to the relatively few situations reported and to the meager resources available for the treatment of parents with this problem;
*summarize the progress made to date in building a comprehensive treatment system;
*enumerate the syndromes of parent problems that may lead to abuse and neglect;
*describe and provide a line item budget for the programs that have been of proven value in treating these families and children; and
*provide a model of a treatment network and its cost for each county.

This report finds that at least 50% of all children who are estimated to become victims of child abuse or neglect during any given year in the State of New Jersey do not come to the attention of the Division of Youth and Family Services and, consequently, they and their families do not receive the help they require and are entitled to. Given a fairly thorough knowledge of the causes and consequences of the social problem of child abuse and neglect, every effort should be undertaken to close this gap in protective service coverage.

21,268 children were under the supervision of the Division of Youth and Family Services for reasons of child abuse, neglect and parental deprivation at the end of calendar year 1975. This figure is expected to have increased by 23.6% during 1976 without vigorous outreach efforts.

The first edition of this report proposed that a comprehensive treatment system be built in each county to meet the needs of abusing families. Since then considerable progress has been made in building such a network. Services

for 4,700 families have been provided through purchase of service contracts during Fiscal Year 1976. The Division expects to expand it's contract capacity to 7,200 families during Fiscal Year 1977. In spite of the progress made to date, the need for a further expansion persists given the inequalities in service provision within and between counties.

Revised Edition Prepared
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and Diane Ferrara

I. AN ESTIMATE OF PROTECTIVE SERVICE NEED

A. The Incidence of Protective Service Situations

The need for protective services is underscored by and coincides with the number of children who are subjected to physical or sexual abuse and emotional or physical neglect during a given year. However, its extent is difficult to determine. Abuse usually occurs in the seclusion of private homes. Its victims are predominantly young children. A variety of public attitudes condone corporal punishment as a disciplinary measure. The relationship between private physicians and their patients is protected by norms of confidentiality. These are but a few of the factors which impede efforts at determining the true extent of child abuse and neglect. Its incidence, therefore, has to be estimated.

There is considerable variation in available estimates. Dr. Vincent Fontana estimates that 1.5 million children are being abused annually; 300,000 of these suffer permanent injuries and 50,000 are expected to die as a result of abuse according to this assessment.[1)] If these findings are extrapolated to the State of New Jersey, 52,500 children could be expected to suffer abuse, 10,500 of these would sustain permanent injuries and 1,750 children would die as a direct or indirect consequence of abuse. This is, without a doubt, an extreme estimate.

In addition, there is the problem of defining what is meant by the terms "child abuse and neglect" and the problem of what type of information to use in making estimates. There is a great deal of inconsistency in the types of statistics used. Some talk about children, others cases, child abuse only, both abuse and neglect, reported cases or confirmed cases. Thus it is critical to be clear about two areas when describing the scope of the problem. First it is necessary to define who is included in the estimates: numbers of children, reported cases, child abuse alone or abuse and neglect combined and so forth. Second, the methodology used in selecting statistical information must be explained to distinguish among those estimates based on reporting rates, generalized from other studies or some other method[2)]. The section entitled "Technical Notes "on p.39 contains a detailed explanation of how estimates for this study were derived. However, for the convenience of the reader, the following two charts are included to help distinguish among use of terms and methodological approaches throughout this discussion:

Child Population Under Study

Abused Children - The Nagi, Light and DYFS estimates agree that these include those children suffering from or at risk of suffering from physical harm and in immediate danger. DYFS also includes sexually abused children in this category.

Neglected Children - Nagi, Light and DYFS agree these children include those suffering from or at risk of suffering from physical and emotional harm, but not in immediate danger. Light includes sexually abused children in this category.

Parentally Deprived - Neither Nagi nor Light include any estimates of parentally deprived children. In this report this category is used to include DYFS applications taken for reasons of marital conflict, family instability, chronic illness, mental illness, family disruption, situations requiring counselling only, endangerment of unborn child and institutionalization of parent.

Protective Services - Nagi and Light see only abused and neglected children as requiring "protective services", whereas DYFS includes victims of abuse, neglect and parental deprivation as defined above in this service category.

Estimate Methodologies

Nagi Estimates - Based on a sample survey of reports (as opposed to actual cases) of abuse and neglect by agencies dealing with children and families to authorities.

Light Estimates - Based on a sample survey of the average numbers of actual or confirmed cases of abuse and neglect known by any one individual.

DYFS Estimates - Based on accepted DYFS applications and so considered to be actual or confirmed cases of abuse and neglect.

From the wide array of estimates of the incidence of child abuse and neglect, this paper uses the procedures developed by Saad Nagi and Richard T. Light. Although the resulting estimates are conservative, they are considered to be based on sounder methodolgical assumptions and procedures. The actual and projected counts of reports received and cases under supervision by DYFS employ a broader definition of child endangerment which includes parental deprivation in addition to abuse and neglect. Thus the aggregate child protective service caseload or estimated applications taken on reports received cannot be directly compared to the Nagi and Light estimates of incidence. Wherever possible, this report identifies that proportion of the Division's caseload or applications taken on reports received which reflects the narrowest definition of abuse and neglect and which is most consistent with Nagi's and Light's approaches, permitting valid comparisons. Aggregate counts of caseloads and applications taken which include parental deprivation are so specified in the text for clarity. Summarizing the findings presented in tables 1, 2 and 3 of the Appendix, it is estimated that between 19,174 and 23,896 children are subjected to abuse or neglect (excluding parental deprivation) throughout the State each year. This represents approximately 1% of all children under 18 years of age. The upper bound on the estimated incidence of abuse and neglect stands at 64,000 children.[3)]

B. Causes and Effects of Child Abuse[4)]

Present reporting of child abuse and neglect suggests that it occurs more often in the homes of the poor. There are, however, a number of factors which bias reporting against the poor. They are least likely to be able to afford private physicians and their discretion; their living conditions are relatively crowded and, consequently, public; and they have a greater exposure to regulatory agencies. They also experience a disproportionate amount of stress and frustration, factors found to be associated with the incidence of abuse and neglect. As long as these biases cannot be controlled for, it has to be assumed that the incidence of child abuse and neglect is evenly distributed across all socioeconomic strata. Our estimates are based on this assumption.[5)]

A number of factors are associated with the incidence of abuse. Some researchers attribute the incidence of abuse to personality traits of the abusing parents. Abusing parents have been variously described as immature, self-centered, impulsive, domineering, and rigid. Many of these efforts are tautological in that they merely describe abusing parents and their behavior after the fact (that is, after abuse has taken place) in the absence of proper control

groups for comparison. There is also a lack of consistency between the traits delineated as being characteristic of abusing parents by different researchers. It cannot be assumed that personality traits alone, even if found to be reliable, could explain or predict acts of child abuse. The childhood experiences of abusing parents appear to play a role as well. Abusing parents were usually deprived of warmth and emotional support and often were themselves victims of abuse or neglect during their childhood.

A cultural factor influencing the incidence of abuse is the attitude toward corporal punishment. If the use of physical force to attain ends or goals is culturally condoned, then abuse is more likely to occur than could otherwise be expected. It appears that abuse is, to a certain extent, the result of learned and systematically reinforced behaviors.

A number of situational and structural factors have a bearing on the incidence of abuse. Abuse occurs disproportionately among the unemployed. The size of a family and the degree of its social isolation also determines, to some extent, the incidence of abuse: The larger the family and the lesser the extent of meaningful relationships with relatives or other outsiders, the greater the likelihood of abuse.

Child abuse also appears to be associated with characteristics and behaviors of children. Homely-looking or retarded children are more likely to be abused than good-looking children. Infants who put considerable demands on a family are also likely targets of abuse. Low birth weight infants appear to be particularly vulnerable, in part because of the special care they require and, in addition, perhaps because of the post-partum separation of mother and child which adversely affects the development of strong emotional attachments. Children who are born from unwanted pregnancies also suffer abuse to a disproportionate extent.

The effects of child abuse and neglect on children and on society are grievous. Apart from a number of deaths which can be attributed to it, a large number of children suffer crippling injuries as a consequence of abuse. The mental and emotional development of abused or neglected children is often severely impaired. Given the prevalence of inconsistent, punitive/lax child-rearing patterns among abusive families, the affected children often lack essential cognitive abilities. The result is all too often poor school performance or school failure. Abused children are also frequently unable to form stable, trusting relationships with peers during adolescence and adulthood. The social isolation they will experience in consequence makes them likely perpetrators of abuse once they grow up and become parents.

A disproportionate number of juvenile delinquents and persons in need of supervision reported experiences of abuse or neglect during their childhood. Based upon various studies it appears that child abuse and neglect will result in adult antisocial behavior. The evidence indicates, then, that child abuse and neglect will extract considerable social costs from this and future generations. There is, thus, a vicious cycle of child abuse and neglect. Given the dire consequences for both the children and society, every effort should be undertaken to break up this cycle.[6)]

C. Current Number of Reports Received and Cases Confirmed

In the twelve months ending Dec. 31, 1975 the Division of Youth and Family Services received 43,971 applications for child welfare services. Of this total 4,504 or 10% were reports of suspected abuse, 7,441 or 17% were reports of suspected neglect and 7,163 or 16% were reports of suspected parental deprivation. This yields a total referral of children potentially at risk of 19,108 or 43% of the total number of applications taken. This compares with approximately 17,150 reports received during calendar year 1974. Although less dramatic than in previous years this increase is significant and can be attributed to a number of factors, including greater public awareness and willingness to report as well as the establishment of an Office of Child Abuse Control operating a 24-hour hotline.

Table 4 in the Appendix provides figures for applications accepted for supervision for abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions during the year 1975. Of the 19,108 potential protective service referrals received during 1975 mentioned above, 3,449 applications for abuse, 5,469 for neglect, 5,176 for parental deprivation, yeilding a total of 14,094, were ultimately accepted for supervision. These are therefore considered confirmed reports. This represents 74% of the applications taken. This compares with an estimated 11,000 acceptances for the 17,150 applications received during 1974, or 64.3%, and with an acceptance rate for cases other than protective service referrals of 71% in 1975. Thus there has been an increase in the rate of acceptance of protective service referrals.

Of the 19,174 to 23,856 children who had previously been estimated to become victims of either abuse or severe neglect (excluding parental deprivation) during 1975, only 3,449 abuse and 5,469 neglect or a total of 8,918 came under the supervision of the Division of Youth and Family Services. Thus more than one half of the victims did not receive the protection and help they require and are entitled to. It should be stressed again that this assessment is based on

conservative estimates. If these estimates are in error they are more likely to underestimate the incidence of abuse than to overestimate it.

D. Projected Need and Caseload Estimates

A comparison of the estimated incidence (Table 4) with the number of confirmed reports of child abuse and neglect (excluding parental deprivation, Table 6) reveals a large gap in protective service coverage. Using the most conservative figures, at least one half of all children estimated to be subject to child abuse or neglect do not come to the attention of the State's child welfare agency. Using the more liberal projections, the upper bound on this count of unprotected children becomes 86% or 53,000 of 62,000 children estimated to become victims of child abuse or neglect during a given year. There is clearly the need to plan for an expansion of protective service delivery to improve coverage. During calendar year 1975 the Division of Youth and Family Services experienced an increase of 23.6% in the number of children under supervision for reasons of child abuse, neglect, or parental deprivation, the entire active protective service caseload.[7] We assume that the caseload of children in need of protection will continue to grow at this rate during 1976. This assumption is based on the persistence of a gap in protective service coverage and the continuation of the effective public awareness campaign using the full range of media including radio, television, and newspapers. In addition, persons and agencies likely to come into contact with abused or neglected children in the course of their work (doctors, hospitals, schools, county welfare boards) will be specially oriented and trained through various training programs already well under way. The Protective Services Resource Institute, a federally funded demonstration project, coordinates these efforts. Information on the Institute and its activities is summarized in the second part of this report.

Intensified comprehensive public information and outreach efforts have been successfully mounted in several states to improve the reporting of child abuse and neglect. Reviews of the experience of New York and Florida indicate that such efforts, upon implementation, can result in increases in the reporting of abuse of up to 58%. We assumed that the average of the differences between the impact of the various efforts and the assumed trend increase in the absence of these efforts would provide the most realistic estimate of the impact of an intensified outreach effort.

As can be seen from Table 5, the aggregate caseload under supervision by Division of Youth and Family Services

as of December 31, 1975 for reasons of child endangerment amounted to 21,268 children. Of this total 3,894 were under supervision for reasons of abuse, and 8,143 for neglect, with another 9,231 under supervision for reasons of parental deprivation. It is anticipated that this total protective service caseload will increase by 4,995 cases to 26,263 during 1976 in the absence of an intensified outreach effort (Table 6). The special training and public awareness campaigns can be expected to add another 3,058 abused, neglected or parentally deprived children to the caseload (Table 8). At the end of 1976, it is thus expected that the Division's broadly defined protective service caseload will be 29,323 children individual cases added through intensified outreach. This total is comprised of 5,371 abused, 11,237 neglected, and 12,715 children parentally deprived. The average daily caseload -- a measure of the number of children under supervision on any given day during the year (which is defined as the average of the beginning- and end-of-the-year caseload figures) -- for 1976 thus becomes 25,296 for all three categories of protective service need. The individual daily average making up this total are: 4,633 abused, 9,690 neglect, and 10,973 parental deprivation. This represents an increase of 4,027 children (18.9%) over the beginning of the year and an increase of 8,777 children (53%) over the end of 1974.

Anticipated Increase in Self-Referrals - Agency statistics show that about 10.5% of all abuse and neglect referrals were made by the child or parent him-or herself during calendar year 1975. This represents 1,343 applications. Research in other states indicates that abusing or neglecting parents often seek help for their problems. It can be expected that the proportion of parent-or self-referred cases will gradually rise for a few years, in particular in response to the public awareness campaigns. Parent-and self-referrals were the only referral category showing consistent increases over the last three years. We could also expect increases in the referrals from physicians, hospitals, and public welfare agencies as these are reached by the intensified outreach effort.

E. Conclusion

This report documents an enormous gap between the number of children who are estimated to become victims of abuse and severe neglect every year and the number of children who actually come to the attention of the Division of Youth and Family Services to receive the services they need. With an increased effectiveness of the State's child welfare agency in identifying endangered children and poorly functioning families through outreach efforts, resulting in extensive

caseload growth, the gap can be expected to narrow. This trend will, however, drastically reveal a second, widening gap: treatment needs versus treatment resources. The extensive caseload growth documented above has to be accompanied by a parallel, intensive growth in the capabilities of the Division of Youth and Family Services to provide adequate and effective treatment.

II. CURRENT SERVICE SYSTEM

The Division of Youth and Family Services is vested with the responsibility for services to children and their families under Titles 9 and 30 of the New Jersey Statutes. These services include both investigatory and helping functions. The following discussions under section A, B, C, and D cover the investigatory functions which the agency is mandated to fulfill. Section E describes the helping services for which there is so much need.

A. Reporting

Under these Statutes the Division must operate a 24-hour emergency telephone service for the receipt of all child abuse reports from any person in the community. Referrals are received at the local district office during business hours and at the central Office of Child Abuse Control (OCAC) at any hour (800-792-8610). Information from reports is kept in a confidential Central Registry information system.

B. Investigating

By law an investigation must be made into all abuse and neglect referrals to the Division within 72 hours. A manual is being developed to be utilized by regular casework staff outlining all policies and procedures governing investigation of child abuse and neglect allegations. In this process contacts are made with the family, the child, the referrant, and the collateral sources involved. Responsibility for the initial investigation is shared as follows:

1. On week nights, weekends and holidays Special Response Units operated by each district office respond to emergencies referred by OCAC. These units are staffed by professional social workers who make immediate contact with families referred, often with police help.

2. During regular business hours all investigations are handled by the district offices who compile their findings in reports and make recommendations for services.

C. Referral to the County Prosecutor

DYFS staff are obligated to report to County Prosecutors situations involving probable criminal conduct on the part of the parent, caretaker or any persons toward a child. These situations require consideration of the objective condition of the child as well as evidence that the injury

or condition was not caused by accident. When investigation reveals that a child was most likely injured by accident rather than gross negligence on the part of the parent or caretaker, and if, from DYFS' point of view, there are no problems and the case would be considered closed, then there is no suspected criminal activity to be reported to the prosecutor. This does not include situations where a parent or caretaker committed an intentional act that produced an unintended harm. For example, when a parent physically disciplines a child, he/she has committed child abuse if the child sustains an injury in spite of the parent's intention not to cause injury.

1. The following are <u>child injuries</u> which must be reported:

   a. death of child;

   b. the subjecting or exposing of a child to unusual or inappropriate sexual activity;

   c. any type of injury or condition resulting in hospitalization or more than superficial emergency room treatment;

   d. any type of injury or condition that requires more than superficial medical attention (e.g., treatment for broken bone at physician's office);

   e. evidence of repeated instances of physical violence committed against a child, or substantially depriving a child of necessary care over a period of time or abandonment of a child.

2. The following are <u>nonaccidental situations</u> which must be reported:

   a. injuries of the above nature which occurred sometime in the past but were not reported at the time of occurrence, regardless of where the injury occurred or who was responsible;

   b. injuries as defined above which appear to be the result of parental refusal to provide medical care on religious grounds with a note of the parent's religion-based refusal. (This does not include cases of religion-based refusal to consent to medical treatment which do not fall under the injury reporting guidelines);

   c. all other cases where, in the professional judgement of the caseworker and supervisor, the circumstances warrant review by the prosecutor.

Referrals are to be made by the Division to the prosecutor only when the caseworker has, after investigation, determined that the alleged incident of abuse or neglect has likely occurred. Referrals shall then be made immediately by telephone with written confirmations to be sent out within 48 hours thereafter.

The prosecutor will take either of the following courses of action upon receipt of a referral:

1. advise the Division staff member making the referral that the prosecutor will not undertake an investigation and request that the prosecutor be advised of any evidence of further or continuing abuse;

2. with advance notice to the Division, undertake an initial investigation using specially designated personnel.

D. Situations Necessitating Removal of Child

In serious cases where there is severe harm or the potential for severe harm to a child and removal is judged to be the only alternative for protecting the child, there are several options. The caseworker can first seek parental agreement for placing the child elsewhere temporarily. If parents do not agree to placement, a Court Order can be obtained by the caseworker prior to removal. As a last resort, a caseworker can now by law remove a child from the home in emergency situations on his/her own authority as long as an Order for Custody is filed with the Court on the next day. This option has only recently been provided by the Dodd law enacted in 1975. When serious physical injuries are diagnosed by a doctor, the child may be held in a hospital for 72 hours to allow the DYFS to render a decision as to whether or not to seek custody. The child has a right to be assigned a guardian ad litem in all proceedings regarding removal from his/her caretaker.

E. Services to Families

Through its district offices or the county welfare board service network, the DYFS is responsible for developing, implementing and monitoring treatment plans for neglect and abuse cases. Such plans may include direct service provision or the purchase of services from other community resources. Following is a discussion of the process through which the protective service system has evolved with an illustration of how the services are actually delivered in a particular county.

1. Program Development

Four units have had primary responsibility for the development of the Division of Youth and Family Services' child protective services program: the Protective Services Resource Institute, the Program Assistance Unit of the Bureau of Family Services, the Bureau of Research, Planning and Program Development and the Purchase of Services Unit. They are currently working toward establishing comprehensive protective services in each county.

a. Protective Services Resource Institute (PSRI)

In 1974 the Bureau of Research, Planning and Program Development prepared a proposal seeking Federal demonstration grant funding for a child Protective Service Resource Institute to be jointly sponsored by the Department of Pediatrics of the New Jersey College of Medicine and Dentistry and the DYFS. With the award of $1.1 million in 1975 for a 3-year period, the joint effort began operations in the spring of 1975.

The Institute draws on the knowledge bases of medicine, social work and the variety of helping disciplines associated with the medical school. It provides comprehensive training in service delivery to various groups throughout the State, develops and coordinates public information programs and offers technical assistance to agencies and organizations for establishing protective services prevention and treatment programs. In addition, it sponsors conferences, institutes and workshops on various aspects of abuse and neglect. Quarterly reports on the vast range services and projects of PSRI are available from their office at the College of Medicine and Dentistry of New Jersey in Piscataway.

b. Program Assistance Unit (PAU)

The PAU was established in 1975 as part of the central administrative office of the Division's Bureau of Family Services for the purpose of assuring systematic protective services program development and expansion. To accomplish this, comprehensive service provision plans are being drawn up for each county. Plans have been completed for Atlantic, Bergen, Cape May, Mercer and Middlesex Counties and for Newark. At the same time the PAU also arranges training for various aspects of programming, serves as liaison and coordinator to other units in the agency involved in planning

these types of programs and helps develop and disseminate public awareness materials and assesses the effectiveness of various services.

One of the most important contributions made by this unit has been the coordination of a committee composed of staff from PSRI, PAU and BRPPD (described below) to develop standards and guidelines for child welfare practice decision making. These standards and guidelines focus on agency intervention, with the primary criterion demonstrating harm to a child. They are to be utilized by caseworkers making critical decisions from the point of initial referral to case termination.

c. Bureau of Research, Planning and Program Development (BRPPD)

In 1972 the BRPPD was created to provide the Division with a skilled research team to collect, analyze and interpret data regarding quantitative and qualitative dimensions of program components and through the practical application of these data, modify existing services in various areas. In the area of protective services, the Bureau writes proposals for federally funded research and demonstration projects, analyzes and prepares summaries for management on outside research, provides technical assistance to other units on setting up and implementing research designs, particularly for evaluative research, prepares reports on the needs of the population for whom protective services are provided. The Bureau carries out a full range of research on protective service delivery, including financing, policy choices, casework intervention methodologies and outcome of programs.

Tangible fruits of the Bureau's efforts have been the Protective Services Resource Institute (noted in (a.) above), the Union County Comprehensive Protective Services System, the description and proposal for a new casework practice model entitled "Decisional-Ecological Managerial Model of Child Welfare Casework Practice", and a brochure for professional medical practitioners outlining early indications of abuse/neglect and noting the responsibility to report. The Bureau is also researching critical aspects of casework decision-making.

d. Purchase of Services Unit

This unit was established in 1975 in response to several problems identified by the Division in the State's protective services system. First, there were few provider resources to handle the multiple needs presented by families where child abuse or neglect had been identified. Second, there was a lack of monetary resources to pay for services. Third, each district office was purchasing services on an individual, per child or per family basis, resulting in great disparity in the number and nature of contracts and providers from county to county. The Purchase Unit was set up to supplement monetary resources by finding the required 25% local match for Title XX service funds, by disbursing State appropriated seed money--Social Service Initiative--and, in the process, helping to establish systematic and comprehensive protective services at the county level.

Using as a guide the treatment scheme developed by BRPPD in the original of this report, the Purchase Unit works with district offices, county welfare boards and PAU to define treatment needs and identify potential providers. These providers are often approached by a Purchase field representative, although many times they contact Purchase on their own initiative. If there is interest on both sides, they then enter into contract negotiations. Once a contract is signed, the provider is given technical assistance especially during the start-up period of the program. All contract monitoring is carried out by the regional purchase office during the contract period.

Seventy-five percent of the cost of these contract services is financed through Title XX of the Social Security Act. The remaining 25% comes from Social Service Initiative funds, other State funds and/or from local public or private donors such as the County Board of Freeholders and the United Way. The kind of services purchased include individual and group counselling, lay therapy, parent education, pediatric, psychological and psychiatric diagnostic work-ups, teaching homemakers, parents anonymous groups, crisis nurseries, visiting nurse services, family planning, crisis hotlines and hospital-based medical and collateral services for severely abused children.

Table 7 at the end of this report shows, on a county basis, the approximate number, dollar amounts, numbers of families served and types of services provided through PRS treatment contracts negotiated for fiscal year 1976. Table 8 shows, by county, the approximate number of homemaker contracts signed, dollar amounts and number of families served. (Approximately half of these services will be directed toward families where abuse and neglect has been identified; the remainder will be provided to the elderly). During 1976, approximately 2,000 families received contracted treatment services. The annual capacity of these programs is expected to grow to 3,000 families per year by the end of fiscal year 1977. In addition, 2,700 PRS families benefited from homemaker services during fiscal year 1976 with an annual capacity of 4,200 families for homemaker services to be developed by the end of fiscal year 1977, representing a total annual capacity of 7,200 families receiving either general protective services or homemaker services.

2. Service Provision - Mercer County Illustrated

To demonstrate how services are obtained through the Purchase process, a very simplified illustration follows outlining the experience of the Mercer County District Office in developing a protective service system.

At the beginning of fiscal year 1976 a Purchase field representative convened meetings with the Mercer District Office and County Welfare Board staffs about client problems and services most needed to help with these problems. The district identified several service providers qualified to offer the needed services. At the same time efforts were initiated to obtain funds for the required non-federal 25% match from local community groups. After extensive meetings with these agencies, in which Purchase staff helped providers understand the particular needs of protective service clients, three contracts were negotiated and signed with the following agencies:

a. Children's Home Society, which provides individual counselling, family therapy, Parent Effectiveness Training, crisis intervention and ancillary services such as referral, outreach and home visitations to families where foster care placement of the child(ren) has occurred;

b. Catholic Welfare Bureau, which provides Parent Effectiveness Training, crisis intervention and ancillary services such as referral, outreach and home visitation where removal or placement of the child has been avoided;

c. Mill Hill Infant Center, which provides day care, individual counselling, group counselling, parent education groups and advocacy to families with particularly young children.

Protective services case flow and management is illustrated by the movement pattern of a hypothetical "typical" case. At the outset a routine, thorough investigation is carried out by a district office protective services worker. If the caseworker determines that special services are appropriate, the family is advised of the availability of one or more of the purchased treatments, training, or services cited above. Families who agree to participate in these services are formally referred by the caseworker to the provider agency which then assumes primary responsibility for case management and service provision. The District Office then transfers the case into an inactive unit. Periodic reports from the provider agency regarding the family's progress are forwarded to and kept by the District. Once services are terminated by the provider, the District Office resumes active supervision of the case until final disposition can be made.

F. Conclusion

During the last two years, there has been a great deal of change in the area of protective service provision. New legislation, expansion of reporting mechanisms, accelerated program design and development, improvement in services and expansion of resources to serve families in need have been the hallmarks of this period. This emphasis on program development and expansion will now have to be properly balanced with evaluation and control of the impact and quality of services as well as a continuing search for new directions and innovations in meeting the need for child protection.

III. A PROPOSED TREATMENT NETWORK AND PROGRAMS

A. Abuse and Neglect Can Be Prevented; Parents Can Be Helped

Abuse and neglect of children may be avoided, corrected, or alleviated by a variety of preventive and rehabilitative programs designed to avoid future harm to children by teaching parents fundamental parenting skills.

1. Preventive Programs - The following programs designed to improve child rearing and home management skills are preventive, usually directed at adolescent parents, but also useful in improving the parenting skills of older inadequate parents.

   a. Preparation for Parenthood Program - This program provides comprehensive educational, medical, social and parent education services for pregnant school-age girls, and for returning dropouts who have babies. An infant and child development center serves as a laboratory school, where young women can practice child care methods with children, in support of the parenthood component.

   b. Family Developmental Center - The Family Developmental Center is designed to provide services for 50 infants from birth to 2 years of age and their adolescent parents. The objectives of the program are to provide an appropriate day care facility for infants, to assure adequate health care, to provide a parent education program for their mothers, and to enable the mothers to continue their high school education.

   c. A Parent Education Program in the Pediatric Clinic - This project combines an educational intervention program involving parents with a comprehensive medical program for young children. Mothers of 20 to 40-month old children are trained in child development in the waiting rooms of pediatric clinics and well-baby stations.

2. Rehabilitative Programs - In recent years a wide variety of treatment programs have been developed for the abusive or neglectful parent.

   a. The Denver Model - The treatment model created by the National Center for the Prevention of Child Abuse and Neglect consists of a variety of programs directed at improving family functioning, including a diagnostic team, crisis nursery, lay-therapist, Family Anonymous, parent education, day care, legal assistance, and parent hot-lines.

The Center reports that the combined use of these program components reduces the need for placement of the abused child out of the natural home to only 10%.

b. The Pace Family Center at Bronx State Hospital - The program provides a wide range of services to families including day care and group work. The basic strategy is to work simultaneously with the parent and the child to improve interaction and teach skills.

c. Teaching Homemakers - This plan works to improve family functioning by providing tangible assistance and training where the parents' lack of knowledge about household management threatens the welfare of the child. In the program established in Mount Vernon, Washington, teaching homemakers go into the home and teach parents, on a one-to-one basis, a wide variety of homemaking and child rearing skills.

3. Comprehensive Emergency Services

In 1973, Nashville, Tennessee developed an organized, multiservice 24-hour emergency response system for families and children in crisis coordinating the activities of all Nashville and Davidson County agencies involved in child protection: social service departments, the police, juvenile courts, hospital child abuse teams, voluntary agencies and other organizations. The purpose of the program is to provide a 24-hour, immediate response capability for meeting emergent, or preventing impending, crises which would otherwise require more intensive, long-term forms of social intervention such as out-of-home child placement or involvement with the juvenile or family court.[8] The system combines preventive and rehabilitative approaches in an effort to ameliorate crises and help families remain intact.

The program provides the following round-the-clock services: hotline service, social work response, caretakers, homemakers, foster family homes, group homes for adolescents, family shelters, a diagnostic team and the availability of an outreach and follow-through staff to coordinate service delivery.

B. Problems Underlying Abuse Treatment Needs

A wide variety of social problems and personal disorders underly the parental dysfunctioning evident in child abuse and neglect. Emotional problems, illness, despondency, ignorance, immobility, drug usage, economic stress all may lead to abuse or neglect.

In terms of severity of child endangerment, the parenting problems underlying the situation can be clustered into three categories. Although these categories are somewhat abstract, they are nevertheless descriptive of a variety of situations known to have been associated with actual cases of child abuse and neglect. It cannot be assumed, however, that child abuse and neglect necessarily result whenever these factors are present. The following Table itemizes:

- the types of problems in each category;
- the proportion of each type as compared to all protective service cases that occur in a typical community; and
- the treatment program needed per type of problem.[9)]

TYPOLOGY AND TREATMENT SCHEME[9)]

TYPOLOGY OF PARENTING PROBLEMS	Estimated % of Total PRS Caseload	PARENT TREATMENT ALTERNATIVES
1. Physical Abuse		
a. Severe personality disorder typified by delusional thinking; hallucinations, uncontrolled impulsive behavior, or impairment of sexual orientation leading to sexual abuse.	3%	a. Parent Development Center Assessment and Coordination of Treatment Psychological treatment Institutionalization if necessary
b. Cold, compulsive, disciplinarian attitude.	5%	b. Home supervision of parent by lay-therapist Psychological treatment Parents Anonymous Parent Hot-Line
c. "Role Reversal" Syndrome characterized by 1) the isolation of the family, 2) the maltreatment of the parents when they were youngsters, 3) the parents looking to the child for emotional support, and resulting in 4) unrealistic expectations being placed on the child.	5%	c. Lay-therapist Parents Anonymous Family Planning Visiting Nurse or Social Worker Parent Hot-Line Psychological Services
2. Neglect		
a. Severely disorganized household lacking household management and parenting skills.	22%	a. Social Work Advocacy with income maintenance, housing authorities, state employment agency, etc. Teaching homemaker Social Work or Visiting Nurse Counseling Psychological Services Parenting classes in Day Care or Hospital
b. Alcoholism and drug addiction	5%	b. Psychological Services Alchoholics Anonymous Drug Rehabilitation Programs Parenting classes in Day Care or Hospital
c. Lack of concern of the parent of the well being of the child resulting in unwanted children, lack of supervision, and economic exploitation.	3%	c. Psychological Services Family Planning Lay-therapist
3. Parent Deprivation:		
a. Combination of personal stress, economic insufficiency, and inadequate undermining parent ability.	35%	a. Social Work Advocacy with income maintenance, housing authorities, state employment agency, etc. Teaching homemaker Parenting classes in Day Care or Hospital
b. Mental retardation of the parent(s) resulting in a lack of knowledge and ability to care for the child.	2%	b. Teaching homemaker Parenting classes in Day Care or Hospital
c. Medical or emotional problems of the parent.	10%	c. Caretaker Homemakers Visiting Nurse Services
d. Marital discord and desertion	5%	d. Family Counseling Psychological Services
e. Young, inexperienced, unskilled mother.	5%	e. Teaching Homemaker Parenting classes in Day Care or Hospital

C. Descriptions - Community Programs

The programs described in this section make up a total package able to provide service to the full range of parenting problems that may lead to the abuse, neglect and deprivation of children. The total package, costing $749,957 will serve 400 families identified as abusing or neglecting families at any given time and over 600 families during the course of the year. The DYFS suggests that each County needs the full range of treatment programs.

The following table provides the total budget and per unit cost of each program component. Not every family under supervision will require all program components. The size and thus the budget of each component was derived by estimating the number of families (out of 400) that would need that type of service.

Projected Cost by Service Program to Serve 400 Families under DYFS Supervision

Program	Total Program Cost/Year	Families Served At Any Given Time[1]	Families Served Per Year[2]	Cost Per Family Served During Year[3]
1. Parent Development Center				
a. Administration	$ 40,250	67	103	$ 390.77
b. Diagnostic Teams	64,542	67	103	626.67
c. Lay-therapists	88,000	25	39	2,256.41
d. Parents Anon.	2,500	40	70	35.71
e. Parent Hot-Line	3,375	400[4]	600	5.62
2. Teaching Homemakers	220,130	150	230	957.08
3. Professional Counselling	126,000	98	150	840.00
4. Parent Development Components (Day Care)	94,210	65	100	942.10
5. Parent Development Components (Hospital)	90,950	100	200	454.75
6. Family Planning Services	20,000	400	600	33.33
TOTAL	$749,957			

1. Indicates the number of families on the caseload at any given point in time.

2. Indicates the number of families on the caseload at some time during a one year period.

3. Represents the annual program cost per family served at some time during a one year period.

4. Based on the size of the "known" PRS population in the community. It is expected that the hot-line will ultimately service the larger community PRS population not on the active caseload as public awareness of this resource increases.

1. Parent Development Center (PDC)

The Parent Development Center will house under one roof four separate program elements directed at the most severely malfunctioning families. The PDC will operate as an autonomous unit supervising families requiring diagnostic and treatment care beyond the capabilities of the Special Protective Service Units to be established in the DYFS District Offices. The PDC will thus have complete responsibility for the children returned to it and appropriate for treatment. The PDC will be administered by a Service Coordinator/Case Manager who will be responsible for directing case flow in the unit. The elements of the Parent Development Center will include:

a. Administration - Budget (serving approximately 67 families at any given time and 103 families per year).

1 Coordinator/Case Manager @	$ 18,500	$18,500
1 Secretary @	7,000	7,000
Indirect Costs	4,750	4,750
Other (Space, Equipment, etc.)		3,000
Emergency Fund		7,000
Total		$40,250

b. Diagnostic Teams - The diagnostic team will assess the mental and physical state of the parents and child. This interdisciplinary team, composed of a psychiatrist, a psychologist, a pediatrician, a social worker, a visiting nurse and an attorney will evaluate the level of family functioning based upon a group meeting with the family as well as individual home visits and physical or psychological evaluations and tests as needed. The team will only see those families with acute problems referred by the special protective service units and will recommend the services, if any, needed by the family.

Budget (serving approximately 67 families at any given time and 103 families per year).

1 Psychiatrist (1/10 time) @	$30,000	$ 3,000
1 Psychologist (1/4 time) @	18,000	4,500
1 Pediatrician (1/4 time) @	20,000	5,000
1 Social Worker @	12,500	12,500
1 Visiting Nurse (1/2 time) @	12,500	6,250
1 Lawyer (1/2 time) @	14,000	7,000
1 Secretary @	7,000	7,000
Indirect Costs		12,312
Transportation @14¢ per mile-10,000 miles		1,400
Other (Space, Equipment, etc.)		5,580
TOTAL		$64,542

c. Lay Therapists - Clinical studies reveal that many abusive parents share certain characteristics of known cases: (1) they were themselves abused as children; (2) they are isolated from the community and their extended families; (3) they expect emotional support from their children in times of crisis. These factors combine to create a dangerous situation for the child in the family. Part of this danger can be eliminated with the use of lay therapists, para-professionals of demonstrated skills in raising their own families, on call to the family on a 24-hour-a-day basis and making frequent home visits to insure that the potentially abusive parent will have someone other than his child to look to for emotional support in time of crisis. In addition, the relationship with the lay therapist will help the parent develop relationships with other adults. When the parent learns to look to other adults for support, the danger to the child is reduced. One supervisor will be required for every ten para-professionals.

Budget (serving approximately 25 families at any given time and 39 families per year).

5 Lay Therapists @	$ 6,500	$32,500
1 Supervisor @	12,500	12,500
1 Secretary @	7,000	7,000
Indirect Costs		12,875
Transportation - 3 cars @ $4,000 purchase +$1,750/year		17,250
Other (Space, Equipment, etc.)		5,875
TOTAL		$88,000

d. Parents Anonymous - Parents Anonymous groups are self-help groups whose membership consists solely of parents who abuse their children or who fear that they will. Professional staff will participate only upon request for the puposes of organization or to deal with specific problems. The purpose of the group is to provide abusive and neglectful parents with the opportunity to talk about their problems in the hope that peer group support will modify their behavior.

Budget (serving approximately 40 families at any given time and 70 families per year).

Supplies	$2,000
Miscellaneous	500
TOTAL	$2,500

e. Parents Hot-Line - The proposed system will have a 24-hour "parent hot-line." The purpose of this line is to make available to parents someone they can speak to in moments of crisis whether or

not they have already come in contact with the DYFS or the Parent Development Center. As in other hot-line programs volunteers will be recruited to man the line and will be trained to offer the warmth, support and advice to parents who might call out of the fear that they are on the verge of battering their child. The hot-line number will be well publicized in the target area.

Budget (serving approximately 400 families at any given time, 600 families per year, and all other calls received).

Publicity	$1,000
Space	900
2 Telephones	320
Other (Equipment, furniture, etc.)	1,155
TOTAL	$3,375

2. Teaching Homemakers

Home services aides would be used to improve parental skill in domestic tasks: household management, nutrition, shopping and budgeting, hygiene and child rearing. As teaching homemakers assist parents in the immediate tasks of child and home management, group and individual instruction will be provided to permit the parent to function eventually without assistance. Non-teaching domestic aid will be provided only when a normally capable mother is unable function for some reason such as illness.

There will be one supervisory homemaker for each ten para-professional home service aides. The aides will be selected on the basis of their capacity to deal with family problems as demonstrated by having successfully raised their own families.

Budget (serving approximately 150 families at any given time and 230 families per year).

2 Supervisors @	$ 12,500	$ 25,000
15 Home Service Aides @	6,500	97,500
2 Secretaries @	7,000	14,000
Indirect Costs		33,875
Transportation (7 cars) @ $4,000 Purchase + $1,750/year		40,250
Other (Space, equipment, etc.)		9,505
TOTAL		$220,130

3. Professional Counselling

The full range of professional services, from short term reality therapy to long term family counselling, will be purchased from a variety of agencies and individual providers.

Budget (serving approximately 98 families at any given time and 150 per year).

7 Counsellors @	$18,000	$126,000

4. Parent Development Component (Day Care)

Participating Day Care Agencies will be staffed and equipped to provide parent skill training to those families of abused or neglected children referred for such assistance. Day care of the child will help relieve stress on the troubled parent and provide a healthy developmental environment for the child. Group sessions will be supplemented by individual in-home instruction provided by parent development para-professionals. One parent development social worker will supervise every five aides.

Budget (serving approximately 65 families at any given time and 100 per year).

1 Parent Development Social Worker @	$ 12,500	$ 12,500
5 Parent Development Para-Professionals @	7,000	35,000
1 Secretary @	7,000	7,000
Indirect Costs		12,875
Training (10% of Para-Professional Salaries)		3,500
Transportation (1 van)	$8,000 Purchase + $3,200/year	11,200
Other (Space, equipment, etc.)		12,135
TOTAL		$ 94,210

5. Parent Development Component (Hospital)

Hospitals come into contact with a wide variety of protective service cases, including abuse, physical and emotional neglect, failure to thrive babies and drug related cases. To deal with these cases, hospital-based programs will be established with two major components: (a) a training program, and (b) Parent Development Units. The training program will provide for the identification of abuse and neglect cases and the appropriate management of cases noted. Although this training will be available to all levels of staff affiliated with the hospital, it will be directed primarily at pediatric and emergency ward staffs.

The parent-child developemnt unit will introduce young parents to child rearing skills which will be taught via group and individual contact with clients both in the hospital and in their homes. Referrals to other system resources will be made as appropriate.

Each five para-professional parent developers will be supervised by a hospital staff trainer/social worker who will be responsible for implementing the hospital staff training program as well.

Budget (serving approximately 100 families at any given time and 200 per year).

1 Hospital staff trainer/social worker @	$12,500	$12,500
5 Parent Development Para-Professionals @	7,000	35,000
1 Secretary @	7,000	7,000
Indirect Costs		12,875
Transportation 3 cars @	$4,000 Purchase +1,750/year	17,250
Training (10% of Para-Professional Salaries)		3,500
Other (Space, equipment, etc.)		2,825
TOTAL		$90,950

6. Family Planning Service

Unwanted children are often abused or physically or emotionally neglected and parents who have demonstrated poor parenting behavior should have every opportunity to take advantage of family planning services so as to minimize the risk of bearing additional unwanted children. In addition, neglect may be aggravated or caused by excessive family size alone, as parents who can adequately provide for and supervise two children often fail miserably with six children.

Family Planning Services will be widely publicized but offered on a strictly voluntary basis through casework counselling and referral to service providers, (both physicians and centers).

Budget (serving approximately 400 families at any given time and 600 per year).

Vendor Services	$100/family	$20,000 (Medicaid would pay the balance)

7. Comprehensive Emergency Service

Comprehensive Emergency Services is a system of coordinated services designed to meet the unpredictable but urgent needs of children and their families in crisis, providing options in care which will protect children and reduce the trauma brought about by the

emergency. The need for protective services, broadly defined, arises not only from problems of abuse and neglect, but from a wide range of family emergencies that can jeopardize the safety of a child. When integrated with an existing network of social services available during traditional working hours, CES completes a framework within which a community can provide essential services to neglected, dependent and/or abused children on a 24-hour, 7-day basis. The goal of maintaining children in their own homes during crisis is attained by providing immediate aid round-the-clock. In situations where lack of shelter endangers the safety of a child, separation of the child from the family is prevented by providing family shelter.

In Nashville, the adoption of the CES program model was accompanied by an extremely rapid growth in the reported child protective service caseload -- some 92% in the first year of operation --which has recently tapered off to a more gradual 67% annual rate. As the N.J. system has already gone through a similar rate of growth in the early stages of development of its PRS treatment system, it is believed that the projected rate of growth of the caseload of families requiring protective services of 23.6% (discussed on Page) will be little affected (at least in the near-term) by the introduction of CES. Based upon Nashville, about 39% of this projected caseload will require emergency services not currently available after traditional business hours. For example, in Atlantic County the projected 1976 average daily caseload in families is 297. About 39% of these, or 116 families, will need a comprehensive system of emergency services after hours beyond investigatory services.

Below is a description of each component of the CES system with accompanying budgets. The budget figures are based on the Nashville-Davidson model serving a community of 500,000 with a service caseload of 2,500. These descriptions make up a model CES program which could be started in communities lacking the required services. In actuality, most communities already have some of the basic components, either on a 9-5 basis or a 24-hour basis, which can constitute the beginning of a CES system. The following cost figures, thus, overstate the marginal or incremental costs of adding CES to county systems possessing some or all of the service components. A precise specification of the marginal costs to each county would require a complete assessment of all available DO, CWA, purchased, and other community service resources. Therefore, actual cost estimates for counties, based on existing resources and gaps in resources, are not included.

a. Emergency Intake provides the central mechanism necessary for the coordination of emergency services. It consists of an answering service with a screening component and backup staff immediately available to go out and handle emergencies. Through this mechanism, children and/or families enter the CES system. Trained social workers are on call 7 days a week, 24 hours a day to receive calls, screen for emergencies and refer to a worker who then does additional screening, makes contact with the family and initiates provision of needed services by one of the other CES components.

For New Jersey, emergency intake for referrals of abuse and neglect is provided by the DYFS Office of Child Abuse Control and Special Response Units in each county throughout the State. Other public and private agencies also provide similar intake services. The expansion of the Division's emergency intake system to include emergencies other than child abuse and neglect and the coordination of the several existing hotline/intake systems is needed.

Budget (serving approximately 100% of the caseload of 2,500 families).

7 screening caseworkers @ 11,500 ea.	$80,500
Telephone costs @ $50/month	600
Total	$81,100

b. Outreach and Follow Through provides immediate casework assistance to children and families in crisis and continues follow-up and supervision beyond the crisis stage to help families find longer-term solutions. Staff for this component must be well trained and experienced in providing protective services. As these workers will service non-abusing/neglecting families as well, they must emphasize the helping rather than the investigative aspects of their function during emergency service provision. These workers provide case management and continuity throughout the period of agency contact and, thus, are the key to the coordination and monitoring of all CES components.

Budget (serving approximately 33% of the caseload or 825 children)

15 caseworkers @ 11,500 ea.	172,500
3 supervisors @ 13,500 ea.	40,500
1 clerical position	7,000
Transportation (@ 4,000 purchase + 1155/year	9,155
Other (space, equipment, etc.)	6,000
TOTAL	$235,155

c. Emergency Caretakers are carefully selected and trained paraprofessionals who go into homes offering temporary care and supervision for children whose parents are absent or unable to provide adequate levels of child care and home management. This service is short-term and transitional as the caretaker is usually relieved the next working day when the parent or relative returns or when a teaching homemaker is assigned. The caretaker can, thus, reduce the need for out-of-home child caring arrangements until the presenting family problem is brought under control. In addition, this temporary service allows more time for placement planning when child removal is necessary. Where possible, it is suggested that caretakers be recruited to work in their own neighborhoods where they are most likely to be a familiar figure and know the character of the neighborhood and its subculture.

Caretaker services are available on a strictly 9-5 basis in most New Jersey communities through in-home day care or homemaker programs. Lags of from several hours to a few days in the arranging of this service are not uncommon. The existing system must be developed to offer a faster response on a 24-hour basis.

Budget (serving approximately 11% of the caseload or 37 children)

4 caretakers serving approximately 37 children for weekly retainer fee plus wage for hours worked @ average of $70.00/child	$2,590

d. Emergency Teaching Homemakers provide 24-hour supportive services to children and their families for the purpose of maintaining children in their own homes when the parent(s) is unable to assume home and child caring responsibility. In addition, to providing domestic help and instruction, the homemaker also assists the social worker in identifying the ongoing needs of the family and forming longer term helping/treatment plans as appropriate. As with the emergency caretaker, this service affords the caseworker additional time to plan and the child and his/her family to prepare for placement when needed.

In New Jersey, homemaker providers generally operate on a 9-5 basis; contract and direct service operations would have to be modified to provide for 24-hour coverage.

Budget (serving approximately 21% of the caseload of 525 children)

11 Homemakers	$49,000
1 Supervisor	10,000
Total	$59,000

e. Emergency Foster Family Homes provide temporary care for children who cannot remain in their own homes but will be quickly returned to their parents or will be shifted to a longer-term or permanent placement as soon as possible. Emergency foster care can help minimize the emotional shock of removing children from their families by providing them a home-like environment as an alternative to institutional placement. These foster parents must be selected for their willingness to immediately accept any child in any condition for short-term placements. This service must be carefully monitored to prevent unnecessarily long placements and breakdowns in case planning.

The Division of Youth and Family Services maintains this capability through its network of some 5,000 approved foster family homes.

Budget (serving approximately 6% of the caseload or 150 children for an average length of stay of two weeks.)

Reimbursement for child care to foster parents @ $80/child	$12,000
Monthly retainer fee for 8 foster parents @ 150.00 each	14,400
Total	$26,400

f. Emergency Shelters for Families are facilities that provide temporary housing for families who have lost their homes or whose home situations are so inadequate that they are compelled to leave abruptly. These facilities may be operated/financed by any agency in the community as long as there are carefully developed procedures to insure availability when needed. The shelter must be able to accomodate entire families, and social work services must be a part of the program to assist displaced families with relocation, referrals to other services, transportation, family counseling and follow-through.

Many New Jersey communities are currently without this service.

Budget for time-limited shelter facility (serving approximately 5% of the caseload or 125 children)

Rent	$16,000
Director	15,000
Assistant Resident Director	10,000
Clerical Position	7,500
Housekeeper/Cook	6,500
Transportation $4,000 car purchase + $500	4,500
Other (food, supplies, etc.)	9,000
Total	$68,500

g. Emergency Shelter for Pre Adolescents (Over 6) and Adolescents provides a residential substitute placement for older youths with special problems which cannot be handled in their own homes or in foster family homes. Services are specifically designed to meet the many needs of this age group.

Budget for time-limited shelter facility (serving approximately 3% of the caseload or 75 children)

Rent	$16,000
Director	15,000
Assistant Resident Director	10,000
Clerical Position	7,500
Housekeeper/Cook	6,500
Transportation 4,000 car purchase + $500	4,500
Other (food)	9,000
Total	$68,500

D. Program Needs Per County

The number of program packages needed in each county (these computations do not include the CES system) in 1976 can be ascertained by dividing the projected 1976 overall daily family caseload by 400. Thus, for example, Middlesex County will likely have 878 families needing treatment at any given time and thus will need 2.20 program packages (or 2.20 of each of the program components) to provide a full and comprehensive program to each family.

The number of total programs (and thus each component) for each county follows:

County of Charge	Projected 1976 Average Daily Caseload in Families	Units of Needed Programming	Cost of Needed Programming
Atlantic	286	.72	$ 539,969
Bergen	332	.83	622,464
Burlington	299	.75	562,468
Camden	547	1.37	1,027,441
Cape May	24	.06	44,997
Cumberland	387	.97	727,458
Essex (Orange)	540	1.35	1,012,442
Gloucester	221	.55	412,476
Hudson	823	2.06	1,544,911
Hunterdon	99	.25	187,489
Mercer	451	1.13	847,451
Middlesex	878	2.20	1,649,905
Monmouth	682	1.71	1,282,426
Morris	332	.83	622,464
Newark	2,156	5.39	4,042,268
Ocean	497	1.24	929,947
Passaic	683	1.71	1,282,426
Salem	106	.27	202,488
Somerset	194	.49	367,479
Sussex	139	.35	262,485
Union	740	1.85	1,387,420
Warren	120	.30	224,987
TOTAL	10,536	26.38	$19,783,861

E. The Treatment Network

The DYFS has statutory responsibility for the protection of children. All citizens have the duty to report suspected instances of abuse and neglect to the DYFS, which must then investigate the reports and if necessary provide for necessary treatment.

The treatment network herein described represents DYFS efforts to develop services for the abused and neglected children and families. The entry point for treatment will generally be reported to the DYFS, but self-referrals will be encouraged and accepted by all components. In time parents voluntarily seeking help should become a substantial portion of the caseload.

The treatment network envisioned here has two branches:

(1) The Parent Development Center - The PDC is designed for treating the most severe cases (about 18% of the caseload) and will be delegated responsibility for the parents referred to it. Periodic reports to the DYFS will be requested, but unless the case is referred back to the DYFS, the PDC will have day-to-day responsibility for protecting the child and providing help and treatment to the parents.

(2) The DYFS District Office - The District Office will retain direct responsibility for most abuse and neglect cases, and coordinate treatment to be provided by the variety of community resources (the teaching homemakers, the Parent Development Programs in day care and hospitals). In these cases the DYFS will serve to organize the treatment program, insure that services are provided, and monitor the home situation.

The coordinative mechanisms envisioned in each County include:

(1) A Child Protection Coordinating Committee - Representing all reporting and treatment agencies, it will provide for network maintenance, overall coordination, public information, and additional resource mobilization.

(2) An Administrative Component - Located within the DYFS District Office, a two or three person administrative component will be responsible for day-to-day supervision, coordination, and system maintenance.

(3) The Position of Coordinator/Case Manager - Both the Parent Development Center and the DYFS will employ one staff member for insuring coordination, planning, and appropriate resource allocation on all cases through a process of continuous case review.

(4) An Information System - Developed by the DYFS, the information system will simplify and structure case recording, rationalize definitions, facilitate interchange of information, and provide for case planning and tracking.

(5) A Manual and Guidelines - Prepared by the DYFS, they will define the roles, procedures, and responsibilities of each component of the system.

APPENDIX

Table 1: An estimate of the number of abused and neglected children for the State of New Jersey and its subdivisions; per annum; based on a procedure developed by Saad Nagi.

County of Charge	Estimated Number of Abused Children	Estimated Number of Neglected Children
Atlantic	122	317
Bergen	641	1,655
Burlington	263	680
Camden	359	927
Cape May	37	96
Cumberland	95	245
Essex (Orange)	353	911
Gloucester	143	371
Hudson	400	1,035
Hunterdon	55	142
Mercer	215	556
Middlesex	467	1,208
Monmouth	371	958
Morris	314	812
Newark	319	826
Ocean	153	396
Passaic	333	859
Salem	47	123
Somerset	161	417
Sussex	64	167
Union	380	983
Warren	55	143
TOTAL	5,347	13,827

Table 2: An estimate of the number of abused and neglected children for the State of New Jersey and its subdivisions; per annum; based on a procedure developed by Richard J. Light.

County of Charge	Estimated Number of Physically Abused Children	Estimated Number of Severely Neglected and Sexually Abused Children
Atlantic	164	382
Bergen	857	1,999
Burlington	352	821
Camden	480	1,120
Cape May	50	116
Cumberland	127	296
Essex (Orange)	472	1,101
Gloucester	192	448
Hudson	535	1,249
Hunterdon	74	176
Mercer	288	671
Middlesex	625	1,458
Monmouth	496	1,157
Morris	420	980
Newark	427	997
Ocean	205	478
Passaic	445	1,038
Salem	63	148
Somerset	216	504
Sussex	86	201
Union	508	1,187
Warren	74	173
TOTAL	7,156	16,700

Table 3: An upper-bound estimate of the number of abused and neglected children for the State of New Jersey and its subdivisions; per annum; based on a procedure developed by Richard J. Light.

County of Charge	Estimated Number of Physically Abused Children	Estimated Number of Severely Neglected and Sexually Abused Children
Atlantic	436	981
Bergen	2,284	5,139
Burlington	938	2,111
Camden	1,280	2,880
Cape May	133	299
Cumberland	338	761
Essex (Orange)	1,258	2,831
Gloucester	512	1,152
Hudson	1,428	3,212
Hunterdon	196	441
Mercer	767	1,726
Middlesex	1,666	3,749
Monmouth	1,322	2,975
Morris	1,120	2,520
Newark	1,139	2,563
Ocean	546	1,229
Passaic	1,186	2,669
Salem	169	381
Somerset	576	1,295
Sussex	230	518
Union	1,356	3,051
Warren	197	444
TOTAL	19,077	42,927

Table 4: Number of confirmed reports of child abuse, neglect, and parental deprivation for the State of New Jersey and its subdivisions; January to December 1975.

County of Charge	Abuse	Severe Neglect	Parental Deprivation*
Atlantic	43	110	200
Bergen	91	134	208
Burlington	79	61	134
Camden	175	290	149
Cape May	10	21	22
Cumberland	65	41	450
Essex (Orange)	287	354	490
Gloucester	61	187	109
Hudson	391	693	148
Hunterdon	27	27	46
Mercer	132	182	317
Middlesex	295	155	614
Monmouth	111	188	557
Morris	146	315	143
Newark	629	1,313	71
Ocean	261	464	511
Passaic	208	415	233
Salem	27	23	122
Somerset	61	54	115
Sussex	34	71	102
Union	276	352	335
Warren	40	19	100
TOTAL	3,449	5,469	5,176

*See pp. 1-2 for explanation of use of this category

Table 5: Caseload under supervision for reasons of child abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions; December 31, 1975.

County of Charge	Abuse	Severe Neglect	Parental Deprivation
Atlantic	48	239	290
Bergen	117	187	365
Burlington	125	137	341
Camden	232	492	379
Cape May	6	21	22
Cumberland	56	109	615
Essex (Orange)	263	349	477
Gloucester	67	188	192
Hudson	397	832	431
Hunterdon	35	61	104
Mercer	122	274	514
Middlesex	232	253	1,286
Monmouth	151	370	854
Morris	159	304	207
Newark	1,003	2,657	688
Ocean	173	377	452
Passaic	267	596	515
Salem	28	36	150
Somerset	65	122	205
Sussex	27	79	174
Union	273	442	778
Warren	48	18	175
TOTAL	3,894	8,143	9,231*

*See pp. 1-2 for explanation of use of this category

Table 6: Projected caseload under supervision for reasons of child abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions; number of children and number of families without intensified outreach impact; December 31, 1975.

	Base Caseload of Children plus 23.6% Increase			
	Abuse	Severe Neglect	Parental Deprivation*	Total
Atlantic	59	295	358	713
Bergen	145	231	451	827
Burlington	155	169	421	745
Camden	287	608	468	1,363
Cape May	7	26	27	60
Cumberland	69	135	760	964
Essex (Orange)	325	431	590	1,346
Gloucester	83	232	237	552
Hudson	491	1,028	533	2,052
Hunterdon	43	75	129	247
Mercer	151	339	635	1,125
Middlesex	287	313	1,589	2,189
Monmouth	187	457	1,056	1,699
Morris	197	376	256	829
Newark	1,240	3,284	850	5,374
Ocean	213	466	559	1,238
Passaic	330	737	637	1,704
Salem	35	44	185	264
Somerset	80	151	253	484
Sussex	33	98	215	346
Union	337	546	962	1,845
Warren	59	22	216	297
TOTAL	4,813	10,063	11,387	26,263

*See pp. 1-2 for explanation of use of this category.

Table 7: Projected caseload under supervision for reasons of child abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions; number of families without intensified outreach impact; December 31, 1975.

	Base Caseload of Families plus 23.6% Outreach			
	Abuse	Neglect	Parental Deprivation*	Total
Atlantic	25	123	149	297
Bergen	60	96	188	345
Burlington	65	70	175	310
Camden	120	253	195	568
Cape May	3	11	11	25
Cumberland	29	56	317	402
Essex (Orange)	135	180	246	561
Gloucester	35	97	99	231
Hudson	205	428	222	855
Hunterdon	18	31	54	103
Mercer	63	141	265	469
Middlesex	120	130	662	912
Monmouth	78	190	440	708
Morris	82	157	107	346
Newark	517	1,368	354	2,239
Ocean	89	194	233	516
Passaic	138	307	265	710
Salem	15	18	77	110
Somerset	33	63	105	201
Sussex	14	41	90	145
Union	140	228	401	769
Warren	25	9	90	124
TOTAL	2,009	4,191	4,745	10,946

*See pp. 1-2 for explanation of use of this category.

Table 8: Projected caseload under supervision for reasons of child abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions; number of children with intensified outreach impact; December 31, 1976.

	Caseload of Children plus 14.4% Outreach			
	Abuse	Neglect	Parental Deprivation*	Total
Atlantic	66	330	400	796
Bergen	161	258	502	922
Burlington	173	189	471	833
Camden	320	679	523	1,522
Cape May	8	29	30	67
Cumberland	77	150	849	1,076
Essex (Orange)	363	482	658	1,503
Gloucester	92	259	264	615
Hudson	548	1,148	595	2,291
Hunterdon	48	84	144	276
Mercer	168	378	709	1,255
Middlesex	320	349	1,775	2,444
Monmouth	208	511	1,179	1,898
Morris	219	420	286	925
Newark	1,384	3,667	949	6,000
Ocean	239	520	624	1,383
Passaic	368	822	711	1,901
Salem	39	50	207	296
Somerset	90	168	283	541
Sussex	37	109	240	386
Union	377	610	1,074	2,061
Warren	66	25	242	333
TOTAL	5,371	11,237	12,715	29,324

*See pp. 1-2 for explanation of use of this category.

Table 9: Projected caseload under supervision for reasons of child abuse, neglect and parental deprivation for the State of New Jersey and its subdivisions; number of families with intensified outreach impact; December 31, 1976.

	Caseload of Families plus 14.4% Outreach			
	Abuse	Neglect	Parental Deprivation*	Total
Atlantic	28	138	167	333
Bergen	67	108	209	384
Burlington	72	79	196	347
Camden	133	283	218	634
Cape May	3	12	13	28
Cumberland	32	63	354	449
Essex (Orange)	151	201	274	626
Gloucester	38	108	110	256
Hudson	228	478	248	954
Hunterdon	20	35	60	115
Mercer	70	158	295	523
Middlesex	133	145	740	1,018
Monmouth	87	213	491	791
Morris	91	175	119	385
Newark	577	1,528	395	2,500
Ocean	100	217	260	577
Passaic	153	343	296	792
Salem	16	20	86	122
Somerset	38	70	118	226
Sussex	15	45	100	160
Union	157	254	448	859
Warren	28	10	101	139
TOTAL	2,237	4,683	5,298	12,218

*See pp. 1-2 for explanation of use of this category.

Table 10: Protective Services Programs Budgeted Under Purchased Contracts During Fiscal Year 1976.

County	Types of Services	Sum Total of Agency Contracts ($)	Number of Families Served for Fiscal Year 1976
Atlantic	Family life Center, hospital based treatment	111,712	200
Bergen	Family services, professional counseling & lay therapy, hospital based treatment	311,684	100
Burlington	Family services, professional counseling & lay therapy	46,578	45
Camden	Family services, counseling & lay therapy, family education	138,466	130
Essex	Hospital based treatment & professional counseling, family education, family therapy, diagnostic services	427,228	150
Gloucester	In-home counseling & family education	40,000	50
Mercer	Hospital based treatment, family services, counseling & lay therapy, infant center-based counseling	324,769	180

Table 10 cont'd

County	Types of Services	Sum Total of Agency Contracts ($)	Number of Families Served FY 1976
Morris	Hospital based treatment & professional counseling, family education program	223,400	50
Passaic	Family counseling and treatment, lay therapy	109,800	40
Union	Family counseling and treatment, lay therapy, diagnostic services	253,287	600
TOTAL		$1,986,924	1,545

Table 11: Protective Services Homemaker Services Budgeted Under Purchase Contract During Fiscal Year 1976.

County	Sum Total of Agency Contracts ($)	Number of PRS Families Served FY 1976
Atlantic	171,330	245
Burlington	61,760	147
Camden	117,100	225
Cape May	23,000	60
Cumberland	51,400	144
Essex	450,000	430
Gloucester	22,750	30
Hudson	109,670	100
Mercer	100,830	250
Monmouth	223,700	350
Morris	61,290	40
Ocean	70,000	40
Salem	113,580	60
Union	168,580	140
Total	$1,744,990	2,261

Technical Notes

Table 1: This estimate is based on assumptions taken from: Saad Z. Nagi, "Child Abuse and Neglect Programs: A National Overview" in: CHILDREN TODAY, Vol. 4 No. 3 (May-June 1975), pp. 13-17. Nagi surveyed agencies and programs involved in child abuse and neglect in a probability sample of 129 counties. The State of Florida appeared to have the most "realistic" (not the highest!) reporting rate based on vigorous outreach efforts. Florida's reporting rate of 13.4 per 1,000 children under 17 years of age, a confirmation rate of 60% or .6, and an abuse rate of 27.9% or .279 were used to arrive at a rate of .00224 as an estimator of the incidence of child abuse and a rate of .0058 as an estimator of the incidence of severe neglect. These rates were applied to the census population under 19 years of age for the State of New Jersey and its subdivisions. The difference in the upper limit of the age-specific reference population was considered to be unproblematic.

As can be seen from a comparison between these figures and those in Table 4 there is usually a discrepancy between estimates and confirmed reports. In two cases (Ocean and Essex (Newark) the number of reports received exceeds the incidence estimate. Logically this could be attributed to either over-reporting or under-estimating. This procedure was, on the other hand, originally designed to estimate the nationwide incidence. Applying it to as small a unit as a county might no longer be permissible and produce fallacious results.

Table 2: The estimate in this table is based on the work by Richard J. Light, "Abused and Neglected Children in America: A Study of Alternative Policies" in: Harvard Educational Review, Vol. 43 No. 4 (November 1973), pp. 556-598. Light expands on the findings reported by David G. Gil in Violence Against Children. Based on survey findings from the year 1965 Gil had estimated that between 2.53 and 4.07 million adults in the U.S. had knowledge of an incident of child abuse among families they knew. Light refines this estimate by making assumptions about:

a. the number of families a respondent was likely to know;

b. how well a respondent might know a certain number of families;

c. the likelihood of a respondent knowing about an incident of abuse as a function of (b.);

d. the likelihood of a respondent's knowledge about an incident of abuse as a function of (a.).

He arrives at a rate of physical abuse of .003 or 3 out of every 1,000 children under 18 years of age. He also estimates severe neglect and sexual abuse to occur at a rate of .007 or 7 out of every 1,000 children. These rates were applied to the New Jersey population under 19 years of age at the time of the 1970 census. A comparison with Table 4 reveals discrepancies similar to those noted in comments on Table 1. The same explanation would apply.

Table 3: These estimates are derived from the article by Richard J. Light as well. They were originally arrived at by varying the assumptions mentioned above. The upper bound is defined by a rate of physical abuse of .008 or 8 out of every 1,000 children under 18 years of age and a rate of severe neglect and sexual abuse of .018 or 18 out of every 1,000 children under 18 years of age.

Table 4: Although an Office of Child Abuse Control (OCAC) has been established to coordinate investigation and reporting of child abuse and neglect and serve as a central registry, data on confirmed reports are as of yet unavailable. Therefore, the following, simple procedure had to be applied to determine the number of confirmed reports:

1. All applications received during 1976 with a disposition of "supervision established" were selected.

2. Of this group, applications with a code for "reason for requesting service" of "11" (abuse, physical or sexual) were considered as confirmed reports of "abuse".

3. Those with a reason code of "9" (emotional neglect) or "10" (physical neglect) were considered as confirmed reports of "severe neglect".

4. Those applications with reason codes from "12" through "17", "20", "22" and "23" were considered as confirmed reports of "parental deprivation" (mild neglect). These codes indicate a wide variety of situations involving parental or family maladjustment.

The criterion of confirmation is thus whether supervision has been established for a case or not.

Table 5: These figures were taken from the 1975 Child Master Record. The codes used to distinguish between these categories are the same as those in Table 4.

Table 6: These estimates are based on the following assumptions:

1. That the caseload under supervision for reasons of child abuse, neglect, and parental deprivation will continue to grow at the same rate as during 1975 (= 23.6%).

2. That it will grow evenly in all counties at that rate.

3. That it will grow at a rate which is 14.4% higher than could be expected otherwise if the outreach effort presently under way will be intensified. This represents the difference between the anticipated rate of growth (23.6%) and the average of measures of outreach impact obtained in New York and Florida.

The number of families was determined by assuming an average of 2.4 children per family with children under 18 years of age. This information was obtained from 1970 census returns.

Footnotes

1) Dr. Vincent Fontana (MD), The Maltreated Child: The Maltreatment Syndrome in Children, Thomas 1971, Second edition.

2) The bases of these estimates are discussed in detail in the technical notes in the Appendix.

3) "Child Abuse and Neglect Statistic." Child Abuse and Neglect Reports. National Center on Child Abuse and Neglect, June 1976.

4) The following summary of research findings draws extensively on: Ross D. Parke and Candace W. Collmer, Child Abuse: An Interdisiplinary Analysis, University of Chicago Press 1975. Parke and Collmer do present a thorough inventory of research findings along with a bibliography of considerable length.

5) The estimates of the incidence per county included in the first edition of this report did adjust for the socio-economic and demographic composition of counties. At the time it appeared to be plausible to do so. Some of the research done since convinced us not to do so for this edition of the report.

6) Kempe, C.H. and Helfer, R. E., Helping the battered child and his family, Lippincott 1972.

7) This represents the increase for these reason categories. The increase for the Protective Services (PRS) program proper was much larger because of an increased initiation of cases into that program.

8) Comprehensive Emergency Services Community Guide. National Center for Comprehensive Emergency Services to Children. Nashville, Tennessee, p.1.

9) The Typology and Treatment Scheme is based on an extensive review of the literature on parental dysfunctioning and treatment alternatives, relying principally on the work of the following authorities in the field:

   a) Vincent DeFrancis, The Fundaments of Child Protection, American Humane Association.
   b) Dr. Vincent Fontana (MD), The Maltreated Child: The Maltreatment Syndrome in Children, ed. 2, Thomas, 1971.
   c) Dr. David Gil, Violence Against Children, Harvard University Press, 1970.

d) Dr. Henry Kempe (MD) and Dr. Ray Helfer (MD), Helping the Battered Child and His Family, J.B. Lippincott Company, 1972; and The Battered Child, University of Chicago Press, 1968.

e) Dr. Brandt Steele, "Parental Abuse of Infants and Small Children", in Anthony, E.J. and Benedik T., eds.: Parenthood: Its Psychology and Psychopathology, Little Brown, 1970.

f) Dr. Leontine Young, Wednesday's Children, McGraw - Hill, 1964.

g) Serpio Richard Zalba, "The Abused Child: II. A Typology for Classification and Treatment" in Social Work, 12:70 - 79, 1967.

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