CHILD ABUSE AND NEGLECT

A Report on Seven Demonstration Projects*

The author presents the results of an experimental program initiated for the purposes of providing comprehensive psychiatric assistance to abused and neglected children and their families. Designed jointly by Massachusetts' U.S.A. Departments of Mental Health and Social Services, the projects are also a demonstration of interagency case collaboration. The paper briefly describes the program philosophy, service delivery strategy, and staffing pattern. Through analysis of data of 332 families and 1,118 individuals treated in the first year, profiles of the abusing/neglecting family, their children, and the adult perpetrator of the situation are developed. Implications for mental health care, the cooperative endeavours of mental health and child welfare agencies, and difficulties in measuring treatment outcomes of this population are discussed.

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This paper presents the findings of seven child abuse/neglect projects conducted in Massachusetts, U.S.A.
The paper is published because the implications drawn from the findings do have relevance for Australian programmes.

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This paper reports the findings of an evaluation of seven child abuse/neglect demonstration projects implemented in the Commonwealth of Massachusetts, United States of America. Drawing from a population of 1118 individuals from 332 families, the author presents a brief description of the programs and a concise profile of those seen in the experimental projects. Specifically, findings are presented which picture the families in treatment, their abused/neglected children, and the adults who perpetrated the situation. Finally implications are drawn for mental health practice and evaluation in this area.

The seven projects began in the Spring, 1980 as a response to a well-publicized trial of two young parents for the beating death of their baby. Designed as a collaborative effort between the Massachusetts Departments of Social Services and Mental Health, the programs provide mental health services to high-risk families who have been identified as being involved in acts of child abuse or neglect. The identification process is the result of a legal statute which requires certain mandated reporters to identify and file written reports of children, under the age of 18 who are suspected to be victims of physical or emotional abuse or neglect.

To best address the varied mental health needs of this target group, the two Departments established the following goals for interagency treatment services:

1. to deliver appropriate, timely, and sufficient mental health services to families in situations of abuse or neglect;
2. to foster interagency cooperation concerning the needs of particular children and their families for such service;
3. to assure that the catchment area has available protective services with professional clinical leadership and expertise, that is, a range of services to be offered on an area basis through community mental health clinics, centers, and other agencies capable of receiving third-party reimbursements;
4. to maximize the collection of third-party payments in delivering diagnostic and treatment services to these families; and,
5. to provide increased case consultation to workers of the Department of Social Service.

All reports of abuse and neglect are investigated by the Department of Social Services which, in turn, refers to the Department of Mental Health those families deemed to be in need of mental health care. The two agencies establish a unified, comprehensive treatment plan

and meet together on a regular basis to assess treatment progress. At this juncture, the Department of Mental Health carries the main responsibility for implementing the range of psychiatric services that are required.

PROGRAM DESCRIPTION

Although largely similar the seven demonstration projects have some differences with respect to staffing pattern, treatment philosophy, service delivery strategies, and service emphasis. Through an open bidding process, projects were funded for approximately $93,000 per year for the seven different regions of the state representing rural, suburban, and urban areas. In all instances, the successful bidders were existing mental health clinics already established in their areas.

Staffing usually consists of four to five persons per project. Most programs decided to use professional staff — social workers, psychologists, nurses, or counsellors — in the provision of services to the families in treatment. Several programs, however, designed their staffing pattern around the use of paraprofessionals who are supervised by professionals.

Although there is more similarity in treatment philosophy than difference, there has been an on-going dialogue over short-term versus long-term care of abusing/neglecting families. Most agree that a short-term intensive treatment emphasizing crisis intervention and relinking the individual and family to community supports would be ideal. However, practice has shown that families in treatment have chronic mental health disabilities and, therefore, have required long-term treatment. This debate continues.

Service delivery strategy has evolved from the clients' accessibility to and motivation for treatment services. An aggressive outreach component has proven necessary in motivating clients and in delivering service. In the first year, projects provided 55% of all service out of the office and 17% after 5 p.m. Another interesting finding was that 78% of the clients never missed an appointment.

The principal services provided by the demonstration projects were:

- screening/diagnostic assessments;
- individual treatment;
- family treatment;
- parent support; and
- parent education.

Whereas most of the screening/diagnostic, family treatment, and parent education activities were performed by master level professionals, paraprofessionals delivered parent support in nine out of ten cases. Each program provided consultation to community agencies and to the area office of DSS.

EVALUATION FINDINGS

During the first year of operation, the author served as the independent outside evaluator of the seven child protection demonstration projects. The findings of this evaluation, summarized below, highlight the families, children, and adult perpetrators of abuse/neglect who were treated by the mental health projects. The programs have continued into their second year of operation, but these findings emanate only from the data of the first year.

FAMILY PROFILE

During the year 1980 - 81, the Massachusetts Department of Mental Health treated 332 families referred to them by the Department of Social Services. Each family had a history of child abuse or neglect and was judged to be in need of mental health services.

The typical family in treatment had the following characteristics:

- 2.4 children in the home;
- 1.7 adults per family;
- 40% of households headed by female;
- an average income of $5,999 with 54% of families receiving welfare (AFDC) benefits;
- 1.2 reports of abuse filed.

One notes the high percentage of familes with low incomes and with females as heads of households.

At intake, clinicians indicated the presence of various indicators of child abuse and neglect. As the reader can see in Table 1, problems included a chaotic home situation, emotional neglect, physical neglect, and lack of supervision. Overall, emotional neglect and abuse were more prevalent than physical neglect and abuse. In 15% of the families, sexual abuse was found to be a problem.

In order to establish a baseline of abuse/neglect, clinicians rated the severity of each family's situation at intake. Then, using the same well-defined scale from 1 (low) to 5 (high), staff re-assessed the situation at the end of the year. Upon analysis of Table 2, the reader will observe the difference between these pre- and post-measures of abuse/neglect severity. There is a positive change in each category, indicating lower severity of the abuse/neglect situation when measured at the end of the projects' first year of operation. Although all differences were significant at the .001 level, families demonstrating emotional abuse and neglect showed the greatest improvement, while the situation of families with problems of sexual abuse revealed the least amelioration.

TABLE !: ABUSE / NEGLECT INDICES

INDICATOR	PERCENT REPORTING "YES"
CHAOTIC HOME	71%
EMOTIONAL NEGLECT	63%
LACK OF SUPERVISION	62%
PHYSICAL NEGLECT	42%
BRUISES, WELTS	27%
BEATINGS	25%
SEXUAL MOLESTATION	15%
SEXUAL ATTEMPT	9%
N = 332	

When each of the measures is combined into an overall severity index, some interesting findings result. Families who made the greatest gains in treatment hac the following correlated characteristics

- o the lowest incomes ($p < .01$);
- o households in which neglect wa: low ($p < .01$); and
- o low incidences of sexual abuse ($p < .05$).

In other words, projects tended to have greater success in treating lower-income families than higher-income families, and to make more progress with families who experienced low incidences of neglect and sexual abuse rather than high.

PROFILE OF CHILDREN IN TREATMENT

Children in treatment at the seven mental health programs numbered 660 the first year. Both males and females were treated, and most lived at home with their natural parents. The following additional characteristics were noted:

- o an average age per child of eleven years;
- o 12% with minority background;
- o 35% being the first-born child;
- o 25% not living at home — 16% residing in a foster home;
- o 40% with history of previous placement;
- o 40% with prior psychiatric treatment — outpatient or inpatient; and
- o 10% receiving special educational services.

Developed is a picture of instability, separation, and educational and emotional problems. At intake, the four most common problems of children were relationships with parents, severe situational stress, inability to deal with multiple family problems, and difficulties in relationships with siblings and peers.

ADULT PERPETRATOR

In the first year of the demonstration program, 285 adults, identified as the perpetrator of the abuse/neglect event, received psychiatric treatment. In developing profile of these individuals, it was discovered that:

- o 72% were female;
- o 9 out of 10 were white;
- o 56% were not married;
- o 9 out of 10 were the child's natural parent; and
- o they average 31 years of age.

Table 3 shows a number of factors that are significantly associated with participation in acts of abuse or neglect. These variables refer to the perpetrator's background history and his or her emotional, social, or criminal behaviour as evidenced in the past or currently in treatment.

A profile of the perpetrator of the abuse/neglect situation is shown in Table 3. This person has experienced a host of problems over the years. It may be said that the adult perpetrator was most likely:

- o the child's parent:
- o not married, that is separated, widowed, divorced, or single;
- o a person with a low educational status; and,
- o a person with a criminal record.

Paradoxically, we see that the adult perpetrator was probably a victim of neglect or physical or sexual abuse in his or her childhood. In addition, this person had a clinically diagnosed emotional problem at the time of entry into the demonstration program.

DISCUSSION

As society becomes increasingly aware of child abuse and neglect, mental health professionals will be called upon to address the problem. Crucial to any provision of psychological assistance is an understanding of the nature of the problem with its causes and impacts, the ability to design delivery systems that are appropriate and effective, and a knowledge of collaborative linkages with a variety of community agencies and resources. It is in this vein that we offer the Massachusetts experience as additional evidence to address the issues mentioned above.

With respect to program design and philosophy, service delivery strategy, and methods for interorganizational cooperation, there seems to be no right or wrong path. A variety of models need to be tested under varying conditions and with varying populations. The Massachusetts experiment has shown that mental health care does make a difference. Several major questions remain. If child abuse and neglect are chronic conditions, can a strategy of crisis intervention be effective and, if so, how? On the other hand, one must also question the cost of long-term care in an environment with limited resources.

The joint project between the Massachusetts Departments of Social Services and Mental Health is instructive for a number of reasons. First, collaboration on referral, screening, treatment plans, and termination gives child welfare personnel added resources to battle abuse and neglect. To access this resource also

TABLE 2

INDICES OF ABUSE / NEGLECT: BEFORE AND AFTER COMPARISON

SEVERITY OF	MEAN SCORE AT INTAKE	MEAN SCORE MAY, 1980	t
PHYSICAL NEGLECT	2.42	1.82	− 9.5***
PHYSICAL ABUSE	2.23	1.75	− 8.3***
SEXUAL ABUSE	1.87	1.36	− 5.6***
EMOTIONAL NEGLECT	2.89	2.18	−10.4***
EMOTIONAL ABUSE	2.74	2.03	−12.5***
SCALE SCORE: 1 (low) to 5 (high)	N = 332	***P <.001	

TABLE 3 CORRELATES OF PARTICIPATION IN THE ABUSE / NEGLECT SITUATION	
VARIABLE	ZERO-ORDER r
EMOTIONAL PROBLEM AT INTAKE	.34***
RELATIONSHIP TO CHILD (non-parent versus parent)	.33***
NEGLECTED AS CHILD	.27***
ALCOHOL PROBLEM	.27***
ABUSED AS CHILD	.24***
DRUG PROBLEM	1.6***
MARITAL STATUS (not married versus married)	−.15***
EDUCATIONAL STATUS (low versus high)	−.11***
SEXUALLY ABUSED AS CHILD	.09*
PREVIOUS CRIMINAL RECORD	.08*
N = 285 *P <.01	***P <.001

acknowledges that many of the causes of the problem are associated with psychiatric disturbances requiring mental health intervention. Second, there is the possibility of innovative treatment approaches as child welfare and mental health staff work closely together. Third, the demonstration programs provide for a consultative component in which mental health workers orient, educate, and support the efforts of protective service and other human service agencies. By addressing this element, the project imparts knowledge for early detection, treatment, and referral of child abuse/neglect cases.

There is one point not mentioned earlier. Clinical work with these families takes a tremendous emotional toll on the staff, creating a high risk of worker burnout. Although this problem does not differ from that experienced by workers who treat difficult or multi-problem families, mental health programs for child abuse and neglect should be careful to build into the projects the necessary supports to aid stressed personnel.

Finally, the reader should be aware of the need for and the difficulty in evaluating these experimental mental health interventions. Generally, the public is demanding greater accountability from its professionals and, in particular, there is an obsessive preoccupation with cost efficiency. Society is demanding the best for the least amount of money.

Related to the issue of fiscal accountability is the quality of our services. Do our treatment modalities work? This question has bothered professionals for a long time. We lack clarity in the relationship of cause and effect. For instance, there are competing theories for the causes of child abuse and neglect. Also, the social sciences do not have the instruments to measure outcomes precisely as do physics, astronomy, and engineering.

The findings of the seven Massachusetts child protective service projects have demonstrated the use of mental health treatment modalities for cases of child abuse/neglect. As society looks for ways to deal with the problem of parental neglect and abuse, mental health professionals will be asked to use their expertise to address the problem. This opportunity must be coupled with the reality which requires us to measure program outcomes as an answer to the demands for accountability.