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7. Author(s)
Berkeley Planning Associates

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9. Performing Organization Name and Address
Berkeley Planning Associates
2320 Channing Way
Berkeley, CA 94704
(Tel.: 415/549-3492)

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16. Abstracts
This report presents a detailed discussion of the methodologies used in evaluating eleven child abuse and neglect demonstration service projects. These methods, which should be adaptable to non-demonstration child abuse and neglect projects as well, include: measuring project goal attainment; monitoring project resource allocation and service costs; determining the quality of the project's case management process; analyzing project organization and management and their relationships with worker job satisfaction and burnout; assessing the effectiveness of alternative service strategies for abusive and neglectful parents; monitoring the progress of abused and neglected children while in treatment; and assessing the impact of a project on its local child abuse and neglect system. In addition to describing the evaluation process, problems encountered and the methods used, the report contains all relevant data collection instruments and instruction manuals.

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The Berkeley Planning Associates evaluation team includes:

Anne H. Cohn, Project Director
Frederick C. Collignon, Principal Investigator
Katherine Armstrong
Linda Barrett
Beverly DeGraaf
Todd Everett
Donna Gara
Mary Kay Miller
Susan Shea
Ronald Starr

with

Helen Davis
Shirley Langlois

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PREFACE

In May of 1974, the Office of Child Development and Social and Rehabilitation Services of the Department of Health, Education and Welfare jointly funded eleven three-year child abuse and neglect service projects to develop strategies for treating abusive and neglectful parents and their children and for coordination of community-wide child abuse and neglect systems. In order to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, the Division of Health Services Evaluation of the National Center for Health Services Research, Health Resources Administration of the Department of Health, Education and Welfare awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report is one of a series presenting the findings from that evaluation effort.

This evaluation effort was the first such national study in the child abuse and neglect field. As such, the work must be regarded as exploratory and suggestive, not conclusive. Many aspects of the design were pioneered for this study. Healthy debate exists about whether or not the methods used were the most appropriate. The evaluation focused on a demonstration program of eleven projects selected prior to the funding of the evaluation. The projects were established because of the range of treatment approaches they proposed to demonstrate, not because they were representative of child abuse programs in general. The evaluation was limited to these eleven projects; no control groups were utilized. It was felt that the ethics of providing, denying or randomly assigning services was not an issue for the evaluation to be burdened with. All findings must be interpreted with these factors in mind.

Given the number of different federal agencies and local projects involved in the evaluation, coordination and cooperation was critical. We wish to thank the many people who helped us: the federal personnel responsible for the demonstration projects, the project directors, the staff members of the projects, representatives from various agencies in the projects' communities. Ron Starr, Shirley Langlois, Helen Davis and Don Perlgut are all to be commended for their excellence in processing the data collected. And in particular we wish to thank our own project officers from the National Center for Health Services Research--Arne Anderson, Feather Hair Davis and Gerald Sparer--for their support and input, and we wish to acknowledge that they very much helped to ensure that this was a cooperative venture.

Given the magnitude of the study effort, and the number and length of final reports, typographical and other such errors are inevitable. Berkeley Planning Associates and the National Center for Health Services Research would appreciate notification of such errors, if detected.

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Introduction

In May of 1974, prior to the first expenditures of funds appropriated under the Child Abuse and Neglect Prevention and Treatment Act, P.L. 93-247, the Office of Child Development and Social and Rehabilitation Services of DHEW jointly funded eleven three-year demonstration child abuse and neglect projects to develop and test alternative strategies of treating abusive and neglectful parents and their children, and alternative models for coordinating community-wide child abuse and neglect systems.

The projects, located around the country and in Puerto Rico, differed in size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. In order to document the context of the different service interventions being tested and to determine their relative effectiveness and cost effectiveness, the Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the demonstration effort. This report presents much of the methodology from that evaluation.

General Process Component. In order to determine the problems inherent in establishing and operating child abuse and neglect programs and to identify the range of management and service strategies for such programs, all aspects of the projects' operations were carefully monitored, primarily through the quarterly five-day site visits by BPA staff. During these structured site visits, interviews, group discussions, record reviews and observation techniques were used. All of the problems and possibilities encountered both in setting up and running different project components were documented. Historical Case Studies of each of the projects, detailing all their activities over the three-year demonstration period, were prepared. Analysis of common experiences across projects resulted in the development of a Handbook for Planning and Implementing Child Abuse and Neglect Programs.

Project Goals Component. For purposes of assessing the extent to which projects accomplished their own unique set of goals, during site visits in the first year of the evaluation, using Andre Delbecq's Nominal Group Process Technique, BPA assisted each project in the clarification of its own specific and measurable goals and objectives. Project staff, administration and advisory board members participated in this reiterative process. At the end of the first year, with project input, attainment measures for each of the goals and objectives were identified, and at the end of the second and third years, BPA staff, using interviews and record reviews, assessed the extent to which projects had accomplished that which they had set out to do.

Cost Analysis Component. To determine the costs of different services, approximately one month out of every four project staff monitored their time and resource expenditures in relation to a set of discrete project activities or services on cost accounting forms developed by BPA. Donated as well as actual resources were accounted for, as were the number of units of service provided in each of the service categories. Calculations were then made for the percentage distribution of all resources to discrete activities and the

unit costs of different services provided by each project in the sample months and on average for the operational phase of the project. The value of donated resources was added to unit costs to determine the total value of services provided. And, once adjustments were made for regional wage and price differences, comparisons were made across projects to determine both the average costs and the most efficient methods of delivering services.

Quality of the Case Management Process Component. In the interest of identifying standards for quality case management process and understanding the relationship between case management and client outcome, BPA consulted with a number of child abuse and medical care audit specialists to identify both the elements of and methods for assessing the quality of case management. The methodology, once pretested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects during their second and third years to review a random sample of case records from each of the treatment workers in a project and interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. By combining these data with that collected through the adult client component, the relationships between case management and client outcome were identified.

Project Management and Worker Burnout Component. In order to determine how project management processes and organizational structures influence project performance and in particular worker burnout, visits were made to each of the projects in the third year to elicit information about management processes, job design and job satisfaction, through interviews and/or questionnaires with project management and staff (including those who had left the project). A combination of both quantitative and qualitative data analysis was then carried out to define organizational and management aspects of the projects, to establish the prevalence of worker burnout among staff, and to determine the relationships between these factors.

Community Systems Component. In order to determine the extent to which the projects had an influence on their local communities in establishing a well-functioning, community-wide child abuse and neglect system, data on the functioning of the eleven communities' child abuse and neglect systems were collected. A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resources committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. These people were re-interviewed at yearly intervals to collect information about the changes which had occurred or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit from project personnel, project advisory board

members, and knowledgeable individuals in the community. Analyses of the information gathered included comparing the essential elements of a well-functioning community-wide system with changes seen in project communities.

Children's Component. Even though very few of the projects directly provided treatment services to the abused or neglected child, because of the paucity of information on the kinds of problems abused and neglected children possess and the benefits of various treatment services for these children, clinicians at the three projects working with children maintained problem-oriented records, developed by BPA, on the children served from the time of intake through termination. The analysis, which included data gathered through the use of select standardized tests, identified the range of problems children possessed and the degree to which these problems appear to be resolvable during treatment.

Adult Client Component. Central to the entire study was the effort to determine the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors. Clinicians at the projects maintained complete records, on forms developed by BPA, on 1724 adult clients receiving treatment during 1975 and 1976, from the time of intake through termination. Data included: basic demographics, information on the nature and severity of the maltreatment, the amount and type of services received by the client, and outcome information including improvements in parents' functioning and reincidence of abuse or neglect. These data were first analyzed by project and for the whole demonstration program to determine the relationships between client characteristics, services received and outcome. Then, data from other parts of the study, including case management and program management information, were included to determine the extent to which these other variables help explain outcome. Finally, data on service costs were used to determine the cost-effectiveness of alternative strategies.

Limitations. The evaluation was concerned with projects selected because of the unique or different approaches they intended to demonstrate, not because they were representative of child abuse and neglect programs across the country. The methods used were largely developed for this study, given it was the first of its kind in the field. No control groups were studied. Thus, the findings cannot be generalized to all child abuse and neglect programs, nor can they be viewed as conclusive. They are, however, suggestive of directions child abuse and neglect treatment programs might take.

INTRODUCTION

History of the Demonstration Effort[1]

During the fall of 1974, prior to the passage of the Child Abuse Prevention and Treatment Act, Public Law 93-247, the secretary's office of the federal Department of Health, Education and Welfare (DHEW) decided to allocate four million dollars to child abuse and neglect research and demonstration projects. A substantial portion of that allotment, approximately three million dollars, was to be spent jointly by the Office of Child Development's (OCD) Children's Bureau, and Social and Rehabilitation Services (SRS) on a set of demonstration treatment programs. On May 1, 1974, after review of over 100 applications, OCD and SRS jointly selected and funded eleven three year projects.[2] The projects, spread throughout the country, differ by size, the types of agencies in which they are housed, the kinds of staff they employ, and the variety of services they offer their clients and their local communities. However, as a group the projects embrace the federal goals for this demonstration effort, which include:

(1) to develop and test alternative strategies for treating abusive and neglectful parents parents and their children;

(2) to develop and test alternative models for coordination of community-wide systems providing preventive, detection and treatment services to deal with child abuse and neglect;

(3) to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness.

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[1] For a detailed listing of major events that occurred during the demonstration period, see "Milestones in the Demonstration Effort " in Appendix A.

[2] The projects include: The Family Center: Adams County, Colorado; Pro-Child: Arlington, Virginia; The Child Protection Center: Baton Rouge, Louisiana; The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico; The Arkansas Child Abuse and Neglect Program (SCAN): Little Rock, Arkansas; The Family Care Center: Los Angeles, California; The Child Development Center: Neah Bay, Washington; The Family Resource Center: St. Louis, Missouri; The Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida; the Panel for Family Living: Tacoma, Washington; and the Union County Protective Services Demonstration Project, Union County, New Jersey. See Appendix B for brief project profiles.

In order to accomplish the third goal, as part of DHEW's strategy to make this demonstration program an interagency effort, the Division of Health Services Evaluation, National Center for Health Services Research of the Health Resources Administration (HRA) awarded an evaluation contract to Berkeley Planning Associates (BPA) in June 1974, to monitor the demonstration projects over their three years of federal funding, documenting what they did and how effective it was.

Overview of the Demonstration Evaluation

The overall purpose of the evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with problems of child abuse and neglect in a systematic and coordinated fashion. The study, which combined both formative (or descriptive) and summative (or outcome/impact-related) evaluation concerns, documented the content of the different service interventions tested by the projects and determined the relative effectiveness and cost-effectiveness of these strategies. Specific questions, addressed with quantitative and qualitative data gathered through a variety of collecting techniques, notably quarterly five-day visits, special topic site visits and information systems maintained by the projects for the evaluators, include:

- What are the problems inherent in and the possibilities for establishing and operating child abuse and neglect programs?
- What were the goals of each of the projects and how successful were they in accomplishing them?
- What are the costs of different child abuse and neglect services and the costs of different mixes of services, particularly in relation to effectiveness?
- What are the elements and standards for quality case management and what are their relationships with client outcome?
- How do project management processes and organizational structures influence project performance and, most importantly, worker burnout?
- What are the essential elements of a well-functioning child abuse and neglect system and what kinds of project activities are most effective in influencing the development of these essential elements?

- What kinds of problems do abused and neglected children possess and how amenable are such problems to resolution through treatment?
- And finally, what are the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors?

During the summer of 1974, the projects began the lengthy process of hiring staff, finding space and generally implementing their planned programs. Concommitantly, BPA collected baseline data on each of the projects' community child abuse and neglect systems and completed design plans for the study. By January 1975, all but one of the projects was fully operational and all major data collection systems for the evaluation were in place. Through quarterly site visits to the projects and other data collection techniques, BPA monitored all of the projects' activities through April 1977, at which time the projects were in the process of shifting from demonstrations to ongoing service programs. Throughout this period, numerous documents describing project activities and preliminary findings were prepared by the evaluators.[1] This report details the methodology used.

[1] See Appendix C for a listing of major evaluation reports and papers.

SECTION I

OVERVIEW OF THE METHODOLOGY BY STUDY COMPONENT

As indicated in the Introduction, the overall purpose of the evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with the problems of child abuse and neglect in a systematic and coordinated fashion. At the time this study began, little evaluation or relevant research work had been done in the area of child abuse and neglect programs. Because of the unique aspects of child abuse and neglect, very few instruments or measures from work in related fields appeared adaptable for the current study. Thus, with few exceptions, the methodology and more specifically the instruments and measures used had to be entirely developed for use in this study. While to the experienced evaluator there may appear to be little in the overall approach that is "new," for the child abuse and neglect field this was a pioneering venture.

In order to accomplish the broad mission of the evaluation and the many specific objectives, the study was divided into distinct components, described briefly below, including: a General Descriptive Component; Project Goals; Cost Analysis; Quality of the Case Management Process; Project Management and Worker Burnout; Community Systems; Children's Impact; and Adult Client Impact.

General Descriptive Component

In order to determine the problems inherent in establishing and operating child abuse and neglect programs and to identify the range of management and service approaches for such programs, all aspects of the projects' operations were carefully monitored, primarily through the quarterly five-day site visits by BPA staff. During these structured site visits, interviews, group discussions, record reviews and observation techniques were used. All of the problems encountered both in setting up and running different project components were documented. Historical Case Studies of each of the projects, detailing all of their activities over the three-year demonstration period, were prepared. Analysis of

common experiences across projects resulted in the development of a Handbook for Planning and Implementing Child Abuse and Neglect Programs.

Project Goals Component

For purposes of assessing the extent to which projects accomplished their own unique set of goals, during site visits in the first year of the evaluation, using Andre Delbecq's Nominal Group Process Technique, BPA assisted each project in the clarification of its own specific and measurable goals and objectives. Project staff, administration and advisory board members participated in this reiterative process. At the end of the first year, with project input, attainment measures for each of the goals and objectives were identified, and at the end of the second and third years, BPA staff, using interviews and record reviews, assessed the extent to which projects had accomplished that which they had set out to do. (A more detailed discussion of the methods used and a sample of the resulting "Project Goals Instrument" appears in Section III.)

Cost Analysis Component

To determine the costs of different services, approximately one month out of every four project staff monitored their time and resource expenditures in relation to a set of discrete project activities or services on cost accounting forms developed by BPA. Donated as well as actual resources were accounted for, as were the number of units of service provided in each of the service categories. Calculations were then made for the percentage distribution of all resources to discrete activities and the unit costs of different services provided by each project in the sample months and on average for the operational phase of the project. The value of donated resources was added to unit costs to determine the total value of services provided. And, once adjustments were made for regional wage and price differences, comparisons were made across projects to determine both the average costs and the most efficient methods of delivering services. (A detailed discussion of the methodology, the forms used and instruction manuals appears in Section IV.)

The Quality of the Case Management Process Component

In the interest of identifying standards for a quality case management process and understanding the relationship between case management and client outcome, BPA consulted with a number of child abuse and medical care audit specialists to identify both the elements of and methods for assessing the quality of case management. The methodology, once pretested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects during their second and third years to review a random sample of case records from each of the treatment workers in a project and interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. By combining these data with that collected through the adult client component, the relationships between case management and client outcome were identified. (A detailed discussion of the methodology and instruments used is found in Section V.)

Project Management and Worker Burnout Component

In order to determine how project management processes and organizational structures influence project performance and in particular worker burnout, visits were made to each of the projects in the third year to elicit information about management processes, job design and job satisfaction, through interviews and/or questionnaires with project management and staff (including those who had left the project). A combination of both quantitative and qualitative data analysis was then carried out to define organizational and management aspects of the projects, to establish the prevalence and nature of worker burnout among staff and to determine the relationships between these factors. (Section VI contains a more detailed discussion of the methodology and instrumentation.)

Community Systems Component

In order to determine the extent to which the projects had an influence on their local communities in establishing a well-functioning, community-wide child abuse and neglect system, data on the functioning of the eleven communities' child abuse and neglect systems were collected.

A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resources committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. Then people were re-interviewed at yearly intervals to collect information about the changes which had occurred or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit from project personnel, Project Advisory Board members, and knowledgeable individuals in the community. Analyses of the information gathered resulted in the identification of the essential elements of a well-functioning community-wide system as well as the kinds of activities service programs can pursue to enhance system operations. (In Section VII this methodology is discussed in greater detail and samples of the instruments used are presented.)

Children's Component

Even though very few of the projects directly provided treatment services to the abused or neglected child, because of the paucity of information on the kinds of problems abused and neglected children possess and the benefits of various treatment services for these children,

clinicians at the three projects working with children maintained problem-oriented records, developed by BPA, on the children served from the time of intake through termination. The analysis, which included data gathered through the use of select standardized tests, identified the range of problems children possessed and the degree to which these problems appear to be resolvable during treatment. (A detailed discussion of this methodology, the data collection instrument and an instrument manual are presented in Section VIII.)

Adult Client Component

Central to the entire study was the effort to determine the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors. Clinicians at the project maintained complete records, on forms developed by BPA, on 1740 adult clients receiving treatment during 1975 and 1976, from the time of intake through termination. Data included: basic demographics, information on the nature and severity of the maltreatment, the amount and type of services received by the client, and outcome information including improvements in parents' functioning and reincidence of abuse or neglect. These data were first analyzed, using a variety of multivariate techniques, to determine the relationships between client characteristics, services received and outcome. Then, data from other parts of the study, including case management and program management information, were included to determine the extent to which these other variables help explain outcome. Finally, data on service costs were used to determine the cost-effectiveness of alternative strategies. (Section IX contains a detailed discussion of this methodology, the data collection instruments and accompanying instruction manuals.)

SECTION II

THE EVALUATION PROCESS

Introduction

Implementing a multi-year, national evaluation of demonstration programs in any social problem area is no easy proposition; to implement such a study in an area like child abuse and neglect, where little prior evaluative research had been done, further complicates the effort. In this section, parts of the evaluation process are discussed and problems encountered are highlighted, including: the organization and management of the evaluation; securing project cooperation; providing projects with technical assistance; providing projects with skills necessary to carry out the evaluation; and logical or technical problems encountered.

Organization and Management of the Evaluation

The complexity of the subject being studied and the correspondingly complex and demanding methodology called for a departure from the more classical organizational structure of a research project. Vertical hierarchical arrangements gave way to more horizontal ones; highly trained and experienced personnel were hired in lieu of research assistants; a team approach emerged. Ten central staff members, most of whom worked close to full time during the contract period, composed the team. With backgrounds as varied as economics, sociology, political science, psychology and social work, most possessed graduate level training in planning, administration and program evaluation. The organization of the evaluation effort can best be understood by looking at the breakdown of responsibilities by (1) general management tasks, (2) study components, and (3) project sites.

General Management Tasks: The project had a Principal Investigator, between 15% to 20% time, to provide oversight management for the study, particularly in the areas of scope, quality and fiscal matters. A full-time Project Director, supported by a full-time Deputy Director, had responsibility for all the day-to-day operations of the study,

including liaison with the various participating federal agencies as well as study consultants. A half-time senior analyst took responsibility for all major data processing activities; and a full-time project secretary not only typed the voluminous documents produced, but also served in a dual capacity by maintaining responsibility for instrument and report production, correspondance, record keeping and maintaining a general coherency to the myriad of activities of the other staff members.

Study Components: While the Project Director maintained overall management responsibility for the direction and scope of all the study components, other staff members handled the day-to-day management of most of the study components. Seven members of the study team each had completed or shared leadership responsibility for one or two of the eight study components. This leadership role included overall responsibility for bringing about the following in a timely fashion: the development of the study component design and methodology; the collection of necessary data; the analysis and interpretation of the data and all related report writing. Study component leaders did not operate independently of the rest of the staff in any of these areas, but rather solicited input at each step. Thus, all members of the study team had any opportunity to both help structure each of the study components, ensuring their relevance and adaptability to each of the projects, as well as to contribute to the interpretation of findings.

Project Sites: Seven members of the study team each had site liaison responsibilities for one or two of the eleven projects. These responsibilities included: conducting the quarterly five-day site visits to the projects and writing up project progress reports after each visit; introducing the project to all data collection instruments for all the study components; insuring that data for all components from a given project were collected in a quality fashion. As such, a site liaison person had to be intimately familiar with all aspects of the study in order to introduce them to the project, as well as familiar with all aspects of their project's activities in order to help the study component leaders interpret data collected from the project on given

parts of the study. Half of the members of the study team visited at least seven, and in some cases all, of the projects during the course of the study. This allowed for checks on possibly biased attitudes toward a given project on the part of the site liaison person.

Breakdown of Responsibilities		
By General Management Tasks	By Study Components	By Project Sites
Oversight management -- Collignon Overall day-to-day management -- Cohn Data processing -- Starr Administrative functions -- Gara	General process -- Cohn Project goals -- DeGraaf Cost -- Barrett Case management -- DeGraaf, Shea Project management -- Armstrong Community systems -- Miller, Shea Children's -- Miller Adult -- Cohn, Collignon	Adams County -- DeGraaf Arlington -- Miller Baton Rouge -- DeGraaf Bayamon -- Everett Little Rock -- Barrett Los Angeles -- Miller Neah Bay -- Barrett St. Louis -- Shea St. Petersburg -- Armstrong Tacoma -- Cohn Union County -- Armstrong

Thus, the project was organized such that each study team member had primary responsibility for a number of discrete tasks. Research assistants were used only on a sporadic basis, forcing all team members to become intimately familiar with many of the details of the study. A pervasive attitude of cooperation and coordination prevailed. Team members were open to input not only from each other on their discrete tasks, but also from the projects themselves, the many federal personnel interested in the study, study consultants and the field in general. From the beginning of the study, numerous reports describing plans, progress and findings were distributed

widely to keep the field abreast of the study activities and to solicit input. The minimal turnover in the study team personnel during the 40 months of the study allowed for continuous growth in the expertise and understanding of the team members about the problem being studied and undoubtedly enabled the team to develop solid working relationships with the large numbers of people outside the team itself who contributed to the study's design and content.

Securing Project Cooperation

Few projects look forward to "being evaluated." Evaluation connotes judgment; it implies criticism; it implies taking time away from other, important activities. While this study, like many other evaluation studies, was not concerned with judgment and criticism in the sense of comparing projects and determining which was best (or worst), it took a full year of interacting with the projects to gain their trust, their confidence and their support for a study which hoped to document their experiences for the field in general. This support was gained, in part, by clarifying, and reclarifying, the study purposes. It was partially gained by providing projects, early on, with feedback (largely in the form of written reports) which had use or value to them (e.g., early site visit or cost reports) and some technical assistance (e.g., helping to clarify project goals). It was also gained in part by tailoring pieces of the study to individual project needs, thereby demonstrating a willingness to meet projects halfway on certain issues. As an evaluation team, we worked quite hard during the first year to gain the projects' support and thus enthusiastic cooperation, believing that this would be the best route to collecting quality data. The projects were required to participate in the evaluation in order to maintain their federal funding; we wanted their participation to be a fuller commitment than merely fulfilling a requirement. We succeeded in doing this, but at no small expense. Perhaps the most notable trade-off had to do with tailoring the design to meet individual project needs. For example, it would have been easiest to enforce standard usage of the evaluation forms across projects from the perspective of data processing

and analysis. However, one project had some in-house forms quite similar to ours and wished to substitute them. Another project wanted to use certain forms on clients served by their parent agency and have resultant data used for certain parts of our analysis. A third project requested that certain forms be translated into Spanish. We complied with all such requests. This meant happier projects but more work for our staff in constructing standardized data sets on all projects once the data were in-house. It seems important for the evaluator to be flexible in this way, particularly when the evaluation will continue over several years.

Providing Technical Assistance

A major issue from the outset of the study was how much, if any, technical assistance should we as evaluators provide to the projects. We determined that, because the purpose of the study was more to document what can be done in child abuse programs than to determine which program performed best, it was reasonable--and perhaps appropriate--to provide the projects with some technical assistance. It was clear that we should, however, maintain an awareness of the possible influence this would have on project performance. The technical assistance we provided took several forms: we assisted the projects consistently during their first year in clarifying goals that were realistic and meaningful. Projects undoubtedly would have done this on their own we primarily helped to speed up this process for them. We acted as a sounding board for directors and staff, providing them with an outsider with whom they could talk out their problems and concerns. Generally we provided no advice, rather a sympathetic ear. Finally, we put projects in touch with each other and other resource people across the country who could help them solve programmatic problems. This greatly facilitated the projects' pool of expertise on which to draw. It may be that the projects functioned more smoothly or more efficiently as a result of this technical assistance. It is not apparent that they altered their overall purposes or directions as a result.

Providing Projects with Skills Necessary to Carry Out the Evaluation

We as a staff had to expand our expertise in child abuse and neglect in order to carry out this study. Bringing in consultants, reading, attending conferences, keeping abreast of new programs generated from the federal government helped us in this regard. At the same time, we needed to train the projects in certain areas so that they could participate in the evaluation. While certain data were gathered through interviews or discussion, most of the data were provided to us by the projects on forms we had developed.

The process of training project staffs in the purposes and use of the forms they were to complete began during the second visit to the projects, at a time when data collection instruments were in draft form. Each measure on each form was discussed; instructions for when and how to complete the forms were presented. (At that time, comments for improvement or revision of the forms were solicited.) Once the instrumentation was complete, forms (in large enough quantities to accommodate each project) and accompanying instruction manuals were forwarded to the projects. This was only the beginning of an ongoing training process that continued throughout the evaluation.

During every site visit after projects began to collect data for us, we provided staff with training in the use of forms. Competing demands for staff time, staff turnover, and unanticipated situations resulted in a need for continuous training. Training needed to be supplemented with feedback--summary analyses of data already gathered, for example--and support to ensure that staff members would maintain a commitment to filling out the forms.

During visits, we checked project records to make sure that forms were being completed in a timely fashion and correctly. As problems were detected, they were discussed with the staff. At certain points in the evaluation, special techniques were used to encourage ongoing and careful use of the forms. For example, mid-way through the evaluation, large posters printed with definitions of key measures used on the Adult Client forms were mailed to all staff members at each project.

Overall, we would conclude that too much time could not have been spent on training of project staff. Our data analyses relied on quality of information; we therefore relied heavily on the project staff to ensure that the study was well done. Anything short of ongoing training would, in our view, be a mistake in a study such as this.

Logistical and Technical Problems

The projects were spread throughout the country; the study continued over a 40-month period; the study utilized an array of methods for data collection; the data were collected at many points in time. These circumstances led to a number of logistical and technical problems which required resolution. Examples of some of the problems unique to this kind of study are summarized below:

- Training projects in the use of evaluation forms could not be done in a central location. All staff members of all projects required training. No one evaluation staff member could visit all projects for purposes of training. Thus, we had to rely on many different people (seven) to train projects. The training clearly had to be standardized; this meant the evaluation staff had to receive intensive training themselves in the purposes and use of each form so that they could transfer this information in a uniform way to all projects. Several days were spent in such in-house training. As projects were taught about the forms, various unanticipated questions arose. Constant telephone communication among evaluation staff members during site visits allowed for these unanticipated questions to be answered in a standard way at all projects.

- Beyond the training of project staff, the site visits themselves needed to be carried out in a standard fashion. Once again, evaluation staff were thoroughly briefed on the purposes and logistics for site visits before going into the field and maintained telephone contact with each other while in the field to guarantee an appropriate amount of standardization. Clearly, given the differences across projects, site visits had to be partially tailored to individual project circumstances.

- Many of the forms projects were filling out were ready for collection at times other than site visits. Given the desire to minimize burdens on the projects in terms of forwarding completing instruments through the mail, and to maximize the quality of data by going over forms at project sites, with project staff, before they were collected, we decided to collect most forms during site visits. Projects kept completed forms for us until our visits, at which time they were edited and missing data was collected.

A Final Note

The planning and implementation of this evaluation was not easy. It required the full time commitment of a large staff as well as cooperation from the projects, their federal sponsors and the federal sponsors of the evaluation. It required constant attention to the concerns of these different groups as well as a myriad of research-related details. It required an enormous production of reports, to keep all interested parties abreast of what we were doing. While we regard the study as a successful one in many respects, in retrospect it is clear that changes in certain strategies would have enhanced the study. These include:

(1) spending even more time with projects in training staff in the use of forms;

(2) not revising data collection instruments once projects started to use them;

(3) presenting federal agency personnel with more in-person briefings on study findings; and

(4) allocating an additional 4-6 months for analysis once all data were collected and processed.

SECTION III

THE PROJECT GOALS COMPONENT

Purpose

The Project Goals Component of the National Evaluation had two purposes, the first of which was to identify unique aspects of individual projects not covered in other components of the Evaluation. Throughout the first year encouraging the articulation of goals served to shed light on important, but otherwise unstudied, parts of projects' programs. The second purpose of the Component was to feed key information back to the projects with regard to goal achievement and to assist them in developing a mechanism for their own self-monitoring. Focusing on the evolution of project direction in the first year and showing how goals had changed or been refined as a program developed was one means to help the respective staffs in understanding the implication of goals. Provision of a goal monitoring instrument specifically tailored to each project was the next step in urging projects to internally monitor goal achievement and a means to facilitate feedback on progress made toward reaching defined goals.

Methodology Process

During the projects' first 6 months, at a time when most of the projects were close to fully operational, BPA staff held goal clarification sessions with each project's staff (or in some cases, staff plus Advisory Board members). These meetings were not designed to enforce the projects' pursual of any particular goals, but were seen as an assistance toward assessment of program directions in the middle of the first year of funding. The nominal group process, as developed by Andre Delbecq and others, was selected as the means for eliciting staff perceptions of the goals of the project.[1] The process produced a list of five to seven top priority goals for each of the demonstration projects.

[1] In the Nominal Group Process, the silent period itself is tension-producing and, as such, idea-producing. It allows time to reflect and think. All members of the group participate. The method encourages the generation of minority ideas, avoids hidden agendas, makes each participant work and contribute, gives each a sense of responsibility for the group's

To further aid the projects in deriving benefit from this goal articulation process, a report was prepared with regard to the identified top priority goals. First, the goals defined through the nominal group process were compared with those goals statements found in the respective grant proposals, to determine if any new goals or directions had emerged as high priority since the projects' inception, or if any grant goals had clearly been eliminated, at least in the eyes of the staff. This analysis pointed out to the staff need to rethink either their project's direction and/or staff's perception of the project and its purposes. Secondly, indicators for measuring the top priority goals identified by staff were suggested. Again, the purpose was not to suggested or push these particular goals, but to provide feedback on what it would mean to select any particular goal, both in terms of work activities to be pursued in achieving the goals, and in terms of the types of evaluation and monitoring that would be required to do goal assessment. The expectation was that the projects' staffs would use this goals analysis to focus the direction of their efforts, to begin to think in terms of program evaluation with regard to goal achievement, and to guide the selection of the data needed to develop subsequent refunding requests.

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success, fosters creativity as well as interaction, allows personal concerns to be aired, and is especially useful in a heterogeneous group since it does not permit any one person or point of view to dominate. Because the silent period is followed by the sharing of all ideas prior to their discussion, all members are assured that their ideas will be heard. In the discussion which follows, the benefits of group interaction, feedback and information-sharing are realized. Group members have a chance to question each other's ideas and clarify them. The group interchange is structured only by the time allotted for discussion and by the voting session, which gives each person another chance to express his or her views.

Not everyone endorses the Nominal Group Process approach. Some believe it is not as creative as it is purported to be and that it really does not encourage new ideas or innovative methods; others feel uncomfortable while using the technique or reserved about the outcome of the technique, in that it does not give dominant recognition to those having ultimate responsibility for program results or to those having the most knowledge and experience. In short, the technique treats all participants equally, rather than recognizing differences in expertise, levels of responsibility or accountability. Ultimately, of course, the results of such group work could be treated only as recommendations, awaiting final action by those having formal authority and responsibility for program actions. This may be done at the cost of some morale.

Six months later, BPA staff conducted another clarification of goals, this time using a modified nominal group process, in which projects' second year Refunding Proposal goals and the goals earlier defined by staff were reconciled into a final goal statement list. It was thought that for the most part these were the goals that each staff would pursue for their final two years of federal funding.

This second goal analysis session also included discussion with projects' staffs regarding the planned and ongoing activities particular to each project and their communities which could be translated into the steps necessary to be taken toward achievement of goals. These specific suggestions were incorporated into an instrument, specifically tailored to each project in order to measure attainment of a project's defined goals.

The Project Goals Instrument

The Project Goals instrument was designed largely from the specific suggestions provided by each staff on how to measure those goals. The format was selected in an effort to make the goal clarification process meaningful and useful to the projects; therefore, rather than a narrative report as such, each project was presented with an individual designed tool, specific to evaluation of goal achievement. Set up in the style of an interview, the instrument was meant to be self-contained as a mechanism for recording progress toward reaching goals. At any given time could be picked up and, on completion, insight could be gained as to where the project stood in relation to its goals.

The goal statements were reworded as questions, a positive response indicating successful goal achievement. However, in no case was it just a matter of a simple "yes" or "no" answer. Indicators, or benchmarks, pointing out the direction of effort necessary in successfully reaching goals were laid out. Interim indicators were translated into "steps" because they point out the range of activities which should be addressed if a project were serious abouting meeting its final goals; and "outcomes," then, were indicators that determine if the goals had indeed been successfully accomplished. Measures, listed under the steps and outcomes,

were the specific questions that should be answered in order to know to what degree the indicators have been carried out. Building on answers to the measures would show the level at which the goals have been achieved.

While not meant to be exhaustive, the steps and outcomes selected for each goal were seen as a realistic scope of indicators for goal assessment. As much as possible, the full range of ideas offered by project staff with regard to the activities they thought particularly important for measuring goal achievement were made part of the instrument. In addition, there were some indicators that were added to complement those selected by the projects' staffs because of their importance for a more complete assessment.

The data necessary to complete the questions raised in the goals instrument could be collected by the projects themselves, using their own forms and evaluation procedures or BPA-provided forms. In instances where BPA was collecting and analyzing data for the other parts of the Evaluation, this information could be provided to the projects for their goal assessment.

Usefulness to the Projects

The goal assessment instrument was useful to the project in two ways. First, it assisted them in directing their daily efforts. The steps and outcomes, together with the various measures, provided specific focus for staff activities and served as an alert when large amounts of time and energy were used in areas unproductive to goal achievement. Secondly, the instrument was also helpful to the projects and their federal monitors in making overall assessments of where the projects stood during critical times in the project history, such as at the beginning of the third year of funding and at the end of the three-year funding period.

While the instrument itself was packaged for the purpose of recording summary information about goal achievement, it could not be fully informative of the projects' progress in meeting their goals unless interpretation was made of the recorded numbers and answers. Explanations were critical as to why or why not there has been successful completion of steps or tasks,

which would then impinge on goal achievement. Constraints, such as change of personnel, newly defined community needs, lack of cooperation and a vast array of other factors could have served to prevent progress. In order to have meaningful data for interpretive purposes, however, it was necessary to have targets or plans established in the beginning of goal monitoring. Important for setting long range sites for work activities, these targets also became a basis of comparison for the analysis of the accumulated information on goals. Thus, the projects were asked upon receipt of this document to record their current planned achievements and/or amount of activity, both for the end of the second funding year and for the end of the three year funding cycle.

Usefulness to BPA

The Project Goals instrument was also useful in carrying out the remainder of the Project Goals Component of the Evaluation. At the end of the projects' second and third years, BPA assessed the projects' progress in goal attainment, using the format suggested in the instrument. In order to gather information relevant to the steps, outcomes and measures, interviews were held with project directors, other staff, and, if applicable, representatives of the community at large. Also, data collected by both the project staff and BPA were assenbled. This broad spectrum of information was integrated with BPA staff knowledge ascertained through ongoing contact with the projects, the projects' reports and refunding proposals and the targets that the projects set for themselves related to their goals. From this, an assessment was made of the degree to which projects have met their defined goals.

THE FAMILY CENTER

ADAMS' COUNTY, COLORADO

PROGRAM GOAL ACHIEVEMENT INSTRUMENT

Date target entries made: ___/___/___
mo day yr

Date(s) for which targets apply:

___/___/___ mo day yr ___/___/___ mo day yr

Date Instrument completed: ___/___/___
mo day yr

BERKELEY PLANNING ASSOCIATES

PROGRAM GOALS: THE FAMILY CENTER, ADAMS COUNTY, COLORADO

I. To foster a multidisciplinary approach in Adams County for the prevention, detection and treatment of child abuse.

II. To improve client functioning by providing responsive intake and treatment.

III. To demonstrate the role of a nurse as an important part of a child abuse team.

IV. To determine the most effective treatment within the context of a Department of social Services, for abused children and their families.

V. To heighten community awareness about the dynamics and treatment of child abuse and about the need to report.

VI. To increase the knowledge of school personnel and their involvement in the child abuse services system.

VII. To provide continuing child abuse coordination, referral and treatment services in Adams County after the demonstration funds have been reduced.

VIII. To develop a child abuse program model which will be applicable to other Departments of Social Services in the state and around the country.

I. Is there a multidisciplinary approach for the prevention, detection and treatment of child abuse in Adams County?

A. Steps

1. Expansion of the Multidisciplinary Review Team.

a. How many new members have been added?

Expected _____ Actual _____ Name the new disciplines represented:

b. What percentage of meetings were attended by new members? _____

2. Establishment of a Community Relations Board.

a. How many meetings have there been of the Board?

Expected _____ Actual _____

b. How many key community agencies are represented on the Board?

Expected _____ Actual _____ Name the key agencies:

3. Implementation of a procedure for providing feedback to other agencies regarding referrals and ongoing treatment services.

a. Is there a written form for feedback on initial referral? _____

b. If yes, what percentage of times was the form actually used?

_____

c. Is there a mechanism for ongoing communication with relevant agencies regarding project cases? _____ If yes, specify procedures:

4. Encouragement by the project regarding development of needed community treatment resources.

-- How many project coordination contacts related to development of new community resources have been made? _____

5. Participation of personnel from a wide variety of agencies in the Speakers Bureau.

   a. How many other agencies are participating in the Speakers Bureau?
   Expected _____ Actual _____

   b. How many people were in attendance at Speakers Bureau presentations made by non-project staff? _____

B. Outcomes

1. Increase in referrals to the project from those agencies or disciplines who initially referred infrequently.

   -- What is the increased percentage of total referrals that have come from those initially referring infrequently?
   Expected _____ Actual _____

2. Filling service gaps with the development of new treatment resources by other community agencies.

   a. How many new community treatment resources have been established?
   Expected _____ Actual _____ Name the new services:

   b. How many people involved in abuse or potential abuse are receiving treatment from the newly established resources? _____

3. Increased number of referrals for services among various community abuse-related agencies.

   a. How many agencies are now referring to other community agencies for services? _____ Name the abuse service agencies referring:

   b. What has been the increase in the volume of referrals among the various agencies?

4. Perception by personnel in agencies in the community that there is an effective multidisciplinary approach in meeting the child abuse problem.

   -- What percentage of agency personnel perceive an effective multidisciplinary approach? _____ Describe the means by which a community-wide assessment was made:

II. Have clients improved due to the provision of responsive intake and treatment?

A. Steps

1. Timely Intake.

a. What is the response times to all referrals?

Expected _____ / _____ Actual _____ / _____
range average range average

b. What is the time from the initial referral to the completion of intake?

Expected _____ / _____ Actual _____ / _____
range average range average

2. Satisfactory transfer of intakes to the ongoing caseloads of ACDSS workers.

a. What is the time between completion of the intake process and first contact by an ACDSS worker?

Expected _____ Actual _____

b. What is the perception of the clients regarding the transfer of his/her case from the Center to an ACDSS worker? Explain how many and by what means clients were followed-up after intake for these perceptions:

c. What is the perception of ACDSS workers regarding the case transfer process? Explain by what means ACDSS workers' opinions were solicited:

3. Implementation of children's treatment services.

a. How many children have been placed in the nursery?

Expected _____ Actual _____ What is the average length of stay? Expected _____ Actual _____

b. What has been the number of hours of therapeutic treatment provided to children in the crisis nursery?

Expected _____ Actual _____

c. What has been the number of hours of treatment provided to abused children in day care homes?
Expected _____ Actual _____

d. What has been the number of hours of treatment provided to children in designated foster care homes?
Expected _____ Actual _____

e. What has been the number of hours of other treatment provided by FC to abused children?
Expected _____ Actual _____ Define the variety of other treatment to children:

4. Implementation of treatment to parents.

a. What has been the number of families provided with a lay therapist? Expected _____ Actual _____

b. How many hours of lay therapy per family has been provided?
Expected _____ Actual _____

c. What has been the number of clients provided with individual therapy, group therapy and parent education classes?
Expected:

Actual:

d. What has been the total number of hours of individual therapy, group therapy, and parent education classes?
Expected:

Actual:

5. Regular case conferences or staffings on FC cases.

   a. How many case conferences/staffings have been held?
   Expected _____ Actual _____

   b. How many cases were reviewed in the case conferences/staffings?
   Expected _____ Actual _____

   c. What has been the perception of the staff about the validity or importance of the regular case conferences/staffings? Describe how this assessment is made:

B. Outcomes

1. Improved functioning of children while in treatment.

   a. What percentage of children at termination had improved in terms of physical growth? _____ Explain how physical growth was measured:

   b. What percentage of children at termination had improved their socialization skills? _____ Explain how these skills were measured:

   c. What percentage of children at termination had improved motor skills? _____ Explain how these skills were measured:

   d. What percentage of children at termination had improved cognitive/language development? _____ Explain how this development was measured:

e. What percentage of children at termination had improved interaction patterns within the family? _____ Explain how these patterns were measured:

2. Improvement of adult clients' functioning while in treatment.

a. What percentage of adults did not reabuse their children while in treatment? _____

b. What percentage of adult clients improved their functioning during treatment? _____ Explain the criteria and the method by which these clients' functioning was assessed:

III. Has the role of a nurse as an important part of the child abuse team been demonstrated?

A. Steps

1. Personal contact with the private physicians in the county.
   -- How many physicians have been contacted and provide information regarding child abuse and the Family Center?
   Expected _____ Actual _____

2. Provision of inservice training to nurses and house staff of all local hospitals.
   a. How many inservice training sessions have been provided?
   Expected _____ Actual _____ Name the hospitals involved:

   b. How many people were in attendance at the training sessions?
   Expected _____ Actual _____

3. Provision of medical assessment to children in the crisis nursery.
   a. How many physical development assessments have been done by the nurse? Expected _____ Actual _____
   b. How many diagnoses of illness have been picked up by the nurse on her visits to the nursery? _____

4. Accompanying the social worker on intakes involving actual abuse.
   -- On what percentage of actual abuse intakes has the nurse gone out initially? Expected _____ Actual _____

B. Outcomes

1. Perception of local physicians and hospital staffs that having a nurse contacting them and providing inservice is important.
   -- What percentage physicians and members of hospital staffs believe that initial and ongoing contact with a nurse is important? _____ Describe the means of making this assessment:

2. Perception of Juvenile Court personnel that testimony provided by the nurse is important for court cases.
   -- What is the perception by Court personnel of the nurses' role? Describe the method of making this determination:

3. Increase in referrals to the project from physicians and hospital personnel contacted by the nurse.
   -- What is the ratio of the current number of referrals from these sources to their initial number of referrals? _____

IV. Within the context of a Department of Social Services, have the most effective treatments for abused children and their families been determined?

A. Steps

1. Conceptualization and implementation of a range of treatment strategies for both parents and children.

a. How many client treatment services are in the planning stage of development? _____ Name the various types of treatment referred to:

b. How many client treatment modalities are fully implemented? Expected _____ Actual _____ Name the various types of treatment referred to here:

2. Designing a plan to assess effectiveness of treatment strategies.

a. Is there an assessment of the child and/or parent on entering the project's caseload? _____ Describe the type of initial assessment(s) done for both parents and children:

b. Are clients reassessed over time? _____ Describe the procedures and intervals for reassessment of both parents and children:

c. Has a control group been defined? _____ If yes, describe group and how it has been identified:

d. How will the client data be analyzed? Describe for both parent and child.

3. Use of a mechanism for keeping track of which services are rendered to each client.

a. Have forms been developed? _____ Describe the scope of the forms and who uses them:

b. On what percentage of clients are service records kept?

Expected _____ / _____ Actual _____ / _____
adult children adult children

4. Implementation of the design for evaluating effectiveness of services.

a. How many children and/or parents have been assessed on entering the caseload?

Expected _____ / _____ Actual _____ / _____
children parents children parents

b. What are the intervals for reassessment of clients?

Expected _____ / _____ Actual _____ / _____
children parents children parents

c. How many client records were completed for the effectiveness assessment? _____ / _____
children parents

B. Outcomes

1. Awareness of the most effectiveness strategies of treatment.
   -- How many treatment services proved effective? _____
   Explain the findings:

2. Use of the results of the assessment of effectiveness.
   a. How have the project's scope of services changed based on the evaluation results?

   b. To what extent have the results been made available to other programs associated with Departments of Social Services?

V. Has community awareness about the dynamics and treatment of child abuse and about the need to report been heightened?

A. Steps

1. Oral presentations made in the community.
   a. What is the number of Speakers Bureau presentations?
      Expected _____ Actual _____
   b. To whom were these presentations made? Describe in terms of number of presentations per type of audience:

   c. How many people were addressed in these presentations? _____

2. Distribution of written material.
   a. How many pieces of written material on abuse have been distributed?
      Expected _____ Actual _____
   b. To what groups or individuals was this written material distributed? Describe the audiences:

3. Provision of media coverage on child abuse and on the Center's role in treatment.
   a. How many media (press, radio and TV) presentations have been made by project staff?
      Expected _____ Actual _____ Describe the scope of the presentations:

   b. How many public service announcements have been made?
      Expected _____ Actual _____

B. Outcomes

1. Increased reporting from those people, agencies or institutions once referring infrequently.
   -- What is the ratio of the percent of referrals from those once referring infrequently to the initial percentage? List the ratio per referral source:

2. New legislation or allocations for child abuse.
   a. How much new state and local legislation regarding child abuse has been passed which was supported by people from Adams County? Describe the scope of the legislation and who locally supported it:

   b. How much new money has been allocated at both the state and local levels for child abuse services? Describe the sources of this new money:

3. Perception by the community that they are more knowledgeable about abuse, its treatment and about the law and the importance of reporting.
   -- How many Center-identified target groups have become more knowledgeable? List the target groups and describe the method of assessment:

4. Increase in number of volunteers for the Center.
   a. What is the ratio of the current number of regularly participating volunteers to the initial number?
      Expected _____ Actual _____
   b. How much money and materials have been donated to the Center since the project's inception?

VI. Has the knowledge and involvement of school personnel increased?

A. Steps

1. Contacting and training school personnel regarding child abuse detection and the need to report suspected cases.
   a. How many inservice training sessions have been held per each school district? Expected _____ Actual _____
   b. How many personnel have been inserviced per school district? Expected _____ Actual _____
2. Working out agreements with school districts regarding referral procedures.
   a. What is the percentage of schools with referral procedure agreements with the Family Center? Expected _____ Actual _____
   b. How many referral procedure agreements are fully operational? Expected _____ Actual _____
3. Involvement of representatives of the school system in FC activities.
   a. How many school representatives are on the Community Relations Board? Expected _____ Actual _____
   b. How many project case conference/staffings have school personnel attended? _____

B. Outcomes

1. Increase in referrals from school personnel.
   -- What is the percent increase of referrals from school personnel? Expected _____ Actual _____
2. Increased knowledge on the part of school personnel about child abuse and its treatment.
   -- How many school personnel have become more knowledgeable? _____ Describe the method used for assessing this knowledge:

3. Involvement of schools in treatment.

   a. Since the first contact by a Center worker, how many schools now have classes or classroom materials about child abuse and/or child development? Expected _____ Actual _____

   b. How many teachers or school personnel are now working with the Center in initial evaluation and reassessment of abused children? _____

   c. How many teachers or school personnel are working with the Center in providing treatment to abused children? _____

VII. Are specialized child abuse services continuing in Adams County after the demonstration funds are reduced?

A. Steps

1. Ongoing contact by Center staff with the state legislature and state level DSS staff.

   a. How many contacts have been made with the state legislature, whether testimony to committees or on a one-to-one basis?

   _____

   b. How many contacts have been made with state-level DSS staff specifically regarding continuation of specialized child abuse programs? _____

2. Ongoing contact with local officials regarding the child abuse needs of the county.

   -- How many contacts were made regarding child abuse services? _____ Name the various contacts:

3. Ongoing contact with local fund-raising groups and foundations.

   -- How many contacts with fund-raising groups have been made?

   _____

B. Outcomes

1. Obtaining funds for continuing specialized child abuse services in Adams County.

   -- How much money has been authorized and appropriated for such services? _____ Describe how the money will be allocated:

2. Family Center services becoming a continuing part of the services offered in Adams County.

   -- How many of the FC services will still be offered after the reduction of demonstration money? _____ Name the services:

VIII. Has a program model applicable to other DSS's been developed?

A. Steps

1. Drawing up and distributing a clear, concise statement of the goals and functions of the project.

   a. How many descriptions of the project have been distributed?

   _____

   b. How many of these descriptions of the FC have been distributed to programs affiliated with Departments of Social Services?

   _____

2. Presentations made around the state and county regarding the Center model of services.

   -- How many presentations have been made by Center staff? _____

3. Assessment of program cost-effectiveness.

   -- Is the program cost-effective? Explain the mode of assessment and the results:

B. Outcomes

1. Publication of an evaluation of the project in terms of performance and cost.

   -- How many such publications are there? _____ Describe the publications:

2. Adoption of this model of services by Department of Social Services in other communities, due in part to Center dissemination of information.

   -- How many other communities have adopted a model similar to that of the Family Center? _____ Describe the programs:

SECTION IV
THE COST ANALYSIS COMPONENT

The basic objective of the cost analysis is to provide information on projects' costs in a different way from that used in traditional budget allocations. While it is useful, in fact essential, in program planning to know project costs in terms of budget items such as payroll, rent and utilities for certain evaluation questions and policy decisions, we would also like to have some knowledge of the costs of the individual services which projects are providing. The cost analysis methodology described here enables us to look at project costs in terms of individual services, such as the cost of providing day care services, or of providing group therapy. This is the basis for answering such questions as the cost-efficiency of service strategies, the cost-effectiveness of individual services, and the unit costs of various services.

The methodology, then, requires the translation of project resources from the traditional budget categories to service and operational components of the project. The resources which projects use include personnel (both paid and unpaid), space, supplies, equipment, telephone and other costs such as purchased services, travel and printing. The project components in which these resources are used include all discrete activities of the project related directly to serving clients and the general community, as well as internal activities necessary for the functioning and development of the project.

I. Monitoring Resource Utilization

Our methodology provides techniques for allocating each of the major types of resources to the project components. The resources which projects use include personnel (both paid and unpaid), purchased services, durable equipment, and non-payroll items (such as rent, utilities, supplies, travel and printing). For personnel, which represents the major resource in the projects, the technique is to have staff monitor the use of their time during periodic intensive cost accounting months, reporting the number of hours

they spend on each of the project's service components. With this information on time allocation of staff, volunteer and consultant time, we allocate personnel costs across services. For non-payroll expenses, durable equipment, and purchased services, projects report expenditures on each major item and also allocate these expenditures to the major project components for which they were used. Finally, the projects record the quantities of services provided during the month for the subset of the service components which reflect direct services to clients. Once this information on the amount and use of various project resources and the units of services delivered has been collected from the projects, BPA's computerized processing of the data aggregates the individual items of data into total costs for each of the project's service components, as well as the cost of delivering a unit of each of the services.

II. Identification of Service Components

The objective in the cost analysis is to determine the costs of each of the project's activities. In order to ensure that comparisons across projects will be feasible, a standard listing of project activities or services components must be used by all projects. A major effort in designing the cost analysis was the identification and definition of a workable listing of these service components.

Initially, BPA staff studied the projects' original grant proposals and sought to identify discrete project activities. During the first site visit to projects, discussions were held with project directors and staff to further clarify what specific activities the project intended to pursue. The listings developed for each individual project were then combined, and generic titles for the different activities identified. The intent was to develop a listing which was exhaustive, non-duplicative and in sufficient detail to sort out the costs of discrete activities, but which also was clearly related to the service strategies being implemented by the projects. The purpose of the evaluation effort is, after all, to assess the effectiveness of service strategies and thus establish guidelines for other communities on how best to set up programs to respond to the problem of child abuse and neglect. This listing was then reviewed with the projects during the

second site visit. With further revisions, the listing constituted the set of service components utilized in the January cost analysis pretest. Refinements from experiences during the pretest resulted in a listing of 42 service components.

The listing is long, yet for any given project only a subset of the total listing of service components is relevant. The uniformity of the list, however, is essential in making across-project comparisons. Some compromises had to be made in the choice and scope of the service components in order to satisfy both the need to make the list appropriate for any given project while maintaining the possibility of analysis across projects. For example, a given service component may seem too broad for one project and too narrow for another. The one project may find that several of their important activities are included in one of the service components, as given, and some subdivision of that service component would be more useful to them for their own cost control. The other project may find that two service components are, in fact, activities that they carry out, but the two are so intimately mixed that staff members have difficulty deciding whether their time is going into one or the other and would prefer that they be combined. The service components and their definitions are shown below; the clustering of service components into generic activity groups follow.

Service Components and Their Definitions

1. Prevention. Activities designed to reach persons "at risk," with general potential to abuse/neglect. For example, hospital visiting to new mothers and parents to develop their awareness of community resources and assess their potential for abuse/neglect; "family life"-type courses and presentations to high school students or adult education students; screening of medical clinic patients to identify "high risk" families. "Prevention" is closely related to "community education" but the essential distinction is that prevention deals specifically with groups in the population which are "at risk."

2. Community Education. Activities designed to promote, among the general public, an awareness of the phenomena of child abuse and neglect, an understanding of the dynamics and causes of abuse/neglect, as well as an awareness of community resources available for treating the problem.

Includes speaking engagements, media appearances and interviews, workshops, poster and pamphlet preparation and distribution, etc.

3. Professional Education. Seminars, workshops and other training activities for professionals in fields related to children or in agencies dealing with abuse/neglect (doctors, police, court personnel, teachers, social workers, etc.). Designed to promote: awareness of and ability to identify abuse/neglect and of the project's role; understanding of reporting requirements and the dynamics of child abuse and appropriate treatment strategies; knowledge of community resources.

4. Coordination. Contacts with other community agencies in the child abuse and neglect system to increase coordination and develop a more effective network for receiving and treating child abuse and neglect cases. Includes one-to-one contacts with agency people, as well as meetings, etc. directed toward developing inter-agency procedures, new services, agreements and other general coordinative efforts. Many activities pursued by the project, such as a Multidisciplinary Review Team, will have spin-off effects on coordination. However, unless the main purpose of the activity is coordination, time should be allocated to another component. Thus, the time spent in Multidisciplinary Review Team meetings would be allocated to the category with that name and less formal review of cases would be allocated to Case Management & Regular Review.

5. Legislation & Policy. Activities directed toward effecting changes in local, state or federal laws and other written policies for child abuse and neglect. For example, helping to draft model legislation or proposed bills or amendments, meeting with legislators to promote legislative changes, etc.

6. Staff Development/Training. Staff meetings and informal interactions to enhance staff knowledge of abuse/neglect, treatment strategies, methods of case handling and modes of working together. May involve outside speakers, consultants. Includes weekly "staff sensitivity" or similar sessions. Includes time spent on giving or receiving "on-the-job" training for staff (paid or volunteer) and in staff supervision directed toward improvement of staff functioning.

7. Program Planning & Development. Developing overall plans for new project components that will have long-term effects. Includes changes in project operation, expansion, project goals and objectives, etc. Developing additional resources (e.g., fund-raising) for continuation of project after federal funding. (NOTE that time spent in planning for any specific project component, such as Day Care, should be allocated to it.)

8. General Management. Budgeting, personnel and other administrative activities not directly related to a specific project component. Includes communication and meetings to discuss administrative matters and routine monitoring of staff. NOTE that time spent on any activity (typing, budgeting, etc.) which is associated with a particular component or components should be allocated to that component, not General Management (e.g., a meeting to discuss staff assignments to Group Therapy and Individual Therapy should be allocated to those two components).

9. Project Research. Project-generated research or research in which project plays a major role on aspects of child abuse/neglect and treatment of it, as well as evaluation research activities of monitoring and assessing your own project's activities, effectiveness, benefits and costs, etc. Includes developing project forms and client records.

10. BPA Evaluation. Activities performed as part of the National Evaluation being conducted by BPA. Includes meetings with BPA staff, reviewing BPA reports, filling out BPA cost, log and client forms.

11. Outreach. (1) After receiving referral or self-referral, this component involves contacts with the potential client to encourage him or her to participate in or accept the project's services. May be in the form of telephone calls or home visits. (2) Activities designed to identify abusive/neglectful families who could benefit from the project's services: e.g., screening of children in day care centers or schools.

12. Intake & Initial Diagnosis. Initial interview and case evaluation (following outreach efforts, if they have occurred), to determine whether abuse/neglect or potential for abuse/neglect is present, and to determine appropriate treatments or assistance. Includes consultation with other agencies, weighing medical reports, sorting out family history and present circumstances. May include medical evaluation. Includes developing a service plan if this is not done by a special Diagnostic Team. Does not include case reviews after the initial intake and diagnostic process is completed. Time spent on such reviews (e.g., developing a revised service plan) should go under Case Management & Regular Review or Multidisciplinary Team Case Review.

13. Case Management & Regular Review. Review of a case after intake, during treatment, for purposes of reviewing client progress and revising treatment plan. Monitoring client's receipt of services, arranging services for clients from other agencies (making appointments, etc.), discussing case with other involved agencies, follow-up. Advocacy services for the client are included here.

14. Court Case Activities. Time spent preparing for and presenting all necessary documents and testimony for court proceedings. Includes other case management functions specifically related to court and legal matters such as meetings with attorneys. Excludes arranging for court ordered placements. Includes transportation and waiting time related to court activities.

15. Crisis Intervention During Intake. Staff member intervenes in a client's crisis situation during intake. Includes emergency meetings at client's home or in the project offices. Does not include intakes which are not serious emergencies.

16. Multidisciplinary Team Case Review. Review of case during intake and/or treatment by a team, typically composed of individuals representing many different disciplines, for diagnosis, case planning and case reassessment. Not included here are the more frequent, more informal case reviews by staff.

17. Individual Counseling. One-to-one counseling typically at worker's office or in client's home. Typically provided by a social worker or other staff (nurse, etc.) to discuss client's situation and problems (primarily social and economic), possible changes in them, and other issues. To be distinguished from Individual Therapy which is usually on a more formalized basis.

18. Parent Aide/Lay Therapist Counseling. One-to-one counseling typically at client's home in which a person designated as a parent aide or lay therapist befriends client and discusses various issues of benefit to client.

19. Couples Counseling. Counseling provided by a professionally trained counselor typically in the counselor's office for married couples or two adults living together to help them resolve difficulties they may be experiencing together.

20. Family Counseling. Counseling provided by a professionally trained counselor typically in the counselor's office for families (parents and children) to help them resolve difficulties they may be having together. At times counseling may be provided to individual family members and at times is provided to the family as a group.

21. Alcohol, Drug & Weight Counseling. Counseling provided either on a one-to-one or group basis directed at helping individuals overcome personal problems of alcoholism, drug addiction and overweight. Includes services offered at a drug abuse clinic, AA, Weight Watchers, Mental Health Center and other specialized treatment centers.

22. 24-Hour Hot Line Counseling. A telephone number a parent can call anytime of day or night to reach out for help and receive therapeutic assistance or at least be assured of reaching a patient listener.

23. Individual Therapy. One-to-one therapy provided to client, which includes all of the following characteristics: provided by a trained psychologist, psychiatrist, or social worker in an office setting; structured by both time (50-60 min.) and appointment (usually once/week, sometimes more often); primarily though not exclusively psychological in focus.

24. Group Therapy. A therapeutic group session, typically two hours in duration, run by one or two persons qualified as group therapists and skilled in a variety of group techniques.

25. Parents Anonymous. A therapeutic group session for abusive and neglectful parents typically organized and run by the parents with support from one or two resource persons who attend the group meetings.

26. Parent Education Classes. A number of sessions provided, typically in a classroom setting, by persons qualified in child development to discuss issues of child development, parenting, etc.

27. Crisis Intervention After Intake. Staff member intervenes in client's crisis situation, by means other than 24-hour hot line, e.g., emergency home visit, emergency meeting at project, etc. Excludes initial contact with client. This is a crisis for the family, not an emergency for the project.

28. Day Care. Child is left at licensed or otherwise designated center for a certain number of hours during the day. Typically day care services are provided five days a week.

29. Residential Care for Children. Long-term (i.e., longer than emergency basis) overnight care of children, providing a warm and reinforcing living environment.

30. Child Development Program. A day care program in which activities are prescribed to deal with psychological, learning and other needs of the children in a therapeutic setting.

31. Play Therapy. The counterpart, for children, of individual therapy, utilizing play equipment to promote the child's self-expression.

32. Special Child Therapy. Speech therapy, physical therapy or other specialized therapy provided to child to fill a particular need or improve developmental ability.

33. Crisis Nursery. A nursery to which a child may be brought any time of day or night and left for short periods of time when parent is in time of crisis.

34. Homemaking. A qualified homemaker or equivalent visits client's home, provides instruction on such topics as nutrition and hygiene, and/or assists in alleviating household stress by helping with cleaning, cooking, child care, etc.

35. Medical Care. Provision of medical services by a physician or other health professional. Includes dental and optometric care.

36. Babysitting/Child Care. Parent is provided with babysitting service either in home or at the project while he/she attends to his/her own affairs.

37. Transportation/Waiting. Client is provided with transportation to and from service appointments, shopping, etc. Excludes court-related transportation and waiting time.

38. Emergency Funds. Client is provided with small amount of emergency money from project, either as a loan or as a gift. Time spent arranging for funds goes under Case Management & Review.

39. Psychological & Other Testing. Psychological and personality testing administered to client by a person trained in the administration of the test as a diagnostic instrument, to be better able to specify client's problems.

40. Family Planning Counseling. Parent is provided with counseling by a qualified family planning counselor, typically at a family planning center, on contraception techniques and the like.

41. Follow-Up. All contacts, either by phone or in person, with clients after they have been terminated or stabilized, or contacts with other agencies/individuals about a terminated client.

42. R & R. Recovery time, or "rest and relaxation." Time not spent directly on any component or service, but used to recoup one's energy after an exhausting client session, etc. Does not include lunch and prescribed breaks.

Status Codes: R = Regular Staff
Full or part-time staff members who are expected to be on duty for all or part of the work week and are accountable to project management for work performance in return for regular pay. Also staff members who are expected to be on duty at certain times, but are paid from some other source, e.g., VISTA, another agency, etc.

S = Substitute or Temporary
Same as above but, by agreement, are expected to stay with the project for only a short time, either to substitute for an absent staff member or to handle some extra work load of limited duration.

C = Consultant
A specialist who works now or has worked professionally in the field of specialty. May be paid by the project by the hour or may donate time which may or may not be compensated by some other source. Does not include regular staff members who are called consultants for special bookkeeping purposes.

RV = Reimbursed Volunteer
A volunteer who contributes to the project, is not paid by project or from any other source for the kind of work done for the project, but receives compensation for expenses, e.g., travel.

V = Volunteer
Same as above, but no compensation.

Since salaries are the dominant cost of projects, the allocation of such payments for staff time has a greater effect on the cost of individual project activities than the allocation of any other resource of the projects. In order to know how to allocate salaries across project activities, we had to know how individual staff members spent their time in relation to specific activities. Because we considered it too burdensome for the projects' staffs to monitor their time continuously, we asked them to monitor time only periodically -- one month out of every three or four during what we refer to as the intensive cost-accounting month.[1] The Time Allocation Form (N-C01C) was used for this purpose.

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[1]The data collected during three intensive cost-accounting months (October 1975, April 1976, and October 1976).

The form contains columns for each day of a month and rows representing 42 possible service components of a project. All individuals contributing directly to the project services record all hours worked during a given month in the appropriate spaces on the form.[1] The form has been designed to be self-contained, providing all of the information necessary in order to fill it out properly. Thus, instructions for filling out the form are provided directly on it. Often, the project director preferred to fill this form in for consultants and others who worked only a few hours per month and on only one or a few service components.

Staff time is accounted for in hours. These hourly allocations are converted into percentages and the percentages are then applied to the individual's pay for the month to produce dollar allocations. These are summed for all staff; the resultant figures are the allocations of payroll expenses across service components.[2]

B. Non-Payroll Expenses

The second set of information requested is a listing of all non-payroll expenses for the month, excluding purchased services. This includes items such as rent, telephone, printing and travel as well as all durable and non-durable equipment and supplies. An identifying title for each non-payroll expense item is listed on the form along with the payment made for said item during the month and the project's percentage estimate of how this item should be allocated across the different project service components. For

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[1] Vacation time, sick leave, time off, and lunch time were not to be recorded by project staff as time spent on one of the 42 service components. The pay that a given person receives in a month is used to determine that person's contribution to the cost of the service components on which he worked that month. This creates no problems for sick leave, time off and lunch time. Vacation time could pose problems if such time is concentrated in certain months, but was handled either through accrual or through post-facto reassignment of costs based on previous time expenditures on service components.

[2] The reimbursements for expenses to parent aides are treated arbitrarily as salary and are combined with consultant fees in the non-staff personnel category.

Status Codes: R = Regular Staff
Full or part-time staff members who are expected to be on duty for all or part of the work week and are accountable to project management for work performance in return for regular pay. Also staff members who are expected to be on duty at certain times, but are paid from some other source, e.g., VISTA, another agency, etc.

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Same as above but, by agreement, are expected to stay with the project for only a short time, either to substitute for an absent staff member or to handle some extra work load of limited duration.

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A specialist who works now or has worked professionally in the field of specialty. May be paid by the project by the hour or may donate time which may or may not be compensated by some other source. Does not include regular staff members who are called consultants for special bookkeeping purposes.

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[2] The reimbursements for expenses to parent aides are treated arbitrarily as salary and are combined with consultant fees in the non-staff personnel category.

IV. Data Processing

After the cost data had been collected and reviewed internally by the projects' administration, each cost accounting booklet and employee time sheet was reviewed by the BPA project site liaison and the cost analyst for reasonableness based on site visit observations and previous reporting periods. The data was subsequently coded, keypunched and processed on a multi-stage program which produced the following sets of printout.

Two series of 15 data output tables were produced for each of the project sites for each cost accounting period. The two series duplicate the same procedures although one is based on Type I data, that is, information that reflects the project's actual expenditures, and the other is based on Type II data, which includes values ascribed to donated resources. The information displayed on each Table is as follows:

Table 1: Total Hours for Each Employee. Based on the Personnel Roster of the Monthly Cost Booklet, the assigned employee number, the status of each (regular, substitute or temporary, consultant, reimbursed volunteer, or volunteer), the total hours each employee contributed, and the total pay, including fringe benefits, are presented on Table 1.

Table 2: Individual Personnel Hour Fractions. Based on the time allocation forms collected for each employee, Table 2 displays the proportion of the total hours expended on each service component. It is this figure which is applied to the individual's pay and distributes it across service components.

Table 3: Total Percentages for Non-Payroll Expenses. This table provides a listing of the non-payroll expenses entered in the Monthly Cost Booklet.

Table 4: Total Percentages for Purchased Services. This table provides a listing of the purchased services entered in the Monthly Cost Booklet.

Table 5: Total Hours for Each Service Component. The hours worked on each service component during a given month are presented both as hours and percents by: regular staff, consultants, substitute staff, reimbursed volunteers, volunteers, and total hours.

Table 6: Total Dollars for Each Service Component. The dollars spent on each service component during a given month are presented by: regular staff payroll, non-staff payroll, non-payroll project expense, purchased service, durable equipment, and for the total budget.

Table 7: Percent of Dollars for Each Service Component. The percent of dollars spent on each service component out of the project's budget are presented by: regular staff payroll, non-staff payroll, non-payroll project expense, purchased service, durable equipment, and for the total budget.

Table 8: Unit Costs of Direct Services to Clients. The number of units provided during the cost accounting month and the cost per unit are presented for the 31 direct service components. The cost per unit figure is derived through the computer division of the volume of units for each service into the total dollars for that service as shown on Table 6.

Table 9: Total Dollars and Hours of Service Component Groups: The dollars and percent of dollars spent and the hours and percent of hours worked are presented by the seven service component groups: community activities, project operations, research, casework activities, treatment services to parents, services to children, and support services to family.

Table 10: Summary of Service Hours and Costs After Overhead Distribution. The computer program distributes the hours and costs involved in Case Management and Regular Review across the direct service components in proportion to the hours expended for each and subsequently distributes the hours and costs associated with the four overhead functions in project operations (i.e., Staff Development & Training, Program Planning & Development, General Management, and R & R) across all the service components in the same manner. The resulting table presents the total hours of effort and percent of hours worked, the labor costs and percent, the non-labor costs and percent, and the total costs and percent of costs spent on each service component.

Table 11: Unit Costs of Direct Services to Clients After Overhead Distribution. Based on the new cost figures for the 31 direct service components, Table 11 presents the volume of units provided for each of those services and the cost per unit once loaded with overhead charges.

Table 12: Total Dollars and Hours of Service Component Groups After Overhead Distribution. The dollars and percent of dollars spent and the

hours and percent of hours worked are presented by the seven service component groups after Project Operations and the Case Management function of the Casework Activities Group have been distributed across the other components.

Table 13: Summary of Service Hours and Costs After Overhead Distribution and Wage/Price Adjustments. For each project a separate wage factor and price factor have been entered into the computer which, when applied to labor and non-labor costs, adjust the data for market conditions in the project's region to a national norm for comparability. Presented in Table 13 are the total hours and percent, labor costs and percent, non-labor costs and percent, and the total costs and percent expended on each service component after the overhead functions have been distributed and after the project's wage and price factors have been applied to the cost data.

Table 14: Unit Costs of Direct Services to Clients After Overhead Distribution and Wage/Price Adjustments. This table presents the volume of units delivered during the month for each direct service component and the cost per unit, based on the new cost figures in Table 13.

Table 15: Total Dollars and Hours of Service Component Groups After Overhead Distribution and Wage/Price Adjustments. The dollars and percent of dollars and the hours and percent of hours worked are presented by the seven service component groups after the overhead functions have been distributed and the wage and price factors have been applied to the costs.

V. Two Types of Cost Analysis

The projects' activities, and thus resource utilizations, go well beyond those which the federal funding alone can support. The sources of projects' resources vary greatly from one project to another. Some projects have additional direct funding from state or local agencies. Most projects utilize volunteer time and other donated resources. Our efforts in the cost analysis are to deal with these differences across projects in a systematic way. To this end, the cost component of our evaluation consists of two levels of analysis; the major difference between the two levels of analysis is that in one, we are concerned with the costs covered by the project budget and in the other, we are concerned with the total cost to the community, as indicated by the value of donated resources utilized by the project.

A. Type I Standardized Cost to the Project

Type I analysis includes the allocation of all time spent on the project, both paid and donated, to the service components. In terms of dollar expenditures, however, we are concerned solely in Type I analysis with the allocation of the dollar resources in the total project budget to the service components, not with the allocation of donated resources which are not part of the project budget. This budget may include funds from sources other than the national demonstration funds and should comprise all monies over which the project management has discretionary control in carrying out its program. This type of analysis is most relevant for analysis of individual project costs and for their use by projects as a management tool. Two adjustments were desirable for comparability of data across projects: (1) distributing the indirect costs incurred by the projects in an equitable fashion to direct service categories; and (2) adjusting the wages and prices to account for local market conditions.

(1) Distributing Indirect Costs. Over the cost accounting months, each of the projects' resources have been allocated across a wide range of discrete activities relating directly to serving clients and the general community, as well as to the functioning and development of the project. Within the direct service components, Case Management & Regular Review can be regarded as an indirect cost of providing those services. The four

components comprising Project Operations (i.e., Staff Development & Training, Program Planning, General Management, and R & R) can be seen as general overhead costs.

Since the true cost of any direct service to clients includes some portion of the operational overhead, we developed a methodology for distributing these indirect costs proportionately across the service components. In an effort to achieve close comparability with the efforts of E.H. White and CPI, who are evaluating other similar federal child abuse and neglect demonstration projects, our approach involved distributing the Case Management component (#13) across the direct service components (#11-#41), based on the proportion of the total hours devoted to those components. This distribution was followed by spreading the Project Operations components (#6, #7, #8, #42) proportionately across all components, also based on how hours are distributed.

More specifically, the overhead hours are distributed proportionately by the hours the project spends on other activities. Then the dollar amounts expended for overhead activities are collapsed into two new expense groupings: labor and non-labor costs. The labor costs included the previous categories of regular staff payroll, non-staff payroll, and purchased services. The non-labor costs included the previous categories of non-payroll project expenses and durable equipment items. Since we had high confidence in the projects' allocation of labor costs, the formula for distributing overhead hours was applied directly to the dollar amounts for labor. However, due to a wide variance in the projects' allocation of non-payroll expenses and durable equipment expenditures, we pooled these costs for each month into a single General Management entry and then distributed that component across all other components in proportion to the hours expended for the activities.

(2) Adjusting Cost Data for Local Conditions. The objective of comparing program expenditures and unit costs for service delivery across the demonstration projects requires that suitable adjustments be applied to raw cost data to account for differences in the market conditions each project faces.[1] These market conditions fall into two broad areas: differences in labor costs, and variations

[1]Some might argue that adjusting for these differences is artificial or otherwise unnecessary; however, given the strong desire to ensure fair comparisons across projects, it was felt that such adjustments were essential.

in prices for non-labor goods and services. Normally, wage and price levels do not vary similarly in areas in a given time period. Therefore, different adjustment factors must be applied to these costs separately.

Our adjustment of wage and salary costs relies upon the most current survey of salaries for social service workers available (State Salary Survey 1974, U.S. Civil Service Commission, Bureau of Intergovernmental Personnel Program, 1976). This survey provides data on salary levels across states available to workers performing comparable functions in social service agencies. The classification used pertains to entry level workers which was found to reflect variations in the same direction as salary levels for classifications of graduate social workers and social service supervisors. Thus, the social service workers classification captures the differences in state salary levels for functions requiring different levels of education, experience and responsibility in social service agencies. To derive the wage adjustment factor from the salary information provided in the survey, state salaries were divided by the national mean salary to find percentage deviations from the norm. To provide comparability among project salary costs, areas that face lower salary costs for the same function must be adjusted upwards relative to those areas that face higher salary costs. Thus, the suitable adjustment factor for salary expenditures is the reciprocal of the percentage deviations found above for each project. The resulting adjustment factors are presented in Table 2.

The adjustment of project raw expenditure data to account for variations in prices for non-labor goods and services relies upon the Current Price Index (CPI).[1] Price data for the CPI is collected for 56 metropolitan and non-metropolitan cities of the United States with separate indexes published for 23 SMSAs. Where separate indexes were not available for a project area, by reason of geographic proximity to project locations, CPI approximations were used. These CPIs were determined by using the CPI of the closest area with a similar budget index as the area without a published CPI. Budget indexes are available for more areas and were considered to be close indicators of the

[1] "Consumer Price Indexes," U.S. Bureau of Labor Statistics, Monthly Labor Review, 1976.

of the appropriate CPI. Using the CPI as an adjustment factor for non-salary costs followed the same logic as that for salary costs, i.e., the reciprocal was employed. The resulting factors are applied to non-payroll expenditures and are shown in Table 3.

Table 2

Adjustment Factors for Salary Costs

Project	Adjustment Factor	Salary Level*
Adams County, Colorado	1.11	$7,176
Arlington, Virginia	1.19	6,700
Baton Rouge, Louisiana	0.94	8,482
Bayamon, Puerto Rico	1.29	6,177
Jefferson County, Arkansas	1.08	7,423
Washington County, Arkansas	1.08	7,423
Los Angeles, California	0.82	9,720
Neah Bay, Washington	0.97	8,256
St. Louis, Missouri	1.22	6,540
St. Petersburg, Florida	0.94	8,498
Tacoma, Washington	0.97	8,256
Union County, New Jersey	0.79	10,092

*National mean minimum salary = $7,984; indicates minimum salary levels in 1974 for the classification of social service worker.

Table 3

Adjustment Factors for Non-Payroll Expenditures

Project	Adjustment Factor	CPI*
Adams County, Colorado	1.01	132.1**
Arlington, Virginia	0.99	135.0
Baton Rouge, Louisiana	1.01	132.3**
Bayamon, Puerto Rico	1.05	127.3**
Jefferson County, Arkansas	1.02	130.3**
Washington County, Arkansas	1.02	130.3**
Los Angeles, California	1.03	129.2
Neah Bay, Washington	1.04	127.5**
St. Louis, Missouri	1.03	129.3
St. Petersburg, Florida	1.00	133.7**
Tacoma, Washington	1.04	127.5
Union County, New Jersey	0.95	139.7

*U.S. city average = 133.1

**Derived from budget index comparisons.

B. Type II Standardized Cost to the Community

In order to assess the actual, that is to say the social, costs of running the eleven demonstration projects, it is necessary to address all accountable resources that are consumed by the projects in providing services. For some projects, the proportion of the resources they utilize but do not pay for is substantial; such a situation has obvious implications for cost efficiency and effectiveness ratios. Hence, it is necessary to standardize the resource bases we are comparing, in order that the unit of service costs more accurately reflect the resources utilized to produce them. Type II analysis seeks to accomplish this objective by ascribing monetary value to resources donated to the projects. Donated resources include personnel (i.e., volunteers and professional consultants with full-time positions elsewhere who donate their time to the project) and non-personnel resources (e.g., rent-free space, equipment, computer time, etc.).

The procedure for estimating the monetary value of donated overhead items and the time of personnel with set salaries elsewhere or in professions with standardized consulting rates is relatively straightforward. With advance notice of our needs, the projects determined the value of donated overhead items and did extensive research in their communities to ascertain hourly rates which their consulting professionals would charge. Lengthy conference calls with project directors or their designated representatives enabled our staff to collect this information. The information supplied by the projects was directly added to their cost data, with only infrequent adjustments made for hourly rates of consultants which deviated substantially from the aggregated ranges provided by all the projects.

Arriving at reasonable hourly rates for volunteers is a somewhat more difficult task. However, since the issue at hand is replicability of the functions performed, rather than of the opportunity costs of the individuals performing the functions, the problem was simplified. While all but one of the projects utilize volunteers, they do so in an extraordinarily varied way. Their estimates for teacher aides, babysitters, child caretakers, drivers, etc., approximated our independent estimates of the value of these

functions. In asking the projects to estimate what they would pay per hour for a service, if they felt it to be critical but had no volunteers to carry it out, their attention was focused on the service rather than on the provider, with remarkably comparable results, particularly when the nature of the function and different market conditions are considered. Only the value attached to the lay therapist/parent aide function required reconciling among the projects which deliver this service.

The value estimates for lay therapists/parent aides by the seven projects providing the service clustered around $4 per hour, although a range of $2.50 per hour to $15 per hour was offered. The wide range is explained in part by the relative importance of the service within the project's service strategy, in part by the variation in the level of responsibility expected of the volunteer in the role, and in part by equating the part-time nature of the service with consultants' contributions and thereby inflating the hourly rate. To resolve these differences, a variety of aspects of the lay therapy/parent aide function were compared, including the number of workers performing the service in each of the projects for the month under consideration, the volume of hours devoted to the service, the project's suggested hourly rate, our own estimation, and the effect of applying local wage factors to the estimates. Finally, we decided on two rates, based on the following criteria: (1) projects whose lay therapists/parent aides devoted more than an average of 20 hours per worker per month to the service were valued at $4.25 per hour (these projects include Adams County, Arkansas, St. Petersburg, and Union County); and (2) those projects whose lay therapists/parent aides devoted less than 20 hours per worker per month were valued at $4 per hour (these projects included Arlington, St. Louis, and Tacoma). The higher rate was used for lay therapists who spend more than 20 hours per month because we felt it likely that they assume a greater responsibility for their cases (our process analysis of lay therapy in the different projects confirmed this). These rates are incorporated into project data after adjusting the cost data for local conditions.

VI. Data Analysis Techniques

A. Unit Cost Comparisons

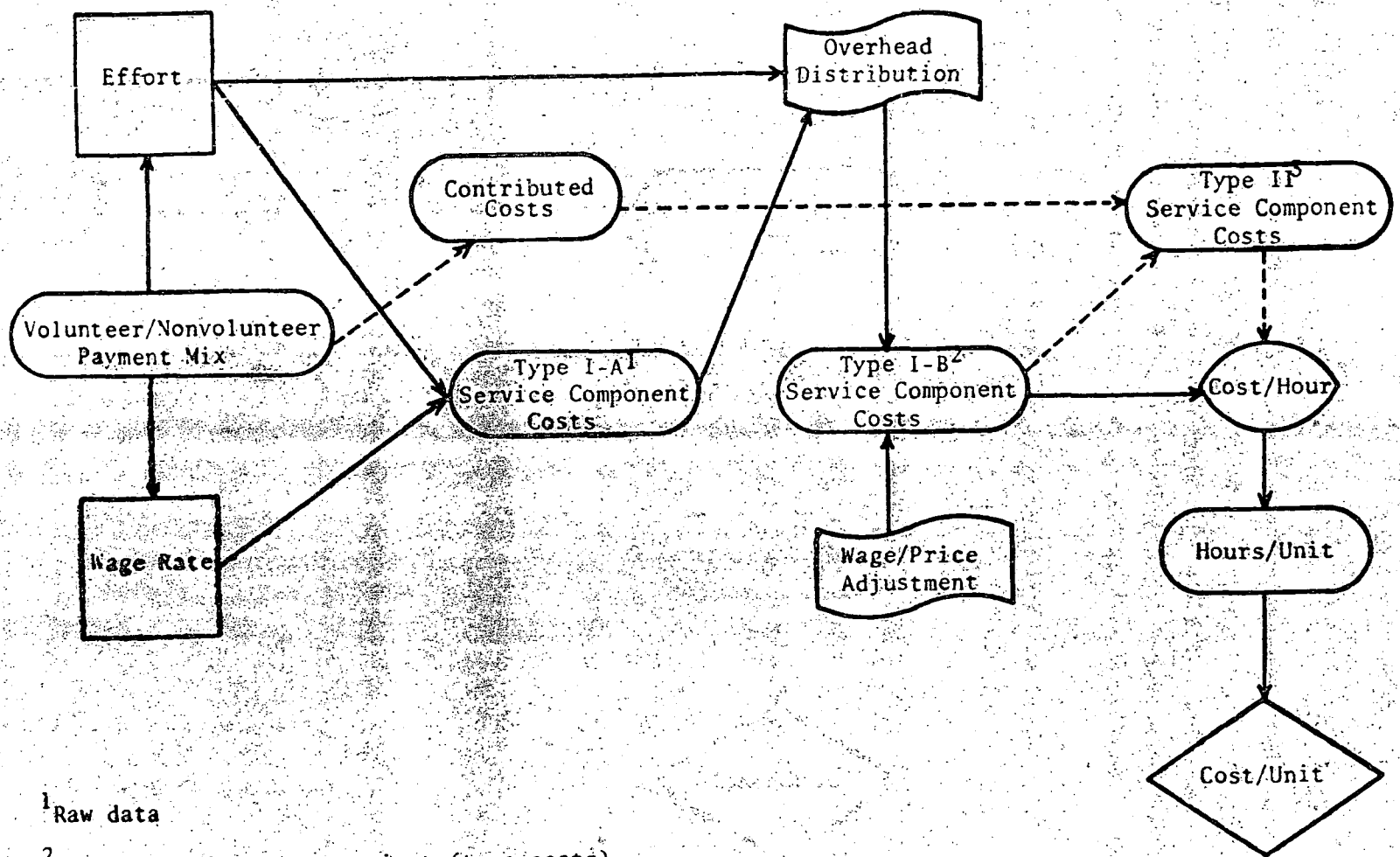
Before valid comparisons can be made, a word of explanation is needed in order to fully appreciate the meaning of unit cost figures. As with all composite measures of an activity, the components which form the unit costs may combine in different ways to produce the same result. As shown in Figure 1, unit costs are a function of a wide number of factors. Clearly at one level, unit costs may vary according to the level of effort which goes into producing one unit of service and according to the wage rates which are applied to this effort. Certain efforts will not contribute to costs if they are unpaid (unpaid volunteer vs. paid staff mix). This range of factors enters into the Type I-A (Raw Data) costs of a service component. Type I-B (Cost to Project) costs are found by adjusting for overhead on the basis of hours and for regional wage/price differences. Type II (Cost to Community) are found by including the value of donated resources. Service component costs are then mediated by the number of hours per unit to identify various types of unit costs (Type I-A, I-B, II). Thus, a change in any one of the variables of hours expended, wage rate, hours/unit, unpaid volunteer mix, overhead, etc., will effect costs/unit. A change in any one variable may also be counterbalanced by an opposite change in another. The point here is that unit cost figures that are similar for different services may lead to the mistaken assumption that the underlying dynamics of the service are similar.

B. Service Volume Economies

Of particular concern to policy makers is understanding how the costliness of a given service is related to the volume at which that service is provided. For example, to what extent does increasing the amount of units of individual counseling within a given project change the cost per unit of this service? This question involves an analysis of each specific service category to determine whether economies or diseconomies of scale may occur.

Two possibilities exist in determining the relationship between cost per unit and number of units provided. Each gives different information to policy makers. At one level, we may examine the question by observing different

Figure 1: Components of Unit Costs



[1]Raw data

[2]Standardized cost to project (true costs)

[3]Standardized cost to community (social costs)

projects operating at different levels of output to note the differences in costs that may occur. This type of comparison refers to service volume economies across projects. Here, we obtain information about whether projects providing a high level of a given service can do so at substantially reduced costs. The second type of analysis involves making comparisons within individual projects where, for a given project operating at different levels of output over time, we observe the corresponding changes in costs.

To identify the across-project service provision economies, we constructed simple two-by-two contingency tables for cost per unit and service volume project data. Projects were classified into two groups for each of their cost and volume characteristics: those above the median value and those below. This was done for a representative subset of individual and group services, based on the average volume and cost to the project (Type I-B) of each service. A hypothetical table is shown in Figure 2.

Figure 2

HYPOTHETICAL COMPARISON TABLE FOR ACROSS-PROJECT ECONOMIES OF SCALE

		Units Provided	
		Below Median	Above Median
Average Cost/ Unit	Above Median	a	b
	Below Median	c	d

Note: a, b, c, d refer to the number of projects falling within each cell.

To identify within-project economies, we observed changes in Type I-B costs and service volume between October 1975 and April 1976 and between April 1976 and October 1976 for a given project. The two variables were again dichotomized but this time in terms of whether costs or volume (1) increased, or (2) stayed the same or decreased. A two-by-two contingency table was then constructed on the basis of these categories as shown in Figure 3. Comparisons were made for

the same subset of individual and group services.

Figure 3

HYPOTHETICAL TABLE FOR WITHIN-PROJECT ECONOMIES OF SCALE

		Change in Service Volume (October to April): stayed the same or decreased	Change in Service Volume (October to April): increased
Change in cost/unit (October to April; April to October; Type I-B): increased		a	b
Change in cost/unit (October to April; April to October; Type I-B): stayed the same or decreased		c	d

Note: a, b, c, d refer to number of projects in each cell.

As a means of summarizing the comparisons made, two statistics were used. Yule's Q was employed as a simple measure of association and was found by the following formula:

$$A = \frac{ad - bc}{ad + bc} \; ; \; -1 \leq Q \leq +1$$

Given the relatively small sample sizes compared, this statistic fulfilled the need for a measure of association as well as involving a relatively simple hand calculation. Also, the sample size precluded the use of the Chi-Square, the more traditional statistic for contingency tables. To determine whether the relationship could be termed significant in a statistical sense, Fisher's exact test was employed. This statistic is suitable for small samples and allows one to determine the exact probability associated with the contingency table cell frequencies by the following formula:

$$P = \frac{(a+b)!\,(c+d)!\,(a+c)!\,(b+d)!}{N!\,a!\,b!\,c!\,d!} \qquad 0 \leq P \leq 1 \qquad (N = a+b+c+d)$$

Thus, for each of the comparisons we were able to determine both the strength and significance of the relationship referring to service volume economies.

C. Cost Efficiency

Analyzing each individual type of service is important to understanding the relative investments necessary for various service volumes. However, such an analysis does not recognize the fact that each type of service is not offered in a vacuum, so to speak. Projects more appropriately may be characterized as delivering a package of interrelated services. Accordingly, one should also analyze the cost relationships associated with this total package.

For this purpose, we have constructed an index of relative cost efficiency. This index reveals the extent to which a project delivers a given package of services at a greater or lesser cost than would other projects who deliver these services. The exact formula for computing the index is as follows:

$$\text{When } E_j = \frac{\sum_i P_{ij} U_{ij}}{\sum_i \overline{P_i} U_{ij}}$$

Where E_j = relative cost efficiency of project j

P_{ij} = price per unit service i at project j

U_{ij} = units of service i delivered at project j

$\overline{P_i}$ = average price per unit service i across all projects

NOTE: If $E_j > 1$, then project more costly than average in delivering its package of services.

The formula can be seen to compute the ratio of a project's costs for its service package to the average costs for these services across all projects. Thus, if the index is above one, the project delivers services at a greater cost than the average; below one, the project is relatively more cost-efficient, i.e., delivers services at a lower cost.

The indexing of overall cost efficiency permits us to answer questions concerning those factors which may contribute to cost-efficiency. To determine across-project correlates, we again constructed contingency tables formed by cross-classifying projects as to whether they were above or below

the average on cost efficiency (E = 1) and above or below the median value for the particular characteristic being tested. Characteristics tested were drawn from the Quality Component and the Management Component of this Evaluation. Somer's D and Kendall's Tau were the summary statistics employed to test the strength of association between the variables and its significance.

VII. Implementation Issues

January 1975 was the pre-test month for the collection and analysis of cost data. The experiences of the projects in pulling together and submitting to us the requested cost data and our own experience in following up with the projects to complete the data sets and in processing the data led to the identification of areas in which the cost analysis design could be improved. The following intensive cost accounting month, May 1975, was experimental as well and did not result in usable data for the analysis. Below are discussions of these implementation issues and, where relevant, their resolution.

A. Completeness of Data

A primary difficulty encountered during the January pretest was the incompleteness of the data collected by the projects and forwarded to BPA. For example, weekly time sheets were missing for some staff members and payroll expenses were missing for others. We perceived a primary source of this difficulty to be the large number of separate forms which had to be completed by the projects. Our solution was to revise the BPA forms. Monthly allocation forms, rather than weekly ones, were devised, reducing the number of forms per individual from four or five to one. All other cost forms were incorporated into a single booklet, the Monthly Cost Statement, to further simplify matters for the projects.

B. Use of Service Component Definitions

The success of the cost analysis depends strongly on the proper use of the service component definitions. If the hours spent on a certain kind

of activity are not entered under the same service component by staff members in a given project or in different projects, then the validity of the cost analysis results could be seriously reduced.

Improper allocations to service components can arise from carelessness on the part of staff members, from misunderstanding of instructions or from ambiguities in the definitions themselves. Although instruction booklets had been prepared which included definitions of the service components and directions for completing each of the cost forms, and these instructions were reviewed by the BPA staff with the project staffs, January was still very much a month of learning for the projects. Definitions of some service components were misunderstood, as were instructions for completing some of the forms. In some instances, instruction booklets were not referred to or were even lost. Our solution was two-fold. First, we spent a fair amount of time on the telephone clarifying for individual projects how to avoid in the future the mistakes made in January. Second, we refined the instructions and definitions and incorporated them on the back of the cost forms themselves. This insures that all staff have access to and can better understand the instructions and definitions, and the forms themselves become self-contained instruments.

Ideally, BPA would additionally check each individual's time sheet to see whether allocations were made properly, but the inordinate amount of time required of BPA would make this infeasible. Thus, observations by the BPA staff during site visits and discussions with project directors are used to reveal misinterpretations of the definitions.

C. R & R

The R & R (rest and relaxation) service category was created with a very special purpose in mind. R & R is that time (and space) that a worker needs to recuperate after an intensive session with a client, prior to engaging in other work. It is akin to other internal services, such as staff development, which are needed as support for the delivery of services to clients and the community. R & R thus does not include lunch, time off, time when "there is nothing else to do," or any time when a staff person is not "on duty." During the pretest, some projects' staffs used this category either for activities such as lunch or perhaps simply to round out

the number of hours recorded for that day to eight. Other staff members did not use this category at all even though it was appropriate for them.

D. Limitations of the Service Component List

In developing the listing of service components we attempted to include all identifiable project activities. One purpose of the pretest was to determine whether there was a need to revise this listing. The pretest indicated the need for several adjustments.

Several projects, feeling that they could not include certain of their activities in one of the existing categories, added new categories to their cost forms. It was determined, upon discussion with these projects, that some of these new categories could be incorporated into existing categories. For example, one project wanted to distinguish routine Intake & Initial Diagnosis from Crisis Intervention During Intake. The project staff members made this distinction on their cost forms and used the data this way for their own purposes; for the across-project evaluation, however, the two categories were combined.

Three other changes suggested by the projects required revisions in the list. First, projects wanted to account for resources spent on Multidisciplinary Team Activities as a category separate from Intake & Initial Diagnosis and/or Case Management & Regular Review. BPA decided to establish this as a new category. Second, projects felt that time spent on court case work, including waiting time at the court house, did not easily fit into the existing categories and is an expenditure of time worthy of independent study. For the January pretest, court-related work was included in case management, but on the revised forms it was a separate service component. Third, because Ongoing Case Review is really an integral part of Case Management, those two categories were combined into one, Case Management & Regular Review.

E. Personnel List

Initially we planned to ask the projects to send us during each intensive cost accounting month a listing of all paid staff and consultants, with the amounts they were paid that month. Then, during each of the non-intensive cost accounting months, project directors would indicate to us

major changes in payroll expenses. We decided, however, for purposes of accuracy and completeness, to make the following changes:

(1) data would be averaged from the cost accounting months conducted during the peak of the project, rather than simulated for intervening months;

(2) the payment entered should include an individual's fringe benefits;

(3) the listing should include all regular staff, consultants and volunteers who contribute directly to the project, regardless of whether an individual is paid from the project budget;[1] and

(4) for those regular staff and consultants not paid by the project, but by some other agency, the listing should include salaries or approximate value of salaries.

F. Project's Perceptions of the Cost-Analysis

Some difficulties encountered with the January pretest were undoubtedly due to some projects' misconceptions of the purposes of the cost analysis. Our intention was that the cost analysis would be useful to projects for their own internal management as well as to the overall evaluation. However, in some projects the cost analysis was not seen as something that would be of use to the project and therefore was not handled with the high degree of concern for completeness and accuracy that BPA expected. Once the projects had an opportunity to see the cost printouts for January and May, they were more appreciative of their potential usefulness and more careful in collecting and recording cost data.

[1] In the case of projects with large numbers of regular volunteers, the number rather than the total listing of names is requested.

G. Promptness of Data Retrieval

With many of the projects we did not receive the cost data within a reasonable period of time after the end of the January pretest, or in fact, after each of the four subsequent cost accounting months. Some projects took as long as four months supplying BPA with the full set of cost data. Our request was to receive cost data within two weeks after the end of a month in order to be able to process the data and return it to the projects quickly while information still was useful for their own management concerns. Some of the delays in returning data to us undoubtedly resulted because some projects in January were not fully operational. They were of necessity more concerned with getting their programs off the ground than with collecting and sending us the cost data. Other delays were due to the projects' inability, for many different reasons, to establish a system during January for collecting the necessary cost data. Confusion over who should be responsible for filling out which forms was one of the primary problems.

H. Optimal Precision

Precision (attention to details) and accuracy (completeness and correctness) are two different issues. The precision of entries in the cost forms varied considerably across projects and from one staff member to another. As far as could be determined, there were no forms in the January pretest that were filled in with too little precision. The tendency was to use more precision than necessary, especially in parts of the forms where it was not needed, while neglecting the overall accuracy requirements to include all major costs and to put them in the right place. An example of too much precision would be the entry of some non-payroll expense in the amount of only $10.00, allocated to a great many service components with percentages as low as 1% each. An example of inaccuracy would be neglecting to indicate any pay for a certain worker who was added to the payroll in the middle of the month. Accuracy is always a necessity in a cost analysis, but the amount of precision can vary depending on the goals of the study. After further experience was gained with the May cost analysis, accuracy increased and some rules were developed to go with the cost forms which led to adequate precision with minimum effort by the projects.

I. Durable Equipment

As several cost accounting months went by, we observed wide variations in the reporting of durable equipment expenditures. It emerged, in the course of conversations with the projects regarding donated resources, that some projects were reporting equipment purchased only during the cost accounting month and others were reporting all equipment purchases during the time elasped since the previous cost accounting month. Since the latter, depreciated and amortized, would more accurately reflect a project's monthly expenditure for these items, we requested a complete list of durable equipment purchased since the beginning of the project. Once depreciated and amortized, the costs involved comprise a very small proportion of the resources consumer -- on average, less than 2% of monthly expenditures. Consequently, we did not re-run the data for October 1975 and April 1976; rather, the durable equipment expenditures appear only in the October 1976 data and only marginally effect the total cost picture.

J. Allocation of Non-Payroll Expenses

Wide variance in the precision and accuracy of allocating non-payroll expenses, including durable equipment, persisted despite discussions with the projects and detailed instructions. Because of the ambiguous nature of such resources as rent, copying, utilities, etc., we resorted to the method of collapsing the non-payroll expenses into a single sum allocated to General Management which in turn was distributed in proportion to the hours expended across the other service components. This provided across-project comparability in handling these expenses and was executed in each of the three cost accounting months used in the final analysis.

N-C07B

Project _____

Month _____

MONTHLY COST STATEMENT

for Child Abuse and
Neglect Projects

General Instructions

1. Please fill in this booklet during each cost accounting month.
2. Time-Allocation form N-C01B is to be used together with this booklet, for complete monitoring.
3. Please be sure that all significant costs are included. For example, it is essential that the personnel list be complete and that, for the time-allocation months, a time sheet be returned for each individual on the personnel list.
4. Please be sure that no costs are double counted. For example, a consultant who is entered once on the personnel list should not be entered again as a purchased service.

Contents

PERSONNEL

Instructions

1. This list is meant to include all persons who regularly contribute directly to the project.
2. Persons to be included in the list are:
   (a) all paid staff, regardless of source of funding
   (b) all consultants paid by the project
   (c) all consultants not paid by the project, but who contribute regularly, e.g., regular members of diagnostic team, regular advisors to staff meetings, etc.
   (d) all volunteer staff.

Name	Status*	Title	Academic Degrees Held	Gross Pay This Month Plus Any Benefits Paid by Proj.

*R = Regular Staff (full-time or part-time)
C = Consultant
S = Substitute or Temporary Staff
RV = Reimbursed Volunteer (e.g., Parent Aide)
V = Volunteer

Non-payroll Expenses

Instructions

1. Please enter all non-payroll expenses for the month, including durable equipment, and their allocations by %
2. For durable equipment over $200 please enter, in addition, the estimated lifetime in years.
3. If desired, any costs with the same allocation, e.g., perhaps rent & utilities, may be combined in a single column.
4. A durable-equipment entry may comprise a group of things, such as a suite of furniture, if all elements have approximately the same lifetime and allocation.

Item →							
Payment This Month →							
Est. Lifetime for Equip. Over $200 →							
1. Prevention							
2. Community Education							
3. Professional Education							
4. Coordination							
5. Legislation & Policy							
6. Staff Development/Training							
7. Program Planning & Development							
8. General Management							
9. Project Research							
10. BPA Evaluation							
11. Outreach							
12. Intake & Initial Diagnosis							
13. Case Mngmt. & Regular Review							
14. Court Case Activities							
15. Crisis Intervention During Intake							
16. Multidis. Team Case Review							
17. Individual Counseling							
18. Parent Aide/Lay Ther. Counsel.							
19. Couples Counseling							
20. Family Counseling							
21. Alco., Drug & Weight Counseling							
22. 24-Hour Hot Line Counseling							
23. Individual Therapy							
24. Group Therapy							
25. Parents Anonymous							
26. Parent Education Classes							
27. Crisis Intervention After Intake							
28. Day Care							
29. Residential Care							
30. Child Development Program							
31. Play Therapy							
32. Special Child Therapy							
33. Crisis Nursery							
34. Homemaking							
35. Medical Care							
36. Babysitting/Child Care							
37. Transportation/Waiting							
38. Emergency Funds							
39. Psychological & Other Testing							
40. Family Planning Counseling							
41. Follow-Up							
42. R & R							

PURCHASED SERVICES

Instructions

1. If services are purchased by project from other agencies for delivery to clients in project's caseload, please enter the agencies, total amounts paid this month and allocations by percent.
2. Individual specialists who work for the project by the hour should be entered as consultants on page 2 or 3 and should not be entered here.

	Agency →							
	Payment This Month →							
1. Prevention								
2. Community Education								
3. Professional Education								
4. Coordination								
5. Legislation & Policy								
6. Staff Development/Training								
7. Program Planning & Development								
8. General Management								
9. Project Research								
10. BPA-Evaluation								
Direct Services to Clients: 11. Outreach								
12. Intake & Initial Diagnosis								
13. Case Management & Regular Review								
14. Court-Case Activities								
15. Crisis Intervention During Intake								
16. Multidis. Team Case Review								
17. Individual Counseling								
18. Parent Aid/Lay Ther. Counsel.								
19. Couples Counseling								
20. Family Counseling								
21. Alcohol, Drug & Weight Coun.								
22. 24-Hour Hot Line Counseling								
23. Individual Therapy								
24. Group Therapy								
25. Parents Anonymous								
26. Parent Education Classes								
27. Crisis Intervention After Intake								
28. Day Care								
29. Residential Care								
30. Child Development Program								
31. Play Therapy								
32. Special Child Therapy								
33. Crisis Nursery								
34. Homemaking								
35. Medical Care								
36. Babysitting/Child Care								
37. Transportation/Waiting								
38. Emergency Funds								
39. Psychological & Other Testing								
40. Family Planning Counseling								
41. Follow-Up								
42. R & R								

QUANTITIES OF PROJECT SERVICES

Instructions

For each selected service provided by project, please indicate total quantity provided this month.

SERVICE	UNITS	QUANTITY
11. Outreach	Cases	
12. Intake & Initial Diagnosis	Intakes	
13. Case Management & Regular Review	Ave. Caseload This Mo.	
14. Court-Case Activities	Cases	
15. Crisis Intervention During Intake	Contacts	
16. Multidis. Team Case Review	Reviews	
17. Individual Counseling	Contacts	
18. Parent Aide/Lay Ther. Couns.	Contacts	
19. Couples Counseling	Contacts	
20. Family Counseling	Contacts	
21. Alcohol, Drug & Weight Counseling	Person Sessions	
22. 24-Hour Hot Line Counseling	Calls	
23. Individual Therapy	Contacts	
24. Group Therapy	Person Sessions	
25. Parents Anonymous	Person Sessions	
26. Parent Education Classes	Person Sessions	
27. Crisis Intervention After Intake	Contacts	
28. Day Care	Child Sessions	
29. Residential Care	Child Days	
30. Child Development Program	Child Sessions	
31. Play Therapy	Child Sessions	
32. Special Child Therapy	Contacts	
33. Crisis Nursery	Child Days	
34. Homemaking	Contacts	
35. Medical Care	Visits	
36. Babysitting/Child Care	Child Hours	
37. Transportation/Waiting	Rides	
38. Emergency Funds	No. of Payments	
39. Psychological & Other Testing	Person Tests	
40. Family Planning Counseling	Person Sessions	
41. Follow-Up	Person Follow-Ups	

NUMBER OF CASES ACCEPTED FOR SERVICES THIS MONTH _____

NUMBER OF CASES CLOSED OR STABILIZED THIS MONTH _____

Time Allocation Form

Instructions

1. For the selected components on which you spend time, please enter the number of hours spent each day.
2. The hours need not sum to any particular total and should not include any part of lunch, time off, etc.
3. Please do not use fractions: write 2.5, not 2½, for example.
4. Please do not add any components. If an allocation cannot be made according to definitions on the back, discuss the matter with the director or call BPA.
5. This form should be filled in by or for all persons who work in any regular capacity directly for the project.

Project _____ Name _____ N-COIC

Month _____ Status Code* _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	← Day of Month →	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
																1. Prevention																
																2. Community Education																
																3. Professional Education																
																4. Coordination																
																5. Legislation & Policy																
																6. Staff Development/Training							0									
																7. Program Planning & Development																
																8. General Management																
																9. Project Research																
																10. BPA Evaluation																
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																17. Individual Counseling																
																18. Parent Aide/Lay Therapist Counseling																
																19. Couples Counseling																
																20. Family Counseling																
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																39. Psychological & Other Testing																
																40. Family Planning Counseling																
																41. Follow-Up																
																42. R & R																

Services to Clients

*R = Regular Staff, full or part time; S = Substitute or temporary staff; C = Consultant; RV = Reimbursed Volunteer (e.g., Parent Aide); V = Volunteer (no pay).

BERKELEY PLANNING ASSOCIATES

TOTAL HOURS SPENT THIS MONTH REFERRING CASES TO ANOTHER AGENCY: [ ]

SECTION V

THE QUALITY OF CASE MANAGEMENT PROCESS COMPONENT

A central feature of the demonstration evaluation is the pioneering effort to determine the elements of quality case management in the child abuse and neglect field. There has been a growing concern for quality service delivery, both because of the increasingly complex nature of social services (and thus the increasing difficulty in effectively managing cases), and because of public demands for accountability on how the very large share of public dollars being allocated to social services is being spent. Given the paucity of empirical work in this area, this study provides an opportunity to document those elements of case management which lead to more effective service delivery, and which, in turn, can be used to determine the quality with which social service agencies operate.

A Survey of Medical Quality Assessment

The medical field, because of an historical interest in issues of quality, provides a framework for studying these elements of social service delivery. Most of the work to date in assessing the quality of the medical process centers on "audits" in which peers or other trained reviewers abstract from written audits, charts or records information on procedures and prescribed treatment. Prodded into existence primarily as a result of the alarming increase in health costs, the technique of utilization review is a particular audit mechanism. Individual hospitals and medical group practices may have their own utilization review procedures, but large utilization review information systems have developed both regionally and nationally. The total of the experiences of those hospitals which participate in a given system have established norms for specific elements of quality care against which current procedures are measured. The Hospital Utilization Review is designed

to detect irregularities in diagnostic and treatment procedures, whereas the Professional Activity Study (PAS) sponsored by the American Hospital Association and others, has concentrated more on assessing length of stay.[1]

Morehead et al. conducted many record audits to measure the extent to which patients receive medical services in accord with generally accepted standards.[2] In her evaluation of the OEO Neighborhood Health Centers, the standards against which care was measured were based on the practices of medical school-affiliated outpatient programs. Trained medical personnel abstracted patient records to produce a program score, based on the average score across all sampled records.

Moving beyond the audit, Sims et al. employed systems analysis to assess the practices of medical care delivery.[3] Defining program boundaries, articulating goals and objectives, and then assessing the extent to which each is achieved, using a variety of measurement techniques, are the components of systems analysis. Their evaluation of the quality of ambulatory care practice in several clinics looked at such elements as comprehensiveness and continuity of care, appointment no-show rates, walk-in patient utilization, and capacity of operation.

Record audits and other assessments of quality of the medical process require the establishment of criteria for measuring levels of adequacy. Whereas Morehead used medical school practices as benchmarks, the Joint Committee on Quality Assurance of the Academy of Pediatrics

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[1]The interested reader is referred to Rona Beth Schumer, "Bibliography," Hospital Utilization Review and Medicare: A Survey, Washington, D.C., DHEW Social Security Administration, 1973, pp. 101-118.

[2]Morehead, Mildred A., Rose S. Donaldson and Mary R. Seravalli, "Comparisons Between OEO Neighborhood Health Centers and Other Health Care Providers on Ratings of the Quality of Health Care," American Journal of Public Health, 61:7, July 1971, pp. 1294-1306.

[3]Sims, Neil H., Burton L. Gordry, Charles W. Nairis and Barbara Seboda, "Self-Evaluation of Ambulatory Care," Advances in Pediatrics, Volume 20, Irving Schulman, Ed., Chicago: Year Book Medical Publishers, 1973, pp. 177-204.

developed an intricate and rigorous means for developing process criteria related to history taking, physical examinations, laboratory tests and treatment. They selected and validated their criteria over several stages, using 450 experts to assist in eliminating all measures that were irrelevant, contraindicated or unacceptable.[1] Whatever the method for establishing criteria, it is apparent that the utility of a quality assessment is considerably enhanced if consensus exists on the criteria used to measure program or staff practices.

While medical quality assessment techniques can be useful in looking at social service delivery, it is not suggested that the medical field models be transferred wholesale, because of some major differences between the two service delivery areas. First of all, physiological problems dealt with by physicians are more concrete and specific than the social behavior and emotional problems dealt with by social service delivers. Scientific research has assisted the medical field in indicating certain treatments to be effective for specific diseases, while little has been done in the social services area to document that particular treatments are effective for specific problems. Also, because hospitals today often suffer from excess capacity while social service programs have a dearth of resources, and because medical care tends to be more capital intensive than social service agencies, which are labor intensive, there is a need to make adaptations in the medical field before conducting social service quality assessment.

Focusing on Case Management

To map out an approach for a process-related quality assessment of the child abuse/neglect projects, a two-day workshop was used to elicit specific suggestions from experts in both medical quality assessment and in child abuse and neglect service delivery. Various alternative approaches were considered, but by consensus from the participants it was decided that a project's case management function, because it in-

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[1] Thompson, Hugh C. and Charles E. Osborne, "Development of Criteria for Quality Assurance of Ambulatory Child Health Care," Medical Care, 12:10, October 1974, pp. 807-829.

volved a wide range of process activities and also appeared to be amenable to assessment within the scope of the overall evaluation, would be the focus of the quality assessment.

"Case management is best understood as a process made up of a series of interconnected steps. . .[that] constitute a framework for activities and tasks in the agency/worker/client relationship." Case management in a child abuse and neglect service agency includes phases of service delivery from intake through diagnosis, development of a treatment plan, management of service delivery and referral, to case termination and follow-up after termination. Good case management, which is important for successful service delivery, implies continuity of service provision, planfulness (i.e., rational decision-making) in designing and executing a treatment package, coordination among all providers of services, effective involvement of the client, timeliness in moving clients through the process and maintenance of an informative and useful case record.

The Methodology

The methodology, developed with extensive input from a number of child abuse/neglect and medical care audit specialists, consisted of visits by teams of child abuse/neglect experts to nine of the projects during their second and third years to review a random sample of cases from each of the treatment workers in a project. A total of 354 cases were included in the study sample. Descriptive and multivariate analyses were used to identify norms of case management across the projects which can serve as minimal standards for the field, as well as the most critical and salient aspects of case management. These data were then combined with information about client outcome to determine if case management is strongly related to successful client outcome.

Selecting Criteria and Measurement Tools

Given that the focus of this effort was to identify the essential elements of case management, the first step was to develop criteria by which to judge the adequacy of this process in each of the eleven demonstration projects. An initial list of criteria was developed by the participants at the Quality Assessment Workshop and refined through consultation with others experienced in child abuse/neglect and general social service delivery.

Several means for measuring the case management practices of the

demonstration projects against these criteria were considered, including record reviews, observation of worker-client interaction, self administered questionnaires for workers, and client interviews. Adaptation of the medical audit approach was selected as the best alternative. The advantages of the adapted medical audit approach are that it takes no special equipment, provides an objective basis of comparison, does not require generation of special data or additional record keeping by the social workers, does not create an artificial situation (such as imposition of an observer at a client-worker interview), and creates minimal disruption to the agency's work. The disadvantages of this approach are that it measures only part of a caseworker's interaction with his or her client, and it might potentially be biased in favor of workers who keep well-documented case records. However, given the expectation of social worker written records, the quality assessment design from the outset was based on "case reviews," combining record audits with caseworker interviews. In this way, the intent was to avoid the problems of severely incomplete information which would arise in an approach relying on social worker records alone.

With the decision on a general approach, it was then possible to translate those criteria considered to be measurable by means of a case audit into data collection instruments. A pre-test of the draft instruments and procedures was conducted at four abuse/neglect programs in mid-1975.

Sampling Design

The use of case reviews as the major components of the quality case management assessment necessitated development of a sampling procedure, since not all cases could be reviewed within the imposed time and budget constraints. The sampling procedure developed had to address the dual needs of drawing reasonably precise conclusions (or make reasonably precise estimates) about each project, as well as drawing confident conclusions across all the projects combined. Two other considerations had to be kept in mind. The projects had varying caseload sizes, ranging from active caseloads of 40 to around 300, and their cases were also terminating at different rates, with some projects having terminated very few and others having terminated a high percentage of cases by the time of the assessment. Also, since it had been hypothesized that differences in case managers would be one of the most important factors determining

differences in quality case management practice, workers had to become a key part of the design.

With these conditions, a sampling strategy was devised which called for taking approximately equal numbers of cases from each site. The exact number of cases sampled varied depending on the actual number of cases available at the time the sample was drawn. At certain projects all cases were reviewed, while at others only a selection was reviewed.

Projects were asked to submit lists of all their cases opened between January 1975 and January 1976. These lists identified the active or terminated status of each case, as well as its most current primary case manager. A stratified random sample was then drawn from each project's caseload using the case managers as the strata, and selecting from each stratum (or each case manager's caseload) a number of cases proportional to the size of his or her caseload, up to a total of usually between 40 and 50 per project. A minimum of two cases were drawn per every worker. Thus, in a project with five workers usually eight or nine cases were selected from each; in a project with 15 workers, at least two cases were reviewed from each, but some would have proportionally more.

The primary goal was to select only closed cases so as to obtain more complete case management information, including data on termination. However, as this was not always possible, the procedure was to first sample from all terminated cases within each stratum, and then to randomly select from the active caseload up to the number allocated to a given case manager.

This sample design provided data on a representative pool of cases across the projects. The stratification on the basis of case manager ensured representation of the range of case handling practices and thus enabled analyses focusing on the role and characteristics of the case manager in determining quality case management.

Data Collection

Following refinement of the methods and instruments as a result of the pre-test, primary data was collected during site visits to nine demonstration projects. Reviews of a sample of cases at each project provided the quantifiable data. Unstructured interviews, using a

checklist of topics, were also held with all project directors and with other staff as needed. The first stage of data collection occurred between March and June of 1976, during which time 245 cases were reviewed. A second round of site visits was held between December 1976 and February 1977, gathering data on an additional 109 cases.

Four acknowledged expert clinicians experienced in delivering direct social services to parents and children conducted the quality assessment site visits, after being thoroughly trained in the procedures and use of the instruments. For most visits a team consisting of two people visited a site in order to allow a balance of perspectives, should they differ. Both assessors participated in an initial interview with the project director at the outset of each visit; all further staff interviews on program-wide issues were done as needed by each assessor independently. The two team members reviewed different cases, with the exception that three to six of the same cases at each project were reviewed separately by both assessors in order to obtain independent data on a subsample of cases for checks on inter-rater reliability.

Two instruments were used to gather the data for the quality assessment:

The Orientation Checklist: This checklist elicits information to provide sufficient background for the assessors to conduct their case reviews. The checklist includes 26 topics that the quality assessment team should cover at the beginning of each site visit. The topics range from organizational structure and political context to caseload per worker. The information covered in this instrument was primarily for the assessor's use and was not tabulated.

The Case Review Instrument: This instrument allowed us to obtain, for a sample of cases, information on case management practices as well as ratings by the assessor on the quality of case management provided for each case. The information collected in the case review instrument is obtained from both the written case record and through interview with the case manager. First, assessors reviewing the case record search for the information asked for in the instrument. This abstracting process takes between 30-45 minutes. Following the record

review, the assessor interviews the primary case manager for 15 to 20 minutes, seeking further background information and any specific case information which could not be found in the written record. This dual approach provides the assessors with sufficient information and "feel" for the case to make valid ratings of the quality of the case management delivered.

The case review instrument gathers, for each case under review, the client's socio-demographic characteristics, some facts about the case (such as the severity of the abuse or neglect incident and whether or not there was court intervention) and primary case manager characteristics (such as age, sex, training, experience and caseload size). The instrument also covers eight basic aspects of case handling practices.

- Timeliness of the process: e.g., time between referral and first contact; time between first client contact and beginning of treatment; and total time as an active case.
- Amount of contact between manager and client: e.g., number of contacts prior to a treatment plan; number of contacts during treatment; and number of follow-up contacts after termination.
- Outside case review: e.g., use of multidisciplinary review teams; use of consultants.
- Referral for treatment: e.g., number of project staff providing services to client; use of outside treatment providers.
- Reassessment of the case: e.g., use of case conferences or staffings.
- Coordination and communication between manager and other treatment agencies: e.g., recontact with reporting source; contacts with outside treatment providers.
- Service continuity: e.g., separation of intake from ongoing treatment; number of primary managers per case.
- Client participation: e.g., presence of the clients at review meetings and case conferences.

Upon completion of each case review, the assessor then makes judgments about the quality with which the case was managed. Fourteen elements or parts of the case management process (from timeliness of intake through frequency of contact, coordination of information on the case, client participation, etc.) as well as overall management quality are rated on five-point scales.

The use of case reviews as the major data source for the quality assessment necessitated a sampling procedure, since not all cases could be reviewed within time and budget constraints. The sampling procedure addressed the need to draw conclusions in which we could have reasonable confidence of representativeness across the total pool of cases. With this condition in mind, a sampling strategy was devised which called for selecting a portion of terminated cases from those projects with large caseloads or all cases (terminated and active) from those projects with smaller caseloads. A stratified sample was drawn from each project's list of cases that were opened between January 1975 and January 1976, using the case manager as the stratum, and randomly drawing from each stratum (that is, each case manager's caseload) a number of cases proportional to the size of his or her caseload to the total project caseload. A minimum of two cases was selected for each caseworker. Stratification on the basis of case managers ensured representation in our sample of the range of case practices and would enable us to perform analyses focusing on the importance of the case manager in determining the quality of case management.

The Data Base

The two rounds of site visits to the demonstration projects yielded a review of 354 cases. As shown in Table I, the number of cases per project ranged from a high of 51 in Union County to a low of 13 in Los Angeles.

TABLE I

Number of Cases Reviewed, by Project

	Total Cases	Terminated Cases
Family Center: Adams County, Colorado	40	22
Pro-Child: Arlington, Virginia	46	46
Child Protection Center: Baton Rouge, Louisiana	45	45
Demonstration Unit: Bayamon, Puerto Rico	35	12
SCAN: Fayetteville, Arkansas	41	34
Family Care Center: Los Angeles, California	13	3
Family Resource Center: St. Louis, Missouri	38	25
Panel for Family Living: Tacoma, Washington	45	42
Protective Services Project: Union County, New Jersey	51	44
	354	272

Quality Controls and Data Processing

A complete system for quality control and error checking was implemented, starting with checks by evaluation staff for missing data and obvious errors. At the time of data collection, ID numbers were assigned to all cases, and names and other identifying information was removed. After the projects and assessors were contacted to supply missing data and to correct errors, forms were logged by project and ID number, keypunched and verified. Random checking was done for form/card congruency, errors were corrected, and data were filed on computer tapes on the University of California CDC 6400 computer, by case and by project. Using SPSS, univariates were run to further check for out-of-range values, missing data and otherwise useless variables. As new variables were constructed, additional univariates, and bivariates, were run and scanned for data problems. In addition, formal reliability tests were employed.

Data Analysis

The central theme in the data analysis was the need to determine which case management practices were the most efficacious in learning about the quality of case management. We relied on theory as we moved through the analysis to make selections and generally to address the questions of interest. In conducting the analyses, we moved from lower-order to higher-order analyses, starting with frequency distributions on all measures, moving to simple correlations and factor analyses, and finally to multivariate analysis techniques. This strategy allowed us to better understand and appraise the quality and nature of the data collected, eliminating many variables or creating new ones before higher-order, multivariate analyses, while identifying many important, although less complex relationships along the way. The remainder of this report describes the analysis steps and the findings.

Table II displays the total set of case management data items used throughout the analysis. For portions of the analysis, these items were integrated with data on client outcome and program characteristics collected for other components of the evaluation.

TABLE II: Quality Case Management Data Items[1]

Case Descriptors

- project site
- *large, bureaucratic setting: Union County and Arlington vs. other
- assessor name
- case status: terminated or active
- type and severity of maltreatment
- *seriousness of maltreatment: severe and moderate abuse or neglect and sexual abuse = serious; other categories = less serious
- identification of client: mother (mother substitute) or father (father substitute)
- age of client
- ethnicity of client
- court supervision of child
- child out of home
- date of referral
- type of referral: self-referral vs. other
- primary responsibility for case management: project or other agency
- difficulty of case -- view of manager: 5-point scale from least difficult to most difficult
- interest of client -- view of manager: 5-point scale from very uninterested to very interested
- responsiveness of client -- view of manager: 5-point scale from very unresponsive to very responsive
- difficulty of case -- view of quality assessor: 2-point scale; least difficult/most difficult

Case Handling Descriptors

- date of first client contact
- *time between date of referral and first client contact
- number of contacts prior to a treatment plan
- time between first client contact and first treatment service
- use of multidisciplinary team reviews at intake
- use of multidisciplinary team reviews during treatment
- use of multidisciplinary team reviews at termination
- *intensity of multidisciplinary team reviews: number of reviews over time in process
- use of case conferences at intake
- use of case conferences during treatment
- use of case conferences at termination
- *intensity of case conferences: number of conferences over time in process

Case Handling Descriptors (continued)

- client presence at multidisciplinary team reviews
- client presence at case conferences
- *intensity of client participation: number of times client present at multidisciplinary team reviews and case conferences
- number of outside consultations
- number of contacts with client over time in process
- contact with reporting source for background information
- contact with reporting source to discuss client's progress
- responsibility for intake: same or different from current case manager
- number of case managers
- reason for more than one case manager
- number of project staff who gave treatment to client
- use of treatment providers outside project
- contact with outside treatment providers
- date of termination
- *time to termination: length of time in caseload/terminated cases only
- *time in process: length of time between referral and termination and referral and review date
- number of follow-up contacts with the client
- number of follow-up contacts with others
- *intensity of follow-up: number of all follow-up contacts

Case Manager Descriptors

- case manager age
- *similarity of age between manager and client: 5-point scale from more than 10 years older than client to more than 10 years younger than client
- case manager sex
- *same sex between manager and client
- case manager ethnicity
- *same ethnicity between manager and client
- similarity of socio-economic experience between manager and client -- manager view: 3-point scale from very similar to not very similar
- case manager degree
- *professional education of manager: Master's Degree and nurses training vs. other
- abuse/neglect training of manager: course work, postgraduate, workshops, in-service training, other

TABLE II (Continued)

Case Manager Descriptors (continued)

- *• intensity of training: number of types of training
- • years experience in abuse/neglect treatment
- • date started with project
- *• months with project: date started to date of case referral
- • caseload size
- *• large caseloads: over 20 cases vs. other

Quality Measurement Descriptors

- • intake -- timing: 2-point scale, poor/good
- • intake -- thoroughness: 2-point scale, poor/good
- • intake -- helping approach: 2-point scale, poor/good
- • record of critical information: 2-point scale, poor/good
- • knowledge of critical information: 2-point scale, poor/good
- • planfulness in case handling: 2-point scale, poor/good
- • frequency of case manager contact with client during treatment: 2-point scale, poor/good
- • reassessment of case during treatment: 2-point scale, poor/good
- • coordination of information from all providers: 2-point scale, poor/good
- • goals: understandable, feasible, being worked on: 2-point scale, poor/good
- • client opportunity to participate in case decisions: 2-point scale, poor/good

Quality Measurement Descriptors (continued)

- • appropriateness of decision to maintain or terminate case: 2-point scale, poor/good
- • follow-up after termination: 2-point scale, poor/good
- • supervision of case manager: 2-point scale, poor/good
- • overall management of the case: 2-point scale, poor/good
- • worker's attitude toward the client: 2-point scale, poor/good
- • worker as a case manager: 2-point scale, poor/good
- *• intake quality: average score of intake-timing, intake-thoroughness and intake-helping approach
- *• general quality: average score of all individual measurement descriptors except intake quality items
- *• overall quality average score of all individual measurement descriptors

*These items were created using two other items for which data was collected directly.

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[1]Certain other client and case descriptors were also collected; however, these were meant to provide background information to the reviewer and were not used in analysis.

ORIENTATION CHECKLIST

Instructions: It is expected that prior to a quality assessment site visit the assessors will have read BPA's case study of the appropriate project. The purpose of this checklist is to assist in understanding the nature of the project being evaluated, supplementing the information found in the descriptive case study. The items listed are meant to be probes for eliciting background data on program context, policies and procedures, in order to facilitate the individual case reviews. The majority of the items on the list should be pursued at minimum with the project director during the initial orientation meeting; additional or verifying information from line staff is left to the discretion of the assessors. The list is not exhaustive and there may be other areas that the assessors wish to explore.

1. History of the project
2. Political/cultural context of the project
3. Organizational structure
4. Services offered
5. Staff composition
6. Present caseload: number and severity/abuse-neglect/sex breakdown
7. Caseload per worker
8. Referral sources (identification of initials of common referral agencies)
9. Case acceptance criteria and procedures
10. Procedures for handling intake, diagnosis, and treatment planning (e.g., use of contracts, etc.)
11. Waiting time for treatment services within project
12. Availability of community resources for treatment referrals (i.e., identification of collateral resources, including explanation of commonly used initials)
13. Amount of contact with client over time in caseload
14. Case reassessments: procedures, frequency, attendance
15. Use of a multidisciplinary review team, case conferences and case staffings (plus other consultants)

ORIENTATION CHECKLIST (Continued)

16. Client drop-outs: number, procedures for handling
17. Length of time in various stages of case management process
18. Client participation: policy, practice
19. Supervision of case workers: procedures, frequency
20. Internal communication and coordination on cases
21. Communication and coordination on cases with outside agencies
22. Termination criteria and procedures
23. Follow-up: policy and implementation of policy
24. Case management quality review procedures within project
25. Flexibility for handling individual client needs
26. Staff consistency in following agency policy and procedures

CASE REVIEW INSTRUMENT (Part A)

Berkeley Planning Associates
2320 Channing Way
Berkeley, California 94704

Column

CARD NUMBER 1 [1]

Client name _____

Project ID No. _____

BPA Client ID No. *(BPA Services)** / / / / / / / / / [2-9]+

Reviewer Name: [10]+
- Davoren 1
- Howze 2
- TenBroeck 3
- Armstrong 4
- Other (specify) _____ 5

Reliability Case: [11]
- Yes 1
- No 2

Date of Review: / / / / / / [15-18]
mo dy yr

Case Status: [19]
- Terminated 1
- Active 2

[20]**

Primary Case Worker Name _____ / / / [21-22]
ID No.

*Where data is available from BPA client forms, the appropriate form is indicated in italics.

+Columns [2-10] are duplicated on all following cards.

**These card columns are to be left blank.

Basic Information

		Yes, checked on BPA Intake form	Yes, determined from other source	No	Unknown	Column
1.	Severity of Case: (check all that apply)					
	For Abuse					
	Death due to abuse. . . .	1	2	3	9	[23]
	Severely injured.	1	2	3	9	[24]
	Moderately injured. . . .	1	2	3	9	[25]
	Mildly injured.	1	2	3	9	[26]
	Emotional abuse	1	2	3	9	[27]
	Sexual abuse.	1	2	3	9	[28]
	Potential abuse	1	2	3	9	[29]
2.	**For Neglect**					
	Death due to neglect. . .	1	2	3	9	[30]
	Severely neglected. . . .	1	2	3	9	[31]
	Moderately neglected. . .	1	2	3	9	[32]
	Mildly neglected.	1	2	3	9	[33]
	Emotional neglect	1	2	3	9	[34]
	Failure to thrive	1	2	3	9	[35]
	Potential neglect	1	2	3	9	[36]

3. Number of abused/neglected children: ___/___/___ [37-38]
Unknown 99

[39-40]**

4. Date of birth of abused/neglected child(ren) *(BPA Intake)*: If more than five children, provide information on four youngest and oldest only.

Youngest.	___/___/___/___/___/___ mo dy yr Unknown 999999	[41-46]
2nd youngest. . . .	___/___/___/___/___/___ mo dy yr Unknown 999999	[47-52]
3rd youngest. . . .	___/___/___/___/___/___ mo dy yr Unknown 999999	[53-58]

[59-60]**

4th youngest. . . .	___/___/___/___/___/___ mo dy yr Unknown 999999	[61-66]
Oldest of other abused/neglected children	___/___/___/___/___/___ mo dy yr Unknown 999999	[67-72]

Column

5. Number of children in household: / / / [73,74]
Unknown 99

6. Total number of children in family, whether or not in household: *(BPA Intake)* / / / [75,76]
Unknown 99

END OF CARD 1 [77-80]**

Column

CARD NUMBER 2 [1]

ID and Reviewer [2-10]

[11]**

7. Identification of client for this review: [12]

- Mother 1
- Mother substitute 2
- Father 3
- Father substitute 4
- Other (specify) _____ 5
- Unknown 9

8. Age of client: *(BPA Intake)* / / / [13,14]
Unknown 99

9. Ethnicity of client: *(BPA Intake)* [15]

- White 1
- Black 2
- Spanish 3
- American Indian 4
- Asian 5
- Other (specify) _____ 6
- Unknown 9

10. Level of education of client: *(BPA Intake)* [16]

- Less than 8 years 1
- 8-11 years 2
- High school diploma 3
- Some college/vocational training . . 4
- College graduate 5
- Post college graduate 6
- Unknown 9

Column

11. Employment of client: *(BPA Intake)*

Employed full time. . . . . 1 [17]
Employed part time. 2
Unemployed. 3
Unknown 9

[18-20]**

12. Estimated yearly family gross income of client: *(BPA Intake)*

From employment. . . . $/ / / , / / / [21-25]
Unknown 99999

From public assistance $/ / / , / / / [26-30]
Unknown 99999

From other sources . . $/ / / , / / / [31-35]
Unknown 99999

13. Court involvement: have any of the abused/neglected children been under court supervision during treatment of the parent?

Yes . . . . . 1 [36]
No. 2
Unknown 9

14. Living arrangements of abused/neglected child(ren): have any of these children been out of the home during treatment of the parent?

Yes . . . . . 1 [37]
No. 2
Unknown 9

[38-40]**

Intake and Plan

15. Date initial referral received:

/ / / / / / [41-46]
mo dy yr
Unknown 999999

16. Type of referral to the project (circle one):

Self referral . . . . . 1 [47]
Report by other agency or individual. 2
Unknown 9

17. Date of first contact with client (any type of contact, i.e., telephone, in-person, or other):

/ / / / / / [48-53]
mo dy yr
Unknown 999999

18. Date of first in-person contact with client:

/ / / / / / [54-59]
mo dy yr
Unknown 999999

[60]**

			Column
19.	Number of contacts (any type) with client, following first contact, prior to decision on treatment plan (circle one):	None . . . . . 0 One . . . . . 1 Two . . . . . 2 Three . . . . . 3 Four . . . . . 4 Five . . . . . 5 Over five . . . . . 6 Not applicable (no treatment plan) . 8 Unknown 9	[61]
20.	Time between first contact with client and provision of first treatment service by project (concerns only services on BPA Services Form; does not include services specific to intake):	Within one day . . . . . 1 Within one week . . . . . 2 Within two weeks . . . . . 3 Within one month . . . . . 4 Over one month . . . . . 5 Not applicable (no services given) . 8 Unknown 9	[62]

21. Have there been multidisciplinary team (MDT) reviews of this case?

	Yes, client present	Yes, client not present	No	NA	Unknown	
At intake/treatment planning	1	2	3		9	[63]
During treatment	1	2	3	8	9	[64]
At termination	1	2	3	8	9	[65]

22.	How many times have outside consultants, other than MDT, been used on the management (not treatment) of this case?	None . . . . . 0 Once . . . . . 1 Twice . . . . . 2 Three times . . . . . 3 Four times . . . . . 4 Five times . . . . . 5 More than five times . . . . . 6 Unknown 9	[66]

23. Have there been case conferences or staffings of this case?

	Yes, client present	Yes, client not present	No	NA	Unknown	Column
At intake/treatment planning	1	2	3		9	[67]
During treatment	1	2	3	8	9	[68]
At termination	1	2	3	8	9	[69]

24. Approximate frequency of contact by case manager with client, while in treatment (verify by interview):

(Write in code from list):

None 0
More than once a week 1
About once a week 2
About twice a month 3
About once a month 4
Less than once a month 5
Once, twice only 6
Varied over time 7
Unknown 9

a. First half of treatment . . . . /___/ [70]

b. Last half of treatment . . . . /___/ [71]

Coordination of Case Information

25. Was there contact with the agency or individual who referred client to project?

	Yes	No	NA (self-referral)	Unknown	
To obtain background, history, other recorded information on the case	1	2	8	9	[72]
To discuss client's status and progress	1	2	8	9	[73]

26. Did current case manager do the intake on this case (verify by interview)?

Yes, alone . . . . . 1 [74]
Yes, with other project staff . . . 2
No 3
Unknown 9

		Column
27. After intake, how many case managers have there been for this client?	One 1	[75]
	Two 2	
	Three 3	
	More than three 4	
	Unknown 9	
28. (If more than one case manager) were these different case managers involved jointly with the case, or were there changes from one to another?	Involved jointly. 1	[76,77]
	Changed, due to staff turnover. . . 2	
	Changed, at request of client . . . 3	
	Changed, staff unavailability (ill, vacation, etc.) 4	
	Changed, lack of success with client. 5	
	Changed, other reason (specify) ___ _____ 6	
	NA (only one case manager). 8	
	Unknown 9	
29. How many people in this project have provided direct treatment to this client (other than case manager)?	None. 0	[78]
	One 1	
	Two 2	
	Three 3	
	Four. 4	
	Five. 5	
	More than five. 6	
	Unknown 9	

END OF CARD 2 [79-80]**

		Column
	CARD NUMBER 3	[1]
	ID and Reviewer	[2-10]
		[11]**
30. Have any agencies (or individuals) outside of the project provided direct treatment or services to this client (while the client was in the project's caseload)?	Yes 1	[12]
	No. 2	
	Unknown 9	

		Column
31. How many contacts have there been with other agencies or individuals--from whom client received direct treatment or services--to discuss client's status and progress (verify by interview)?	None 0	[13]
	One 1	
	Two 2	
	Three-five 3	
	Over five 4	
	NA (no treatment or services) . . . 8	
	Unknown 9	
32. Does this project have primary case management responsibility for this client, or does some other agency have primary responsibility?	This project is primary 1	[14]
	Other agency is primary 2	
	Joint responsibility between this project and other agency 3	
	Unknown 9	

33. Have any family members of the client received services or direct treatment at the project?

	Yes	No	NA, person(s) not in household	Unknown		
Spouse/mate	1	2	8	9	[15]	
Abused/neglected child(ren) .	1	2	8	9	[16]	
Other child(ren)	1	2	8	9	[17]	
Grandparents	1	2	8	9	[18]	
Other (specify) _____	1	2	8	9	[19]	[20]**
Unknown	1	2	8	9	[21]	

Termination and Follow-Up

34. Date case terminated (or stabilized) *(BPA Impact)*:	/ / / / / / (mo dy yr)	[22-27]
	NA (case not closed) 888888	
	Unknown 999999	
35. How many follow-up contacts have there been with the client after case was closed (or stabilized (verify by interview)?	None 0	[28]
	One 1	
	Two 2	
	Three-five 3	
	More than five 4	
	NA (case not closed) 8	
	Unknown 9	

			Column
36. How many follow-up contacts have there been with other agencies or individuals working with the client after case was closed/ stabilized (verify by interview)?	None	0	[29]
	One	1	
	Two	2	
	Three-five	3	
	More than five	4	
	NA (case not closed)	8	
	Unknown	9	
37. What is the case manager's assessment of the difficulty involved in handling this case, compared to other cases in the project's caseload (get by interview)?	Among the most difficult	1	[30]
	More difficult than average	2	
	Average	3	
	Less difficult than average	4	
	Among the least difficult	5	
	Unknown	9	
38. What is the case manager's assessment of the degree to which the client is interested in treatment (get by interview)?	Very uninterested	1	[31]
	Somewhat uninterested	2	
	Neither interested nor disinterested	3	
	Somewhat interested	4	
	Very interested	5	
	Unknown	9	
39. What is the case manager's assessment of the degree to which the client was responsive in treatment (get by interview)?	Very unresponsive	1	[32]
	Somewhat unresponsive	2	
	Neither responsive nor unresponsive	3	
	Somewhat responsive	4	
	Very responsive	5	
	Unknown	9	
40. What is the degree of similarity between the case manager's and this client's socio-economic experience (get by interview)?	Very similar	1	[33]
	Somewhat similar	2	
	Not very similar	3	
	Unknown	9	
			[34-40]**

INTERVIEW CHECKLIST

Instructions: The purpose of the checklist is to assist in understanding the management of this case, supplementing the data found in the written records. The items are meant to be probes for eliciting sufficient information to make the following overall case ratings. The topics suggested are to be used at the assessor's discretion, depending on the completeness of the case record.

1. Circumstances of the abuse (or neglect) incident.
2. Identification of stress conditions found in this client's family.
3. Relationship between the client and the abused (or neglected) child(ren).
4. Description of client's functioning on characteristics associated with abuse (or neglect), i.e., isolation, expression of anger, sense of independence, etc.
5. Mental and physical health and developmental status of abused (or neglected child(ren).
6. Kind of intervention provided immediately following referral
7. Goals of treatment for this client.
8. Treatment plan for this client.
9. Description of services provided to this client.
10. Client's progress, or lack of, during treatment.
11. Extent to which case was reassessed, both formally and informally, while client was in treatment.
12. Termination decision.
13. Kind of follow-up provided.
14. Type of supervision received for handling this case.
15. Worker's feelings about client.

Reviewer Assessment of Case: Based on Worker Interview and Record

	Very Poor	Poor	Adequate	Good	Very Good	NA	Unknown	Column
41. Intake -- timing.	1	2	3	4	5		9	[41]
42. Intake -- thoroughness.	1	2	3	4	5		9	[42]
43. Intake -- helping approach. . .	1	2	3	4	5		9	[43]
44. Record of critical information.	1	2	3	4	5		9	[44]
45. Knowledge of critical information	1	2	3	4	5		9	[45]
46. Planfulness in case handling. .	1	2	3	4	5		9	[46]
47. Frequency of case manager's contact with client during treatment	1	2	3	4	5		9	[47]
48. Reassessment of case during treatment.	1	2	3	4	5		9	[48]
49. Coordination of information from all providers.	1	2	3	4	5		9	[49]
50. Goals: understandable, feasible, being worked on . . .	1	2	3	4	5		9	[50]
51. Client opportunity to participate in case decisions. . . .	1	2	3	4	5		9	[51]
52. Appropriateness of decision to maintain or terminate case. . .	1	2	3	4	5		9	[52]
53. Follow-up after termination . .	1	2	3	4	5	8	9	[53]
54. Supervision of case manager on the case	1	2	3	4	5		9	[54]
55. Rate the overall management of this case.	1	2	3	4	5		9	[55]
56. Rate the worker's attitude toward the client	1	2	3	4	5		9	[56]
57. Rate this worker as a case manager.	1	2	3	4	5		9	[57]

	Among the most difficult	More difficult than average	Average	Less difficult than average	Among the least difficult	Column
58. Rate the difficulty of this case, from your perspective. . . .	1	2	3	4	5	[58]

[59-80] **

CASE REVIEW INSTRUMENT (Part B)

Case Manager Information

Berkeley Planning Associates
2320 Channing Way
Berkeley, California 94704

Column

CARD NUMBER 4 [1]

Project Number / / / [2,3]

[4-11]**

A. Case Manager Name: _____

Case Manager ID Number (to be filled in later): / / / [12,13]

B. Age: / / / [14,15]

Unknown 99

C. Sex:

Male	1	[16]
Female	2	

D. Ethnicity:

White	1	[17]
Black	2	
Spanish	3	
American Indian	4	
Asian	5	
Other	7	
Unknown	9	

E. Degree (circle highest attained):

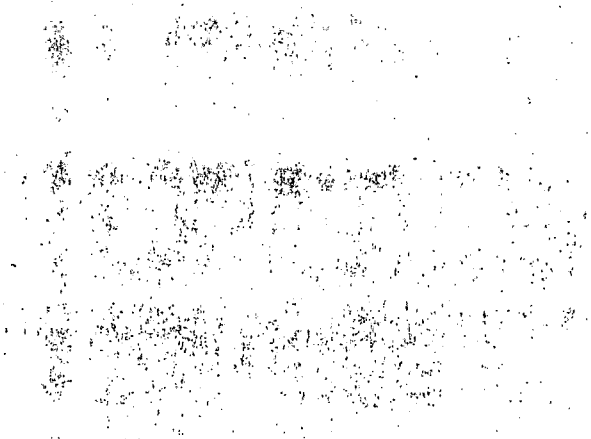
High school	1	[18]
AA	2	
BA	3	
MSW	4	
Other Master's	5	
RN	6	
Other (specify) _____	7	
Unknown	9	

F. Special training in child abuse/neglect (circle all that apply):

	Yes	No	Unknown	
MSW coursework	1	2	9	[19,20]** [21]
Post-graduate work/continuing education	1	2	9	[22]
Workshops	1	2	9	[23]
Inservice	1	2	9	[24]
Other (specify) _____	1	2	9	[25]

** These card columns are to be left blank.

		Column
G. Years experience in family treatment:	Less than one 1	[26]
	One 2	
	Two 3	
	Three 4	
	Four 5	
	Five 6	
	More than five 7	
	Unknown 9	
H. Years experience in child abuse/neglect treatment	Less than one 1	[27]
	One 2	
	Two 3	
	Three 4	
	Four 5	
	Five 6	
	More than five 7	
	Unknown 9	
I. Date started with project:	/ / / / (mo yr)	[28-31]
	Unknown 9999	
J. Date left project:	/ / / / (mo yr)	[32-35]
	NA(still with project) 8888	
	Unknown 9999	
K. Current caseload (number of families):	/ / /	[36-38]
	Unknown 999	
		[39-80]**



SECTION VI

THE PROGRAM MANAGEMENT AND WORKER BURNOUT COMPONENT

In order to determine the extent and causes of worker burnout in the demonstration projects and to understand the relationship between worker performance and project performance, data were collected from each project on relevant management, organizational and worker-related variables and systematically analyzed. First, however, we conducted a thorough search of the relevant literature to identify the specific hypotheses to be tested and to select those existing, standardized measures which would be of use in our study. We found few existing studies on worker burnout that could be used as guides. In this section we present our principle questions, discuss the data collection process, the data items themselves, and data checking and analysis techniques. Finally, we describe the data set.

A. Principle Questions

The primary concern in studying burnout in child abuse and neglect projects is to identify the causes of burnout and areas for solution. In order to accomplish this, the following were asked:

(1) How prevalent is burnout in the demonstration projects?

(2) Is burnout the same as lack of job satisfaction?

(3) To what extent is burnout associated with worker characteristics?

(4) To what extent is burnout associated with organizational factors?

(5) To what extent is burnout associated with management processes?

(6) What combinations of worker, organizational and management factors best account for worker burnout?

The hypothesis that guides the exploration of the relationships among burnout, personnel, management and organizational factors is: that burnout is directly associated with personnel characteristics and management processes and indirectly related to organizational factors. If the hypothesis is correct, it would infer that child abuse and neglect program administrators and planners should concentrate on improving management practices and work climate before planning to reorganize the agency's structural characteristics. Or, that reorganization efforts must be examined for their possible effects on work climate and management.

B. Data Collection

Data were collected by BPA staff during special three-day visits to all projects in the late summer of 1976 using questionnaires, interviews and record reviews. Questionnaires pertaining to an individual's job-related attitudes and experience were given to all staff members (including those who had left the project) to complete; many workers were additionally interviewed. Interviews were also conducted with the project director and a representative from the host agency to obtain descriptions of the project operation and functioning. And, project records were reviewed for information on absenteeism, turnover and other statistical data.

Each visit began with a staff meeting in which the study format was introduced and the purpose of the research presented. At this time the participants' questions and concerns were addressed. During the staff meeting or shortly thereafter, all participants presently employed in the project completed the five-page questionnaire which included questions for demographics, burnout, job satisfaction, work environment, and views on program management. Individuals who had terminated with the agency were contacted and a questionnaire, with a

self-addressed envelope, was mailed to each.[1] The questionnaire included an addendum which asked them about their decision to terminate employment. In addition to the questionnaire, 113 workers, both terminated and non-terminated, whose schedules permitted, were interviewed. The interviews ranged from 30 to 60 minutes in length.and took place in a secure room, where the employee could talk without inhibition. All interviewees were assured that the conversation would be held in strictest confidence. While standard questions were asked of each worker, the interview format was intended to be informal and designed to explore personal feelings and reflections with the participant about his/her job and the project management. Workers who reported that they were burned out were asked to share a description of the burnout symptoms they had experienced. Workers who had burned out and did not terminate their employment were also asked to discuss what they believed had contributed to their burnout conditions. Workers who had quit their jobs were asked to discuss the reasons leading to termination. The workers who had not burned out were asked to offer their assessment of why they had not burned out. All workers were asked to describe their self-nurturing habits.

In addition to the questionnaires completed by all staff and the open-ended interviews held with many of the workers, a special interview was conducted with the project director.[2] This interview elicited information about the project director, project operations, internal communication and coordination patterns, leadership, job designs,

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[1]Of the 167 questionnaires administered or mailed to terminated and non-terminated employees, 162 were completed and returned, a response rate of 97%. There were nine terminated staff who did not receive a questionnaire because forwarding addresses were not available. Approximately four of the nine workers had been requested to leave their jobs in the projects because of unsatisfactory work performance and were known to be hostile to project management.

[2]In one project, the interview was given to the assistant director due to the director's illness.

organizational disruptions, the project's relationship with the host agency, and the management problems and strengths.

An interview was also conducted with a representative from the host agency who had had the most contact with the project and who was most informed about the project's historical development. During these interviews, information was collected about the project's history, interagency policies and procedures, interagency communication and relationships, problems, and budgetary information.

Data collected previously from project directors by BPA staff on the project's structural characteristics, size, span of control, formalization and centralization complete the data set.

C. Data Items

The data collected include information about worker characteristics, management processes, organizational variables, and job-related attitudes. Table 1 presents a listing of all these independent, control, mediating and dependent variables, as well as the definitions of each.

TABLE 1

Listing of All Variables[1]

I. Independent Variables: The items used as independent variables in the analysis consist of descriptors of management processes or the work environment. These are those integrative functions that blend human characteristics and organizational structure into an effective and efficient working agency.

- Leadership. The extent to which the project director provides structure and support, the degree to which the director provides direction and emotional support, enhancing the feelings of personal worth and importance of the staff.

[1] All asterisked items are subscales of the Work Environment Scale, developed by Rudolph H. Moos and Paul M. Insel, Consulting Psychologists Press, Inc., Palo Alto, California, 1974.

Table 1 (continued)

- Communication. The extent to which information provided to workers is timely, adequate, and appropriate.

- Task orientation.* Assesses the extent to which the climate emphasizes good planning, efficiency and encourages workers "to get the job done."

- Clarity.* Measures the extent to which workers know what to expect in their daily routines and how explicitly rules and policies are communicated.

- Autonomy.* Assesses the extent to which workers are encouraged to be self-sufficient and to make their own decisions. Includes items related to personal development and growth.

- Innovation.* Measures the extent to which variety, change and new approaches are emphasized in the work environment.

- Staff support.* Measures the extent to which supervisors are supportive of workers and encourage workers to be supportive of each other.

- Pressure.* Measures the extent to which the press of work dominates the work milieu.

- Involvement.* Measures the extent to which workers are concerned and committed to their jobs. Includes items designed to reflect enthusiasm and constructive activity.

- Peer cohesion.* Measures the extent to which workers are friendly and supportive of each other.

- Control.* Measures the extent to which management uses rules and pressure to keep workers under control.

II. Control Variables: As control variables in the analysis, personnel characteristics are used. Workers have important differences in work motivation, attitudes, education, age, interests, skills, work experience and work roles. These differences suggest that some individuals may be more susceptible than others to burnout; therefore these relationships need to be controlled in assessing relationships between independent and dependent variables. They include:

Table 1 (continued)

- Age
- Sex
- Job title
- Job status. The amount of time worked in the agency, i.e., full or part time.
- Supervision responsibility. Measures the extent to which workers have supervision responsibilities over other workers, students or volunteers.
- Years of education. Includes the number of years completed in high school, undergraduate and graduate education.
- Field of study. Includes the major areas of study in both undergraduate and graduate education.
- Highest degree received
- Work experience. (1) years employed in social service is any job experience prior to this job with a social agency; (2) months employed in the project is the number of months the worker has been employed in the project; (3) experience with abuse or neglect is the number of years experience with child abuse prior to and including the experience with the project.
- Salary. The average monthly salary, including fringe benefits, for each worker.

III. Mediating Variables: As mediating variables in the analysis we use descriptors of organizational structure. Structure is the framework for operating within an agency, and is the blueprint describing how personnel are arranged in relation to each other and to the task. Structural variables used to categorize the eleven projects were size, complexity, span of control, formalization, centralization and turnover rate.

- Size. (1) Total number of staff employed in the agency, including all volunteers, students, and consultants who work with the project on a consistent basis, full or part time;

Table 1 (continued)

(2) client load -- the average monthly project caseload, the average number of clients seen by the project each month.

- Complexity. The degree of structural differentiations within a social system, i.e., the number of different professional disciplines involved in the project on a regular basis.

- Lateral span of control. The average number of personnel directly responsible to each first-line supervisor in the project.

- Formalization. The extent to which rules, procedures, instructions and communications are explicit. (1) Recruitment -- the project has written and implemented procedures for recruiting and employing personnel; (2) job codification -- the degree of personal flexibility and latitude permitted in one's job; (3) rule observation -- the degree to which workers feel monitored and constrained to obey the organization's rules; (4) specificity of job description -- the degree to which job expectations are specified and explicit.

- Centralization. The extent to which authority to make decisions concerning control of resources, program policies and procedures, and control of work is concentrated or distributed in the agency as determined by the level at which decisions are authorized. (1) Centralization, program -- the extent to which program procedures, policies and distribution of resources are controlled by director, board or host; (2) centralization, job -- the extent to which decisions about an individual's job or case management responsibilities (daily work schedules, interview appointments, delivery of services) are dictated by a supervisor, coordinator or director.

- Turnover rate. The number of terminated workers divided by the average number of employees employed in the project.

IV. Dependent Variables: For analysis purposes, our dependent variables are indicators of attitudes toward jobs, and more specifically job discontent, as described below.

- Burnout. The extent to which a worker has become separated or has withdrawn from the original meaning and purpose of his work, i.e., the extent to which workers express attitudes of

Table 1 (continued)

estrangement from their clients, jobs, co-workers or project.
• Job satisfaction.** The positive affective orientation towards facets of work situations, job, salary, promotion opportunities, supervision, co-workers, i.e., the relative gratification or happiness of the work situation.
• Absenteeism. The average number of days absent per month.
• Termination. Terminated workers are all staff personnel who have left the agency. Non-terminated personnel are workers presently employed in the agency, including workers on leave of absence and those who have reduced their work time from full-time to part-time employment.

**Job Description Index (JDI) was used. This scale was developed by Patricia Smith, Lorne M. Kendall, and Charles L. Hulin. The Measurement of Satisfaction in Work and Retirement. Chicago, Rand McNally and Company, 1969.

D. Data Checking and Measurement Development

Prior to analysis of the data, strict attention was given to methodological issues that could compromise the applicability and utility of the results. Primary attention was given to concerns of the reliability and validity of the items.[1]

To test the reliability or internal consistency of the burnout scale, the Cronbach alpha test was completed on each of the five subscales and then on the total scale. After one highly unreliable item, "I have become disenchanted with our profession's willingness to help clients," was deleted, the Cronbach alpha

[1]Objective data items, such as caseload size, span of control, or worker age were also collected through other parts of the overall evaluation and were easily verified.

for the remaining subscales were: for project, .67; for co-worker, .81; for job, .71; and for opportunities, .72. The Cronback alpha for the total burnout scale was .88. In all analyses the summed burnout scale was used as an individual's burnout score, a high burnout score meant no burnout and a low burnout score meant high burnout.

The burnout scale was examined for its convergent and discriminant validity. The scale was compared with already well established reliable and valid measures of job discontent and examined for consistency with interview findings. As we expected, burnout was highly correlated with these well established reliable and valid measures of job satisfaction, absenteeism, and termination. The burnout scale and job satisfaction inventory were correlated at .59, $P<.001$. Burnout was also negatively correlated with termination, $-.36$, $P<.001$. A mean absenteeism rate was calculated for each project. In the event that data was not available for a particular worker, the project mean was assigned. Using this method, burnout was negatively related to absenteeism ($-.23$, $P<.001$).

In addition, testing for convergent validity, the burnout scale appears to have some face validity in that it differentiates between burned out and non-burned out individuals. Thus, individuals who reported being burned out in individual interviews with the researcher tended to have lower scores on the burnout scale.

In conjunction with Moos' scale, leadership, communication and turmoil and change subscales were developed. When one item, "leaders apply pressure on staff members to complete all their work on time," was deleted, the leadership scale had intercorrelation of $r \leq .4$ and above. One communication item, "my best source of information regarding what is going on in the project is informal conversation," was deleted from the communication subscale. The remaining inter-item correlation was .4 or above. The turmoil and change subscale was deleted from the analysis because of a low inter-item correlation of .10.

Two measures of job satisfaction with demonstrated reliability and validity, the Job Description Inventory (JDI, Smith, Kendall and Hulin, 1969) and G.M. Faces (Kunin, 1955), were used. In the analysis,

the JDI scale was summed to equal an individual's job satisfaction score. The Faces were treated as a separate and second score of satisfaction, but because of the consistent and redundant correlations between the two measures, the results using the Faces with all other variables are not reported in the findings.

E. Data Analysis

After obtaining a description of the data through a univariate analysis, bivariate analyses using Pearson correlations and contingency analyses were used to explore the relationship of burnout to personnel, organizational structure and management, as well as the relationship between management and structure. Partial correlations and tri-level contingency analyses were used to explore the relationship between burnout and management, controlling for organizational structure and demographic variables. Regression analysis was used to determine which among the significant relationships established in the prior analysis explained the most variance in burnout, thereby intending to substantiate a hierarchy of relationships with burnout among the variables. Finally, discriminant analysis was completed to determine the best predictors of burnout.

Job Assessment Questionnaire

Card #1 Col.

Project: _____ ID# [ ][ ][ ][ ] BPA Use Only 1-4

Name: _____

Age: _____ years 5-6

Sex: [ ] (1) male [ ] (2) female 7

Job Title: 8-9

[ ] (1) project director
[ ] (2) coordinator
[ ] (3) supervisor
[ ] (4) trainer
[ ] (5) doctor
[ ] (6) nurse
[ ] (7) social worker
[ ] (8) psychologist
[ ] (9) lay therapist
[ ] (10) researcher
[ ] (11) case aide
[ ] (12) teacher
[ ] (13) other (specify) _____

Is your position in the agency classified as: 10

[ ] (1) paid permanent
[ ] (2) paid temporary
[ ] (3) permanent volunteer
[ ] (4) temporary volunteer
[ ] (5) other (specify) _____

Do you work: [ ] (1) full time (37 hours or more per week) 11
[ ] (2) part time (less than 37 hours per week)

Do you have supervisory responsibilities over other agency personnel? 12

[ ] (1) yes
[ ] (2) no

Years of elementary or high school completed: (circle the highest grade of elementary or high school completed. If you graduated from high school, circle 12) 13-14

01 02 03 04 05 06 07 08 09 10 11 12

Years of undergraduate education completed: 0 1 2 3 4 5 15

Major undergraduate field: 16-17

[ ] (1) sociology
[ ] (2) social work
[ ] (3) psychology
[ ] (4) education
[ ] (5) nursing
[ ] (6) pre-med
[ ] (7) counseling
[ ] (8) English
[ ] (9) History
[ ] (10) other (specify) _____
[ ] (11) double major (specify) _____ _____
[ ] (12) not applicable

Col.

Years of graduate school completed: 0 1 2 3 4 5 6+ — 18

Major graduate field: — 19-20

- ☐ (1) sociology
- ☐ (2) social work
- ☐ (3) psychology
- ☐ (4) education
- ☐ (5) medicine
- ☐ (6) counseling
- ☐ (7) English
- ☐ (8) History
- ☐ (9) nursing
- ☐ (10) other (specify) _____
- ☐ (11) not applicable

Highest degree received: — 21

- ☐ (1) AA
- ☐ (2) BA/BS
- ☐ (3) MA/MS
- ☐ (4) MSW
- ☐ (5) MD
- ☐ (6) PhD
- ☐ (7) Professional doctorate
- ☐ (8) None
- ☐ (9) Other (specify) _____

Years employed in a social service or family service job: (circle the number of years) — 22-23

01 or less 02 03 04 05 06 07 08 09 10+

Months employed in project: _____ months — 24-25

Total amount of experience working with child abuse families: — 26-28

_____ years, _____ months

Card #1 — 80

JOB DESCRIPTION INDEX

Card #2 Col.

ID# ____ BPA Use Only 1-4

Think of your present job. Think first about your CLIENTS, then about the PROJECT, then about your CO-WORKERS, then about your JOB, and about the OPPORTUNITIES IN YOUR JOB. Under each of these characteristics of your job is a set of statements. Circle the number (1,2,3,4,5) beside each statement, that MOST REPRESENTS how you feel. The items may not always seem to apply; just give general impressions. We want your first response of how you feel about the statement.

	Almost Always	Very Often	Sometimes	Seldom	Almost Never	
MY CLIENTS						
a. I feel optimistic about our clients. . . .	1	2	3	4	5	5
b. I realize that our clients cannot be helped no matter how hard I work	1	2	3	4	5	6
c. Our clients make unrealistic demands on our agency	1	2	3	4	5	7
d. Our clients are demanding too much emotional involvement from me.	1	2	3	4	5	8
e. Most of our clients' problems can be dealt with	1	2	3	4	5	9
f. I have become disenchanted with our profession's willingness to help clients .	1	2	3	4	5	10
MY PROJECT						
a. This organization has problems which a person cannot do anything about.	1	2	3	4	5	11
b. I no longer believe that this project can really accomplish any good	1	2	3	4	5	12
c. This project has goals which are important to me.	1	2	3	4	5	13
d. Even when the project makes mistakes, I still support the project.	1	2	3	4	5	14
e. This project has rules and policies that are not made to help clients	1	2	3	4	5	15
f. My views are elicited and considered when organizational and management changes are planned.	1	2	3	4	5	16
MY CO-WORKERS						
a. My co-workers and I work closely together.	1	2	3	4	5	17
b. My co-workers want to help others, e.g., clients and each other	1	2	3	4	5	18
c. I don't accept most of my co-workers' views, interests, or values.	1	2	3	4	5	19

	Almost Always	Very Often	Sometimes	Seldom	Almost Never	Col.
MY CO-WORKERS (continued)						
d. I feel a lack of sharing among my co-workers	1	2	3	4	5	20
e. My co-workers and I share an interest in each others' lives, beyond our work environment.	1	2	3	4	5	21
f. I have confidence in the capabilities of my co-workers	1	2	3	4	5	22
MY JOB						
a. My job is meaningless.	1	2	3	4	5	23
b. My job is only necessary in order to have other things I want and need.	1	2	3	4	5	24
c. I am in charge of how my job is done	1	2	3	4	5	25
d. My job is self-fulfilling.	1	2	3	4	5	26
e. I am discontented with my job.	1	2	3	4	5	27
f. My job absorbs most of my interest and attention during the work day.	1	2	3	4	5	28
g. My job is an important job in this agency's program	1	2	3	4	5	29
OPPORTUNITIES IN MY JOB						
a. I have the opportunity to really help other people	1	2	3	4	5	30
b. I do not believe that it is possible to improve society's problems through this job.	1	2	3	4	5	31
c. I have reached my maximum growth potential in this job.	1	2	3	4	5	32
d. I am able to express myself in my work	1	2	3	4	5	33
e. I have the chance to engage in self-directed productive activity in my job	1	2	3	4	5	34
					Card #2	80

MORE STATEMENTS ABOUT MY JOB

Card #3 Col. 1-4

ID# _____ BPA Use Only

Circle (3) for yes, (2) for no, or (1) for when the word or phrase is not applicable, you are uncertain, or cannot decide what best represents your job.

THE WORK I DO IS:	Yes	No	???	Col.
fascinating	3	2	1	5
routine	3	2	1	6
satisfying	3	2	1	7
boring	3	2	1	8
good	3	2	1	9
creative	3	2	1	10
respected	3	2	1	11
hot	3	2	1	12
pleasant	3	2	1	13
useful	3	2	1	14
tiresome	3	2	1	15
healthful	3	2	1	16
challenging	3	2	1	17
on your feet	3	2	1	18
frustrating	3	2	1	19
simple	3	2	1	20
endless	3	2	1	21
gives sense of accomplishment	3	2	1	22
THE PAY I GET IS:				
adequate for normal expenses	3	2	1	23
barely live on it	3	2	1	24
bad	3	2	1	25
satisfactory profit sharing	3	2	1	26
income provides luxuries	3	2	1	27
insecure	3	2	1	28
less than I deserve	3	2	1	29
highly paid	3	2	1	30
under paid	3	2	1	31

PROMOTION OPPORTUNITIES I HAVE ARE:	Yes	No	???	Col.
good opportunity for advancement	3	2	1	32
opportunity somewhat limited	3	2	1	33
promotion on ability	3	2	1	34
dead-end assignment	3	2	1	35
good chance for promotion	3	2	1	36
unfair promotion policy	3	2	1	37
infrequent promotions	3	2	1	38
regular promotions	3	2	1	39
fairly good chance for promotion	3	2	1	40
SUPERVISOR I HAVE:				
asks my advice	3	2	1	41
hard to please	3	2	1	42
impolite	3	2	1	43
praises good work	3	2	1	44
tactful	3	2	1	45
influential	3	2	1	46
up-to-date	3	2	1	47
doesn't supervise enough	3	2	1	48
quick tempered	3	2	1	49
tells me where I stand	3	2	1	50
annoying	3	2	1	51
stubborn	3	2	1	52
knows job well	3	2	1	53
bad	3	2	1	54

(continued on next page)

	Yes	No	???	Col.
SUPERVISOR (con't.)				
intelligent	3	2	1	55
leaves me on my own	3	2	1	56
around when needed.	3	2	1	57
lazy.	3	2	1	58
CO-WORKERS I HAVE ARE:				
stimulating	3	2	1	59
boring.	3	2	1	60
slow.	3	2	1	61
ambitious	3	2	1	62
stupid.	3	2	1	63
responsible	3	2	1	64
fast.	3	2	1	65
intelligent	3	2	1	66
easy to make enemies.	3	2	1	67
talk too much	3	2	1	68
lazy.	3	2	1	69
unpleasant.	3	2	1	70
no privacy.	3	2	1	71
active.	3	2	1	72
narrow interests.	3	2	1	73
loyal	3	2	1	74
hard to meet.	3	2	1	75

Circle the face that indicates the way you feel about your job in general: Col. 77

1 2 3 4 5 6 7

Card #3 80

WORK ENVIRONMENT

Card #4 Col.

ID# [| | | |]
BPA Use Only

1-4

Below are 47 statements about the place in which you work. The statements are intended to apply to all work environments. However, some words may not be obvious in meaning. For example, the word "supervisor" is meant to refer to the immediate boss, manager, supervisor, or department head that you report to.

You are to decide which statements are true of your work environment and which are false. Circle the appropriate response.

If you think the statement is TRUE or mostly TRUE of your work environment, circle the (2) at the end of the sentence. If you think the statement is FALSE or mostly FALSE of your work environment, circle the (1) at the end of the sentence.

PLEASE BE SURE TO ANSWER EVERY STATEMENT

		True	False	
1.	The work is really challenging.	2	1	5
2.	People go out of their way to help a new employee feel comfortable	2	1	6
3.	Supervisors tend to talk down to employees.	2	1	7
4.	Few employees have any important responsibilities	2	1	8
5.	People pay a lot of attention to getting work done.	2	1	9
6.	There is constant pressure to keep working.	2	1	10
7.	Things are sometimes pretty disorganized.	2	1	11
8.	There's a strict emphasis on following policies and regulations .	2	1	12
9.	Doing things in a different way is valued	2	1	13
10.	There is not much group spirit.	2	1	14
11.	The atmosphere is somewhat impersonal	2	1	15
12.	Supervisors usually compliment an employee who does something well.	2	1	16
13.	Employees have a great deal of freedom to do as they like	2	1	17
14.	There is a lot of time wasted because of inefficiencies	2	1	18
15.	There always seems to be an urgency about everything.	2	1	19
16.	Activities are well planned	2	1	20
17.	If an employee comes in late, he can make it up by staying late .	2	1	21
18.	New and different ideas are always being tried out.	2	1	22
19.	A lot of people seem to be just putting in time	2	1	23
20.	People take a personal interest in each other	2	1	24
21.	Supervisors tend to discourage criticisms from employees.	2	1	25
22.	Employees are encouraged to make their own decisions.	2	1	26

	True	False	Col.
23. Things rarely get "put off 'till tomorrow"	2	1	27
24. People cannot afford to relax	2	1	28
25. Rules and regulations are somewhat vague and ambiguous	2	1	29
26. People are expected to follow set rules in doing their work	2	1	30
27. This place would be one of the first to try out a new idea	2	1	31
28. Work space is awfully crowded	2	1	32
29. People seem to take pride in the organization	2	1	33
30. Employees rarely do things together after work	2	1	34
31. Supervisors usually give full credit to ideas contributed by employees	2	1	35
32. People can use their own initiative to do things	2	1	36
33. This is a highly efficient, work-oriented place	2	1	37
34. Nobody works too hard	2	1	38
35. The responsibilities of supervisors are clearly defined	2	1	39
36. Supervisors keep a rather close watch on employees	2	1	40
37. Variety and change are not particularly important	2	1	41
38. Supervisors do not inform staff regarding agency procedures and changes in a timely fashion	2	1	42
39. The lack of good communication gets in the way of me doing my job	2	1	43
40. Leaders are able to tolerate uncertainty without anxiety and upset	2	1	44
41. My best source of information regarding what is going on in the project is informal conversation	2	1	45
42. Leaders apply pressure on staff members to complete all their work on time	2	1	46
43. People are told what is expected of them in their job	2	1	47
44. Leaders have not clearly defined their own roles nor are they clear about what others' responsibilities are	2	1	48
45. The way we do things in this agency changes a lot	2	1	49
46. Leaders do not regard the comfort, well being, and contributions of staff members	2	1	50
47. There is a lot of absenteeism in this agency	2	1	51
48. Leaders maintain a closely knit organization and attempt to resolve inter-staff conflict	2	1	52

Questions on pages 5 and 6 are from the Job Description Index (JDI) developed by Patricia Smith, Lorne M. Kendall, and Charles L. Hulin. Card #4 80

Questions 1-58 on page 7 and 8 are from the Work Environment Scale (WES) developed by Rudolf H. Moos and Paul M. Insel.

ADDITIONAL QUESTIONS FOR WORKERS WHO HAVE LEFT THE PROJECT

Card #5 Col.

Project: _____ ID# | | | | | BPA Use Only

Name: _____ 1-4

Below is a list of items that are often given as reasons for leaving a job. Please weight the items in terms of their importance in influencing you to leave the child abuse and neglect demonstration project.

	Very Important	Important	Somewhat Important	Not Very Important	Not Relevant	
a. salary	5	4	3	2	1	5
b. limited opportunity for promotion	5	4	3	2	1	6
c. kind of supervision received while on the job	5	4	3	2	1	7
d. the way the project was organized	5	4	3	2	1	8
e. the project management	5	4	3	2	1	9
f. limited opportunity for personal growth and development	5	4	3	2	1	10
g. client population served by the project	5	4	3	2	1	11
h. amount of work required	5	4	3	2	1	12
i. lack of participation in decision making	5	4	3	2	1	13
j. better opportunity in the new job I have now	5	4	3	2	1	14
k. job was not compatible with interests and/or needs	5	4	3	2	1	15
l. co-worker relationships	5	4	3	2	1	16
m. project policies	5	4	3	2	1	17
n. project goals	5	4	3	2	1	18
o. the work had little meaning or importance	5	4	3	2	1	19
p. disillusioned with the amount of good that can be accomplished through my profession	5	4	3	2	1	20
q. attitude toward clients became less optimistic	5	4	3	2	1	21
r. disillusioned with the amount of good that could be accomplished through this agency	5	4	3	2	1	22

	Very Important		Important	Somewhat Important	Not Very Important	Not Relevant	Col.
s. personal reasons, unrelated to job itself or co-workers. . .	5		4	3	2	1	23
t. other reason (specify) _____							
_____	5		4	3	2	1	24
						Card #5	80

Guide for Worker Job Satisfaction and Burnout Discussion

I. Nature of working in this project

Probes:
- a. What makes this project an attractive place to work?
- b. What is the nature of the project management?
  1. decision-making
  2. job autonomy
  3. communication
  4. coordination
  5. role clarification
  6. group sharing
  7. job pressure
- c. Do you want to be working in this agency? Why? Why not?

II. Nature of your job:

Probes:
- a. What is your job?
- b. Are you doing what you expected to be doing when you were first hired?
- c. What is frustrating about your job?
  1. Do you feel your training prepared you for this job?
  2. Do you feel you have adequate supervision and support to do this job?
  3. Do you have enough autonomy and freedom to make decisions about your job?
  4. Do you feel this job offers enough opportunity to grow and develop your skills?
  5. Are you satisfied with your salary?
- d. Does this job suit your interests and vocational wishes?
- e. How would you improve your job?
- f. How do you nurture yourself off the job?

III. Nature of relationships with co-workers

Probes: a. Are there good working relationships among your co-workers?

1. Do you find that people are supportive of each other and seem to care about each other?
2. Do workers give each other assistance on individual cases, sharing resources, referral information and techniques of working with clients?
3. Do the work units work more closely together than individuals across work groups?
4. Does your work group and/or co-workers socialize after working hours?

b. How do you explain why these good or bad working relationships exist?

1. organizational structure
2. client demands
3. job pressures
4. supervision
5. co-workers characteristics

c. What are your expectations regarding the importance of co-worker relationships?

IV. Nature of working with child abuse clients

Probes: a. How would you describe your clients? How well do they conform to the expectations you had when you were first hired?

b. What is frustrating or rewarding about working with your caseload?

c. How do you handle your feelings about clients?

Guide for Management and Organization Discussion with Director

Project Name: _____

Project Director: _____

Work Experience:

As a clinician	As an administrator
_____ less than one year	_____ less than one year
_____ 1-3 years	_____ 1-3 years
_____ 4-6 years	_____ 4-6 years
_____ 7-9 years	_____ 7-9 years
_____ 10+ years	_____ 10+ years

How long with this project? _____ years, _____ months

Promoted from within this agency? _____ yes, _____ no

Recruited from outside the agency? _____ yes, _____ no

I. Describe how the organization works

Probes:
a. the organizational structure
b. leadership/supervision process
c. communication process
d. coordination process
e. job design of service delivery
f. staff relationships
g. general personnel policies on compensatory time, sick leave, vacation, leaves of absence

II. Describe the changes that the project has undergone since its beginning (since you have been director) and what their impact has been on the project

Probes:
a. major changes in these areas:
1. number of director/staff changes

2. number of organizational changes due to the internal operation of the project
3. number of changes in the service delivery structure (program changes)
4. any changes imposed on project by external actors
5. have goals/purposes changed drastically

III. Describe the project's relationship with the host agency

Probes:
a. Does this project have any written agreements with the host agency pertaining to specific program procedures, for personnel interaction, client referrals, joint committees or other activities, or are all interactions informal?
b. How does the host agency monitor the project's progress, operations, and decisions?
c. How does the project fit in with the other activities the host agency is involved with?
d. To what extent is the project affected by the internal operation or organization of the host agency?
e. How are fiscal matters handled? Do you have freedom to spend your budget independently of the host agency's OK? What is the overhead cost charged the project? What are the procedures for developing agreements on fiscal matters?
f. About how much time is devoted to coordination, communication with the host agency (how frequently do you communicate with the host, in what manner, i.e., telephone calls, meetings, etc.)?

IV. What do you see as the management/administrative problems that have affected service delivery and project performance?

Probes:
a. organizational structure, bureaucracy, relationship with host agency
b. hiring/recruitment/training of workers
c. staff changes
d. relationships with community institutions
e. relationships with federal monitors in Washington, D.C.

V. Do you enjoy being a manager or project director in this project?

Probes: a. Does it provide opportunities for growth and development?

b. Does it provide opportunities for improving the community system and service delivery for clients?

c. What are the frustrations? What have you learned that helps you cope with these frustrations (specific examples)?

d. Do you like being an administrator? What are the satisfactions?

VI. How do child abuse clients versus other client types affect management, morale, turnover, etc.?

VII. What do you want from the management analysis? How can it be helpful to you?

Management Information: Structural Aspects of the Project

Name of Project _____ Site Liaison _____

Name of Reporter _____ Date _____

1. WHAT ARE THE PERSONNEL SELECTION AND RECRUITMENT PROCEDURES?

   a. What are the official written procedures? (bring back a copy)

   b. What flexibility exists in terms of hiring (e.g., special emergency approval)?

2. CAN WE GAIN ACCESS TO INFORMATION REGARDING TURNOVER (PROMOTION TO ANOTHER OFFICE AS WELL AS LEAVING THE PROJECT) AND ABSENTEEISM (SICK LEAVE AND WORK LEAVE, BY NUMBER OF DISTINCT TIMES ABSENT)?

   _____ Yes _____ No _____ Not sure

   a. Who do we call for information? _____

   b. Where are these records located? _____

   c. Do we need special permission from workers? _____

3. WHAT IS THE SIZE OR SCALE OF THE ORGANIZATION?

   a. The number of personnel employed:

   _____ full-time _____ volunteers

   _____ part-time _____ consultants _____ total

   b. Size of yearly budget (including funds from all sources) $_____

   c. Average monthly expenditure (from all sources) $_____

4. WHAT IS THE SPAN OF CONTROL IN THE PROJECT? (SPAN OF CONTROL REFERS TO THE NUMBER OF MEMBERS MANAGED BY THE AVERAGE SUPERVISOR AND/OR ADMINISTRATOR.)

List each person who has supervisory position	Number supervised*	Level of responsibility**
a.		
b.		
c.		
d.		
e.		

5. WHAT IS THE LEVEL OF COMPLEXITY OF THIS PROJECT (THE DEGREE OF STRUCTURAL DIFFERENTIATION WITHIN THE ORGANIZATION)?

   a. List the administrative staff (e.g., director, coordinator, accountant, secretary, the full-time members of the organization who perform the non-service delivery activities). Note who are support staff.

	Administrative staff	Position
1.		
2.		
3.		
4.		
5.		

* The number of people directly responsible to the reported individual.

**The level of supervision (e.g., first line supervisor, coordinator, etc.).

5. b. List how many levels of authority exist. How many individuals are within each level if different from span of control?

Level of authority/position	No. individuals within each
1.	
2.	
3.	

c. List the number of service delivery levels (e.g., lay therapist, caseworker I, caseworker II) represented in the project.

Service delivery levels	No. individuals within each
1.	
2.	
3.	
4.	
5.	

d. List the number of professional disciplines represented in this project (e.g., psychiatrist, social worker, nurse, lawyer).

Professional disciplines	No. individuals within each
1.	
2.	
3.	
4.	
5.	
6.	

e. How many sub-units or departments are in the project (the lowest level of administrative unit in the agency, which is not further subdivided)?

_____ (number)

6. ASK A REPRESENTATIVE FROM EACH LEVEL OF AUTHORITY, MENTIONED IN QUESTION 5b, THE FOLLOWING QUESTIONS.

Name _____ Level of Responsibility _____

Project _____ _____

a. Who is most likely to make the decision regarding the following issues?

	Worker	Supervisor	Coordinator	Project Director	Advisory Board	Levels superior to Project Director
1. promotion of workers						
2. salary increases for workers						
3. procedures to be used in review of cases						
4. social work methods to be used with clients						
5. assignment of casework responsibilities						
6. size of caseload						
7. authorization of emergency funds to clients						
8. referrals to other community agencies						
9. personnel practices						
10. scheduling of appointments with clients						

b. List the names of individuals, external to the project, who make important decisions regarding project functioning (e.g., advisory board chairman, district supervisor).

1. _____
2. _____
3. _____
4. _____

7. ASK A REPRESENTATIVE OF EACH LEVEL OF AUTHORITY MENTIONED IN QUESTION 6 THE FOLLOWING QUESTIONS.

Name _____ Level of Responsibility _____

Project _____

		Definitely true	More true than false	More false than true	Definitely false
a.	I feel that I am my own boss in most matters				
b.	A person can make his own decisions here without checking with anybody else				
c.	People here are allowed to do almost as they please				
d.	People here feel as though they are constantly being watched to see that they obey all the rules				
e.	There is no rules manual				
f.	There is a complete written job description for my job				
g.	Whatever situation arises, we have procedures to follow in dealing with it				
h.	Everyone has a specific job to do				
i.	Going through the proper channels is constantly stressed				
j.	Whenever we have a problem, we are supposed to go to the same person for an answer				

BRING BACK RULE AND PROCEDURE MANUALS, IF AVAILABLE.

Schedule Used to Collect Information on Turnover and Absenteeism

Terminated Staff

Project Name _____

Worker Name and Address	Position in Project	Dates of Employment	Present Employment Post/Position

Absenteeism (including those workers who have left the agency) Project _____

Worker Name	Number of Days Sick Leave	Number of Days Leave Taken	Number of Days Vacation Time	Number of Months for Which Data Collected

SECTION VII

THE COMMUNITY SYSTEMS COMPONENT

Development of the methodology for assessing changes in the demonstration communities' systems for child abuse and neglect and the projects' contributions to such changes took place during the first six months of the three-year evaluation period. The original intention was to provide an assessment of community system change by (a) analyzing service statistics both before the demonstration projects' implementation and after several years of operation, (b) analyzing documented projects' efforts to enhance community system operation and (c) conducting periodic structured interviews with representatives of key community agencies to elicit their perceptions of improved community system operation.[1] As more was learned about the communities during this early stage of the evaluation, these plans were modified significantly to reflect the actual situations as found in the ten communities. In essence, a descriptive case study approach replaced more structured survey and data analysis plans, due to a lack of availability of case statistics as well as an inability to control for a myriad of factors (both from within and outside the community) that may have influenced the community system. Data for this assessment were collected in the following ways:

A. Data Collection

1. Community Agency Representative Interviews. During our first site visits to the projects in the fall of 1974, with the help of the project directors, an inventory of all key agencies in each of the eleven communities was made based on our knowledge of child abuse/neglect systems. Interviews were conducted with representatives of the key agencies in order to gather baseline information on the services available, the way services were coordinated, the degree of awareness of both professionals and citizens about child abuse and neglect, and the existence of any gaps, duplications or other problems in the system.[2] These interviews were carried out using structured

[1] See Community Systems Report on Analytical Design and Baseline Data by Berkeley Planning Associates, March 1975.

[2] The focus of the data collection was on the way community systems operated prior to the funding of the demonstration projects.

interview guides developed specifically for this purpose.

The key agencies in every community included, at a minimum: the protective service agency, the Juvenile Court or other court with responsibility for child abuse cases (e.g., Family Court), the Police Department, the Sheriff's Office, the school district office, one or more hospitals which provided care to a large number of infants and children, and the foster care agency of the community. In addition to these agencies/programs, various others were identified as particularly important in certain communities. These included: private counseling or social service agencies, mental health centers, public health nursing departments, community hotline agencies, children's treatment programs, and centralized record keeping sources such as state central registries. Where an agency was considered key to the community's child abuse and neglect system, they were included in this round of interviews. The descriptive baseline information received from these key agency representatives was judged to be highly accurate (based on the evaluators' observations and consistency between those interviewed) with respect to categorizing the operation in the community systems, including the identification of strengths and weaknesses in these systems prior to the demonstration's implementation; these observations thereby provided the basis for describing the changes later observed which are included in this report.

A second and third round of interviews with community agency representatives, using similar but more detailed questionnaires, was conducted in January 1976 and January 1977 in order to provide comparative information at several points in time. In addition to determining the changes which had occurred in the way these communities handled child abuse and neglect problems, respondents were also asked to provide information on the role played by the demonstration project in enhancing the community system's operation.

2. Statistical Record Keeping. In addition to the information collected through community interviews, the design of this component relied heavily on analysis of service and caseload statistics from the various community agencies within the child abuse/neglect service system. The original plan was to compare the changes in these statistics from the baseline period (one year prior to the project's implementation) through termination, a period of four years. However, the first round of interviews with community agency representatives pointed out numerous constraints relative to the availability and quality of the numerical or statistical baseline data which were necessary for the analysis. Thus, for example, few communities had what would be considered community-wide statistics of unduplicated numbers of cases in the service system, proportions of abuse versus neglect cases, the sources of reports of cases, or final data on the disposition of cases (e.g., foster care placements, problems satisfactorily resolved, permanent placements, etc.). In the few cases when communities did have adequate data, it was often found that owing to the differences in record keeping procedures, philosophies, and definitional problems, these data were not comparable across communities. And, finally, in several agencies, there was reluctance to undertake the necessary collection of ongoing service data for the next three years which would be necessary for comparative analysis among projects.

In response to these constraints, we limited the number of agencies in each community for this record keeping to the two which appeared most central to child abuse and neglect, the protective service agency and the juvenile (or comparable) court. These agencies were requested to maintain ongoing data on various aspects of reporting and service delivery on instruments that we had developed. Even with this reduction, however, not all of these agencies could provide adequate data in the format required. Protective service statistics tended to be complete, but not always comparable across communities, while data from the courts are less consistent for each community. When the data were judged reliable, they have been used in the analysis as supporting evidence for the more descriptive analysis of community system changes.

3. Project Record Keeping. The two areas in which the demonstration projects were most consistently directing their community efforts were the improved coordination among agencies and professionals, and the increased education of professionals and community citizens. In order to gauge the amount of effort expended in these areas which could later be compared with the effectiveness of those efforts, projects kept data on the number and type of coordination and education activities undertaken, the focus of those activities, and the observable results.

In addition to these structured data collection mechanisms, other information relative to the operation of the community systems and changes which were occurring, was gathered informally from demonstration project directors during each site visit, by means of written materials supplied by the projects, and often through attendance at community or project Advisory Board meetings.

All of the information collected was checked by the evaluators for accuracy, hand tabulated, and analyzed.

B. Data Analysis

All of the collected data, both quantitative and qualitative, relative to changes which each community system has undergone and information about the demonstration projects' community activities has been integrated to analyze the impact of the projects on their respective community systems and to identify effective approaches to the implementation of coordinated and effective community-wide service delivery systems. Intra-community analyses and across-community analyses have been undertaken to portray a broad picture of both the individual project's successes and the achievement of the overall demonstration program relative to community impact.

1. Intra-Community Analysis

In the intra-community analysis, we were concerned with assessing each community "on its own terms" or in terms of its own baseline condition prior to the demonstration period. This is particularly important due to the diversity of the communities along parameters such as geographic setting, state child abuse legislation and administrative policies, the extent to which communities were "child abuse aware," and the amount of previous efforts to achieve greater coordination and more effective service delivery prior to the demonstration period.

The analysis of the communities depended upon a comparison of each system from the baseline period (1972-1973) through the three-year demonstration period, in this case roughly through January 1977. The analysis was focused on five specific issues within each community:

a. System Operation: the functional roles and interrelationships among the key agencies in the service delivery system;

b. Caseload Size and Case Outcomes: the magnitude of the reported abuse and neglect problem in each community and the dispositions made of cases entering the system;

c. Legislative and Resource Base: the legislative foundation and level of resource commitment to abuse and neglect in each community;

d. System Coordination: the nature and extent of collaborative arrangements among key agencies in the system;

e. Community Knowledge and Awareness: the amount of education provided to professionals and citizens and the level of knowledge and awareness of the dynamics of abuse and neglect and the community resources available for its treatment.

These five areas were chosen because they represent the most salient features of a community's system for dealing with abused and neglected children, and also because they are the primary areas in which the demonstration projects, to a greater or lesser extent, had planned to focus their non-direct service delivery efforts.

2. Across-Community Analysis

In addition to assessing the changes in individual community systems, and the extent to which the demonstration projects affected the communities in which they were located, we were particularly interested in carrying out comparisons across communities (1) to determine the commonalities and dissimilarities in their respective efforts and achievements, (2) to identify, to the extent possible, those factors which facilitated or hindered the adequate functioning of community systems in different localities under varying conditions, and (3) to more fully describe different aspects of communities that were particularly noteworthy and which might constitute replicable models for other programs.

A slightly different, but complementary, approach from the assessment of individual community systems was taken for the across-community analysis portion of this report.

The communities in which these eleven demonstration projects operated differed in many respects at the time of federal funding. Some were urban, central city, while others were primarily suburban or rural. The populations ranged from primarily middle class (Arlington, Virginia) to very low income (Puerto Rico and St. Louis). Some communities had extensive services for abused and neglected children and their parents; others could claim little beyond the maintenance services of a protective services agency and foster care placement. Some communities were, in general, very well educated about abuse and neglect and relatively sophisticated in their understanding of the dynamics of the problem and potential solutions, while others were almost exactly the opposite. And in some communities there were networks of coordination mechanisms which operated as successful integrative forces to reduce gaps and duplications, while in others little or no coordination existed between service providers. In order to analyze the demonstration projects as a group and develop conclusions about the success of their activities in developing more effective community systems for dealing with child abuse and neglect, it was necessary to construct a framework that (a) would accomodate the variety of types of information available, (b) would allow for comparisons across communities, and (c) was also

capable of accommodating the major differences among communities. It was particularly important that the framework not depend on a single perspective of the "only" or "best" way of organizing and maintaining an adequate community system, but that the framework be focused on general concepts whose inclusion in any community were considered central, but the specifics of which could be implemented in different ways according to the community's unique situation or context.

After three years experience with the eleven demonstration communities and others around the country, it has become clear that concepts that are generally subscribed to as essential elements of any social service delivery system are equally applicable to child abuse and neglect systems. A listing of such concepts, refined to reflect child abuse and neglect systems more specifically, became the tool in analyzing changes in each of the demonstration communities. This listing of "essential elements of a well functioning child abuse and neglect system," which has general applicability to any community, includes:

a. Community Coordinating Mechanisms: including, at a minimum, the availability of a multi-agency coordinating or advisory body whose function is to monitor the overall operation of the community system and plan for needed changes, and the existence of well-articulated, formal coordination agreements between key agencies;

b. Interdisciplinary Input: provision is made for obtaining input from various disciplines (e.g., social work, medical, legal, psychological) at all stages of the service decision-making process, including but not limited to the existence of a multidisciplinary review team;

c. Centralized Reporting System: a 24-hour centralized reporting and response system is available and known to all community residents (this may or may not include a state central reporting system);

d. Service Availability: provision is made for handling the full range of child abuse and neglect cases (emotional as well as physical abuse and neglect and sexual abuse) and a wide variety of treatment and preventive services are available for both parents and children, including therapeutic, supportive, advocacy, and educational services, crisis and long-term services, and residential as well as day services;

e. Quality Case Management: minimum standards of case management, including prompt investigation of reported cases, appropriate assignment of clients to service providers, planful treatment provision, ongoing case review, coordination with other service providers, and referral to other services as necessary, timely termination, and follow-up of closed cases are adhered to by all service providers;

f. Community Education and Public Awareness: all community residents, both professional and lay, are provided with education to heighten their awareness of the problem of child abuse and reduce the stigma attached to the problem and are instructed as to their reporting responsibilities and the procedures to follow in identifying and reporting suspected cases.

These six elements, then, represent the factors and concepts which are present in well-functioning, effective community systems for dealing with problems of child abuse and neglect. Although there are certainly other important factors, these can be regarded as the necessary minimum; they represent the criteria by which we have judged the overall effectiveness of the demonstration projects' efforts toward improving their own community systems' operation. We have assessed the extent to which the project communities, individually and as a group, embody each concept, the unique ways some communities have dealt with problems around implementation of the concepts, the problems which still remain in some communities, the factors which appear, in general, to facilitate or hinder positive achievements, and the relative effectiveness of the demonstration projects' efforts to implement these functional elements. As such, we have taken

As indicated earlier, this study was carried out on projects selected because of the new and different service strategies they proposed to demonstrate, and not because they were representative of child abuse and neglect programs across the country. The findings represent the collective experiences of these demonstration projects and the communities in which they are located, and do not necessarily reflect child abuse and neglect service systems in general. For this reason, care must be used in generalizing from the findings. In addition, because no control communities, without demonstration projects, were studied during this three-year time period -- a period which saw a proliferation of child abuse and neglect activities across the country -- no firm conclusions can be drawn about the impact of the projects per se on their communities; any discussion of such impact must be seen as suggestive, not conclusive.

COMMUNITY SYSTEM INFORMATION

PROTECTIVE SERVICES

Agency Name _____

Respondent's Name _____

Title _____

Address _____

_____

Telephone _____

Interviewer _____

Date _____

Briefly re-introduce BPA and the Evaluation.

We are interested in reviewing with you again how this agency handles cases of abuse/neglect and your perceptions about the child abuse and neglect system in (community) . Basically we want to determine what changes, if any, have occurred since the fall of 1974. After you answer each question, therefore, will you also tell me whether the current situation you are describing is different from the situation 1-1/2 years ago.

1) Now, could we talk about what happens to clients in your agency. First, which agencies or individuals generally refer cases to you?

Changes?

2) Approximately how many cases are reported to you each month (year)?

_____ abuse cases/month _____/year

_____ neglect cases/month _____/year

Changes?

3) If the number of reports has increased or decreased, ask "Do you have any ideas about what caused this increase/decrease?"

4) Do you know which agencies are mandated by law to receive reports of abuse/neglect? Which are they?

Changes?

If there are changes, ask "Would you say this change will significantly improve the community system?"

5) Do you send copies of reports you receive to any other agency? Which one(s)?

Changes?

Investigation

6) What happens when a case is reported/referred to you -- do you usually do some kind of investigation? If yes, who on your staff does this?

Changes?

7) How long after a report is received does your staff begin this investigation?

Changes?

8) What does this investigation procedure consist of?

Changes?

9) Do you usually make a home visit in conjunction with your investigation? If yes, elaborate.

Changes?

10) Do you ever make an investigation in conjunction with other agencies? Which agencies?

Changes?

11) How often do you do these joint investigations?

Changes?

12) Do you contact other agencies about a case during an investigation? Which agencies?

Changes?

13) About how long does the investigation take?

Changes?

14) What criteria do you use in deciding that a case is or is not an abuse/neglect case?

Changes?

15) After the case is investigated, about what proportion of cases are substantiated as abuse or neglect?

Changes?

16) After an investigation has been made, do you ever send a case to court? If yes, what is your agency's function in relation to those cases sent to court?

Changes?

Services

Could we now talk first about those clients to whom you give services, and then we'll talk about cases you refer elsewhere.

17) If your agency doesn't bring all cases of abuse/neglect into its caseload, how do you decide which cases to accept and which to drop or refer elsewhere?

Changes?

18) Do you provide services only to cases where abuse/neglect has been substantiated? If not, do you also provide services to clients who are suspected of abuse/neglect or who may have a potential for abuse/neglect?

Changes?

19) About how long is it between completion of investigation and the time the client begins receiving services?

Changes?

20) What services do you provide to these clients?

Changes?

21) Do you ever purchase services from other agencies for clients? If yes, what services do you purchase? From which agencies?

Changes?

22) Do you ever provide a lump sum of money to other agencies/programs (e.g., to hold a day care "slot" whether or not a child uses it)?

Changes?

23) Which services do <u>most</u> of your clients receive?

Changes?

24) How long do you usually continue to work with a case? What percent of your cases would you say "drop out" before the services are completed?

Changes?

25) What criteria do you use in deciding to terminate a case? Do you ever follow-up on cases after they have been terminated? What type of follow-up do you do?

Changes?

Staffing

26) Are any of your staff specifically assigned to work with abuse/neglect cases? How many people?

27) About what proportion of their time would you say they spend?

_____ Less than 10% _____ Close to 25% _____ Close to 50%

_____ Close to 75% _____ Close to 100%

28) How many of your staff ever work with abuse/neglect cases?

29) About what proportion of their time would you say they spend?

_____ Less than 10% _____ Close to 25% _____ Close to 50%

_____ Close to 75% _____ Close to 100%

30) Have any of your staff received specific training dealing with abuse/neglect cases since the fall of 1974? If yes, from whom was the training received?

Changes in staffing?

Referrals

Now let's talk about the ways in which you refer cases to other agencies.

31) Where do you most often refer cases? (If these agencies are unfamiliar ask for the agency director's name -- we will follow these up by phone.)

Changes?

32) About what proportion of your cases are referred to other agencies?

Changes?

33) Once you've referred a case, what follow-up procedures are carried out by this agency? Do you tell the client to go to the other agency? Do you make an appointment for them? Do you call the agency to ask whether the client kept the appointment? Do you check with the client to see if they kept the appointment or went to the agency? Do you take the client to the appointment?

Changes?

34) Once you refer a case elsewhere, do you consider that case closed? (If not) when do you terminate a case? How do you decide this?

Changes?

35) Do you consult with the agency to whom you've referred a case before you terminate that case?

Changes?

Other Functions

36) Do you have any specific coordination procedures with other agencies for dealing with abuse/neglect cases? Would you explain these to me. For example, do you: share staff, have joint funding, have verbal or written agreements, arrange purchase of services, consult with other agencies in service planning for a client, or have joint staff training?

37) Have any of these coordination/referral procedures been implemented since the fall of 1974? If yes, how did they come about?

38) Is there a Community Child Abuse/Neglect Task Force or Committee in the community? Do you participate on this Task Force/Committee?

39) (If yes to above) when was the Task Force begun? What was the impetus for developing the Task Force?

40) Is your agency involved in any community education endeavors, that is, do you give talks, presentations, workshops related to child abuse/neglect? Would you explain these.

Is this agency doing more or less community education than in the fall of 1974?

Would you say there has been more education about abuse/neglect in the community than in the fall of 1974? (If yes) which agencies/programs seem to be most involved in this?

Data

41) Have any of your record keeping procedures or forms changed during the past 1-1/2 years? If yes, please explain. (Pick up copies of new forms)

Project Assessment

42) Has your agency had any contact with (project) ? If yes, please explain the nature of these contacts.

43) Have any coordination agreements or arrangements been established between your agency and the project? If so, please describe them.

44) What do you see as the role of (project) in the community child abuse and neglect system here?

45) What, in your opinion, have been the most positive aspects of (project) since it began? (Probe with: What successful things have they accomplished?)

46) What, in your opinion, have been the problems associated with the project?

47) Do you foresee any other problems for the project in attempting to implement its program during the next year?

48) We are interested in knowing whether you feel that the services provided to clients by (project) are effective in helping them to overcome their problems. Would you say that the services are: _____ very effective;

_____ effective; _____ somewhat effective; _____ not effective;

_____ very ineffective.

49) Because it is sometimes difficult to determine whether services are actually helping people, we are also interested in knowing whether you think the project generally offers high quality services. Would you say that project services are of: _____ very high quality;

_____ high quality; _____ average quality; _____ low quality;

_____ very low quality.

50) What were the characteristics of the project's services that you had in mind when making this judgment?

51) Are you basing your judgments about the effectiveness and quality of the services the project offers on information their clients have shared with you, your own contacts with the project, discussions with other people in the community, or what?

52) What would you think other people in the community would say about the quality and effectiveness of the services which the project offers?

53) What is your overall reaction to the project?

54) Considering all of the agencies in the community handling child abuse/neglect cases, would you say the system for dealing with abuse/neglect in (community) is: _____ very effective; _____ moderately effective; _____ not effective; _____ very ineffective?

55) What do you see as the major problems, if any, which inhibit the efficient operation of the child abuse/neglect system here?

56) What would need to change in order to solve these problems?

57) Who do you think should have the responsibility for effecting these changes?

Name of Unit _____

DATA TABULATION FORM FOR PROTECTIVE SERVICES

1976

II(a).

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
A. ABUSE REPORTS													
1. No. New Reports Received													
2. No. Repeat Reports Received													
3. No. Reports Investigated													
4. No. Reports Substantiated													
B. NEGLECT REPORTS													
5. No. New Reports Received													
6. No. Repeat Reports Received													
7. No. Reports Investigated													
8. No. Reports Substantiated													
C. TOTAL ABUSE AND NEGLECT REPORTS													
9. Source of Reports:													
a. Protective Services													
b. Physician													
c. Hospital													
d. Law Enforcement Agency													
e. School													
f. Court													
g. Other Agency													
h. Spouse													
i. Sibling													
j. Relative													
k. Acquaintance, Neighbor													
l. Anonymous													
m. Unknown													
n. Self-Referral													
10. No. of Reports (Cases) Accepted for On-Going Services													
11. No. of Reports Referred to Court													
12. No. of Reports Referred to Other Treatment Agency													
13. No. of Reports Referred for Foster Care/Placement													
14. No. Reports Forwarded to Central Registry													
15. No. Reports Forwarded to Court													

DEFINITION FOR DATA TABLUATION FORM
PROTECTIVE SERVICES

DEFINITIONS FOR COMMUNITY DATA FORM:

1,5. No. New Reports Received: Reports of cases which are new to this agency, i.e., the agency has not received any reports on them previously, and has not had them as a case.

2,6. No. Repeat Reports Received: Reports of cases on which this agency has previously received reports, or has previously had as a case.

3,7. No. Reports Investigated: Of the reports received (#1,2,5 & 6), the number for which an investigation was performed. Investigation refers to whatever activities this agency specifies as constituting an investigation, e.g. home visits, telephone contacts, contacting other agencies, etc.

4,8. No. Reports Substantiated: Of the reports received, the number which are substantiated cases of abuse or neglect, according to this agency's standards for case substantiation.

9. Source of Reports: Source of the report to this agency.

9a. Protective Services: Cases identified within this agency, either by the Protective Services Unit or by another unit of the agency.

10. No. of Reports Accepted for Ongoing Services: Of the reports received, the number which have been accepted for provision of ongoing services by this agency. Excludes cases which have been opened for an initial investigation or evaluation only. Refers only to cases which will remain open for some ongoing service provision.

11. No. of Reports Referred to Court: Of the reports received, the number which have been referred to the Court for investigation, hearings, or some other court action. These may be cases which will remain with your agency, or will be terminated from your agency upon referral to Court.

12. No. of Reports Referred to Other Treatment Agency: Of the reports received, the number which have been referred to another agency for treatment, either in addition to the services they will be receiving from this agency or as an alternative to services from this agency.

13. No. of Reports Referred for Foster Care/Placement: Of the reports received, the number which are referred for placement or foster care--this may be to a foster care unit in this agency, to another foster care agency, to the Court, or whatever is the appropriate mechanism for foster care or placement referral. Placement includes, in addition to foster care, institutional placement, placement with other individuals (including relatives) and adoption.

14. No. Reports Forwarded to Central Registry: Of the reports received, the number on whom reports were forwarded to the Central Registry.

15. No. Reports Forwarded to Court: Of the reports received, the number on whom reports were forwarded to the Court for its information. This is to be distinguished from item 11, which involves actual referral to the Court for services, hearing, etc., although, of necessity, a referral to the court implies that a report is simultaneously forwarded. Therefore, all referrals should be counted as reports also. "Reports forwarded" means simply that the Court has been informed, for its records, of the case.

PROJECT NAME _____

LOG OF ABUSE/NEGLECT COMPLAINTS/REFERRALS NOT PROVIDED ON-GOING PROJECT SERVICES

N-C19A
BERKELEY PLANNING ASSOCIATES

DATE	FAMILY NAME	ADDRESS	SOURCE OF REFERRAL	REPEAT REPORT Yes/No	ABUSE OR NEGLECT	ASSESSMENT/ EVALUATION (No/Yes/Type; e.g., home visit, telephone contact	SUBSTANTIATED Yes/No	TO WHOM REFERRED: Court, Foster care/ placement, other (specify)	REPORT SENT TO: COURT	REPORT SENT TO: CENTRAL REGISTRY	REASON FOR NOT PROVIDING ON-GOING SERVICES

Project Name _____

Please check (or write in) the appropriate boxes

PROJECT LOG OF COMMUNITY COORDINATION/EDUCATION ACTIVITIES

Berkeley Planning Associates N-C1108

Date (write in)	Local Agency/Organization	Type	Description	Purpose/Subject Area	Attendance (write in)	No. staff involved (write in)	Results	Comments
	Schools	Professional Educa.	Speech	Etiology of abuse/neglect			Request for Add'l. Education	
	Police	Community Education	Seminar/Workshop	Increased knowledge of reporting laws			Volunteers Recruited	
	Hospitals	Inter-Agency Coord.	Conference	Increased knowledge of project			Formal Procedures Implemented	
	Protective Services	Intra-Agency Coord.	Meeting	I.D. of cases			New Services Developed	
	Court	Other	Pamphlet/Poster Distribution	Child Development			New Legislation Adopted	
	Day Care		Other Written Documentation	Research			Increased Referrals to Project	
	Nurses		Other	Coordination of Existing Services			Informal Results	
	Other Agency			Development of New Services			Other	
	Students			Legislative Action				
	General Community			Other				
	TV/Radio							
	Newspaper/Magazine							
	Other							

SECTION VIII

THE CHILDRENS COMPONENT

Instrument Development

Although many of the projects in the demonstration effort provided some services to children (e.g., day care, psychological testing, family therapy, crisis nursery, or referral for medical and other treatments) only three of the projects, the Family Center in Adams County, the Family Care Center in Los Angeles, and the Family Resource Center in St. Louis, provided what could be called therapeutic services of sufficient duration and intensity that any measurement of change in the children's deficits or problems would be feasible. At these projects, the clinicians working with the children saw them frequently enough (often every day) over a sufficiently long period, to become thoroughly familiar with their problems and to be able to assess variation in behavior and functioning. Therefore, although some basic information relative to children was collected at all eleven projects, data collection as it relates to more specific concerns about the characteristics of abused and neglected children and their progress while in treatment was carried out only at the above mentioned sites.

Early in the course of this evaluation study, a thorough review of the literature related specifically to abused and neglected children, including all previous studies of these groups of children, a focused review of the child development literature, and an in-depth review of available standardized tests was carried out. From this review, and with the advice of consultants[1] and demonstration project staff who had had experience in the evaluation and/or research of abused/neglected children, a preliminary recordkeeping form to be used for all children receiving direct services from the Adams County and St. Louis projects was developed in the Spring of 1975 (the Los Angeles project did not begin seeing children until October 1975.) This recordkeeping form and accompanying instruction manual,

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We gratefully acknowledge the contributions to this evaluation design made by Elizabeth Elmer, Carolyn Newberger, Martha Rodeheffer and Carol Schneider.

a paper discussing the develpment of the form, a paper on the general characteristics and problems of abused and neglected children, and a review of various standardized tests for children were distributed to the projects in June, 1975.* The preliminary recordkeeping instrument was pre-tested for six months on all children entering the project during that time. At the end of six months, the pre-test experiences with the form were explored, and based on recommendations from the projects' staff and our consultants, the final instrument, the Children's Progress Booklet was developed and put into practice in January, 1976.

Data Collection

The Children's Progress Booklet required that the clinician working most closely with an individual child to maintain a series of data on that child from the time he/she entered the project until termination. Background information, including the child's age, race, sex, type and severity of maltreatment sustained, and other special characteristics of the child were recorded at intake. Shortly thereafter, the clinicians recorded the child's initial achievement on various standardized developmental tests, primarily the Bayley Scales of Infant Development, the McCarthy Scales of Child Development, and the Peabody Picture Vocabulary Test depending on the child's age (not all children, therefore, received a "battery" of tests.) These tests were chosen for two primary reasons:

(1) they are widely accepted, well-standardized tests for the age groups in question that provide assessments in various areas of child development hypothesized to be relevant to abused and neglected children, and

(2) they tended to be tests already in use at the projects, thus eliminating the need to duplicate, or interfere with the project's established testing sequence.

The tests were repeated at six months intervals and at termination.

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* Copies are available from Berkeley Planning Associates.

Using a checklist of behaviors commonly thought to be problem areas for many abused and neglected children, the clinicians also recorded those problems which a child exhibited upon entry to the project. Up to sixteen behaviors per area were assessed in the functional areas of (1) physical growth and development, (2) socialization skills and behavior, (3) motor skill development, (4) cognitive/language development, and (5) interaction patterns with family, using categories of "no problem, mild problem, or severe problem." In the areas of motor skill development and cognitive/language development, narrative comments from clinicians were elicited in lieu of specific behavior assessments because of the wide variations in ages of the children (age appropriate behavior in these areas were too numerous to be listed) and because the results of standardized tests present a more complete and accurate picture of a child's overall functioning in these areas.

Progress toward overcoming identified problems in each functioning area were rated at quarterly intervals, and a final scoring was completed at termination. Narrative comments relevant to the child's progress were also recorded.

Finally, the frequency with which the children received any services from the project or other community agencies (if known to the project), any reincidence of abuse or continuing neglect, and the occurrence of a major event in the child's life (e.g., placement away from home, a family move, loss or gain of a family member) were recorded monthly.

The data were collected for all children entering the projects (or receiving services from the projects) between January 1976, and February 1977 (some data was also recorded retrospectively for children entering before January 1976, although this was an individual project's decision). A preliminary analysis of the data was conducted in June 1976, and all the forms were collected for the final analysis in March 1977.

Data Analysis

The data were edited and coded by BPA staff. Due to the nature of the data and the desire to conduct interpretive analysis as well as statistical analyses, some of the analysis was carried out manually, although certain analyses, such as frequency distributions of problems and all correlations

of variables were conducted by computer, using an SPSS package.

The data were analyzed first by individual projects, and then for children at the three projects combined. Frequency distribution and percentages for all intake and termination variables including test scores were computed.

For those children whose parents were also receiving services from the projects, certain data from the Adult Client component of this evaluation relative to the child's family (e.g., socio-economic status, previous record of abuse/neglect, primary problems of the parents at intake) were also retrieved. These data were used primarily in a qualitative fashion in this analysis, to further explore the familial characteristics of the child's environment.

Finally, simple correlations between variables hypothesized to be of interest (such as the correlations between progress in treatment and reincidence) were carried out. The number of children on which we had data was too small to warrant any higher order analyses.

CHILDREN'S PROGRESS FORM

Intake Information

Child's Name _____ Date of Birth ___/___/___/___
mo. day yr.

Sex: _____ Race: White ____ Black ____ Spanish Speaking ____ Other _____

Date Entered Program: ___/___/___/___ Date Terminated: ___/___/___/___
mo. day yr. mo. day yr.

Special Characteristics:

____ Premature
____ Product of Multiple Birth
____ Adopted/Foster Child
____ Mentally Retarded
____ Emotionally Disturbed
____ Learning Disorder
____ Other (specify) _____

Severity of Case:

For Abuse	For Neglect
____ Severely injured	____ Severely neglected
____ Moderately injured	____ Moderately neglected
____ Mildly injured	____ Mildly neglected
____ Emotional abuse	____ Emotional neglect
____ Sexual abuse	____ Failure to thrive
____ Potential abuse	____ Potential neglect

With whom is child living? _____

Who has legal custody of child? _____

Explain the circumstances surrounding the current abuse/neglect situation, and the specific maltreatment received by the child.

Worker's Name _____

TESTING RECORD

(Please circle any Termination Tests)

WECHSLER INTELLIGENCE SCALE	Date Tested: / /	Date Tested: / /	Date Tested: / /	Date Tested: / /
Age Equivalent Score				
I.Q. Score				
McCARTHY SCALES OF CHILDREN'S ABILITIES	**Date Tested: / /**	**Date Tested: / /**	**Date Tested: / /**	**Date Tested: / /**
Verbal Score				
Perceptual Performance Score				
Quantitative Score				
Memory Score				
Motor Score				
General Cognitive Score				
BAYLEY SCALES OF INFANT DEVELOPMENT	**Date Tested: / /**	**Date Tested: / /**	**Date Tested: / /**	**Date Tested: / /**
Mental Development Score				
Psychomotor Development Score				

Other Tests (Specify test and sub-test area. Write in dates and skip one line between tests)

Test	Date Tested: / /	Date Tested: / /	Date Tested: / /	Date Tested: / /

Physical Characteristics and Growth Patterns at Intake

Date Completed: ___/___/___/___
mo. day yr.

Physical Exam Performed? _____ Results: _____

Re-Exams Scheduled? _____

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESS-MENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Psychosomatic physical problems				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorders				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PATTERNS:

Socialization Skills and Behavior at Intake

Date Completed: / / / /
mo. day yr.

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESS-MENT POSSIBLE
Agression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PLAN:

Cognitive/Language Development At Intake

Date Completed: ___/___/___/___
mo. day yr.

INITIAL OBSERVATIONS AND PROBLEMS NOTED:

GOALS:

TREATMENT PLAN:

Motor Skill Development At Intake

Date Completed: / / / /
mo. day yr.

INITIAL OBSERVATIONS AND PROBLEMS NOTED:

GOALS:

TREATMENT PLAN:

Interaction Patterns With Family at Intake

Date Completed: / / / /
mo. day yr.

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Responsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parent's expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PLAN:

Diagnostic Summary

Quarterly Progress

Month: _____ (write in)

Physical Characteristics and Growth Patterns

Physical Exam Performed? _____

Results: _____

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESSMENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorder				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Socialization Skills and Behavior

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESSMENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Infer Quarterly Progress

Month: _____ (write in)

Cognitive/Language Development

PROGRESS NOTES AND OBSERVATIONS:

Cognitive:

Language:

Progressed ____

Regressed ____

No Change ____

No Assessment Possible ____

Quarterly Progress
Motor Skill Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Progressed ____
Regressed ____
No Change ____
No Assessment Possible ____

Quarterly Progress

Interaction Patterns with Family

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Unresponsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parents' expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Termination Information

Date Terminated: / / / /
mo. day yr.

Reason for Termination:

What arrangements for child have been made:

Physical Characteristics and Growth Patterns at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Psychosomatic physical problems				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body-rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorders				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Socialization Skills and Behavior at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Cognitive/Language Development at Termination

FINAL OBSERVATIONS

Cognitive:

Language:

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

FINAL OBSERVATIONS:

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Interaction Patterns with Family at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Responsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parent's expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

I.D. No. | | | | | | | | |
(BPA Use Only)

Services Provided to Child by Project or Other Agency

SERVICE CATEGORIES	August		September		October		November		December					
	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other
Day Care (no. hours) (23-24)														
Child Development Program (no. sessions) (25-26)														
Play Therapy (no. sessions) (27-28)														
Individual Therapy (no. contacts) (29-30)														
Medical Care (no. visits) (31-32)														
Testing (no. tests) (33-34)														
Speech or Other Specialized Therapy (no. sessions) SPECIFY TYPE _____ (35-36)														
Foster Care ("X" if Yes) (37)														
Residential Care (no. days) (38-39)														
Crisis Nursery (no. days) (40-41)														
Advocacy Services (no. times) (42-43)														
Other (specify) _____ (44-45)														
Other (specify) _____ (46-47)														
	(175)		(176)		(177)		(178)		(179)					

Place an (X) in the box if any of the following occurred during a given month:

	August	September	October	November	December		
Death of child, due to abuse (48)							
Severe physical abuse (49)							
Moderate physical abuse (50)							
Mild physical abuse (51)							
Sexual abuse (52)							
Emotional abuse (53)							
Death of child, due to neglect (54)							
Severe physical neglect (55)							
Moderate physical neglect (56)							
Mild physical neglect (57)							
Failure to thrive (58)							
Emotional neglect (59)							
Child moved (60)							
Loss of family member (61)							
Gain of family member (62)							
Court Action (63)							
Child removed from home (64)							
Child returned to home (65)							
	(175)	(176)	(177)	(178)	(179)		

INSTRUCTION MANUAL

FOR

CHILDREN'S PROGRESS FORMS

EVALUATION

OF THE

NATIONAL DEMONSTRATION PROJECT

IN

CHILD ABUSE AND NEGLECT

(January 1976)

TABLE OF CONTENTS

THE CHILDREN'S PROGRESS FORM - OVERVIEW

The Children's Progress Form was developed as an evaluative instrument for assessing the development and progress of children who are receiving direct services from any of the Demonstration Projects. In addition, it will, hopefully, serve as a means for the clinicians working with children to maintain adequate information on these children for case management purposes.

There are basically 7 sections to this booklet for children. The first page requires minimal Intake Information on the child (which is supplemented by Intake Information on the family recorded on the regular BPA Intake Sheet). Page 2, the Testing Record, provides space to record the scores of all tests administered to the child. The third section (pages 3 through 7) is to be used for recording initial information on the child's functioning in the areas of Physical Growth and Development, Socialization Skills and Behavior, Cognitive and Language Development, Motor Skills, and Interaction with Parents and Other Family Members. The fourth section of the booklet (page 8) is the Diagnostic Summary Sheet to be used for synthesizing the total information. The fifth section (pages 9 through 23) contains quarterly forms on which the progress of the child in each of the functioning areas specified above. The sixth section of the booklet (pages 24 through 28) are the forms to be filled out when a child is terminated from services. There are separate forms, again, for each of the five functioning areas. The final page of the booklet (page 29) is the Services to Children form, which is to be filled out monthly.

The forms in this booklet may be used as the case record for the child if they prove adequate for that purpose in the projects' opinion. If, on the other hand, projects feel they require more information than this booklet calls for, or they would like the information more frequently than quarterly, the booklet may be used to summarize information from the projects' weekly or monthly record-keeping instruments. Our interest at the current time is in having a mechanism which describes the status of the child at entrance to the program, the services he/she receives, his/her progress at quarterly intervals, and the status of the child at termination, as well as an indication of the tests (or observations) used by each project to make this determination of "progress."

WHO SHOULD FILL OUT THE BOOKLET?

The clinician(s) working most closely with the child should fill out the forms in the booklet. If other individuals are responsible for various portions of the child's program or therapy (e.g. testing specialists), the primary clinician(s) should consult with these individuals when completing the forms.

WHEN SHOULD THE FORMS BE FILLED OUT?

The Intake Form (page 1) should be filled out at the time the child is entered into the project. (The regular Intake Form [gold] is also filled out for the family at that time.)

The Testing Record (page 2) form should be filled out each time any test (standardized tests, checklist forms, structured observations, etc.) are administered to the child.

The five Initial Functioning (pages 3 through 7) and Diagnostic Summary (page 8) forms are to be filled out at the time the initial diagnostic and treatment planning phase for the child has been completed. For some projects, this phase may not be completed for several weeks in order to space out any tests which are to be administered and/or allow the clinician(s) to become somewhat more familiar with the child. However, these forms should definitely be completed within one month after the child's entry into the project.

The Quarterly Progress forms (pages 9 through 23) are to be filled out three months after the Initial Functioning form, and every three months thereafter. Thus if a child entered the project in January, and the Initial Functioning forms were completed that month, the Quarterly Progress forms for that child would be filled out in April, July, and October. Children currently in the project's caseload should have Quarterly Progress Forms filled out in January, April, July and October of 1976. Because this booklet is intended to be used only through July, 1976, only three sets of Quarterly Progress forms have been included.

The five Termination forms (pages 24 through 27) are to be completed at the time the child is terminated (or drops out) from services.

The Services to Children form (page 28) is to be filled out each month that the child remains in the project.

EXPLANATION OF FORMS

1. Intake Form:

All required information on the Intake Form should be recorded when the child first enters the project. Please provide sufficient detail in describing the circumstances of the current abuse/neglect incident and the maltreatment (i.e. broken bones, burns, psychological trauma) received by the child. If more than one clinician is working with the child, the primary worker's name should appear on the form.

2. Test Record Form:

This form provides spaces for recording the scores of the three standardized tests which are to be administered to all children, the

Vineland Scale of Social Maturity, the McCarthy Scale of Children's Abilities, and the Bayley Scales of Infant Development (for children under 30 months only).

The righthand side of the form may also be used for recording the scores of any other tests administered to the child. The name of the test and the sub-test areas should be specified.

Please be sure to date all test results.

3. Initial Functioning Forms:

These five forms provide spaces for evaluating the child's level of performance and behavior when he/she enters the project in five specific areas. The Physical Characteristics and Growth Patterns, Socialization Skills and Behavior and Interaction Patterns with Family forms contain both a checklist of specific problems which are each to be rated and space for narrative related to other observations, the goals and treatment plans. The forms for Cognitive/Language Development and Motor Skill Development contain space for a narrative explanation of the child's problems at Intake in these areas, the goals of treatment and the treatment plans.

On the forms with checklists, please be sure to rate each problem area (definitions of these areas are found on pages 5 through 11 of the Manual. If there are other specific problems in the three functioning areas with checklists, these may be written in the "other" lines, and assessed in the same manner as the checklist indicates. If the "other" line is used, however, the same problems should be assessed each quarter on the Progress forms, and a final rating should be given them on the Termination form. On the forms without checklists, the problems noted should be as specific as possible.

The Goals established for the child in each functioning area should relate to the problems noted for that area. For example, if the problem is a lack of ability to play cooperatively, the goal might be to have the child "play with at least two other children for 15 minutes."

The Treatment Plans should explain what programs, therapies, or activities are to be undertaken with the child to help reach the established goals.

4. Diagnostic Summary Forms:

The Diagnostic Summary form is to be used for an overall assessment or description of the child which incorporates information from the preceding forms, the results of tests, and the clinician's observations. The comments or recommendations of outside consultants, therapists, testing specialists, etc., should be incorporated in this overall assessment.

5. Quarterly Progress Forms:

There are three sets of five Quarterly Progress forms. Each of the five forms is to be filled out every 2 months, beginning with the third month after the child has been accepted for services and the five Initial Functioning Forms have been completed. As with the Initial Functioning Forms, the Progress forms for Physical Characteristics and Growth Patterns, Socialization Skills and Behavior and Interaction Pattern with Family include both a checklist for depicting progress (or the lack of it) on specific indicators, and space for narrative comments. The Cognitive/Language Development and Motor Skill Development forms contain an overall rating scale for the whole functioning area, and space for narrative comments.

For both the checklist of specific indicators and the overall ratings, the ratings of progress should be made in comparison to the rating made the preceeding quarter, not from the time the child entered the project. For example, even though a child's motor skills may have improved overall since entering the project, if they have not improved during the preceeding 3 months, the "no change" column should be checked. Also, if some behavior has gotten worse during the last 3 months, even though, overall, the child has made improvements in that area since entering the project, the "regressed" column should be checked.

Please remember to write in, and assess the progress of any problems which were written in the "other" category on the Initial Functioning Forms with checklists.

On the forms without checklists (Cognitive/Language and Motor Skills) reference should be made in the progress notes to those problems identified for each area in the Initial Functioning Forms.

The "No Assessment Possible" category should be used only if, for some reason, the clinician has been unable to sufficiently observe or test the child in a specific area in order to make a judgment (e.g. the child has been hospitalized for a long period or placed in a foster home).

6. Termination Forms:

The five Termination Forms are to be filled out at the time the child ceases to be considered a project "case." The "Reason for Termination" should be as specific as possible, e.g. "all goals accomplished" or "parent withdrew child from the project." "What Arrangements Have Been Made for the Child"refers to any special plans for the child after termination, e.g. "child has been enrolled in pre-school/day-care," or "child has been placed with foster parents."

In addition to these questions, the five forms have both checklists for rating the status of specific indicators at termination and spaces for

narrative explanation of the Goals Accomplished, Problems Remaining, and Recommendations.

NOTE: Any final tests administered to the child should be recorded on the Testing Record (page 2).

7. Services to Children Form:

The Services to Children Form is to be completed each month to detail all services received by the child. The first column, marked "Pro.," refers to all services provided directly by the project. The second column, marked "Other," includes all services received by the child from other sources, e.g. Day Care Program, Child Guidance Clinic, etc. This column should also be used to show all services purchased for the child by the project from other sources.

When completing the Services form, please be sure to use the unit (e.g. sessions/contacts/times, etc.) specified for the particular service category.

The bottom half of the Services form has spaces for noting whether any significant events have occurred during the month which may help to explain changes in the child's functioning. An (X) should be placed in the appropriate box if any of these events have taken place during the month.

EXPLANATION OF THE FIVE DEVELOPMENTAL/FUNCTIONING AREAS

The five developmental/functioning areas we have delineated for the evaluation of children's progress cover most of the specific characteristics, behaviors and situations which clinicians have found some abused/neglected children exhibit during treatment. Some of these areas, such as social behavior, are best evaluated through observation in the treatment setting, while others, such as cognitive development, require the administration of some test(s) which have been standardized to provide normative information on a large number of children. The possible drawbacks of these tests for use for abused/neglected children are discussed in the accompanying review of standardized tests. However, at the moment, they are still the best mechanisms available for assessing cognitive, language, and motor skill development.

Within the generic areas outlined (physical characteristics and growth patterns, socialization skills and behaviors, cognitive and language development, motor skill development, and interaction with family), there are numerous indicators of the strengths and weaknesses of the child. The following list of indicators are the ones felt to be applicable to abused and neglected children, and those in which negative findings would indicate deficits which require remediation. With the exception of some

of the standardized tests, particularly the Intelligence tests, the following indicators are most appropriate for children ages 0+ to 10 years. Other indicators will need to be developed if projects begin to work with older children.

These indicators, again, represent only a beginning list, and clinicians working with children should feel free to add other indicators as their experience uncovers additional problems which appear characteristic of abused/neglected children.

A. Physical Characteristics and Growth Patterns

The following are indicators which help to pinpoint problems in this area.

1. Height/weight/head circumference: Are each of these within the normal range for the child's age?

2. Physical defects: Does the child display any untreated fractures, sprains, hematomas, eye or ear damage, or general physical weakness? These are usually best assessed through a physical examination and the injuries may be pre or post abuse/neglect.

3. Sleeping patterns: Does the child have any sleeping pattern disturbances, including an inability to sleep regularly, prolonged sleep, animal dreams, or an inability to wake up refreshed? This is usually best ascertained from the mother or caretaker, although programs which include "nap time" may provide the opportunity for assessing this indicator.

4. Eating patterns: Does the child eat incessantly if given the chance, does he hoard food, or is he totally unresponsive to food and eats, if at all, mechanically? This should be distinguished from the "finicky" eater, a stage most children go through at some time.

5. Malnutrition: Is there any evidence of malnutrition in the child?

6. Crying: Does the child cry incessantly, cry through seemingly unprovoked, or not cry when he is obviously distressed or hurt? Is his crying of the lusty, angry variety, or does he withhold that emotion and merely whimper and whine?

7. Pain agnosia: Is the child immune to pain, e.g. appears not to feel pain even when obviously hurt fairly seriously?

8. Pain dependent behavior: Does the child purposefully injure himself or engage in activities which are painful or self-mutilating, e.g. head banging?

9. Psychosomatic physical problems: Does the child exhibit emotionally related physical problems such as persistent eczema, asthma, enuresis or bowel problems? These should be distinguished from occasional wetting or soiling problems when highly excited or engrossed in a certain task or play.

10. Hyperactivity and hyperresponsiveness: Is the child in constant motion, unable to control his body movements, or unable to respond to situations at a level appropriate for his age?

11. Tics, twitches, body rocking: Does the child exhibit facial or other tics, twitches, or engage in excessive body-rocking?

12. Bites nails or fingers: Does the child incessantly bite his nails and fingers, particularly in normally non-stressful situations?

13. Failure to recuperate following physical illness: Does the child require an excessive amount of time to recover from normal childhood illnesses, including lack of energy, prolonged sleeping, constant irritability? Is he/she sick more than usual, or does he/she appear to be generally physically weak?

14. Stuttering/stammering/other speech disorders: Does the child exhibit these or any other speech disorders which interfere with his ability to verbalize? These should be distinguished from baby talk (unless the child is past 5 years of age) or an inability to correctly pronounce certain words or consonants, e.g. "wight" for "right."

B. Socialization Skills and Behaviors

1. Aggression/acting out: Is the child overly aggressive; fights constantly with others, bullies, or ridicules other children?

2. Apathy/withdrawal: Is the child generally uninvolved with his surroundings, stares blankly, unresponsive to stimuli both painful and pleasant?

3. Affection: Is the child able to give, and receive, affection from others?

4. Happiness quotient: Is the child generally happy, smiling, content, or is he unhappy, crying, distressed, generally worred about many things?

5. Hypermonitoring: Is the child constantly "on his guard," vigilant about the situation or people (particularly adults), appearing to expect trouble or adversity to the point of interfering with his/her involvement with tasks or play?

6. Attention span: Does the child wander aimlessly from one activity to another, have trouble becoming or staying involved with playthings?

7. Accident proneness: Does the child constantly run into things, spill things, or fall? (Although this may be a sign of neurological problems, it is more often a lack of body awareness.)

8. Ability to protect self: Can the child protect himself in dangerous situations, or from other bullying children, or does he/she seem oblivious to peril and acquiescent when threatened?

9. Sense of self: Does the child have an age-appropriate sense of who he/she is? Does he respond to his name, appear proud of his accomplishments?

10. Attachment/detachment to parents/other adults, objects: Does the child indicate a strong sense of feeling for his family; is he/she discriminating in his acceptance of strangers; is he/she overly attached to certain objects or ways of doing things? Is he/she reasonably distractable when familiar people must depart or when objects are left behind?

11. Reaction to frustration: Does the child over-react to an inability to perform, e.g. throw temper tantrums? Is he/she somewhat creative in his approach to problem solving? Does he give up easily?

12. Reaction to change: Does the child overreact to changes (moving, a change of routine, a new activity) by screaming, withdrawing or constantly referring to the previous situation? Can he be distracted with a new situation? Is the reaction of severely long duration?

13. General interaction with adults: Does the child generally enjoy and get along with adults, and while initially wary of strangers, does he/she usually "warm up" given some time and encouragement? Is he/she looking for constant attention, or always prefer children to adults for compansionship? Does he/she deliberately "test" or provoke adults?

14. General interaction with peers: Is the child able to enjoy and play cooperatively with other children for a time period appropriate to his/her age? Is she/she able to perform adequately in either the "leader" or "follower" role? Is the child a constant loner, or does he/she usually enjoy compansionship? Is he/she looking for constant attention or always prefer adults to children for compansionship? Does he/she kick, bite or tease other children? Do other children avoid interacting with him/her?

C. Cognitive and Language Development

The areas of cognitive and language development do not lend themselves easily to the kinds of specific indicators used for the other areas. Both

involve a long process of building upon previous skills and knowledge learned at different times for different children.

For younger children, cognition usually includes the child's ability to understand signs and symbols; his discrimination of form, size, color, depth, space, position, and permanence of objects, and the internalizing of certain repeated activities and situations. For the older child, cognition involves an increasing ability to receive and process information, to solve concrete problems, to conceptualize quantities, numbers, and time, and an ability to generalize and to see relationships and think logically.

In younger children, verbal skills include discriminating among sounds, beginning to articulate certain sounds, and eventually speaking in a reasonably coherent fashion although often omitting pronouns and articles. The older child will begin to use phrases, to speak in appropriate tenses and to verbalize his experiences (story-telling) as well as just articulating his needs or repeating what he has heard.

Although there are some obvious signs that a child's cognitive and language development is lagging, e.g., the child of three does not speak at all, or the child of five cannot recognize very simple pictures he has seen repeatedly, it is difficult in many cases to clearly recognize deficits in these areas, because the child's cognitive and language skills change so rapidly between the ages of 2 and 7 years.

In general, cognitive and language development is most easily assessed through the use of standardized tests which normally include sub-tests in five or six areas, all of which, when combined, make up a general cognitive or language (verbal ability) score. Some of these tests include the Bayley Scales of Infant Development, the Denver Developmental Screening Test, the Goodenough Harris Drawing Test, and the Illinois Test of Psycholinguistic Abilities. Any of these tests might be used to measure a child's cognitive and language ability, although each test is designed for different age ranges.

D. Motor Skills

Like cognitive and language development, the development of motor skills, both normative and perceptual, are less easily evaluated without the aides of some standardized tests or checklists to enable the child's performance to be measured against other children of his/her age group. Again, as with cognitive and language development, motor skills are acquired by building on previous skills and through repetition.

Examples of gross motor skills in children include walking, running, hopping on one foot, throwing a ball, balancing on a beam, etc. Fine motor skills include finger and hand dexterity measures such as unbuttoning a coat, picking up small items, catching a ball, etc. Perceptual motor

abilities involve associating a motor image with its corresponding visual, auditory or tactile one. This includes copying a circle or line, drawing a man or woman, tracing a line in a maze, or building a block tower.

Although it is certainly possible to assess the child who cannot perform the above tasks (or other motor skill tasks) without age-specific standards of "normal" children, it is difficult to determine whether a child's inability to perform at a certain age is a definite deficit in that area or merely that his motor skills are developing at a slightly decelerated pace which will accelerate eventually of its own accord.

Some of the tests which assess a child's motor skills include the Bayley Scales of Infant Development, the Denver Developmental Screening Test, and the McCarthy Scales of Children's Abilities.

E. Interaction Patterns with Family

1. Weak child-parent bond: Does there appear to be little understanding, caring or interest between parent (particularly mother) and child? Especially in infants and toddlers, is there an overt affection and interest by the parent in the child's activities and interests?

2. Fearfulness toward parent: Does the child appear afraid of the parent, hesitant to approach him/her, or resist physical closeness?

3. Unresponsiveness toward parent: Does the child ignore the presence of the parent; does he physically or otherwise remove himself from any interaction, or deliberately not listen to the parent?

4. Parent's perception of child's needs: Does the parent appear to perceive what the child is asking for when exhibiting certain behaviors? Can he/she discern the difference between the child's need for attention, companionship, help, direction or comforting by the behavior of the child?

5. Parent's response to child's needs: Does the parent appear to understand/accept the child's needs and provide an appropriate response? Does the parent respond with anger, embarrassment or indifference to child's fear, distress or pain?

6. Child's ability to share feelings: Is the child included in sharing experiences; can the child explain his/her feelings appropriately? Is there a sense between family members that they constitute a close, intimate unit? Do family members support one another?

7. Provocativeness/pain dependent behavior: Does the child deliberately do things to provoke the parents' anger; does he persist in an activity when repeatedly requested to refrain from it? Does the child appear to expect punishment, and seem almost resigned/pleased when it occurs.

8. Role reversal: Does the child adopt a "parenting," protective attitude toward the parent, becoming solicitous and over-anxious to please? Is he constantly looking for signs and signals as to what the parent needs and then providing an appropriate response?

9. "Differences" from parents' expectations: Does the parent give clues that the child's personality, looks or behaviors are inherently different from what he/she expected or desired? Some examples might be, "All my other children talked (or walked, played games, etc.) by this age," "She's so unattractive," or "He's always in the way."

10. Harsh discipline: Does the parent exact extreme punishment for seemingly minor infractions? Is corporal punishment very harsh or inappropriate to the child's age? Is there a reconciliation period quite soon after the punishment?

In using the above indicators as guides for determining the strengths and weaknesses of individual children, there are some important things which should be kept in mind. First, these indicators (and any standardized tests administered) are not toally comprehensive in nature. There may be other characteristics, behaviors or deficits beyond those we have collected which constitute a warning signal that the child is having problems in a particular area. The workers should feel free to include other indicators in either the checklists or the narrative descriptions which they believe to be important manifestations of developmental lags or maladjustments.

Second, there will obviously be times when a child exhibits a variety of negative behaviors or the parent-child interaction appears less than satisfactory. No isolated incident of behavior nor an infrequent constellation of behaviors should be cause for diagnosing a child as having a major problem, since children, like adults, have marked mood swings and "off-days." What should be looked for are patterns of behavior which are both consistent and of long duration, as it is these patterns which are most indicative of major problems.

Finally, in completing those sections of the booklet requiring information on the five functioning areas (the initial functioning form, quarterly progress notes, and termination information), it should not be inferred either that a child will (or should) be tested in each area, or that he would exhibit problems in each area. It is quite possible that a child would manifest deficits in only one or two of the areas, or that within a given category, the child might display negative behaviors or test scores on only a few of the indicators. It remains with the clinicians working most closely with the child to determine whether the preponderence of evidence suggests that the number of deficits exhibited, or the intensity of the deficit warrants that they be labeled as real problems, and that they therefore are to be included in the child's goals of treatment and treatment plan. For any of the five areas where a child exhibits only one problem,

and this is not severe, it is unlikely that the clinician would consider the child to have a general deficit in that area. If, for example, the child appears competent in all socialization areas for his age group, but is prone to accidents, it is doubtful whether the clinician would diagnose the child as having a significant socialization/behavior problem.

SECTION IX

THE ADULT CLIENT COMPONENT

An integral part of the BPA evaluation of the National Demonstration Program in Child Abuse and Neglect was the Adult Client Impact Analysis. In this component, we were interested in determining what kinds of adult clients the projects were serving, what kinds of services are provided to those clients, what kinds of changes these clients undergo during the course of treatment, and what the effectiveness and cost-effectiveness of alternative service strategies are. The purposes of the Adult Client Impact Component were:

(1) to describe the demographic and case history characteristics of the clients served;

(2) to determine what kinds and what quantity of services are provided to adult clients;

(3) to determine what kinds of outcomes projects had on their clients;

(4) to begin to assess the effectiveness and cost-effectiveness of alternative service strategies or mixes of services for different types of abusers or neglectors.

In this section we describe the methodology used for collecting, processing and analyzing information from the projects on their adult clients in order to achieve the above purposes. In Part I, we discuss the Data Base, including the data collection instruments, training clinicians in their use, collection of data, methods for checking data reliability, utility and validity, data storage and processing, and the kinds of data. In Part II we present the sequencing of steps in the analysis, the kinds of techniques used and the rationale for decisions made.

Part I: The Data Base

Overview

All of the objectives of the client analysis required the collection of data on individual cases served by the projects. The data were collected on every adult client who entered the projects' caseloads from January 1975 through November 1976, and to whom treatment services were provided directly by the projects. The data were recorded by those case managers in the project who had direct contact with the client, with assistance from others providing treatment services to the client. This may have been one or more individuals. In very few instances was the person filling out the form a lay or volunteer worker; lay or volunteer workers did, however, provide information to case managers which was used in completing the forms.

The Data Collection Instruments

A number of different forms were completed on the clients, at various points during the treatment process. These included:

INTAKE FORM: This form, which is a modified version of the American Humane Association National Reporting Form, was completed by the end of the intake process, typically within one month after the initial report on a case was received, and reflects data on the entire family. Information includes: source of referral; case status; severity of case; identification of perpetrator; legal actions taken; number, age, and sex of children in family; size of household; ages, marital status, education, race or ethnicity and employment status of parents; sources and amount of family income; primary problems of parents which help explain actual or potential abuse/neglect situation; and services planned for parents and children.

GOALS OF TREATMENT FORM: By the end of the intake process when goals of treatment have been specified, these goals were recorded on the top portion of the form. If these goals changed during the course of treatment, such changes were noted. At the time of termination, the extent to which the treatment goals were accomplished was recorded.

CLIENT IMPACT FORM: Clinicians rated individual parents on their functioning in relation to 13 proxy measures which are indicative

of a parent's proclivity towards abuse or neglect as well as rating the parent's potential for future abuse and neglect at the time they enter the project's caseload and at the time they are terminated. The proxy measures include: general health; control over personal habits; stress created by living situation; sense of child as person; behavior toward child; awareness of child development; extent of isolation; ability to talk out problems; reactions to crisis situations; way anger is expressed; sense of independence; understanding of self; self-esteem.

CLIENT FUNCTIONING FORM: At the end of each month while a parent was receiving treatment, clinicians indicated whether or not abuse or neglect had occurred, by severity of the incidence, and whether or not any major crises in the parent's life had occurred. The specific reincidence measures are categorized as: death of child due to abuse; severe physical abuse; moderate physical abuse; mild physical abuse; sexual abuse; emotional abuse; death of child due to neglect; severe physical neglect; moderate physical neglect; mild physical neglect; failure to thrive; emotional neglect. The events include: gaining or losing a spouse; changes in employment; moving; being hospitalized; losing a close friend or relative; child returning to or being removed from home. In addition, every one to three months the clinicians recorded whether the parent's functioning had improved, stayed the same or regressed in relation to the measures which appear on the CLIENT IMPACT FORM.

SERVICES FORM: At the end of each month while a parent was receiving treatment, clinicians recorded the frequency with which the parent was receiving different treatment services from the project directly, purchased by the project from other agencies, or from other agencies. The services include: psychological or other testing; review by diagnostic team; social work counseling; parent aide/lay therapist counseling; individual therapy; group therapy; Parents Anonymous; couples counseling; family counseling; alcohol, drug and weight counseling; family planning counseling; 24-hour hotline; crisis intervention; child management classes; job training; homemaking; medical care; welfare; babysitting or

transportation; or certain services for their children. The units of frequency of services differ from one service category to another.

FOLLOW-UP FORM: After a case was terminated, if the project had any contact with the case, a follow-up form was completed which elicited the nature of the follow-up (was it client of clinician initiated, for example), whether abuse or neglect had reoccurred, and the clinician's perception of the parent's potential for future abuse or neglect.

Training Clinicians in the Use of the Forms

The complete set of forms were first introduced to project staff members during site visits in the fall of 1974. Group training in the uses and purposes of the forms was conducted; the rationale for inclusion of certain data items and definitions of specific variables were discussed; questions and concerns were responded to. Following these in-person training sessions, detailed Instruction Manuals were sent to all workers in each project. During each subsequent site visit, staff meetings were held to provide ongoing training -- to go over the forms, instructions on their use, and definitions of terms. At these times any questions clinicians had were discussed, as were solutions to any problems uncovered during previous data collections. While all staff including lay or volunteer treatment workers received training in the use of the forms, the manager on a given case was responsible for filling out the forms.

Collection of Data

As indicated, projects began filling out the BPA forms on all cases accepted into the project's caseload as of January 1, 1975.[1] Case managers filled out the forms as part of their record keeping activities, maintaining the forms in their own case files. Special interviews with clients were not required in order to fill out the forms, although conversations with other workers familiar with the case were often necessary and encouraged. BPA initiated collection of the forms in June, collecting the INTAKE, SERVICES, and FUNCTIONING FORMS on all cases, and all forms on terminated cases. During

[1] A few projects opted to fill out forms on cases opened prior to January 1975.

all future visits to projects, BPA retrieved all forms on terminated cases. Names were removed from these forms and ID numbers assigned at the project sites. Projects, not BPA, maintained the Master List, to ensure confidentiality. In January 1977 projects completed forms on all cases whether they had been terminated or not. By February, all completed forms had been retrieved by BPA.

Data Checking

A critical aspect of the adult client component was the actual checking of the data to reduce the number of errors and missing data and to assess and maximize the reliability and validity of the data. The following discussion explains the steps for checking for errors and missing data, other reliability checks, and generally the process for assessing the comparability of data across workers and projects.

(1) Checking for errors and missing data

First, during each site visit, all forms to be collected and a sample of other forms were scanned by the BPA site liaison person for missing data and obvious errors. Clinicians were requested to complete or correct forms with easily identified problems before they were brought back to the BPA offices. Once forms were retrieved from the projects, a series of error checks were implemented:

(a) retrieved forms were recorded on a log by project and by client ID number, checking to make sure that all forms necessary on a given case had been collected and were filled out.

(b) Forms were then sorted into types (e.g., SERVICES, FUNCTIONING FORMS) and hand edited for missing data, unusual data, poorly formed letters and numbers, and stray marks. If necessary, either the BPA or demonstration project staff were contacted to clarify ambiguities or to supply missing data. If the demonstration projects were contacted, small problems were handled by phone; major problems were handled by mail.

(c) Forms were keypunched and verified; random checking was done of form/card congruency.

(d) Preliminary univariates were run, using SPSS, giving all values for each variable. Out-of-range values (e.g., question

coded 2 when only Blank or 1 is allowable) and unusual values (e.g., $65,000 appears as a client's public assistance income) were spotted and corrected.

(e) Regular univariates were run, including the construction of new variables, and were also scanned for data problems. These univariates were returned to the projects; any problems they noted were corrected.

(f) In other level analyses, including bivariate and multivariate tables and regressions, data errors were watched for and corrected when possible.

(2) Other reliability checks

During three site visits, formal reliability tests were employed. All clinicians were provided with fictionalized child abuse or child neglect cases. The cases included descriptions of the maltreatment of the child and the parent's situation, attitudes and behavior from the parent's perspective, the hospital staff's perspective and the perspectives of others involved with the case. Clinicians were asked to read the case(s) in a meeting run by a BPA staff member and then to complete certain questions on BPA client forms including the severity of the case and the parent's functioning. Once completed forms were collected, clinicians discussed why they rated the case as they did. Discrepancies in rating were discussed to help clinicians understand how BPA would have expected them to complete the forms for the given case; these sessions served as powerful training tools. Comparisons were made across workers and projects to determine which, if any, of these key measures were eliciting unreliable data. Measures consistently found to be unreliable were dropped.

(3) Checking on comparability of service modes across projects

One aspect of the analysis plan called for the pooling of adult client data from across projects (to increase the sample size) and exploring what kinds of impacts different mixes of services produced for different kinds of clients. While the projects differed in many respects -- e.g., organizational base, amount of emphasis placed on treatment versus community education, community context -- there were many common elements of the treatment programs themselves. In addition to analyzing individual project data, it was desirable to look at the entire data set, clustering those services or clients

that were similar across projects, and conducting analyses. In order to do this, one must have confidence that data and the data items collected from different projects are comparable. This means not only checking to make sure that project staff members are interpreting the meaning of variables in the same way (as described in the previous section), but also checking to insure that there is comparability in what services projects are providing to their clients (e.g., group therapy at Project A is akin to group therapy at Project B).

In addition to providing projects with definitions of the different service categories, self-administered questionnaires were used to determine the comparability of same-named service categories across projects. Clinicians were asked to describe the services they offered in terms of certain key service dimensions (such as length of service, setting, focus or orientation, degree of formality, training/experience of provider). The information gathered coupled with informal observations by BPA staff of project service offerings was analyzed to determine similarity of same-named services across treatment workers within a given project and across projects. Where sufficient similarity was found, data on those services was pooled.

Data Storage and Processing

The data were initially stored on cards organized by project, with separate decks representing each of the seven forms. As monthly service and other data were collapsed into aggregate figures for a given case, the data were transferred onto tapes. The tapes are stored at the University of California Computer Center and run on a CDC 6400 computer. FORTRAN has been the language used for some of the merging of data, data processing and data management; most analyses were done using SPSS.

Kinds of Data

(1) Impact data

Recidivism has traditionally been the principal indicator of outcome of service interventions in the child abuse/neglect field. As pointed out in earlier literature reviews, recidivism by itself is not a sufficient measure of program impact, particularly in a study such as this in which we have only collected data on clients while they were in treatment. Some

clients may not reabuse or continue to neglect their children while in treatment because of the supportive or perhaps watch-dog nature of the treatment environment. Reincidence perpetrated by other clients may go undetected by the treatment providers. Some clients will have had their child(ren) removed from the home while in treatment, and reincidence will thus be an irrelevant question of impact during treatment. And, as many studies have shown, recidivism has often not been observed for many clients until two to three years after cases are terminated, even when the short-run lack of reincidence has been ample justification for organizations to close cases as "successfully treated." Researchers such as ourselves and child abuse/neglect programs thus have a need for indicators which suggest long-term changes in family functioning and modification of abusive and neglectful behavior while a client is still in treatment.

We therefore selected four different ways of looking at impact. (One, the extent to which goals of treatment were accomplished for individual clients was used only for a subset of cases -- those included in the quality assessment). We included recidivism or reincidence as one measure, believing that despite the limitations, it still remains an important concept of impact. Additionally, we measured what the client's primary clinician views as the client's potential or propensity for future abuse, and we looked at client improvement on a number of select proxy measures or indicators of the client's potential for abuse or neglect. The range of impact indicators used in BPA's analyses are as follows:

(a) Reoccurrence of abuse and neglect by nature and severity as determined in four ways:
- did any abuse or neglect occur at all?
- did any severe abuse or neglect occur at all?
- was there any reoccurrence of the precipitating problem, i.e., if the parent came in as a physical abuser, did any physical abuse reoccur?
- was there serious reoccurrence of the precipitating problem?

(b) Clinician's assessments of potential for abuse/neglect, as determined in four ways:
- changes in propensity for abuse or neglect in general;
- propensity at termination for abuse or neglect in general;
- changes in propensity for the precipitating problem;

- propensity at termination for precipitating problem.

(c) Changes on the 13 client functioning indicators (drawn from the theoretical literature, pretested in the OCD evaluation of the Extended Family Center demonstration in San Francisco and refined for this national study), as determined by:

- positive change vs. no change or negative change on each individual measure for which client had a problem at intake;
- positive change vs. no change or negative change on all measures as a group for which client had a problem at intake.

(2) Service data

The services analyzed, which were provided to clients in many different mixes, included: individual counseling or therapy; multidisciplinary team review; parent aide counseling; couples or family counseling; other specialized individual counseling; group therapy; parent education classes; day care; homemaking; other advocacy and supportive services. Variables for these services were constructed on the basis of whether or not the service was received (binary datum) and the amount of service received (e.g., the number of units received).

(3) Intervening variable data

A number of different kinds of intervening variables were used in the analyses; some describe the project's caseload, some describe the project characteristics. Demographic characteristics of the cases included: number and ages of children in the family; size of household; age of adults; marital status; education; race/ethnicity; employment; income.

Other relevant characteristics of the case included: nature and severity of the abuse/neglect committed; primary problems in household leading to incident; previous record of abuse/neglect; identification of perpetrator; and source of referral.

Project or service characteristics included: type of agency; size of caseload; training of staff; quality of case management (derived from the study's Quality Component); frequency of contact with client; and length of treatment.

(4) Cost data

For each of the different kinds of services, the average cost per unit of service, based on the experiences of all eleven projects, was used (derived from the Cost Component of the study).

Development of Functioning Indicators: Proxy Measures for Parents' Potential for Abuse and Neglect

In the summer of 1973, when BPA began efforts to evaluate the effectiveness of alternative service strategies for abusive and neglectful parents, no reliable measures or scales for assessing an abuser's or neglector's potential for future maltreatment of a child existed. As part of BPA's evaluation of the Extended Family Center, an OCD demonstration abuse/neglect treatment program in San Francisco, a set of such measures were developed. Refined versions of these measures constitute an important aspect of BPA's proposed design for determining the success of different service strategies.

The development of the measures began with a search for possible indicators of parent functioning which are indicative of the potential for abuse or neglect. A listing of over 50 such indicators was developed from a careful study of the literature, which contains many different but not empirically tested perspectives on abuse and neglect, and from interviews with abusive and neglectful parents, and select professionals working in the field. The listing was critiqued by other professionals working in the field and was reduced to 28 indicators, reflecting parental situations, attitudes and behaviors.

Simultaneous with this effort, the study sample was identified. The sample consisted in part of all parents receiving treatment services from the Extended Family Center. Since the Center had a caseload limit of 25 families at any time, and cases are treated for a year on average, the study sample was expanded to include abuse and neglect cases from San Francisco's Department of Protective Services with similar characteristics. Over 50 parents were included in the final sample.

Clinicians working most closely with these parents were the primary source of data. After being trained in the use of data collection instruments, the clinicians recorded judgments about the functioning of the sample

parents on the 28 indicators retrospectively to the time the parent entered the treatment program, and prospectively for March and June of 1974. In addition, information on the demographic characteristics of the parents, the case history and the type and amount of services the parents received was collected.

In order to assess the reliability of the information collected, data on parent functioning was also recorded by a clinician who knew the parent but worked outside the treatment program as well as being collected by the researcher through direct interviews with the parents.

Analysis of data collected focused on sorting out those indicators out of the original set of 28 which were reliable, valid and non-redundant and as such would have utility in future studies of child abuse treatment programs. Reliability was determined by comparing the responses of the two clinicians and the responses of the primary clinician and the parent. The Tau C Statistic was used for this purpose. Validity was explored by interviewing all clinician respondents, asking them which of the indicators they felt they could most accurately respond to. Redundancy was determined by looking at which indicators varied together over time, suggesting that they were all indicative of the same phenomena of change in the parents' functioning. Factor analysis was used here. As a result of these reliability, validity and redundancy tests, the original listing of 28 indicators was reduced to 13. This listing includes: GENERAL HEALTH, CONTROL OVER PERSONAL HABITS, STRESS CREATED BY LIVING SITUATION, SENSE OF CHILD AS PERSON, BEHAVIOR TOWARD CHILD, ASSESSMENT OF CHILD DEVELOPMENT, EXTENT OF ISOLATION, ABILITY TO TALK OUT PROBLEMS, REACTIONS TO CRISIS SITUATIONS, WAY ANGER IS EXPRESSED, SENSE OF INDEPENDENCE, UNDERSTANDING OF SELF, and SELF ESTEEM.

In order to gain some understanding of the predictive power of the 13 select indicators, the correlations between each of the indicators and whether abuse or neglect reoccurred and clinicians' judgments of the parents' potential for future abuse were explored. Additionally, the predictive power of the indicators as a group was explored through the use of classification. The indicators were shown to be very powerful as a group in predicting reincidence and propensity.

Part II: Data Analysis

Preliminary Statement

In this section we present the hypotheses tested in the Adult Client Impact Component and the kinds of analyses done with the client data during the course of the three-year evaluation.

We collected information on many variables. The information included a variety of ways of looking at impact. Many different types of services are offered to clients and information was collected on each. The clients themselves varied on a number of different dimensions and data were collected on a range of client characteristics to capture these different dimensions. It was not possible at the outset to specify which of the host of variables would prove most useful. A central theme in the analysis has been the need to determine which of the impact, service and intervening variables were the most efficacious for learning about the effectiveness of treatments in child abuse and neglect. We relied on theory and on our hypotheses, while working through the steps specified below to make selections once the analysis was underway.

Focus of the Impact Analysis

The evaluation of the effectiveness of service strategies was the principal concern of our study. What is the effectiveness of different service strategies? To what extent is the receipt of services associated with positive impacts on client behavior? Ideally, the information provided by this analysis should improve the ability of treatment providers to prescribe effective services to clients and to allocate limited funds to the most cost-effective services. Clearly, the effectiveness of services varies with the way in which services are provided, the needs of families, and the nature and severity of the behavior toward children. Thus, we analyzed the relationship of different family characteristics and situations to the nature of service provision and to the effectiveness of different kinds of service strategies.

Steps in the Analysis

(1) Hypotheses about service effectiveness

We first identified a number of hypotheses about service effectiveness which we intended to test. The hypotheses were drawn from the limited available literature on service effectiveness, from careful study of the philosophies or approaches used by profedsionals in the field, and from our own first-hand observations. Inherent in all of them was the notion that services can reduce most clients' potential for abuse or neglect. The nature, frequency, intensity and duration of treatment services or the mere delivery of any service may influence outcomes as may characteristics of the client and the program. The hypotheses were not necessarily mutually exclusive nor compatible; rather, some of the hypotheses represented conflicting views, a reflection of the current lack of empirical information and theoretical disagreements in the field on the effect of various services. The hypotheses included the following notions:

- success of treatment is related to characteristics of the client, including history and nature of maltreatment, client age and ages and number of children, household stability, and socio-economic factors;
- success of treatment is related to the mix of services a client receives;
- success of treatment is related to the manner in which services are provided, including length of time in treatment, experience/training of the service provider, and the quality of case management;
- certain services are more effective than others given select intervening factors, including client characteristics and the nature of service provision.

(2) Analytical steps

In conducting the analysis, we systematically addressed each of the categories of hypotheses just discussed. In so doing, we moved from lower-order to higher-order analyses, starting with frequency distributions on all impact, service and intervening variables, moving to contingency tables and simple correlations, and finally to multivariate analysis for

select variables. This strategy had several advantages:

(a) It allowed us to better understand and appraise the quality and nature of the data collected and to thus eliminate many variables before the higher-order, multivariate analysis.

(b) In the absence of well-defined theories (or rather, given the plurality of poorly defined theories) in the child abuse and neglect field, the simpler analyses were illuminating in identifying hypothesized relationships unworthy of further exploration and thus in reducing theoretical models for multivariate testing. At the same time, the simpler analyses that did prove interesting facilitated the understanding of conclusions ultimately based on the multivariate analyses.

(c) Finally, the simple analyses provided the descriptive tables and distributions needed to provide management information to the projects and their monitors and to develop basic project descriptions.

The basic steps in the analysis, listed here, are discussed briefly. It is important to note that certain basic data checking steps preceded even the preliminary analyses discussed here. Most important among these data checking steps were the reliability and utility testing of variables, prior to their use in the analysis, and the checks to assure that pooling of data across projects was feasible. These data checking procedures were discussed in Part I.

Analysis Steps

A. Preliminary Analysis: Univariate and Bivariate
   1. Frequency Counts on Data
   2. Simple Cross Tabulations and Correlation Matrices
B. Reduction of the Number of Variables: Creation of Service Mixes
C. Assessment of Impact: Multivariate Analyses
   1. Impact and Client Characteristics (intervening variables)
   2. Impact and Service Mixes or Types
   3. Impact and Nature of Service Provision (intervening variables)

4. Impact and Combined Service and Intervening Variables

D. Cost-Effectiveness Analysis

Preliminary Analysis: The main purposes of the preliminary or lower-order analyses were to provide the descriptive data on the project's caseloads and service activities, to identify simple relationships between variables, and to provide information necessary for the reduction of the number of variables for later analysis.

Initially, frequency counts were run on all intervening, service, and impact variables for each project and for the whole program. These frequency counts were used to describe what clients are seen by the projects, and to compare the projects' caseloads with what is known about abusers and neglectors around the country. As a benchmark, we made use of the data from the American Humane Association's National Reporting Form.

At this point in the analysis, as part of the data checking, all variables were looked at to determine whether or not for specific variables there is variation across cases (for example, did we see only improvement on the functioning indicators) and whether there was too much missing data or too many out of range scores. In addition, questions of particular interest were highlighted, including: what is the distribution between severe and less severe and abuse and neglect cases handled by the projects? Are the projects serving the kinds of cases typically detected and reported (e.g., low income families, minority families) or is it apparent that they have been successful in identifying and serving the range of cases thought to exist? Do the projects typically serve only the adult female in the household or are adult males served as well? What kinds of services do projects offer with more frequency than others?

Second, simple cross tabulations of the frequency relationships and correlation matrices were run to uncover simple relationships between variables, including:

(a) nature and severity of abuse/neglect committed and client characteristics;

(b) client characteristics and referral source;

(c) nature and severity of abuse/neglect committed and the number and type of services received;

(d) discrete services received and impact measures;

(e) nature and severity of abuse/neglect committed and impact measures;

(f) client characteristics and impact measures;

(g) changes in family situation and impact measures;

(h) nature of service provision and impact measures.

Reduction of the Number of Variables, Creation of Service Mixes: The actual number of variables on which data were collected was quite large. The need to narrow the number of variables to be used in the higher-order analysis was clear, as was the need at the outset to eliminate simply useless variables. At many different steps in the data processing and analysis process, search strategies were used to eliminate variables. The criteria used for eliminating variables and thus making selections for the final analysis included:

(a) theoretical clarity and relevance;

(b) the quality, comparability and reliability of the data generated for measuring the variable;

(c) the capacity for capturing the influence of dimensions underlying many other variables;

(d) conceptual distinctions (and statistical non-correlation) with other variables selected for analysis;

(e) variability of observations on the variable within projects and across the demonstration program;

(f) the amount of missing data.

The steps in the data processing itself directed toward eliminating variables are described in Part I of this section. These included searches for missing data or out of range scores, lack of reliability on ratings, and lack of validity or clarity of the variables themselves. During the data analysis itself, as previously mentioned, we first studied basic frequency distributions on all variables to detect missing or erroneous data and variables for which there was not variation across cases. Second, we explored the frequency relationships between variables to highlight variables that were conceptually uninteresting. And, we studied the simple correlations between variables to determine instances in which two variables which conceptually were similar were so highly correlated that only one of

the two variables needed to be included in the higher-order analyses. While the simple correlations served as a powerful tool in identifying the conceptual distinctions between pairs of variables, factor or cluster analysis also was used to further identify redundancy within groups of variables (e.g., the service variables, the intervening variables). For many factors of conceptual interest (for example, family economic and social pressures) we had numerous indicators (e.g., employment, marital status, income) and the best indicators for the factor were selected. Similarly, since some services always occurred together, they were more meaningfully analyzed collectively.

The identification of these service mixes was a most important step in the analysis. Working from our hypotheses about service mixes, based on our observations of how staff prescribe services for clients, and utilizing cluster analysis, we determined how services clustered. After studying the frequency relationships and correlations of these service mixes to the different impact measures, we used these service mixes in the multivariate analysis.

Multivariate Analysis: The multivariate analyses sought to determine the relationships among services received, the nature of services, client characteristics, and impact. The findings of the analysis permit assessment of the effectiveness of various service strategies and potentially constitute guidelines for better prescription of services to families. Because of the concerns some researchers raise about the appropriateness of using multivariate analysis techniques on this data set, we relied on lower order analyses for determining the primary study findings and used the multivariate analyses to further confirm these findings.

First, we performed regression analyses of the relationship of select program impact measures as dependent variables with the service variables and/or intervening variables as independent variables, based on our hypotheses about service effectiveness. As part of these analyses, we used variance partitioning to sort out the relative effects of the independent variables. Since, as we expected, the percentage of clients "successful" was closer to 50% than to 0% or 100%, the bias estimation problems of least squares regression with binary dependent variables was not particularly problematic.

The first set of multivariate analyses consisted of looking at impact and select client characteristics. Could we account for improvements on our impact measures by client characteristics such as age, marital status,

or employment stability? Understanding this helps programs in predicting outcomes of treatment for different clients.

The second set of multivariate analyses consisted of an examination of the relationships between reincidence, changes in propensity and changes on the functioning indicators and types or mixes of services received. Did certain types or mixes of services account for positive impact more than others? We were concerned with understanding which services, in general, seemed to be associated with improvements in the parents' abusive or neglectful behavior more than others. Such findings assist programs in selecting the packages of services they will offer to their clients.

In the third set of multivariate analyses, we were concerned with understanding whether or not variation in the nature of service provision explains improvement in reincidence, propensity, and improvement on the functioning indicators. Could improvement be predicted by examining the frequency or quality of service provision? Answers to these questions are helpful to programs in mapping out how they will provide services.

The fourth set of multivariate analyses was concerned with the relationships between measures of impact and types or mixes of services, the nature of service delivery and client characteristics. Did the application of some services, in particular ways for particular clients, account for impacts better than others? While the most difficult of the multivariate analyses, given the problems of deciding which variables to include or exclude, the findings here have significant utility for program planners and service providers both in selecting service offerings and deciding how to offer services and in developing service packages for particular clients.

Next, since the coefficient of determination (R-square) provides a weak measure of the power of overall models for prediction when the dependent variable is binary, we converted select regressions into classification functions to test how many of the clients' outcomes could have been correctly predicted using the various regression models estimated. This test of prediction is far more strict and powerful than R-square and conveys the kind of intuitive understanding of the analysis to outside audiences which has made R-square popular in research.

The above analyses were undertaken for data on the overall population of clients, as well as for individual projects.

As a final step, the analysis of service strategies were converted into rough cost-effectiveness comparisons. We compared service impacts with the unit costs of services, available from the Cost Analysis component of the study. While the findings of the final step in the analysis must remain suggestive rather than conclusive, they are helpful to program planners in making choices between services with similar impact potential but different costs.

CLIENT INTAKE FORM

CLIENT INTAKE FORM (N07-128)
BERKELEY PLANNING ASSOCIATES

PLEASE NOTE THAT THIS FORM IS TO BE COMPLETED BY THE END OF THE INTAKE PROCESS

1. Client's Name _____
   Mother/mother substitute
   _____
   Father/father substitute
2. Worker's Name _____
3. Project _____

CASE HISTORY (07)

4. Date report received ___/___/___ 11-16
   mo day yr

5. Source(s) of Referral (check all that apply)
   17 ☐ Private Physician
   18 ☐ Hospital
   19 ☐ Public Social Service Agency
   20 ☐ School
   21 ☐ Law enforcement agency
   22 ☐ Court
   23 ☐ Parent/substitute
   24 ☐ Sibling
   25 ☐ Relative
   26 ☐ Acquaintance/ neighbor
   27 ☐ Self referral
   28 ☐ Anonymous
   29 ☐ Other agency (specify) _____
   30 ☐ Unknown

6. Date intake and diagnosis completed
   ___/___/___ 31-36
   mo day yr

7. Has this case been reviewed by a Diagnostic Review Team?
   37 ☐ Yes 39 ☐ No
   38 ☐ No, but will be

8. Case status for current incident (check all that apply)
   40 ☐ Abuse established
   41 ☐ Strong indication of abuse
   42 ☐ Weak indication of abuse
   43 ☐ Indication of potential abuse
   44 ☐ Neglect established
   45 ☐ Strong indication of neglect
   46 ☐ Weak indication of neglect
   47 ☐ Indication of potential neglect

9. Severity of case (check all that apply)

For Abuse	For Neglect
48 ☐ Death due to abuse	55 ☐ Death due to neglect
49 ☐ Severely injured	56 ☐ Severely neglected
50 ☐ Moderately injured	57 ☐ Moderately neglected
51 ☐ Mildly injured	58 ☐ Mildly neglected
52 ☐ Emotional abuse	59 ☐ Emotional neglect
53 ☐ Sexual abuse	60 ☐ Failure to thrive
54 ☐ Potential abuse	61 ☐ Potential neglect

10. Person(s) identified as responsible for abuse/ neglect (check all that apply)
    62 ☐ Mother/mother substitute
    63 ☐ Father/father substitute
    64 ☐ Other (specify) _____
    65 ☐ Unknown

(08)

11. Legal actions taken for current incident up to end of intake (check all that apply)
    11 ☐ No legal action taken to date
    12 ☐ Case reported to legally mandated agency(s)
    13 ☐ Court hearing held
    14 ☐ Court supervision, child at home
    15 ☐ Child removed from home temporarily (1 day to 2 weeks)
    16 ☐ Child placed in foster or other longer term care
    17 ☐ Child removed from home permanently
    18 ☐ Criminal action against abuser/neglector
    19 ☐ Other (specify) _____
    20 ☐ Unknown

12. Previous record/evidence of abuse/neglect by perpetrator(s) (check all that apply)
    21 ☐ record of abuse
    22 ☐ record of neglect
    23 ☐ no record of either
    24 ☐ unknown
    25 ☐ evidence of abuse
    26 ☐ evidence of neglect
    27 ☐ no evidence of either
    28 ☐ unknown

13. Report forwarded to (check all that apply)
    29 ☐ Central Registry
    30 ☐ Law enforcement
    31 ☐ No report forwarded
    32 ☐ Court
    33 ☐ Protective Services

14. Case referred to (check all that apply)
    34 ☐ Court
    35 ☐ Foster care/other placement agency
    36 ☐ No case referral
    37 ☐ Protective Services
    38 ☐ Other treatment agency(s)

HOUSEHOLD CHARACTERISTICS (09)

15. Date of birth and sex of children in family
    Child involved in abuse/neglect:

Name	Date of birth	Sex
_____	___/___/___ 11-16	☐ 17
_____	___/___/___ 18-23	☐ 24
_____	___/___/___ 25-30	☐ 31
_____	___/___/___ 32-37	☐ 38

    Other Children in Family:

_____	___/___/___ 39-44	☐ 45
_____	___/___/___ 46-51	☐ 52
_____	___/___/___ 53-58	☐ 59
_____	___/___/___ 60-65	☐ 66

    Total number of children in family ☐☐ 67-68

16. Special characteristics of child(ren) involved in abuse/neglect (check all that apply)
    69 ☐ Premature
    70 ☐ Mentally retarded
    71 ☐ Physically handicapped
    72 ☐ Emotionally disturbed
    73 ☐ Adopted/foster child
    74 ☐ None
    75 ☐ Unwanted pregnancy
    76 ☐ Unliked child
    77 ☐ Product of multiple birth
    78 ☐ Other (specify) _____

(10)

17. All adult household member(s) (enter the number of individuals in each category in the appropriate space)
    11 ☐ Natural mother
    12 ☐ Mother substitute
    13 ☐ Natural father
    14 ☐ Father substitute
    15 ☐ Grandparent(s)
    16 ☐ Other relative(s)
    17 ☐ Other(s)

18. Approximate ages of parent(s)/parent substitute(s)
    18-19 ☐☐ Mother/mother substitute
    20-21 ☐☐ Father/father substitute

19. Present marital status of parent(s)/parent substitute(s) (check one)
    22 ☐ Legal marriage
    23 ☐ Consensual union
    24 ☐ Never married
    25 ☐ Divorced/legally separated
    26 ☐ Widow/widower
    27 ☐ Marriage partner temporarily absent
    28 ☐ Marriage partner permanently absent
    29 ☐ Unknown

20. Level of education completed

Mother/ substitute	Father/ substitute	
33 ☐	37 ☐	Less than 8 years education
34 ☐	38 ☐	8-11 years education
35 ☐	39 ☐	High school degree
36 ☐	40 ☐	Some college/vocational training
37 ☐	41 ☐	College graduate
38 ☐	42 ☐	Post graduate
39 ☐	43 ☐	Unknown

21. Ethnicity/race of parent(s)/parent substitute(s)

Mother/ substitute	Father/ substitute	
44 ☐	50 ☐	Caucasian
45 ☐	51 ☐	Black
46 ☐	52 ☐	Spanish surname
47 ☐	53 ☐	American Indian
48 ☐	54 ☐	Other (specify) _____
49 ☐	55 ☐	Unknown

22. Employment of parent(s)/parent substitute(s)

Mother/ substitute	Father/ substitute	
56 ☐	60 ☐	Employed full-time
57 ☐	61 ☐	Employed part-time
58 ☐	62 ☐	Unemployed
59 ☐	63 ☐	Unknown

23. Estimated yearly family gross income
    From employment $☐☐☐☐☐ 64-68
    From public assistance ☐☐☐☐☐ 69-73
    From other sources ☐☐☐☐☐ 74-78
    Unknown ☐ 79

(11)

I.D. No. ☐☐☐☐☐☐ 1 2 3 4 5 6
(B.P.A. Use Only)

24. Primary problems in the household which help explain the actual or potential abuse/neglect situation (Check all that apply)
    11 ☐ Marital problems
    12 ☐ Job related difficulties
    13 ☐ Alcoholism
    14 ☐ Drugs
    15 ☐ Health problem (physical)
    16 ☐ Mental health problem
    17 ☐ New baby in home
    18 ☐ Argument/physical fight
    19 ☐ Financial difficulties
    20 ☐ Mental retardation of parent
    21 ☐ Unknown
    22 ☐ Pregnancy
    23 ☐ Heavy continuous child care responsibility
    24 ☐ Physical abuse of spouse
    25 ☐ Recent relocation
    26 ☐ Overcrowded housing
    27 ☐ History of abuse as child
    28 ☐ Normal method of discipline (explain) _____
    29 ☐ Social isolation
    30 ☐ Other (specify) _____

25. Services planned for parent(s) (check all that apply)

Mother/ substitute	Father/ substitute	
91 ☐	50 ☐	Taken in for assessment only
92 ☐	51 ☐	No services planned
33 ☐	52 ☐	Social work counseling
34 ☐	53 ☐	Parent aide/lay therapist
35 ☐	54 ☐	Group therapy
36 ☐	55 ☐	Parents Anonymous
37 ☐	56 ☐	Couples counseling
38 ☐	57 ☐	Family counseling
39 ☐	58 ☐	Individual therapy
40 ☐	59 ☐	Homemaking
41 ☐	60 ☐	Alcohol, drug, weight counseling
42 ☐	61 ☐	Child management classes
43 ☐	62 ☐	Employment assistance
44 ☐	63 ☐	Housing assistance
45 ☐	64 ☐	Welfare assistance
46 ☐	65 ☐	Family planning assistance
47 ☐	66 ☐	Medical care
48 ☐	67 ☐	Residential care
49 ☐	68 ☐	Other (specify) _____

26. Where will parent(s) receive these services? (check all that apply)
    69 ☐ Directly by the project
    70 ☐ Purchase of service by the project
    71 ☐ Referral to other agencies in community

(12)

27. Services planned for child(ren) (check all that apply)
    11 ☐ Day Care
    12 ☐ Therapeutic day care
    13 ☐ Medical care
    14 ☐ Play therapy
    15 ☐ Individual therapy
    16 ☐ Other (specify)
    17 ☐ Speech or other specialized therapy
    18 ☐ Foster care
    19 ☐ Residential care
    20 ☐ Psychological evaluation
    21 ☐ No services planned

28. Where will child(ren) receive these services? (check all that apply)
    22 ☐ Directly by the project
    23 ☐ Purchase of service by the project
    24 ☐ Referral to other agencies in community

Adapted from the American Humane Association National Reporting Form

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GOALS OF TREATMENT FORM

BERKELEY PLANNING ASSOCIATES

I.D. No. | | | | | | (B.P.A. Use Only)

Client's Name _____

Worker's Name _____

GOALS OF TREATMENT WHEN ENTERED CASELOAD

Please specify the goals of treatment for parent (i.e., the behavioral, attitudinal and/or situational changes to be accomplished).

NARRATIVE

Specify changes in goals of treatment and intermediate achievement of goals while client is in caseload.

ACCOMPLISHMENTS OF TREATMENT

Please specify what goals were (and were not) accomplished during the course of treatment (i.e., the behavioral, attitudinal and/or situational changes accomplished).

REASONS FOR CLOSING CASE

CLIENT IMPACT FORM (NS2-528)
BERKELEY PLANNING ASSOCIATES

OMB 68S74005 Exp. 6-77
I.D. No. _____ (B.P.A. Use Only)

Client's Name _____

Worker's Name _____

Date Report Received / / / / / (mo day yr)

Date Terminated / / / / / (mo day yr)

Please circle the point on the scales which indicates client's functioning at time client entered caseload.	CLIENT FUNCTIONING INDICATORS	Please circle the point on the scales which indicates client's functioning at time client is terminated.
1 2 3 4 5 poor good	GENERAL HEALTH	1 2 3 4 5 poor good
1 2 3 4 5 no control control	CONTROL OVER PERSONAL HABITS: (drugs, alcohol, overeating) SPECIFY _____	1 2 3 4 5 no control control
1 2 3 4 5 stressful unstressful	STRESS CREATED BY LIVING SITUATION	1 2 3 4 5 stressful unstressful
1 2 3 4 5 extension of self separate person	SENSE OF CHILD AS PERSON	1 2 3 4 5 extension of self separate person
1 2 3 4 5 inappropriate appropriate	BEHAVIOR TOWARD CHILD	1 2 3 4 5 inappropriate appropriate
1 2 3 4 5 unaware aware	AWARENESS OF CHILD DEVELOPMENT	1 2 3 4 5 unaware aware
1 2 3 4 5 isolated not isolated	EXTENT OF ISOLATION	1 2 3 4 5 isolated not isolated
1 2 3 4 5 unable able	ABILITY TO TALK OUT PROBLEMS	1 2 3 4 5 unable able
1 2 3 4 5 poor good	REACTIONS TO CRISIS SITUATIONS	1 2 3 4 5 poor good
1 2 3 4 5 inappropriately appropriately	WAY ANGER IS EXPRESSED	1 2 3 4 5 inappropriately appropriately
1 2 3 4 5 dependent independent	SENSE OF INDEPENDENCE	1 2 3 4 5 dependent independent
1 2 3 4 5 poor good	UNDERSTANDING OF SELF	1 2 3 4 5 poor good
1 2 3 4 5 low high	SELF ESTEEM	1 2 3 4 5 low high

Using your own definitions, please circle the point on the scales which indicates your view of client's propensity at time client entered caseload.	PROPENSITY	Using your own definitions, please circle the point on the scales which indicates your view of client's propensity at time client is terminated.
1 2 3 4 5 very likely unlikely	POTENTIAL FOR FUTURE ABUSE	1 2 3 4 5 very likely unlikely
1 2 3 4 5 very likely unlikely	POTENTIAL FOR FUTURE NEGLECT	1 2 3 4 5 very likely unlikely

CLIENT FUNCTIONING FORM (N154-165B)

BERKELEY PLANNING ASSOCIATES

I.D. No. _____ (B.P.A. Use Only)

Client's Name _____

Worker's Name _____

Place an (X) in the box indicating if any of the following occurred in a given month:

		1976 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Death of child, due to abuse	(11)												
Severe physical abuse	(12)												
Moderate physical abuse	(13)												
Mild physical abuse	(14)												
Sexual abuse	(15)												
Emotional abuse	(16)												
Death of child, due to neglect	(17)												
Severe physical neglect	(18)												
Moderate physical neglect	(19)												
Mild physical neglect	(20)												
Failure to thrive	(21)												
Emotional neglect	(22)												
Client gained a spouse/mate	(23)												
Client lost a spouse/mate	(24)												
Client/mate became employed	(25)												
Client/mate became unemployed	(26)												
Client/mate changed jobs	(27)												
Client moved	(28)												
Client hospitalized	(29)												
Client lost close relative/friend	(30)												
Child out of home	(31)												
Child returned home	(32)												
New family member	(33)												
Client/mate imprisoned	(34)												

Specify either monthly or quarterly parent's functioning on each of the indicators below in relation to previous recording using the following codes: improved = (+), stayed the same = (0), regressed = (−).

		1976 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
General Health	(35)												
Control over personal habits: drugs, alcohol, overeating)	(36)												
Stress created by living situation	(37)												
Sense of child as person	(38)												
Behavior toward child	(39)												
Awareness of child development	(40)												
Extent of isolation	(41)												
Ability to talk out problems	(42)												
Reactions to crisis situations	(43)												
Way anger is expressed	(44)												
Sense of independence	(45)												
Understanding of self	(46)												
Self esteem	(47)												
		(154)	(155)	(156)	(157)	(158)	(159)	(160)	(161)	(162)	(163)	(164)	(165)

SERVICES PROVIDED TO PARENT (N116-133B)

BERKELEY PLANNING ASSOCIATES

I.D. No. _____ (B.P.A. Use Only)

NOTE: Be sure to record amount of service provided, using units specified under specific service (e.g., no. contacts, no. sessions, etc.). "Project" = services provided to parent by the project; "Purchased" = services purchased by the project; and "Other" = services received by the parent from another agency.

Client's Name _____

Worker's Name _____

SERVICE CATEGORIES 1976	July			August			September			October			November			December		
	Project	Purchased	Other	Project	Purchased	Other	Project	Purchased	Other	Project	Purchased	Other	Project	Purchased	Other	Project	Purchased	Other
No services provided this month																		
Psychological or other testing (no. tests) (11-12)																		
Case Review by Multidisciplinary Team (no. reviews) (13-14)																		
Individual Counseling (no. contacts) (15-16)																		
Parent Aide/Lay Therapist Counseling (no. contacts) (17-18)																		
Individual Therapy (no. contacts) (19-20)																		
Group Therapy (no. sessions attended) (21-22)																		
Parents Anonymous (no. sessions attended) (23-24)																		
Couples Counseling (no. contacts) (25-26)																		
Family Counseling (no. contacts) (27-28)																		
Alcohol Counseling (no. sessions attended) (29-30)																		
Drug Counseling (no. sessions attended) (31-32)																		
Weight Counseling (no. sessions attended) (33-34)																		
Family Planning Counseling (no. sessions) (35-36)																		
24 Hour Hotline (no. of calls) (37-38)																		
Crisis Intervention (no. contacts) (39-40)																		
Parent Education Classes (no. sessions attended) (41-42)																		
Job Training (no. sessions attended) (43-44)																		
Homemaking (no. contacts) (45-46)																		
Medical Care (no. visits) (47-48)																		
Residential Care for Child (no. days) (49-50)																		
Day Care (no. sessions) (51-52)																		
Crisis Nursery (no. days) (53-54)																		
Welfare Assistance ("Y" if Yes) (55)																		
Auxiliary Services: babysitting (no. times) (56-57)																		
Auxiliary Services: transportation (no. rides) (58-59)																		
Emergency Funds (no. dollars) (60-62)																		
	(134-136)			(137-139)			(140-142)			(143-145)			(146-148)			(149-151)		

CLIENT FOLLOW-UP FORM (N66-66)
BERKELEY PLANNING ASSOCIATES

I.D. No. _____
(B.P.A. Use Only)

1. Client's Name _____

2. Worker's Name _____

3. Date of follow-up / / / /

4. Initiator of follow-up

- [ ] Project
- [ ] Client
- [ ] Other (specify) _____

5. Nature of follow-up

- [ ] Phone conversation with client
- [ ] Home visit with client
- [ ] Client visited project
- [ ] Other direct contact with client (specify) _____
- [ ] Phone conversation with other agency working with client (specify agency) _____
- [ ] Personal visit with other agency working with client (specify agency) _____
- [ ] Other (specify) _____

6. Briefly describe what took place during this follow-up contact.

7. Has abuse or neglect reoccured?

- [ ] Yes, Death due to Abuse
- [ ] Yes, Moderate physical abuse
- [ ] Yes, Mild physical abuse
- [ ] Yes, sexual abuse
- [ ] Yes, emotional abuse
- [ ] No
- [ ] Unknown
- [ ] Yes, Death due to Neglect
- [ ] Yes, Moderate physical neglect
- [ ] Yes, Mild physical neglect
- [ ] Yes, Failure to thrive
- [ ] Yes, emotional neglect

8. If answer to above is YES or UNKNOWN, will client return to project caseload?

[ ] Yes [ ] No; if NO, why not?

_____

9. What changes, if any, do you see in the client since he/she left your project's caseload?

10. What is your current perception of parent's potential for future abuse?

- [ ] Very likely
- [ ] Somewhat likely
- [ ] Unlikely

11. What is your current perception of parent's potential for future neglect?

- [ ] Very likely
- [ ] Somewhat likely
- [ ] Unlikely

INSTRUCTION MANUAL FOR ADULT CLIENT FORMS

Evaluation, National Demonstration Program in
Child Abuse and Neglect

List of Contents

INTRODUCTION

As part of the evaluation of the National Demonstration Program in Child Abuse and Neglect, Berkeley Planning Associates is asking each of the Demonstration Projects to maintain complete records on the adult clients in their caseloads. This Instruction Manual provides information on the types of forms to be used for clients and explanations as to their use. The data collected on these client forms will have many important uses in BPA's evaluation. We therefore request that project staff carefully study this Instruction Manual and conscientiously complete all the client forms as specified in this Manual.

OVERALL INSTRUCTIONS

What forms are there for adult clients?

There are four different sets of data items to be collected on the adult clients in each family handled by your project: basic family characteristics and case history; client's functioning; services provided to the client; and follow-up information on the client. Different forms are to be used for each of these data sets as specified below:

(1) Basic Family Characteristics and Case History

The INTAKE FORM, adapted from the American Humane Association National Reporting Form, has been developed by BPA for recording basic information about client families. The INTAKE form is to be completed for each family not eliminated from the project's caseload after initial investigation by the time the project's intake and diagnosis process is completed (in most cases this will be within the first month after the case is reported to your project).

(2) Client's Functioning

There are three forms related to client functioning: (a) the CLIENT IMPACT FORM, (b) the CLIENT FUNCTIONING FORM, and (c) the GOALS OF TREATMENT FORM.

(a) The CLIENT IMPACT FORM has been developed by BPA for recording adult clients' functioning at the time they enter the project caseload and at the time they are terminated (or, in the case of projects which do not terminate clients, when they are "stabilized"). One form is to be used for each adult client. Thus, if the project is serving more than one adult in a family, one form would be used for each adult. The left column of the form is to be completed by the time the project's intake and diagnosis process is completed (in most cases this will be within the first month after the case is reported to your project). The right column of the form is to be completed at the time the client is terminated.

(b) The CLIENT FUNCTIONING FORM has been developed for recording adult clients' functioning while they are in the project's caseload. Client functioning is to be recorded on this form at the end of each calendar month (or in the case of the bottom third of the form, once every three months) while the client is in the caseload.

(c) The GOALS OF TREATMENT FORM has been developed for recording the goals of treatment for a given client. The top of the form should be completed by the end of the intake and diagnosis process, and as soon as the goals of treatment have been identified. If, during the course of treatment, the goals change, such changes should be recorded in the middle of the form. When the client is terminated, goals achieved are to be specified at the bottom of the form.

(3) Services Provided to Parents

The SERVICES PROVIDED TO PARENT form was developed so that projects can maintain complete records on services provided to adult clients either directly by the projects, purchased by the project from other agencies, or provided by other agencies. Services provided to adult clients are to be recorded in the appropriate column on the form at the end of each calendar month after the intake and diagnosis process is completed.

(4) Follow-Up Information on Client

The CLIENT FOLLOW-UP FORM has been developed by BPA for recording follow-up contacts with clients after they have been terminated from the project's caseload. Each time a follow-up contact is made with an "ex-client", a CLIENT FOLLOW-UP FORM is to be completed. Follow-up contacts include direct contact with the client, as well as discussion about client's status with other agencies working with client.

Who Should Complete the Forms?

The forms should be completed by the person or persons on the project's staff who have direct contact with the client. For some projects, the person or persons completing the CLIENT INTAKE FORM may be different from the person or persons completing the rest of the forms. However, whenever possible, the same person or persons should complete the CLIENT IMPACT, CLIENT FUNCTIONING, GOALS OF TREATMENT, and SERVICED PROVIDED forms throughout the time the case is part of the project's caseload. If only one person is completing the forms for a given client, this should be the person who has the most direct contact with the client. If two or more persons are completing the forms together, they should be those persons who have direct contact with the parent in different settings (ex: the social worker, the group therapist and the lay therapist). The CLIENT FOLLOW-UP FORM should be completed by the person conducting the follow-up.

How Should the Forms be Filed?

BPA recommends that two sets of alphabetical, central files be maintained: an Active Cases file and a Terminated Cases file. Additionally, BPA recommends that forms on each family in the caseload be stored in a family folder.

How Will Projects Get the Forms?

BPA will supply projects with sufficient numbers of BPA-developed forms for the project's use. Projects will note that many of the forms cover calendar months January, 1976 through December, 1976. Comparable forms starting with January, 1977 will be provided to the projects by December, 1976.

How Will Data Be Processed?

Carbon copies of completed forms for terminated cases will be collected by BPA staff from the projects during each site visit. BPA staff will code the forms and store the data on computer tapes. BPA will provide projects with data output displaying frequency counts on data from forms collected. Additionally, BPA will undertake a cross-project analysis of the data collected. Summaries of these analyses will be distributed to all projects.

A Caution

The forms are printed on a special kind of carbon paper. Please be careful not to have one form on top of another when filling it out, or else your writing on the top form will come through on the bottom form. Also, please use black ball point pen or dark pencil when completing forms. If you have any questions about the use of the forms which are not answered in this Instruction Manual, please do not hesitate to address them to the BPA staff liaison for your site or to the BPA Study Project Director at: (415) 549-3492 or, 2320 Channing Way, Berkeley, California 94704.

INSTRUCTIONS FOR USE OF CLIENT INTAKE FORM

This form is to be used for all families who are accepted for continuing services by your project after initial screening.

The form is to be completed by the end of your project's intake and diagnosis process.

In answering questions, consider the adult or adults in the family who will be receiving services from your project (or from an agency in the community to which you will refer them) to be the "parent/parent substitutes."

All questions on the form are to be answered. Please first review the "Explanation of the Severity Index" and the "Explanation of Service Categories" in this manual before completing the form.

INSTRUCTIONS FOR USE OF THE CLIENT IMPACT FORM

This form is to be completed for each adult client in your caseload. The left column of the form is to be filled out by the time the intake and diagnosis process for the client is completed. Prior to answering the questions on the front page, review the "Explanation of Parent Functioning Indicators" in this manual. Then, circle the point on the scale next to the Client Functioning Indicators which best represents the client's functioning on the indicator at the time the client entered your project's caseload.

The right column of the form is to be completed at the time the case is terminated or otherwise dropped from the project's caseload. Circle the point on the scale next to the client functioning indicators which best represents the client's functioning at the time the client was terminated from your caseload. You may wish to review the "Explanation of Client Functioning Indicators" before filling out this part of the form.

INSTRUCTIONS FOR USE OF THE CLIENT FUNCTIONING FORM

This form is to be completed monthly for each adult client in your caseload, starting with the month during which the intake and diagnosis process was completed.

On the top two-thirds of the form, indicate with an (X) in the appropriate space if any of the listed events occurred during a given month. These events include the reoccurance of abuse or neglect as well as other life stress situations. (You may want to periodically review the "Explanation of Severity Index" in this manual while filling out the form.) Please remember that the form is being completed for a single adult and not for the family. Therefore, if a mother has reabused her child and the father was not involved in this reincidence, an (X) will be placed in the appropriate box on the FUNCTIONING FORM for the mother but not on the father's. If both parents were involved in the reincident, an (X) would be placed on both forms.

On the bottom third of the form, in the appropriate space, record whether the client has improved (+), stayed the same (0), or regressed (—), on each of the client functioning indicators from where he (she) was the previous month. (You may wish to review the "Explanation of Client Functioning Indicators" in this manual periodically.) If you wish, recordings on this bottom third of the form may be done quarterly rather than monthly.

INSTRUCTIONS FOR USE OF THE GOALS OF TREATMENT FORM

This form is to be completed for each adult client in your caseload. First, by the end of the intake and diagnosis process, the goals of a treatment identified for the client should be recorded on the upper part of the form. Prior to doing this, review the "Explanation of Goals of Treatment" in this manual. During the course of treatment, if the goals should change or if you wish to record any significant activities or events with regard to the goals, enter relevant comments in the middle of the form. When the case is terminated (or, in the case of a few projects, when the case has stabilized) describe at the bottom of this form which goals were accomplished and which were not, as well as the reasons for closing the case.

INSTRUCTIONS FOR USE OF SERVICES PROVIDED TO CLIENTS FORM

This form is for recording the services adult clients receive either directly from your project, through purchase of service, or from other agencies in the community.

All services provided to adult clients are to be recorded on this form each month, starting with the end of the first calendar month after the client has entered your project's caseload, and until the client is terminated from your caseload.

In the column which represents the current calendar month record the frequency with which each service was received by the client. If a client did not receive a certain service, leave that space blank. If the client did not receive any services at all during the month, check the space which so indicates.

Please note that the "amount" of a given service to be recorded varies from one service to another. The unit of frequency for which a given service is to be recorded appears in parentheses next to the name of the service. Thus, if a client received group therapy, specify the number of sessions attended; and so on. Before filling out this form, review the "Explanation of Service Categories" in this Instruction Manual.

Although BPA is asking projects to record services provided to the client each month, you may wish to record services provided to the client at more frequent intervals. Your project may already be using some kind of contact form, attendance records, or dictation for keeping track of contacts with clients. These could be tallied at the end of the month, or you could simply keep a running count of services provided daily or weekly in the appropriate calendar months in pencil; at the end of the month, tally all services received during the month, erase notes made during the month, and write the sum in the appropriate place.

INSTRUCTIONS FOR USE OF FOLLOW-UP FORM

This form is to be completed each time your project makes a follow-up contact with a client after they have been terminated from your project's caseload. A follow-up contact may consist of a phone call conversation or personal visit with the "ex-client" or a phone conversation or personal visit with someone from another agency working with the client. Answer all questions on the form. (If abuse or neglect has reoccurred, you may wish to review the "Explanation of Severity Index" in this Instruction Manual before answering question 8.)

If on the basis of the follow-up contact, the decision is made that the client will return to the project's caseload, you should continue with the use of the CLIENT IMPACT, CLIENT FUNCTIONING, GOALS OF TREATMENT, and SERVICES FORMS. At the end of the first calendar month after re-entry, and then each subsequent month, record in the appropriate columns of those forms the data requested. In addition, on the front of each of these four forms, make a note of the date of re-entry.

EXPLANATION OF SEVERITY INDEX

The CLIENT INTAKE FORM, the CLIENT FUNCTIONING FORM, and the CLIENT FOLLOW-UP FORM ask for information regarding the severity of the case. Below are definitions of the categories to be used in indicating severity. Please note that for the purposes of recording severity on the INTAKE FORM, you will be considering both the incident bringing the family to your caseload, as well as previous incidents of abuse or neglect.

ABUSE*

Death due to abuse: Child's death due to non-accidentally inflicted injuries.

Severely injured: Child found to have multiple fractures, head injuries, massive bruises, burns and/or severe hematomas including both old and new injuries.

Moderately injured: Child found to have a single fracture, numerous bruises, a few severe bruises, burns covering small areas of the body, and/or lacerations with no history of previous injuries.

Mildly (slightly) injured: Child showing superficial, light bruises, few in number.

Emotional abuse: It is obvious to outsiders that child is severely scapegoated by family, outwardly rejected, subjected to severe chronic verbal abuse, or overly protected, smothered, with no privacy and no space to grow emotionally.

Sexual abuse: Child sexually molested in some way by a family member or someone functioning as a family member, or parent passively involved in molestation of child.

Potential abuse: Determined by studying the family and finding a constellation of the particular factors found in abusive families including: loneliness and isolation; inappropriate expectations of child; anxiety with exaggerated response toward child; problem with own mother and/or father; abuse provoking attributes of child resulting from either his behavior or qualities which have negative associational effects for parent; and the potential for precipitating a crisis. In addition, there is a high probability that child would be abused.

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* Definitions modified from Adams County, Colorado, Department of Social Services.

NEGLECT

Death due to neglect: Child's death due to omission of proper care.

Severely neglected: Child found severely malnourished, excessively ill-clad, provided with grossly inadequate hygienic care, without proper shelter or sleeping arrangements and/or left unattended, unsupervised for long periods of time to the point of extreme danger to child's life.

Moderately neglected: Child moderately malnourished, ill-clad, dirty, without proper shelter or sleeping arrangements, left for short periods of time without supervision and/or exposed to unwholesome or demoralizing circumstances with danger to physical and mental health.

Mildly (slightly) neglected: Child ill-clad, dirty, poorly supervised and/or exposed to unwholesome circumstances with no immediate danger to physical and mental health.

Emotional neglect: It is obvious to outsiders that child is receiving little or no emotional support, attention, love or caring from the family. This absence or omission of affection, or the random or inappropriate expression of it, may take many forms including lack of any physical touching of child or lack of any words of praise.

Failure to thrive: Child is malnourished, for psychological reasons, i.e., fails to thrive within the household.

Potential neglect: Parent is unaware of child. Determined by studying the family and finding a constellation of the particular factors usually found in neglectful families including: parent unaware of child's needs; parent not involved with child; parent directs no energy toward child; parent does not expect child to meet his/her needs and is withdrawn from child; or generally passive toward child.

EXPLANATION OF SERVICE CATEGORIES

The CLIENT INTAKE FORM and the SERVICES PROVIDED TO PARENT FORM ask for information regarding services provided to parents and children. Below are definitions of the service categories listed on those forms.

Psychological or other testing: Psychological and personality testing administered to client by a person trained in the administration of the test as a diagnostic instrument in order to be better able to specify client's problems.

Case review by multidisciplinary team: Review of a case during intake and/or treatment by a multidisciplinary review team, typically composed of individuals representing many different disciplines, for diagnosis and case planning purposes. Not included here are the more infrequent, more informal ongoing case reviews by staff.

Individual counseling: One to one counseling typically at the worker's office or in client's home provided by a worker (usually but not necessarily trained in social work) in which the worker and client discuss client's situation and problems and possible changes in them, and other issues. This is to be distinguished from individual therapy which is usually on a more formal basis, and is defined below.

Parent aide/lay therapist counseling: One to one counseling typically at client's home in which a person designated as a parent aide or lay therapist befriends client and discusses various issues of benefit to the client.

Individual therapy: One to one therapy provided to client by a trained psychologist, psychiatrist, or the equivalent, typically in the therapist's office and typically for one hour sessions. This differs from individual (social work) counseling, which is usually on a less formal basis.

Group therapy: A therapeutic group session, typically two hours in duration, run by one or two persons qualified as group therapists and skilled in a variety of group techniques. If your project is providing several therapy groups, and each is using a different therapeutic technique, or is for a different type of group (e.g., mothers, fathers, couples) write in space provided the nature of the therapy in the group in which the client is participating.

Parents Anonymous: A therapeutic group session for abusive and neglectful parents typically organized and run by parents with support from one or two resource persons who attend the group meetings. If a group is called Parents Anonymous but the resource persons or sponsors do in fact therapeutically lead the group, under BPA definitions, the service would be called group therapy.

Couples counseling: Counseling provided by a professionally trained counselor typically in the counselor's office, for married couples or two adults living together, at planned times to help them resolve whatever difficulties they may be experiencing together.

Family counseling: Counseling provided by a professionally trained counselor, typically in the counselor's office, for families (parents and children) at planned times to help them resolve whatever difficulties they are having together. At times counseling may be provided to individual family members and at times counseling is provided to the family as a group.

Alcohol, drug and weight counseling: Counseling provided either on a one-to-one basis or in a group, directed at assisting individuals overcome personal problems of alcoholism, drug addiction, and overweight. Includes services offered at a drug abuse clinic, Alcoholics Anonymous, Weight Watchers, Mental Health Centers and other specialized treatment centers.

Family planning counseling: Parent is provided with counseling by a qualified family planning counselor, typically at a family planning center, on contraception techniques and the like.

24 hour hotline: A telephone number a parent can call anytime, day or night, to reach out for help and receive therapeutic assistance or at least be assured of reaching a patient listener.

Crisis intervention: Staff member intervenes in client's crisis situation by means other than 24 hour hotline, e.g., emergency home visit, emergency meeting at project, etc. The intervention may occur during working hours as well as after hours.

Parent education classes: A number of sessions by one or more persons qualified in child development to discuss issues of child development, parenting and the like. Typically provided in a classroom setting.

Job training: A number of sessions provided by qualified persons directed at developing job skills of participants. Training may be provided in a classroom setting or on-the-job.

Homemaking: A qualified homemaker or equivalent visits client's home and provides instruction on such topics as nutrition and hygiene, and assists client in alleviating household stress by helping with cleaning, cooking, child care, and whatever else will benefit parent.

Medical care: Provision of medical services by a physician or other health professional. Includes dental and optometric care.

Residential care for child: A home or other facility where a child can live on a temporary basis either during or after some precipitating crisis in order to escape the stresses of life at home.

Day care: Child is left at a licensed or otherwise designated center for a certain number of hours during the day. Typically day care services are provided for a certain number of hours 5 days a week.

Crisis nursery: A nursery to which a child may be brought any time of day or night and left for short periods of time while parent is going through time of crisis.

Welfare assistance: Client is receiving some form of financial or other assistance from either the local public or a local private welfare agency.

Auxiliary services: babysitting: Parent is provided with babysitting services either in home or at the project while he/she attends to his/her own affairs.

Auxiliary services: transportation: Client is provided with transportation to and from service appointments, to go shopping, and the like.

Emergency funds: Client is provided with small amount of emergency money from project, either as a loan or as a gift.

EXPLANATION OF GOALS OF TREATMENT

The GOALS OF TREATMENT FORM asks the clinician to specify the goals of treatment for the client, first, when the intake and diagnosis is completed. In specifying the goals of treatment, one should consider:

> Are there any behavioral changes or behavioral modifications which it is hoped the client will undergo during the treatment? (ex: learning new ways to express anger; abandoning drug habit; going to work on time each day; serving regular meals; keeping the house clean.)
>
> Are there any attitudinal changes which it is hoped the client will undergo during treatment? (ex: having more realistic expectations of child; having a better sense of self; feeling more positive about self.)
>
> Are there any situational changes which it is hoped will occur while client is in treatment? (ex: an improved relationship with spouse/mate; a more stable household; a more stable financial situation; a new apartment; more friends to talk to.)

The goals of treatment may be determined by the individual completing the form, or by that individual with any other persons involved in the intake and diagnosis process, including outreach and intake workers, members of a diagnostic review team and the clients themselves.

The premise behind the Goals of Treatment form is that goals of treatment are important for providing direction for treatment and for providing a standard against which one can ascertain if clients have improved. There can be different levels of goals, depending on the time frame selected. However, BPA's purpose is to measure change at termination and, therefore, we are interested in a listing of major goals for the end of provision of treatment by the project. The revised Goals of Treatment form allows room for as many as five such major goals. Projects may wish to set up intermediate goals as steps toward avhievement of the final, major goals; such steps could be noted for the social worker's own use on a separate sheet of paper.

Criteria for determining goals of treatment for the BPA form

Because the projects deal with child abuse and neglect, it can be assumed that preventing and/or halting abusive and neglectful behavior is an overriding goal of treatment for all adult clients; it is not necessary to repeat this as a goal of treatment for individual clients.

The goals selected should meet the following standards: (1) they should be outcomes of treatment, i.e., the result or effect of providing services, not the methods or means to that outcome; (2) they should be realistically attainable by the end of treatment; (3) they should be stated in clear, specific terms so that one can know exactly what is hoped for and so that goal

achievement can be assessed; and (4) they should cover important elements or parts of a client's life.

Examples of goals that do not meet the criteria

"Have therapy at the Mental Health Center" -- a means toward the outcome; what is the desirable outcome of this therapy?

"Resolution of problems" -- too broad, not measurable as stated; what problems?

"Get in touch with feelings" -- jargon; needs more specificity.

"May need watching" -- cannot determine if goal is being met; not an outcome statement.

(for a child) "Change father's behavior so that child is less frightened" -- goal is stated for father rather than for the child; should be rephrased.

"Same goals as for mother" -- what is that goal? Need more information.

Examples of appropriate goals of treatment

1. Regarding behavioral changes
   a. abandon drug habit
   b. keep house cleaner than at present
   c. serve regular meals to family
2. Regarding attitudinal changes
   a. have more realistic expectations of child
   b. accept role as a single parent
   c. increase understanding of husband and his problems
3. Regarding situational changes
   a. improve relationship with spouse
   b. improve stability in household
   c. develop more friendships

EXPLANATION OF CLIENT FUNCTIONING INDICATORS

The CLIENT IMPACT and the CLIENT FUNCTIONING FORMS are designed so that clinicians working most closely with a given adult client may record how client functioning changes during the course of treatment. The indicators for client functioning used on the form are derived from extensive work BPA has done on child abusers and neglectors in San Francisco. The indicators, which were initially drawn from the child abuse/neglect literature, have shown to be reliable measures and valid predictors of a client's propensity to abuse or neglect his/her child(ren) as well as the actual recurrence of abuse or neglect. In addition, the indicators have been shown to be conceptually distinct. The definitions of the indicators below should be carefully studied by all clinicians using the CLIENT IMPACT and CLIENT FUNCTIONING FORMS. The definitions attempt to illustrate what high and low ratings on the scales would imply.

(1) GENERAL PHYSICAL HEALTH: General health is defined as a client's physical (not mental) well-being. A low rating of this indicator would imply that a client's physical health is either chronically or sporadically so poor as to inhibit most daily activities. A high rating would imply that client's physical health or well being is good and stable and does not get in the way of daily activities. Questions to think about prior to rating client include:

> Does parent need the care of a physician or some other medical specialist very often? Does parent's physical health get in the way of certain activities? Does parent have any chronic health conditions? How does parent's health in general compare with others you know? Does parent's health go up and down or is it generally the same?

(2) CONTROL OF PERSONAL HABITS: Personal habits refers to those habits that are destructive, primarily including drug addiction or abuse, and alcoholism. Very excessive overeating may be another such personal habit which negatively influences daily functioning. Ratings should reflect the degree to which day to day responsibilities are impaired by the personal habit. A low rating would indicate that the client has no control over personal habits like drug addiction or alcoholism; i.e., a client indulges in habit in such a way that he/she is unable to effectively carry out day to day responsibilities such as child care, household maintenance, holding down a job. A medium rating would imply that although the parent has a self-abuse personal habit, he/she only occasionally fails to carry out day to day responsibilities. A high rating would indicate that client does have control over personal behavior such that he/she does not actively indulge in personal habits like alcohol or drug abuse, or if he/she has the habits they do not interfere with any daily responsibilities. Question to think about prior to rating client include:

Does the client (in fact) have a drug, alcohol, overeating or comparable personal habit? Does this habit get in the way of other activities? Has the client tried to stop? How successful has the client been in controlling or stopping the problem?

(3) STRESS CAUSED BY LIVING SITUATION: A client's living situation refers to the household in which the client is living and more specifically the relationships between the different members of the household. Stress refers to the degree of tension or compatibility between household members. This may be caused as much by the physical set-up of the living situation as by the actual responses family members have to each other. A low rating would imply that the client experiences a great deal of stress or tension from his/her living situation. A high rating implies that the client experiences little or no tension or stress from his/her living situation. Questions to think about prior to rating client include:

Who is living in the household? Are there problems within the household which make life difficult or pressured for the client? Is life relatively pleasant? If the client has a mate, is the relationship filled with constant argument, conflict, or tension? If the client is single, how much stress is caused either by being the only adult in the household or by the many temporary relationships the client might have with other adults?

(4) SENSE OF CHILD AS PERSON: The client's sense of his/her child as a person refers to the way in which the client thinks about and reacts to his/her child. A low rating would indicate that the client thinks of the child as an extension of himself/herself and not as a separate person; the client seeks much of his/her gratification from the child and is unwilling or unable to perceive that the child has his/her own thoughts, own needs, own way of doing things. A high rating would indicate that the client is able to perceive of the child as a separate person and that the client does not seek gratification solely through his/her child. Questions to think about before rating client include:

Does client seek all of his/her gratification from the child? Is the client pleased with the child only when the child behaves exactly as the parent wants the child to behave? Does the parent see child merely as an extension of himself or herself, or as a person, who is independent, who has his or her own thoughts and ways of doing things?

(5) BEHAVIOR TOWARD CHILD: Behavior toward child refers to the extent to which a clinician believes that client behaves appropriately or inappropriately toward the child. Ratings reflect the extent to which outside observers perceive noticably inappropriate behavior such as verbally lashing out at child, totally ignoring child's presence or overly responsing to child, (e.g., never letting the child get dirty, etc.). A low rating would indicate that the client is generally unresponsive, negative toward child or overly responsive, smothering. A high rating would indicate that client is generally responsive in his/her observable interactions with child (positive and cherishing) but not smothering. A medium rating would indicate that parent exhibits negative behaviors but not in the extreme. Questions to consider prior to rating client include:

> What situations can you think of when you have seen the parent with own child? How has the parent behaved? How does this compare with the way other parents you know would behave in similar situations? What was the parent's tone or voice? What overt actions or expressions of affection did you observe? How did the parent react when the child started to cry or otherwise "misbehave?"

(6) AWARENESS OF CHILD DEVELOPMENT: Awareness of child development refers to the extent to which client understands how children develop and what kinds of things one can expect a child of a given age to be able to do and not to do. A low rating would imply that client has unrealistic expectations of child and does not understand child's needs (e.g., toilet training at a far too early age; expects preschooler to take on major household responsibilities; assumes that child's crying is misbehavior and not a normal expression of a young child's needs). A high rating would imply that client understands and therefore expects age-related child behavior and anticipates child's needs. Questions to consider before rating client include:

> How well would you say parent understands what a child of a given age normally can and can't do? How well is parent aware of own child's needs and how to care for child (regardless of whether or not parent actually carries out appropriate behavior)? Does the parent have a reasonable understanding of what the range of normal children's behavior includes?

(7) EXTENT OF ISOLATION: Extent of isolation refers to the extent to which a client is isolated from others. Ratings reflect whether (or not) client has any friends or relatives to turn to for friendship, help, or support and/or tends to spend time alone rather than with others. A low rating indicates that the client has no significant or positive contacts with others and tends to spend time alone. A high rating indicates that client does have significant contacts with others (i.e., has other people to turn to for help) and tends to spend time with others. A medium rating would imply that even if client has people to socialize with, he/she does not have relatives or friends to lean on in times of need. Questions to consider prior to rating client include:

> Does the parent have any relatives/friends in the vicinity? Are these friends or relatives people the parent can count on for friendship, help, support? Would you say that the parent is generally isolated? Does parent tend to be a loner? Does the parent socialize with other people? Are these people that the client can turn to in times of need?

(8) ABILITY TO TALK OUT PROBLEMS: Ability to talk out problems refers to the extent to which a client is able or unable to talk in a constructive way about the various problems or situations he/she is confronting. A low rating may indicate that client is closed, withdrawn, or otherwise cannot talk about his/her problems; or, a low rating may indicate that while client is able to verbalize about his/her problem, he/she does so in a non-constructive way and is not open to working through the problem with someone else. A high rating implies that client is able and does talk about his/her problems and to work through them in a productive manner. Questions to consider before rating client include:

> Given that you or someone else is available to listen, to what extent is the parent able and willing to talk about his or her problems? Is the parent open or closed? Does the parent only tell part of the story or only talk about selected problems? Does the parent talk a lot about problems without being receptive to working with the problems?

(9) REACTIONS TO CRISIS SITUATIONS: Reactions to crises (i.e., job loss, new baby, moving, problems with spouse, income problems, death) refers to the ways in which a client responds to crisis situations -- with anxiety and difficulty or with some amount of composure ("cool"). A low rating would indicate that client consistently experiences great anxiety or tension when crisis situations or problems arise. A high rating would imply that problems or crisis situations are not excessively anxiety-producing nor immobilizing, but rather the client strives to handle and achieve some control over the situa-

tion. A medium rating would indicate that either the client can handle some crises but not others, or the client has some but limited control over his/her reactions to most crises. Questions to consider prior to rating client include:

> How does parent behave when confronted with crisis situations or problems? Would you say that the parent experiences excessive tension or anxiety when crisis situations arise? Does parent tend to view all new situations as "crises?" Does parent react differently to different types of crises?

(10) WAY ANGER IS EXPRESSED: Way anger is expressed refers to the extent to which the clinician perceives that the client appropriately or inappropriately expresses or controls his/her feelings of anger. A low rating indicates that the client expresses anger inappropriately without any control, (i.e., parent lashes out at innocent or uninvolved persons, resorts to damaging physical displays of anger, or totally suppresses anger). A high rating indicates that the client can express and channel angry emotions in constructive ways (i.e., this may include physical but not damaging expressions of anger). Consider the following questions before rating client on this indicator:

> Do you think that the parent has any control over his/her anger? Have you ever seen the parent angry? How has he/she behaved?

(11) SENSE OF INDEPENDENCE: Sense of independence refers to the extent to which the client is able to do things on his/her own. A low rating implies that the parent feels dependent on others and cannot get things done or make decisions on his/her own. A high rating implies that, although the client might be able to ask others for help, he/she does not feel insecure about doing things on his/her own, being independent or autonomous, making his/her own decisions. It is very likely that within the early stages of treatment, dependency on the part of the parent toward the clinician or others is a positive and important aspect of treatment. In the long run, however, independence is seen as the positive form of behavior. Thus, early indications of dependence on the part of the client do not necessarily indicate negative assessments. Questions to consider before rating client include:

> To what extent does parent need others to get things done; can parent independently take steps to find a job, a new apartment, etc? Is parent willing to go off and do new things on his/her own, i.e., take initiative? Is parent independent enough or does parent trust self enough to be able to ask for help when it is needed? Is parent able to initiate new relationships with people?

(12) UNDERSTANDING OF SELF: Understanding of self refers to the extent to which you perceive that the client has a realistic sense of his/her needs, likes, dislikes, behaviors and situation. A low rating indicates that client has a poor understanding of himself/herself (i.e., does not recognize any of the sources of his/her emotional reactions or the reasons why he/she behaves in certain ways). A high rating indicates that client understands himself/herself well enough to have a sense of his/her reactions to situations, people, behaviors (i.e, what makes him/her angry). Questions to consider prior to rating client on this indicator include:

> How well does parent understand his or her feelings and life situations? Is parent aware of his or her needs, likes and dislikes? Could parent describe his/her own patterns of behavior, likely reactions to a situation? Does parent understand self well enough to be able to initiate control over what is going on?

(13) SELF ESTEEM: Self esteem refers to the extent to which the client has a positive or negative image of himself/herself. This self image that the client has may not be at all related to your assessment of the client's understanding of self; additionally, the client's self image may differ from your image of the client. A low rating would indicate that client does not feel good about himself/herself and has a negative self image (i.e., parent assumes his/her own incompetence, inability to please others, general worthlessness). A high rating would indicate that the client has a positive self image and does feel good about himself/herself. Questions to consider prior to rating client include:

> How good would you say the parent feels about self? What situations can you think of in which the parent demonstrates feelings of worthlessness or insecurity? Does parent feel inferior? Does parent feel socially valued, accepted by others?

(14) POTENTIAL FOR FUTURE ABUSE: This indicator refers to your judgment of how likely it is that the client will abuse his/her child. Use your own definition of potential or propensity. Consider all aspects of child abuse, both physical and emotional as well as sexual. When making this rating, assume that the client will be receiving no services. Ask the question: how likely is it that this client will abuse his/her child if no (additional) services are offered? A low rating would indicate that it is very likely. A high rating would indicate that it is very unlikely. Think about other clients you have worked with or situations you've seen in which abuse re-occurred before rating client on this scale.

(15) POTENTIAL FOR FUTURE NEGLECT: This indicator refers to your judgment of how likely it is that the client will neglect or continue to neglect his/her child(ren). Use your own definition of potential or propensity. Consider all aspects of child neglect, both physical and emotional. When making this rating assume that the client will be receiving no services. Ask the question: how likely is it that this client will neglect his/her child if no (additional) services are offered? A low rating would indicate that it is very likely. A high rating would indicate that it is very unlikely. Think about other clients you have worked with or situations you have seen in which neglect re-occurred (or did not stop) before rating client on this scale.

APPENDIX A

MILESTONES IN THE DEMONSTRATION/EVALUATION EFFORT

1973	October:	Issuance of request for proposals from communities interested in establishing a demonstration program.
1974	January:	Congress passes Child Abuse Act, Public Law 93-247, establishing National Center on Child Abuse and Neglect (NCCAN).
	April:	Issuance of request for proposals for evaluation contract.
	May:	Award of three-year evaluation contract to Berkeley Planning Associates.
	July:	Presentation of evaluation plans to OCD, SRS and HRA -- Rockville, Maryland and Colorado Springs, Colorado.
	August:	First meeting of projects, federal monitors and evaluators -- Alexandria, Virginia.
	September:	First round of site visits to projects; collection of baseline data.
	November:	Begin second round of site visits to projects.
1975	January:	NCCAN funds 20 additional three-year demonstration projects.
		Ten of eleven projects fully operational.
		Projects begin record keeping for BPA.
	February:	Workshop on strategies for assessing quality -- Berkeley, California.
	March:	Third round of site visits.
		Meeting with projects -- Washington, D.C.
	May:	Projects receive second year of funding.
	June:	Begin fourth round of site visits.
	July:	Quality assessment pre-test.
	September:	Six projects assigned new Project Monitor.
		First year or evaluation work completed.

1975	November:	Evaluation assigned new Project Officer.
	December:	Second year of evaluation work funded.
1976	January:	Begin fifth round of site visits.
		Meeting with projects -- Atlanta, Georgia.
	March:	Begin quality assessment visits.
	April:	Meeting with projects -- Berkeley, California.
	May:	Begin sixth round of site visits.
		Projects receive third year funding.
		Finalization of high priority evaluation questions.
	July:	Projects receive additional funding for third year.
	August:	Begin project management/worker burnout data collection visits.
	September:	Seventh round of site visits.
		Third year of evaluation funded.
	November:	Meeting with projects -- Annapolis, Maryland.
	December:	Begin final quality assessment visits.
		End of data collection on projects' community-related activities.
		End of adult client data collection period.
1977	January:	Begin eighth and final round of site visits.
		Final community systems data collection.
	April:	Formal end of demonstration period.
		End of process data collection.
		End of child client data collection period.
		Meeting with projects -- Houston, Texas.
	September:	Draft evaluation reports completed.
	December:	Final evaluation reports completed.

GENERAL PROCESS COMPONENT

1974	July-August:	Study project grantproposals; identification of key project elements.
	September:	First site visit, identification of project characteristics and activities planned.
	October:	First site visit report, including descriptions of each project.
	November:	Second site visit, further identification of planned activities and implementation problems.
	December:	Second site visit report outlining problems and progress.
1975	March:	Third site visit, assessment of progress and problems.
	April:	Third site visit report outlining problems and progress.
	June:	Fourth site visit, further assessment of progress and problems.
	July:	Fourth site visit report outlining problems and progress.
	September:	Individual project case studies detailing all aspects of project functioning, highlighting the range of implementation problems generic to setting up such projects.
1976	January:	Fifth site visit, assessment of progress.
	February:	Fifth site visit report outlining progress.
	May:	Sixth site visit, assessment of progress.
	July:	Project Accomplishments report, including progress to date gleened from sixth site visit.
	September:	Seventh site visit, assessment of progress.
	October:	Seventh site visit report outlining progress.
1977	January:	Eighth site visit, assessment of progress and future plans.
	August:	Individual project case studies detailing all aspects of project implementation, operation and future plans.

PROJECT GOALS COMPONENT: SCHEDULE OF KEY ACTIVITIES

1974	September:	Discussions with project staff to identify project goals.
	November:	Delbecq Nominal Group Process with project staff to specify goals more clearly.
1975	January:	Report presenting individual project goals and discussing changes from original grant proposal.
	June:	Final clarification of goals with project staff and identification of measures of successful accomplishment.
	September:	Report presenting instruments for assessing accomplishment of individual project goals.
1976	January:	Project directors specify targets for goal accomplishment by end of second year.
	May:	Interviews with project staff and record reviews to determine extent to which goals were accomplished during first two years.
	July:	Report discussing extent to which each project accomplished its own goals during the first two years.
1977	January:	Final assessments with projects of extent to which goals were accomplished.
	August:	Individual project case studies including final assessment of project goals accomplishment.

COST COMPONENT: SCHEDULE OF KEY ACTIVITIES

1974	September:	Identification of discrete project service/activity categories.
	November:	Introduction of draft cost forms and methodology to projects.
	December:	Finalization of cost forms.
1975	January:	Cost methodology pre-test month.
	April:	Report presenting pre-test results and analysis plans.
	May:	Cost accounting month.
	September:	Report analyzing January and May cost data.
	October:	Cost accounting month.
1976	February:	Report analyzing January, May and October cost data.
	April:	Cost accounting month.
	September:	Report analyzing all cost data collected through April 1976.
	October:	Cost accounting month.
1977	May:	Final cost report presenting all findings.

PROJECT MANAGEMENT AND WORKER BURNOUT COMPONENT:

SCHEDULE OF KEY ACTIVITIES

1976	May:	Preliminary collection of management and organizational structure data.
	July:	Finalization of management, job satisfaction and burnout measures.
	August-September:	Visits to all projects to collect management, job satisfaction and burnout data.
	November:	Preliminary qualitative findings.
1977	January-April	Editing, processing of data.
	April:	Paper presenting further refined qualitative findings.
	June:	Final report presenting all management and burnout findings.

CASE MANAGEMENT QUALITY ASSESSMENT: SCHEDULE OF KEY ACTIVITIES

1975	February:	Workshop on strategies for quality assessment.
	April:	Report on Workshop.
	June:	Preliminary design plans report.
	July:	Pre-test at four sites.
	September:	Report presenting results of pre-test.
	December:	Report presenting final analysis plans.
1976	March-May:	Quality assessment visits at nine projects.
	July:	Memo highlighting qualitative findings from visits.
	October:	Working paper discussing reliability of instrument.
		Working paper presenting case management norms.
	December-January 1977:	Final quality assessment visits.
1977	June:	Final report presenting quality case management findings.

ADULT CLIENT COMPONENT: SCHEDULE OF KEY ACTIVITIES

1974	September:	Introduction of plans for adult client data collection to projects.
	November:	Finalization of measures.
		Presentation of proposed forms to projects and training in their use.
	December:	Finalization of forms.
		OMB clearance package submitted.
1975	January:	Projects initiate use of forms on all new adult clients.
	May:	OMB clearance received.
	June:	Collection of preliminary data.
	July:	Preliminary design report.
	September:	Report presenting preliminary client data.
	December:	Final design report.
1976	January:	Collection of forms on terminated cases.
		Further training in use of forms.
		Modest revision of forms.
		First reliability test.
	May:	Collection of forms on terminated cases.
		Further training in use of forms.
		Second reliability test.
		Collection of information on the content of services.
	July:	Working paper on the comparability of adult client services across projects.
		Working paper on the comparability of adult client impact data across projects.
	August:	Working paper analyzing intake data.
		Working paper analyzing service data.
		Working paper analyzing impact data.
	September:	Collection of forms on terminated cases.
		Third reliability test.
	October:	Addendum to working paper on comparability of impact data.
		Projects stop filling out forms on new cases.

ADULT CLIENT COMPONENT: SCHEDULE OF KEY ACTIVITIES (continued)

1977	January:	Projects complete data sets on all cases.
		Collection of all forms on cases terminated and those not yet terminated.
	February-April:	Cleaning, editing, processing of all adult client data.
	August:	Final report presenting assessment of the effectiveness of alternative services for different kinds of clients.

CHILDREN'S COMPONENT: SCHEDULE OF KEY ACTIVITIES

1975	January:	Development of problem-oriented children's instrument.
	February:	The three child-serving projects begin pre-test of instrument.
	June:	Collection of preliminary pre-test data.
	July-December:	Pre-test data analyzed; instrument revised.
1976	January:	Three projects begin using revised children's instrument.
	March:	Report outlining analysis plans.
	June:	Collection of preliminary data.
	November:	Report presenting preliminary data analysis.
1977	April:	Final collection of children's data.
	July:	Final report presenting all findings.

COMMUNITY SYSTEMS COMPONENT: SCHEDULE OF KEY ACTIVITIES

1974	July-August:	Development of baseline data collection instruments.
	September:	Begin collection of baseline data.
	October:	First site visit report, part II, presenting preliminary baseline data.
	November:	Complete collection of baseline data.
1975	March:	Report presenting design and analysis plans and complete set of baseline data.
	September:	Addendum to baseline data report.
	December:	Revision of community data collection instruments.
1976	January:	Collection of community system impact data after 18 months of project operations.
	August:	Report discussing impact of projects on community systems during first 18 months.
1977	January:	Final collection of community system impact data.
	March-April	Papers identifying essential elements of a well-functioning community-wide child abuse/neglect system.
	August:	Final community systems impact report.
		Individual project case studies including discussion of impact project had on its local community system.

APPENDIX B

PROJECT PROFILES

As a group, the projects demonstrated a variety of strategies for communityOwide responses to the problems of abuse and neglect. The projects each provided a wide variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and paraprofessionals in the provision of these services; they each utilized different coordinative and educational strategies for working with their communities; and they were housed in different kinds of agencies and communities. While not an exhaustive set of alternatives, the rich variety among the projects has provided the field with an opportunity to systematically study the relative merits of different methods for attacking the child abuse and neglect problem.

Each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado

The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred on to the central Child Protective Services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia

Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a Multidisciplinary Diagnostic Review Team, as well as to provide consultation to individual workers.

The Child Protection Center: Baton Rouge, Louisiana

The Child Protection Center, a protective services-based agency, tested out a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all CPC cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases.

The Arkansas Child Abuse and Neglect Program: Little Rock, Arkansas

In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource-poor state, like Arkansas, could expand its protective service capability by using lay therapists, supervised by SCAN staff, to provide services to those abuse cases.

The Family Care Center: Los Angeles, California

The concept behind the Family Care Center, a hospital-based program, was a demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington

This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri

A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different-aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida

Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as Parent Education classes, which others could then adopt.

Panel for Family Living: Tacoma, Washington

The Panel, a volunteer-based private organization, demonstrated the ability of a broadly-based multidisciplinary, and largely volunteer, program, to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey

This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private service agencies in the county.

APPENDIX C

Listing of Major Evaluation Reports and Papers

Reports

(1) A Comparative Description of the Eleven Joint OCD/SRS Child Abuse and Neglect Demonstration Projects; December 1977.

(2) Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977; December 1977.

(3) Cost Report; December 1977.

(4) Community Systems Impact Report; December 1977.

(5) Adult Client Impact Report; December 1977.

(6) Child Impact Report; December 1977.

(7) Quality of the Case Management Process Report; December 1977.

(8) Project Management and Worker Burnout Report; December 1977.

(9) Methodology for Evaluating Child Abuse and Neglect Service Programs; December 1977.

(10) Guide for Planning and Implementing Child Abuse and Neglect Programs; December 1977.

(11) Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings; December 1977.

Papers

"Evaluating New Modes of Treatment for Child Abusers and Neglectors: The Experience of Federally Funded Demonstration Projects in the USA," presented by Anne Cohn and Mary Kay Miller, First International Conference on Child Abuse and Neglect, Geneva, Switzerland; September 1976 (published in International Journal on Child Abuse and Neglect, Winter 1977).

"Assessing the Cost-Effectiveness of Child Abuse and Neglect Preventive Service Programs," presented by Mary Kay Miller, American Public Health Association Annual Meeting, Miami, Florida; October 1976 (written with Anne Cohn).

"Developing an Interdisciplinary System for Treatment of Abuse and Neglect: What Works and What Doesn't?", presented by Anne Cohn, Statewide Governor's Conference on Child Abuse and Neglect, Jefferson City, Missouri; March 1977 (published in conference proceedings).

"Future Planning for Child Abuse and Neglect Programs: What Have We Learned from Federal Demonstrations?", presented by Anne Cohn and Mary Kay Miller, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"What Kinds of Alternative Delivery Systems Do We Need?", presented by Anne Cohn, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"How Can We Avoid Burnout?", presented by Katherine Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Evaluation Case Management", presented by Beverly DeGraaf, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Quality Assurance in Social Services: Catching up with the Medical Field", presented by Beverly DeGraaf, National Conference on Social Welfare, Chicago, Illinois; May 1977.