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ABSTRACT

This summary report describes the development of advocacy components in seven Parent-Child Center programs designed to integrate local services for families with children from birth to 5 years. The major problems and the accomplishments of each national advocacy component goal are outlined. Chapters discuss (1) The Advocacy Concept and the Evaluation Design, (2) National Goals and Local Program Objectives, (3) The Families Served by the Advocacy Component (including data on all families with information on referrals, home visits, and illustrative cases), (4) The Families Served by the Advocacy Components (specific data on 25 families from each of the seven centers), (5) Group Meetings, Mass Meetings, Councils, and Workshops for Advocacy Component Families, (6) Relationships Between the Advocacy Components and Community Agencies, and (7) Staff Functions and Training. (SET)

THE ADVOCACY COMPONENTS OF SEVEN PARENT-CHILD CENTERS: A FINAL REPORT ON THE START-UP YEAR

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Special thanks are due the PCC Directors, and the Advocacy staffs at the seven Centers with an Advocacy Component. Despite frequent data collection demands and extensive site visits these individuals have through their hospitality and their cooperation made data collection a great pleasure. The efforts on our behalf by the Components, re: scheduling and accompanying CCR staff on family and agency visits, has made documentation of Advocacy's first year a genuine collaborative effort.

SUMMARY

INTRODUCTION

Seven of the thirty-three Parent-Child Centers (PCCs) were funded by the Office of Child Development (OCD) for an additional $100,000 each, in order to develop Advocacy Components (ACs). This Advocacy effort is defined as a model designed to meet the needs of children from birth to five years, and of their families within a particular catchment area, through local service integration and, when necessary, through the creation of new services. The ACs were not to provide direct services, unless such were necessary, on a temporary basis, to demonstrate the need for and effectiveness of a hitherto non-existent service. The typical AC has between one and two professionals and four and eight non-professionals on staff.

This is the summary of the report provided to OCD by the Center for Community Research (CCR) on the Advocacy start-up year. The report is based on information collected during four site visits to each program, monthly telephone contact with the Advocacy Coordinators, and program statistics received monthly from the programs. Site visit activities included interviews with Advocacy staff, the chairman of the PCC Policy Advisory Council, 25 families at each of the Advocacy Components, and with 5-7 community agency administrators in each community. The major thrust of the first year evaluation was to document the start-up process and to provide OCD with data on agency changes and on changes in both knowledge and use of community resources by the families

served.

The following discussion will consist of the presentation of each of the national goals set forth for the Program by OCD, followed by a statement of the major accomplishments and problems associated with its implementation.

GOAL

1. TO IDENTIFY THE UNMET NEEDS OF LOW-INCOME FAMILIES WITH CHILDREN 0-5 YEARS IN A DESIGNATED CATCHMENT AREA.

Accomplishments

During the first year of the Advocacy effort, needs assessments were completed on behalf of 2,422 families living in the seven AC communities. The majority of families assessed were identified through door-to-door efforts. The needs assessment served as a means of gaining entré to families' homes, and as a means for identifying individual family problems on a case-by-case basis.

Through the needs assessment effort, 4,739 children 0-5 were identified. Seven hundred ninety of these children are reported to have had no immunizations, and four hundred fifty-two children were receiving no yearly medical check-ups. By the end of the first Advocacy year, 230 children had check-ups, 160 had immunizations, and 182 families were enrolled in a public health

facility with complete coverage.

Problems

In most instances, needs assessment data collected were not tabulated in such a manner as to give statistics on community-wide problems. The needs assessments, as developed by the ACs, served primarily as a family intake tool, rather than as a means of portraying community needs.

Each Component developed its own needs assessment focus so that there is no comparability of data across the seven programs.

GOAL

2. TO IDENTIFY ALL PRIVATE AND PUBLIC PROGRAMS (LOCAL, STATE, AND FEDERALLY-SUPPORTED) THAT PROVIDE SERVICES FOR RESIDENTS IN THE CATCHMENT AREA, AND TO COMPILE INFORMATION ON EXISTING COMMUNITY SERVICES.

Accomplishments

Resource identification, as implemented by the ACs, includes a thorough understanding of what services each agency offers, eligibility requirements, and staff functions. The ACs identified agencies and resources previously unknown to PCCs. Identification of resources by means of actual staff visits to the agencies was found to be the most effective method of obtaining in-depth information about the agency and its functioning. Workshops with other

agencies were also found to be a particularly effective mechanism for in-depth learning about what other agencies do.

Agency Directories were developed at three Components.

Problems

Identification of resources and the compiling of detailed and complete information turned out to be far more complex and time-consuming than originally anticipated. Several Components had not yet finished their in-depth investigation of all resources available in the community. In some instances, the information obtained by non-professional staff was not sufficiently precise to be used in day-to-day referral activity. This necessitated time-consuming repeat calls and visits by individual workers.

GOAL

3. TO IDENTIFY THE GAPS BETWEEN NEEDS AND EXISTING SERVICES.

Accomplishments

Although AC staffs had lived and worked in the community prior to the AC year, they felt that their previous knowledge of service gaps was refined and deepened as a function of the Advocacy experience. In several communities, definable gaps in service were identified as part of the needs assessment effort. For instance, in one urban community it was discovered that the City Health Clinic was simply not open a sufficient number of hours. Once the large proportion

of women and children who were going unserved at the clinic was brought to the attention of the administration, the clinic's hours were extended.

Problems

Lack of systematic data from the needs assessment on a community-wide basis makes it impossible to state with any specificity what gaps exist. In addition, because of the lack of systematic data, the ACs have not been in a position to go to the agencies and state what percentage of eligible families is unserved and the hard data which could be used to document need decisively and convincingly are lacking. Community agencies were, for the most part, only vaguely aware that a needs assessment had been done and had virtually no knowledge of any findings.

GOAL

4. TO PROMOTE THE DEVELOPMENT OF COMMUNITY RESOURCES WHICH WILL FILL GAPS IN EXISTING SERVICES.

Accomplishments

In one rural community, an outstanding effort to fill a gap in medical services has been realized. The PCC/AC serves two counties. Prior to the AC effort, one county, with a population of 35,000, had one Public Health Doctor and two nurses; the other county, with a population of 18,000, had one doctor and one nurse. Following a massive effort to obtain certification of need for

a clinic in each county, local and federal resources were mobilized to provide money and personnel. As a result, both clinics are operational and staffed by the National Health Service Corps. Each clinics' staff includes a doctor, nurse, dentist, dental assistant, pharmacist, and x-ray technician.

In the other rural areas, some gaps in existing resources are being filled as a result of AC intervention. In one community, the AC is subsidizing the two County Health Departments to perform examinations for children 0-5. Also, a county health clinic is working with the State Health Department in order to secure family planning services, as a result of AC intervention. The Welfare Department in one rural community has hired two homemakers and plans to hire two more as a result of AC demonstrating the need for and effectiveness of such staff.

Problems

Much has been learned by all of the Components about the constraints which impede agency change and the development of new resources. Agencies lack money and staff with which to make changes which they, themselves, may value. Many agencies cannot implement change or start new programs at the local level because they are dependent on state or federal agencies for policies and guidelines.

The ACs can do much to educate community residents to the need for services, to stimulate them to the point of using services,

and to facilitate the process by which services are made available. However, to date there have been only a few instances in which it has been possible to effect the creation of new services.

GOAL

5. TO ASSIST IN BRINGING TOGETHER A COMPREHENSIVE AND EFFICIENT DELIVERY SYSTEM OF SERVICES.

Accomplishments

At three Components, ongoing interagency meetings have been instituted at the administrative level, designed to promote joint problem-solving, information exchange, coordination, and the stimulation of new ideas. As an outcome of those meetings, efforts have been made by agencies to pool transportation to distant resources in one community, a food cooperative has developed in another rural community, and the local family planning agency has gained entré to local schools.

The ACs have fostered coordination of services in several communities even without regular interagency meetings. Examples of such coordination include an AC-sponsored workshop for all agencies with outreach workers, to obtain training in the detection of lead poisoning conditions; an effort to prevent duplication of services by the Department of Social Services and the Department of Housing in a public housing project; and a project in which AC staff acted as a catalyst for an experimental program involving patient advocacy in an inner-city hospital.

Some major initiatives in the direction of coordination and improved service delivery have been made by several Components which have used their outreach capacity to facilitate the work of other agencies. Such efforts included helping clients with enrollment procedures and helping Welfare Departments by using AC outreach workers to attest to family needs in relation to various kinds of emergencies. Thus, one urban Welfare Department has allowed the AC to assess the need for furniture grants and another rural Welfare Department twenty-five miles from the catchment area has used AC staff located within the community to attest to the need for emergency grants. In addition, the Welfare Departments in several communities have become more vigilant in ensuring that clients get full benefits to which they are entitled as a result of AC intervention and efforts at coordination.

Problems

Administrators resist attendance at additional meetings. Particularly in urban areas where the number of agencies is great, agency coordination with even a single agency is complex and time-consuming. Day-to-day service demands often preclude the setting aside of time for the exercise of a planning and coordinating function.

Turnover in the coordinator position at several Components has been negatively associated with the development of strong coordinating relationships at the administrative level. While

referral linkages exist with other agencies, ongoing planning and coordinating relationships were initiated but in some cases were not carried through after the original Coordinator left.

GOAL

6. TO ASSIST FAMILIES BY REFERRING THEM TO SPECIFIC AGENCIES AND FOLLOW-THROUGH TO ENSURE THAT THE SERVICES ARE PROVIDED.

Accomplishments

Assistance to families has gone far beyond referral and follow-through. A total of 6,931 home visits were made to 1,913 families, and 2,450 referrals were made on behalf of 1,089 families.

Forty-two percent of all referrals were in the area of health, 14% were for housing, and 14% for education-related needs. Other referrals were for welfare needs, food and clothing, and employment. In seventy percent of all referrals, the outcome was either positive or was expected to be positive in the near future. The success of a referral is highly dependent on the service area, e.g., whereas 72% of all health-related outcomes were either positive or near-positive, only 31% of housing referrals were thus characterized.

Each AC developed referral linkages with many agencies, so that referrals and follow-through were conducted on the basis of specific knowledge of agency services and requirements, and of well-developed contacts with agency staffs.

Interviews with families revealed that the majority had a positive view of Advocacy and felt that they had benefited considerably not only from referrals, but also from a supportive relationship with a concerned worker.

Problems

The tremendous need on the part of many families for continued support has led to a relatively great number of home visits per referral. It was originally intended that, following assessment of a family's needs, referral would be effected and, in the process, the family would learn how to negotiate the service delivery system on its own. In reality, many families have problems which cannot really be helped by means of referral activity. These families require and seek out a continuing supportive relationship. Interviews with families revealed considerable emphasis on the Advocate as "friend" and "loyal supporter." In most instances, the feeling of getting "help" can best be defined in terms of the relationship between an outreach worker and the family.

It was very difficult to motivate many of the families to follow through on a referral, despite repeated efforts. With

regard to preventive services in particular, major efforts are required to foster and maintain an adequate level of motivation among a group which characteristically responds to needs on a crisis basis only.

A minority of families reported that they did not find Advocacy helpful because they had a need for direct services and not for referrals, which they felt they could effect on their own.

GOAL

7. TO DEVELOP A TRAINING PROGRAM FOR CHILD ADVOCATES IN CONNECTION WITH LOCAL COLLEGES AND OTHER AGENCIES.

Accomplishments

All of the Components provided training for outreach workers in a variety of technical and content areas. In-service training was provided through course work, workshops, seminars, sensitivity training sessions, and direct practice supervision, conducted by community agency personnel, university consultants, and PCC/AC professional staff.

Training focused on interviewing skills, record-keeping, report writing, and problem-solving skills. Training sessions were conducted on a wide variety of topics including mental retardation, lead poisoning, nutrition, and health care.

At two Components, AC Coordinators taught Advocacy-related courses at local colleges.

Problems

The staffing pattern of the ACs represents a high ratio of non-professionals to professionals. The preponderence of non-professional staff requires that considerable time be spent on training activities. The need for extensive training and supervision conflicts with the time available for service delivery activities. The difficulty of starting an innovative program in an area, i.e., child advocacy, in which there is no known curriculum with a non-professional staff should not be underestimated.

Initially, lack of adequate training in interviewing skills resulted in imprecise, incorrect, and superficial needs assessment data. Difficulties arose with respect to record-keeping and follow-through on behalf of clients, as did problems of over-identification with clients.

There was a fifty percent turnover among outreach workers, which means that much of the benefit of in-service training was lost before it could be used to the benefit of the program. For the most part, new aides received only cursory pre-service training due to the demands of ongoing service. The high turnover rate was attributed to job dissatisfaction and job insecurity. Turnover rate was lower at those ACs which hired PCC parents and staff, rather than indigenous community people not previously associated with PCC. It is likely that staff and parents experienced with PCC had a better idea of what to expect and a greater commitment to the success of the program than did people with no history of relationship to PCC.

GOAL

8. TO ENSURE THE DELIVERY OF ADEQUATE SERVICES TO EXPECTANT MOTHERS AND THEIR NEW-BORN BABIES.

Accomplishments

A total of 403 pregnant women were identified, 90% of whom were already receiving some form of pre-natal care.

Several Components worked to improve and humanize the pre-natal care available to women in their communities. One urban Component played a significant role in one hospital's changeover to a more personalized and more adequate system of pre-natal care.

Several Components started groups for pregnant women, seeking to provide information which would improve the quality of pre-natal care.

Problems

Sustaining the interest and participation of participants was extremely difficult; thus, attendance at pre-natal groups tended to be low and sporadic.

Efforts to provide already existing health agencies with referrals, feedback, and input on the needs of the client population seem to be more fruitful than are efforts to provide this service directly through the ACs.

GOAL

9. TO IDENTIFY HIGH-RISK MOTHERS AND CHILDREN SO THAT NECESSARY MEDICAL, NUTRITIONAL, AND OTHER NEEDED SERVICES CAN BE AVAILABLE TO THEM.

Accomplishments

One hundred and thirty-one high-risk pregnant women were identified by the ACs. Ninety-one percent of them reported some form of pre-natal care.

The vast majority of the families identified were multi-problem families. Serious health problems and housing conditions ranging from inadequate to utterly deplorable were prevalent among the population served.

Problems

The identification of high-risk mothers and children proved very difficult with a non-professional staff. The ACs tended to view the vast majority of families as multi-problem in that both income and emotional instability are prominent. The identification of such a high proportion of multi-problem families was responsible for the already discussed emphasis on case Advocacy and the development of ongoing supportive relationships. In effect, a major part of the program, as it developed, involved focus of specific attention on multi-problem families.

While not formulated as a specific goal, it is clear that emphasis on education of families to the need for, and use of,

resources was of primary importance to the OCD planners. Thus, CCR has added the following goal:

GOAL

10. TO HEIGHTEN FAMILY AWARENESS AND UTILIZATION OF EXISTING RESOURCES AND TO ENCOURAGE THE DEVELOPMENT OF COMMUNITY ORGANIZATION EFFORTS AT THE FAMILY LEVEL.

Advocacy efforts place heavy emphasis upon educating families so that they will be able to independently negotiate the service delivery system. To this end, an Advocacy-related referral entails not only contact with an agency, but an educative process through which the client is made aware of the need for a particular service and the methods by which it can be obtained. This differs from the traditional case work referral, which usually involves only contact to another agency on behalf of a client and subsequent follow-through.

Accomplishments

Considerable AC activity focused on education, both during individual home visits and in a variety of workshops and mass meetings held for AC families. Workshops and mass meetings dealt with such topics as drugs, welfare rights, dental care, child development, housing, programs for economic advancement through career development, family planning, health care, and consumer education. Attendance at these meetings has generally been quite good and local evaluations have been positive.

Some ongoing groups were particularly focused on providing members with an educational experience. One such group involved approximately 30 teenage mothers who were taught a great deal both about child development and about resources available to them in the community.

Attempts have also been made to organize groups of parents into committees to work in their own behalf on issues of community concern. Most of these efforts were focused on housing needs and tenants rights.

Problems

Attempts to organize committees of ongoing families have not met with much success; sustained participation is difficult to achieve.

The planning activities involved in organizing a workshop or meeting are extensive and very time-consuming. In any given month during which a workshop was planned at a Component, this involved so much staff time that there was a marked dimunition in referrals made by staff. The relative long-range educational benefits of a family-by-family referral approach vs. a mass meeting approach are simply unknown.

SUMMARY

It should be clear from the foregoing summary that much has been accomplished in the first year. While it is true that agencies have not altered their course in major ways, and that in most cases

new services have not been instituted, in retrospect it seems unrealistic to have expected that such changes could occur within a single year. What has been established is a foundation of relationships and collaborative efforts with other agencies which has facilitated the referral process, and which may or may not in the future serve as a first step in developing joint initiatives to effect change in the service delivery network. At most of the ACs, the relationships are well established, and the agency administrators are positive, feeling that the AC effort is well directed. In most communities, however, there seems to be little optimism on the part of agencies that major agency change will come about as a result of Advocacy efforts. Nevertheless, the Advocacy effort is welcomed by most agency administrators who are impressed with the ACs outreach capability and its potential for family education. Joint planning efforts, referrals, and calling practice abuses to the attention of agency administrators are all welcomed.

Agency identification and the establishment of relationships represent the primary achievement and effort of the first year. Now that this has been accomplished, a series of collaborative efforts and joint initiatives may be forthcoming.

In terms of families, the accomplishments have also been significant. While it cannot be said that families are now making their own referrals and that the Advocates have "done themselves out of a job" as was originally and over optimistically anticipated, important relationships with families have been

established. Families feel that they are deriving support and benefit, referrals are being made, some needs are being met, and some education has taken place.

The start-up year of any program is fraught with difficulties and Advocacy has had its share. The indications are, however, that a good beginning has been made and that the benefits should be considerable if the effort is continued.

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CHAPTER I

THE ADVOCACY CONCEPT AND THE EVALUATION DESIGN

1.0 Overview

The Child Advocacy Components of the Parent-Child Center (PCC) program have completed their first year of operation and are currently into their second year. The present report by the Center for Community Research (CCR) is designed to tell the story of the start-up year. This is the third report in a series which includes a report on the program at its inception, and a volume of six-month case studies.

The Child Advocacy program was developed as a component of the Parent and Child Center (PCC) program, in order to expand the potential of the PCC program. The limitations of the PCC program were stated in a memorandum dated April 4, 1971, from the Director of the Office of Child Development (OCD) Dr. Edward Ziegler, to the Secretary of Health, Education, and Welfare:

1. Children enter the program after the period of gestation and delivery, sometimes without the benefit of adequate pre-natal and newborn care.

2. Children leave the program at age 3, in some areas without the benefit of appropriate continuing attention.

3. Older siblings are excluded as the primary objects of concern, and are benefitted only because of the need for total family development and parent participation.

4. In many areas, there is an absence or deficiency of the necessary supportive structures for child and family development (medical, social, educational).

5. PCCs serve only a very limited number of children and families in need, and community impact is, thus, diluted.

Seven of the 33 PCCs were selected by OCD staff as sites for Advocacy Components (ACs), to serve as a demonstration of the Advocacy concept and how it might develop as a part of the PCC program. The seven PCC/ACs are located in rather differing communities. Three PCC/ACs: Huntington, West Virginia; Leitchfield, Kentucky; and La Junta, Colorado, are located in rural communities. One of these serves Mexican-American families primarily; the second and third serve other Caucasian families primarily. The four urban Components: Baltimore, Md., Cleveland, Ohio; Boston, Mass., Jacksonville, Florida all serve predominantly black populations. Two Components define public housing projects as their target area, the other two deal with areas surrounding the projects. In the rural communities and in one southern urban community there is a scarcity of resources available to the target population. In the remaining three urban communities there are extensive resources, but these tend to be unresponsive to the needs of the community and therefore under-used by the target group.

The Child Advocacy concept was given considerable emphasis during the 1970 White House Conference on Children. It was pointed out that both parents and child-serving agencies often fail in meeting the needs of children because of lack of resources and lack of knowledge. The Child Advocate was defined as an individual who, acting on behalf of children, would help them secure their basic needs. The Advocacy Component of the

Parent-Child Center is defined as a model designed to meet the needs of children from birth to five years, and their families, through local service integration and, where necessary, the creation of new services. Reflecting the original concept, the needs of each family were assessed through survey procedures. Family needs were to be met by educating community residents to use existing services, by helping toward the better integration of existing services and, whenever necessary, by advocating for and assisting in creation of new services.

The first task for the Advocacy Components was to develop specific program objectives with the consultation of, and within a framework provided by, the Office of Child Development. From the time of this initial definitional activity, on a monthly basis throughout the program year, CCR has followed the development of program objectives and kept track of the weaving and twisting of a dynamic program in its formative year. Chapter II of this report is devoted to objectives, and to a complete description of what they were initially, and how and why they changed.

Subsequent to the development of objectives, ACs focused on needs assessments, developing relationships, making referrals on behalf of families, and on developing a core of knowledge and establishing relationships with community resources. The development of relationships with families, and a discussion of what was done for families is the subject of Chapters III and IV. Each of

the seven projects sent information to CCR monthly on the number of families telephoned, the number home visited, and the number referred. The nature and outcome of each referral was described briefly. Data on telephone calls, home visits, and referral activity to all Advocacy families are presented in Chapter III. In addition to the monthly monitoring, CCR conducted interviews with a representative random sample of families within the first month of program operation (T1) and after a year of program (T2). Data from interviews with this sample are used to supplement the more limited program statistics. Data on the sample families are presented in Chapter IV. These data provide a documentation of AC efforts. Essentially, they provide information as to how many people received which kinds of services, together with consumer evaluations of both Advocacy and community services. No formal attempt has been made to measure the impact of the ACs on the families served; the implicit assumption of the evaluation has been that getting people to necessary services has an impact on their lives. When considering such basic issues as health, housing, food, and clothing, it is assumed that concrete data at the immediate criterion level, are adequate to justify a program. In addition to the presentation of enumerative data, some of the stories underlying the numbers are presented to allow the families themselves to speak to the issue of the difference that Advocacy has made in their lives.

Following an initial period devoted to the assessment of needs and the establishment of relationships with families, a number of Components began implicitly or explicitly to work toward the goal of educating families to the need for, and use of services. An initial assumption of the Advocacy Coordinators appeared to be that the major constraint to service utilization was an impersonal, fragmented and inhospitable system of service delivery. As the year proceeded, and as many of even the best AC efforts to refer families were not followed through by the families, there was increasing recognition that underutilization of services resulted not only from poor service delivery systems but also from the orientation of a consumer group which responds primarily on a "crisis only" basis and which therefore seeks out services only in cases of emergency. Thus, education of AC families, not originally explicit in the national goals for the program, became an important focus in several Components. Attempts to organize workshops, mass meetings, and ongoing groups are detailed in Chapter V.

The processes of identifying community resources, of developing a core of knowledge about services offered, of understanding eligibility requirements and staff responsibilities, and of building collaborative relationships with other agencies are detailed in Chapter VI. CCR interviewed the AC Coordinators about their relationships with other agencies initially and updated this information during the course of three subsequent on-site visits. In

addition, CCR conducted interviews at 4-6 key agencies within each community both at the time of program inception and at the end of the first year.

The final chapter of the report focuses on the AC staffs. Described are staffing patterns, turnover, staff responsibilities, and staff training.

2.0 Methods of procedure

Although the seven ACs required varying lengths of start-up time, all seven were operational by April, 1972. CCR interviewers initially visited each site between April 15 and May 19, 1972.

During the initial visit, a minimum of three hours was spent in interview sessions with the Advocacy Coordinator. All full-time staff members were interviewed for between 30 and 60 minutes. Twenty-five parents of families whom the AC intended to serve were interviewed. Finally, interviews were conducted with representatives of four or five agencies with which each AC expected to work most closely.

Sampling of families within ACs was based on lists supplied by the ACs of families with whom each Advocacy Component expected to work. Lists ranged in numbers from 75 to more than 150. An initial list of 100 families with which the Component planned to work was an OCD requirement. These names had been generated through various forms of prior needs assessment activities.Twenty-five "primary

targets" were then selected from each list, using random number tables, with 10 or more alternate names also being selected in the event that some of the original 25 were unavailable or unwilling to be interviewed. In actual practice, due to the problem of target subjects not being at home, (particularly in rural areas where follow-up was unfeasible), approximately a quarter of the family interviews were conducted with families living in close proximity to either the primary targets or their alternates.

The pre-selected names were returned to the AC in advance so that families selected could be contacted and advised that interviewers would stop by at a predetermined time. Most interviews were conducted in the homes. However, at one AC the families were selected for interviewing after the arrival of the interviewers, and some of the parents chose to be interviewed at the PCC rather than being met in the home.

AC staff accompaniment during both T1 and T2 visits at most Components turned out to be an excellent technique from the standpoint of both research and program staff. The research staff was able to gain entré and ready cooperation from the interviewees. During T2 visits, in particular, AC staff members were able to provide additional information about each respondent. Conversely, AC outreach staff members reported that they learned from the experience of watching trained interviewers work, and that they often become aware of previously unrecognized needs.

In addition, post-interview discussions between CCR and AC proved mutually stimulating.

Appointments for the interviews with agencies in the communities were made by AC staffs. These interviews were conducted at each respective agency, with either the head of the relevant service, or with a senior staff delegate of that person. An AC staff member accompanied the CCR interviewer during approximately one-fifth of these interviews.

At the rural ACs, T1 interviewing took from 8 to 10 man days. Each site was visited by at least two staff members for 4 or 5 days. At the urban Components the interviewing generally took two staff members for three days each. T2 interview visits were typically shorter because of the decrease in the number of families available for re-interview.

Site visits were conducted in May, 1972, in September, 1972, in February, 1973, and in May, 1973. The September and February visits were generally of two or three days duration and were designed to update information on relationships with families and agencies, the ongoing process of staff training, and on the overall style and functioning of each AC. The May visit was for the purpose of updating all this information and rounding out the picture of the first year, but also for the purpose of conducting T2 interviews with families and agency administrators.

CHAPTER II

NATIONAL GOALS AND LOCAL PROGRAM OBJECTIVES

1.0 Introduction

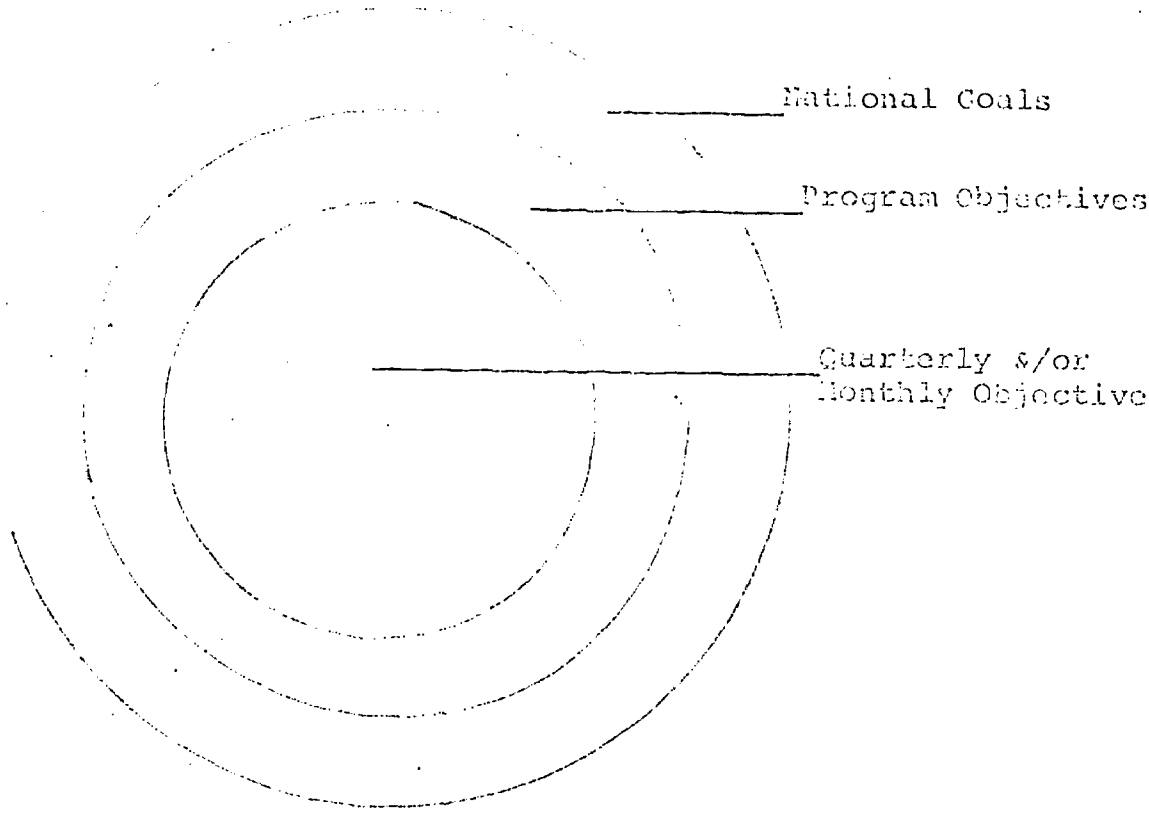
This chapter is intended as an overview which focuses on both National goals and local program objectives. OCD goals for the program are presented, as are the ways in which the OCD goals were structured at the local level. The relationship between National goals and local objectives and changes in objectives are also presented. Specific details related to each goal are discussed more fully in the rest of this report.

The data presented in this chapter derive from four sources:

- The objectives developed by each Component for its first year of operation.
- Quarterly objectives developed by each Component.
- Four site visit interviews with AC Coordinators.
- Monitoring calls.
  CCR monitored the monthly objectives of the AC's by having a staff member call each Coordinator to find out what was planned for the coming month and what was actually accomplished during the previous month.

1.1 Patterning of objectives

The seven Advocacy Components, although different in terms of populations served and of host communities, all operate within the framework of similar goals and objectives. This may be graphically represented as follows:



The picture is one of interdependency and of discrete steps taken in order to meet program objectives and National goals.

1.2 The function and development of goals and objectives

1.2.1 National goals

The majority of the goals set forth on the National level are long-range in time scale; it cannot be expected that they will be accomplished within the first year of program operation. However, they do set forth the philosophy and framework within which the Components function, and specify areas for concentration.

While calling attention to focal areas, this is the level at which flexibility is greatest. The goals are broad-based and are, in a sense, statements of problems, the solutions to which are tailored differently by each individual Component.

1.2.2 Program objectives

Using the National goals as guidelines, each Component developed shorter-range objectives that focused more specifically on the needs of their particular community. It was the responsibility of each AC to translate National goals into measurable objectives that would take into account the concerns and needs of their client population, the nature of their community, the availability or limitations of existing resources and the manpower capabilities of the individual program.

The process used in deciding upon objectives varied from program to program. In some, workshops were organized to gain community input regarding areas of concentration for the new Component. Agency personnel, neighborhood residents, and PCC members and staff met to exchange ideas on the needs of the community, and the role that AC could play in meeting these needs. These workshops served two functions: they made the AC a more community-based program and they started the process of introducing the AC to its potential consumers and resource linkages. The objectives of most AC's were developed by the PCC Directors and AC Coordinators who drew upon their own knowledge of the community.

Regardless of how decisions were made, the program objectives were to form the structure which would define the basic operations of each Component.

1.2.3 Quarterly and/or monthly objectives

Quarterly and/or monthly objectives are set in the shortest time frame and are the most specific in nature. In a sense, these objectives structure the day-to-day "business" of Advocacy in that they are the tasks requiring immediate or near future attention. These objectives may be ongoing from month to month, such as continuing the needs assessment survey, or they may include activities such as arranging a mass meeting which will occur only once. Although specific and structured, the variety of possible monthly or quarterly objectives is great. That is, the desired end may be similar in many cases, but as there are few prescribed procedures for attaining the ends, the tasks set forth in these objectives can be as innovative and experimental as imagination and capability allow.

1.3 National goals as they relate to specific program objectives

The following presents the specific program objectives for the seven AC's and the National goals to which they are directly related. In cases where only a portion of the program objective is relevant to the National goal, that portion has been underlined.

NATIONAL GOALS	PROGRAM OBJECTIVES
#1. To identify the unmet needs of low-income families with children 0-5 years in a designated catchment area.	°Locate and assess needs of pregnant women and their families, assist with information, service referral and follow-through for both mothers and children. °To become personally acquainted and actively involved with the residents of the catchment area, but to concentrate on identifying the needs of pregnant females and their families, and setting up a referral system which provides a range of choices while our supportive involvement enhances their personal growth. °Pre-natal care: identify needs, assist in counseling, transportation, referral. °Family planning: identify family units, provide information, motivational efforts °Immunizations: identify needs, provide information, establish clinic relations, recordkeeping system. °Well-Baby Clinic: identify target children, establish referral system, provide information, recordkeeping, follow-through.
#2. To identify all private and public programs (local, State and Federally-supported) that provide services for residents in the catchment area, and to compile information on existing community services.	°Information services to make parents aware of resources for children and, in particular, to develop a Consumer Resource Handbook. °To develop a working relationship with agencies and policy makers whose work affects the target population, while assuming the role of middlemen as communicators, interpreters, and change agents. °Assessing health, nutrition, educational and social service resources. Taking steps toward improving services. °Establish guide document for all community resources. °Information services regarding home budgeting, public assistance; developing Consumer Guide to Resources.

NATIONAL GOALS	PROGRAM OBJECTIVES
#3. To identify the gaps between needs and existing services.	°No relevant program objectives.
#4. To promote the development of community resources which will fill gaps in existing services.	°Develop walk-in mini community health centers using concept of multi-disciplin health center. °Comprehensive health program through National Health Service Corps. °Solicit medical manpower through National Health Service Corps. °Obtain mobile health unit visits. °Assist in setting up licensing of day care facilities.
#5. To assist in bringing together a comprehensive and efficient delivery system of services.	°To develop a working relationship with agencies and policymakers whose work affects the target population, while assuming the role of middlemen as communicators, interpreters, and change agents. °Assessing health, nutrition, educational and social service resources, taking steps toward improving services. °Develop linkages to specialty groups and hospitals. °Coordinate transportation to services. °Immunizations: identify needs, provide information, establish clinic relations, recordkeeping system. °Assist in setting up multi-agency Child Advocacy Council. °Integration, mobilization and creation of Social Service resources.

NATIONAL GOALS	PROGRAM OBJECTIVES
#6. To assist families by referring them to specific agencies and follow-through to ensure that services are provided.	°Locate and assess needs of pregnant women and their families, assist with information, service referral and follow-through for both mothers and children. °To assist with information and referrals to help overcome housing problems. °To become personally acquainted and actively involved with the residents of the catchment area, but to concentrate on the needs of pregnant females and their families, and setting up a referral system which provides a range of choices while our supportive involvement enhances their personal growth. °Focal children's medical care: get more children to the clinic on a regular basis. °Family Planning: to assist with information and referral. °Conne ting families with needed services: make families and Component aware of needs, make referrals or appointments, follow-through. °Pre-natal care: identify needs, assist in counseling, transportation, referral. °Immunizations: identify needs, provide information, establish clinic relations, recordkeeping system. °Well-Baby Clinic: establish referral system, provide information, recordkeeping follow-through. °Child problems: screening and referral. °Effect model delivery system for Children's services - referral, transportation follow-through. °Assist in meeting medical, nutritional, and dental problems in the target population. °Assist in child development and child care °Assist in the provision of legal and financial advice. °Family Planning: identify family units, provide information, motivational efforts.

NATIONAL GOALS	PROGRAM OBJECTIVES
#7. To develop a training program for Child Advocates in concert with local colleges and other agencies.	°Develop a corps of Advocate Assistants. °Provide staff training. °To identify and train staff in interviewing skills, listening skills, observational skills, recording skills, knowledge of available resources, how adults learn, child rearing practices, etc. °Recruit and train volunteers. °Provide staff training.
#8. To ensure the delivery of adequate services to expectant mothers and their new-born babies.	°Locate and assess needs of pregnant women and their families, assist with information, service referral and follow-through for both mothers and children. °To become personally acquainted and actively involved with the residents of the catchment area, but to concentrate on identifying the needs of pregnant females and their families, and setting up a referral system which provides a range of choices while our supportive involvement enhances their personal growth. °Pre-natal care: see that more mothers receive better care, earlier in their pregnancies. °Pre-natal care: identify needs, assist in counseling, transportation, referral. °Assist in meeting medical and nutritional needs among pregnant women.
#9. To identify high-risk mothers and children so that necessary medical, nutritional and other needed services can be available to them.	°Special emphasis on teenage pregnancy. °Identify and aid high-risk pregnant women.

NATIONAL GOALS	PROGRAM OBJECTIVES
To heighten family awareness of existing and needed resources and to encourage the development of community organization efforts, at the family level. This goal is not set forth, formally, on the National level.	°Information services to make parents aware of resources for children and, in particular, to develop a Consumer Resource Handbook. °Encourage participation on Tenant Council. °Health education for parents. °Ongoing education in health and nutrition. °Family Planning: identify units, provide information, motivational efforts °Immunizations: identify needs, provide information, establish clinic relations, recordkeeping system. °Information services regarding home budgeting, public assistance; developing Consumer Guide to Resources. °Formation of Tenant Housing Committee to overcome housing problems.

As can be seen from this presentation, local objectives were developed in response to National goals. Activities undertaken in response to each of the National goals are detailed below.

National Goal #1: To identify the unmet needs of low-income families with children 0-5 years in a designated catchment area.

Three of the seven AC's list this goal as a specific program objective, although all Components are actively engaged in identifying the unmet needs of the target population.

In the first year of the Advocacy effort, 2422 needs assessments were completed. The needs assessment survey has served as a means of gaining entré to families' homes; as a tool for teaching interviewing techniques; and as a source of information on family problems, community concerns, community attitudes toward agencies, and gaps in community services.

Although considered a valuable and necessary aspect of program by almost every AC Coordinator, the needs assessments have also created some problems. It was intended to serve, or did serve, several and different functions which caused some difficulty. Initially, the local needs assessment was intended to provide each Component with information on the prevalence of various sorts of problems and needs. These data were meant to form the basis from which program objectives could be developed and prioritized. However, needs assessment surveys did not get underway until after objectives were developed and so the needs assessment was used in order to provide information on individual families. Thus the needs assessment was variously seen as a research instrument and a clinical assessment tool.

The needs assessment did serve its function as a clinical tool for the evaluation of individual family needs. Many of the needs assessments were treated essentially as intake interviews at a social service agency. In several programs the needs assessments have not been tabulated so that no data exist on incidence or prevalence rates of various problems.

As a research tool, local needs assessments sometimes lacked the specificity necessary for data reduction and for compiling information. For instance, at one Component where there was an interest in pre-natal care, the question was asked: "Did you receive pre-natal care?" After most women answered in the affirmative, the Advocate realized that the question offered no information as to at what point women in that community typically seek out medical care or how many visits characterize the typical pregnancy. Thus, although through the process of needs assessment pregnant women were identified, questions remain unanswered concerning the pre-natal care of the women in that community.

In addition to the differing views regarding intent and use, some Components misunderstood the time frame in which the needs assessment was to be set. Initially, several Coordinators thought that a certain number of needs assessments were to be completed through a concerted effort and then, through word-of-mouth, random contacts and agency referrals, more assessments would be done. In fact, the needs assessment survey is intended by OCD to be an ongoing activity. This mandate has several ramifications.

Some Components view the needs assessment as a means of introducing the AC to families, and of gaining credibility with families so that referrals can be effected. For these Components, whose primary objectives center around referrals,

an ongoing needs assessment presents problems in manpower allocation and, to some degree, program credibility. The problem is rather circular in nature: the more families which are assessed, the more problems that need referral; the more time spent on assessment, the less time available for referrals; if fewer referrals are being made, the less likely are people to support, trust and participate in the AC. This is most true of Components that adhere to a case model of Advocacy.

The necessity for ongoing needs assessments have more general positive results. Four AC's have, or are planning to expand their catchment areas so as to widen their populations for assessment. If these expansions can be effected without interfering with other aspects of the AC function, as discussed above, services to target families will increase beneficially.

In addition, a continuous needs assessment encourages change and reevaluation of both the program operations and of the assessment instrument. Several Components have revised their needs assessment questionnaires to focus on areas brought to the attention of the AC by previous assessments. One AC has amended its questionnaire so that the emphasis is now more on community issues than on individual needs and problems. If more Components would tabulate their needs assessments on an ongoing basis, and draw profiles of the information gathered,

these data could be used more effectively to structure program activities. The ongoing assessment can be a valuable and timely tool with which to measure program accomplishments and possible areas of deficiency.

National Goal #2: To identify all private and public programs (local, State and Federally-supported) that provide services for residents in the catchment area, and to compile information on existing community services.

Five of the AC's have translated this goal into a program objective. However, the process of identifying agencies and forming linkages is an ongoing activity at all Components. Of the five Components listing this as an objective, three AC's specifically mention the development of a Resource Guide. In fact, three guides have been produced, two for use by Advocacy families and one for internal and agency use. One other such guide is in the production stage.

All material relevant to this goal is presented in Chapter VI on the relationships between the AC's and community agencies.

National Goal #3: To identify the gaps between needs and existing services.

This goal is not listed as an objective by any AC as its content is dependent upon findings relating to Goals 1 and 2. That is, data obtained from the needs assessment survey should show community residents' perceptions of their unmet needs, and of needs that cannot be handled because of a lack or gap in services. The identification of service agencies should act

somewhat like a check upon the needs assessment data. In the process of learning about existing resources, the AC should also learn of the services that are not available.

The needs assessment should have served two functions in relation to this goal: (1) it should have catalogued residents' responses concerning service gaps, and (2) it should have provided information that the AC's could bring to the attention of Agency Administrators in order to show the extent to which a service gap is producing unmet needs. At most Components, the needs assessments were not used in these ways. Data obtained from the assessments, if tabulated at all, were not made available in a manner which would lend itself to such use. In addition, at most of the agencies interviewed by CCR, Administrators were unaware of the results of the needs assessment (in some cases, agency personnel were not aware of the fact that the AC's had conducted such surveys). Thus, information gathered from the needs assessments was not, for the most part, used to show the existence of service gaps or the need for new services.

In actuality, the process of identifying gaps between needs and existing services was more informal than the structure of the goals might lead one to believe. Needs assessment data may not have been tabulated for the purpose of pointing out gaps, however, the consensus "feeling" on the part of AC staff, concerning findings that focused on gaps in services, was taken into account. In addition, the PCC Directors and AC Coordinators,

having lived and worked in the community, had their own "feelings" about the nature of the important service gaps. Given this "sense" of the situation, discussion with Agency Administrators could verify the existence of a gap.

In some cases, actual gaps in services were uncovered. However, in other cases, gaps in services were found to exist not because there were not provisions for these services, but rather because the services were "on the books," but were not being implemented by the agencies. A discussion of this type of situation will be presented in Chapter VI.

National Goal #4: To promote the development of community resources which will fill gaps in existing services.

This is another goal which cannot be specifically translated into first year program objectives as its development is predicated upon findings obtained from activities related to other goals. However, one rural AC did include, "To develop walk-in mini community health centers" as an objective. It was possible to specify this objective prior to program implementation, because the gap between unmet needs and existing services had been well known to the entire community for quite some time.

The outcome of this objective and the results of other efforts by the AC's are described in Chapter VI.

National Goal #5: To assist in bringing together a comprehensive and efficient delivery system of services.

In one form or another, six Advocacy Components list this goal as a program objective. Like the three preceding goals, the processes involved in meeting this goal relate primarily to agency contacts and relationships. Thus, a complete discussion of this goal will be found in Chapter VI.

National Goal #6: To assist families by referring them to specific agencies and follow through to ensure that the services are provided.

All but one AC includes this goal in their lists of program objectives; and in all but one rural Component, this goal has structured the major part of the AC's activities. In a sense, movement toward meeting this goal represents a culmination of efforts expended to meet Goals 1 through 5. When AC staff members become engaged in making referrals and follow up to resources, data from families and agencies are in place. The variety of information gathered from needs assessments and agency identification activities is now put to use to serve the target population in a way which is, initially at least, most meaningful to them.

The process of referral and the statistics relevant to this area are presented in Chapter III.

National Goal #7: To develop a training program for Child Advocates in concert with local colleges and other agencies.

This goal is discussed more fully elsewhere, specifically in Chapter VII. However,at this time it should be noted that although all Components provide some form of training for staff members, four AC's include this goal as an objective.

At two urban Components, objectives called for the training of community residents as Child Advocates or assistants. As discussed later in this chapter, these objectives were deferred due to the unexpected amount and intensity of training needed by full-time staff members. At two other Components, AC Co-ordinators are teaching Advocacy-related courses at local colleges. Such courses serve to increase community awareness of AC efforts, in addition to widening the base of potential community Advocates.

National Goal #8: To ensure the delivery of adequate services to expectant mothers and their new-born babies.

This goal, closely related to Goal #6, has been translated into program objectives by five of the AC's. In practice however, this goal encompasses a large portion of the work done by all AC programs. To begin to meet this goal entails the identification of appropriate resources, the establishment of referral linkages, the location and assessment of the target population and then the performance of the referral process. These efforts have resulted in the identification of 403 pregnant women, the delivery of pre-natal care, well-baby services and immunizations from existing resources, in addition to the provision of specialized pre-natal services by the AC's themselves.

Complete information pertinent to this goal is presented in Chapters IV and V.

National Goal #9: To identify high-risk mothers and children so that necessary medical, nutritional and other needed services can be available to them.

Most AC's seemed to have had difficulty defining this goal and implementing activities specific to its accomplishment. Two Components include an emphasis on high-risk pregnant women in their objectives and have planned special programs for these groups. However, the work done for and with the children of these women is similar to that done for all target children.

For a period in the beginning of the program year, some Coordinators misunderstood the definition of a high-risk mother. When the term was defined to include expectant mothers who were under eighteen years of age, over forty, or incompetent, a total of 121 women were located and assessed.

The term "multi-problem family" was never defined operationally and was used by each Coordinator to characterize the situation of the majority of their families. This lack of clarity meant that almost any activity performed by the AC's in response to the needs of their populations constituted a step toward meeting this goal.

CCR has become aware of an additional goal at the National level which is implicit in the OCD conception of Advocacy. This goal can be defined as follows:

- To heighten family awareness and utilization of existing resources and to encourage the development of community organization efforts at the family level.

This goal, although not written into the National goals, is one pursued by all Components and specifically mentioned in the objectives of five AC's. In a sense, it describes the desired outcome of all Advocacy efforts, and thus forms a philosophical basis upon which activities are structured.

Although never clearly stated as a goal, it would seem that no AC could properly fulfill its mandate without including in its work plan measures that would effectively disseminate information to the target population. These measures can be as elaborate as a mass meeting or as simple as a short discussion held between an outreach worker and a family during a home visit. The emphasis on education of families as inextricably tied to the referral process, differentiates Advocacy referrals from traditional casework referrals. For instance, an emphasis on education of the families means that ideally AC workers do not merely refer persons to the health clinic, but also explain to the family their rights as patients, provide them with a clear notion of the importance of the particular type of health care, and outline for them the needed steps to properly negotiate the health care delivery system.

When interviews were first conducted with AC staff members in May, 1972, the concept of increasing community awareness was already a part of the AC program. The majority of staff interviewed at that time said that they saw their main goal as: "Working themselves out of a job." The idea was to train each individual to be an Advocate for himself and his family, thus making an organized program unnecessary. While workers now realize that this is a goal requiring more time than originally anticipated, Coordinators and staff members still speak of creating an independent, vocal, and cohesive community as a primary objective.

1.3.1 General vs. specific objectives

In drafting program objectives, the individual Components had to make decisions as to how to best structure their efforts. To this end, some programs wrote very general, broad-based objectives, under which a variety of tasks could be included. Other program objectives were highly specific, making focused tasks a necessity. Each type of objective has its advantages and drawbacks:

GENERAL OBJECTIVES	SPECIFIC OBJECTIVES
Longer time frame	Shorter time frame
Flexible tasks	More focused tasks
Difficult to evaluate	Easier to evaluate

General objectives, being broader in scope, take longer to fulfill and, in some cases, may never be completed. These objectives may involve ongoing tasks, such as monitoring which, while effecting noticeable change and progress, may theoretically continue throughout the life of the AC. However, they do allow for a great variety of possibilities in terms of tasks considered relevant to the accomplishment of the objective. This seeming advantage of task variety also makes evaluation of "success" somewhat difficult.

The following may serve to illustrate the above points:

- GENERAL OBJECTIVE - "To develop a working relationship with agencies and policy makers whose work affects the target population, while assuming the role of middlemen as communicators, interpreters, and change agents."

- SPECIFIC OBJECTIVE - "Assist in setting up multi-agency Child Advocacy Council."

Although very different in scope and focus, these two objectives led to the establishment of Advocacy Councils comprised of agency representatives and AC staff members. The Component whose objective was general, took several steps, other than the organization of the Council, in order to fulfill the objective within its framework. However, this Component was not bound to develop a Council; the AC with

the specific objective, may have taken the same types of actions as the other Component, but had, in some sense, made a commitment to the establishment of a Council. In terms of evaluation, the Council developed as a result of the general objective is a progress step toward accomplishment, whereas the other Council in some way represents an end point.

1.3.2 Revisions and/or changes in objectives

Regardless of whether they are broad-based or specific, objectives have been changed and even dropped. Although the reasons vary, generally objectives are changed or dropped because the need is not as great as originally anticipated or the objective is unrealistic in terms of present capabilities. The following are examples of such changes:

- Identifying the unmet needs of and providing appropriate referrals for pregnant women.

All but one Component lists an objective similar to the one above. The one Component that does not is a rural AC whose primary objective is that of establishing basic health care facilities.

This is a broad objective that allows for a variety of tasks, however four Coordinators have said that the need for AC involvement in this area is not as great and/or specific as anticipated. These four Coordinators, from both urban and rural programs, have not identified many expectant mothers in need of pre-natal attention. Data from all Components

submitted on the Supplementary Monthly Monitoring Forms, show that of the 403 pregnant women identified through needs assessments, only 39 reported that they were not receiving pre-natal care. At one Component, 51 pregnant women were interviewed during the initial needs assessments survey and it was found that 49 of these women were receiving pre-natal care. Although not abandoning efforts for this group, the emphasis has, in some sense, been scaled down.

- To effect appropriate health referrals to all Advocacy families.

This is a general objective that encompasses several areas: well-baby services, immunizations, check-ups, dental examinations, etc. The trend, in relation to this objective, seems to be to concentrate on some areas more heavily than others. Thus, more referrals are made for check-ups or medical coverage enrollment than are made for dental care. Efforts to help families receive check-ups appear to be ongoing, while those in other areas seem to be handled on an "as-needed" basis.

- Obtain mobile health unit visits

This objective is not only specific in scope, but also specific to the needs of a particular AC community. Health unit visits were obtained, but because of poor turnout rates and the AC's interpretation that families were anxious regarding the unit, the objective has been re-evaluated. The community need for a health care facility remains the same, but the altered objective for meeting this need now includes the establishment of a permanent, free clinic.

- To develop a corps of Advocate Assistants

This is an example of an objective chat had to be deferred because of present resource capabilities. Two urban Components had hoped to train community volunteers to act as Advocates. At the time that this objective was developed, neither AC Coordinator was aware of the time commitment necessary to train regular staff. Given the priority to train permanent staff members, the development of a volunteer corps was seen by the Coordinators as unrealistic at this time.

At one rural AC, the revisions made did not entail just one or two objectives, but rather a reorientation of the total program. This Component moved from a basically casework approach to a class Advocacy orientation with a greater emphasis on community organization.

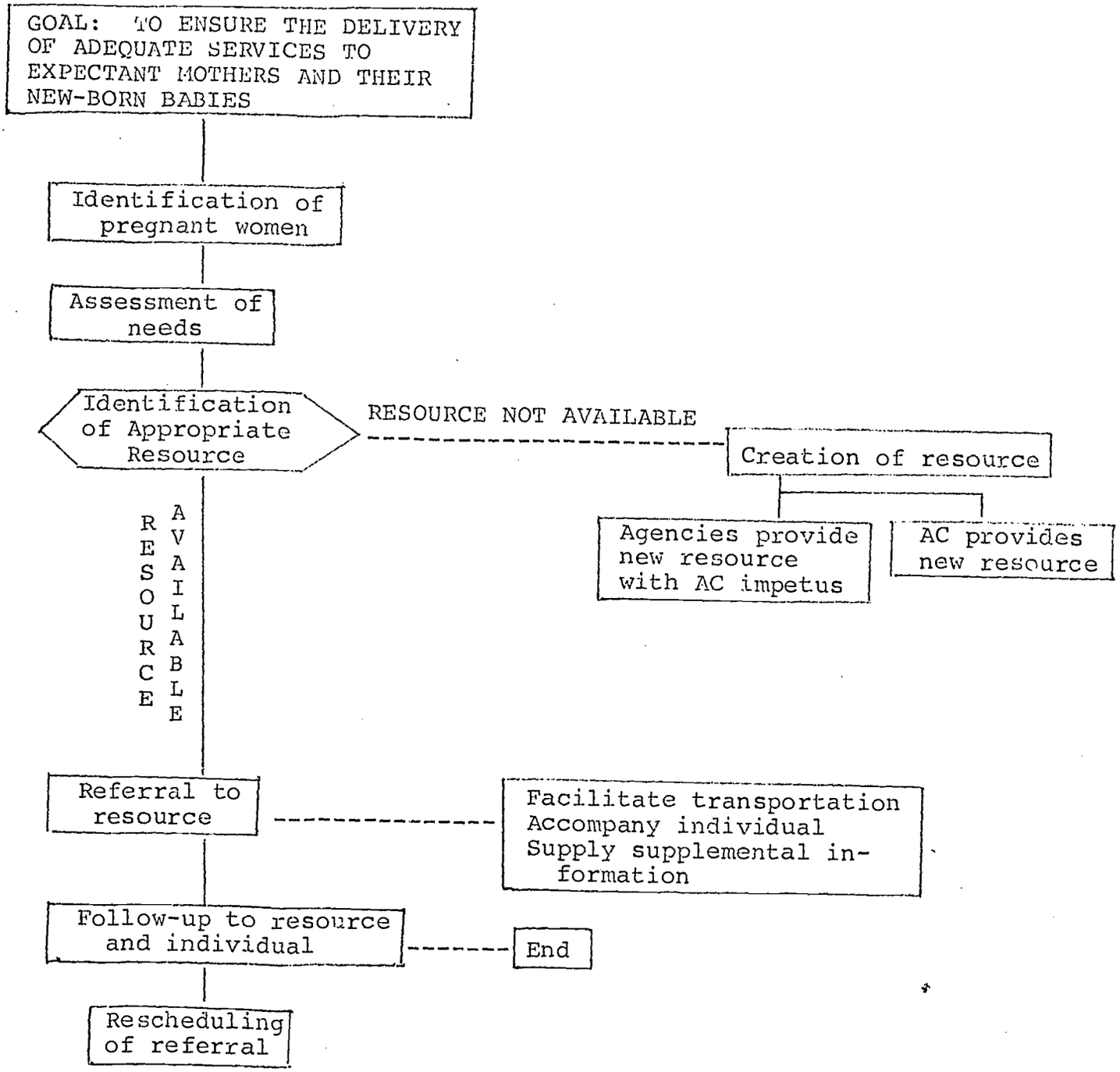
1.4 The process of achieving objectives

1.4.1 The relation of objectives to National goals

The interrelationship between National goals and objectives means that a task completed toward accomplishment of one objective touches upon another. The table below illustrates some possible overlapping in tasks and the number of the National goal to which they may be relevant.

NATIONAL GOAL NUMBER	TASK
1	Door-to-door needs assessment survey
8, 9	Special group sessions
6, 8, 9	Development of information dissemination techniques
6, 8, 9	Facilitating transportation
6, 8, 9	Accompanying individuals to resources
1, 3, 6, 8	Meeting with community representatives
1, 6, 8, 9	Casework-type home visits
1,2,3,4,5,6,8,9	Agency contacts and visits
1,2,3,4,5,6,7,8,9	Meetings with agency personnel

On a more specific level, the proceeding chart represents the possible steps to be taken in effecting achievement of a goal.


GOAL: TO ENSURE THE DELIVERY OF ADEQUATE SERVICES TO EXPECTANT MOTHERS AND THEIR NEW-BORN BABIES
Identification of pregnant women
Assessment of needs
Identification of Appropriate Resource
RESOURCE NOT AVAILABLE
Creation of resource
Agencies provide new resource with AC impetus
AC provides new resource
RESOURCE AVAILABLE
Referral to resource
Facilitate transportation
Accompany individual
Supply supplemental information
Follow-up to resource and individual
End
Rescheduling of referral

As can be seen from this discussion, the process of defining objectives and of relating these to National goals is highly complex. The remainder of this report is devoted to the process of evaluating to what extent progress has been made toward meeting National goals.

CHAPTER III

THE FAMILIES SERVED BY THE ADVOCACY COMPONENT: DATA ON ALL FAMILIES, AS REPORTED BY THE AC's

The activities reported on in this and the next chapter relate to National Goal #6, namely:

- to assist families by referring them to specific agencies and follow through to ensure that the services are provided.

Data presented in this chapter reflect AC activities on behalf of families, and the relationships between the Advocacy Components and the families served. The discussion is based on numbers collected monthly from each of the Components. The CCR Information System generates program statistics regarding the number of telephone calls and home visits, a brief description of the underlying reasons for every referral, and the outcome of every resource contact on behalf of a family.

1.0 Known characteristics of the AC population

No two Components used the same needs assessment instruments. Therefore, uniform data relating to the demographic and need characteristics of the total AC population are not available. Data on a few key issues were collected from the Components monthly, in uniform fashion. These data are presented in Table 1, below.

Table 1. Characteristics of the AC population as a whole.

	TOTAL	URBAN	RURAL
Needs assessments	2,422	1,493	929
Children 0 - 5	4,739	2,212	2,527
Pregnant women	403	227	176
Receiving pre-natal care	364	215	149
% pregnant women receiving care	(90)	(94)	(84)
High-risk pregnant women	131	80	51
Under 18	111	74	37
Receiving pre-natal care	102	74	28
% receiving pre-natal care	(91)	(100)	(75)
Over 40	20	6	14
Receiving pre-natal care	13	3	10
% receiving pre-natal care	(65)	(50)	(71)
Unimmunized children	790	444	346
% of all children identified	(16)	(20)	(13)
Children 0-5 not receiving medical care	452	153	299
% of all children identified	(9)	(6)	(11)
Families on:			
Welfare	1,504	1,237	267
Commodities/Food Stamps	1,220	905	315
Medicaid	1,214	959	255

Needs assessments were conducted on a total of 2,422 families with children ages 0-5. Over one-half of the families assessed are on welfare. Four thousand seven hundred thirty-nine low income children ages 0-5 were identified during this first year of the Advocacy program.

Several issues, which were part of the original OCD mandate, never emerged as important problems. For instance, very few high-risk pregnant women over the age of forty were identified. Similarly, the number of pregnant women identified who were not receiving any pre-natal care was considerably less than anticipated. Ninety percent of the women identified were receiving some kind of pre-natal care. However, the concern about immunizations was supported by the first year's experience. Seventeen percent of children ages 0-5 were unimmunized at the time of the needs assessment.

2.0 Telephone contacts

The total number of telephone calls, the number of different families called, the mean number of families called among families telephoned as well as among all AC families, the median and the range of number of calls in three rural and four urban Components, are presented in Table 2. All figures represent the number of calls made over the twelve month period.

Table 2. Number of telephone calls, number of different families, mean, median, and range of calls among rural and urban families.

	COMPONENT	NO. TELE. CALLS	# DIFF. FAMILIES CALLED	MEAN # CALLS/ FAMILY AMONG FAMILIES CALLED	MEAN # CALLS/ ALL AC FAMILIES	MEDIAN # CALLS	RANGE
RURAL	1.	142	57	2.49	.69	0.69	0-28
	2	39	29	1.34	.21	0.59	0-3
	3	63	31	2.03	.31	0.55	0-20
URBAN	4	313	160	1.96	1.29	1.46	0-7
	5	1081	335	3.23	1.88	1.35	0-22
	6	508	170	2.98	1.22	0.84	0-8
	7	407	174	2.34	1.49	1.36	0-11
TOTAL		2553	956				

A total of 2,553 telephone calls have been made by the AC's to 956 different families. Individual program means, medians and ranges are presented, rather than overall program statistics because the variation is so great.

It is clear from the data on telephone calls that the telephone is not consistently used by any Component for keeping in touch with families (an average of fewer than two calls per day per center). A large proportion of families has never been called. The absence of phones or the difficulty of getting

through to families on party lines makes this form of contact almost irrelevant in some rural areas. On the other hand, a very small proportion of families has been called a great many times, as is evident from the wide range in frequency of calls at several Components. However, the mean and median number of calls per family, even among families who were called at all, is small.

3.0 Home visits

The total number of home visits, the number of different families visited, the mean number of visits per family among families visited and among all AC families, the median, and the range of home visits, are presented in Table 3.

Table 3. Number of home visits, number of different families, mean, median, and range of visits among rural and urban families.

	COM-PON-ENT	NO. OF HOME VISITS	# DIFF. FAMILIES VISITED	MEAN # VISITS/ FAMILY AMONG FAMILIES VISITED	MEAN # VISITS/ ALL AC FAMILIES	MEDIAN # CALLS	RANGE
RURAL	1	1,154	201	5.74	5.63	4.84	0-37
	2	430	179	2.40	2.28	2.09	0-10
	3	1,164	184	6.33	5.65	2.31	0-36
URBAN	4	491	194	2.53	2.03	1.87	0-11
	5	1,261	497	2.54	2.19	1.89	0-16
	6	1,200	404	2.97	2.89	3.03	0-10
	7	1,231	254	4.85	4.20	3.70	0-24
TOTAL		6,931	1,913				

In Components one and three where the major program focus is on developing relationships with families, 184 and 201 different families were visited respectively, for an average of slightly more than five visits each. However, the average is misleading: while a few families were visited many times, some were not visited at all, and most were visited far less than the once every two months implied by the average value.

In both these Components, monthly home visits are considered a program ideal to which the AC aspires. The inability to meet this self-initiated goal is a function of many factors: transportation problems; poor weather, which at times makes almost any visiting impossible; and the extra attention required to assist certain families at particular times. In addition, if families are not home when a visit is made, often the visit cannot be rescheduled for the same month.

In Component two, the major focus is on class advocacy rather than on case advocacy. In this Component, the greatest emphasis is on working with other agencies in order to educate and stimulate the community to organize and advocate for better health care, education, and housing. Although the number of different families who have received home visits is essentially the same as in the other rural Components, the amount of contact with each family has been considerably less. On the average, families at this Component have received two visits.

Components five, six, and seven have conducted approximately the same number of visits as Components one and three. However, the urban Components have visited a far greater number of different families. Thus, while rural Components one and three have visited 184 and 201 different families, respectively, urban Components five, six, and seven have visited between 254-497 different families.

As might be expected, those Components reporting visits to a larger number of different families see these families less often than do those Components which visit fewer families. Most families in the urban Components have been visited between two and four times. (As is apparent from the range of number of visits, there are a few families at each of these Components which have been visited with far greater frequency.)

Component four has conducted a third as many visits, to a smaller number of families, than any other urban Component. In fact, the pattern of home visits at this urban Component is more similar to rural Component two than it is to any of the other urban Components.

4.0 Referrals

The data on referral activity for the Components are presented in Table 4, below. Throughout this report, a referral is defined as the notification of a family, as well as of a resource, that the services of the resource are needed. Any one

referral may require several, or in some instances many contacts, with both the family and the resource.

Table 4. Number of referrals, number of different families, mean, median, and range of referrals among rural and urban families.

	COM-PON-ENT	# OF REFER-RALS	# DIFF. FAMILIES REFERRED	MEAN # REFERRALS/ FAMILY AMONG FAMILIES REFERRED	MEAN # REFERRALS/ ALL AC FAMILIES	MEDIAN # CALLS	RANGE
RURAL	1	220	117	1.88	1.07	1.22	0-7
	2	72	47	1.53	.38	0.67	0-5
	3	442	112	3.95	2.15	1.20	0-20
URBAN	4	559	204	2.74	2.31	2.29	0-11
	5	349	178	1.96	.61	0.72	0-8
	6	393	199	1.97	.95	0.95	0-7
	7	415	232	1.79	1.42	1.70	0-6
TOTAL		2,450	1,089				

The seven Components have made 2,450 referrals on behalf of 1,089 families. It is interesting to compare these figures with those relating to the number of home visits. Overall, nearly three times as many home visits as referrals have been made to almost twice as many different families: there are over 800 families which have been visited but never referred.

Comparison of data in Tables 3 and 4 is particularly striking. At all three rural Components and at three urban Components, more families have received home visits than they have referrals. In Component 1, 117 different families have been referred, 201 have received home visits; in Component 2, 47 families have been referred, 179 have received home visits; in Component 3, 112 families have been referred, 184 have been visited at home; in Component 5, 178 families have been referred, 497 have been visited; in Component 6, 199 families have been referred, 404 families have been visited; and in Component 7, 232 families have been referred, 254 families have been visited. Only in Component 4 does the referral rate outstrip the number of home visits.

Among those families who have had a referral, the average number of referrals per family at the various AC's ranges from less than two to almost four. However, among all AC families with which the AC's have had some contact, the different AC averages range from almost zero to only slightly over two. In Component 2, only 1 in 3 families has received any referral.

The relatively low level of referrals compared to home visits can be attributed to several factors. First, and most important, it is difficult to motivate many of the families to follow through on a referral. In many cases, repeated home visits are required in order to effect a single referral. In

Components where transportation was initially provided and then decreased sharply, still additional visits and more concentrated efforts were required to motivate families to keep referral appointments. Where transportation is provided (in the rural areas) all outreach workers report numerous instances of having gone to pick up a family for an appointment, only to be told that the family cannot, or does not wish to, keep the appointment on that particular day. In several Components, excellent resources were identified and mobilized on behalf of the families; however, even with repeated home visits and follow-up, very few families used the resource. One of the lessons learned from this first program year has been that, even with the most personalized approach, many families are very difficult to motivate. With regard to preventive services in particular, major efforts are required in order to foster and maintain an adequate level of motivation among a group which heretofore responded only to needs of a crisis nature.

A second factor contributing to the low referral/home visit ratio, is the paucity of resources to which families can be referred in rural areas. Most of the families are already on welfare; unless the family has a health problem which has gone unattended, i.e., if a family has not had immunizations nor health examinations, there is little additional service available. On the other hand, in urban areas where many families were found to be using various services already, existing services are not

necessarily the answer to a family's problems. For instance, the often desperate housing situation of many families can be resolved by a referral in only rare instances.

As will be discussed in the next chapter, many families feel that they derive considerable benefit from the home visit itself. They feel supported, liked, and as if there is someone on whom they can depend. It had been anticipated that once a family's needs had been assessed, appropriate referrals would be made and that, in the process, the families would learn how to negotiate the complexity of the various service delivery systems. Thus, the relationship between the AC and most families was to be time-limited and defined in terms of referral. In practice, the inability of many families to mobilize themselves or resources on their own behalf has led to the maintenance of ongoing relationships. There are families which need an ongoing supportive relationship. This, too, contributes to the low referral/home visit ratio.

While most families have had between 0 and 2 referrals, it is clear from the ranges presented in Table 4 that a few families have had a very large number of referrals. The following chronology of referrals made on behalf of one rural family illustrates the kinds of problems frequently encountered

during the referral process; these problems are particularly characteristic of families on whose behalf a large number of referrals have been made. (Fifteen referrals were made on behalf of this particular family.)

MAY 5 home visits

- This family needed clothing which the AC provided as its in-kind service.
- The mother was interested in family planning services. The AC facilitated transportation to the health department. Birth control methods and counselling were made available.
- The AC contacted three agencies to learn whether it would be possible for the mother to obtain support for her children from a previous marriage. This could not be done since there was a husband, able to work, living in the home.
- The AC provided educational material and information to this family.
- The AC again provided clothing.
- The AC contacted and made an appointment with a dentist for treatment of the family. The appointment was kept and follow-up appointments were scheduled.

- Appointments were made for medical examinations for the family.

- The family was interested in finding new housing. The AC contacted several resources, made appointments.

JUNE 1 home visit

- Family needed clothing and received it through AC.

JULY 2 home visits

- The family was having problems with their mail delivery. They never received a notice that their bank account was overdrawn and that the sheriff had summoned the family with a warrant. The AC is working with the Post Office to correct the situation.

AUGUST 5 home visits

- Dental treatment needed. The AC contacted a local dentist but the family had to wait for an appointment.

SEPT.

- Follow-up on problem with Post Office. Post Office will now send all of the family's mail to one station for pick-up.

OCTOBER 1 home visit

DEC. 2 home visits

APRIL

- Family needs a medical card. Applications had been mailed to the family but the AC was needed to help in their completion.
- The AC did a follow-up on the problem of obtaining support for the children of a previous marriage. A recent court ruling stated these children were eligible for a monthly grant if they are not being supported by the absent parent. The AC contacted Public Assistance and filed an application for this grant.
- The AC again made a referral to the Health Department for family planning services.
- The family needed winter clothing. The AC provided them with it, and material for clothing as well.
- The mother has diabetes. The AC arranged for diabetic screening tests and contacted the Health Department to give the tests.

This chronology is illustrative of the many types of referrals made on behalf of some families and of the many contacts to different agencies and home visits required to complete these referrals.

The graphs on the following seven pages represent a pictorial display of home visit and referral activity at each of the AC's on a month-by-month basis.

The graphs highlight the following points:

- Home visit activity outstrips referral activity at all but one urban Component.
- There is marked fluctuation in home visit and referral activity from month to month. Such fluctuation is related to other program activities, which at times compete for the outreach worker's time and preclude her making home visits or referrals. Also, in rural areas, activity tends to decrease during the winter months when roads are often impassible.

Figure 1. Home visit and referral activity in Component 1.

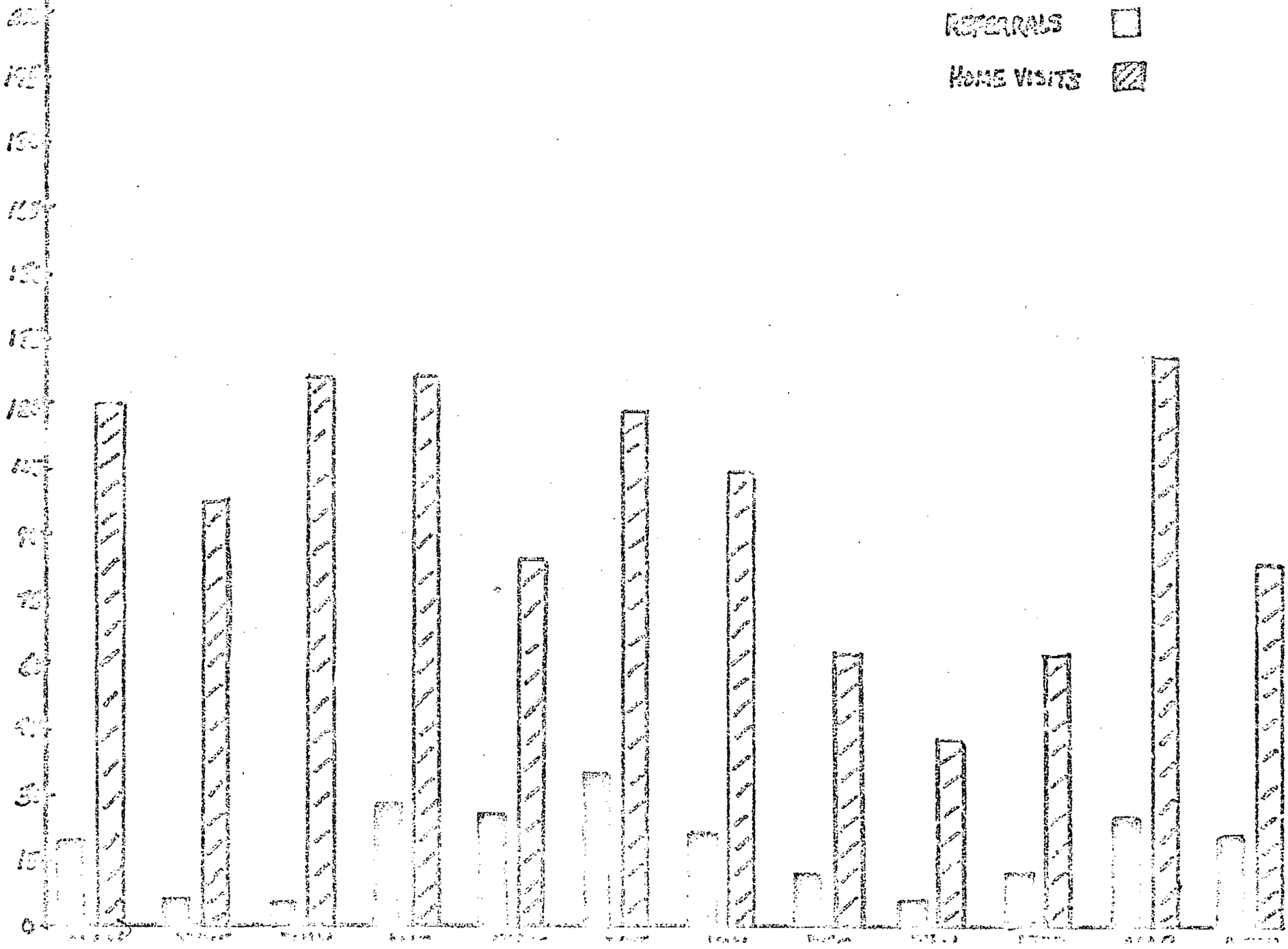


Figure 2. Home visit and referral activity in Component 2.

Figure 3. Home visit and referral activity in Component 3.

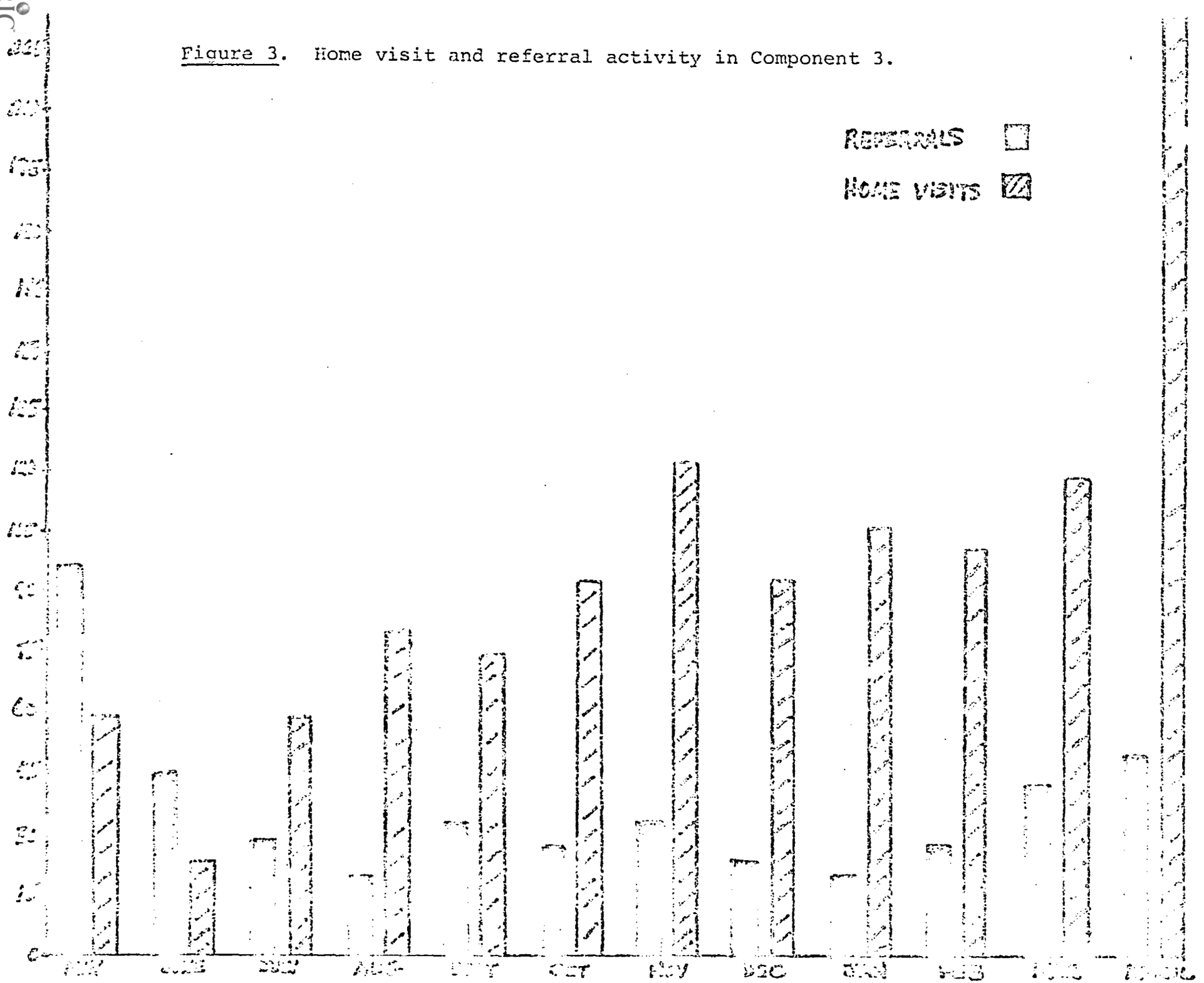


Figure 4. Home visit and referral activity in Component 4.

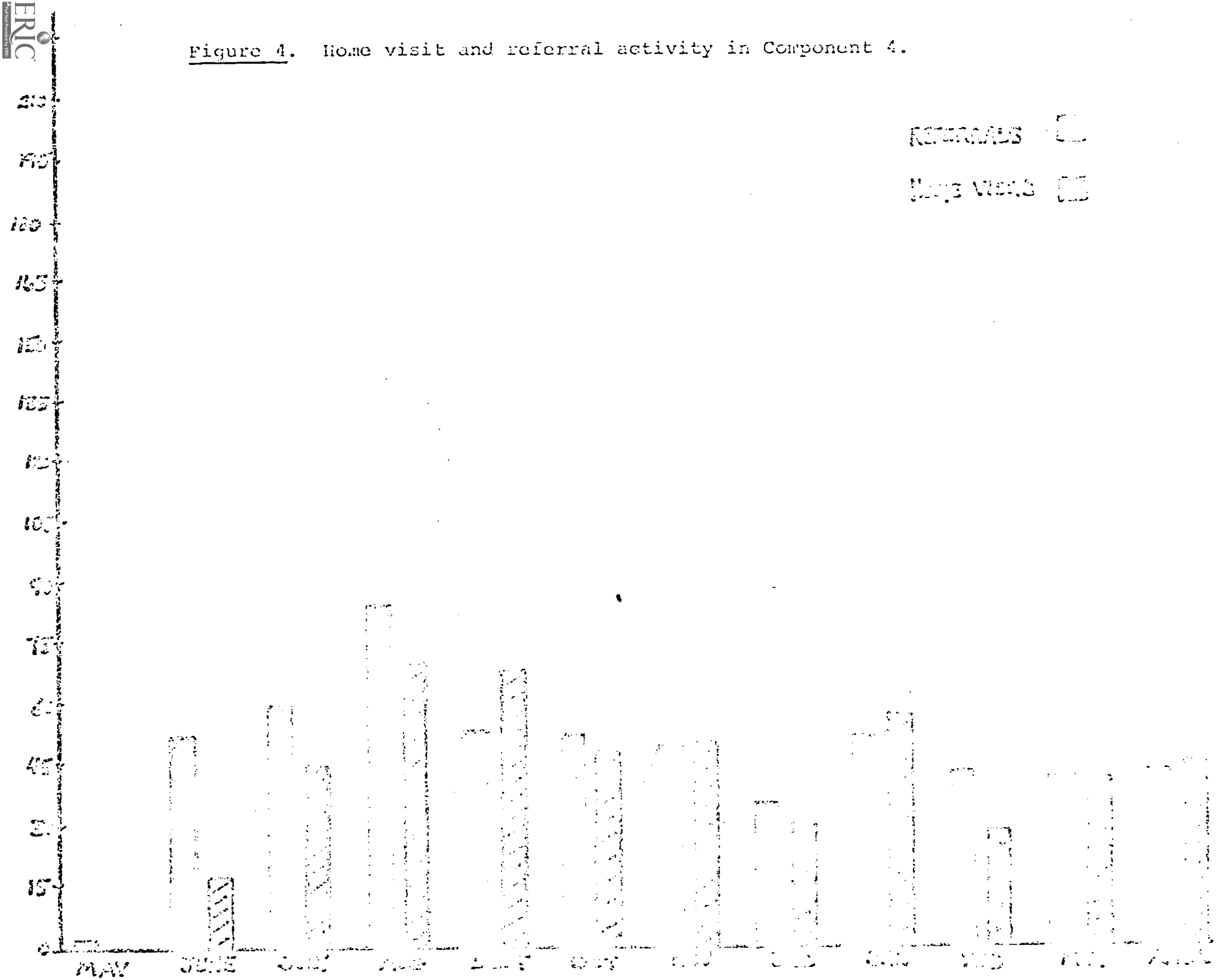


Figure 5. Home visit and referral activity in Component 5.

Figure 6. Home visit and referral activity in Component 6.

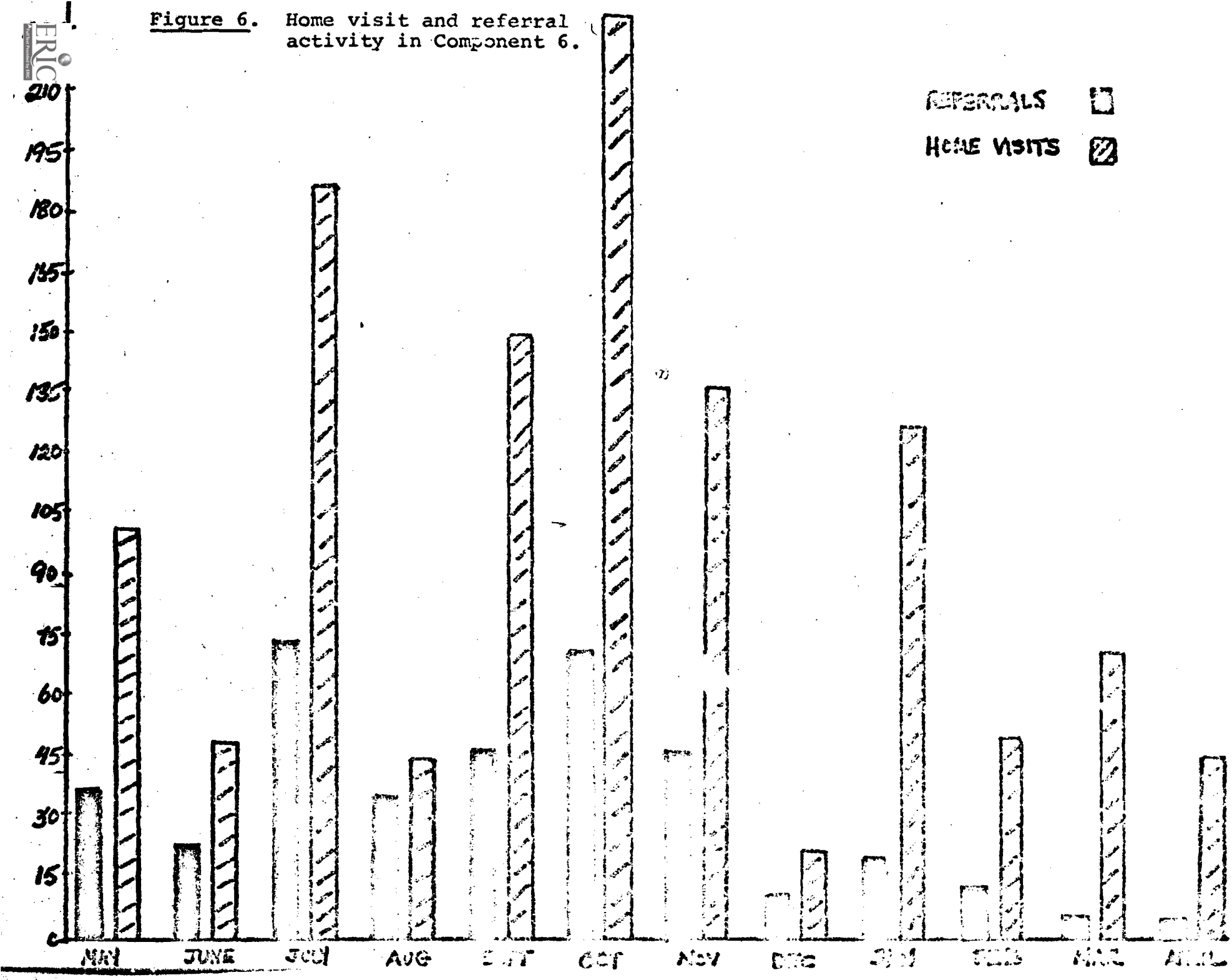
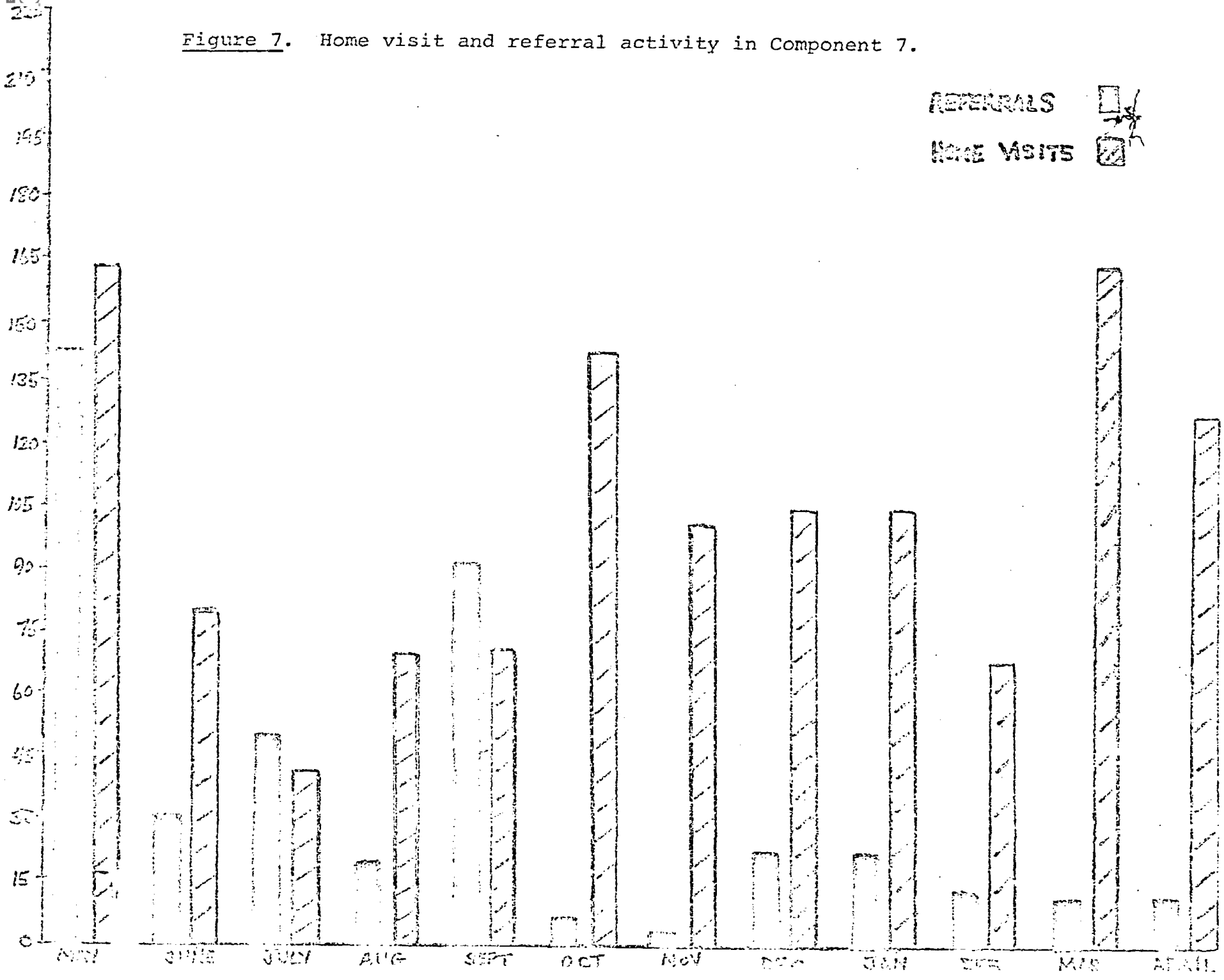


Figure 7. Home visit and referral activity in Component 7.



4.1 Types of referrals

A tabulation of referrals by major service area is presented below in Table 5.

Table 5. Number of referrals in major service areas.

TYPE OF REFERRAL	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Health	1,029 (42)	418 (57)	611 (36)
Housing	349 (14)	49 (7)	300 (17)
Education	354 (14)	34 (5)	320 (19)
Welfare	215 (9)	51 (7)	164 (10)
Support services	134 (5)	103 (14)	31 (2)
Employment	119 (5)	18 (2)	101 (6)
Psychological	35 (1)	15 (2)	20 (1)
Miscellaneous	215 (9)	46 (6)	169 (10)
Total number of referrals	2,450 (99)	734 (100)	1,716 (101)

The majority of referrals are related to health care. This is particularly the case in rural areas, where more referrals are for health care than for all other referrals combined. This is a reflection of the lower level of health care in rural communities, e.g., there are more unimmunized children, more children who have never been to a dentist, more children who have not had a well-baby examination. Therefore, the top priority in the rural Components relates to referrals meeting health care needs.

Housing referrals are relatively numerous among the urban programs, but relatively less frequent in rural areas. The urban ACs have developed a network of relationships with public housing around relocation or improvement of existing conditions. In the rural areas, common arrangements involve absentee landlords. Moreover, there is generally no public housing or central housing authority in rural areas. Thus, effective housing referrals become impossible.

Referrals for support services, i.e., food and clothing, are far more frequent in rural areas.

4.1.1 Health referrals

Specific categories of health referrals made are presented in Table 6.

Table 6. Frequency of referrals for various health-related problems.

HEALTH-RELATED PROBLEM	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Check-ups	230 (22)	94 (22)	136 (22)
Immunizations	160 (16)	84 (20)	76 (12)
Dental work	95 (9)	65 (16)	30 (5)
Nutrition/vitamins	92 (9)	52 (12)	40 (7)
Family planning	80 (8)	47 (11)	33 (5)
Speech problems	14 (1)	13 (3)	1 (*)
Enrollment for medical coverage	182 (18)	10 (2)	172 (28)
Eye check-ups/glasses	15 (1)	9 (2)	6 (1)
Pre-natal care	79 (8)	9 (2)	70 (11)
Hearing problems	10 (1)	8 (2)	2 (*)
Hospital admissions	16 (2)	8 (2)	8 (1)
Medical appliances	10 (1)	7 (2)	3 (1)
Medical miscellaneous	46 (4)	12 (3)	34 (6)
Total medical referrals	1,029 (100)	418 (99)	611 (99)

* less than 1%

Check-ups, immunizations, dental work and check-ups, vitamins, and family planning, represent the vast majority of rural health referrals. In the urban Components, enrollment for coverage in a medical plan is the single greatest reason for health referrals, although check-ups and immunizations also constitute a major reason for referral. Referral of pregnant women for pre-natal check-ups is an additional important aspect of referral activity in urban areas.

4.1.2 Housing referrals

The frequency of various kinds of referrals for housing problems are presented below in Table 7.

Table 7. Frequency of referrals for housing-related problems.

HOUSING-RELATED PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Relocation	190 (54)	25 (51)	165 (55)
Household appliances/ furniture	40 (11)	12 (24)	28 (9)
Repairs	52 (15)	7 (14)	45 (15)
Loans	2 (1)	2 (4)	0 -
Pest control	24 (7)	1 (2)	23 (8)
Eviction	7 (2)	1 (2)	6 (2)
Rent problems	10 (3)	0 -	10 (3)
Miscellaneous	24 (7)	1 (2)	23 (8)
Total housing referrals	349 (100)	49 (99)	300 (100)

Referrals related to relocation, due to dilapidated housing conditions or overcrowding, represent a major thrust in several urban Components. At these Components, extensive efforts were made to help families find new housing or to improve the condition of existing housing.

4.1.3 Education referrals

Table 8. Frequency of referrals for education and child care-related problems.

EDUCATION-RELATED PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRAL
PCC	183 (52)	14 (41)	169 (53)
Day care	81 (23)	6 (18)	75 (23)
Head Start	34 (10)	5 (15)	29 (9)
Adult basic education	22 (6)	2 (6)	20 (6)
College or equivalent enrollment	5 (1)	1 (3)	4 (1)
Special schooling	9 (2)	0 -	9 (3)
Miscellaneous	20 (6)	6 (18)	14 (4)
Total education referrals	354 (100)	34 (101)	320 (99)

The majority of referrals in this area are referrals made to PCC. At one Component in particular, a great deal of recruiting and referral was done for PCC. Referrals for day care

were made on behalf of a large number of urban children. As is noted elsewhere, only 10% of all educational referrals took place in rural areas.

4.1.4 Welfare referrals

Table 9. Frequency of referrals for welfare-related problems.

WELFARE-RELATED PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Enrollment	30 (14)	[illegible] (25)	17 (10)
Special services	47 (22)	10 (20)	37 (22)
Food Stamps	42 (20)	8 (16)	34 (21)
Incr. payments	50 (23)	6 (12)	44 (27)
Miscellaneous	46 (21)	14 (27)	32 (20)
Total welfare referrals	215 (100)	51 (100)	164 (100)

AC staffs' increasing familiarity with welfare eligibility requirements and services has enabled outreach staff to obtain benefits for some AC families. Although most eligible families were already receiving welfare prior to the advent of the AC effort, a substantial number of families were not receiving all available benefits or services.

4.1.5 Support services referrals

Table 10. Frequency of referrals for support services.

SUPPORT SERVICES	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Clothing	82 (61)	59 (57)	23 (74)
Food	52 (39)	44 (43)	8 (26)
Total support service referrals	134 (100)	103 (100)	31 (100)

While one urban Component does have families which at times are so destitute that they lack even food and clothing, this situation is more typical in rural areas, as has been noted previously. Hence, the finding that the majority (77%) of these services are provided in rural areas is not surprising.

4.1.6 Employment-related referrals

Table 11. Frequency of referrals for employment-related problems.

EMPLOYMENT-RELATED PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Job placement	71 (60)	16 '89)	55 (54)
Job training	45 (38)	0 -	45 (44)
Miscellaneous	3 '2)	2 (11)	1 (1)
Total employment referrals	119 (100)	18 (100)	101 (99)

Again, the urban-rural differences are striking. First, whereas almost half of such urban referrals involve job training, there was not one such referral made in a rural area, reflective primarily of the paucity of such programs in rural areas. More generally, of all employment-related referrals, only 15% occur among rural AC's. Cast another way, whereas seven percent of all contacted urban families received such services, only two percent of rural families received employment-related referrals.

4.1.7 Psychological referrals

Table 12. Frequency of referrals for psychological problems.

PSYCHOLOGICAL PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Psychiatric referral	15 (43)	9 (60)	6 (30)
Developmental problems	8 (23)	3 (20)	5 (25)
Diagnosis	5 (14)	2 (13)	3 (15)
Retardation	7 (20)	1 (7)	6 (30)
Total psychological referrals	35 (100)	15 (100)	20 (100)

Referrals for psychological problems which require both training in diagnosis and available facilities have not been a significant aspect of any AC's activity.

4.1.8 Miscellaneous referrals

Table 13. Frequency of referrals for various miscellaneous problems.

MISCELLANEOUS PROBLEMS	TOTAL NUMBER OF REFERRALS	RURAL REFERRALS	URBAN REFERRALS
Legal aid	43 (20)	19 (41)	24 (14)
Transportation	26 (12)	15 (33)	11 (6)
Baby sitting	10 (5)	0 -	10 (6)
Information	136 (63)	12 (26)	124 (73)
Total miscellaneous referrals	215 (100)	46 (100)	169 (99)

It is interesting that despite very close working relationships between Legal Aid and several of the AC's, relatively few referrals have been made. Referrals to agencies which provide information about community activities and resources are clearly more frequent in urban areas than in rural areas where such agencies do not exist.

4.2 The outcome of referrals

Presented in Tables 14a and 14b are the outcomes associated with the 734 referrals made on behalf of rural families, and with the 1,716 referrals made on behalf of urban families.

Table 14a. Contacts to resources: level of outcome - rural

	LEVEL OF OUTCOME								
TYPE OF REFERRAL	1	2	3	4	5	6	7	8	9
Medical	4 (50)	64 (93)	4 (75)	6 (18)	8 (32)	28 (35)	0 -	81 (74)	223 (56)
Housing	3 (38)	0 -	1 (25)	4 (12)	13 (52)	13 (16)	0 -	5 (4)	10 (2)
Educational	0 -	1 (1)	0 -	0 -	0 -	1 (1)	0 -	1 (1)	31 (8)
Welfare	1 (12)	2 (3)	0 -	12 (36)	2 (8)	10 (12)	1 (50)	6 (5)	17 (4)
Support Services	0 -	0 -	0 -	0 -	0 -	10 (12)	0 -	4 (4)	89 (22)
Employment	0 -	1 (1)	0 -	5 (15)	1 (4)	7 (9)	0 -	3 (3)	1 (*)
Psychological	0 -	1 (1)	0 -	0 -	1 (4)	3 (4)	1 (50)	6 (5)	3 (1)
Miscellaneous	0 -	0 -	0 -	6 (18)	0 -	9 (11)	0 -	4 (4)	27 (7)
Base: Total contacts to resource by outcome	8	69	5	33	25	81	2	110	401
% of total referrals made	1%	9%	1%	5%	3%	11%	*	15%	55%

1 = No report of outcome.
2 = Appointment made, but not kept; end of referral.
3 = Appointment made but not kept; new appointment made/to be made.
4 = Problem unresolvable (family ineligible, insufficient resource, etc.)
5 = Appointment kept, no action by resource.
6 = Promises made by resource, but no action yet.
7 = Partial solution; end of case.
8 = Partial solution; more expected.
9 = Problem resolved.

In 70% of all referrals, the outcome is either positive (Outcome 9) or expected to be positive in the near future (Outcome 8). This is particularly the case with medical referrals, the category in which most referrals were made, overall. As most ACs have developed good working relationships with community health resources and can be reasonably assured that referrals will be followed through by these agencies, it is not surprising to find that approximately 65% of all the positive or near positive referrals are in the medical area. In contrast, only 3% of the referrals with positive or near positive outcomes are in the areas of housing and employment. This is not a reflection of the ACs' relationships with the relevant agencies, but rather an indication of the conditions prevailing in all AC communities; both jobs and adequate, low-cost housing are in short supply within all of the programs' catchment areas.

Eleven percent of the referrals resulted in "promises made by the resources, but no action yet" (Outcome 6). For the most part, this indicates that the client has been placed on a waiting list, either until the resource can be secured as is the case with houses and jobs, or until eligibility can be determined, i.e., for welfare benefits or enrollment in a medical facility.

The low percentage (9%) of referrals terminated as the result of broken appointments (Outcome 2) does not reflect the true number of broken appointments, but rather the persistence of follow through efforts on the part of the ACs. A broken appointment sometimes

resulted in an official "termination of referral" but only after repeated appointments had been broken.

Table 14b. Contacts to resources: level of outcome - urban.

TYPE OF REFERRAL	LEVEL OF OUTCOME								
	1	2	3	4	5	6	7	8	9
Medical	17 (26)	45 (42)	8 (32)	5 (8)	13 (15)	20 (7)	7 (21)	151 (39)	345 (53)
Housing	14 (21)	19 (18)	2 (8)	29 (44)	29 (34)	71 (25)	6 (18)	71 (18)	59 (9)
Educational	4 (6)	6 (6)	0 -	14 (21)	8 (9)	84 (29)	3 (9)	87 (22)	109 (17)
Welfare	1 (2)	23 (21)	0 -	7 (11)	19 (22)	23 (8)	2 (6)	30 (8)	59 (9)
Support Services	0 -	0 -	0 -	0 -	0 -	0 -	0 -	7 (2)	24 (4)
Employment	1 (2)	7 (6)	2 (8)	9 (14)	13 (15)	21 (7)	5 (15)	17 (4)	26 (4)
Psychological	2 (3)	0 -	0 -	2 (3)	4 (5)	5 (2)	0 -	5 (1)	2 (*)
Miscellaneous	27 (41)	8 (7)	13 (52)	0 -	0 -	64 (22)	10 (30)	23 (6)	24 (4)
Base: Total contacts to resource by outcome	66	108	25	66	86	288	33	391	648
% of total referrals made	4%	6%	1%	4%	5%	17%	2%	23%	38%

1 = No report of outcome.
2 = Appointment made, but not kept; end of referral.
3 = Appointment made but not kept; new appointment made/to be made
4 = Problem unresolvable (family ineligible, insufficient resource, etc.)
5 = Appointment kept, no action by resource.
6 = Promises made by resource, but no action yet.
7 = Partial solution; end of case
8 = Partial solution; more expected
9 = Problem resolved.

Sixty-one percent of all referrals made by urban ACs resulted in positive (Outcome 9) or near positive (Outcome 8) outcomes. The greatest proportion of referrals with these outcomes was in the area of medical care.

While the outcome trends are similar, in most cases, to those described for rural referrals, a greater proportion of urban than rural referrals resulted in no action from the resource (Outcomes 5 and 6). This is understandable when the relatively high number of referrals made for employment and housing, the success of which is dependent upon conditions often beyond the ACs' control, are considered.

5.0 What the AC has meant to families: some illustrative cases

In the midst of so many numbers it is all too easy to lose sight of the fact that, in a great many instances, the referrals and home visits have made a tremendous difference in the lives of individuals. Comments made by families to CCR interviewers are presented in the next chapter. In addition, during each site visit, Advocacy staff was asked to tell CCR about their outstanding cases, outstanding in the sense that they felt they had really been effective on behalf of the family. In order to illustrate the kind of work which has been done on behalf of families, one outstanding story from each of the Components is presented below.

COMPONENT 1

The AC had completed a needs assessment on this family but all details did not emerge until a relationship with the family had been established. When the husband attacked an older stepchild, a nine year old girl, and the mother had him put in jail, AC became

more involved along with the Welfare Department and the County Prosecutor.

At this time, the AC found out more about the focal child, age 4, who had been born with an obstructed rectum, and talked with the parents about getting him medical attention. Through the Welfare Department, Advocacy learned about The Crippled Children's Foundation in a city fifty miles away, and obtained an application for the family.

An appointment was made and transportation was provided. During the year, the AC made at least three trips to The Crippled Children's Foundation so that the child's problem could be corrected. In addition, the AC and the Foundation were able to find a family living near the hospital who had a room in which the mother could stay. She was also provided with meal tickets at the hospital while her son was there.

After several operations, a rectum was constructed. Now, the child only needs to see a doctor for observation every six months. However, because of all the time spent in surgery and seeing doctors, he is not yet ready for Head Start. Special arrangements have been made for him to attend the PCC even though he is past the age limit.

COMPONENT 2

Mrs. Z., nine months pregnant, was referred to the AC by her sister, an AC participant. This woman has four other children between the ages of 5 and 12, her husband had deserted her, and she had no means of economic support.

When the AC met her, Mrs. Z had fifty cents in her pocket and large hospital bills for the pre-natal care she had been receiving. Since she knew where her husband was working, she wanted the AC to make him support herself and the children.

The AC referred her to the Welfare Department to obtain ADC and Medicaid coverage. The AC also applied for food stamps and day care for the children. They arranged for a homemaker to care for the children while Mrs. Z. was in the hospital delivering her baby.

Four days after the AC had met her, Mrs. Z. was receiving emergency welfare benefits, had applied for food stamps, and the paperwork had been completed to obtain a homemaker for babysitting services for the children. A few days later, Mrs. Z. entered the hospital and delivered her child.

When Mrs. Z. returned home, the AC had collected baby clothes that had been cleaned and donated to them. The AC delivered these along with groceries, formula, and baby food purchased from their contingency fund. However, upon delivering them, the AC Coordinator discovered that Mrs. Z. was not at home but next door at her mother-in-law's using the bathroom. Her own house did not have toilet facilities or running water.

The AC spoke with the Health Department, describing Mrs. Z.'s living conditions as inadequate and dangerous. According to the

AC Coordinator, the Director of this Agency was reluctant to visit this dwelling because he said "those conditions do not exist in this community any longer." Nevertheless, at the AC's insistence a Health Department representative did finally go to evaluate the housing conditions and could not, himself, believe it.

On the basis of a Health Department memorandum and an inspection by the Welfare Department, a decision was finally reached that plumbing lines would be brought into the house to provide water and toilet facilities at a cost of approximately $1,000 which would be paid by these two departments.

COMPONENT 3

One family served by a rural AC lives in a three-room shack without running water and no toilet facilities of any kind. They have only the most basic furniture.

The family has little money to live on. The father is a farm laborer and gets paid $8.00 per day; when it rains he cannot work, and then there is no money coming in at all.

When the AC first started to visit this family, the children, ages six, three, and eighteen months, were afraid and would hide behind the door. The mother appeared to be pregnant. She denied it, saying she had a thyroid condition.

The AC persuaded her to see a doctor and it was confirmed that she was already six months pregnant and anemic as well. Medication was prescribed and she has since delivered her baby without complications.

Since the AC has been visiting this family the children have become more outgoing and are always happy to see the Outreach Workers. They have received immunizations, and medical and dental screenings with the AC providing the transportation to these services.

Because of the deplorable conditions of the home, the AC went to the Department of Child Welfare and contacted their Homemaker Service. Since then, a homemaker has been working with the mother showing her how to keep house and care for the children. The Advocacy Component has also helped with in-kind clothing, an in-kind crib and couch; they arranged for a church group to help with other furniture and dishes.

COMPONENT 4

The mother in this family had returned from the hospital with her newborn five-day-old baby to discover that the house, in which she had been living, was all boarded up. While in the hospital she had left her older child with a friend.

The mother called the Department of Social Services to try to get help but the social worker was not in, it was a Friday.

DSS said that the social worker would call back on Monday. The mother, with her older child and five-day-old baby no longer had a home so they stayed with their friend over the weekend.

On Monday, the mother and her friend decided to go to DSS. Because she had told DDS that her house had been broken into (this is what she assumed when she saw the house boarded up), she was told that before anything could be done she would have to file a police report.

At this point the woman's friend decided to contact the AC to see if they could help. The Coordinator spoke with DSS and obtained some money immediately.

While the AC was contacting various resources, a process which took a week and a half to complete, the woman and her children had to stay in a small apartment with her friend. After continued intervention by the AC Coordinator, this family did obtain permanent dwelling,furniture, and clothes and milk for the baby.

COMPONENT 5

This family consists of a 40 year old pregnant woman and her two teenage children. They were living in a three-family home which was in extremely poor condition; the house had lead paint, exposed wires, and rats.

When the AC first met this woman she wished to move. Since she was a welfare recipient, the AC worker went to the welfare caseworker to see what could be done. The caseworker had never seen the house so an appointment was made for her to visit the family. The caseworker did not, however, keep the appointment even after follow-up by the AC.

The next action taken by the AC was to go to the housing inspector. This person came to the home, investigated the conditions and then contacted the landlord. The landlord was instructed to make repairs; he paneled some walls and put in a used stove. The AC, considering these to be only superficial repairs, was dissatisfied and followed up the matter to the housing inspector. The AC was then told, "it's in the courts." No time period was given for when action could be expected.

One day, while the family was still waiting for action from the courts, there was no heat or water in the apartment. The AC contacted the local Tenants' Association which provided temporary housing for the family. With the AC and the Tenants' Association working together a five room apartment in a renovated building was found.

The Advocacy Component also referred the son for a temporary job. He had dropped out of school and was unable to find work; he worked at the job they found for him for a while and then

stopped. At that time, AC got applications for schools for him and helped him apply. As a result, he will be receiving his diploma in June.

COMPONENT 6

The Advocacy Component completed a needs assessment on one family when the son, age 4, was in a hospital for the mentally retarded outside of the city. During this interview, the mother indicated that she would like to visit her son but she was unable to pay someone to take her there.

The AC then contacted the County Welfare Department for information, and was told to call Children's and Family Service Division. This agency informed the AC that the child, who is brain-damaged, has been cared for by the County since 1969; the mother had taken care of the child at home for two years but he had become too difficult for her to handle. The County Social Worker did visit the child once each month but could not take the mother because of other job requirements to complete on the way to the hospital.

After further contact with the AC, the County Welfare Department said they would provide transportation money so that the mother could visit her son. Soon after, the mother contacted the AC to say she had received this money from the Welfare Department.

COMPONENT 7

This AC has acted as a liaison between agencies and one particular family to help provide a solution to this family's problems.

In August, the AC located Mrs. X., nine months pregnant, and her two children living with her mother in the housing project. Mrs. X. had her baby soon after, so the first action the AC took was to refer her to the well-baby clinic. After that, they referred her to the Parent-Child Center: one of the children was two years old; Mrs. X. became an active participant and was no longer an active Advocacy family.

There was no more contact between the AC and Mrs. X. until mid-December. At that time, Mrs. X.'s mother contacted the AC because her daughter had been acting strangely. She was no longer attending the PCC and had taken her two oldest children to her former husband, telling him she was tired of being the only one responsible for them. The husband turned the children over to his mother.

Mrs. X. was reported to Protective Services for Children because she violated the temporary custody probation granted by the Juvenile Court when she obtained her divorce. The result of this action was the placement of the two older

children in the paternal grandparents' home; the baby was placed in a foster home until a hearing could be held. Mrs. X.'s mother called the AC to ask if they could help her daughter or at least find out what was going on. If her daughter could not get custody of the children, she wanted to try to have them placed in her own care.

The AC first contacted the family's social worker to determine what could be done and tried to find a solution that would satisfy the family and the agency. After a conference between Mrs. X. and the social worker it was determined that she was able to take care of her family and that she really did want the children. Both the AC and Protective Services felt that Mrs. X. had become frustrated because there was no one to help her.

A custody hearing was held and it was decided that Mrs. X. would keep the baby if Mrs. X. returned to her mother's to live. The two older children were temporarily maintained with the paternal grandparents. They were later returned to live with their mother when the court felt she was able to provide them with a better home environment.

The AC has encouraged Mrs. X. to become more responsible with regard to the future. After the hearing, the AC stepped aside to allow the family to function independently.

6.0 Progress toward achievement of the relevant national goal

There can be no question that a large number of families were referred to specific agencies and that services were actually delivered in a large proportion of cases. At the same time, it has become apparent that referral activity is extremely demanding and time consuming, often requiring repeated home visits. It has also become clear that many needs cannot be met through referral and that for many families an ongoing relationship appears to be the most valued resource.

CHAPTER IV

THE FAMILIES SERVED BY THE ADVOCACY COMPONENT: DATA ON A SAMPLE OF FAMILIES INTERVIEWED ON SITE

1.0 Background

The method and procedure used to select this sample have been presented in Chapter 1; the following represents a brief recapitulation.

In May, 1972 (T1), interviews were conducted by CCR staff with 171 randomly-selected families: 25 at each of six ACs, 21 at the seventh, where there was insufficient enrollment. In May, 1973 (T2), only 74 of these families were available for re-interview. Table 15 shows the status of each of the 97 families who could not be reinterviewed.

Table 15. Status of the 97 families unavailable for T2 interviews.

		TOTAL	URBAN	RURAL
Moved	N	41	34	7
	%	(42)	(53)	(21)
Joined PCC	N	26	19	7
	%	(27)	(30)	(21)
Requested inactive status	N	8	0	8
	%	(8)	-	(24)
Not home, not available	N	22	11	11
	%	(23)	(17)	(34)
Total	N	97	64	33
	%	(100)	(100)	(100)

The largest proportion of families unavailable for T2 interviews moved, some were referred to PCC, some chose not to be involved with Advocacy, and some were simply not available despite repeated attempts to contact them for the T2 interviews.

All of the T1 data were reanalyzed, in terms of comparing the total sample of 171 with the attenuated sample of 74, in order to see if the latter represented a biased sub-sample.

Chi-square analyses revealed no significant differences. Therefore, it is assumed that there is no systematic bias in the attenuated sample of 74 families, at least in terms of the variables available for this analysis. However, the sample is weighted in favor of rural families. Of the original 171 families, 100 were urban, and 71 were rural; in the remaining sample 36 are urban, and 38 are rural. Thus, whereas 42% of the original sample was from rural areas, 51% of the current sample is from rural areas. Put another way, whereas 64% of the original urban sample was not available at T2, only 46% of the rural sample was no longer available.

The mobility of the AC population turned out to be far greater than had been anticipated. In several urban Components, mobility was so high that 4/5 of the sample had moved, or could not be re-interviewed for other reasons. The 74 families on which T1 and T2 data are available represent 3.7% of the 1,981 Advocacy families on behalf of whom the ACs performed some activity, i.e., a telephone call, a home visit, or a referral. Thus, the data presented in this chapter should be regarded as merely suggestive of AC activities on behalf of families. This conclusion is based not only on the small sample size, and the resulting possibility of gross sampling error, but also on the fact that the pattern of AC staff activity vis-a-vis sample families was undoubtedly influenced by the knowledge that program evaluation was being in part based on this sample. Thus, it can

be expected that the experiences of the sample represent an overestimate of AC activity on behalf of all other families. In fact, the following data on average number of phone calls, home visits, and referrals to sample families bear out this conclusion. The mean number of phone calls to the sample is greater than the mean number of calls to all AC families. The mean number of home visits in rural areas to the CCR sample is approximately twice as high as the largest mean for home visits at any Component (6.33). The mean number of visits at urban AC's to CCR sample families is twice as great as is the mean number of home visits to all AC families visited in three Components; in the fourth Component this mean is 4.85 and is still smaller than the mean number of visits to CCR sample families. Referral activity on behalf of the CCR sample in rural areas is twice as great as is the referral activity in any rural Component (highest mean = 2.15). The urban mean for CCR families is virtually the same as referral activity for all families at one Component, and greater than referral activity at the other three.

Table 16. Mean number of telphone calls, home visits, and referrals to 74 sample families.

		URBAN (N=36)	RURAL (N=38)
Telephone calls	N	114	64
	$\bar{X}$	3.16	1.68
	SD	3.00	3.64
Home Visits	N	201	438
	$\bar{X}$	5.58	11.52
	SD	4.68	11.12
Referrals	N	78	185
	$\bar{X}$	2.16	4.86
	SD	1.99	5.57

Aside from the extra attention received by sample families, data cited in the following pages support the representativeness of the sample in other respects. However, data on the CCR sample should be interpreted with considerable caution both because of the relatively small size of the sample and because AC activity vis-a-vis the CCR sample families has been greater than the activity on behalf of the AC population as a whole.

2.0 Demographic characteristics of the CCR sample.

Table 17. Sex of respondent.

		TOTAL	URBAN	RURAL
Male	N	7	6	1
	%	(9)	(17)	(3)
Female	N	67	30	37
	%	(90)	(83)	(97)
Base (Total number of respondents):		74 (99)	36 (100)	38 (100)

The vast majority of respondents interviewed are female.

Table 18. Age of respondent.

		TOTAL	URBAN	RURAL
Under 21	N	9	6	3
	%	(12)	(17)	(8)
21 to 30	N	36	18	18
	%	(49)	(50)	(47)
31 to 40	N	22	10	12
	%	(30)	(28)	(32)
41 to 50	N	5	1	4
	%	(7)	(3)	(10)
Over 50	N	2	1	1
	%	(3)	(3)	(3)
Base (Total number of respondents):		74 (101)	36 (101)	38 (100)

The sample of women is young; the majority are under 30. Data are not available on the ages of women in all AC families. However, on an impressionistic basis, the sample appears representative.

Table 19. Ethnicity of respondents.

		TOTAL	URBAN	RURAL
Black	N	34	33	1
	%	(46)	(92)	(3)
Puerto Rican	N	3	3	-
	%	(4)	(8)	-
Mexican-American	N	9	-	9
	%	(12)	-	(24)
American Indian	N	-	-	-
	%	-	-	-
Other Caucasian	N	28	-	28
	%	(38)	-	(74)
Base (Total number of respondents):		74 (100)	36 (100)	38 (101)

In the urban Components nearly all families worked with are Black, and in the rural Components families are primarily Caucasian. One rural Component works with Mexican-American families.

Table 20. Education level of respondents.

		TOTAL	URBAN	RURAL
6 years or less	N	9	1	8
	%	(12)	(3)	(21)
7 to 9 years	N	24	7	17
	%	(32)	(19)	(45)
10 to 11 years	N	22	13	9
	%	(30)	(36)	(24)
Completed high school	N	14	10	4
	%	(19)	(28)	(10)
Some college	N	3	3	-
	%	(4)	(8)	-
College graduate	N	1	1	-
	%	(1)	(3)	-
N.A.	N	1	1	-
	%	(1)	(3)	-
Base (Total number of respondents):		74 (99)	36 (100)	38 (100)

The majority of AC sample families have not completed high school. The proportion of relatively less educated respondents is higher in rural areas than it is in urban areas. These data are consistent with data drawn from much larger samples of PCC families; therefore, there is reason to believe that the sample is representative along this dimension.

Table 21. Number of children under five years of age.

		TOTAL	URBAN	RURAL
One child under five years of age	N	32	15	17
	%	(45)	(45)	(45)
Two children under five	N	22	8	14
	%	(31)	(24)	(37)
Three children under five	N	13	6	7
	%	(18)	(18)	(18)
Four children under five	N	4	4	-
	%	(6)	(12)	-
Base (Total number of respondents):		71 (100)	33 (99)	38 (100)
Total number of children under five		131	65	66

The majority of families have either one or two children below the age of five.

Table 22. Total number of children.

		TOTAL	URBAN	RURAL
One child in family	N	10	4	6
	%	(14)	(11)	(16)
Two children in family	N	15	7	8
	%	(20)	(19)	(21)
Three	N	11	5	6
	%	(15)	(14)	(16)
Four	N	17	8	9
	%	(23)	(22)	(24)
Five	N	6	4	2
	%	(8)	(11)	(5)
Six	N	8	4	4
	%	(11)	(11)	(10)
Seven	N	1	-	1
	%	(1)	-	(3)
Eight	N	3	1	2
	%	(4)	(3)	(5)
Nine	N	3	3	-
	%	(4)	(8)	-
Base (Total number of respondents):		74 (100)	36 (99)	38 (100)
Total number of children		277	144	133

The 74 families have 131 children below the age of 5 and a total of 277 children living at home. Thus, the typical sample family has one or two children 0-5 and either one or two older children. The average number of children per family is 3.7. This figure is consistent with the number of children per PCC family and is quite likely to be representative of the Advocacy population as a whole.

Table 23. Husband present in household.

		TOTAL	URBAN	RURAL
Yes	N	46	14	32
	%	(62)	(39)	(84)
No	N	28	22	6
	%	(38)	(61)	(16)
Base (Total number of respondents):		74 (100)	36 (100)	38 (100)

Single parent families predominate in urban areas, whereas two parent families are characteristic of rural areas. These data are consistent with all other data on this population.

Table 24. Employment status of father.

		TOTAL	URBAN	RURAL
Not working	N	15	5	10
	%	(20)	(14)	(26)
Employed - part-time	N	10	3	7
	%	(14)	(8)	(18)
Employed - full-time	N	21	7	14
	%	(28)	(19)	(37)
No father	N	28	21	7
	%	(38)	(58)	(18)
Base (Total number of respondents):		74 (100)	36 (99)	38 (99)

In homes where there are fathers, the majority of fathers are employed either full or part-time.

Table 25. Employment status of mother.

		TOTAL	URBAN	RURAL
Not working	N	67	30	37
	%	(90)	(83)	(97)
Employed - part-time	N	3	3	-
	%	(4)	(8)	-
Employed - full-time	N	2	2	-
	%	(3)	(6)	-
N.A.	N	2	1	1
	%	(3)	(3)	(3)
Base (Total number of respondents):		74 (100)	36 (100)	38 (100)

The great majority of mothers interviewed are not employed.

Table 26. Number of families receiving public assistance, food stamps, Medicaid, commodities.*

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Receiving public assistance	N	44	26	18	44	27	17
	%	(59)	(72)	(47)	(59)	(75)	(45)
Receiving food stamps	N	33	15	18	35	17	18
	%	(45)	(42)	(47)	(47)	(47)	(47)
Receiving Medicaid	N	41	25	16	44	26	18
	%	(55)	(69)	(42)	(59)	(72)	(47)
Receiving commodities	N	18	8	10	21	12	9
	%	(24)	(22)	(26)	(28)	(33)	(24)
Base (Total number of respondents):		74	36	38	74	36	38

* Numbers total to more than the indicated base because some respondents receive more than one welfare service.

The data on welfare and welfare services show essentially no changes between T1 and T2. This is not surprising as only 215 referrals were made to welfare agencies and only 112 of these had a successful outcome.

3.0 Relationship between sample families and the AC.

Table 27. Number of times respondent was visited by AC.

		TOTAL	URBAN	RURAL
Not visited	N	-	-	-
	%	-	-	-
Only once or twice	N	2	-	2
	%	(3)	-	(5)
A few times (3-9)	N	20	12	8
	%	(27)	(33)	(21)
About once a month (about 12 times)	N	15	9	6
	%	(20)	(25)	(16)
About twice a month (about 20 times)	N	19	7	12
	%	(26)	(19)	(32)
About every week (more than 50 times)	N	18	8	10
	%	(24)	(22)	(26)
Base (Total number of respondents):		74 (100)	36 (99)	38 (100)

The majority of sample families report that they were visited once a month or more. As has already been pointed out, these data overstate the extent to which home visits were made to the entire AC population of 1,981 families. These data are also highly subjective, as monitoring data presented in Chapter III show that the range of number of visits to families was from 0-37. Thus, no family was actually

visited 50 or more times, even though rather frequent visits may convey a similar feeling to visits conducted weekly. This finding highlights one of the problems of basing any program evaluation on self-report and speaks to the importance of regularly-collected program statistics, which supplement subjective data from program participants.

Table 28. Family initiated contacts with the AC.

		TOTAL	URBAN	RURAL
Yes	N %	40 (54)	24 (67)	16 (42)
No	N %	34 (46)	12 (33)	22 (58)
Base (Total number of respondents):		74 (100)	36 (100)	38 (100)

Fifty-four percent of the families interviewed indicated that they had contacted the AC in relation to a problem. While this percentage is likely to be much too high to apply to the entire population, nevertheless, it does suggest the visibility of the ACs to the families.

Table 29. Nature of home visits.*

		TOTAL	URBAN	RURAL
Support and encouragement	N	54	21	33
	%	(73)	(58)	(87)
Referral or appointment	N	47	27	20
	%	(64)	(75)	(53)
Information	N	51	31	20
	%	(69)	(86)	(53)
Transportation	N	34	12	22
	%	(46)	(33)	(58)
Accompany individual	N	16	5	11
	%	(22)	(14)	(29)
Other	N	10	6	4
	%	(14)	(17)	(11)
Base (Total number of respondents):		74	36	38

* Percentages add to more than 100 because the home visits often served several purposes.

The majority of families perceive home visits as involving a combination of support and encouragement, referral to an agency, and information. Nearly half the families in the sample report that they were provided with transportation at one time or another; this proportion being considerably higher in rural areas.

A majority of the families interviewed by CCR reported a variety of specific benefits which they had derived from AC initiated referrals. These will be discussed separately under the areas of health, housing, education, welfare, etc. Families

manifest a positive attitude toward Advocacy and particularly to the worker they know best. Asked to respond to an open-ended question about what AC has done for them over the past year, the very human and important aspects of the Advocacy effort, and the difference it made to some families become apparent. The following represent some of the responses given:

> "I was upstairs in bed. I was in labor and X (the worker) happened by to see me. X carried me out of here and took me to the hospital just in time. Also when I had no money to catch the bus, they took me to the doctor's when I was five months pregnant and my legs were all swollen up."
>
> "They be there when you need them. They helped me so much. I moved here and didn't know nobody and they been helping me ever since, with my food stamps, my surgery, everything."
>
> "I learned to stop whipping my little girl because they said that don't make her act good and they told me what to do with her instead."
>
> "They made a difference in my life. I'm the type of person who doesn't like to get out and talk to people. If it weren't for my friend (Outreach Worker) I wouldn't get anything done. She comes by all the time."
>
> "Advocacy helped me find out my rights and how to get action from welfare."

"They are a real help. I don't know what I would do without Advocacy."

"Yes, my worker helped me. If it wasn't for her, I wouldn't have known about Head Start."

"Before I didn't know where to go for information. Now I just call Advocacy and ask where to go or where I can go to find out more."

"It has definitely made a difference in my life. Helping me find a new home was like traveling on a magic carpet."

"Yes they sure have helped. Taken us to places for things." This is from a family in which the six-year-old has cerebral palsy, the four-year-old has crossed eyes and has been taken by AC to the eye clinic which has recommended an eye operation which the father will not permit, and the seven-year-old is retarded, has a heart murmur and kidney infection. All of the children have been seen by a physician and are being treated as a result of Advocacy efforts. AC got them on Medicaid and got special assistance from welfare due to the children's disabilities.

"I'm going to have a baby and I would never get backwards and forwards to the doctor if it wasn't for them."

"My worker listens to me. She encourages me. She lifts me up. If you have somebody like her, you've got it made. She makes an effort."

While the great majority of comments are positive, a small proportion of respondents expressed disappointment or complained about a lack of assistance.

"They haven't been able to really help us. They try, but they can't do it. My husband needs a job and there aren't any. We need to move but can't afford any place else."

"I don't know what they've been doing. They certainly haven't been helping me."

"They used to help but they cut their transportation off and so there's nothing they can really do. I know where to go, I just don't have any way to get there."

"They can't give any services, so who needs them? I don't need anybody to call the clinic, I can make my own appointment."

In most instances, the feeling of getting "help" can best be defined by the relationship between an outreach worker and the family. Those people who are able to engage in a supportive concerned relationship are likely to feel better. In addition, people with concrete, specific needs for which services exist have been helped by Advocacy. However, people who either cannot benefit

from a supportive relationship or who have not developed a relationship with their particular worker, or who have needs for which services do not exist, do not feel that they have been helped. For these people the ACs inability to provide direct services is a source of frustration and disappointment. In several rural areas, there is virtually no available solution for families who live in deplorable housing conditions. Many are resigned to these conditions, or at least are aware that Advocacy cannot really help them. The following notes by CCR interviewers on two families are typical of the kinds of situations encountered:

> "When we got to her home, Mrs. X. started crying because her electricity had been turned off. The family is two bills behind ($94 for 4 months) and her husband is very sick. He hardly works, but works when he can so welfare won't pay them anything. Mrs. X. and the outreach worker agreed that there didn't seem to be anything which could be done."

> "This was a family living in unbelievable plight. The mother couldn't spell her family name. Her daughter spelled it for her. A family of 12 lives in three filthy, fly-infested rooms. Lighting is dim and the children literally are all over and on top of each other. The mother was dressed in rags. The house is set in the

middle of a ditch; the porch is sagging and broken. The 15-year-old daughter has a heart problem and six fingers on each hand and each foot. The mother was appreciative of transportation help, but is basically overwhelmed."

4.0 Services needed and received by families in the sample.

4.1 Medical needs and referrals.

In all ACs, emphasis is placed on facilitating the delivery of health-related services, and on motivating the families to seek out ongoing, preventive medical care. The high percentage (42%) of health-related referrals made by ACs is reflective of this emphasis, as is the variety of special groups, sessions and meetings sponsored by the ACs dealing with health care practices, and the quantity and quality of relationships developed between the Components and health service agencies.

Given such extensive health-related efforts, it would be expected that Advocacy families would be both more aware of the need for preventive medical care, and, in fact, be receiving increased levels of such care. Since awareness is a very difficult concept to measure, most data presented are based upon actual behavior. However, the data stem from respondents' self reports, many of which cover a time period of a year. This source of error may account in part for the somewhat lower than expected number of persons reporting AC involvement in procuring health care. It is unreasonable to expect that persons will remember every instance in which the AC facilitated a referral or performed some action that made the delivery of a service possible.

After completing an interview with an Advocacy mother, the outreach worker who accompanied the CCR staff member said, "she didn't even mention that I got her daughter a job." Certainly, this would be an action one would expect a mother to recall even more clearly than a possible appointment, arranged by the AC, for a routine check-up.

Table 30. Health needs: problems and concerns.

		T1			T2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Health needs	N	43	15	28	41	14	27
	%	(58)	(42)	(74)	(55)	(39)	(71)
No need reported	N	31	21	10	33	22	11
	%	(42)	(58)	(26)	(45)	(61)	(29)
Base	N	74	36	38	74	36	38
	%	(100)	(100)	(100)	(100)	(100)	(100)

Respondents were asked whether they had any needs, concerns or problems in the area of health. It was predicted that at Time 2 (T2) the number of respondents reporting a concern would increase due to a heightened awareness of health maintenance requirements This prediction is not supported by the data. Differences betwen T1 and T2 reports are negligible. For the most part, needs mentioned centered around check-ups and ongoing medical and dental treatment for children.

Data indicate that twice as many rural respondents as urban respondents report some type of health problem. This may result from the scarcity of health care facilities available in the rural catchment areas: regardless of whether or not a facility is needed currently, it can be expected that concern would be highest among persons who have the greatest difficulty obtaining care when the need arises. Conversely, health care is often taken for granted when services are more easily accessible.

Table 31. Enrollment in a medical plan or service during the AC year.

		TOTAL	URBAN	RURAL
Enrolled	N	28	25	3
	%	(37)	(70)	(7)
Not enrolled	N	46	11	35
	%	(63)	(30)	(93)
Base	N	74	36	38
		(100)	(100)	(100)
AC helped in enrollment	N	12	11	1
	%	(43)	(44)	(33)
No AC involvement in enrollment	N	16	14	2
	%	(57)	(56)	(67)
Base: All persons enrolled in a medical plan during the past year	N	28	25	3
	%	(100)	(100)	(100)
Percentage of sample enrolled with AC involvement		(16)	(31)	(3)

Data in Table 31 indicate that 37% of the sample was enrolled for some type of medical service during the Advocacy year, and that most of the enrollments were on behalf of urban families. This is not surprising, as comprehensive health care services for which enrollment might be necessary are not available in rural areas.

Of the 28 families who were enrolled for medical services, 43% report that the AC was in some way involved in their enrollment. The remaining 16 persons report that they negotiated enrollment on their own. There is, of course, no means of measuring the amount of influence that AC workers may have had in encouraging persons to register for services. For example, discussions of services available at the local clinic may have prompted self-enrollment, but it cannot be expected that a respondent will recall that the AC provided the motivation.

Parenthetically, the CCR sample is representative of all Advocacy families for whom referrals have been effected, in terms relating to this particular dimension. Sixteen percent of all family referrals were for enrollment in a medical plan and, in fact, 16% of the CCR families were also assisted in enrollment by the AC. As noted, the AC was involved in enrollment on behalf of only 12 families. However, the impact is actually greater: bearing in mind that the average AC family has between three and four children, each referral in fact represents the registration for health care services of from four to six persons.

Table 32. Check-ups for family members during the AC year.

		TOTAL	URBAN	RURAL
Check-ups for family members	N	49	28	21
	%	(66)	(78)	(55)
No check-ups for family members	N	25	8	17
	%	(34)	(22)	(45)
Base	N	74 (100)	36 (100)	38 (100)
AC involvement in obtaining check-ups	N	21	8	13
	%	(43)	(29)	(62)
No AC involvement in obtaining check-ups	N	28	20	8
	%	(57)	(71)	(38)
Base: all persons who received check-ups	N	49	28	21
Percent of sample receiving check-ups with AC involvement		(28)	(22)	(34)

In Table 32 are represented the number of respondents reporting that all family members, exclusive of children 5 or under, received a medical check-up during the past year. The data show that although the majority of all sample families have received check-ups, the proportion is greater among urban families. This may again be related to the relatively limited services available in rural areas and the difficulty entailed in reaching existing resources.

Sixty-two percent of the 21 rural respondents receiving check-ups report that the AC helped them obtain this service. This high rate of AC involvement is probably another reflection of the dearth and inaccessibility of rural health facilities. Once again, the number of check-ups received through a single referral is greater than one, as respondents are most often speaking for themselves and other family members.

The percentage of urban families who report AC assistance in this area (29%) is less than half that for rural families. This may be accounted for not only by the availability of services, but also by the fact that 70% of the urban sample is enrolled in some type of medical program for which check-ups are most often a prerequisite.

Table 33. Check-ups for children 5 years or younger during the past year.

		T1			T2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Yes	N	106	54	52	107	59	48
	%	(81)	(83)	(79)	(80)	(84)	(76)
No	N	25	11	14	26	11	15
	%	(19)	(17)	(21)	(20)	(16)	(24)
Base: children 5 and under	N	131	65	66	133	70	63

There has been little percentage change from T1 to T2, as manifested in Table 33. At both times, urban children were more

likely to receive check-ups. Looking specifically at the rural sample, it becomes apparent that regardless of whether adult family members receive preventive medical care (c.f. Table 32), parents do seek this service on behalf of their children. Still, twenty percent of the target children population have not had an examination during the course of the Advocacy year.

Table 34. Immunization status of children 5 years or under.

		T1			T2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Respondent doesn't know which shots child received	N	12	7	5	8	3	5
	%	(9)	(11)	(7)	(6)	(4)	(8)
No immunizations at all	N	11	2	9	4	0	4
	%	(8)	(3)	(14)	(3)	-	(6)
Not up to date on immunizations	N	33	18	15	19	11	8
	%	(25)	(28)	(23)	(14)	(16)	(13)
Immunized appropriate to age	N	75	38	37	102	56	46
	%	(57)	(58)	(56)	(77)	(80)	(73)
Base: all children 5 or under	N	131	65	66	133	70	63
	%	(99)	(100)	(100)	(100)	(100)	(100)

This is an area in which the Advocacy Components have had a marked impact. There is a significant Chi Square (X^2=11.94, $P < .01$) associated with the increase between T1 and T2, in the number of children now fully immunized or immunized appropriate to age.

The efforts made by Advocacy Components to ensure that children are immunized have been extensive. At one AC, provisions were made to have the Public Health Nurse dispense immunizations at the PCC one day per month. Other Components arranged for mobile health units to come to the catchment area, or negotiated for extended clinic hours so that working mothers could bring their children in for immunizations. Ultimately, 77% of the CCR sample children were immunized. Among the total AC population, 160 different families were referred for immunizations. These 160 family referrals represent 15% of all referrals for health related problems and, because of the number of children under 5 per family, may represent immunizations for more than 450 children.

Comparing the CCR sample children to all children 0-5 identified by the ACs, we find that the CCR sample is representative of this population along this particular dimension. Of the 4739 children identified by the ACs through April 1973, 790 or 16% of these children were unimmunized. Looking at Table 34, we see that 17% of the sample children are either unimmunized or not up to date on their immunizations. The eight children whose parents were uncertain of the shots they had received are not included in this figure.

Table 35. Dental examinations during the AC year.

		TOTAL	URBAN	RURAL
Respondents				
Yes	N	42	22	20
	%	(57)	(61)	(53)
No	N	32	14	18
	%	(43)	(39)	(47)
Base	N	74	36	38
	%	(100)	(100)	(100)
Spouses				
Yes	N	28	10	18
	%	(61)	(71)	(56)
No	N	18	4	14
	%	(39)	(29)	(44)
Base	N	46	14	32
	%	(100)	(100)	(100)
Children				
Yes	N	74	35	39
	%	(46)	(54)	(40)
No	N	88	30	58
	%	(54)	(46)	(60)
Base: all children of dental age	N	162	65	97
	%	(100)	(100)	(100)
AC involvement in obtaining dental check-ups	N	24	10	14
	%	(42)	(37)	(47)
No AC involvement in obtaining dental check-ups	N	33	17	16
	%	(58)	(63)	(53)
Base:all families which received dental check-ups	N	57	27	30
	%	(100)	(100)	(100)
Percentage of sample receiving check-ups with AC involvement		(32)	(28)	(37)

Data previously presented relating to medical check-ups showed that it was more likely for children than for parents and older family members to receive examinations. There is a reverse trend with respect to dental examination: the majority of respondents and spouses have seen a dentist during the past year, whereas only 46% (54% urban, 40% rural) of the children are reported to have had examinations.

The relatively low rate of dental check-ups may reflect a tendency of parents to initiate dental care later than the recommended age of 3 years. It appears more difficult to motivate families to seek preventive dental care than is the case with other forms of health care. One AC made comprehensive arrangements for quality dental care on behalf of its population; the incidence of unkept appointments was so high as to discourage participating dentists. Only after much effort on the part of AC staff did the attendance rate improve.

Nine percent of all health related referrals (data presented in Chapter III) among AC families were made for dental care. Within the CCR sample, 42% of the families receiving dental care report that the AC was in some way involved in getting them to the dentist. In both the entire AC population and the CCR sample, reports of Advocacy assistance with respect to dental care were most numerous in rural programs. As presented in Chapter III, there were 30 dental referrals made by urban ACs and 65 referrals by rural Components on behalf of all AC families. However, figures are biased as one rural AC provided direct dental care in the form of check-ups as part of its initial needs assessment.

Table 36. Pre-natal care.

		Pregnancy during AC yr.			Last pregnancy prior to the AC year		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Received pre-natal care	N	22	16	6	63	28	35
	%	(100)	(100)	(100)	(85)	(78)	(92)
Did not receive pre-natal care	N	0	0	0	9	6	3
	%	-	-	-	(12)	(17)	(8)
No answer or not applicable	N	-	-	-	2	2	0
	%	-	-	-	(3)	(6)	-
Base	N	22	16	6	74	36	38
	%	(100)	(100)	(100)	(100)	(101)	(100)
AC involved	N	8	6	2			
	%	(36)	(38)	(33)			
No AC involvement	N	14	10	4			
	%	(64)	(62)	(67)			
Base: all persons receving pre-natal care	N	22	16	6			
	%	(100)	(100)	(100)			

On the National level, all Advocacy Components are charged with facilitating the delivery of pre-natal care services. The data show that of the 22 women who either had a child or became pregnant during the Advocacy year, 100% received pre-natal care, as compared with only 85% prior to the AC year.

Data submitted by the ACs on Supplementary Monthly Monitoring Forms show that 90% of the 403 pregnant women identified, report having received pre-natal care. The percentage of high risk pregnant women reporting pre-natal care is even higher: ninety-six percent.

Among the 22 pregnant women in the CCR sample, eight (36%) report AC involvement in obtaining pre-natal care. Parenthetically, the CCR sample does not appear to reflect total AC experience: only 20% of all pregnant women identified were aided by the AC relative to pre-natal care. Moreover, the 20% is likely inflated: ACs reported on the basis of number of referrals, not of different individuals referred.

Table 37. Trimester during which pre-natal care began.

		Pregnancy during AC yr.			Pregnancy prior to AC yr.		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
First trimester	N	14	9	5	36	15	21
	%	(64)	(56)	(83)	(57)	(54)	(60)
Second trimester	N	6	5	1	19	10	9
	%	(27)	(31)	(17)	(30)	(36)	(26)
Third trimester	N	2	2	0	8	3	5
	%	(9)	(13)	-	(13)	(10)	(14)
Base: All women who had children or became pregnant during these time periods and had pre-natal care	N	22	16	6	63	28	35
	%	(100)	(100)	(100)	(100)	(100)	(100)

A major concern with respect to pre-natal care is not whether a doctor was seen at all during pregnancy, but when ongoing medical attention was sought. The data presented show that both before and during AC participation, the majority of women began receiving pre-natal care during the first trimester of their pregnancy. However, the percentage of women receiving care in their first trimester is highest for those who had a baby or became pregnant during the Advocacy year. The most marked difference appears among rural subjects, where the figures increase 23 percentage points. Less pronounced differences appear in the second and third trimester categories.

Table 38A. Evaluation of medical services by respondents who have had contact with these services.

		T1			T2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Satisfactory	N	8	1	7	54	33	21
	%	(50)	(20)	(64)	(93)	(95)	(91)
Unsatisfac-tory	N	8	4	4	4	2	2
	%	(50)	(80)	(36)	(7)	(5)	(9)
Base	N	16	5	11	58	35	23
	%	(100)	(100)	(100)	(100)	(100)	(100)

Table 38A shows increased utilization of, and increased satisfaction with, available medical services in T2; for the most part this response pattern reflects experience with health clinics.

Table 38B. AC involvement and respondents' evaluation of change in medical services

		TOTAL	URBAN	RURAL
AC involvement	N %	21 (38)	11 (31)	10 (43)
No AC involvement	N %	37 (62)	24 (69)	13 (57)
Base: Persons having contact with medical service during AC year	N %	58 (100)	35 (100)	23 (100)
Evaluation of change in service quality				
Better	N %	18 (41)	16 (57)	2 (12)
No Change	N %	23 (52)	9 (32)	14 (88)
Worse	N %	3 (7)	3 (11)	0 -
Base: Persons having contact with medical service both before and during AC year	N %	44 (100)	28 (100)	16 (100)

Twenty-one of the 58 (38%) persons having contact with a medical service during the past year report that the AC was in some way responsible for connecting them with the service. As might be expected on the basis of prior discussion, this percentage

was higher in rural, than in urban areas.

The data presented on evaluation of changes in services, refer to respondents' evaluations of change in medical services delivered. These changes may include reduced waiting time and/or respondents' perceptions of the patient-medical personnel interaction. Only respondents who had contact with the medical service both before and during the AC year were asked for such an evaluation.

The urban respondents show the most change, and the most positive evaluation: fifty-seven percent perceive an improvement in medical services as compared to twelve percent of the rural respondents. However, the majority of all respondents report no change in the quality of services delivered.

4.2 Housing needs and referrals

Table 39. Housing needs: problems and concerns*

		T1			T2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Need repairs on house/ apartment	N	22	11	11	28	8	20
	%	(42)	(44)	(39)	(39)	(23)	(56)
House/apartment too small and/or too expensive	N	19	11	8	23	12	11
	%	(36)	(44)	(29)	(32)	(34)	(31)
Pest control problem	N	2	2	-	10	8	2
	%	(4)	(8)	-	(14)	(23)	(6)
Safety/security of house or neighborhood	N	10	1	9	10	7	3
	%	(19)	(4)	(32)	(14)	(20)	(8)
Base: Number of housing problems mentioned	N	53	25	28	71	35	36
	%	(101)	(100)	(100)	(99)	(100)	(101)
Number of respondents reporting housing needs	N	35	19	16	43	19	24
	%	(47)	(53)	(42)	(58)	(53)	(63)
Base: Total number of respondents		74	36	38	74	36	38

*Multiple responses occurred.

Forty-seven percent of the families mentioned a total of 53 housing problems in T1; fifty-eight percent of the families mentioned 71 problems in T2. Thus, an additional eleven percent of the families have either become sensitized to the fact that they have a housing problem or are willing to talk about this problem to a stranger.

Table 40. Changes in housing status.*

		TOTAL	URBAN	RURAL
Relocation	N	17	7	10
	%	(43)	(37)	(50)
Repair	N	8	2	6
	%	(21)	(10)	(30)
Change in rent	N	6	5	1
	%	(15)	(26)	(5)
Pest control	N	-	-	-
	%	-	-	-
Membership in Block or Tenants Association	N	1	1	-
	%	(3)	(5)	-
Other	N	7	4	3
	%	(18)	(21)	(15)
Base: total number of changes reported	N	39	19	20
	%	(100)	(99)	(100)
Number of different people reporting change in housing conditions	N	33	15	18
	%	(45)	(42)	(47)
Number of people not reporting change	N	41	21	20
	%	(55)	(58)	(53)
Base: total number of respondents	N	74	36	38
	%	(100)	(100)	(100)
AC involvement in effecting change	N	10	6	4
	%	(30)	(40)	(22)
No AC involvement in effecting change	N	23	9	14
	%	(70)	(60)	(78)
Base: number of persons reporting change in housing conditions	N	33	15	18
Percentage of sample reporting change in housing with AC involvement	%	(14)	(17)	(10)

* multiple responses occurred

Thirty-three (45%) of the families report a change in their housing situation during the course of the Advocacy year. Ten (30%) of these 33 respondents attribute this change directly to AC intervention. As in the case of previous discussion about AC involvement, it is probable that the number of individuals who report such involvement represent a lower bound estimate of the number of actual instances. That is, it is quite possible that families have been stimulated to make changes or improvements in housing because their involvement with AC has heightened their awareness of the need and potential for such activity. Thus, while 10 families report direct assistance, some of the remaining 23 families may well owe their activity to indirect and non-perceived stimulation from AC.

Projecting to the entire AC population, from the 10 sample families reporting AC-related housing changes, it can be estimated that 267 families have received help with housing during the AC year. Data presented in Tables 14 a and b show that the ACs reported 349 housing referrals, 229 of which had either a positive outcome (#9) or an expected positive outcome in the near (#8) or distant (#6) future.

Table 41. Knowledge of whom to contact in regard to housing problems.

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Don't know	N	49	20	29	22	3	19
	%	(66)	(56)	(76)	(30)	(8)	(50)
Welfare Department worker	N	2	-	2	2	-	2
	%	(3)	-	(5)	(3)	-	(5)
Advocacy Component worker	N	-	-	-	22	13	9
	%	-	-	-	(30)	(36)	(24)
Housing Authority or Legal Aid office	N	15	13	2	2	2	-
	%	(20)	(36)	(5)	(3)	(6)	-
N.A./Other	N	8	3	5	26	18	8
	%	(11)	(8)	(13)	(35)	(50)	(21)
Base: Total number of respondents	N	74	36	38	74	36	38
	%	(100)	(100)	(99)	(101)	(100)	(100)

The data show a clear trend in the direction of fewer respondents stating that they do not know what to do in the face of a housing problem. Approximately one-half of those who said that they did not know what to do in T1 state that they would contact the AC in T2.

The knowledge by families that they can contact the AC with regard to a housing or any other kind of problem does not, of course represent increased knowledgeability about available community resources and how they can be negotiated. As was discussed in Chapter III, the dependence on the AC for problem solution is characteristic of the many families which have come to rely on the AC as a continuing source of support and assistance. Continued education in who can be contacted and how, will hopefully, over time, enable some of these families to function effectively independent of

AC involvement. It should be recognized however, that there are families for whom continued support will be required if they are to engage in the service delivery network.

Table 42. Evaluation of Housing Authority by respondents who have had contact with it.

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Satisfactory	N	3	1	2	8	7	1
	%	(27)	(11)	(100)	(38)	(35)	(100)
Unsatisfactory	N	8	8	-	13	13	-
	%	(73)	(89)	-	(62)	(65)	-
Base: Respondents who have had contact with Housing Authority	N	11	9	2	21	20	1
	%	(100)	(100)	(100)	(100)	(100)	(100)

The number of respondents who had contact with the Housing Authority during the AC year nearly doubled. A slightly higher proportion of respondents are satisfied with the Housing Authority, but the majority are still dissatisfied with the services received.

4.3 Welfare needs and referrals

Table 43. Welfare needs: problems and concerns.*

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Need more $ for food, clothing, shelter	N	21	10	11	21	9	12
	%	(51)	(50)	(52)	(39)	(45)	(35)
Difficulty obtaining welfare, food stamps, Medicaid	N	14	8	6	24	7	17
	%	(34)	(40)	(29)	(44)	(35)	(50)
Other	N	6	2	4	9	4	5
	%	(15)	(10)	(19)	(17)	(20)	(15)
Base: number of welfare problems mentioned	N	41	20	21	54	20	34
	%	(100)	(100)	(100)	(100)	(100)	(100)
Respondents reporting welfare needs	N	35	19	16	40	17	23
	%	(47)	(53)	(42)	(54)	(47)	(60)
Base: total number of respondents	N	74	36	38	74	36	38

* multiple responses occurred

Nearly one-half of the respondents in T1, and slightly more than one-half of the respondents in T2, mentioned problems related to welfare. The number of welfare problems mentioned increased in T2, probably as a result of the heightened awareness to needs, and/or the greater willingness to discuss those needs with strangers.

Whereas in T1, 51% of the concerns centered around money, in T2, the largest proportion of problems centered around actually obtaining benefits. This may be an indication of an increased knowledge of benefits available and an awareness of eligibility requirements for obtaining such benefits.

Table 44. Changes in welfare status.

		TOTAL	URBAN	RURAL
New people on welfare	N	4	3	1
	%	(36)	(38)	(33)
New people on food stamps	N	2	1	1
	%	(18)	(12)	(33)
New people on commodities	N	1	1	-
	%	(9)	(12)	-
New people on Medicaid	N	4	3	1
	%	(36)	(38)	(33)
Base: total number of changes reported	N	11	8	3
	%	(99)	(100)	(99)
Number of different people reporting change in welfare	N	6	3	3
	%	(8)	(8)	(8)
Number of persons not reporting change	N	68	33	35
	%	(92)	(92)	(92)
Base: total number of respondents	N	74	36	38
	%	(100)	(100)	(100)
AC involvement in effecting change	N	6	3	3
	%	(100)	(100)	(100)
No AC involvement in effecting change	N	-	-	-
	%	-	-	-
Base: number of persons reporting change in welfare status	N	6	3	3
	%	(100)	(100)	(100)
% of total sample reporting a change in welfare with AC involvement	%	(8)	(8)	(8)

Six sample families report changes in their welfare status; all of them attribute the changes directly to AC involvement. Extrapolating from the study sample, changes in welfare status would be expected among 161 families in the AC population. In fact, data presented in Tables 14a and b show that the ACs report 215 welfare-related referrals, of which 145 had either a successful outcome (#9), immediate expectation of successful outcome (#8), or more long-range expectations (#6). Thus, once again it can be seen that the sample families are generally representative of the AC population as a whole.

Table 45. Evaluation of welfare services by those on welfare (T2).

		TOTAL	URBAN	RURAL
Got better	N	8	5	3
	%	(18)	(19)	(17)
No change	N	27	14	13
	%	(61)	(54)	(72)
Worse	N	9	7	2
	%	(20)	(27)	(11)
Base: people on welfare	N	44	26	18
	%	(99)	(100)	(100)

Among the 44 people on welfare, relatively few feel that welfare service deliver is better. In fact, the number reporting improvement corresponds closely with the number reporting changes in services received. Those who have had an actual

change perceive improvement in welfare service delivery; others do not. The reports of "no change" perceived are a striking reflection of the lack of actual AC-initiated changes in Welfare departments, (discussed in Chapter VI on Agencies).

4.4 Educational needs and referrals

Table 46. Educational needs: problems and concerns.*

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Need nursery/day care services	N	12	8	4	21	12	9
	%	(43)	(44)	(40)	(41)	(41)	(41)
Need adult education services	N	3	2	1	9	6	3
	%	(11)	(11)	(10)	(18)	(21)	(14)
Need better schools or problems w/school-age children	N	13	8	5	21	11	10
	%	(46)	(44)	(50)	(41)	(38)	(45)
Base: number of education needs mentioned	N	28	18	10	51	29	22
	%	(100)	(99)	(100)	(100)	(100)	(100)
Respondents reporting education needs	N	26	18	8	40	20	20
	%	(35)	(50)	(21)	(54)	(56)	(53)
Base: total number of respondents		74	36	38	74	36	38

* multiple responses occurred.

There has been a marked increase in the number of people reporting educational needs, both for themselves and their children. Apparently, AC involvement has served to sensitize a substantial number of people to the need and potential for educational advancement for themselves and for their children.

Table 47. Changes in education status.

		TOTAL	URBAN	RURAL
Adult education	N	3	2	1
	%	(15)	(18)	(12)
Day care/child care	N	3	3	-
	%	(15)	(27)	-
Head Start	N	9	5	4
	%	(45)	(45)	(44)
Other	N	5	1	4
	%	(25)	(9)	(44)
Base: total number of changes reported	N	20	11	9
	%	(100)	(99)	(100)
Number of different people reporting change in educational status	N	20	11	9
	%	(27)	(31)	(24)
Number of people not reporting change	N	54	25	29
	%	(73)	(69)	(76)
Base: total number of respondents	N	74	36	38
	%	(100)	(100)	(100)
AC involvement in effecting change	N	12	5	7
	%	(60)	(45)	(78)
Base: number of persons reporting change in educational status	N	20	11	9
% of sample who report a change in education status with AC involvement	%	(16)	(14)	(18)

Twenty people in the sample report changes in educational status. More than half (60%) of these attribute the changes to AC involvement, i.e., 16% of the CCR sample reported making a change in educational status with AC involvement.

Projecting to the entire AC population, from the 12 people who report changes in educational status as a result of AC involvement, it can be expected that approximately 321 people would show some change in educational status. Referring back to data presented in Tables 14 a and b, it can be seen that 349 referrals in education were reported by the AC. Three hundred thirteen of these referrals are reported to have either a successful outcome (#9), and anticipated positive outcome in either the immediate (#8) or more distant (#6) future. Once again, it can be seen that the experiences of the sample are rather closely representative of the experiences of the AC population at large.

Table 48. Knowledge of whom to contact in order to get a child into nursery school or a day care program.

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Don't know	N	34	16	18	12	2	10
	%	(46)	(44)	(47)	(16)	(6)	(26)
Advocacy Component worker	N	2	-	2	48	30	18
	%	(3)	-	(5)	(65)	(83)	(47)
Parent-Child Center	N	18	7	11	10	1	9
	%	(24)	(19)	(29)	(14)	(3)	(24)
Head Start or Day Care Center	N	20	13	7	4	3	1
	%	(27)	(36)	(18)	(5)	(8)	(3)
Base: Total number of respondents	N	74	36	38	74	36	38
	%	(100)	(99)	(99)	(100)	(100)	(100)

Relative to Table 48, while there are some T1-T2 shifts in terms of whom people would contact, the most important shift is in the decrease in number of people who say that they would not know whom to contact. Once again, it must be recognized that this does not represent an increased knowledge of community resources, but rather an expression of confidence in the AC staff.

Table 49. Evaluation of educational services by respondents who have contact with these services (Head Start, adult education, day care, and PCC).

		TIME 1			TIME 2		
		TOTAL	URBAN	RURAL	TOTAL	URBAN	RURAL
Satisfactory	N	2	-	2	41	23	18
	%	(33)	-	(67)	(95)	(96)	(95)
Unsatisfactory	N	4	3	1	2	1	1
	%	(67)	(100)	(33)	(5)	(4)	(5)
Base: respondents who have had contact with educational services	N	6	3	3	43	24	19
	%	(100)	(100)	(100)	(100)	(100)	(100)

The number of respondents who report contact has increased sharply in T2. The vast majority of T2 respondents report satisfaction with educational facilities.

4.5 Other services needed and received by AC families

Table 50. Other services for which referrals have been made.

		TIME 2		
		TOTAL	UNEM.	NUMB.
Job training	N	6	6	-
	%	(12)	(29)	-
Job placement	N	11	5	6
	%	(22)	(24)	(21)
Legal Aid	N	3	-	3
	%	(6)	-	(11)
Clothing	N	14	3	11
	%	(29)	(14)	(39)
Food	N	5	1	4
	%	(10)	(5)	(14)
Other	N	10	6	4
	%	(20)	(29)	(14)
Base: number of services	N	49	21	28
	%	(99)	(101)	(99)
Number of different people reporting a referral	N	29	14	15
	%	(39)	(39)	(39)
Base: total number of respondents	N	74	36	38

Data presented in Table 50 reflect services already received and services for which referrals have been made. Thus, the 14 families who report clothing referrals have actually received clothing, whereas 11 families who report report job placement referrals have been referred but have not necessarily yet found a job.

A high proportion of the sample has been referred for job-related and vital services-related problems.

5.0 Family participation in group and community activities

Table 51. Attendance at AC-sponsored meetings.

		TOTAL	URBAN	RURAL
People attending meetings	N	24	16	8
	%	(32)	(44)	(21)
People not attending meetings	N	50	20	30
	%	(68)	(56)	(79)
Base: total number of families	N	74	36	38
	%	(100)	(100)	(100)

Approximately 32% of the sample report having attended at least one AC-sponsored meeting. This appears to be a relatively high proportion, in view especially of the fact that several AC's held very few meetings, so that if a participant did not attend a particular meeting there might have been no further opportunity for such participation. In fact, 28 of the 50 (56%)

people who stated that they did not attend a meeting, report that to their knowledge no meetings were held. Twenty-four of these people are in rural areas, where indeed two of the Components did not emphasize group meetings.

Table 52. Frequency of attendance at meetings.

	NUMBER OF MEETINGS									
	URBAN					RURAL				
	1	2	3	4	5	1	2	3	4	5
Number of people attending	4	5	2	3	2	3	5	0	0	0

The majority of urban respondents attended either one or two meetings. None of the eight rural respondents attended more than two meetings.

Table 53. Topics discussed at meetings attended.

	NUMBER OF RESPONDENTS REPORTING ATTENDANCE AT A MEETING	
	URBAN	RURAL
Health	12	8
Housing	9	-
Welfare rights	8	-
Education	8	4
Dental care	8	3
Drugs	5	-
Pre-natal	3	2
Nutrition	2	2
Base: number of different people attending meetings	16	8

A substantial number of participants attended meetings in the areas of health, housing, welfare, education, and dental care.

Table 54. Attendance at community meetings.

		TOTAL	URBAN	RURAL
Yes	N	9	4	5
	%	(12)	(11)	(13)
No	N	65	32	33
	%	(88)	(89)	(87)
Base: total number of respondents	N	74	36	38
	%	(100)	(100)	(100)

Even though the vast majority of respondents attended AC-sponsored meetings, they were not sufficiently motivated to attend community meetings.

6.0 SUMMARY

SAMPLE REPRESENTATIVENESS

- 171 interviews were conducted at T1; 74 respondents were available for reinterview at T2 one year later. Forty-two percent of those who could not be reinterviewed moved from the catchment area. Chi-square analyses showed no significant differences between the full T1 sample and the attenuated T2 sample.

- The 74 sample families on whom T1 and T2 data are available represent 3.7% of the 1,981 families with which the ACs have made some intervention.

- Considerable caution is urged in making generalizations on the basis of this sample to the entire AC population both because of the small size of the sample and because sample families were visited and referred more often than other families. In other words, more was done on behalf of sample families than on behalf of the AC population at large.

DEMOGRAPHIC CHARACTERISTICS

- Ninety percent of the sample is female.

- The majority of respondents are under 30.

- Forty-eight percent of the sample is black, 38% is other Caucasian and 12% is Mexican-American.

- Seventy-four percent of the total sample (90% rural, 58% urban) has not completed high school.

- Seventy-six percent of the families have between one and two children age 0 - 5. The families represented by the sample have 131 children in this age range.

- The average number of children per family is 3.7. There are a total of 277 children represented by the sample.

- Fathers are present in 62% of the homes (39% urban, 84% rural).

- Fifty-nine percent of the families are receiving public assistance.

RELATIONSHIPS BETWEEN THE ACs AND THE SAMPLE FAMILIES

- The majority of families report AC staff home visits once a month or more.

- The majority of families perceive home visits as involving a combination of support and encouragement, referral to an agency and information.

SERVICES NEEDED AND RECEIVED

Health referrals

- Sixteen percent of the sample reports enrollment in a medical plan as the result of AC intervention. Each such enrollment represents the registration of from four to six persons for health care services.

- Twenty-eight percent of the sample reports AC involvement in obtaining check-ups.

- There is a significant increase from 57% at T1 to 77% in T2 in the number of children 0 - 5 who are immunized appropriate to their age level.

- Thirty-two percent of the sample report receiving a dental check-up as a function of AC intervention.

- Twenty-two women in the sample were pregnant during the AC year. Eight of these report AC involvement in obtaining prenatal care. The remaining women state that they sought out prenatal care on their own.

- Forty-one percent (57% urban, 12% rural) of the sample reports that medical facilities had improved in their service delivery over the past year.

Housing referrals

- Fourteen percent of the sample reports a change in housing conditions as a result of AC intervention.
- There is a marked decrease from T1 to T2 in the proportion of respondents who state that they would not know whom to contact concerning a housing problem.

Welfare referrals

- Eight percent of the sample reports AC involvement regarding a shift in Welfare status.
- Only 13% of the sample reports improvement in Welfare service delivery.

Education referrals

- Sixteen percent of the sample reports change in educational status.

- The proportion of respondents who report that they would not know where to turn for advice concerning an educational problem decreased from 46% in T1 to 16% in T2.

ATTENDANCE AT MEETINGS

- Thirty-two percent of the sample (44% urban, 21% rural) report attendance at AC sponsored meetings. Meetings attended covered a wide range of topics, e.g., health, housing, welfare and rights.

CHAPTER V

GROUP MEETINGS, MASS MEETINGS, COUNCILS, AND WORKSHOPS FOR AC FAMILIES

1.0 Introduction

Activities described in this chapter are relevant to the implicit national advocacy goal of educating families so that they may:

- better understand the importance and relevance of health-related services and practices: e.g. immunizations, medical and dental check-ups, pre-natal care.
- better understand their rights vis-a-vis service delivery systems. This includes knowledge of what services are supposed to be available through Welfare, the Department of Housing, and the local Health Plan and how to negotiate these systems in order to obtain services.
- advocate on their own for changes in the service delivery system and for the creation of new services.

Some of the group activities described are also relevant to certain aspects of national goal #8 to ensure the delivery of adequate services to expectant mothers and their new born babies.

In an effort to meet their goals, each Component organized a special group or held a mass meeting or a workshop for participating families. At three urban and one rural Components this effort to involve families directly in the AC program has been ongoing or at least an important aspect of program implementation.

There are several advantages to groups as a means to meeting objectives related to family education. One significant advantage is that expertise in a given area can be made available to a group more easily than to an individual. For example, a program may elicit cooperation from resource specialists, whereas it is not as likely that these same specialists would agree to accompany outreach workers during home visits. Thus, a group activity is both a parsimonious use of time and an effective means of conveying important information to a larger audience.

At the individual level, participation in group activities can help to foster self awareness and self confidence. Participants can also learn that they can have a voice in determining what happens to them and that this voice can and should be heard outside the Advocacy Component.

At the community level, group activities can be seen as a possible training ground for future community organizers. One Coordinator views group participation in terms of the adage, "Each one, reach one." An informed, knowledgeable community person may have access to a portion of the community not otherwise readily available to the Component.

In addition, such persons are potential community leaders who may, at some point, be able to help the community perform its own advocacy functions, independent of a structured, federally-funded program.

In this chapter discussion will focus on the different types of group activities attempted and on the constraints attendant upon such activities.

Major difficulties have been encountered with respect to the stimulation of interest, and the maintenance of family attendance and involvement. For example, at one urban AC, in which weekly meetings are conducted relating to a variety of topics, parents are offered transportation to and from the meeting, free lunch and child care services; yet attendance hovers around only four or five families per week. When CCR interviewed families from this Component's area, some mothers told interviewers, "I just don't like to leave my house."

At other ACs the difficulty lies in sustaining interest. After an initial burst of enthusiasm, group attendance declines and new participants do not enroll. As will be discussed in the section on groups, such decline in involvement is particularly characteristic with regard to pregnant women. Only one of all the groups initiated has maintained itself (and increased its membership) throughout the program year.

2.0 Mass meetings/workshops

Mass meetings and workshops are usually specific in scope, often relying on experts outside of the Component's organization. Although usually called in response to an ongoing need requiring action, a mass meeting or workshop is itself a short-term project. That is, action, if indicated, is taken immediately and follow-up is not usually an integral part of this event. However, planning for such an event is extremely time-consuming. In addition to the preparation of content, publicity, and location, possible provision of transportation and support services must be taken into account. In rural areas especially, some Coordinators feel that these ancillary considerations make mass meetings or workshops so difficult as to preclude their being a major thrust of the AC.

The level of success associated with such meetings has varied, as have the measures of outcome, themselves. Typically, evaluations have been cast in terms of the number of persons attending, the substance of the presentation, the degree of audience participation or the subjective account of the overall effect

The following meetings and workshops have been sponsored and organized during the first Advocacy year:

- Since its inception, an urban AC has been concerned with the large scale drug problem in its community and has made information available to its families. However, providing information during a home visit, or dispensing information in a rental office of the housing project were not considered to be the most effective techniques of information dissemination. Therefore, the Component coordinated efforts with a local drug abuse project, and sponsored a large, seminar-type meeting in an auditorium centrally located within the area. For weeks prior to the meeting, outreach workers on home visits reminded families of the coming event; posters announcing the seminar were displayed in shop windows and in apartment building lobbies. The meeting drew an audience of approximately one hundred persons, with the majority ranging in age from ten to twenty years. On the agenda were a film on drug abuse, a display of harmful narcotics and drugs, a presentation by two ex-addicts, a talk on services available to persons with drug problems and a question and answer period.

This mass meeting reached a population not normally readily available to the Component and, perhaps more important, afforded participants the anonymity needed for acceptance of the information.

- A rural AC together with a local community college, sponsored a State House Conference on the Young Child. This all day conference was attended by community residents and by representatives from eleven state and local agencies. As part of the meetings, Advocacy families planned and participated in a seminar addressing the question of parent involvement and development in child-centered programs. Other conference topic areas discussed included the rights of children, developmental day care needs, revenue sharing monies vis-a-vis children's programs and the maintenance of bi-lingual, bi-cultural education programs.

- An urban AC conducts weekly workshops at the Parent-Child Center, chaired by resource personnel or by specialists from within the AC, to which all Advocacy and PCC families are invited.

The first few meetings were used as sounding boards, to discover topics of interest for subsequent meetings. Topics have since included housing, welfare rights, day care, education and drugs. Even though lunch is served and child care services provided, attendance of Advocacy families is low, four to five families at each meeting. PCC family participation is somewhat higher, but these persons are, for most part, already at the Center for program.

- A rural Component conducted two two-day workshops for Advocacy mothers and their children. Working with the PCC health and education staff members, AC families were given the opportunity to participate in various Parent-Child Center activities. At one point in the workshop, mothers and children were separated; mothers participated in a health class conducted by the PCC nurse, while the children were divided into groups, according to age categories, and worked with by the education staff. Another activity involving both mothers and children as a group, taught basic child care techniques through the understanding of mother-child interaction.

Attendance ranged from 13 to 19 mothers for each of the two workshops.

- Resident Group Meetings conducted by an urban AC are regarded as "Mass Meetings" because they do not, as yet, adhere to a regular, ongoing schedule. Following a preliminary fact-finding session, four such meetings have been held to date. Community resource persons are invited to attend; topics covered thus far have included the proposed cuts in service agency budgets (two meetings), welfare rights, and programs for economic advancement through career development. An average of forty persons have attended each meeting and it is estimated that eighty percent of the audience is comprised of Advocacy families.

- A rural Advocacy Component held a one-day Family Planning Workshop attended by approximately 100 persons. The audience was comprised of both men and women, high school students and older adults. The workshop was a multi-media presentation followed by group discussions.

- An urban Advocacy Component, in conjunction with its PCC, sponsored a Hunger Meeting during which information was disseminated and a film was shown. Materials for the program were supplied by a state food committee, an organization concerned with the elimination of hunger and malnutrition through education and agency coordination. Of the thirty families attending this meeting, twenty were Advocacy families.

- A rural Component organized a "Brush-In" for parents and children in order to emphasize the importance of preventive dental care. The program involved a puppet show, educational films for different age levels, a speaker on nutrition and diet, a cooking demonstration, and the actual "Brush-In" during which free toothbrushes and squares of fluoride paste were distributed. Approximately 40 agencies were requested to encourage their members, clients or associates to participate. In total, roughly 250 children and 50 adults attended.

- A rural Component organized two mass meetings in order to inform families of available benefits to persons with black lung disease. Families were given legal advice on how to file for benefits and eligibility requirements were discussed. Thirty-seven Advocacy and PCC families attended.

- A welfare workshop was organized by the staff of an urban AC. Speakers from the County Welfare Department and a local Welfare Rights Organization made presentations. The 46 AC families who attended received information on eligibility requirements for food stamps, aid to dependent children, emergency funds and other services available from the Welfare Department.

- Four Consumer Education programs have been organized by a rural Advocacy Component. The programs, held at four different sites within a county of the AC catchment area, have been chaired by the AC/PCC nutritionist with assistance from the AC staff. The meetings included discussions on proper diet, food purchasing and cooking demonstrations. Parents are active participants in these workshops, bringing foods to be used in the demonstration and exchanging information on economical shopping practices. Attendance ranged from twelve families at one meeting to twenty-one at another.

3.0 Committees of Advocacy families

Committees of Advocacy families have proven a successful vehicle for community organization in only one of the seven Advocacy Components. Although attempts to develop committees have been made at one other Component, the result was a single meeting with no follow-up on the part of the families.

Whereas mass meetings provide the anonymity desired by many persons, the committee requires that each person "stand up and be counted." The committee is, in a sense, a goal-oriented, action organization. It is formed with a specific purpose or focus in mind and its members are usually charged with planning for a particular project or developing action recommendations for other organizations.

In order to form a committee, the project at hand must be one with which potential members can identify and perceive as within their power to affect. Thus, for example, it may be easy to convince a group of people that the rent scale increase in a public housing project is of concern to them, but less easy to persuade them that there may be appropriate action that they can take. For such reasons, it may be that the formation of effective, active committees of Advocacy families will become more widespread only as Component participants gain more confidence in their abilities.

Following are examples of efforts to organize committees around specific issues:

- A rural Advocacy Component, concerned about the lack of well-baby services within its catchment area, had completed a special Health Survey to establish the need for this type of service, and to assess potential for utilization of such services. Once the Survey was completed, a Clinic Board was formed to evaluate Survey results and plan steps for action. The Board is comprised of ten community families drawn from the AC's tri-county catchment area. It has obtained Health Department cooperation and, should the Clinic be established, current Board members will become members of the Comprehensive Health Association which is the governing body of all health-related resources in the area.

- A concerned Citizens Advocate Group has been formed in one community of a rural AC's catchment area. Comprised of 18 individuals, the group seeks to define priorities and is preparing recommendations for community action and projects.

The group is seen as the seminal committee of community organizers who will perform needed community advocacy functions, separate from the established AC.

- A Tenant Housing Committee was organized by a rural AC in an effort to bring community pressure to bear upon the problems affecting a local public housing project. Staff members sent flyers to the 70 families residing in the project and then personally visited each family to encourage participation in the Committee's first meeting. During this first meeting, at which 18 families were represented, problems were discussed and action recommendations formulated. The Committee remained active for some three months, at which point the AC staff member who had been advising the group resigned and interest waned to such a degree that meetings have been discontinued.

- An urban AC had included in its objectives,: "to encourage participation in the Tenants' Council." The Council had been formed prior to the creation of the AC; however, it was faltering and could have, potentially, been

invigorated by AC family involvement. Through talks during home visits and large meetings on housing problems, Component staff sought to encourage AC family participation. A small number of persons did attend a meeting, but their involvement did not continue. Families felt that the Council was "not responsive to the community." This then seems to be a case where the problems are real enough to touch the people, but the people do not feel that they have the power to effect change.

4.0 Ongoing group meetings

In all but two Components, attempts have been made to organize groups of Advocacy families to meet on a regular, ongoing basis. In most instances, the target population has been pregnant women, teenage girls, or young mothers, reflective of a central goal of each Component, namely, to ensure that every pregnant woman in its catchment area receives adequate pre-natal care. In all the urban communities pre-natal care is available. In rural communities, the availability and accessibility of pre-natal care can be a real problem.

In those communities where pre-natal care is available, the purpose of a pre-natal group may not be immediately apparent. A leader of one such group explained that although quality care was provided at several clinics and hospitals in the area, people do not "like" to attend the classes. Either the location of the classes is "inconvenient" or the woman is just not "motivated" to attend. Staff at this particular Component did not feel that they were in any way duplicating a service. Rather, they felt that they were providing a more convenient and personalized service. Given that it is the responsibility of the AC to coordinate the efforts of existing services and to create new services only when gaps are discovered, this pre-natal group may be seen as a duplication of services. On the other hand, if established services are not utilized, the creation of a new resource may be justified if the service is offered in a manner which makes it acceptable to consumers.

However, underutilization of AC services is as much a problem as underutilization of existing resources.

As will be seen in the discussion of individual groups, attendance at most pre-natal group sessions dropped significantly and rapidly. In all cases, this decline in participation either caused the AC to change the format of the sessions or to abandon its efforts.

The problem seems to be less one of motivation than of actual need. As Coordinators evaluate data obtained from needs assessments, they are finding that most women report that they have received pre-natal care; the number of pregnant women not receiving care is far lower than several Coordinators had anticipated. The need that now seems to be indicated is for data that will show when, during their pregnancy, women began to receive this care. Once this is accomplished, and it is being done at one Component, appropriate action, either referral or group formation, can follow.

Groups concerned with pre-natal care were most common; however, other groups developed, as follows:

- A Teenage Mothers Club, organized by an urban AC, must, in some sense, be considered the most "successful" of all groups. It is the only group to have maintained itself throughout the program's life and to have steadily increased its membership. The Club was developed in response to a need presented to the AC by a community agency. The agency was concerned that once a teenager left school to have a baby, there were no available resources to provide continuing care, service and support. Meeting weekly, the teenagers have structured their

own sessions with the help of an AC staff member. Child care and child development are discussed, as are job training programs, continuing education, and social activities. Several members have since returned to school or joined the PCC and several have expressed an interest in acquiring new skills and working within the community. At Christmas time, the teenagers solicited contributions from neighborhood merchants and organized a sale, the proceeds from which were used to make and distribute Christmas baskets to needy residents. Although seventeen invitations were mailed for the first meeting, only three mothers attended. Through referrals by the teenagers themselves, as well as by the PCC and AC outreach workers, active membership currently totals 32.

- A teenage rap group, with an emphasis on problems in family planning, was started during the first summer of an urban AC's operation. Originally, the group was comprised of teenagers from AC families and was chaired by two Component staff members who had been specially trained by a local family planning agency.

Resource persons spoke at some meetings and the teenagers were given the opportunity to plan the topics for subsequent meetings. At this time, an average of fifteen adolescents attended the four sessions held in August. When school began in September, the teenagers no longer attended the meetings. At this point, the AC staff members made plans to conduct these sessions at a neighborhood youth employment center using the teenagers who came to get their pay checks there as an audience. Meeting format remained the same and sessions continued for several months until the employment center lost its funding and was forced to close. To date, nothing more has been done by the AC with either set of teenagers.

- An urban AC organized group sessions for expectant mothers. These sessions were chaired by a nurse who was an AC staff member, together with a consulting nutritionist. The weekly class was begun early in AC operations, but drew only three or four women per session at the onset. Despite such low attendance, staff members continued to plan agendas and to invite resource persons to speak at meetings. A few months after the group's inception, participation grew to approximately thirteen women. However, as the AC staff member who headed the group said, "You can't keep women pregnant forever," and so the size

of the group diminished to five. Few new expectant mothers came to the AC meetings and although sessions still continue, attendance is now somewhere between two or three women per week.

- A rural Advocacy Component organized classes in natural childbirth. A childbirth trainer, familiar with the Lamaze method of natural childbirth, and a registered nurse were recruited by the AC to conduct this ten-week course. The class meets once a week and is attended by ten Advocacy mothers who began the course when they were approximately seven months pregnant; prospective fathers are invited to attend. The method and procedure of natural childbirth and pre-natal care and nutrition are among the topics discussed.

- In the beginning of its program year, a rural AC conducted a pre-natal care information class. The course ran for eight weeks, chaired by the AC nurse, and coordinated with the County Health Department. Twenty women enrolled in the program; however, only eight women completed the course.

- An urban AC held one discussion group meeting with pregnant women to ascertain what the needs of this target population were. This session was meant to be the first in a number of subsequent meetings that were never actualized. Information gained during this exploratory meeting was, however, used to structure a six-week Mother

and Child Care Course. The course was held during the fall and was attended, weekly, by five Advocacy mothers and ten PCC mothers. Sessions were conducted by Red Cross personnel, a volunteer nurse and two AC staff members who had been trained by the Red Cross.

- A rural AC has made arrangements with the social service component of the local health department, to conduct monthly group discussions. A social worker from the department meets with five AC members who are unwed mothers in order to informally discuss and exchange feelings about common problems.

- An urban AC has provided staff members to the local elementary school in order to conduct weekly health and grooming classes for forty-seven young boys. The program was ongoing for several months when the staff members involved in the classes terminated their employment. At that point the Coordinator led the classes, but he too has terminated and the program has been disbanded.

- During the spring of 1972, a rural Component organized monthly rap sessions for teenagers. Approximately thirty teenagers attended each session held until the end of the summer. During this period, the youths

discussed their needs and problems in the community, and, in an effort to act as "youth advocates," cooperated in a voter registration drive. In September, interest among the members declined as some found jobs and others returned to school. The group is no longer active.

5.0 Projects

5.1 A rural food cooperative

One rural Advocacy Component began a project of family group participation that cannot truly be considered under any of the previously discussed categories of activities. The project, a Food Cooperative, was started in response to the rising cost of meat and the growing difficulties that families were having in meeting this increase. In addition, and perhaps more important than the actual provision of meat, the AC saw this Cooperative as a vehicle to encourage community organization and involvement around a tangible issue. It was seen as a means by which residents could become actively involved in the life of their community and, if successful, would produce the degree of self-confidence needed to move on to further activities.

In order for the cooperative to become functional, several tasks had to be completed: participants had to be recruited, a mechanism for collecting monies had to be formulated, provisions had to be made for monthly transportation to a large

wholesale meat market and then plans for the purchasing and distribution of the products had to be set. AC staff members held several meetings with community residents to discuss the proposed Cooperative and to gain both their commitment and participation. Component staff was aware of the fact that, initially, the cooperative venture would place great demands on their time and resources, but it was planned that the responsibility of the operations would be transferred to the communities once the program was set in motion.

Membership in the Food Cooperative has grown from an initial twenty families to approximately one hundred and seventy five families. Although regular community meetings are held with AC staff and residents, and the program has been operational for three months, to date it still has not become a solely community operated effort. Membership continues to grow, but the transfer of major responsibility from the AC to the community is taking more time than the AC originally anticipated.

5.2 An experimental baby food project

Since June 1, 1972, a rural Advocacy Component has been buying and distributing baby food to target children as part of an experiment. As instituted, the long-range goal of this experiment is to convince the commodities program of the desirability of including baby food in their program.

The plan was to locate 30 experimental babies, from newborn to 3 months of age, and 30 control babies. A supply of baby food would be delivered to the mothers of the experimental group every two weeks until the child was one year old. During the food delivery visit, the babies would be weighed, measured and checked by an AC staff member. There are no control babies being monitored by the AC staff. Rather, 30 case histories of 30 one-year old babies were compiled for comparison purposes.

In September of 1972, there were 18 babies participating in the program. Currently the experimental group numbers 23. Data collected on this group seem to show that the experimental babies are steadily gaining weight and are sick less often than are the control group babies.

Delivery of the baby foods every two weeks requires considerable staff time, particularly as families are frequently out when the AC worker comes to visit and a second visit is not unusual. No evaluation of this effort can be made until such time as the experiment is terminated and the policy makers involved with commodity foods reach a decision. If baby foods become a part of the commodities food program, the AC will have made an outstanding contribution.

6.0 Progress toward achievement of the relevant national goals

At present the amount of staff time required for the organization and/or maintenance of any family group activity is unknown. The impression is that these activities take a

great deal of staff time and that the benefits derived by the families are extremely difficult to demonstrate. An exchange of information as to what kinds of meetings or groups have seemed to be successful and what kind have elicited only minimal participation would be most helpful. The overall impression is that groups for expectant mothers have met with minimal success and have not played an important role in prenatal care. It is suggested that AC efforts be directed toward other issues and activities.

CHAPTER VI

RELATIONSHIPS BETWEEN THE ADVOCACY COMPONENTS AND COMMUNITY AGENCIES

1.0 Introduction: sources of information

This chapter describes the nature of relationships developed by the ACs with other community agencies during the first year of the AC program. Activities described in this chapter are relevant to the achievement of the following national goals:

- to identify all private and public programs that provide services for residents in the catchment area, and to compile information on existing community services.
- to identify the gaps between needs and existing services.
- to assist in bringing together a comprehensive and efficient delivery system of services.
- to promote the development of community resources which will fill gaps in existing services.

The information presented is drawn primarily from two sources:

- Four site visits to each AC. During extensive interviews with the AC Coordinators, topics discussed included: process of resource identification, development of new

linkages, meetings with other agencies, joint AC-agency workshops or other community activities coordinating efforts, and efforts to induce changes.

- Site visits to community agencies in May 1972 (T1) when the Advocacy effort was just getting underway, and in May 1973 (T2) after one year of AC operation.

1.1 Designation of community agencies

In May, 1972, Advocacy Coordinators were asked by CCR to select the four or five agencies with which they expected to work most closely during the ensuing year. At each of these agencies, CCR staff met with either the Administrator of the agency, or with the Supervisor of the unit (s) most relevant to the Advocacy effort.

In May, 1973, interviews were conducted at all agencies with which Advocacy had indeed had contact. In cases where anticipated relationships had not developed, the Coordinator was asked to identify (for CCR interview) other agencies with which a relationship had developed. At Components in which all of the anticipated relationships were preserved and in which linkages had been developed with additional important agencies, these agencies were visited also.

Table 55 shows the number of agencies interviewed at TI, the number of agencies interviewed at T1 and T2 according to the original plan, and the number of agencies interviewed at T2 only.

Table 55. Number of agencies interviewed at each site visit.

T1 only	T2 only	T1 & T2
7	11	26

In the case of 26 agencies, AC's had developed relationships as anticipated. In the case of 7 agencies, anticipated relationships never developed. Often, this occurred as a function of de-funding of Federal programs, or of changes in community agency catchment areas away from the AC target areas. In 23 of the 26 cases involving repeat follow-up at the same agency, the same person was interviewed at both T1 and T2, assuring some continuity of viewpoint.

The types of agencies at which CCR conducted interviews is as follows:

Table 56. Distribution of agencies, by functional area, at which interviews were conducted.

HEALTH	WELFARE	HOUSING	EDUCATION	LEGAL	COMMUNITY SERVICES
15	11	1	3	4	3

The sample, which is weighted in favor of health and welfare agencies, reflects the AC's emphasis on ensuring health and welfare services to families.

2.0 Identification of resources

Identification of agencies and services has been a major task at all AC's. It stems from the AC's mandate to identify the gaps in existing services and to function as a coordinating mechanism for referrals. Before an appropriate referral can be made, workers need to understand fully what each agency does; before service gaps can be identified, it is necessary to find out what exists in the community.

A complex and time consuming process, the identification of agencies, has been ongoing at each of the Components throughout the first year. AC's must establish in detail what services each agency offers, eligibility requirements, and staff functions. As a result of a major commitment to this area of activity, the AC's were able to identify agencies and resources previously unknown to the PCC's. In most instances, this information was acquired either through a visit by the Advocacy Coordinator to the agency, or through a visit by an agency representative to the Advocacy Component. Some agencies sent several of their staff to conduct a training workshop for AC staff on eligibility requirements, staff functions, and services rendered.

One rural welfare department even prepared an extensive illustrated booklet specifically for use by AC staff. Clearly, these activities go far beyond a superficial checking of Service Directory listings.

At several Components, Advocacy staff members in addition to the Coordinator were included in the visits to other agencies; such visits were reported to be particularly helpful in the orientation to an agency. As a function of these personal contacts, AC staff is able to recommend an agency or service based on direct and personal knowledge of how things are done.

Three Components developed Agency Directories. The reaction to these Directories by other community agencies ranges from considerable enthusiasm and praise for their value, to total ignorance of their existence.

At several other Components, Directories were planned but as yet not developed. At two Components, Agency Directories are still planned. The lesson gained from indepth familiarity with agencies, was that in many communities such Directories already exist. In at least one AC, the intention was to adapt the already existing Agency Directory to make it suitable for distribution to AC families. To date, this task has not been accomplished at any AC.

3.0 Relationships between individual agencies and the AC

The ACs have developed a variety of relationships with agencies, depending on both individual AC style, and on the particular agency involved. The relationship with some agencies is based on a referral linkage; with others, on an exchange of service elements; with still others, the relationship may include an emphasis on seeking change either within the agency or, jointly, within the community.

Table 57, summerizes the information contained in sections 3.0 - 5.0 inclusive.

Table 57: A number of agencies reporting different kinds of activities vis-a-vis the ACs.

Referrals from AC	Joint workshops, ongoing meetings & staff training	Referrals to AC	Use of AC Out-reach capabil-ity	Agencies reporting <u>new</u> services or facilities as a function of AC effort
37	17	19	11	5
Base: 37 agencies				

3.1 Referral-based relationships

Approximately half of the relationships with other agencies are operationalized in terms of referral activity. A referral linkage is the sole ongoing basis of the relationship between the agency and the AC in 20 out of the 37 agencies visited in T2. Relationships with the remaining 17 agencies are manifest in terms of joint ongoing meetings and projects, as well as of referral.

A referral linkage exists when the AC has identified the referral procedures and/or a specific person to whom referrals are made. Using these linkages, Advocates have been able to shorten waiting time for their families, and in many instances to ensure more personal treatment, as well. Familiarity with enrollment and eligibility procedures has also enabled AC staff to prepare families for appointments, and to ensure that the particular agency is indeed the appropriate resource for that family. Such linkage also facilitates the process of follow-up

to the agency, by identifying a specific person who can be called at each agency, in order to determine the outcome of a referral.

Nineteen of the agencies interviewed have referred clients to the AC. Usually such referrals occur when the agency does not have the resources to help the client, and hopes that the AC will either be able to make an appropriate referral or will provide the agency with assistance in the servicing of that client. For instance, in rural areas agencies refer clients to AC for transportation to services. A few agencies state that some of their referrals to AC are based on their impression that the AC staff has better rapport with some families. As one rural welfare administrator said, "Sure we refer to Advocacy - maybe they have a better working relationship with a family than we do - they are out there and get out more often - if the issue is protective services, we represent more of a threat - sometimes they can establish rapport when we can't." Recognition of the AC as a coordinating mechanism for referrals, or as an agency adjunct, seems to be growing in several communities.

3.2 Relationships based on an exchange of services

3.2.1 Outreach on behalf of other agencies

In several instances the Advocacy Components are facilitating the service delivery procedures of other agencies. Examples of this include the following:

- In one rural community, the AC has offered transportation to families served by other agencies, in conjunction with AC planned trips to resources. This was the best known and most highly valued activity of the AC among agencies interviewed in this community.

- In an urban community, workers from the City Department of Social Services use the AC outreach workers to assess eligibility for furniture grants. This is not done as a matter of DSS policy, but rather as a function of relationships developed between the DSS and AC staff.

- In a rural community, both the County Welfare Department and the County Health Department sometimes ask the AC to assess individual family needs. The AC is located in the catchment area, whereas the Welfare Department is 25 miles away. Thus in emergency situations, particularly when the weather makes roads impassible, the AC can facilitate and speed service delivery. For instance, the welfare administrator explained that, when a family needs a large grant for emergency funds, AC verification of the emergency is sufficient for making the grant. Prior to this time, families in dire need had to wait until a welfare outreach worker was available to verify need.

- In an urban area, Advocacy staff provided outreach services for the major health facility in the catchment area. An AC worker called all families who had a health appointment for the following day, to remind them or to encourage them to come. This practice was not found to be of particular value and was discontinued.

- In another urban area, each AC outreach worker spent three hours per week in the emergency room of a children's hospital as Patient Advocates. This was part of an eight-week demonstration project aimed at 1) improving patients' understanding of the hospital and its procedures; 2) increasing patient awareness of the need for preventive medical care; and, 3) sensitizing hospital personnel to the non-medical needs of the population using their services. This demonstration has led to efforts on the part of the hospital to establish a permanent patient advocacy program in their facility.

- In an urban community the AC staff were trained in the screening and registration procedures used by a community health clinic. Subsequently functioning as outreach workers, they now conduct the first step in the enrollment of families in the facility.

3.2.2 Use of community agency's staff as resources for AC staff training or for AC sponsored community workshops

In five of the Components, agencies have served as a source of training for AC staff and in four of the Components, agencies have provided staff and information for AC-sponsored community meetings and workshops. The following are examples of such relationships:

- In an urban community, a health agency provided staff and materials for an AC-sponsored community workshop on drugs. In this same community the health facilities provide the AC with a large number of flyers and public information pamphlets which the AC distributes to its families.
- A university-based social sciences center participated in the training of an urban AC staff.
- In another urban location, the State Division of Retardation provided training for AC staff in administering the Denver Development Screening Test and the Vineland Social Maturity Scale to children in the catchment area. In those instances where the AC worker felt the child might have a problem, referrals were made to a psychologist for further testing.
- A major Child Development Center has provided staff at a rural AC with training in interviewing and identification of high-risk children.

- In an urban AC, the Family Planning Agency provided AC outreach workers with training so that they could provide information about family planning during home visits.

- In an urban Component, representatives from a number of different agencies, e.g. a settlement house, housing, and family planning, have sent resource staff to workshops for AC families.

- In an urban AC, the Department of Social Services Nutritionist acted as a resource person to AC-sponsored meetings and workshops for AC families.

- In a rural area, the Legal Services Agency, local County Welfare Departments, Planned Parenthood, and the local Junior College all report having provided resource personnel for AC staff training and for community workshops.

- In an urban area, the Welfare Department and the Welfare Rights Organization sent representatives who spoke and participated in a workshop for AC families on welfare rights.

3.2.3 Advocacy on behalf of other agencies

A few of the agencies report that the AC acted on their behalf to elicit public support for agency activities.

- In a rural area, the Legal Services Director reports that the AC was helpful in supporting the agencies' effort to secure the services of VISTA lawyers.

- In an urban area, the Welfare Administrator reports that when the Demonstration Project was threatened with cutbacks, the AC was most active and effective in lobbying against such a loss.

- A Mental Health agency reports that the PCC Director helped them obtain a grant which enables them to send consulting staff to various rural agencies that have impact on the lives of children. The Mental Health agency provides weekly training and consultation for PCC/AC staff.

4.0 Changes in agency policy and procedures as a function of Advocacy efforts

Much has been learned by all of the omponents about the constraints which impede agency change. This aspect of agency relationships has developed far more slowly than had been anticipated. Agencies lack money and staff with which to make many of the changes which they, themselves, desire. Also, many agencies cannot implement change at the local level, because they are dependent on State or Federal agencies for policies and guidelines. As one District Manager of a large City Department of Social Services said: "The agency is locked in by

laws when it comes to real changes. We can be creative and innovative within the structure, but we really can't make changes because of the laws and guidelines."

Recognizing these constraints, most of the Components have concentrated on building relationships, and on working with individual agencies in a mutual effort to maximize the service potential of the agency within the existing agency structure. Where close working relationships at the administrative or working level have developed, the ACs have functioned as an overall watchdog or monitor to ensure that policies which exist are fully implemented and that services are delivered as effectively as possible. A few administrators report that the AC has brought to their attention abuses in terms of staff negligence or insensitivity. As they point out, such monitoring does not change policy, however, it does improve the level of service delivery. As one Welfare Administrator interviewed by CCR said: "Advocacy gets on us mostly about staff that are either rude, slow, or misinformed. They help keep us on our toes." Welfare Administrators were particularly attuned to, and rather appreciative of, this AC function.

In some instances, advocates have developed sufficiently strong relationships within agencies to ensure the delivery of service in cases which might ordinarily be turned away. However, such activities can best be characterized as a stretching of institutional policies to accomodate single cases, rather than as real changes in agency policy.

The ACs have sought to educate community residents to the need for services, to stimulate them to the point of using the services, and to facilitate the process by which services are made available. Some agency Administrators view education and outreach as Advocacy's most useful roles. As the Administrator of a large urban Drug Abuse Program said: "They can play a large role in the area of education. Through their field work they have great contacts for education. The outreach aspect is probably the most important aspect -- most agencies don't have an outreach arm."

The ACs have established referral linkages, and have developed working relationships and patterns of mutual aid with other agencies. They have not acted against agencies in an adversary role: they act as mediators and coordinators, rather than as instigators and exposers. None of the Advocates has brought suit against any agency. Inextricably entwined with the PCCs, which have worked to become recognized, accepted community agencies, it is improbable that any Component could assume an adversary role.

Through work with the AC, some agency changes have occurred:

- In an urban setting, certain procedural changes have occurred in the Obstetrics-Gynecology Clinic of a City Hospital. Whereas previously, a pregnant woman was seen by a different doctor at each visit, currently a pregnant mother is introduced to a team of three doctors and one nurse. One member of this

team is always available to do the pre-natal check-ups and the actual delivery. Thus the shift has been from impersonal faceless care to a group practice type of arrangement. In addition, a system has been instituted which allows pregnant women to receive not only pre-natal check-ups, but also pre-natal education. Women are scheduled in groups of eight for two-hour time periods. Two such groups are scheduled for the same two-hour period. In this manner, one group receives its pre-natal check-up while the other participates in an educational session; the second hour the groups are reversed.

- The immunization clinic of a City Health Department has extended its hours of service from one three hour day per month to one three hour and one eight hour day per month.

- In a rural community, the Welfare Department reports having hired two homemakers, and plans to hire two more, as a direct result of the AC demonstrating both the need and the effectiveness of homemaker staff.

5.0 Filling gaps in services available through stimulating the creation of new resources or through subsidizing existing agencies to provide new services.

It is unrealistic to expect that new services will be created during a one-year period. Clearly it takes considerable time to identify a gap in service, to stimulate all relevant community people to work on the creation of a new resource, to find funding, and to bring the new resource to the point where it is installed and functional.

- One outstanding effort to create a new resource has actually been realized in a rural community. The PCC/AC serves two counties, both of which had major gaps in health care services. One of the counties, with a population of 35,000 has one Public Health Doctor and two Public Health Nurses. The other county, population 18,000, has one doctor and one nurse. Both doctors are located twenty-five miles from the catchment area. A major effort was made to obtain certification of need for a clinic in each county. This involved months of meetings and consciousness-raising through newspaper coverage. Then, the AC and the local CAP agency mobilized both local and federal resources in order to provide necessary money and personnel. As a result of this effort one of the clinics is now operational and staffed by National Health Service Corps.

Services are provided by a doctor, nurse, dentist, dental assistant, pharmacist and x-ray technician. The second clinic is under construction, and staff has already been recruited and assigned.

- In an urban area, a blind 3-year-old was identified during the needs assessment. The Bureau of Blind Services was encouraged to begin a pre-school program for blind children which now operates for three hours per week.

- In a rural community, the AC is using some of its funds to subsidize two County Health Departments to perform examinations for children 0-5. Previously, because of lack of funds, the Health Department did not provide services to this age group. Currently the Health Department is doing all necessary work, e.g. vision and hearing examinations, serology, and urine analysis.

- The County Health Clinic in a rural area reports that the AC has made them so aware of the need for family planning that the Health Clinic is working with the State Health Department to get family planning services.

6.0 Interagency coordination

6.1 Interagency committees and councils

At three Components, ongoing interagency meetings have been instituted. In some communities a Planning Council antedated the Advocacy effort and the Coordinator has joined this Council, rather than seeking to institute a new group. Interagency meetings, which include agency administrators and public officials are convened for the purposes of problem solving, information exchange, coordination of effort, and the generation of new ideas.

In communities where the AC has sponsored and initiated ongoing inter-agency meetings, the agency staffs expressed very positive attitudes toward these meetings. They indicated that an exchange of ideas centered around common problems led to new ways of viewing situations, and to new problem-solving approaches. In communities where such meetings were initiated but discontinued due to a change in Coordinators, agency administrators expressed their disappointment that the meetings had been discontinued.

In several instances, CCR interviewed agency administrators who, while they expressed concern about a particular area, were unaware that another agency was experiencing the same concerns. Through inter-agency coordination it might be possible that the problem could be at least partially resolved. For instance, in one community the Family Planning Agency and Legal Aid were both concerned about the long waiting lists for abortions

at the City Hospital. It is possible that if these two agencies coordinated their efforts the situation could be improved. In communities where regularly scheduled inter-agency meetings are ongoing, some new initiatives in response to community problems are developing:

- A tri-county Advocacy Council was instituted in a rural community. Council meetings have promoted contact among agency administrators and public officials who previously had no opportunities to meet together on a regular basis. Agency administrators in this community were uniformly enthusiastic about the meetings. Joint efforts are being made to document the need for a Free Health Clinic and a multi-purpose building to house a coordinated Children and Parent Participation Center. All the agencies involved participated in the planning and lent their support to an AC sponsored Consumers' Food Cooperative which has been launched. USDA approval was required in order to allow families to use food stamps for the purchase of meat through the Cooperative; approval was achieved through the combined effort of cooperating agencies.

- In another rural community, all of the social service and health agencies meet every other month

in order to exchange information and coordinate efforts. Sharing of transportation by agencies which take families to resources (located 60 miles away) has been effected as one outcome of these meetings. In addition, the potential loss of the community's ambulance service due to new federal requirements, unrealistic in this rural area, has been identified as a major problem; a joint coordinated effort is being made by all agencies to deal with this problem.

- In an urban Component there are three Ad-Hoc Committees, in the areas of health, education, and welfare. Each such group meets with representatives from agencies in each of these areas once a month in order to exchange information and to generate ideas for possible implementation.

6.2 Linking agencies with one another

While Inter-Agency Councils and ongoing meetings among all relevant agencies are not part of the design of every Component, the ACs have facilitated other community cooperative planning efforts.

- An urban AC sponsored a meeting attended by all community agency outreach workers, at which training was given in the detection of possible lead poisoning conditions.

- In an urban community, the AC sponsored a meeting between the Department of Housing and the Department of Social Services in order to effect coordination between them, since the Department of Housing was planning to institute its own social services program, which might duplicate that of the DSS.

- In a rural community, the Planned Parenthood Director reported that through AC sponsored meetings she had gained entré into the local Junior College and had, for the first time gained access to a particular high school for the dissemination of birth control information.

- A rural County Health agency reports having learned through the AC about an emergency fund for prenatal and infant care for non-welfare families which is available through the State Health Department.

7.0 How agencies see the Advocacy effort

There is considerable range from one community to another in terms of the extent to which Advocacy efforts are visible to and understood by the agencies.

In AC programs where the major effort is directed toward getting families to use existing resources, agencies see Advocacy as a program which helps to motivate reluctant families to the use of services. In ACs where the major effort is directed toward community education and agency change, the agencies tend to be more aware of AC achievements which go beyond outreach, education and referral. In other words, the manner in which the agencies see the AC is in part dependent on the AC's own definition of its major purpose. For instance, in one Component where the primary emphasis is on referrals and on providing encouragement and support to families, the agencies have a relatively limited view of the AC function. The agencies in this community are aware of referrals from the AC, of the Guide to Resources which the AC has compiled, and they are particularly aware of the AC as a transportation resource. On the other hand, they are unaware of the existence of the needs assessment or of other Advocacy efforts. At one County Welfare Department, when asked to define Advocacy, the social worker said: "I hate to sound simple but for me it's providing transportation."

In another Component, where the primary emphasis is on agency coordination community education and organization through workshops and meetings, all of the agencies interviewed were aware of, and well informed about, the Advocacy effort. Agency administrators were aware of the needs assessment, contact with the AC was on a weekly basis both by phone and by personal visit, and there was a continuous flow of information and planning exchange. The agencies in this community see the

AC as an important force in the community. This is the only community in which agencies were aware of the needs assessment and of the data generated.

Most administrators are impressed with Advocacy's outreach and education capability due particularly to the fact that underutilization of existing services is seen as a major problem in all communities. A few administrators see Advocacy as a "voice of the poor," a voice which ensures that the rights of low income people will be represented. However, some of those who see Advocacy in this role point out that Legal Aid fulfills this role in a more visible and effective manner. It is interesting to note that the Legal Aid agencies interviewed are particularly sympathetic to the Advocacy effort, and are especially eager to work with the ACs. In one community the relationship is so close that nearly all activities are jointly planned and discussed.

Turnover in Coordinators appears to be related to the visibility of the Advocacy effort. With respect to one AC in which there had been Coordinator turnover, all six of the administrators interviewed indicated that they had had extensive contact with the first Coordinator and that plans had been made for joint efforts in a variety of areas; in recent months, following the change in Coordinators, there had been no contact with Advocacy except at the line staff level, in connection with referrals. As an agency administrator put it, "They may be doing some real

good things, but we don't know whom to call any more so we haven't done any planning with Advocacy for months."

This loss of contact with the AC at the administrative level is mentioned at all ACs where there has been turnover in Coordinators. As one Agency Director who had at one time worked very closely with the AC said, "I've lost contact with Advocacy. I'm really sorry I've lost all contact with them."

Due to inadequate preparation for turnover, the new (or Acting) Coordinator often has not been introduced to agency administrators. As a result, most new or Acting Coordinators have relied on the contacts developed at the line staff level, and have not attempted to establish their own contacts at the administrative level. The outcome is that Advocacy plays a limited role in community planning and coordination, functioning instead primarily as an information and referral service with an outreach arm.

8.0 The advocacy role within other agencies

Some community agencies already perform certain aspects of the advocacy function. Community Health Clinics, Legal Aid groups, and Family Planning programs often have community outreach workers on their own staffs. The specific charge of these workers includes recruitment, enrollment, and follow-up to families. In these instances, the major and very important differences between outreach as practiced by other agencies and outreach as practiced by the ACs is that the former recruit

for their own agencies, whereas the ACs recruit for all agencies.

Some agencies have staff who are specifically assigned to act as a voice for the consumers of their own services. For instance in one hospital visited by CCR staff, a "Patient Advocate" went through the emergency room as a patient, using a hidden tape recorder to record staff and patient interaction. This procedure, together with other studies done on patient flow and waiting room time led to changes in hospital routine over the past year which include shortened waiting time in the emergency room, and improvement in staff treatment of patients.

Legal Aid and community groups which provide Legal Services are seen by other agencies, and see themselves, as the "voice of the poor." Often they lack a social services capability, and openly state that they lack the knowledge of resources which could be helpful to their clients.

It is important for the ACs to be aware of agencies which do have advocates within their own structures, and to develop linkages with these agency-based advocates which can be particularly helpful in terms of a coordinated effort on behalf of changes in service delivery and in motivating the community to use available resources.

9.0 Progress toward achievement of national goals

Resource identification (which includes a detailed knowledge of services, eligibility, and staff functions) and the development

of referral linkages are complex tasks; in this area much has been accomplished during this first year. Some ACs have gone beyond identification and referral linkages, to establish collaborative relationships of mutual aid and cooperation. The creation and maintenance of such relationships is dependent on the manner in which Advocacy is defined by each individual AC and on lack of turnover in the Coordinator position. The creation of such collaborative relationships must precede changes in agency procedures and policies. However, even after the relationships have been developed, money and staff shortages, as well as the inability to change policy at the local level, are significant constraints which impede desired change.

Agencies are generally sympathetic to the Advocacy effort; however, in some cases they are disappointed that initial plans regarding collaboration never developed. In most communities, an important reservoir of good will has been established. Since the relation of the AC to other community agencies is defined by AC Coordinators as one of mediation and coordination, rather than of antagonism, it is particularly important that the agencies see Advocacy as a constructive and helpful force in the community.

CHAPTER VII

STAFF FUNCTIONS & STAFF TRAINING

1.0 Introduction

The training of staff is relevant to national goal number 7; namely:

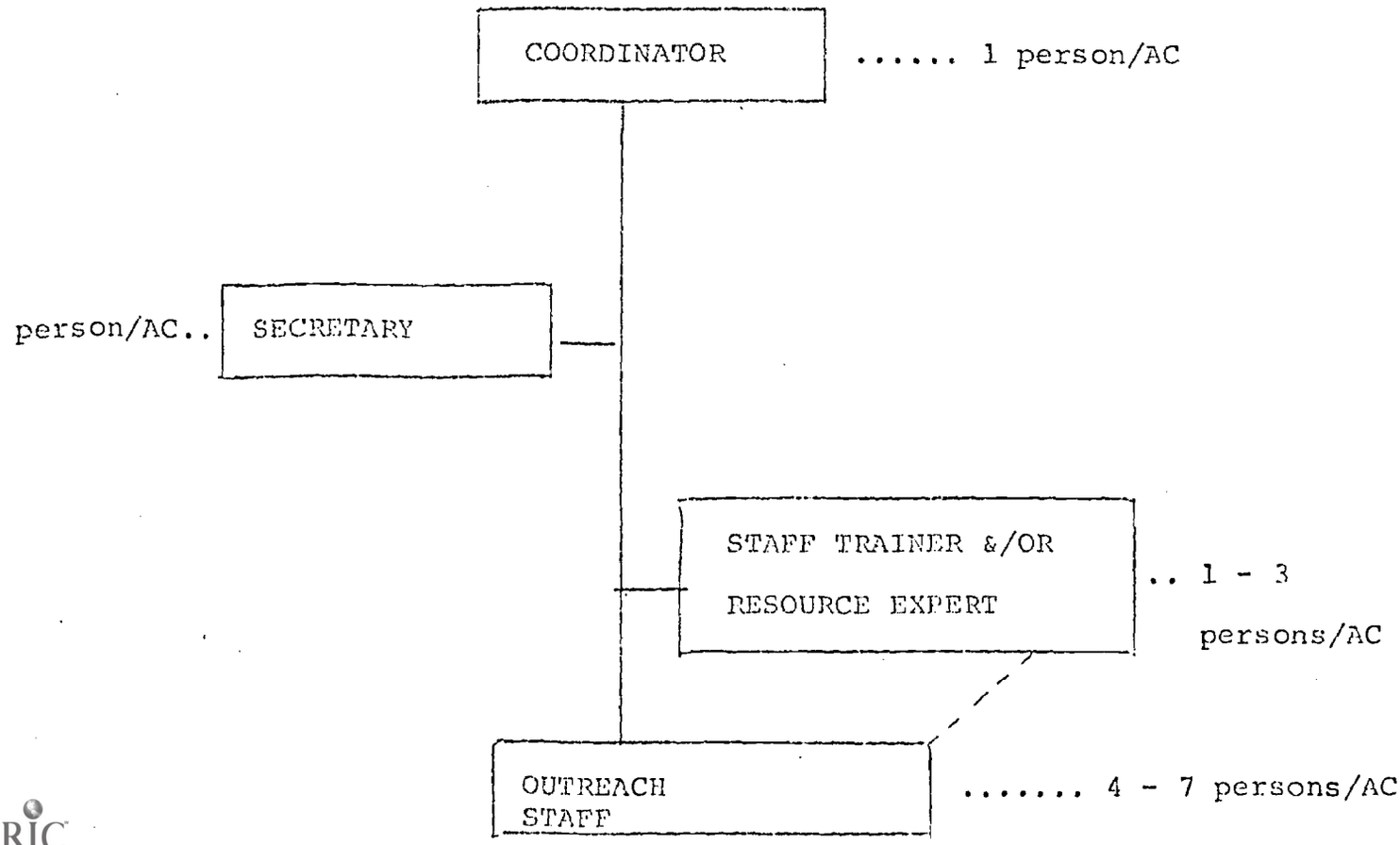
- To develop a training program for child advocates in concert with local colleges and other agencies.

The material presented in this chapter was obtained from the following sources:

- Interviews with AC staff members at T1 and again at T2.
- Four site visit interviews with AC Coordinators.

2.0 Staff organization

With one exception, the staffing pattern of an Advocacy Component may be represented as follows:



The exception to this pattern is one rural AC which does not have a staff trainer or resource expert on staff. However, this Component has two transportation aides whose primary responsibilities are providing transportation to resources which are a considerable distance from the families. No other AC has comparable persons on staff.

3.0 Staff roles

3.1 Coordinator

The OCD guidelines for the Advocacy Components are quite explicit as to the kinds of qualifications needed by the Coordinator:

> "The Advocate is a key person in the success or failure of the program and must combine many skills in order to carry out the objectives. This person must understand early childhood development; family life in the catchment area; be knowledgeable about community organization and resources; be able to elicit the cooperation of other agencies; and administer a complex program."

In day-to-day operations, the primary responsibilities of the Coordinator center around program planning, contacts with resources, staff supervision and administration, with an emphasis on the latter. Only one Component has a Coordinator who works

directly with families. Supervisory and administrative experience, and experience in working with other agencies seem to be the most important requirements of an effective Coordinator. Knowledge in the specific content area of early childhood may be helpful, but cannot compensate for the kinds of experience listed above.

Problems have developed with regard to supervisory ability and understanding. In some instances, Coordinators have been anxious to allow staff members a large degree of responsibility and independence and have therefore provided a minimum of supervision. Often this has caused a slow down or break down in the flow of operations. Staff participation in decision making regarding the direction of program does not mean that professional supervision should be waived or neglected.

Where the Coordinator lacks knowledge in a specific area, supervision can be arranged through the use of outside consultants. Here again, the important concept is that of understanding need and making the appropriate arrangements so that staff continues to get training. The only skill which cannot be compensated for by outside consultants is administrative ability. Knowledge in a content area in no way ensures that the individual will be able to administer and provide direction to a program as complex as Advocacy.

3.2 Staff trainer or resource expert

Six of the Advocacy Components have between one and three staff who, in addition to the Coordinator, function as staff trainers and resource experts. At one rural and one urban Component there are three specialists who relate to either health, housing, education, welfare or resources in general. These persons work with the resources in their area of expertise and provide special supervision to outreach workers on problems which arise in these areas. Another rural Component uses social work students in this capacity during their field placement. The remaining three Components have a single person who is responsible for agency contacts and/or staff development and training.

For the most part, this type of staff pattern has proved successful. However, in some cases, experience has led the Coordinators to re-evaluate the desired qualifications, or the job description of the resource expert. For instance, a nurse could well be hired to fill the position of health specialist. Such a person is familiar with the content area of the job. That is, she is aware of health needs and problems, is knowledgeable about health resources and is familiar with the processes required to alleviate problems. However, it does not necessarily follow that she will be able to effectively supervise staff members or develop and maintain agency contacts within her area.

In actual practice much of the day-to-day supervisory responsibility has fallen on the resource specialist. Where this individual has had no supervisory experience, the results tend to be less than optimal. If the resource specialists are persons knowledgeable in their content area then they can act as a valuable program resource, both to the Coordinator and to the outreach workers; but they cannot be given sole responsibility for supervision of staff and for agency contacts at the administrative level.

3.3 Outreach worker

Components maintain between four and seven outreach workers. These persons are the target families' primary contacts with the AC. For the most part, outreach workers are indigenous to the community, and thus familiar with family life in the catchment area. These persons conduct the majority of needs assessments, home visits and referrals. At several Components outreach workers have participated in the task of identifying resources and services. At others, this task has been accomplished by the specialists and the Coordinators.

4.0 Staff turnover

Eighteen of the 35 outreach workers have left the program since its inception one year ago. This fifty percent turnover is attributable to job dissatisfaction, job insecurity and pregnancy. Five persons in the resource expert category have left;

and four secretaries have also left. The only program with both a nurse and a nutritionist lost both of these individuals. Three of the original Coordinators have left the program; one of these three programs has had two Coordinators and is currently headed by a third. Acting Coordinators are in charge at two programs that have lost their Coordinators.

The high rate of turnover is not inconsistent with the experience of other poverty programs. The Kirschner Study[1] on the start-up year of the PCCs reports a 27% turnover rate, with turnover rates of 70-100% in a number of programs. There is some indication that turnover was less in those ACs in which outreach staff was hired from among PCC staff and parents rather than from the community at large. Perhaps staff hired from within PCC had a more realistic idea of what would be expected of them and had a greater committment to the success of the program and for these reasons were less likely to be disappointed or dissatisfied than staff having no PCC experience.

5.0 Training of AC staff

Considerable emphasis was placed on staff training at all of the Components. Training has included course work, workshops, and seminars by agency personnel and university consultants on specific issues and services, sensitivity training, report writing and direct supervision of practice. Training has included both emphasis on content, e.g., child development, health practices, information, and nutrition, and an emphasis on technique and basic job skills, e.g., interviewing, information gathering, report writing. Examples of training in both content and technique are given to illustrate the variety of approaches used.

[1] Kirschner Associates Inc., 1970, A National Survey of the Parent-Child Center Program; Office of Child Development, Contract No. B89-4557

5.1 Training in technique and basic job skills

At three Components, and recently at a fourth, interviewing skills have been taught through on-the-job demonstration: trainers or supervisors and in some cases the Coordinator or experienced PCC staff have accompanied outreach workers in order to demonstrate interviewing techniques and to provide on-the-job supervision following observation of the workers.

Three Components have had university-run training sessions or college level courses offered to staff. These courses have covered such skills as interviewing, record-keeping, listening and observing. Other Components hired university consultants to conduct training sessions.

Staff meetings are held at all Components for the purposes of teaching report writing and interviewing skills and/or problem-solving. Staff meetings are also used to provide workers with case-oriented supervision. The frequency of such meetings ranges from three times a week at one Component to every other week at another.

Individual supervision on planning and case management is provided systematically at three of the Components. Individual supervision ranges from one-half hour each day to one hour per week. Sensitivity training has been included at two Components.

5.2 Training on content areas relevant to AC work

At five Components agency personnel have been invited to speak not only about what their agency does, but also about content areas in which they have expertise. Workers have participated in training sessions on mental retardation, lead poisoning, nutrition and health care. Such lectures by outside

resource personnel and field trips to agencies in the community have increased the knowledge of outreach workers considerably.

5.3 Comments on training

Staff training has consumed a great deal of time at all of the Components. At three of them it is considered to be one of the formal objectives. Since staff training involves a considerable expenditure of time, it seems wise to recognize this and to give it the status of an objective during the start-up Advocacy year.

Staff turnover presents a problem in terms of training, in that much of the training occurred at the beginning of program, and thus new staff does not get the benefit of this training. As noted, fifty percent of the original outreach workers are no longer working in the program. In several programs the turnover in outreach workers has been so great that only one or two of the original staff remain. In most instances training cycles are not repeated and the outreach worker with the most longevity introduces new outreach workers to the families and shows her what she does with them for a couple of days.

At several Components it had been thought that Advocacy assistants or volunteers could be recruited and trained. So much effort was required to train full-time staff that training part-time workers did not turn out to be feasible.

The most common problems associated with staff training were as follows:

- Lack of adequate training in interviewing skills resulting in imprecise, incorrect, and superficial information. Inability to probe and to get at underlying problems was a considerable problem.
- Overidentification with clients and a readiness to jump to their defense without hearing the agency side of the story.
- Inability to keep accurate records and to provide the Coordinators with precise information.

The Coordinators have expressed the opinion that in most instances, staff development has proceeded very well and that there has been considerable improvement in all areas of skill and knowledge.

6.0 Advocacy as a new career

The OCD guidelines state:

> "Training efforts should be directed not only at program needs but should include a broader spectrum such as identifying child advocacy as a new career and involving educational institutions in the development and implementation of a curriculum for advocates. Another focus might be the development of jobs in the public and private sectors."

This is an area in which the activity level during the first

year of program operations has not been very great. With few exceptions, the training of AC staff has consumed the time and effort that might otherwise, or in coming years, be directed at a broader population.

At two Components, one urban and one rural, Coordinators have undertaken to teach college level courses on advocacy-related topics. In these courses, students are made aware of AC efforts and of the need for advocacy activities.

At only one Component has an attempt been made to create advocate positions at another institution. The Coordinator of an urban AC negotiated with a nearby hospital to assist hospital personnel in implementing a demonstration project. The project called for the use of AC outreach workers as "patient advocates" in the hospital's emergency room. Outreach workers helped patients through the emergency room procedures, informed patients of their rights and responsibilities, made certain that patients understood doctors' instructions and wrote comments on the quality of the patient-doctor interaction. Workers were given supervision by hospital personnel and were included in hospital staff meetings. During such meetings, AC workers were given the opportunity to present their comments and recommendations for improvement of the emergency room situation. As a result of this demonstration project, the hospital is now seeking funds to develop a training

program for patient advocates that would make this position a part of the hospital's permanent staffing pattern.

7.0 Staff impressions and discussions of the first year experience

When interviews were first conducted with AC staff members in May, 1972, the majority of the staff said that they saw their jobs as "helping people to help themselves." One year later this is still the perceived thrust. However, the time scale for achievement has become more realistic. Workers now understand that connecting people to services and teaching people to make these connections for themselves, is a complex process. Before families can advocate on their own behalf, workers realize that families' levels of confidence must be increased. In fact, this is what many of the workers see as the AC's major accomplishment during the year. "We've established credibility in the community. We've gained the reputation of being a positive force in the community that works for the person. We're working to instill a sense of confidence in them (families) that will allow them to effectively contact agencies on their own."

Asked if they could think of anything planned a year ago, but unaccomplished to date, staff members mentioned a few specific activities such as establishing a clinic, a night telephone line and a tenants'committee. However, the most

frequent response was that, "a lot has been done, but I don't think we've reached any of our goals 100%." Workers do not see that as a major disappointment. Rather, they seem to view this as a growing understanding of the complexities and difficulties inherent in the program.

In terms of experiences with agencies, staff members are learning that stimulating change is more difficult than was originally anticipated. In working with agencies, staff has learned that policy decisions are, for the most part, made at the federal and state and not at the local levels. Perhaps more importantly, staff has gained a different impression of agency personnel through direct experience. Personal contact with agency personnel has gone a long way toward changing the image of the agency administrator as an insensitive, nonresponsive bureaucrat. More and more, AC staff are coming to realize the constraints under which agencies operate, in addition to accepting the idea that "agency people are people also."

Looking forward to the coming year, staff members see themselves continuing to work toward accomplishment of the same or similar objectives. In addition, the majority of staff members are expecting to work within an expanded catchment area and to place more emphasis on public information and education.