(1986).
13. Health Services Administration: Indian health trends and services. DHHS, U.S. Government Printing Office, Washington, DC, 1978.
14. Center for Health Statistics: Indians in Wisconsin: births, deaths and population, 1968–1972. Wisconsin Department of Health and Social Services, Division of Health, Madison, WI, June 1976.
15. Center for Health Statistics: Indians in Wisconsin: births, deaths and population, 1978–1982. Wisconsin Department of Health and Social Services, Division of Health, Madison, WI, May 1984.
16. Moriyama, I. M.: Problems in measurement of accuracy of cause-of-death statistics. Am J Public Health 79: 1349–1350 (1989).
17. Office of the Secretary, Office of Special Concerns: A study of selected socioeconomic characteristics of ethnic minorities based on the 1970 census; vol. III, American Indian. DHEW Publication No. (OS) 75-122. U.S. Government Printing Office, Washington, DC, 1974, pp. 7–11.
18. Minnesota Center for Health Statistics: Minority populations in Minnesota: a health status report. Minnesota Department of Health, Minneapolis, MN, April 1987.
19. Minnesota Center for Health Statistics: Healthy people: the Minnesota experience. Minnesota Department of Health, Minneapolis, MN, May 1982.

Networking in a Rural Community Focuses on At-Risk Children

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Synopsis

The need to integrate social and medical services to deal with the issues of child abuse prevention and treatment has been documented frequently. In rural areas, referral to the various programs developed to reach the at-risk child is hampered by lack of communication, personal contact, and understanding of the roles and functions among the staffs of the agencies involved. Networking provides an interdisciplinary team approach to foster communication and coordination among the agencies' staffs and increase the effectiveness of their efforts. A model for developing an interagency network in a rural area is presented, eliciting key liaison persons as coordinators.

One of the most pressing health care issues to be targeted by many agencies is identification of at-risk children—those who are abused or neglected, growing up in alcohol and other drug addicted families, and floundering in foster care as victims of dysfunctional families—and prevention of abuse of these children. The need for multifaceted and coordinated social and medical services to deal with these issues has been frequently documented (*1–3*).

In rural areas, the problems of identifying and providing adequate intervention for these children are made more difficult by distances and lack of resources (*4*). Most child welfare professionals travel infrequently to these outreach locations. Specific services to deal with immediate crisis intervention, counseling for abuse or molestation, and the prevention of juvenile delinquency are located in the larger communities.

Contacts between county child welfare and justice agencies and the local providers such as physicians, nurses, and school personnel are infrequent and brief. Referral and consultation among staff of the various county and community programs developed to reach the at-risk children are often hampered by lack of communication, personal contact, and understanding of the roles and functions among the staffs of the involved agencies (*5*). Each provider of services becomes familiar with a small circle of resource people, but the broad range of agencies available to the rural community are often under-used, and their roles not clearly defined.

Setting

The Klamath-Trinity basin of California consists of 1,000 square miles of mountainous terrain and encompasses a population of approximately 6,000 people. The average town has 1,500 people, a population that swells during the tourist season in the summer and early fall. According to the 1980 census, 22 percent of the families living in this district of Humboldt-Del Norte County had incomes below the poverty level. The poverty rate was strongly influenced by the isolation and the decline of its two major industries, fishing and logging. The Hoopa Indian Reservation, one of the largest Indian reservations in California, is located in the valley of this mountain region.

Local service providers include resident family prac-

tice physicians, nurses, counselors, teachers, and part-time law enforcement officers and public health nurses. Most of the other medical and social service agencies are located at the county seat, a distance of 50 miles separated by two mountain passes.

Network Coordination

As the public health nurse-nurse practitioner who managed the local branch of the Humboldt-Del Norte County Health Department, I initiated the Klamath Trinity Interagency Network. My role as public health nurse brought me in contact with a broad range of medical providers and representatives from mental health, child welfare, the schools, and other social services. Acting as liaison among the diverse organizations, I was in a pivotal position to bring together an interagency network (*6*).

The networking agency was prompted by the lack of coordination among the multiple disciplines working with child abuse prevention and treatment. It was a common practice for several agencies involved with a high-risk family to develop intervention strategies independently (*7*). In addition, roles and responsibilities of new programs were unclear to many providers.

I spoke with several agency representatives to gather support for the idea of creating an interdisciplinary network for all medical and social service agencies serving the Klamath-Trinity area. The purpose of the network would be to bring together local and out-of-town providers, to provide a forum to communicate roles and responsibilities among the different agencies, and to enhance cooperation and coordination of services.

To ensure a greater representation and broader participation in the network, I enlisted two other key liaison persons in the community as coordinators—the director of the Indian child welfare program located on the Hoopa Indian Reservation and the school counselor working at the largest of the elementary schools in the district. The Indian child welfare director, in addition to her close involvement with judicial and child protection agencies, acted as advocate for Native American concerns. The school counselor had direct contact with many children in high-risk families and also brought in the participation of other school staff. There were two main barriers to overcome in planning a successful coalition of agencies: the time limitations and travel involved for most of the providers and securing the participation and commitment of such a diverse group.

Outcome

To accommodate these restraints of time and travel, the solution was to schedule interagency meetings during an extended lunch hour on a bimonthly basis. A notice of the first meeting and agenda were sent to various agencies: school, social service, medical, law enforcement, emergency response agencies, Headstart Programs, Indian justice project, drug and alcohol prevention, mental health, youth services, and local resource centers. Additionally, telephone or personal invitations from the three coordinators were extended to each agency representative to introduce the idea and purpose of the meeting.

The first Klamath-Trinity Interagency Network meeting was held in early June 1988 at a restaurant centrally located on the Hoopa Indian Reservation. Representatives from 30 different agencies attending were surprised at the diversity of professionals present at the meeting.

The first meeting was co-chaired by the three coordinators. The statement of purpose was discussed and all participating agency members were introduced. At each subsequent meeting, three keynote speakers were invited to describe their agency's function, eligibility requirements, and referral information.

The meetings acted as a forum for bringing up common problems or issues as well as informing those attending of pertinent events, new services, or changing personnel. Small committees were encouraged to meet separately regarding similar services or problems and then address the larger group to discuss progress or outcomes of these discussions.

Evaluation

The network met regularly during the year 1988–89 and grew to include members of 40 agencies from a variety of disciplines. A listing of all network members was collated and distributed, and a brief description was requested from each agency for future publication in an interagency directory serving the Klamath-Trinity district. A full-page listing of phone numbers for emergency, social service, and medical resources was published in the local paper as a public service announcement for area residents.

Many themes emerged from the dialogue among the various network members. Issues of drug dependency, unemployment, and family violence were recognized as common problems. Drug and alcohol prevention teams were formed that included members from the network as well as community leaders. Community programs were developed with a local base such as an AIDS prevention task force, a newly formed domestic violence program sponsored by the tribal clinic, and a school attendance program that elicited coordination from local businesses.

By rotating the keynote speakers at meetings, regular

participation and involvement was encouraged among the different members. Members of other organizations working with children heard about the network and asked to be allowed to present their programs; among them were special education staff and drug prevention specialists.

Another important factor in maintaining a high level of support and participation was flexibility in determining the course of the network. At first the group followed the original agenda with presentations by the various agencies, each outlining their specific programs and objectives. As the members became more familiar with each other and their programs, the network began to focus on specific issues. Letters that were the result of input and support from the various agency representatives were sent to administrators or county supervisors regarding funding cuts or the need for services in the district.

The plan was to evaluate the purpose and effectiveness of the network after 1 year. At the last meeting of the school year, the members voiced a need to become more action-oriented, to address and attend to specific pressing issues, and to move away from the idea of a general get-together luncheon. The members voted to continue the network in the following school year, 1989–90.

Recognition

The Klamath-Trinity Interagency Network and the three coordinators were recognized in June 1989 for their efforts to serve the children and residents of the rural district. A certificate of recognition was presented at a prevention celebration sponsored by the Humboldt County Office of Education, College of the Redwoods, Humboldt County Drug-Free Schools Consortium, Juvenile Justice and Delinquency Prevention Commissions, and the Kingsview-Humboldt Alcohol and Drug Program.

Conclusion

The function of a networking agency has been described as a "commitment to the tasks ... rather than to any formal organization structure" (*8*). The aim is to become a forum for interagency cooperation, a means of coordinating community response. Particularly in developing strategies to aid the at-risk children, the network needs to be flexible and ever evolving.

The intent of a multidisciplinary approach in preventing child abuse is to keep constant a high level of care in the community. In rural districts, the obstacles of distance and limited resources make it essential to develop a community network of the many professionals serving the area. The network's ultimate goal would encompass both early identification of risk groups and integrated services to provide the most effective strategies in coping with the issue at hand.

References

1. Christensen, M .L., Schommer, B., and Velasquez, J.: Pt. 1: An interdisciplinary approach to preventing child abuse. Matern Child Nurs J 9: 108–112 (1984).
2. Crime Prevention Center: Child abuse prevention handbook. Office of the Attorney General, Sacramento, CA, 1985.
3. Schmitt, B. D.: The prevention of child abuse and neglect: a review of the literature with recommendations for application. Child Abuse Negl 4: 171–177 (1980).
4. Saunders, E., and Goodall, K.: A social services-public health partnership in child protection: a rural model. Public Health Rep 100: 663–666, November–December 1985.
5. Cutler, D., and Madore, E.: Community-family network therapy in a rural setting. Community Ment Health J 12: 144–155 (1980).
6. McLemore, M.: Nurses as health planners. J Nurs Adm 1: 13–17 (1980).
7. Reder, P.: Multi-agency family systems. J Fam Ther 8: 139–152 (1986).
8. Barber, J. H., and Kratz, C., editors: Towards team care. Churchill Livingstone, New York, 1980.

Household Survey of Child-Safe Packaging for Medications

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Synopsis

In an investigation of the prevalence of safety packaging of medications, 131 randomly selected Min-