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Evaluation of Child Abuse and Neglect Demonstration Projects 1974-1977 Volume III. Adult Client Impact

Berkeley Planning Associates, California

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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

In addition to describing the kinds of clients served, the kinds of services provided and the impacts of services on clients at eleven demonstration child abuse/neglect projects, this report presents an analysis of the effectiveness of alternative service strategies for abusive and neglectful parents. Several different kinds of impact measures are used, including reincidence while in treatment and reduced propensity for future maltreatment by the time services are terminated. The analyses include: the relationship between different client characteristics and impact; the relationship between different mixes of services received and impact; and the combined relationships between client characteristics, services received and impact. Analyses are presented for individual projects and for the whole demonstration program. The report includes a detailed discussion of the methodology.

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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.[1] 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.

[1]See Methodology Section of this report and particularly page 14.

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SUMMARY

Introduction

In May of 1974, prior to expenditure of funds appropriated to the Child Abuse and Neglect Prevention and Treatment Act, Public Law 93-247, the Office of Child Development and Social and Rehabilitation Services, of DHEW, jointly funded eleven three-year child abuse and neglect service projects in order to develop and test alternative strategies for treating abusive and neglectful parents and their children and alternative models for coordination of community-wide child abuse and neglect systems. The projects, spread throughout the country and in Puerto Rico, differed by 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 content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report presents the final analyses of treatment service effectiveness based on that evaluation. The purpose of this report is to describe the relative effects of different treatment strategies for different kinds of clients.

I. Methodology

In order to assess the relative effects of alternative service strategies for different types of abusers and neglectors, a system for collecting, processing and analyzing information on all adult clients who entered the demonstration projects' caseloads for treatment during a 22-month period (January 1975-November 1976) was developed. The information required was recorded by those case managers in the projects who had direct contact with the client on forms developed by the evaluator. Complete data sets, which included information on client characteristics, services received and outcomes--from the time of intake through termination --on 1724 cases were collected during the study. A range of by-project and overall program analysis techniques were used to winnow the number of items in the data set and to address the study questions. The study has a number of limitations which must be kept in mind when interpreting the findings. Data were collected from projects selected because of the different or unique strategies they proposed to demonstrate, not because they were representative of child abuse programs in general. There were no control groups, no data were collected directly from clients, and no follow-up data were collected. The impact measures used reflect the state of the art at the time the study began, and are largely judgmental. In sum, findings must be regarded as suggestive of the demonstration experience and not conclusive.

II. Descriptive Analysis

The projects did serve a heterogeneous group of clients who, as a group, differ from cases routinely handled by public protective services departments in that a somewhat greater proportion are physical abuse (as opposed to neglect) cases; and they tend to have somewhat larger families, higher educational levels and suffer from financial and health problems as well as social isolation. While household conflict is not as problematic among this study population as it is with protective services cases in general, the study cases are more likely to have been abused as children. Most families in the study sample had two adults, two or three children (one or more of whom are pre-schoolers), with the male adult employed but not the female adult. Many families suffer from marital and financial problems, mental health problems, heavy, continuous child care responsibility and social isolation.

The most frequently received service was that of one-to-one counseling (including individual counseling and individual therapy). This service was most often complemented by crisis intervention, multi-disciplinary team reviews, lay therapy, couples and family counseling, child care as well as transportation and welfare assistance. All other services were provided to 15% or fewer of the clients. Clients, on average, received three different types of services, were in treatment six to seven months, and had contact with service providers about once a week. Of all the clients served by the demonstration projects, approximately 24% received a service package which included lay services (lay therapy counseling and/or Parents Anonymous) along with other services. Only 13% received a group treatment package (including group therapy or parent education classes as well as other services); and over half (57%) received a social work model package (individual treatment but no lay or group services). Service receipt did vary considerably by project.

Service receipt varied somewhat depending upon the type of maltreatment, although cases designated as serious (in terms of the severity of the assault on the child) were more likely to receive multidisciplinary team case review, couples/family counseling and crisis intervention. Some client characteristics appear to have been relevant in decisions to provide clients with certain mixes or models of service.

Approximately 30% of the cases in the study population severely reabused or neglected their children while they were in treatment. By the end of treatment, 42% of the clients were reported to have reduced propensity for future abuse or neglect. A somewhat smaller percent were said to have improved in aspects of daily functioning indicated to be a problem at intake. Variations on these outcomes are seen for individual projects.

III. Outcome Analysis

Reincidence While in Treatment

Most client characteristics are not highly associated with reincidence. The type of abuse or neglect that brought the case into treatment in the first place and the seriousness of that maltreatment, however, are useful predictors of whether or not there will be reincidence. The services a client receives may be a function of whether or not reincidence in treatment has occurred or may help explain why there is not reincidence. Keeping this in mind, specialized counseling is the service most highly associated with severe reincidence. Seriousness of the assault that brought a case into treatment has a much stronger relationship with reincidence than these or any other services, or service models.

Improvement in Select Areas of Daily Functioning

Clients who both physically abuse and neglect their chilren, emotional maltreators and clients with severe household situations (including a history of abuse and neglect) are less likely to improve on the functioning indicators used in this study. Other client descriptors have either very small or no relationships to whether or not such improvement is reported. Clients who are in treatment for at least six months, and clients who received lay services (lay therapy counseling or Parents Anonymous) are the clients most likely to show improved functioning by the end of treatment. While no one discrete service stands out as having a strong effect on this outcome when others are controlled for, the lay service model (receipt of lay therapy and/or Parents Anonymous along with other services) does have the strongest effect of the service models studied. The lay model also has the strongest effect on improvement in each of the select areas of functioning, followed by the group model. Client descriptors contribute somewhat to interpreting this outcome.

Reduced Propensity for Future Abuse or Neglect

While potential and physical abusers are somewhat more likely to have reduced propensity for future abuse and neglect than other types of maltreators, there do not appear to be any client descriptors that have a strong effect on this outcome. Clients receiving lay services (Parents Anonymous and lay therapy) were found to be those more likely to have improved by the end of treatment than clients receiving other services. Length of time in treatment appeared to have a strong effect on outcome; frequency of contact had a small but substantively interesting effect. The only client descriptors which helped to explain outcome when considered along with service provision were the absence of substance abuse as a problem and the absence of severe reincidence during treatment. When cases are studied by type of maltreatment, the lay model continues to appear as having a stronger effect than other services for all groups except physical abusers, for whom the group service model has a stronger effect.

IV. Discussion and Implications

Outcome Findings and Implications

Given that about 30% of the clients served were reported with severe reincidence while in treatment, the initial intervention strategies of the projects are called into question, suggesting that projects were not sufficiently protecting families' children. Also only 42% of the projects' clients who were reported at the beginning of treatment to be likely repeators, many of whom did severely reabuse or neglect during treatment, were found to have reduced propensity for future abuse or neglect by the end of treatment. Comparisons with findings from other studies to determine the validity of this finding are not possible, given the paucity of other evaluation studies in the field and lack of comparability between those completed to date. These findings do suggest that (a) more effective, early intervention strategies for protecting the child must be identified, and (b) irrespective of the success of early intervention, child abuse and neglect programs currently can probably not expect to have much more than a 40-50% success rate.

Treatment Outcome Findings and Cost Implications

It was learned in this study that relative to any other discrete services or combinations of services, the receipt of lay services--lay therapy counseling and Parents Anonymous--in combination with professional services is more likely to result in positive treatment outcome. Group services (group therapy, parent education classes) as supplements to a treatment package also have a notable effect, particularly for the physical abuser. Providing treatment for more than six months also appears to contribute toward treatment success.

These services which proved more effective also tend to be those which are the least expensive. For example, providing just lay therapy counseling to a client for one year costs $377 as contrasted with $546 for group therapy and $767 for individual counseling. The annual cost for a client in a program emphasizing lay services is $1380 as contrasted with $1691 in a program emphasizing individual counseling. The cost per successful outcome in a lay-oriented program is $2590 per client year, the most cost-effective treatment program. Comparable costs per successful outcome in a program emphasizing the social work model (i.e., individual counseling) is $4462 and $4081 in a program emphasizing group services. The group model is more effective and less costly than the social work model. In addition, it is more cost-effective to keep a client in treatment over six months.

Future Research and Evaluation

The data base generated during this study is amenable to many additional, important analyses, notably concerned with service prescription and the dynamics of the treatment process. For example, what are the crises and other problems confronted by clients while in treatment that may

explain both severe reincidence while in treatment as well as final treatment outcome? In addition, there is a great need for additional data to be collected so that the longer term effects of treatment, from both client and clinician perspectives, can be studied.

INTRODUCTION

History of the Demonstration Effort

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 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.[1] 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 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;

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[1]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.

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

Overview of the Demonstration Evaluation

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. The overall purpose of this 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 site 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. Concomitantly, 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. This report presents part of the final knowledge gained from the projects' joint experiences.[1]

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

Project Profiles

As a group, the projects demonstrated a variety of strategies for community-wide 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 Center 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 program, 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 services 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.

The 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.

The Adult Client Impact Analysis of the Evaluation

The central concern of the evaluation of the Joint OCD/SRS child abuse and neglect demonstration projects has been the assessment of the effectiveness of alternative service strategies for abusive and neglectful parents. Both the federal sponsors of the demonstration and each of the individual projects were interested in testing out both existing and new approaches to treatment, in order to expand the knowledge base about treatment effectiveness. The evaluation served as the vehicle for documenting and analyzing the projects' collective experiences in treating abusive and neglectful parents. The purposes of the Adult Client Impact analysis were:

(1) to describe the demographic and case history characteristics of the clients served by the demonstration projects;

(2) to determine what kinds and what quantity of services were provided to adult clients;

(3) to determine what kinds of short-term impacts the projects had on their adult clients;

(4) to begin to assess the effectiveness and cost-effectiveness of alternative service strategies or mixes of services for different types of clients.

The overall concern, then, was not to compare the demonstration projects against each other, in terms of which project was most "successful" with its clients, but rather to assess the general effectiveness of different treatment approaches in reducing the likelihood of future abuse or neglect for different types of clients. This report presents the findings from an analysis of 1724 adult clients who received treatment services from the demonstration projects. Care must be

used in interpreting the findings from this effort. The data were generated from projects selected as demonstrations because of the different or unique approaches to treatment they proposed to implement, not because they were representative of child abuse and neglect programs across the country. And because of the varied techniques used to recruit or identify clients, clients served are not necessarily representative of abusive and neglectful parents in general. Thus, one cannot generalize from the findings to the field. In addition, a number of constraints were placed on the types of data collected and the methods of data collection, as discussed in Section I. These constraints limit the findings to suggestive, but not conclusive, findings about treatment effectiveness.

SECTION I: METHODOLOGY[1]

Overview

In order to assess the relative effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors, a system for collecting, processing and analyzing information on all adult clients who entered the demonstration projects' caseloads for treatment during a 22-month period (January 1975-November 1976) was developed. The information required was recorded by those case managers and treatment workers in the projects who had direct contact with the client, on forms developed by the evaluator. Complete data sets on 1724 cases were collected during the study.

Data Items

Three different kinds of data were collected on each client included in the study: client descriptors (including the nature and severity of the maltreatment, or potential maltreatment, that brought the case into treatment, as well as personal and household client characteristics); service descriptors (including the amounts and types of services received directly from the project and from other agencies); and outcome measures (including improvement in select aspects of daily functioning, reduced propensity for future abuse or neglect, and reincidence of abuse or neglect during treatment). Table I.1 displays the total set of data items. These data were integrated with information on service costs, and case and program management practices also collected during the evaluation to constitute the Adult Client Impact data set.

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[1]See Appendices B, D and E for detailed discussion of methodology

TABLE I.1: Adult Client Impact Data Items*

Client Descriptors

- date of referral
- source of referral
- date intake completed
- case status (established or not)
- severity of case (type and severity of maltreatment)
- perpetrator
- legal actions taken
- previous record/evidence of maltreatment
- number, age, sex of maltreated child(ren)
- number, age, sex of other children in family
- special characteristics of children
- identification of all adults in household
- parents' ages
- parents' marital status
- parents' education
- parents' race/ethnicity
- parents' employment
- amount and sources of family income
- primary problems in household leading to maltreatment
- services planned for parent(s)
- services planned for child(ren)

Service Descriptors (amount, type, source)

- multidisciplinary team review (# reviews)
- individual counseling (# contacts)
- parent aide/lay therapy counseling (# contacts)
- couples counseling (# sessions)
- family counseling (# sessions)
- alcohol counseling (# sessions)
- drug counseling (# sessions)
- weight counseling (# sessions)
- 24-hour hotline counseling (# calls)
- individual therapy (# contacts)
- group therapy (# sessions)
- Parents Anonymous (# sessions)
- parent education classes (# sessions)
- crisis intervention (# contacts)
- day care (# days)
- residential care for child (# nights)
- crisis nursery (# visits)
- homemaking (# contacts)
- medical care (# visits)
- babysitting (# times)
- transportation (# rides)
- emergency funds (amount dollars)
- welfare assistance (yes or no)
- family planning counseling (# sessions)
- job training (# sessions)

Service Descriptors (continued)

- psychological/other testing (# tests)
- follow-up (# times)

Impact Descriptors

(a) Improvement on functioning indicators
- general health
- control over personal habits
- stress from 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

(b) Reduction in propensity
- potential for future abuse
- potential for future neglect

(c) Accomplishment of goals of treatment

(d) Reincidence while in treatment
- severe physical abuse
- moderate physical abuse
- mild physical abuse
- sexual abuse
- emotional abuse
- severe physical neglect
- moderate physical neglect
- mild physical neglect
- failure to thrive
- emotional neglect

(e) Reason for termination

*Definitions of these terms appear in Appendix C.

Methods of Data Collection

A number of different forms were developed to be completed by treatment workers at various points during the treatment process. These forms, which appear in Appendix C along with the instructions for their use, include: an Intake form, a Goals of Treatment form, a Client Impact form, a Client Functioning form, a Services form, and a Follow-Up form. In the fall of 1974, the complete set of forms was introduced to projects' treatment staff; group training in the uses and purposes of the forms was conducted (such training continued during quarterly site visits to the projects for the duration of the evaluation). Project case managers began filling out these forms on all cases accepted into the projects' treatment caseload as of January 1, 1975.[1] Collection of forms on terminated cases occurred during the quarterly site visits over the next 24 months. In the winter of 1977, forms on all cases opened for treatment by November 1, 1976 were collected, whether they were terminated or not.[2]

Quality Controls and Data Processing

A complete system for quality control and error checking was implemented, starting with intensive and ongoing training of treatment staff in the use and purposes of the forms. Random checks of the quality of form completion were made during site visits. Forms on terminated cases were checked by evaluation staff first at the project sites at the time of collection for missing data and obvious errors, and again at the evaluator's offices. At the time of data collection, ID numbers were assigned to all case, and names and other identifying information was removed. After treatment staff were contacted to supply missing data and to correct errors, and forms were logged by project and ID number, forms were batched by type, keypunched and verified. Random

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[1]With very few exceptions, forms were completed by the person responsible for the management of the case. This person also provided some of the treatment services to the client and often received input from other treatment workers (lay therapists, group counselors, etc.) before completing the forms.

[2]Forms for cases not terminated by this time were completed as if the case had been terminated.

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 to the above, two types of formal reliability tests were employed. To determine the reliability of certain intake and impact measures, workers completed portions of the Adult Client forms for three fictionalized child abuse or neglect cases. Ratings were compared across workers and projects to determine which measures were eliciting unreliable data; measures consistently found to be unreliable were dropped. To determine the comparability of services with the same name across projects, because of the concern that real differences across projects would affect the comparability of services, in addition to providing projects with definitions of service categories, a content analysis of the services offered by each project was conducted; services with the same key dimensions across workers or projects were provided with the same name or label.

In summary, a variety of efforts was undertaken to make sure that the data were of the highest quality possible and that the data items and the data itself was comparable from across projects to allow for comparison and pooling.[1]

Data Analysis

The central theme in the data analysis was the need to determine which of the client descriptor, service and impact variables were the

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[1]A major concern, given that some projects would be able to provide data only on a small number of cases, was that the data be amenable to pooling, to maximize the number of cases, and thus the variety of analyses possible. In order to be confident of pooling, given the many differences across projects, analysis of those data items of relevance for this part of the study, e.g., services, was essential to make sure that all projects interpreted or used the terms in the same way. (see Appendix E)

most efficacious for learning about the effectiveness of treatments for child abuse and neglect. We relied on theory and the study hypotheses 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 contingency tables, simple and partial correlations and factor analyses, and finally to multivariate analysis techniques. This strategy, as depicted in Table I.2, allowed us to better understand and appraise the quality and nature of the data collected, eliminating many variables or creating new ones before the 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 I.2

Data Analysis Steps

A. Preliminary, Descriptive Analyses

1. Frequency counts on all data, for the entire data set and by project
2. Simple bivariate analyses (cross-tabulations, correlation matrices) within data categories (client descriptors, service descriptors, outcome descriptors)
3. Reduction in number of variables within data categories using theory and factor analysis

B. Outcome Analyses

4. Simple bivariate analyses across data categories
   (a) client characteristics and service receipt
   (b) client characteristics and outcome
   (c) service receipt and outcome
5. Creation of service models
6. Multivariate analyses (multiple regression, discriminant function analysis)
   (a) outcome and select client descriptors
   (b) outcome and select service descriptors and service models
   (c) outcome and most salient client and service measures
7. Cost-effectiveness analysis

Limitations

There are a number of constraints that were placed on this study which limit the degree to which one can generalize from the findings. First, the demonstration effort was not a controlled experiment. Projects were selected to reflect a diversity of organizational settings and treatment strategies which are not necessarily representative of child abuse and neglect programs in general; no control groups were established; clients were not randomly assigned to treatment services. While numerous, useful analyses can be performed on the data collected, findings must be interpreted in this context--generalizations to what might occur in all child abuse and neglect programs cannot be made. Second, the study began at a time when only rudimentary measures of short-term treatment impact existed[1] Given the state of the art, the best available short term impact measures--which were amenable to an evaluation study such as this--were used.[2] Conscious efforts were made to maximize their reliability and validity. The impact measures remain as subjective judgments, however, and must be interpreted in that light. Third, the study was limited to treatment workers as sources of data. Clients were not contacted directly to ascertain assessments about treatment effectiveness. Thus, the impact measures are clinical assessments made by those persons responsible for the management and treatment of a case; they may differ from client assessments of impact and may be biased. Finally, the data collection period extended only though the end of treatment for any given client; no follow-up was conducted. This study results reflect changes in client functioning only during treatment and not necessarily what happens after service delivery is completed.

In the context of these limitations, there exists debate about the most appropriate ways to analyze and interpret the adult client data set. Stricter viewpoints would limit analysis to within-project data because of the differences across projects in terms of organizational base, staffing patterns, treatment techniques and admissions criteria. While we have done such analyses, we have also compared data across projects--recognizing project differences--and we have pooled data from all projects to describe the overall demonstration program experience--recognizing the constraints on generalizing from resultant findings.

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[1] What may appear to some as an obvious measure of impact--reincidence of abuse or neglect--was (a) not a sufficient impact measure for this study in part because no after-treatment follow-up was conducted and (b) at the time the study began, not well operationalized by researchers in the field.

[2] The measures used are discussed at length in Section III.

SECTION II: DESCRIPTIVE ANALYSIS[1]

As the first step in the data analysis, descriptions of the data set were generated including: (a) the kinds of families that appeared in the projects' caseloads; (b) the kinds of services provided to these clients; and (c) the kinds of outcomes reported. Data are analyzed by project and for the entire demonstration program.

Summary of Findings

The projects did serve a heterogeneous group of clients who, as a group, differ from cases routinely handled by public protective service departments in that a somewhat greater proportion are physical abuse (as opposed to neglect) cases, and they tend to have somewhat larger families, higher educational levels, and suffer from financial and health problems as well as social isolation. While household conflict is not as problematic among this study population as it is with protective service cases in general, the study cases are more likely to have been abused as children.

The most frequently offered service was that of one-to-one counseling (including individual counseling and individual therapy). This service was most often supplemented with crisis intervention, multidisciplinary team reviews, lay therapy, couples and family counseling, as well as transportation and welfare assistance. All other services were offered to 15% or fewer of the clients. Clients, on average, received three different types of services, were in treatment 6-7 months and had contact with service providers about once a week. Approximately 30% of the clients received a service package which included (but was not limited to) lay services (lay therapy counseling and/or Parents Anonymous). Only 12% received a group treatment package (including group therapy or parent education classes as well as other services); and over half (54%) received a social work model package (individual treatment but no lay or group services).

Service receipt varied somewhat depending upon the type of maltreatment; cases designated as serious (in terms of the severity of the assault on the child) were more likely to receive multidisciplinary team case reviews and crisis intervention. Some client characteristics appear to have been relevant in decisions to provide clients with certain mixes or models of service.

Approximately 30% of the cases severely maltreated their children while in treatment; 42% of those identified at intake as having a potential for continued maltreatment were reported with reduced propensity for maltreatment by the time services were terminated.

A. The Kinds of Families That Appeared in the Projects' Caseloads

Prior to addressing questions of the relative success or effectiveness of treatment, it is important to look at who was receiving services. What kinds of families, both in terms of the nature and severity of abuse or neglect committed and their salient demographic characteristics, did the projects serve? To what extent are these families similar to those served by protective services and other child abuse and neglect agencies across the country?

1. Who did the Projects Serve?

The characteristics of the families served by the projects appear on Table II.1. The column on the far right presents data for all families served by the projects as a group.

Source of Referrals. Cases were referred to the projects from a wide variety of sources, and very often more than one source. The largest percentage of cases across all projects were referred by a public social service agency; other agencies referred cases in the following order: schools, hospitals and law enforcement. Close to 10% of the cases were referred by acquaintances or neighbors; another 9% were self-referrals. Only 3% of the referrals were from private physicians. Notable variations in individual projects include: Arkansas and Tacoma received relatively higher percents of referrals from private physicians (11% and 7%); Arlington and Bayamon received very few referrals from the medical community; Baton Rouge had quite a high rate of referral from the schools (27%) as well as law enforcement (18%); St. Louis and Tacoma had high rates of self-referrals (33% and 26%). (Los Angeles reports that most of their cases were referred by the medical community; St. Petersburg reports that close to one-third of their cases were self-referrals.)

Nature of the Problem. Of the cases seen by the projects, over one-quarter were labeled as cases in which the alleged abuse was established, and over one-tenth in which the alleged neglect was established. Baton Rouge, St. Louis and Tacoma had consistenly higher substantiation rates for abuse than other projects; Bayamon had considerably higher substantiation rates for neglect.

TABLE II.1

Information on Cases Served by the Projects During 1975 and 1976*

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Source of Referral**									
Private physician	3%	2%	2%	--	11%	4%	7%	1%	3%
Hospital	15	5	17	4	14	19	17	19	14
Social service agency	12	13	11	75	12	35	20	17	19
School	21	22	27	3	11	1	5	15	16
Law enforcement	9	6	18	2	3	--	3	11	8
Court	--***	7	1	--	3	3	8	3	3
Parent	3	8	5	2	2	1	3	4	4
Sibling	1	1	--	--	1	--	--	--	.5
Relative	5	6	16	2	11	1	10	7	7
Acquaintance/neighbor	11	17	8	3	17	3	7	7	10
Self	11	7	2	4	6	33	26	5	9
Anonymous	4	3	5	--	9	--	1	2	3
Case Status									
Abuse established	29%	10%	42%	29%	37%	41%	34%	21%	26%
Neglect established	3	14	5	24	11	6	14	18	12
Type of Maltreatment									
Potential abuse/neglect only	46%	30%	9%	25%	15%	13%	18%	23%	28%
Emotional maltreatment only	8	21	6	22	11	17	19	14	14
Sexual abuse	5	2	14	2	4	1	2	5	4
Physical abuse	37	14	49	20	51	60	39	27	31
Physical neglect	4	31	18	28	11	4	16	28	20
Physical abuse and neglect	--	4	4	3	8	5	6	4	3
Severity of Case									
Serious assault on child	18%	24%	27%	42%	43%	37%	32%	33%	28%
Previous record/evidence of maltreatment	23%	29%	21%	63%	62%	32%	23%	32%	29%
Responsibility for Maltreatment									
Mother	47%	54%	50%	48%	52%	73%	49%	52%	52%
Father	31	20	35	25	25	12	16	22	24
Both	16	23	13	14	20	14	34	22	29
Other	6	3	3	13	2	1	1	5	5
Legal Actions Taken									
None	40%	38%	25%	44%	19%	19%	15%	30%	31%
Court hearing	11	7	10	1	15	12	33	5	10
Court supervision, child home	2	4	15	--	4	5	7	1	4
Temporary removal	5	3	15	1	4	4	43	7	8

(Legal Actions Taken continued on next page)

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 12 and 11, respectively; information on these cases has been included in calculations for the "Total" column. Individual statistics for Neah Bay clients have not been included because they were not made available to the evaluator. Numbers in any of the variable sets may not add to 100% owing to rounding.

**Numbers do not add to 100% since more than one category may have been checked for a given case.

***Indicates less than one-half percent.

Table II.1 (continued)

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Legal Actions Taken (continued)									
Foster care	6%	5%	6%	2%	9%	21%	18%	11%	9%
Permanent removal	--	<1	--	--	--	--	1	1	<1
Criminal action for adult	3	1	4	1	1	5	5	5	3
Reported to mandated agency	56	32	21	5	70	47	24	60	46
Reported to central registry	21	40	30	--	48	18	3	40	30
Information on Children									
Premature child	6%	4%	5%	1%	5%	8%	13%	4%	5%
Mentally retarded child	2	6	5	6	1	1	7	4	4
Physically handicapped child	4	3	2	10	5	4	4	3	4
Emotionally disturbed child	3	6	18	2	2	1	12	6	6
Adopted/foster child	4	8	1	1	4	8	4	4	5
Unwanted pregnancy	4	4	5	5	6	3	7	6	5
Information on Household: Composition									
Mother/mother substitute present	98%	76%	87%	100%	97%	98%	91%	98%	92%
Father/father substitute present	71	44	59	71	69	51	60	54	58
Families with one adult	25	39	32	23	22	36	36	37	31
Families with 3 or more adults	3	15	10	9	9	12	8	7	8
Average number children in family	2.3	2.0	2.6	3.3	2.3	2.3	2.5	2.7	2.4
Families with one child	27%	45%	26%	11%	32%	26%	33%	26%	30%
Families with 4 or more children	19	12	23	41	18	10	22	30	21
Families with pre-schoolers	78	57	66	83	89	97	88	65	73
Information on Household: Education									
Mother: post-high school	8%	23%	21%	19%	8%	24%	26%	10%	15%
Father: post-high school	19	34	25	40	21	28	26	15	23
No high school degree in family	58	50	73	63	67	41	70	71	61
Information on Household: Race/Ethnicity									
Mother: Caucasian	80%	69%	63%	48%	80%	56%	92%	42%	65%
Father: Caucasian	84	72	66	41	79	65	84	45	68
No minorities in family	75	66	59	38	78	55	81	39	59
Information on Household: Employment									
Mother employed	36%	49%	30%	27%	31%	22%	17%	27%	34%
Father employed	80	84	85	66	80	79	76	74	79
No employment in family	23	19	31	35	29	44	42	38	30
Information on Household: Income									
Average total family	$8100	$10,000	$7400	$5000	$5400	$5500	$6000	$7500	$7700
Income <$5500	42%	46%	57%	73%	77%	73%	69%	67%	56%
Income >$12,000	15	24	17	5	5	6	7	13	15
Information on Household: Age									
Average age of mothers	27 yr	32 yr	30 yr	31 yr	25 yr	26 yr	26 yr	31 yr	29 yr
Average age of fathers	31	36	33	39	29	30	28	36	33

Table II.1 (continued)

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Problems in Household Leading to Maltreatment*									
Marital	44%	38%	41%	58%	40%	44%	40%	33%	40%
Job related	21	20	24	8	18	18	24	10	18
Alcoholism	9	17	8	36	8	6	5	15	13
Drugs	4	8	2	3	4	5	7	8	6
Physical health	14	20	16	32	18	14	28	18	19
Mental health	29	34	24	38	23	31	13	29	29
New baby	11	8	11	7	17	9	23	9	11
Argument/physical fight	21	21	18	50	15	22	18	14	20
Financial problems	41	42	46	57	57	49	65	43	46
Mentally retarded parent	1	3	5	3	5	--	1	4	3
Pregnancy	4	2	2	2	6	6	5	4	4
Heavy continuous child care	32	21	39	38	39	56	51	27	33
Physical spouse abuse	12	10	10	23	11	10	10	7	11
Recent relocation	18	16	16	1	24	10	36	10	16
Abused as child	41	8	16	8	21	36	38	9	21
Normal discipline	26	12	14	20	31	21	31	19	21
Social isolation	35	28	15	14	38	50	19	24	29
N =	349	267	131	95	180	78	93	370	1686

*More than one item may have been checked for a given case.

In terms of type of maltreatment, the projects served a wide variety of cases. Twenty-eight percent were labeled as potential abuse or neglect cases, with Adams County seeing a substantially higher proportion of these than other projects. An additional 14% were labeled as cases of emotional maltreatment, with Adams County and Baton Rouge seeing the fewest of these. For the remaining 58% of the cases, typically more than one type of maltreatment was identified. In sorting out the most serious of the actions toward the child, 4% were categorized as sexual abuse cases (many of which were in the Baton Rouge caseload), 31% were categorized as physical abuse, 20% as physical neglect and 3% as both physical abuse and neglect. Thus, overall, the projects served more abuse than neglect cases, with St. Louis, followed by Baton Rouge, serving the highest proportion of such cases. Projects with the most varied caseloads included Arlington and Union County; this is likely explained by the projects' existences as the local protective services agencies responsible for serving all identified cases in the county. Other projects were more likely to hand-pick the cases they served.

Twenty-eight percent of all cases were those in which a serious assault on the child occurred. Arkansas and Bayamon had a greater proportion of such cases in their caseloads, followed by St. Louis, Union County and Tacoma. Approximately the same percent of cases were identified as having a previous record or evidence of maltreatment. Once again, Arkansas and Bayamon had the greatest proportion of such cases.

Across all cases mothers were labeled as responsible for the maltreatment in 52% of the cases, fathers in 24% and both parents in 29%. This pattern generally holds up in individual project caseloads; the most significant exception is St. Louis, where mothers were labeled as responsible much more frequently than in other projects.

In 31% of the cases overall no legal action was taken (including reporting the cases to the designated mandated agency or the central registry, as well as court intervention). The differences are interesting, with Arkansas, St. Louis and Tacoma, three essentially private agency programs, ensuring legal intervention for a higher proportion

of their cases than the other projects. Beyond the reporting of cases to legally mandated agencies (46%) or central registries (30%), the legal actions taken are rather minimal, with 10% or fewer of the cases going through a court hearing and/or having a child removed on a temporary basis. This is reflective of the small number of severe abuse or neglect cases. Permanent removals rarely occurred. In Baton Rouge, Arkansas and Tacoma one sees these activities occurring more frequently; this has mostly to do with the legal systems in these projects' communities, since these projects did not have significantly higher proportions of severe cases than other projects.

Demographic Information. First we look at the composition of the households. Across all projects, 92% of the families served had a mother or mother substitute present in the household. All of the individual projects, except for Arlington where only 76% of the families had a mother figure present, were close to this average. The overall percentage of families with a father or father substitute present was substantially lower--58%. Data from individual projects suggest that in Adams County, Bayamon and Arkansas a father figure is more likely to be present than in the other projects. Irrespective of a client's actual legal marital status, an important factor for these families is whether there is only one adult in the household. In 31% of the families this was the case, with cases in Adams County, Bayamon and Arkansas less likely to have only one adult in the home.

The size of households also varied by the number of children present. While 30% of the families overall had only one child, close to one-half of the families in Arlington had only one. Twenty-one percent of all families had four or more children; a large proportion of these larger families were in Bayamon and Union County. Across all projects 73% of the families had pre-schoolers; families with pre-schoolers appear with greater frequency in the caseloads of Arkansas, St. Louis and Tacoma. (One hundred percent of Los Angeles' families had pre-schoolers.)

Next, we look at certain demographic characteristics of the members of the household. Educational attainment across all projects is generally low, with 15% of all mothers possessing post-high school education and 23% of all fathers, and 61% of the families with no high school degree. Families in Adams County, Arlington and St. Louis are most likely to have at least one adult with a high school degree, although Tacoma's caseload represents the largest proportion of more highly educated mothers and Bayamon's the largest proportion of more highly educated fathers.

Approximately 60% of all families in the projects' caseloads were Caucasian. Higher percents of Caucasian families were seen in Adams County, Arkansas and Tacoma. (In addition, St. Petersburg's caseload was 100% Caucasian.) Projects serving the greatest proportions of minorities were Bayamon and Union County. (And Los Angeles, whose caseload was 100% Black.)

The average age of parents across all projects was 29 years for mothers and 33 years for fathers. Adams County, Arkansas, St. Louis and Tacoma tended to serve younger mothers as well as younger fathers. (Los Angeles also served very young parents.)

In close to 80% of all families across projects at least the father (if present) was employed; in addition, 34% of the mothers were employed. However, in 30% of the families, no adult was employed. The highest employment rate among males was seen in Baton Rouge, followed by Arlington. The lowest rate was in Bayamon (St. Petersburg and Los Angeles also had very few employed males). The highest employment rate among women was seen in Arlington. Tacoma had the lowest. The overall highest employment rates were in Arlington. Closely related to employment rates was annual family income. The overall project average was $7700, with Arlington highest at $10,000 and Bayamon lowest at $5500. (The average family income in Los Angeles was even lower, at about $3800.)

Finally, we look at the prevalence of different kinds of problems in the households which appeared to be precursors to or causes of the maltreatment that brought cases to the projects' attention. The problems most frequently cited as leading to the maltreatment across all

projects are: marital problems; financial problems; and problems arising from heavy, continuous child care responsibilities. Other salient problems include mental health problems and social isolation. These items appear to be significant problems in each of the individual projects' caseloads with minor exceptions. Marital problems appeared less frequently in Union County; mental health problems appeared less frequently in Tacoma; heavy, continuous child care responsibilities were less prevalent in Arlington (the project with the largest proportion of families with only one child); and social isolation did not seem as problematic for the families of Baton Rouge, Bayamon and Tacoma. In Bayamon, arguments, physical fights including physical spouse abuse, are cited more frequently as problems than in other projects; in Tacoma recent relocations appear more frequently than elsewhere.

Summary of Characteristics of Families Served by the Demonstration Projects as a Group

The projects then did serve a heterogeneous group of families both in terms of the type of maltreatment and other characteristics. Cases were referred to the projects from many different agencies and individuals, most notably social service agencies, schools, hospitals, and neighbors or acquaintances. Close to 10% of the cases were self-referrals. In well under half of those cases referred and accepted for treatment, the alleged abuse or neglect was actually established. And, 28% were labeled as potential rather than actual cases. Fourteen percent were identified as emotional abusers and neglectors only, and 4% as sexual abusers. The remaining 54% of the cases had physically maltreated their children--31% by physical abuse, 20% by physical neglect, and 3% a combination of both. Of all the cases, 28% are classified as those in which a serious assault occurred (including sexual abuse and severe or moderate physical abuse or neglect,[1]) and 29% were classified as those with a previous record or evidence of abuse.

In most cases (52%) the mother was identified as responsible for the maltreatment, a responsibility shared with the father in 29% of the cases and attributed to the father alone in 24%. Under one-third of all cases (presumably the potential cases) required no legal intervention or formal reporting. For the remaining cases, the "legal" action taken most frequently was the formal reporting of cases (46% to a legally mandated agency; 30% to a central registry). Only 10% of all cases required a court hearing, and fewer than that more extensive legal intervention.

[1]The percentage of serious maltreatment may well be greater if certain forms of emotional maltreatment are included, but there is no way to differentiate serious from mild emotional maltreatment for this data set.

Most families served by the projects as a group had: two or three children, including one or more preschoolers; two adults present, both of whom were Caucasian, neither of whom had a high school degree, with the male adult employed, but not the female. Marital and financial problems are likely to help explain the abuse or neglect incident, which may have additionally been triggered by heavy, continuous child care responsibilities, social isolation and mental problems.

2. How Do the Demonstration Project Cases Compare with Those Seen by Other Agencies?

For purposes of establishing the representativeness of the data set relative to cases of abuse and neglect treated by other agencies across the country--most notably protective services cases--characteristics of the clients served by the demonstration projects were compared with those families reported to the American Humane (AH) in Denver, Colorado on the National Reporting Form developed under grants from the U.S. Office of Child Development from protective services agencies in 30 states during 1976.[1] Comparisons focused on the characteristics of those reports received by protective services agencies and validated, rather than looking at all reports, because the cases in the evaluation data set are those that the projects chose to provide treatment services to and in that sense are most comparable to the validated AH cases.

With respect to the source of referral, as can be seen by comparing data on Tables II.1 and II.2, there are few differences between the two data sets. A greater proportion of cases reported to the demonstration projects come from social service and other agencies and a smaller proportion from law enforcement and private citizens. This is to be expected since many of the projects are not the legally mandated agency to receive reports--as is the case with agencies reporting to AH--but rather receive many referrals from those types of agencies reporting to AH.

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[1] Of the 30 states, only one, Louisiana, houses one of the demonstration projects under study. Because of variation in state reporting laws, these data are not necessarily a reflection of the incidence of maltreatment in these 30 states.

Characteristics of Families Reported During 1976 from Thirty States on the National Reporting Form to the American Humane and Validated (unless otherwise stated)

*Source of Referral[a]	All Cases	Validated Cases
Private physician	2%	3%
Hospital	10%	13%
Social service agency	9%	9%
School	11%	15%
Law enforcement	11%	14%
Court	2%	2%
Parent	9%	8%
Sibling	1%	1%
Relative	13%	10%
Acquaintance/neighbor	18%	14%
Anonymous	6%	3%
Other agency	5%	5%
	N= 40,576	19,627

Simple Classification of Maltreatment

Substantiated abuse	43%
Substantiated neglect	47%
Substantiated abuse and neglect	10%

Expanded Classification of Maltreatment

Physical abuse	18%
Physical neglect	49%
Sexual abuse	3%
Emotional abuse/neglect	32%

Severity of Maltreatment for Involved Children

No treatment	70%
Moderate	22%
Severe	8%
Serious[c]	30%

Legal Actions Taken for Involved Children

Court ordered placement	8%
Permanent removal	<1%
Voluntary placement	8%

Information on Household

One adult at home	39%
Mother: average age	25 yrs.
Father: average age	35 yrs.
Teenage parent in family	at least 15%
Mother: Caucasian	69%
Father: Caucasian	75%
Mother: high school degree	33%
Father: high school degree	41%
Mother: employed	30%
Father: employed	76%

Information on Household (continued)

Income less than $5500	approximately 51%
Income more than $12,000	approximately 13%
Average family income	at least $6760
Families on public assistance	42%

Information on Children

Average number children in household	1.7
Premature	2%
Mentally retarded	3%
Physically handicapped	3%
Emotionally disturbed	7%

Problems in Household Leading to Maltreatment[a,d]

Marital problems	38%
Alcoholism	16%
Drugs	3%
Physical health problems	5%
Mental health problems	17%
New baby in home	12%
Argument/fight	35%
Financial difficulties	39%
Heavy, continuous child care responsibilities	26%
Physical spouse abuse	13%
Recent relocation	17%
Overcrowded housing	20%
History of abuse as child	10%
Normal method of discipline	9%
Social isolation	14%

[a] More than one item may be checked for a case; thus numbers will not add to 100%.

[b] Percents reported here reflect state reporting laws and not necessarily actual incidence.

[c] Serious includes: hospitalized, permanent disability or fatality.

[d] Based on 4,167 reports received by AH in 1975.

*It is interesting to compare the AH source of reports for all cases and validated cases: clearly significant proportions of reports coming into protective service agencies from relatives, acquaintances and neighbors, as well as anonymously, are later found to be invalid cases, suggesting a tremendous need for more public awareness of what child abuse and child neglect are to reduce inappropriate referrals and thus inappropriate use of the protective service system. More specifically, of the 15,185 reports received from these sources, 9,881 or 65% were found invalid, as compared with only 44% of the reports from all other sources being found invalid.

Comparing cases by type of maltreatment is less straightforward, given the differences in categories used on the evaluation intake form and the National Reporting Form, as well as differences in types of cases included in the reporting. For example, no potential cases appear in the AH data set per se, yet comprise 28% of the study data set. It may be that cases classified on the AH form as emotional maltreatment are comparable to these potential cases. If one looks at the distribution of the remainder of our cases in the categories of physical abuse, physical neglect, emotional maltreatment and sexual abuse, one sees a major difference: the demonstration projects served a substantially greater proportion of physical abuse than that seen by protective services in general, which, as mentioned earlier, is reflective of the demonstration projects' selective intake criteria. In generalizing findings from the study, therefore, one must keep this difference in mind.

In terms of severity of the case, the two data sets are, however, the same. Twenty-eight percent of the study cases were labeled as those in which a serious assault on the child occurred (this category includes cases labeled as moderate physical abuse and neglect). The comparable AH data shows that 30% of the cases were those in which the child required treatment, i.e., serious cases.

In looking at a variety of household characteristics, the following is seen: the two data sets are quite comparable with respect to number of adults in household, race/ethnicity, employment, age of parent, and proportion with incomes under $5500 or over $12,000. However, families in the study data set have more children in their families, higher educational attainment, and are less likely to be on public assistance. These differences may be due to the fact that many of the demonstration projects are private agencies and thus come in contact with a slightly different kind of client.

Finally, in looking at the problems identified in the household as leading to the maltreatment[1], a few additional differences between the two data sets are seen. While many problems are frequently seen in both data sets, the study cases are more likely to possess problems associated with abuse cases--poor physical health and mental health, financial problems, social isolation and abuse as a child. And, they are more likely to use discipline methods considered normal to them but not by outsiders.

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[1]For these purposes, we look at AH data from 1975.

Because the two data sets are comparable on so many characteristics, analysis can continue with the knowledge that findings are reflective of the kinds of cases seen by protective services in general. However, one must keep in mind that the study data set is slightly skewed, due to the higher proportions of physical abuse cases and other differences noted. For critical analyses, abuse and neglect cases will be looked at separately so that generalizations can be made.

B. The Kinds of Services the Projects Provided to Their Clients

Before attempting to determine the relative effectiveness of different services, an assessment was made of what services were provided to clients in the data set. (See Tables II.3, II.4 and II.5.)

1. Service Provision Across Projects

Of all possible service types, only one--one-to-one counseling--was offered to at least 78% of the clients at each project, except for Arkansas which relied on lay therapy with professional back-up rather than one-to-one counseling as the primary service for its clients. The second more frequently offered services by all the projects were crisis intervention, couples or family counseling and multidisciplinary team reviews with approximately 25% of the cases in all projects except Arlington, Union County and Arkansas receiving these services. Group therapy was a frequently offered service only in St. Louis and Tacoma. Only Bayamon provided special alcohol or drug counseling to a large proportion (29%) of their clients, while only St. Louis and Tacoma did likewise with parent education classes. With respect ot children's services, only Adams County provided some form of children's services to at least 25% of its clients. Only Tacoma, St. Louis and Arkansas provided transportation and babysitting to over one-fourth of their caseloads. Otherwise, services were provided to well below 25% of the cases in a project's caseload including: Parents Anonymous, family planning, and homemaking.

It is useful to also consider the service packages (which could be referred to as models) offered to clients in different projects.

PERCENT DISTRIBUTION OF CLIENTS RECEIVING SERVICES BY PROJECT*

SERVICE	ADAMS COUNTY (n=167)	ARLINGTON (n=324)	BATON ROUGE (n=162)	BAYAMON (n=177)	ARKANSAS (n=207)	ST. LOUIS (n=98)	TACOMA (n=113)	UNION COUNTY (n=456)	TOTAL (n=1724)
Multidisciplinary team review	59%	20%	30%	80%	26%	83%	27%	18%	35%
One-to-one counseling	89	90	96	95	32	78	88	89	83
Lay therapy	17	4	1	1	98	21	27	18	23
Group therapy	6	8	4	9	6	83	36	5	12
Parents anonymous	10	1	2	2	23	7	6	--	5
Couples/family counseling	48	33	28	66	8	29	35	34	35
Special counseling	7	1	1	29	3	3	4	6	7
Family planning	10	3	2	10	1	--	--	8	5
Crisis intervention	28	19	40	35	29	46	33	42	33
Parent education	14	1	1	7	4	28	64	5	11
Homemaking	4	2	17	1	1	--	4	8	5
Child services	31	16	22	2	17	6	7	23	18
Welfare	28	16	20	5	30	18	43	37	26
Transportation/babysitting	13	23	20	10	33	79	46	24	27
Other	31	16	39	31	24	4	48	24	26

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in calculations for the "Total" column.

Table II.4

PERCENT DISTRIBUTION OF CLIENTS RECEIVING DIFFERENT SERVICE MODELS BY PROJECT*

Service Model	ADAMS COUNTY (n=167)	ARLINGTON (n=324)	BATON ROUGE (n=162)	BAYAMON (n=177)	ARKANSAS (n=207)	ST. LOUIS (n=98)	TACOMA (n=113)	UNION COUNTY (n=456)	TOTAL (n=1724)
Lay Services (includes lay therapy and/or Parents Anonymous as well as other services, including professional services)	25%	4%	3%	2%	98%	22%	29%	18%	24%
Group Services (includes group therapy and/or parent education classes as well as other services, but not any lay services)	10	8	6	14	--	64	58	5	13
Social Work Services (includes individual counseling or therapy as well as other services but not any lay or group services	56	79	88	79	1	9	12	69	57
Other (client received no lay, group, or individual counseling therapy services)	8	8	4	5	1	4	2	8	6

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in calculations for the "Total" column.

Table II.5

PERCENT DISTRIBUTION BY PROJECT OF CLIENTS BY NUMBER OF DIFFERENT TYPES OF SERVICES RECEIVED, LENGTH OF TIME IN TREATMENT AND FREQUENCY OF CONTACT WITH SERVICE PROVIDED*

Number of different types of service received	ADAMS COUNTY (n=167)	ARLINGTON (n=324)	BATON ROUGE (n=162)	BAYAMON (n=177)	ARKANSAS (n=207)	ST. LOUIS (n=98)	TACOMA (n=113)	UNION COUNTY (n=456)	TOTAL (n=1724)
1	13%	31%	17%	9%	22%	4%	4%	19%	18%
2	13	26	24	19	21	11	9	21	20
3	19	18	17	18	16	11	17	14	16
4	22	11	14	17	14	13	15	14	14
5 or more	34	15	29	37	27	60	55	32	32
Length of time in treatment									
Up to 6 months	5	24	26	10	23	11	10	17	17
3-6 months	19	23	28	16	30	20	19	22	22
6-12 months	31	27	30	22	33	35	37	33	31
over 12 months	46	26	16	52	14	34	35	29	30
Frequency of contact with service provider									
1 per month	22	30	24	31	10	6	10	28	23
1-2 times per month	13	26	23	25	8	19	17	17	19
3-4 times per month	22	25	22	30	14	22	18	17	21
weekly or more often	44	19	31	14	69	52	56	39	38

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data 13, and 7, respectively; information on these cases has been included in the calculations for the "Total" column.

Four service packages or models were identified: a lay model in which a client received lay therapy and/or Parents Anonymous, in addition to other services including professional services; a group model in which clients received group therapy and/or parent education as well as other individual non-lay services; a social work model in which a client received individual counseling and other non-lay, non-group services, and a model in which a client received no individual counseling and no lay or group services. Arkansas is the one project that stressed a one-service model, with 98% of the cases receiving the lay strategy. Adams County, Arlington, Baton Rouge, Bayamon and Union County all provided more than half of their clients with the social work model but each additionally provided some clients with other service strategies. In St. Louis and Tacoma more than half the cases received the group model.

It is interesting to note the differences across projects in terms of the number of types of services offered to individual clients. Over 50% of the clients in St. Louis and Tacoma received five or more services. Over 50% of the clients in Adams County and Bayamon received four or more services. These are all projects with relatively small caseloads, with an ability to select both the type and number of clients they wished to serve. Such conditions seem to be associated with an ability to provide extensive and varied service packages to their clients. In the three large protective service-based projects, Arlington, Baton Rouge and Union County, we see at least 40% of the clients receiving only one or two different types of services.[1] Clearly projects with large caseloads, perhaps with little relationship to staff size, have a difficult time ensuring that clients receive many different kinds of services.

When considering average frequency of contact, we see a similar pattern. Sixty-nine percent of Arkansas' cases were seen once a week or more; 52% of St. Louis'; and 56% of Tacoma's. These smaller programs were able to maintain more freuqent contact with their clients.

In terms of length of time in treatment, Bayamon kept a larger proportion of cases in treatment over one year, followed by Adams County. Arlington, Baton Rouge, Arkansas and Union County--all protective service based programs--had relatively large proportions of cases in treatment for less than 6 months.

[1]This is also true in Arkansas, a protective services-affiliated project.

Summary of Service Provision for the Whole Demonstration Program

Clearly, the one service provided to most cases was one-to-one counseling (including individual counseling and individual therapy). In addition to this one common service, services were provided as follows: around 30% of the cases received multidisciplinary team reviews, couples/family counseling and crisis intervention; close to 20-25% received lay therapy, babysitting or transportationn and welfare assistance. Close to 15% received child services; close to 10% received group therapy or parent education classes; and close to 6% or fewer received special (alcolhol, drug) counseling, Parents Anonymous, family planning counseling, and homemaking.

In terms of "service models," 24% of the cases received a service package which included lay services (lay therapy counseling and/or Parents Anonymous); 13% received group services other than Parents Anonymous; and 57% received individual rather than gropp services, exclusive of lay therapy counseling.

Clients received varying numbers of different types of services. Just over 30% of the clients received five or more different services while just under 40% received only one or two services. The remainder received three or four services. The average time in treatment was about 6-7 months; the average frequency of contact was about once a week.

2. Does Type of Service Received Vary by Type of Client?

It is important to know whether or not certain services were provided to clients on the basis of certain identifiable characteristics, e.g., is there any pattern to the way in which services are prescribed beyond the differences one sees in individual projects. The answer to this question allows assessment of the approrpiateness of the projects' service prescription process and further identification of salient client characteristics and services which may be related to outcome.

As shown in Table II.6, which reports type of maltreatment in relation to service receipt, there are very few remarkable deviations for a given client type from the percents of all cases receiving a particular service. However, as shown in Table II.7, cases that are both physical abuse and neglect are more likely to have contact with service providers on a weekly basis than other cases.

Table II.6

PERCENT DISTRIBUTION OF SERVICES RECEIVED BY TYPE OF MALTREATMENT FOR ALL CASES SERVED BY THE DEMONSTRATION PROJECTS

SERVICE	TYPE OF MALTREATMENT						
	POTENTIAL ABUSE/NEGLECT (n=359)	EMOTIONAL MALTREATMENT (n=226)	SEXUAL ABUSE (n=73)	PHYSICAL ABUSE (n=605)	PHYSICAL NEGLECT (n=318)	PHYSICAL ABUSE & NEGLECT (n=67)	ALL CASES (n=1648)
MDT REVIEW	30%	39%	41%	41%	29%	40%*	36%
ONE-TO-ONE COUNSELING	85	83	90	80	84	76	83
LAY THERAPY COUNSELING	20	24	16	27	20	30 *	23
GROUP THERAPY	9	18	4	16	8	16 *	13
PARENTS ANONYMOUS	4	4	1	9	2	9 *	6
COUPLES/FAMILY COUNSELING	30	39	41	36	34	34	35
SPECIAL COUNSELING	6	7	4	5	10	12 *	6
FAMILY PLANNING	3	7	3	5	8	9 *	5
CRISIS INTERVENTION	26	30	38	36	38	37 *	33
PARENT EDUCATION CLASSES	9	9	7	14	6	12 *	10
HOMEMAKING	4	4	8	4	9	10 *	5
CHILD SERVICES	14	18	16	22	18	31 *	19
WELFARE	24	25	27	23	33	37 *	26
TRANSPORTATION/ BABYSITTING	23	29	15	28	28	34	27
OTHER	23	25	34	26	28	31	26

* Chi-square significant at less than or equal to .05.

Table II.7

PERCENT DISTRIBUTION OF AVERAGE CONTACT WITH SERVICE PROVIDERS BY TYPE OF MALTREATMENT AND SERIOUSNESS OF ASSAULT

AVERAGE FREQUENCY OF CONTACT	TYPE OF MALTREATMENT						SERIOUSNESS OF ASSAULT	
	POTENTIAL ABUSE/NEGLECT (n=359)	EMOTIONAL MALTREATMENT (n=226)	SEXUAL ABUSE (n=73)	PHYSICAL ABUSE (n=605)	PHYSICAL NEGLECT (n=318)	PHYSICAL ABUSE & NEGLECT (n=67)	SERIOUS (n=622)	NON-SERIOUS (n=1102)
LESS THAN ONCE A MONTH	25%	17%	27%	21%	26%	12%*	20%	24%*
1-2 TIMES A MONTH	21	21	14	16	21	12	17	19
3-4 TIMES A MONTH	21	20	18	19	20	25	21	20
WEEKLY OR MORE OFTEN	33	42	41	43	33	51	42	36

*Chi-square significant at less than or equal to .05.

When considering service receipt as a function of the severity of the case (as defined by seriousness of the assault on the child) an interesting pattern emerges. Table II.8 indicates that serious cases are more likely to receive multidisciplinary team reviews, couples/family counseling, family planning and crisis intervention than non-serious cases. In general they receive more different types of services than non-serious cases, and are seen somewhat more frequently than non-serious cases.

Service delivery patterns further emerge when studying the relationships between specific client descriptors and service receipt. Table II.9 indicates the following:

- Clients receiving multidisciplinary team reviews are more likely to have preschool children, have two adults in the household, have substance abuse as a problem, have been abused as a child, and to have problematic family conflicts;
- Clients receiving lay therapy counseling are more likely to have preschool children, to be Caucasian, unemployed, abused as a child, have heavy child care responsibilities, and to be socially isolated, but less likely to have substance abuse or family conflict as problems;
- Couples or family counseling were more often provided to older couples, who were employed but suffered from family conflict;
- Crisis intervention and children's services were provided more often to younger parents, with younger children, who were isolated, with heavy, continuous child care problems as well as financial problems due to unemployment.

As seen in Table II.10, certain clients are somewhat more likely to have received certain service models:

- those receiving the lay model are less likely to be substance abusers, but more likely to have heavy child care responsibilities or legal intervention among other things;
- those receiving the social work model are more likely to be substance abusers, and less likely to have heavy child care responsibilities or legal intervention.

Table II.8

PERCENT DISTRIBUTION OF SERVICE RECEIPT FOR SELECT SERVICE BY SERIOUSNESS OF THE CASE

	SERIOUSNESS OF CASE	
	SERIOUS CASE (n=622)	NON-SERIOUS CASE (n=1102)
MDT REVIEW	45%	30%*
ONE-TO-ONE COUNSELING	82	83
LAY THERAPY COUNSELING	25	21
GROUP THERAPY	14	13
PARENTS ANONYMOUS	6	5
COUPLES/FAMILY COUNSELING	39	32 *
FAMILY PLANNING	8	3 *
SPECIAL COUNSELING	9	5
CRISIS INTERVENTION	40	30 *
PARENT EDUCATION	12	10
HOMEMAKING	6	5
CHILD SERVICES	21	17

* Chi-square significant at less than or equal to .05.

TABLE II.9

PERCENT DISTRIBUTION OF SERVICE RECEIPT FOR SELECT SERVICES BY CLIENTS WITH PARTICULAR CHARACTERISTICS

SERVICE (N)	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES IN FAMILY		NO ADULT EMPLOYED		4 OR MORE CHILDREN		ONE ADULT IN FAMILY		SUBSTANCE ABUSE		SOCIALLY ISOLATED		FAMILY CONFLICT		HEAVY CHILD CARE RESPONSIBILITIES		PARENT ABUSED AS CHILD		LEGAL INTERVENTION	
	YES (1154)	NO (430)	YES (719)	NO (1005)	YES (721)	NO (1003)	YES (489)	NO (1235)	YES (383)	NO (1341)	YES (413)	NO (1311)	YES (344)	NO (1380)	YES (479)	NO (1245)	YES (464)	NO (1260)	YES (256)	NO (1468)	YES (332)	NO (1392)	YES (1054)	NO (657)
MDT REVIEW	37%	28%*	32%	38%*	35%	36%	33%	36%	33%	36%	28%	38%*	40%	34%*	42%	33%*	44%	32%*	39%	35%	50%	32%*	34%	38%
ONE-TO-ONE COUNSELING	80	87*	83	83	88	79*	84	82	82	83	87	82*	88	81*	81	84	86	81*	77	84*	82	83	81	87*
LAY THERAPY COUNSELING	27	13*	26	20*	16	28*	28	21*	22	23	23	23	15	25*	33	18*	18	24*	36	20*	29	21*	26	17*
GROUP THERAPY	14	7*	15	11*	12	13	17	10*	9	13*	14	12	9	13*	18	10*	14	12	12	13	17	11*	13	12
PARENTS ANONYNOUS	6	1*	6	5	3	7*	4	6	4	6	5	6	4	6	9	4*	7	5	10	4*	12	4*	6	5
COUPLES/FAMILY COUNSELING	32	39*	27	40*	36	34	27	38*	38	34	21	39*	37	34	34	35	43	32*	39	34	36	34	33	38*
SPECIAL COUNSELING	6	5	6	7	9	4*	8	6	9	6*	5	7	21	3*	8	6	11	5*	6	8	7	6	6	8*
FAMILY PLANNING	5	4	6	4	7	4*	7	4*	8	4*	5	5	8	4*	7	4*	6	5	9	4*	6	5	5	5
CRISIS INTERVENTION	35	28*	37	30*	37	31*	45	29*	39	32*	35	33	39	32*	40	31*	39	31*	43	32*	35	33	35	31
PARENT EDUCATION CLASSES	13	3*	13	9*	10	11	13	10	7	12*	10	11	6	12*	15	9*	11	11	21	9*	20	8*	11	10
HOME-MAKING	6	3*	7	4*	7	4*	10	3*	6	5	6	5	4	5	7	5*	2	6*	11	4*	2	6*	6	3*
CHILD SERVICES	21	12*	21	16*	20	17	21	17	13	20*	22	17	18	18	25	16*	17	19	31	16*	20	18	22	13*

* Chi-square significant at less than or equal to .05.

Table II.10

PERCENT DISTRIBUTION OF CLIENT CHARACTERISTICS
BY SERVICE MODELS

	CLIENT CHARACTERISTICS											
SERVICE MODELS	PRESCHOOL CHILDREN YES (n=1154)	PRESCHOOL CHILDREN NO (n=430)	TEENAGE PARENT YES (n=719)	TEENAGE PARENT NO (n=1005)	MINORITIES YES (n=721)	MINORITIES NO (n=1003)	NO ADULT EMPLOYED YES (n=489)	NO ADULT EMPLOYED NO (n=1235)	FOUR OR MORE CHILDREN YES (n=383)	FOUR OR MORE CHILDREN NO (n=1341)	ONE ADULT IN HOUSE-HOLD YES (n=413)	ONE ADULT IN HOUSE-HOLD NO (n=1311)
LAY	29%	14%	27%	22%	16%	30%	28%	22%	23%	24%	24%	24%
GROUP	15	7	17	11	14	13	17	12	10	14	13	13
SOCIAL WORK	51	73	52	61	64	52	50	60	60	56	59	56
OTHER	5	7*	5	7*	6	6*	4	6*	7	5	4	6

	CLIENT CHARACTERISTICS											
SERVICE MODELS	SUBSTANCE ABUSE YES (n=344)	SUBSTANCE ABUSE NO (n=1380)	SOCIALLY ISOLATED YES (n=479)	SOCIALLY ISOLATED NO (n=1245)	FAMILY CONFLICT YES (n=464)	FAMILY CONFLICT NO (n=1260)	HEAVY CHILD CARE RESPONSIBILITY YES (n=256)	HEAVY CHILD CARE RESPONSIBILITY NO (n=1468)	PARENT ABUSED AS CHILD YES (n=332)	PARENT ABUSED AS CHILD NO (n=1392)	LEGAL INTERVENTION YES (n=1054)	LEGAL INTERVENTION NO (n=657)
LAY	15%	26%	36%	20%	20%	26%	38%	22%	32%	22%	28%	18%
GROUP	11	14	14	13	14	13	16	13	20	12	14	13
SOCIAL WORK	69	54	44	62	61	55	39	60	44	60	53	64
OTHER	6	6*	6	6*	5	6	7	6*	4	6*	6	6*

* Chi-square significant at less than or equal to .05.

Multivariate analysis techniques (analyses such as multiple regression, in which three or more independent variables are considered simultaneously with respect to a dependent variable) were used to better understand the composite picture of those who received the different service packages or models. A small, but significant, proportion of the variance in whether or not a client received the lay service model was accounted for by the select set of client descriptors. Significant but small positive effects were seen, with respect to receiving lay services, for the following cases: cases in which there had been a serious assault on the child; socially isolated families; non-minority clients; parents with young children; and parents without substance abuse or family conflict problems. Little explanation for the receipt of group services was accounted for by client characteristics but included young parents with preschool age children. In terms of receipt of the social work model it was seen that older, minority parents with no preschool children, parents who are employed and suffer from problems related to substance abuse, and parents who are not isolated are more likely to have received this service package.

These patterns do suggest that, at least for those variables measured, service delivery was not particularly related to client characteristics and needs. Projects instead tended to deliver the same services (see Appendix E for discussion of the comparability of same-named services across projects) to different types of clients in their caseloads, with only marginal differences in service prescription related to client need.

C. The Kinds of Outcomes Seen[1]

Using the clinician's judgment of whether or not, by the end of treatment, there was reduced propensity for either abuse or neglect for clients who were reported to be likely repeaters at intake as a measure of treatment outcome (Table II.11), we note that no one project reports overwhelming success with clients.[2] Relative to the 42% of clients overall who

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[1] See Appendix G for operationalization and selection of outcome measures.

[2] It is important to keep in mind that data sets for each project include some cases who had been in treatment for at least three months but not formally terminated by the projects at the time of final data collection. When these non-terminated cases were removed from the data base, however, outcome scores changed only 2-3 percentage points.

Table II.11

PERCENT DISTRIBUTION BY PROJECT OF OUTCOME SCORES FOR SEVERE REINCIDENCE DURING TREATMENT AND REDUCED PROPENSITY FOR ABUSE OR NEGLECT*

	ADAMS COUNTY	ARLINGTON	BATON ROUGE	BAYAMON	ARKANSAS	ST. LOUIS	TACOMA	UNION COUNTY	TOTAL
Reduced propensity for abuse or neglect	49% (n=121)	41% (n=186)	48% (n=96)	43% (n=123)	56% (n=169)	25% (n=81)	58% (n=93)	29% (n=321)	42% (n=1208)
Severe reincidence during treatment	19 (167)	13 (324)	32 (162)	35 (177)	51 (207)	22 (98)	17 (113)	36 (456)	30 (1724)

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data; information on these cases has been included in the calculations of the "Total" column.

improved in this area, more than half of Tacoma's clients (58%) were reported as having reduced propensity, as were Arkansas' (56%). Of the remaining projects, between 25% and 49% were said to have improved.

In considering severe reincidence during the time the client was in treatment--which is less a measure of final success and more a measure of effectiveness of project intervention at selected points in treatment--we see a range of reincidence scores across projects from as low as 13% in Arlington to as high as 51% in Arkansas. The proportion across all projects was 30%.

As the third way of looking at impact, we consider the percentage of clients at each project who improved on each of those select functioning indicators on which they had problems at intake. As shown on Table II.12 well under 20% of the clients at all projects except Tacoma exhibited improved general health by the end of treatment. Cases treated in Tacoma were also clearly the exception with respect to reduced feelings of one's child as an extension of oneself, improved behavior toward child, improved ability to talk out problems, increased understanding of self and increased independence--greater proportions of cases in this project improved in these areas than in other projects. With respect to reduced stress in the living situation, Tacoma's cases did least well, with Arkansas being most successful in this area, followed closely by most of the other projects. Arkansas and Tacoma reported improved awareness of child development in approximately 30% of their cases, as well as improved expression of anger, improved reactions to crisis situations, and improved self-esteem. There are many possible explanations for Tacoma's and Arkansas' seemingly greater success with cases in many areas of functioning than other projects, as is analyzed in Section III.

A composite score of improvement on all those functioning indicators on which a client had problems at intake helps to summarize the above. As seen on Table II.13 close to half of the clients in Arkansas and Tacoma improved on at least one-third of those areas indicated to be a problem at intake, whereas closer to 30% of those clients in Adams County, Arlington, Bayamon and St. Louis were reported with such improvement. The experiences of Baton Rouge and Union County were much like the overall demonstration experience--about 40%.

Table II.12

PERCENT DISTRIBUTION BY PROJECT OF OUTCOME SCORES FOR IMPROVEMENT ON FUNCTIONING INDICATORS*

FUNCTIONING INDICATORS	ADAMS COUNTY (n=156)	ARLINGTON (n=297)	BATON ROUGE (n=155)	BAYAMON (n=143)	ARKANSAS (n=194)	ST. LOUIS (n=96)	TACOMA (n=105)	UNION COUNTY (n=448)	TOTAL (n=1613)
GENERAL HEALTH	10%	11%	7%	18%	14%	10%	23%	13%	13%
STRESS FROM LIVING SITUATION	30	29	28	21	35	24	18	30	28
SENSE OF CHILD AS PERSON	26	16	18	19	28	26	41	18	22
BEHAVIOR TOWARD CHILD	31	20	27	34	35	25	37	26	28
AWARENESS OF CHILD DEVELOPMENT	28	16	19	22	31	15	31	22	23
ABILITY TO TALK OUT PROBLEMS	24	15	19	24	35	30	43	25	25
REACTION OF CRISIS SITUATION	23	20	19	24	34	16	31	22	23
WAY ANGER IS EXPRESSED	16	18	17	18	30	16	28	19	20
SENSE OF INDEPENDENCE	21	11	16	15	25	16	36	17	18
UNDERSTANDING OF SELF	19	10	19	14	30	23	36	17	19
SELF ESTEEM	21	9	19	15	29	17	31	17	19

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the number of cases on which we have data; information on these cases has been included in calculations of the "Total" column.

Table II.13

PERCENT DISTRIBUTION BY PROJECT OF COMPOSITE SCORE OF IMPROVEMENT ON FUNCTIONING INDICATORS: PERCENT OF THOSE FUNCTIONING INDICATORS IDENTIFIED AS PROBLEM AT INTAKE ON WHICH CLIENT IMPROVED*

	ADAMS COUNTY (n=154)	ARLINGTON (n=295)	BATON ROUGE (n=154)	BAYAMON (n=143)	ARKANSAS (n=196)	ST. LOUIS (n=96)	TACOMA (n=107)	UNION COUNTY (n=429)	TOTAL (n=1594)
A little (improved on 0-33% of those areas identified as problem at intake)	66%	70%	59%	66%	51%	71%	53%	59%	62%
Some (improved on 34-66%)	15	14	18	21	22	17	26	17	18
A lot (improved on 67-100%)	19	16	23	13	27	13	21	24	21

*Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7 respectively; information on these cases has been included in the "Total" column.

Summary of the Overall Demonstration Experience with Respect to Outcome

In summary, close to 30% of all the cases served by the demonstration projects exhibited severe reincidence while in treatment.[1] By the end of treatment,[2] 42% of the cases were said to have reduced propensity for abuse or neglect. Fewer than 30% of the cases improved on any one of the select functioning indicators, with greater percents of cases reported to have experienced reduction in household stress and improved behavior toward child (both 28%), followed by improved ability to talk about problems (25%). Projects seemed to have little influence on clients' general health (13%). Thirty-nine percent of the clients were reported to have improved in at least one-third of those areas of functioning that were identified by caseworkers as a problem at intake. (In Section IV these outcomes are discussed and compared with those of other evaluation studies in the child abuse field.)

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[1] This percent does not reflect the actual number of families in which there was reincidence, but rather the number of individual clients who reabused or neglected their children. If both parents in a household (a) were responsible for the reinjury and (b) were in treatment at a project, each parent was counted as one case in which there was reincidence.

[2] For a small percent of cases, rather than the end of treatment, data reflect the clients' status as of January 1, 1977.

SECTION III: TREATMENT OUTCOME

Practitioners and theorists alike in the field advocate certain services as being the most effective. In this, the first large-scale child abuse and neglect treatment outcome study which allows for comparative service analysis, their views are tested to determine the relative effects of different treatment interventions. Characteristics of the client are taken into account to see if they, in any way, influence treatment outcome. Treatment outcome is defined in three different ways for the purposes of this study: (a) absence of reincidence while in treatment; (b) improvement in select areas of daily functioning by the end of treatment; and (c) reduced propensity for future abuse and neglect by the end of treatment. Each of these three versions of outcome are considered separately in this section. In considering each version of outcome, first select client characteristics are studied to see if client descriptors have utility in predicting outcome. Second, the relationships of each service type and service model type to outcome are explored. Finally, combinations of client and service descriptors are studied and cost information is included to assess the relative costs and effects of different service mixes for different client types. Because of methodological concerns about the appropriateness of conducting these final analyses on the data set, the results, which are presented in Appendix J, have been used only to further substantiate, but not to formulate, the study findings.

Throughout the analysis, our interest is in determining the experiences of the demonstration projects individually and as a group. We have therefore generated and studied the data within projects, across projects and for the whole demonstration effort. To facilitate the presentation of the analysis, and related findings, we first present data for the whole demonstration project, followed by a discussion of how individual project data support or differ from these findings where relevant. Readers interested strictly in the data and the analyses for an individual project can easily construct them from the data tables.

It should be pointed out that debates exist among researchers about whether or not pooling data from across the projects is methodologically defensible, given the differences between the projects included in the study. Every effort was made during the data collection to maximize the comparability of data items and the data and to account for those provider, service or client factors that may influence treatment outcome. We feel comfortable pooling the data, given that data are also studied by project, and that findings do not vary greatly from individual projects to the whole data set.[1] However, recognizing the different perspectives on what the best approaches to analysis are is important. Also important is recognizing the limitations on the generalizability of findings from individual projects or from the whole demonstration effort to the field, given the methodological constraints discussed in Section I, the diversity of treatment activities within and across projects and other salient differences between the projects which may not be reflective of the field in general.

A. Reincidence While in Treatment

"Reincidence while in treatment" as an outcome measure suggests the success of projects in intervening in family situations early and intensely enough to prevent further occurrence of maltreatment. While individual clients may well be successes by the end of treatment even if they reabuse or continue to neglect during treatment, and thus "reincidence while in treatment" cannot serve as a proxy measure of final treatment outcome, it is a measure with utility. Identification of the characteristics of those clients who reabuse or neglect can be useful in future service planning, as can the identification of what kinds of services they received.

For the analysis, the presence or absence of severe reincidence while in treatment is the measure used ("severe" reincidence includes the more serious forms of physical abuse or physical neglect, as well as sexual abuse).

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[1]For example, lay therapy is one service shown to be more effective than others for the whole data set. A concern of some has been that data from the Arkansas project--where 98% of the clients received lay services--biases the overall data set because of the high rate of improvement in Arkansas. However, in other projects--such as Union County--clients receiving lay services apparently did better in treatment than clients not receiving lay services.

Summary of Findings

Most client characteristics are not highly associated with reincidence. The type of abuse or neglect that brought the case into treatment in the first place and more clearly the seriousness of that maltreatment, however, are useful predictors of whether or not there will be reincidence. The services a client receives may be a function of whether or not reincidence in treatment has occurred or may help explain why there is or is not reincidence. Keeping this in mind, specialized counseling is the single service most highly associated with severe reincidence, as is the lay service model the service package most highly associated; receipt of parent education classes is least associated with this outcome. Seriousness of the assault that brought a case into treatment has a much stronger relationship with reincidence than these or any other services or service models.

1. Relationships Between Client Characteristics and Severe Reincidence

It is important to determine which, if any, of a variety of salient client characteristics are related to reincidence while in treatment for purposes of treatment planning. Do some kinds of people reabuse or continue to neglect their children while in treatment programs irrespective of the nature and quality of services offered? Is it possible to predict reincidence on the basis of client characteristics alone? And, which client characteristics might be most useful in explaining or interpreting reincidence?

To address these questions, the relationships between client characteristics, identified earlier to be the most salient and least redundant, and reincidence were studied.[1] The overall finding is that while most client characteristics are not highly associated with reincidence, the type of maltreatment, the seriousness of the assault, and the severity of the situation seem to help explain reincidence.

The client characteristics examined include: age of children, age of parents, race, employment, size of family, amount of family conflict, substance abuse, isolation, history of abuse as a child, special child responsibilities, legal intervention and total income, as well as the type of maltreatment, seriousness of the assault, and the severity of the family situation.

[1]See Appendix G for selection of salient client characteristics.

Table III.1 shows how reincidence is related to type of maltreatment identified at intake. Severe reincidence varies considerably with type of maltreatment. For the whole demonstration data set, only 7% of the potential maltreaters seriously assaulted their children during treatment, whereas 60% of the sexual abusers and 51% of the clients who both physically abused and neglected their children committed some serious assault during treatment. Twenty-four percent of the emotional maltreaters, 36% of the physical abusers and 37% of the physical neglectors were reported with serious reincidence. This pattern with respect to potential cases being least likely to abuse or neglect while in treatment and sexual abusers and physical abusers/neglectors being most likely holds up in those individual projects where the number of cases is large enough to make an assessment.

With respect to the seriousness of the assault on the child that brought the case into treatment, for the whole data set significantly great percents of cases (56%), labeled as "serious", severely abused or neglected their child while in treatment than did non-serious cases (15%). This pattern is consistent for within-project data for all projects except Tacoma where no difference in reincidence rates is seen. Tacoma's intense use of both professionals and lay treatment workers during the first months of treatment may account for the lower percent of reincidence among their serious cases.

Other client characteristics help to explain or predict this outcome only slightly. When looking at the whole data base (Table III.2) slightly greater but significant percents of some types of clients are reported as reabusing or neglecting: parents of preschool children; parents in racially mixed or all minority households; unemployed parents; parents in households with family conflicts; parents with heavy, continuous child care responsibilities and families in which legal intervention was required. At most, one or two of these characteristics are significantly related to reincidence in individual projects. In Adams County, Arlington, and St. Louis no client characteristics appear to be related to reincidence.

Table III.1

PERCENT DISTRIBUTION OF CLIENTS WITH SEVERE REINCIDENCE BY TYPE OF MALTREATMENT, SERIOUSNESS OF ASSAULT, AND SEVERITY BY PROJECT**

	TYPE OF MALTREATMENT						SERIOUSNESS OF ASSAULT		SEVERITY				
	POTENTIAL ABUSE OR NEGLECT	EMOTIONAL MALTREAT-MENT	SEXUAL ABUSE	PHYSICAL ABUSE	PHYSICAL NEGLECT	PHYSICAL ABUSE & NEGLECT	SERIOUS CASE	NON-SERIOUS CASE	NOT SEVERE 0	1	2	3	SEVERE 4
ADAMS COUNTY	10% (n=41)	--	25% (n=8)	23% (n=107)	--	--	40% (n=65)	5%* (n=102)	3% (n=31)	7% (n=46)	19% (n=58)	52% (n=27)	40%* (n=5)
ARLINGTON	3 (97)	5% (n=58)	20 (5)	21 (44)	24% (n=92)	22%* (n=9)	31 (81)	7* (243)	4 (137)	12 (105)	25 (56)	22 (18)	63* (8)
BATON ROUGE	--	13 (8)	63 (24)	33 (81)	26 (23)	20* (5)	55 (62)	17* (100)	16 (37)	23 (66)	47 (47)	70 (10)	50* (2)
BAYAMON	--	28 (36)	--	42 (31)	48 (48)	100* (6)	60 (75)	16* (102)	21 (44)	14 (36)	32 (44)	56 (25)	68* (28)
ARKANSAS	9 (35)	48 (21)	70 (10)	56 (105)	72 (18)	73* (15)	85 (87)	26* (120)	17 (58)	59 (63)	64 (58)	67 (21)	100* (7)
ST. LOUIS	--	26 (19)	--	27 (59)	--	25 (4)	32 (38)	17 (60)	7 (28)	25 (24)	27 (22)	33 (18)	33 (6)
TACOMA	13 (15)	28 (18)	33 (3)	17 (42)	14 (14)	--	19 (42)	16 (71)	3 (35)	21 (24)	27 (37)	22 (9)	13 (8)
UNION COUNTY	13 (106)	30 (57)	95 (19)	43 (121)	46 (116)	63* (19)	70 (162)	18* (294)	11 (158)	31 (128)	59 (104)	72 (53)	77* (13)
TOTAL	7 (359)	24 (226)	60 (73)	36 (605)	37 (318)	51* (67)	56 (622)	15* (1102)	10 (530)	25 (499)	42 (433)	55 (183)	62* (79)

* Chi-square significant at less than or equal to .05.

** Individual statistics Los Angeles or St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "Total" row.

Table III.2

PERCENT DISTRIBUTION OF CLIENTS WITH SEVERE REINCIDENCE BY CLIENT CHARACTORISTICS BY PROJECT**

	ALL CASES	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES		NO ADULT EMPLOYED		FOUR OR MORE CHILDREN	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	19% (n=167)	20% (n=121)	13% (n=39)	12% (n=41)	21% (n=126)	10% (n=40)	21% (n=127)	14% (n=29)	20% (n=138)	14% (n=29)	20% (n=138)
ARLINGTON	13 (324)	15 (172)	11 (126)	15 (158)	10 (166)	15 (113)	11 (211)	15 (62)	12 (262)	11 (38)	13 (286)
BATON ROUGE	32 (162)	28 (96)	38 (48)	22 (63)	37 (99)	30 (66)	32 (96)	35 (43)	30 (119)	24 (37)	34 (125)
BAYAMON	35 (177)	34 (110)	14 (29)	47 (45)	30 (132)	41 (123)	20* (54)	41 (54)	32 (123)	42 (69)	30 (108)
ARKANSAS	51 (207)	49 (181)	70 (20)	59 (98)	43* (109)	77 (39)	45* (168)	62 (60)	46 (147)	56 (39)	49 (168)
ST. LOUIS	22 (98)	23 (79)	--	21 (48)	24 (50)	27 (41)	19 (57)	18 (38)	25 (60)	30 (10)	22 (88)
TACOMA	17 (113)	15 (91)	33 (12)	9 (64)	27* (49)	13 (23)	18 (90)	20 (45)	15 (68)	17 (24)	17 (89)
UNION COUNTY	36 (456)	41 (289)	28* (153)	38 (190)	35 (266)	40 (263)	32 (193)	42 (151)	34 (305)	39 (135)	36 (321)
TOTAL	30 (1724)	31 (1154)	24* (430)	30 (719)	29 (1005)	26 (1003)	34* (721)	35 (489)	27* (1235)	34 (383)	28 (1341)

*Chi-square significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "total" row.

Table III.2 Continued.

	FAMILY CONFLICT YES	FAMILY CONFLICT NO	SUBSTANCE ABUSE YES	SUBSTANCE ABUSE NO	SOCIALLY ISOLATED YES	SOCIALLY ISOLATED NO	PARENT ABUSED AS CHILD YES	PARENT ABUSED AS CHILD NO	HEAVY CHILD CARE RESPONSIBILITIES YES	HEAVY CHILD CARE RESPONSIBILITIES NO	LEGAL INTERVENTION YES	LEGAL INTERVENTION NO
ADAMS COUNTY	20% (n=59)	18% (n=108)	8% (n=26)	21% (n=144)	21% (n=70)	17% (n=97)	21% (n=91)	16% (n=76)	16% (n=31)	19% (n=136)	20% (n=138)	14% (n=29)
ARLINGTON	15 (82)	12 (242)	17 (84)	11 (240)	14 (96)	12 (228)	29 (28)	11 (296)	10 (30)	13 (294)	16 (148)	10 (175)
BATON ROUGE	38 (37)	30 (125)	56 (16)	29* (146)	22 (27)	33 (135)	53 (30)	27* (132)	15 (20)	34 (142)	32 (85)	30 (76)
BAYMON	39 (100)	29 (77)	35 (75)	34 (102)	61 (23)	31* (154)	62 (13)	32 (164)	67 (15)	32* (162)	59 (27)	30* (148)
ARKANSAS	69 (32)	47* (175)	65 (20)	49 (187)	45 (73)	54 (134)	53 (45)	50 (162)	44 (52)	53 (155)	50 (159)	54 (48)
ST. LOUIS	36 (25)	18 (73)	20 (10)	23 (88)	25 (49)	20 (49)	23 (40)	22 (58)	13 (15)	24 (83)	26 (57)	18 (40)
TACOMA	25 (32)	14 (81)	43 (14)	13* (99)	13 (24)	18 (89)	17 (35)	17 (78)	21 (34)	15 (79)	17 (75)	14 (35)
UNION COUNTY	43 (88)	35 (368)	42 (95)	35 (361)	39 (107)	36 (349)	56 (43)	34 (413)	43 (56)	36 (400)	36 (349)	37 (102)
TOTAL	35 (464)	28* (1260)	33 (344)	29 (1380)	31 (256)	29 (1468)	30 (479)	29 (1245)	36 (332)	28* (1392)	32 (1054)	25* (657)

*Chi-square significant at less than or equal to .05.

In Baton Rouge, whether or not a parent was abused as a child appears to be related to reincidence. In Tacoma young parents and substance abuse appear as important explanatory factors; in Bayamon, social isolation, heavy child care responsibilities, legal intervention and young parents are important factors; and in Union County, having preschool children is significant. In Arkansas three client characteristics are found of importance--being a young parent, not having minorities in the household and presence of family conflict. With a few within-project exceptions, no one client characteristic appeared to differentiate those with or without severe reincidence more clearly than did the seriousness of the assault that brought the case into treatment.

As a more complete check on the relationships between select client characteristics and severe reincidence while in treatment, multivariate analysis (multiple regression) techniques were used on the whole data set. This allows for understanding the combined effects of client descriptors and the effects of each, when controlling for the others. (See Appendix J for results.) Seriousness of assault appeared to clearly have the largest effect on whether or not there is severe reincidence while in treatment in the multivariate analysis. All other client characteristics used appeared to have no significant effect. This confirms earlier findings that seriousness of assault is the only select client descriptor that can be meaningfully used to predict reincidence while in treatment.

2. Relationships Between Service Receipt and Reincidence

In considering reincidence, it must be kept in mind that a positive or strong relationship with a given service may not indicate causality. While clients receiving a particular service may reabuse or neglect because of the inadequacy or inappropriateness of the service they are receiving, it is also plausible that clients begin to receive particular service because there has been reincidence, or that the client was receiving a service precisely because clinicians perceived a high likelihood of reincidence. Relationships between service receipt and reincidence in treatment are studied with all these possibilities in mind.[1]

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[1] Future researchers may wish to examine the data set more definitively to try and determine whether service receipt most often precedes or follows reincidence. The raw data includes monthly service receipt for each client and indicates month(s) in which reincidence occurred.

As shown in Table III.3, and keeping in mind that 30% of all cases in the data set were reported with severe reincidence, significantly different and larger proportions of clients receiving the following services were reported with reincidence than were those not receiving the service: specialized (alcohol, drug) counseling (57%), family planning (51%), crisis intervention (41%), child services (41%), homemaking (40%), welfare assistance (40%), lay therapy counseling (39%), transportation or babysitting (36%), and multidisciplinary team review (33%). For no service did a significantly different but smaller proportion of cases receive the service but reabuse or neglect; i.e., no service appeared as one which potentially "curbed" reincidence. When looking at individual project data, only in Arlington was receipt of a service -- couples or family counseling -- significantly related to a lack of reincidence. Within each project, receipt of two or three different services was significantly related to the presence of reincidence. The only service significant at more than three projects was crisis intervention. (It can be hypothesized that this service is frequently provided as a result of reincidence while in treatment, or certainly as a result of a family's cry for help which may result in reincidence.)

It is difficult to interpret meaningfully the relationship between individual services and reincidence for many reasons, not the least of which is that services are rarely offered in isolation but rather as part of a service package. It is thus useful to study the relationships between service packages or service models and reincidence. As seen in Table III.4, clients receiving lay services as part of the service package were most likely to have severe reincidence (38% vs. 29% or less receiving other service models). This suggests that in terms of the overall demonstration experience, cases handled in part by lay persons were less likely to receive the kind of intense supervision early on that may help avoid reincidence. However, the conclusion must be tempered by individual project experiences. In fact, Arkansas accounts in large part

Table III.3

PERCENT DISTRIBUTION OF CLIENTS WITH SEVERE REINCIDENCE
BY SERVICES RECEIVED FOR ALL SERVICES BY PROJECT**

	MDT REVIEW		ONE TO ONE COUNS.		LAY THERAPY		GROUP THERAPY		PARENTS ANONY-MOUS		COUPLES/ FAMILY COUNS.		SPECIAL COUNS.		FAMILY PLANNING	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY (19%)	25% (n=98)	10%* (n=69)	18% (n=148)	21% (n=19)	17% (n=29)	19% (n=138)	20% (n=10)	19% (n=157)	24% (n=17)	18% (n=150)	26% (n=80)	12%* (n=87)	46% (n=11)	17%* (n=156)	31% (n=16)	17% (n=151)
ARLINGTON (13%)	11 (65)	13 (259)	13 (293)	7 (31)	23 (13)	12 (311)	32 (25)	11* (299)	--	13 (322)	7 (106)	16* (218)	--	13 (320)	38 (8)	12 (316)
BATON ROUGE (32%)	37 (49)	29 (113)	33 (155)	--	--	32 (161)	71 (7)	30 (155)	--	32 (159)	39 (46)	28 (116)	100 (2)	31 (160)	33 (3)	31 (159)
BAYAMON (35%)	37 (142)	26 (35)	35 (168)	22 (9)	--	35 (176)	47 (15)	33 (162)	33 (3)	35 (174)	43 (116)	18* (61)	48 (52)	29* (125)	56 (18)	32 (159)
ARKANSAS (51%)	66 (83)	46* (134)	45 (67)	54 (140)	51 (202)	60 (5)	50 (12)	51 (195)	50 (48)	51 (159)	53 (17)	51 (190)	67 (6)	50 (201)	33 (3)	51 (204)
ST. LOUIS (22%)	25 (81)	12 (17)	28 (76)	5* (22)	19 (21)	23 (77)	26 (81)	6 (17)	29 (7)	22 (91)	14 (28)	26 (70)	67 (3)	21 (95)	--	22 (98)
TACOMA (17%)	23 (30)	15 (83)	18 (99)	7 (14)	20 (30)	16 (83)	10 (41)	21 (72)	29 (7)	16 (106)	23 (40)	14 (73)	25 (4)	17 (109)	--	17 (113)
UNION COUNTY (36%)	42 (84)	35 (372)	38 (406)	22* (50)	33 (83)	37 (373)	39 (23)	36 (433)	--	36 (456)	36 (154)	36 (302)	82 (28)	33* (428)	58 (36)	35* (420)
TOTAL (30%)	33 (611)	27* (1113)	29 (1427)	33 (297)	39 (389)	27* (1335)	29 (214)	30 (1510)	39 (91)	29 (1633)	30 (599)	29 (1125)	57 (112)	28* (1612)	51 (88)	28* (1636)

*Chi-square significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which data were available, 13 and 7 respectively; information on these cases has been included in the calculations of the "Total" row.

Table III.3 Continued.

	CRISIS INTER-VENTION		PARENT EDUCA-TION		HOME-MAKING		CHILD SERVICES		WELFARE		BABYSIT/ TRANSP.		OTHER	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY (19%)	22% (n=46)	17% (n=121)	29% (n=24)	17% (n=143)	43% (n=7)	18% (n=160)	19% (n=52)	18% (n=115)	21% (n=47)	18% (n=120)	18% (n=22)	19% (n=145)	29% (n=52)	14%* (n=115)
ARLINGTON (13%)	22 (60)	11* (264)	--	13 (320)	33 (6)	12 (318)	15 (53)	12 (271)	14 (51)	13 (273)	18 (73)	11 (251)	6 (52)	14 (272)
BATON ROUGE (32%)	32 (65)	31 (97)	--	32 (160)	29 (28)	32 (134)	42 (36)	29 (126)	42 (33)	29 (129)	34 (32)	31 (130)	40 (63)	26 (99)
BAYAMON (35%)	59 (61)	22* (116)	15 (13)	36 (164)	100 (2)	34 (175)	75 (4)	34 (173)	63 (8)	33 (169)	71 (17)	31* (160)	52 (54)	27* (123)
ARKANSAS (51%)	67 (60)	44* (147)	56 (9)	51 (198)	50 (2)	51 (205)	56 (36)	50 (171)	56 (63)	49 (144)	65 (69)	44* (138)	60 (50)	48 (157)
ST. LOUIS (22%)	18 (45)	26 (53)	11 (27)	27 (71)	--	22 (98)	33 (6)	22 (92)	33 (18)	20 (80)	26 (77)	10 (21)	25 (4)	22 (94)
TACOMA (17%)	19 (37)	16 (76)	18 (72)	15 (41)	20 (5)	17 (108)	13 (8)	17 (105)	20 (49)	14 (64)	12 (52)	21 (61)	26 (54)	9* (59)
UNION COUNTY (36%)	51 (190)	26* (266)	42 (24)	36 (432)	46 (37)	36 (419)	55 (103)	31* (353)	51 (170)	28* (286)	43 (110)	34 (346)	44 (111)	34 (345)
TOTAL (30%)	41 (574)	24* (1150)	24 (183)	30 (1541)	40 (88)	29* (1636)	41 (315)	27* (1409)	40 (444)	26* (1280)	36 (465)	27* (1259)	38 (444)	27* (1280)

*Chi-square significant at less than or equal to .05.

Table III.4

PERCENT DISTRIBUTION OF CLIENTS WITH SEVERE REINCIDENCE

BY SERVICE MODEL BY PROJECT**

	LAY	GROUP	SOCIAL WORK	OTHER
ADAMS COUNTY	21% (n=42)	29% (n=17)	16% (n=94)	14% (n=14)
ARLINGTON	21 (14)	26 (27)	11 (257)	8 (26)
BATON ROUGE	--	56 (9)	32 (142)	--
BAYAMON	33 (3)	32 (25)	36 (140)	22 (9)
ARKANSAS	50 (203)	--	67 (3)	100 (1)
ST. LOUIS	18 (22)	29 (63)	--	--
TACOMA	18 (33)	15 (65)	23 (13)	--
UNION COUNTY	33 (83)	50 (22)	38 (316)	23 (35)
TOTAL	38 (414)	29 (231)	28 (981)	15* (98)

*Chi-Square significant at less than or equal to .05

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "Total" row.

for this reincidence rate. In Adams County, Arlington, St. Louis, Tacoma and Union County, either the same or smaller proportion of cases receiving the lay model were reported with reincidence as compared to those receiving other service models. In these projects, unlike Arkansas, lay workers tended to carry less responsibility for cases, particularly during the first months of treatment when the likelihood of reincidence may well be higher.

As shown in Table III.5, which contains data only for the whole study set, more frequent contact and delivery of more services were both related to reincidence, suggesting that projects provided more intense service to those predicted to be repeaters or those that in fact were.

Despite the fact that many significant relationships were found between service receipt and reincidence, the proportional difference between serious and non-serious cases in terms of reincidence (56% to 15%) was greater than for any given service, for the whole data set.

In order to better understand the associations between service receipt and severe reincidence while in treatment, multivariate analyses were conducted (see Appendix J for multiple regression results). Of particular concern is the relative effect of receipt of each discrete service when other services are controlled for. Specialized counseling was found to have the largest effect on (or relationship to) whether or not there is severe reincidence. Services with small but significant effects include parent education classes (a negative relationship), crisis intervention and welfare assistance. Services with notable but insignificant effects include child services, lay therapy and family planning. These relationships support the earlier findings.

As a less complex way of looking at service receipt and severe reincidence, rather than using discrete services in the regression analysis, the service models or packages were used. The probability of severe reincidence was found to be greater for those who received lay services than those who received the other models. Group and social

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[1] A positive relationship implies that severe reincidence is more likely to occur for clients receiving the service.

Table III.5

PERCENT DISTRIBUTION OF NUMBER OF DIFFERENT SERVICES RECEIVED AND FREQUENCY OF CONTACT WITH SERVICE PROVIDER BY SEVERE REINCIDENCE

	NUMBER OF DIFFERENT TYPES OF SERVICE RECEIVED					FREQUENCY OF CONTACT WITH SERVICE PROVIDER			
	1	2	3	4	5 OR MORE	LESS THAN ONCE A MONTH	1-2 TIMES A MONTH	3-4 TIMES A MONTH	WEEKLY OR MORE
SEVERE REINCIDENCE (n=509)	21%	20%	24%	30%	42%	18%	21%	28%	42%

worker models have similar probabilities of severe reincidence. This confirms that the lay service model is most related to severe reincidence while in treatment for the whole study population.

When running this same multivariate analysis controlling for seriousness of assault, the effects of each of the service model types are reduced. The probability of severe reincidence is greater for those who seriously assaulted their child than for those receiving any particular service model. In other words, seriousness of assault better predicts reincidence than does service model receipt. When further controlling for type of maltreatment (e.g., physical abuse, sexual abuse, physical neglect) the effect of seriousness of assault is not diminished. This confirms earlier findings, seen both within projects and for the whole data set, that the seriousness of the case at intake is the single best predictor of reincidence.

B. Improvement in Select Areas of Daily Functioning by the End of Treatment

As a proxy measure of longer-term treatment outcome, assessments about a client's improvement (or lack thereof) by the end of treatment in select areas of daily functioning theorized to be related to abusive and neglectful behavior were made. Because the measures are not proven to be related to child maltreatment, findings must be regarded as suggestive, not conclusive. A composite score of improvement in those areas noted to be a problem at intake was constructed for use in the outcome analysis. Client characteristics and service provision variables are studied in relation to both improvement in discrete areas of functioning and the composite score to better understand the relative effects of service strategies.

Summary of Findings

Clients who both phsyically abuse and neglect their children, emotional maltreaters and clients with severe household situations (including a history of abuse and neglect) are generally less likely to improve on the functioning indicators used in this study. A few other client descriptors have small relationships to such improvement--notably those reflecting a great deal of internal family stress. Clients who received lay services (lay therapy counseling or Parents Anonymous)

are the clients most likely to show improved functioning by the end of treatment. Clients receiving Parents Anonymous, in particular, were more likely to improve in select areas of functioning than clients receiving any other service. While no one discrete service stands out as having a strong effect on this outcome when others are controlled for, the lay service model (receipt of lay therapy and Parents Anonymous along with other services) does have the strongest effect of the service models studied. The lay model also has the strongest effect on improvement in each of the select areas of functioning, followed by the group model. Client descriptors, including the presence of reincidence during treatment, contribute somewhat to interpreting this outcome.

1. Relationships Between Client Characteristics and Improvement in Select Areas of Functioning

Before exploring the relationships between services received and improved functioning, it is important to determine which, if any, of a variety of salient client characteristics are related to this outcome, e.g., do some kinds of people improve in select areas of functioning irrespective of the nature and quality of services offered? Is it possible to predict improved functioning on the basis of client characteristics alone? And, which client characteristics might be most useful in explaining or interpreting improved functioning?

To address these questions, the relationships between client characteristics, identified earlier to be the most salient and least redundant, and improved functioning were studied. The overall finding is that there are some small, generally insignificant, but interesting associations between client characteristics and this proxy measure of outcome. Most notably, the type of maltreatment, the seriousness of the assault on the child, and the severity of the situation partially explain family functioning outcomes; others do not.

The client characteristics examined include: age of children, age of parents, race, employment, size of family, amount of family conflict, substance abuse, isolation, history of abuse as a child, special child responsibilities, legal intervention and total income, as well as the type of maltreatment, seriousness of the assault, and the severity of the family situation.

As shown in Table III.6, when considering the entire study population, clients who have both physically abused and neglected their children and emotional maltreaters are least likely to have improved a lot (in two-thirds or more of the areas in which they had problems at intake) than other types of maltreaters. While the differences in the proportion of clients who improved a lot across client types is not great (15% at most), these two types of maltreaters were undoubtedly somewhat more challenging for the projects to work with, with respect to daily functioning. Clients who had seriously abused or neglected their children, however, demonstrated essentially the same amount of improvement in functioning as non-serious maltreaters. Thus, even though the serious cases appear much more likely to reabuse or neglect while in treatment, they initially appear just as likely to improve by the end of treatment. However, the severity of the situation (a combined score of seriousness of assault, previous record of abuse/neglect, whether or not the alleged maltreatment was substantiated and the number of problems which the family confronts) has a small, direct relationship to improved functioning and a significant one; the more "severe" the case, the less likely there is improved functioning.

Of the many client characteristics, those that appeared to be significantly related to improved functioning are: having at least one adult in the household employed, an absence of family conflict, an absence of social isolation and an absence of heavy, continuous child care responsibilities. In other words, families burdened with these problems appear somewhat less likely to improve in treatment.

As shown in Table III.7, a study of the relationships between select client descriptors and improvement in specific aspects of client functioning reveals very few associations of significance. Some of the exceptions include:

- Clients with substance abuse problems are somewhat more likely to have improved health, although they are somewhat less likely to have reduced stress from their living situation, increased awareness of child development or improved ability to talk about their problems;

Table III.6

PERCENT DISTRIBUTION OF CLIENTS WITH IMPROVED FUNCTIONING BY TYPE OF MALTREATMENT SERIOUSNESS OF ASSAULT, SEVERITY AND CLIENT CHARACTERISTICS

IMPROVEMENT ON FUNCTIONING INDICATORS	TYPE OF MALTREATMENT						SERIOUSNESS		SEVERITY				
	POTENTIAL ABUSE OR NEGLECT (n=327)	EMOTIONAL MALTREAT-MENT (n=207)	SEXUAL ABUSE (n=69)	PHYSICAL ABUSE (n=572)	PHYSICAL NEGLECT (n=292)	PHYSICAL ABUSE & NEGLECT (n=65)	SERIOUS ASSAULT (n=582)	NON-SERIOUS ASSAULT (n=1012)	NOT SEVERE 0 (n=480)	1 (n=462)	2 (n=403)	3 (n=174)	SEVERE 4 (n=75)
A LITTLE** (62%)	61%	68%	61%	59%	65%	69%*	64%	60%	59%	61%	61%	65%	80%*
SOME (18%)	15	20	20	19	14	22	17	18	18	20	17	19	11
A LOT (21%)	24	12	19	22	21	9	18	22	24	20	22	16	9

*Chi-square significant at less than or equal to .05.

**A little indicates improvement on one third or less of the measures reported to be a problem at intake; some indicates improvement on one third to two thirds; a lot indicates improvement on more than two thirds.

Table III.6 Continued.

IMPROVEMENT ON FUNCTIONING INDICATORS	CLIENT CHARACTERISTICS											
	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES IN FAMILY		NO ADULT EMPLOYED		FOUR OR MORE CHILDREN		FAMILY CONFLICT	
	YES (n=1079)	NO (n=384)	YES (n=672)	NO (n=922)	YES (n=650)	NO (n=944)	YES (n=461)	NO (n=1133)	YES (n=358)	NO (n=1236)	YES (n=426)	NO (n=1168)
A LITTLE	61%	63%	63%	61%	60%	63%	67%	60%*	64%	61%	68%	59%*
SOME	18	18	17	18	19	17	16	19	20	17	17	18
A LOT	22	19	20	21	21	20	17	22	16	22	15	23

IMPROVEMENT ON FUNCTIONING INDICATORS	CLIENT CHARACTERISTICS									
	SUBSTANCE ABUSE		SOCIALLY ISOLATED		PARENT ABUSED AS CHILD		HEAVY CHILD CARE RESPONSIBILITIES		LEGAL INTERVENTION	
	YES (n=318)	NO (n=1276)	YES (n=458)	NO (n=1136)	YES (n=317)	NO (n=1277)	YES (n=248)	NO (n=1346)	YES (n=976)	NO (n=606)
A LITTLE	70%	60%*	68%	59%*	64%	61%	65%	61%*	61%	63%
SOME	12	19	17	18	19	18	21	17	18	18
A LOT	19	21	16	23	17	22	14	22	22	19

* Chi-square significant at less than or equal to .05.

Table III.7

PERCENT OF CLIENTS WHO IMPROVE ON THE FUNCTIONING INDICATORS BY SERIOUSNESS OF ASSAULT, AND OTHER CLIENT CHARACTERISTICS

FUNCTIONING INDICATORS	CLIENT CHARACTERISTICS													
	ASSAULT		PRESCHOOL CHILDREN		TEENAGE PARENT		NO ADULT EMPLOYED		FAMILY CONFLICT		SUBSTANCE ABUSE		SOCIALLY ISOLATED	
	SERIOUS (n=588)	NON-SERIOUS (n=1026)	YES (n=1090)	NO (n=394)	YES (n=676)	NO (n=937)	YES (n=468)	NO (n=1147)	YES (n=426)	NO (n=1174)	YES (n=319)	NO (n=1296)	YES (n=456)	NO (n=1157)
GENERAL HEALTH	14%	12%	13%	11%	15%	11%*	14%	12%	13%	13%	17%	12%*	14%	12%
STRESS FROM LIVING SITUATION	26	30	28	30	29	28	26	29	22	30*	24	29*	26	29
SENSE OF CHILD AS PERSON	21	23	23	20	21	23	18	24*	20	23	18	23	21	22
BEHAVIOR TOWARD CHILD	27	28	29	26	26	29	25	29	26	29	26	29	27	28
AWARENESS OF CHILD DEVELOPMENT	24	22	24	20	22	24	20	24	19	24	18	24*	23	23
ABILITY TO TALK OUT PROBLEMS	28	24	27	21*	27	24	27	25	24	26	21	27*	26	25
REACTION TO CRISIS	22	24	24	22	24	23	23	24	21	24	21	24	21	24
WAY ANGER IS EXPRESSED	19	21	20	20	19	21	20	20	18	21	18	21	20	20
SENSE OF INDEPENDENCE	19	18	20	13*	18	18	18	18	17	19	18	19	17	19
UNDERSTANDING OF SELF	19	19	20	17	20	18	18	20	19	19	17	20	19	19
SELF ESTEEM	18	19	20	15*	20	18	17	19	17	19	18	19	17	19

*Chi-square significant at less than or equal to .05.

- Clients with older children are less likely to improve their ability to talk about their problems, or have an improved sense of independence or sense of self.
- Clients with problematic family conflicts are much less likely to have reduced stress from their living situations.
- Clients in households where no adult is employed are less likely to have an improved sense of their child(ren) as a person.

As a more complete check on the relationships between select client characteristics and amount of improvement in those areas of functioning identified as a problem at intake, multivariate techniques were used (notably, multiple regression). It is important to check whether or not relationships betweeen client characteristics and improved functioning are diminished or strengthened or remain the same when controlling for other variables. (See Appendix J for the multiple regression results.) The effect of the degree of family conflict on improved functioning was found to be significant, negative and substantively important. Substance abuse appears to inhibit improvement. Physical abuse and potential maltreatment have comparable significant, but positive effects; that is, such cases have a higher probability of improved family functioning at the end of treatment.

Multivariate relationships between improvement on each of the functioning indicators separately and the select client characteristics were also studied with the use of multiple regression. Race/ethnicity and degree of family conflict appeared to have slight, significant effects on improvement in situation; employment status and age of children had slight, significant effects on improvement in sense of child. But, in general the multivariate analyses supported earlier conclusions that client characteristics do not have strong stable or significant relationships with improvement in select areas of functioning.

2. Relationships Between Service Receipt and Improvement in Select Areas of Functioning

Having concluded that there are few significant direct relationships between client characteristics and improved functioning in select areas for the whole data set, the bivariate relationships

between service receipt and this aspect of outcome are studied both for the whole data set and within projects. The findings of this analysis are presented in Tables III.8 through III.11, which display composite and individual scores of improvement on the functioning indicators by discrete service receipt and service model receipt. The composite score reflects the percentage of indicators on which a client had a problem at intake and improved during the course of treatment.

Twenty-one percent of all clients improved in at least two-thirds of those areas in which they had problems at intake. Thirty-two percent of those receiving Parents Anonymous had this much improvement and 25% of those receiving lay therapy--a smaller but still significant figure--showed such improvement. No other services appeared to have significant positive relationships with improvement; couples/family counseling, and specialized counseling did have significant, but negative significant, but negative relationships. Clients receiving these services were least likely to improve. Within most projects, no significant relationships are seen between service receipt and improvement on this composite score. In Adams County, receipt of lay therapy has a negative relationship with improvement as does receipt of couples/family counseling as did intervention in Union County. In Bayamon, both group therapy and parent education classes appear to have had a positive impact, as did parent education classes (and welfare) in Tacoma. Thus, within-project experiences varied somewhat from the overall demonstration experience, as might be expected.

The relationships between services and improvement are more easily understood and interpreted when service packages are considered. The differences between service model receipt, for the whole study population, are significant; clients receiving the lay service model (lay therapy or Parents Anonymous supplementing other services) are the most likely group to have improved in select areas of functioning, followed by those receiving the group model and finally those receiving the social work model. In most projects no significant differences are seen between service model receipt and this outcome (sometimes because of the small number of cases receiving one or two of the service model

Table III.8

PERCENT DISTRIBUTION OF CLIENTS RECEIVING SELECT SERVICES BY COMPOSITE SCORE FOR IMPROVEMENT IN AREAS OF FUNCTIONING WHICH WERE A PROBLEM AT INTAKE BY PROJECT**

COMPOSITE SCORE OF IMPROVEMENT ON FUNCTIONING INDICATORS BY PROJECT	ALL CASES	MDT REVIEW		ONE-TO-ONE COUNS.		LAY THERAPY COUNS.		GROUP THERAPY		PARENTS ANONYMOUS		COUPLES/ FAMILY COUNS.		SPECIAL COUNS.		CRISIS INTERVENTION		PARENT EDUCATION		HOME-MAKING		CHILD SERVICES		WELFARE		BABY-SITTING/ TRANSP.	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	66%	65%	69%	64%	80%	82%	63%*	50%	67%	59%	67%	68%	65%*	55%	67%*	65%	67%	75%	65%	86%	65%	67%	66%	70%	65%	50%	69%
A LITTLE	15	14	16	14	21	--	18	20	15	18	15	21	9	--	16	20	13	8	16	--	16	10	17	13	16	20	14
SOME	19	22	15	22	--	18	19	30	18	24	18	12	26	46	17	15	20	17	19	14	19	22	17	17	19	30	17
A LOT	(154)	(93)	(61)	(135)	(19)	(28)	(126)	(10)	(144)	(17)	(137)	(78)	(76)	(11)	(143)	(46)	(108)	(24)	(130)	(7)	(147)	(49)	(105)	(46)	(108)	(20)	(134)
ARLINGTON	70	72	69	71	58	67	70	68	70	--	70	68	71	100	69	70	70	75	70	83	70	69	70	75	69	69	70
A LITTLE	14	13	14	13	27	--	15	12	14	50	14	17	12	--	14	19	13	--	14	17	14	15	14	11	15	14	14
SOME	16	16	17	17	15	33	16	20	16	50	16	15	17	--	17	11	17	25	16	--	17	17	16	15	17	17	16
A LOT	(295)	(64)	(231)	(269)	(26)	(12)	(283)	(25)	(270)	(2)	(293)	(101)	(194)	(4)	(291)	(54)	(241)	(4)	(291)	(6)	(289)	(48)	(248)	(47)	(295)	(70)	(225)
BATON ROUGE	59	70	54	60	50	100	59	29	61	33	60	73	54	100	59	70	51	50	59	56	60	67	57	59	59	69	57
A LITTLE	18	15	20	18	17	--	18	14	18	33	18	9	22	--	18	13	22	50	18	20	18	18	18	25	16	16	19
SOME	23	15	26	22	33	--	23	57	21	33	23	18	25	--	23	17	27	--	23	24	23	15	25	16	25	16	25
A LOT	(154)	(47)	(107)	(148)	(6)	(1)	(153)	(7)	(147)	(3)	(151)	(44)	(110)	(2)	(152)	(64)	(90)	(2)	(152)	(25)	(129)	(33)	(121)	(32)	(122)	(32)	(122)
BAYAMON	66	65	72	66	80	--	67	40	68*	33	67	68	64	69	65	64	68	31	70*	100	66	75	66	60	67	50	68*
A LITTLE	21	19	28	21	20	100	20	20	21	67	20	19	25	19	22	19	22	8	22	--	21	25	21	40	20	50	18
SOME	13	16	--	13	--	--	13	40	11	--	13	13	11	12	13	17	10	62	8	--	13	--	13	--	13	--	14
A LOT	(143)	(114)	(29)	(138)	(5)	(1)	(142)	(10)	(133)	(3)	(140)	(90)	(53)	(42)	(101)	(47)	(96)	(13)	(130)	(2)	(141)	(4)	(139)	(5)	(138)	(12)	(131)
ARKANSAS	51	47	52	51	51	51	40	73	50	43	54	38	52	67	51	58	48	33	52	100	51	59	49	62	46*	48	53
A LITTLE	22	29	19	19	24	22	20	--	23	21	22	25	22	17	22	22	22	33	21	--	22	18	23	11	27	23	21
SOME	27	24	28	31	25	27	40	27	27	36	24	38	26	17	27	20	30	33	27	--	27	24	28	27	27	29	26
A LOT	(196)	(51)	(145)	(65)	(131)	(191)	(5)	(11)	(185)	(47)	(149)	(16)	(180)	(6)	(190)	(60)	(136)	(9)	(187)	(2)	(194)	(34)	(162)	(63)	(133)	(69)	(127)
ST. LOUIS	71	73	60	71	70	62	73	68	88	43	73	70	71	33	72	77	65	70	71	--	71	83	70	72	71	71	68
A LITTLE	17	17	13	15	25	19	16	20	--	29	16	15	17	33	16	11	21	15	17	--	17	--	18	11	18	18	11
SOME	13	10	27	15	5	19	11	13	13	29	11	15	12	33	12	11	14	15	12	--	13	17	12	17	12	10	21
A LOT	(96)	(81)	(15)	(76)	(20)	(21)	(75)	(80)	(16)	(7)	(89)	(27)	(69)	(3)	(93)	(44)	(82)	(27)	(69)		(96)	(6)	(90)	(18)	(78)	(77)	(19)
TACOMA	53	54	53	53	57	66	49	54	53	43	54	58	51	--	55	63	49	51	58*	80	52	38	55	67	42*	54	53
A LITTLE	26	29	25	28	14	24	27	22	29	14	27	30	25	50	25	29	25	33	13	20	27	50	24	19	32	32	21
SOME	21	18	22	19	29	10	24	24	19	43	19	13	25	50	19	9	26	16	29	--	22	13	21	15	25	14	26
A LOT	(107)	(28)	(79)	(93)	(14)	(29)	(78)	(37)	(70)	(7)	(100)	(38)	(69)	(4)	(103)	(35)	(72)	(69)	(38)	(5)	(102)	(8)	(99)	(48)	(59)	(50)	(57)
UNION COUNTY	59	66	57	56	79*	52	60	77	58	--	59	66	55*	57	59	66	53*	50	59	70	57	63	57	58	59	57	59
A LITTLE	17	16	18	19	6	19	17	5	18	--	17	12	20	14	18	16	19	13	18	8	18	17	17	18	17	17	17
SOME	24	18	26	25	15	30	23	18	25	--	24	22	25	29	24	18	29	38	24	22	25	20	26	24	25	26	24
A LOT	(429)	(83)	(346)	(382)	(47)	(81)	(348)	(22)	(407)		(429)	(145)	(284)	(28)	(401)	(187)	(242)	(24)	(405)	(37)	(392)	(99)	(330)	(166)	(263)	(110)	(319)
TOTAL	62	65	60	62	61	56	63*	63	61	46	63*	66	59*	67	59*	62	62	56	62	71	6	64	61	64	61	60	62
A LITTLE	18	18	18	17	20	19	18	16	18	22	18	16	19	17	18	16	18	21	17	12	18	15	18	16	19	20	17
SOME	21	18	22	21	19	25	19	21	21	32	20	17	22	17	23	23	20	23	20	18	21	21	21	21	21	20	21
A LOT	(1594)	(570)	(1024)	(1321)	(273)	(373)	(1221)	(202)	(1392)	(90)	(1504)	(551)	(1043)	(547)	(1047)	(102)	(1487)	(180)	(1414)	(85)	(1509)	(298)	(1296)	(430)	(1164)	(453)	(1141)

*Chi-squared significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 13 and 17, respectively; information on these cases has been included in the calculations for the "Total" row.

Table III.9

PERCENT DISTRIBUTION OF CLIENTS RECEIVING SELECT SERVICE MODEL BY COMPOSITE SCORE FOR IMPROVEMENT IN AREAS OF FUNCTIONING BY PROJECT**

COMPOSITE SCORE OF IMPROVEMENT BY PROJECT	SERVICE MODELS			
	LAY SERVICES	GROUP SERVICES	SOCIAL WORK SERVICES	OTHER SERVICES
ADAMS COUNTY				
A LITTLE	76%	53%	62%	79%
SOME	7	18	17	21
A LOT	17	29	21	--
	(n=41)	(n=17)	(n=82)	(n=14)
ARLINGTON				
A LITTLE	62	70	71	67
SOME	8	11	14	24
A LOT	31	19	16	10
	(13)	(27)	(234)	(21)
BATON ROUGE				
A LITTLE	50	33	62	50
SOME	25	22	18	17
A LOT	25	44	21	33
	(4)	(9)	(135)	(6)
BAYAMON				
A LITTLE	33	40	71	80*
SOME	67	10	22	20
A LOT	--	50	7	--
	(3)	(20)	(115)	(5)
ARKANSAS				
A LITTLE	51		67	--
SOME	22		33	--
A LOT	27	--	--	100
	(192)		(3)	(1)
ST. LOUIS				
A LITTLE	64	69	89	100
SOME	18	19	--	--
A LOT	18	11	11	--
	(22)	(62)	(9)	(3)
TACOMA				
A LITTLE	59	50	54	50
SOME	22	32	15	--
A LOT	19	18	31	50
	(32)	(60)	(13)	(2)
UNION COUNTY				
A LITTLE	52	86	56	81*
SOME	19	10	19	3
A LOT	30	5	25	16
	(81)	(21)	(295)	32
TOTAL				
A LITTLE	56	60	63	74*
SOME	19	20	17	13
A LOT	25	20	19	13
	(398)	(219)	(893)	(84)

*Chi-square significant at less than or equal to 0.5.

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases, 13 and 7, respectively; information on these cases has been included in calculations for the "Total" row.

Table III.10

PERCENT DISTRIBUTION OF CLIENTS RECEIVING SELECT SERVICES BY IMPROVEMENT ON EACH OF THE INDIVIDUAL FUNCTIONING INDICATORS

	ALL CASES	MDT REVIEW		ONE TO ONE COUNS.		LAY THERAPY COUNS.		GROUP THERAPY		PARENTS ANONYMOUS		COUPLES/FAMILY COUNS.	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
GENERAL HEALTH	13% (n=1614)	15% (n=571)	11% (n=1043)	13% (n=1342)	10% (n=272)	16% (n=376)	12%* (n=1238)	13% (n=202)	13% (n=1412)	10% (n=90)	13% (n=1524)	12% (n=554)	13% (n=1060)
STRESS FROM LIVING SITUATION	28 (1615)	27 (568)	29 (1047)	29 (1341)	24 (274)	31 (375)	27 (1240)	27 (203)	29 (1412)	36 (90)	28 (1525)	23 (555)	31* (1060)
SENSE OF CHILD AS PERSON	22 (1609)	24 (568)	21 (1041)	21 (1337)	25 (272)	27 (373)	20* (1236)	29 (201)	21* (1408)	37 (90)	21* (1519)	22 (552)	22 (1057)
BEHAVIOR TOWARD CHILD	28 (1611)	31 (568)	26 (1043)	28 (1339)	28 (272)	35 (371)	26* (1240)	30 (201)	28 (1410)	43 (88)	27* (1523)	29 (553)	28 (1058)
AWARENESS OF CHILD DEVELOPMENT	23 (1613)	24 (569)	22 (1044)	22 (1342)	24 (271)	29 (373)	21* (1240)	21 (202)	23 (1411)	31 (90)	22 (1523)	21 (553)	24 (1060)
ABILITY TO TALK OUT PROBLEMS	25 (1615)	28 (571)	24 (1044)	25 (1342)	27 (273)	33 (373)	23* (1242)	32 (203)	25* (1412)	37 (90)	25* (1525)	21 (555)	28* (1060)
REACTION TO CRISIS SITUATIONS	23 (1600)	22 (571)	24 (1029)	24 (1339)	22 (261)	31 (360)	21* (1240)	27 (203)	23 (1397)	44 (89)	22 (1511)	21 (555)	24 (1045)
WAY ANGER IS EXPRESSED	20 (1598)	18 (570)	21 (1028)	20 (1336)	19 (262)	28 (360)	18* (1238)	24 (203)	19 (1395)	30 (90)	19* (1508)	16 (554)	22* (1044)
SENSE OF INDEPENDENCE	18 (1610)	17 (570)	19 (1040)	19 (1337)	16 (273)	25 (374)	16* (1236)	23 (201)	18 (1409)	32 (90)	18* (1520)	17 (553)	19 (1057)
UNDERSTANDING OF SELF	19 (1614)	19 (571)	20 (1043)	18 (1341)	23 (273)	28 (374)	17* (1240)	30 (201)	18* (1413)	38 (90)	18* (1524)	18 (554)	20 (1060)
SELF ESTEEM	19 (1613)	18 (572)	19 (1041)	19 (1340)	19 (273)	28 (373)	16* (1240)	21 (203)	18 (1410)	36 (90)	18 (1523)	19 (556)	19 (1057)

*Chi-square significant at less than or equal to .05.

Table III.10 Continued.

	SPECIAL COUNS.		CRISIS INTERVENTION		PARENT EDUCATION		HOME-MAKING		CHILD SERVICES		WELFARE		BABYSITTING/ TRANS.	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
GENERAL HEALTH	26% (n=102)	12%* (n=1512)	17% (n=547)	11%* (n=1067)	16% (n=180)	12% (n=1434)	14% (n=85)	13% (n=1529)	17% (n=301)	12%* (n=1313)	15% (n=434)	12% (n=1180)	14% (n=453)	12% (n=1161)
STRESS FROM LIVING SITUATION	30 (100)	28 (1515)	24 (549)	30* (1066)	22 (180)	29* (1435)	26 (85)	28 (1530)	30 (300)	28 (1315)	28 (433)	29 (1182)	29 (454)	28 (1161)
SENSE OF CHILD AS PERSON	23 (102)	22 (1507)	21 (546)	23 (1063)	37 (178)	20* (1431)	15 (85)	22 (1524)	22 (298)	22 (1311)	22 (431)	22 (1178)	26 (453)	20* (1156)
BEHAVIOR TOWARD CHILD	33 (102)	28 (1509)	27 (545)	28 (1066)	39 (175)	27* (1436)	24 (83)	28 (1528)	27 (301)	28 (1310)	26 (431)	29 (1180)	27 (450)	30 (1161)
AWARENESS OF CHILD DEVELOPMENT	24 (102)	23 (1511)	21 (547)	24 (1066)	36 (179)	21* (1434)	20 (85)	23 (1528)	23 (300)	23 (1313)	23 (433)	23 (1180)	25 (453)	22 (1160)
ABILITY TO TALK OUT PROBLEMS	25 (102)	25 (1513)	28 (549)	24 (1066)	34 (180)	24* (1435)	19 (85)	26 (1530)	28 (300)	25 (1315)	28 (433)	25 (1182)	29 (453)	24* (1162)
REACTION TO CRISIS SITUATIONS	34 (101)	23* (1499)	23 (548)	24 (1052)	29 (179)	23 (1421)	24 (85)	23 (1515)	28 (298)	22 (1302)	25 (425)	23 (1175)	27 (449)	22 (1151)
WAY ANGER IS EXPRESSED	26 (102)	20 (1496)	17 (547)	22 (1051)	29 (178)	19 (1420)	12 (85)	21 (1513)	19 (298)	20 (1300)	21 (425)	20 (1173)	23 (448)	19 (1150)
SENSE OF INDEPENDENCE	28 (102)	18* (1508)	19 (546)	18 (1064)	32 (178)	17* (1432)	15 (85)	19 (1525)	21 (298)	18 (1312)	23 (430)	17* (1180)	22 (450)	17* (1160)
UNDERSTANDING OF SELF	25 (102)	19 (1512)	18 (548)	20 (1066)	32 (180)	18* (1434)	15 (85)	19 (1529)	20 (301)	19 (1313)	20 (432)	19 (1182)	22 (452)	18 (1162)
SELF ESTEEM	28 (102)	18* (1511)	19 (549)	18 (1064)	22 (179)	18* (1434)	19 (85)	19 (1528)	22 (299)	18 (1314)	22 (431)	17 (1182)	22 (451)	17* (1162)

*Chi-square significant at less than or equal to .05.

Table III.11

PERCENT OF CLIENTS WHO IMPROVE ON FUNCTIONING INDICATORS BY SERVICE MODELS

FUNCTIONING INDICATORS	SERVICE MODELS			
	LAY	GROUP	SOCIAL WORK	OTHER
GENERAL HEALTH	16% (n=401)	13% (n=219)	12% (n=910)	8% (n=84)
STRESS FROM LIVING SITUATION	31 (400)	24 (220)	29 (909)	15* (86)
SENSE OF CHILD AS PERSON	30 (398)	32 (217)	17 (909)	19* (85)
BEHAVIOR TOWARD CHILD	35 (396)	32 (217)	25 (913)	19* (85)
AWARENESS OF CHILD DEVELOPMENT	29 (398)	28 (218)	19 (912)	17* (85)
ABILITY TO TALK OUT PROBLEMS	33 (398)	32 (220)	21 (911)	15* (86)
REACTION TO CRISIS SITUATIONS	33 (385)	25 (219)	20 (911)	11* (85)
WAY ANGER IS EXPRESSED	28 (385)	24 (218)	17 (909)	7* (86)
SENSE OF INDEPENDENCE	26 (399)	26 (216)	14 (909)	7* (86)
UNDERSTANDING OF SELF	28 (399)	28 (218)	14 (911)	7* (86)
SELF ESTEEM	28 (398)	19 (219)	15 (910)	11* (86)

*Chi-square significant at less than or equal to .05.

types). However, in Union County the lay service model appears as the most effective, followed by the social work model. And, in Bayamon where only three cases received lay services) the group model appears significantly more effective than the others.

In addition to being interested generally in whether or not different services contribute toward improved functioning, it is useful to explore the particular ways in which services are related to outcome; i.e., those particular aspects of a parent's attitudes and behaviors that seem to change as a result of receiving particular services. In order to gain some insight into this, relationships between the receipt of a particular service or service models and improvement during treatment on select functioning indicators are explored for the whole study population. The following is seen:

General Health. Whereas 13% of all cases in the data set exhibited improved general health during treatment, a significantly greater percent of those clients receiving specialized (alcohol, drug) counseling (26%) were reported with improved health, as did between 15% and 17% of those receiving MDT review, lay therapy, crisis intervention and child services.

Stress from Living Situation. Twenty-eight percent of all clients were said to have reduced stress from their living situations. No significant, positive relationships were seen with service receipt; however, those receiving family counseling, crisis intervention or parent education classes were less likely to improve in this area. The lay and social work service models were, however, significantly related to reduction in household stress.

Sense of Child as Person. Close to 38% of the clients receiving Parents Anonymous or parent education classes changed their attitudes toward their children from extensions of themselves to separate persons, as compared with 22% of all cases. Clients receiving lay therapy (27%) and group therapy (29%) also were more likely to improve on this measure than other clients included in the data set. The lay and group models have a significant, positive relationship with this improvement.

Behavior Toward Child. With respect to behavior toward child, Parents Anonymous again appears as an effective service: 28% of all cases improved their behavior toward their children during treatment, whereas 43% of those receiving Parents Anonymous did. Parent education and lay therapy counseling also appear to be helpful services in this area, whereas services most typically provided by a protective service department--individual counseling, crisis intervention, welfare--are among those least likely to be helpful in this area. As would be predicted, the lay model, followed by the group model, are significantly and positively related to this improvement.

Awareness of Child Development. Clients receiving parent education classes were more likely to have increased their awareness of child development (36%), as were those receiving lay therapy counseling (29%). A significant, proportion of those receiving Parent Anonymous were, as well. Once again, the lay model followed by the group model are significantly and positively related to increased awareness of child development.

Ability to Talk Out Problems. Parent Anonymous appears to be the most useful of the services in improving a parent's ability to talk about his or her problems. Thirty-seven percent of those receiving this service showed improvement (compared with 25% of all cases). Clients receiving lay therapy counseling, group therapy, parent education classes, and babysitting or transportation also did better than other cases. Those receiving couples or family counseling did less well. Lay and group treatment packages are more highly related to this improvement than the social work model.

Reactions to Crisis Situations. By a substantial proportion (44% as compared with 23%) clients receiving Parent Anonymous were reported with improved abilities to handle crisis situations. A significantly higher proportion of those receiving lay therapy, group therapy and specialized counseling also improved. Here the lay model is clearly the most useful strategy.

Way Anger is Expressed. Once again, Parents Anonymous appears to be the treatment of choice for helping clients improve the ways in which they channel their anger. Thirty percent of clients receiving this service showed improvement in the way anger is expressed as compared

with 20% of all clients. Clients receiving lay therapy counseling also were more likely to improve than other cases, whereas couples or family counseling had a significant but negative relationship with improvement in this behavior. Again, of the service packages, the lay model appears to be the most helpful in improving expression of anger.

Sense of Independence. Parent education classes and Parents Anonymous were services mostly highly and significantly associated with increased sense of independence as well. Thirty-two percent of clients receiving either of these services improved as compared with 18% of all cases. Twenty-eight percent of those receiving specialized counseling improved in this area as did 25% of those with lay therapy and comparable percents of those receiving babysitting or transportation and welfare assistance. Both the lay and group models have significant, positive relationships here.

Understanding of Self. Parents Anonymous is also the service associated with the most frequent improvement in one's self understanding. We see that 38% of the clients receiving this service improved as compared with 19% of all clients. Also significant are lay therapy, group therapy and parent education classes as well as the lay and group service packages.

Self-Esteem. Finally, 19% of all clients exhibited improved self-esteem from the clinicians' perspective, as did those receiving more typical protective services, whereas 36% of clients receiving Parents Anonymous exhibited improved self-esteem, as did significant but smaller percents of those receiving lay therapy, specialized counseling, transportation or babysitting and parent education. The lay model is the service model most highly associated with this outcome.

It is clear that clients receiving Parents Anonymous, lay therapy, group therapy and parent education do quite well with respect to improvement on most select aspects of functioning, as do clients receiving the lay, and in some instances the group, treatment model. This may be explained in part by the type of client who receives this service and by the characteristics of those projects which more frequently offered these services. Certainly the Arkansas project, which emphasized lay therapy as well as Parents Anonymous, accounts for much of the

improvement in these areas, as does Tacoma. These projects, which had smaller caseloads per worker and/or smaller overall caseload sizes, very likely were able, through the above-mentioned services or service models, to provide clients with the kinds of support necessary for improvement in these select areas of daily functioning. Reincidence while in treatment was somewhat higher for clients receiving these services, possibly suggesting a trade-off between emphasizing services that help defray immediate crises versus those that in the longer run may reduce reactions to daily stresses.

In conclusion, Parents Anonymous, lay therapy, group therapy, and parent education classes appear as services associated with improvements in select aspects of client functioning as do the lay and group treatment models. Of all these services and service models, Parents Anonymous appears almost consistently to have a stronger effect.

Because it is useful to understand the relative effectiveness of each discrete service when controlling for other services, multivariate analyses were undertaken notably multiple regression. (See Appendix J for results). It was confirmed that receipt of Parents Anonymous does have a significant probability that improvement would occur, and a higher probability than any of the other services. And, multivariate analyses confirmed that the lay model has a greater effect than other models for this particular outcome. The group model was found to be more effective than the social work model.

Multivariate analyses were also performed for improvement on the select functioning indicators individually and service model receipt. The lay model was again found to have a greater effect than other service delivery models on all aspects of functioning except for "sense of child as person" (for which the group model had the greater effect) and "stress in living situation" (for which no model had a significant relationship). In all cases, the group model had a greater effect (and a significant one) than the social work model.

In conclusion, the lay model of service delivery appears to have a greater effect on improvements in select areas of client functioning than other service delivery models, followed by the group model.[1]

3. Combined Relationships of Client Characteristics and Service Provision Variables with Improvement in Select Areas of Functioning

Finally, in order to begin to understand the combined effects of client characteristics and service provision on improvement of the functioning indicators, a series of multivariate analyses were performed. The findings are only suggestive of the more complex relationships between variables, and limited to the extent that they do not take account of individual project differences. (The results appear in Appendix J.) First, seriousness of assault was controlled for, and the relationships between service model receipt and improvement of the functioning indicators were considered. While seriousness of assault was found to be negatively related with this outcome, the relative effect of the service models remained basically unchanged. When most of the select service provision and client descriptors are considered as a group, in terms of their relative effect on improved functioning, significant positive effects for the following variables are seen: receipt of the lay service model, the group service model, individual counseling, length of time in treatment; as well as absence of family conflict, absence of social isolation, and employment of at least one household member. Other

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[1] A number of additional multivariate analyses were used to assess the relationships of different combinations of service delivery variables and client outcome, given that the analyses performed with the discrete set of services and the set of service models accounted for relatively little variance in the dependent variable. Certain service variables were consistently found to have significant, although often small, positive effects on outcome. These variables include: the lay service model; frequency of receipt of individual counseling; receipt of lay therapy; receipt of Parents Anonymous; and length of time in treatment. The group service model showed up as having a large and relatively stable effect. It would appear that these service delivery variables are consistently positively associated with improved family functioning.

services which approached statistical significance and had sizeable positive effects are: Parents Anonymous and specialized counseling. When severe reincidence and severity of the case are taken into account along with the subset of the service and client descriptors found to have significant effects on this outcome, it was seen that clients not experiencing severe reincidence are more likely to exhibit improved functioning. This begins to suggest that clients prone to reincidence, e.g., the more serious cases, are simply less likely to improve in treatment irrespective of the services they receive. The relative effects of different service strategies remained unchanged, however, when reincidence is taken into account.

C. Summary Outcome Measure: Reduced Propensity for Future Abuse and Neglect by the End of Treatment

As a summary measure of outcome, clinicians were asked to assess whether or not a client with a propensity for future abuse or neglect at intake had experienced a reduction in such propensity during the course of treatment.[1] While a simple, in fact most rudimentary measure, it does serve as a barometer of clinicians' views about treatment effect. Limitations of the findings must, of course, be kept in mind, because of the nature of this outcome measure. Relationships between client characteristics and service provision variables and reduced propensity are studied to further define the relative effectiveness of different treatment strategies.

Summary of Findings

While physical abusers and potential maltreaters are generally more likely to have reduced propensity for future abuse and neglect than other types of maltreaters, there do not appear to be any client descriptors that have a strong effect on this outcome. Clients receiving lay services (Parents Anonymous and/or lay therapy to supplement other services) were found to be those more likely to have improved by the end of treatment than clients receiving other services. Length of time in

[1] Clients who were not reported at intake with a propensity for future abuse or neglect were excluded from the analyses described in this section.

treatment appeared to have a strong effect on outcome; frequency of contact had a small but substantively interesting effect. The only client descriptors which helped to explain outcome when considered along with service provision were the absence of severe reincidence during treatment and the absence of substance abuse as a problem. When cases are studied by type of maltreatment, the lay model continues to appear as having a stronger effect than other services for all groups except physical abusers, for whom the group service model has a stronger effect.

As a further check on the relationships between select client characteristics and the summary outcome measure--reduced propensity for future abuse or neglect--multivariate analyses were used (see Appendix J for results). It is important to know if any individual client characteristics have an effect on reduced propensity when controlling for other client variables. No substantial or particularly significant relationships were found. It can be concluded that variance in propensity is not accounted for by these client characteristics for the whole data set nor that any particular client characteristic has a meaningful probability that propensity would be reduced, except in a few project-specific situations.

1. Relationships Between Client Characteristics and Reduced Propensity

Before exploring the relationships between services received and reduced propensity, it is important to determine which, if any, of a variety of salient client characteristics are related to this outcome. Do some kinds of people do well in treatment programs irrespective of the nature and quality of services offered? Is it possible to predict the success of treatment on the basis of client characteristics alone? And, which client characteristics might be most useful in explaining or interpreting effectiveness of different mixes of services?

To address these questions the relationships between client characteristics, identified earlier to be the most salient and least redundant, and this summary measure were studied. The overall finding is that client characteristics are not highly associated with the summary outcome measure.

The client characteristics examined include: age of children, age of parents, race, employment, size of family, amount of family conflict, substance abuse, isolation, history of abuse as a child, special child responsibilities, legal intervention and total income, as well as the type of maltreatment, seriousness of the assault, and the severity of the family situation.

As shown on Table III.12, when considering the whole study population the type of maltreatment that brought a case to the projects is not significantly related to reduced propensity for maltreatment but a substantively interesting pattern is present. A range of 16% difference in improvement exists between the different types, with the smallest proportion of those who both physically abused and neglected and the largest proportion of physical abusers improving, followed by the potential maltreaters. In the projects where the number of cases within a category is large enough to allow for comparisons, this pattern is generally followed. Arkansas and Union County had greater success with emotional maltreaters relative to their other cases than was the overall demonstration experience, however. In Union County, this is a statistically significant relationship.

Seriousness of the assault does not appear to have strong predictive or explanatory power with respect to reduced propensity for the whole data set. Variation on this is seen within projects. Adams County, Bayamon and Arkansas appeared to have greater success with the serious cases. In Arkansas this difference is significant. Given the differences across three projects in terms of structure, staffing and location, there appear to be no obvious project characteristics that explain this. Baton Rouge, on the other hand, had somewhat more success with less serious cases.

The severity of the family situation, for all cases, does appear to be related to reduced propensity, although not with statistical significance. The more serious the case, the less likely it is that improvement was reported. While for some projects (e.g., Union County) severity appears to have no relationship with reduced propensity, for many, where the number of cases in categories is large enough to make

Table III.12

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY TYPE OF MALTREATMENT, SERIOUSNESS OF ASSAULT AND SEVERITY BY PROJECT**

	TYPE OF MALTREATMENT						SERIOUSNESS OF ASSAULT		SEVERITY				
	POTENTIAL ABUSE & NEGLECT	EMOTIONAL MALTREAT-MENT	SEXUAL ABUSE	PHYSICAL ABUSE	PHYSICAL NEGLECT	PHYSICAL ABUSE & NEGLECT	NON-SERIOUS	SERIOUS	NOT SEVERE 0	1	2	3	SEVERE 4
ADAMS COUNTY (49%)	43% (n=30)	60% (n=5)	50% (n=4)	49% (n=78)	67% (n=3)	--	43% (n=47)	53% (n=74)	59% (n=22)	53% (n=32)	56% (n=41)	27% (n=22)	--*
ARLINGTON (41%)	50 (50)	36 (31)	25 (4)	56 (25)	36 (62)	25 (n=8)	39 (59)	42 (127)	42 (65)	44 (57)	37 (41)	40 (15)	38 (n=8)
BATON ROUGE (48%)	67 (9)	--	50 (14)	52 (46)	47 (15)	--	53 (36)	45 (60)	53 (19)	47 (43)	36 (25)	75 (8)	100 (1)
BAYAMON (43%)	44 (23)	52 (25)	67 (3)	39 (23)	34 (35)	33 (6)	36 (61)	50 (62)	56 (27)	44 (18)	46 (33)	25 (20)	40 (25)
ARKANSAS (56%)	72 (25)	45 (20)	63 (8)	55 (82)	47 (17)	50 (14)	44 (71)	65* (98)	71 (45)	52 (54)	51 (45)	53 (19)	33 (6)
ST. LOUIS (25%)	40 (10)	14 (14)	--	29 (49)	--	--	28 (32)	22 (49)	23 (22)	19 (21)	11 (18)	50 (16)	25 (4)
TACOMA (58%)	67 (12)	69 (13)	67 (3)	53 (38)	58 (12)	50 (8)	57 (37)	59 (56)	62 (26)	57 (21)	53 (32)	63 (8)	67 (6)
UNION COUNTY (29%)	21 (70)	36 (45)	--	38 (86)	34 (83)	15* (13)	30 (112)	29 (209)	25 (114)	33 (86)	32 (71)	28 (40)	30 (10)
TOTAL (42%)	44 (230)	39 (160)	38 (50)	46 (440)	37 (230)	30 (57)	43 (743)	39 (465)	43 (342)	43 (337)	41 (313)	39 (150)	36 (66)

* Chi-square significant at less than or equal to .05.

** Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in calculations for the "Total" row.

an assessment, this pattern in apparent. This is particularly true in Adams County where the relationship is a significant one.

Of the range of other client descriptors (see Table III.13) none appears to significantly differentiate improvers from non-improvers for the whole data set. In general, within-project analyses reveal the same thing --client characteristics are not strong predictors of reduction in propensity. Notable exceptions include: in Adams County families with at least one minority member were much less likely to improve whereas in Arkansas just the opposite was true; in both Arlington and Arkansas older parents were much more likely to improve; in Bayamon presence of family conflict appeared to impede improvement as did substance abuse in Tacoma. Thus differences from the whole demonstration effort may reflect individual projects' inability to successfully work with certain kinds of clients.

Multivariate analysis techniques were used as a further check on these findings. (See Appendix J.) No client characteristics were found to have a meaningful effect on whether or not propensity would be reduced.

2. Relationships Between Reduced Propensity for Abuse and Neglect and Service Receipt

To the extent that individual services on their own help to produce or result in treatment effectiveness, one would expect to see significant relationships between service receipt and reduced propensity. As discussed earlier, 42% of all cases were reported with reduced propensity; comparable proportions were seen for serious and non-serious cases. As shown in Table III.14, looking across service receipt for the whole study group, significantly greater percents of clients receiving lay therapy (52%) were thought to have reduced propensity. And, a substantial proportion of cases receiving Parents Anonymous (59%) were reported with improvement. A large proportion of all cases receiving lay therapy or Parents Anonymous were served by the Arkansas project -- it is quite likely that many of the unique characteristics of that project (notably small caseloads, heavy reliance on lay persons, the rural setting) account for the success of these services in terms of the overall demonstration experience. However, in those few other projects

Table III.13

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY CLIENT CHARACTERISTICS BY PROJECT**

	CLIENT CHARACTERISTICS											
	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES		NO ADULT EMPLOYED		FOUR OR MORE CHILDREN		ONE ADULT IN HOUSEHOLD	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	49% (n=88)	44% (n=27)	55% (n=31)	47% (n=90)	41% (n=90)	71%* (n=31)	50% (n=24)	49% (n=97)	45% (n=20)	50% (n=101)	63% (n=16)	47% (n=105)
ARLINGTON	43 (106)	35 (63)	33 (92)	49* (94)	41 (122)	41 (64)	47 (36)	39 (150)	29 (24)	43 (162)	38 (60)	42 (126)
BATON ROUGE	46 (57)	52 (29)	49 (41)	47 (55)	50 (58)	45 (38)	48 (29)	48 (67)	45 (20)	49 (76)	54 (26)	46 (70)
BAYAMON	37 (75)	53 (19)	57 (35)	38 (88)	52 (44)	38 (79)	42 (43)	44 (80)	39 (51)	46 (72)	42 (24)	43 (99)
ARKANSAS	56 (142)	69 (16)	46 (87)	67* (82)	62 (135)	32* (34)	46 (52)	61 (117)	63 (35)	55 (134)	55 (29)	56 (140)
ST. LOUIS	25 (68)	--	15 (41)	35 (40)	23 (47)	27 (34)	17 (30)	29 (51)	33 (9)	24 (72)	24 (25)	25 (56)
TACOMA	58 (76)	46 (11)	62 (53)	53 (40)	56 (78)	67 (15)	59 (39)	57 (54)	50 (22)	61 (71)	58 (26)	58 (67)
UNION COUNTY	28 (213)	32 (99)	30 (141)	29 (180)	24 (136)	33 (185)	31 (118)	29 (203)	28 (101)	30 (220)	35 (104)	27 (217)
TOTAL	42 (843)	40 (267)	40 (531)	43 (677)	44 (717)	39 (419)	40 (377)	42 (831)	38 (284)	43 (924)	42 (315)	41 (893)

*Chi-square significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which data were available, 13 and 7 respectively; information on these cases has been included in the calculations of the "Total" row.

Table III.13 Continued.

	CLIENT CHARACTERISTICS											
	FAMILY CONFLICT		SUBSTANCE ABUSE		SOCIALLY ISOLATED		PARENT ABUSED AS CHILD		HEAVY CHILD CARE RESPONSIBILITY		LEGAL INTERVENTION	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	42% (n=43)	53% (n=78)	35% (n=17)	51% (n=104)	44% (n=57)	53% (n=64)	47% (n=73)	52% (n=48)	46% (n=26)	50% (n=95)	52% (n=99)	36% (n=22)
ARLINGTON	44 (57)	40 (129)	37 (54)	42 (132)	41 (63)	41 (123)	39 (23)	41 (19)	53 (19)	40 (167)	35 (84)	46 (101)
BATON ROUGE	47 (19)	48 (77)	20 (10)	51 (86)	47 (17)	48 (79)	52 (23)	47 (73)	46 (11)	48 (85)	55 (51)	39 (44)
BAYAMON	33 (66)	54* (57)	33 (55)	52 (68)	39 (18)	44 (105)	18 (11)	46 (112)	55 (11)	42 (112)	44 (18)	43 (103)
ARKANSAS	48 (25)	58 (144)	56 (18)	56 (151)	48 (63)	61 (106)	51 (35)	58 (134)	58 (43)	56 (126)	53 (131)	68 (38)
ST. LOUIS	33 (21)	22 (60)	38 (8)	23 (73)	26 (39)	24 (42)	27 (30)	24 (51)	15 (13)	27 (68)	21 (47)	27 (33)
TACOMA	57 (28)	59 (65)	92 (12)	53* (81)	73 (22)	54 (71)	63 (27)	56 (66)	59 (29)	58 (64)	56 (63)	63 (27)
UNION COUNTY	23 (66)	31 (255)	28 (69)	30 (252)	37 (73)	27 (248)	32 (28)	29 (293)	28 (39)	29 (282)	30 (250)	25 (68)
TOTAL	38 (334)	43 (874)	36 (247)	43 (961)	42 (361)	41 (847)	43 (257)	41 (951)	46 (194)	41 (1014)	41 (757)	42 (440)

*Chi-square significant at less than or equal to .05.

Table III.14

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY TYPE OF SERVICE RECEIVED BY PROJECT**

	ALL CASES	MDT REVIEW		ONE TO ONE COUNS.		LAY THERAPY		GROUP THERAPY		PARENTS ANONYMOUS		COUPLES/ FAMILY COUNS.		SPECIAL COUNSELING	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	49% (n=121)	42% (n=71)	58% (n=50)	52% (n=105)	25% (n=16)	62% (n=26)	45% (n=95)	50% (n=10)	49% (n=111)	50% (n=14)	49% (n=107)	36% (n=64)	63%* (n=57)	33% (n=9)	50% (n=112)
ARLINGTON	41 (186)	46 (41)	39 (145)	42 (172)	29 (14)	30 (10)	42 (176)	40 (20)	41 (166)	--	41 (186)	39 (54)	42 (132)	33 (3)	41 (183)
BATON ROUGE	48 (96)	52 (33)	46 (63)	48 (93)	33 (3)	--	48 (95)	75 (4)	47 (92)	100 (2)	47 (94)	46 (33)	49 (63)	50 (2)	48 (94)
BAYAMON	43 (123)	43 (97)	42 (26)	44 (119)	25 (4)	--	43 (123)	78 (9)	40 (114)	100 (2)	42 (121)	42 (81)	45 (42)	44 (39)	43 (84)
ARKANSAS	56 (169)	57 (44)	56 (125)	55 (53)	57 (116)	56 (165)	50 (4)	40 (10)	57 (159)	61 (38)	55 (131)	69 (13)	55 (156)	40 (5)	57 (164)
ST. LOUIS	25 (81)	22 (69)	42 (12)	25 (68)	23 (13)	35 (20)	21 (61)	23 (70)	36 (11)	60 (5)	22 (76)	33 (21)	22 (60)	67 (3)	23 (78)
TACOMA	58 (93)	58 (24)	58 (69)	61 (79)	43 (14)	71 (24)	54 (69)	51 (35)	62 (58)	80 (5)	57 (88)	65 (34)	54 (59)	100 (4)	56 (89)
UNION COUNTY	29 (321)	25 (52)	30 (269)	30 (291)	27 (30)	44 (62)	26* (259)	40 (15)	29 (306)	--	29 (321)	16 (101)	36* (220)	43 (21)	28 (300)
TOTAL	42 (1208)	41 (439)	42 (769)	41 (993)	44 (215)	52 (317)	38* (891)	39 (173)	42 (1035)	59 (69)	41* (1139)	36 (411)	44* (497)	46 (88)	41 (1120)

*Chi-square significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "total" row.

Table III.14 Continued

	FAMILY PLANNING		CRISIS INTERVENTION		PARENT EDUCATION		HOME-MAKING		CHILD SERVICES		WELFARE		BABYSITTING/ TRANSPORT.		OTHER	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	27% (n=11)	51% (n=110)	53% (n=38)	47% (n=83)	41% (n=17)	50% (n=104)	50% (n=6)	49% (n=115)	56% (n=43)	45% (n=78)	58% (n=40)	44% (n=81)	44% (n=16)	50% (n=105)	53% (n=42)	52% (n=79)
ARLINGTON	100 (2)	40 (184)	45 (38)	40 (148)	67 (5)	40 (183)	80 (5)	40 (181)	58 (33)	37 (153)	40 (25)	41 (161)	41 (46)	41 (140)	64 (28)	37* (158)
BATON ROUGE	33 (3)	48 (93)	49 (39)	47 (57)	50 (2)	48 (94)	44 (18)	49 (78)	38 (24)	51 (72)	52 (21)	47 (75)	39 (26)	51 (70)	46 (44)	50 (52)
BAYAMON	56 (16)	41 (107)	42 (43)	44 (80)	82 (11)	39* (112)	50 (2)	43 (121)	75 (4)	42 (119)	50 (4)	43 (119)	50 (10)	43 (113)	44 (41)	43 (82)
ARKANSAS	100 (2)	56 (167)	42 (53)	63* (116)	63 (8)	56 (161)	50 (2)	56 (167)	42 (31)	59 (138)	54 (57)	57 (112)	52 (62)	59 (107)	57 (42)	56 (127)
ST. LOUIS	--	25 (81)	18 (40)	32 (41)	16 (25)	29 (56)	--	25 (81)	40 (5)	24 (76)	31 (16)	23 (65)	24 (68)	31 (13)	33 (3)	24 (78)
TACOMA	--	58 (93)	69 (29)	53 (64)	62 (60)	52 (33)	100 (4)	56 (89)	57 (7)	58 (86)	56 (41)	60 (52)	67 (45)	50 (48)	64 (42)	53 (51)
UNION COUNTY	42 (24)	28 (297)	28 (134)	30 (187)	31 (13)	29 (308)	17 (24)	30 (297)	38 (72)	27 (249)	32 (125)	28 (196)	26 (73)	30 (248)	37 (76)	27 (245)
TOTAL	47 (62)	41 (1146)	39 (423)	43 (785)	49 (147)	41 (1061)	40 (62)	42 (1146)	45 (234)	41 (974)	44 (333)	41 (875)	39 (357)	43 (851)	48 (322)	39* (886)

*Chi-square significant at less than or equal to .05.

where the number of cases is large enough to make an assessment (Adams County, St. Louis, Tacoma and Union County for lay therapy and Adams County for Parents Anonymous), these services appear to have been effective. In Union County, most notably, there is a statistically significant difference in improvement between those receiving lay therapy and those not. (This is an urban project, with large case-loads and heavy reliance on professionals.) The one other service that showed up in the within-project analysis to have significant relationships with reduced propensity is parent education in Bayamon -- perhaps reflecting some special needs of Puerto Rican Clients. (Clients receiving couples or family counseling improved less than those not receiving it.)

As seen in Table III.15, the lay service model--once again, a service package consisting of many services but certainly including lay therapy or Parents Anonymous--shows up as the service model most highly related to reduced propensity (53% of clients receiving this package improved, compared to 42% of all cases and 38-39% of those receiving the group or social work model). Once again, it is clear that the Arkansas cases account for a good deal of the improvement here. However, in all projects providing the lay model to enough cases to make a judgment, the lay model continues to appear to be the most effective. And, in Union County, that relationship is a statistically significant one.

It is critical to look at certain service delivery variables to see if they help explain reduced propensity. As shown in Table III.16, the number of different services a client receives does not appear to be related to this outcome for the whole data set. Even in those projects with the number of cases large enough for analysis purposes, there appears to be no consistent or clear relationship between number of services and effect. However, it is apparent that clients who are in treatment a longer period of time do somewhat better in treatment. Only in Arlington, Arkansas and Union County are the differences statistically significant, but for the whole data set 14% more of those clients in treatment 6 months or more improved, compared to those in treatment a shorter period of time; in most projects this same pattern is seen. Although a strong, positive relationship might be hypothesized

Table III.15

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY SERVICE MODEL BY PROJECT**

	LAY	GROUP	SOCIAL WORK	OTHER
ADAMS COUNTY	56% (n=36)	29% (n=14)	54% (n=59)	25% (n=12)
ARLINGTON	30 (10)	41 (22)	43 (143)	18 (11)
BATON ROUGE	67 (3)	67 (6)	46 (84)	33 (3)
BAYAMON	100 (2)	78 (18)	36 (99)	25 (4)
ARKANSAS	56 (165)	--	33 (3)	100 (1)
ST. LOUIS	35 (20)	20 (54)	17 (6)	100 (1)
TACOMA	74 (27)	49 (55)	67 (9)	50 (2)
UNION COUNTY	44 (62)	15 (13)	27 (226)	20* (20)
TOTAL	53 (334)	39 (185)	38 (635)	26* (54)

*Chi-Square significant at less than or equal to .05

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in calculations of the "Total" row.

Table III.16

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY NUMBER OF DIFFERENT SERVICES, LENGTH OF TIME IN TREATMENT AND FREQUENCY OF CONTACT BY PROJECT**

	NUMBER OF DIFFERENT SERVICES					LENGTH OF TIME IN TREATMENT		AVERAGE FREQUENCY OF CONTACT			
	1	2	3	4	5	UNDER 6 MO.	6 MO. OR MORE	ONCE A MONTH OR LESS	TWICE A MONTH	THREE OR FOUR TIMES A MONTH	WEEKLY OR MORE OFTEN
ADAMS COUNTY	70% (n=10)	50% (n=12)	35% (n=23)	45% (n=31)	53% (n=45)	38% (n=29)	52% (n=92)	40% (n=15)	60% (n=15)	39% (n=28)	52% (n=63)
ARLINGTON	39 (54)	35 (46)	46 (37)	36 (22)	52 (52)	24 (81)	54* (105)	41 (44)	44 (54)	40 (47)	37 (41)
BATON ROUGE	55 (11)	57 (21)	38 (16)	43 (14)	47 (34)	50 (48)	46 (48)	44 (18)	50 (22)	58 (24)	41 (32)
BAYAMON	40 (10)	25 (24)	59 (22)	35 (17)	48 (50)	33 (33)	47 (90)	29 (34)	41 (27)	50 (42)	55 (20)
ARKANSAS	53 (34)	68 (34)	55 (29)	56 (25)	51 (47)	41 (92)	74* (77)	78 (9)	77 (13)	71 (24)	50* (123)
ST. LOUIS	50 (2)	20 (5)	50 (10)	18 (11)	21 (53)	24 (25)	25 (56)	--	29 (14)	12 (17)	30 (47)
TACOMA	40 (5)	67 (9)	29 (14)	57 (14)	67 (51)	52 (27)	61 (66)	44 (9)	31 (13)	56 (16)	67 (55)
UNION COUNTY	27 (60)	34 (71)	15 (41)	33 (48)	32 (101)	22 (121)	34* (200)	25 (88)	30 (56)	22 (58)	35 (119)
TOTAL	40 (187)	42 (224)	39 (194)	40 (184)	43 (419)	33 (458)	47* (750)	34 (221)	42 (214)	41 (256)	45 (517)

*Chi-Square significant at less than or equal to .05

**Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases in which we have data, 13 and 7, respectively; information on these cases has been included in calculations of the "Total" row.

between the frequency of contact between service providers and clients and reduced propensity, only a small relationship is seen for the whole data set. Thirty-four percent of those clients seen once a month or less had reduced propensity as compared to 45% of those seen weekly or more often. Only in Arkansas is a statistically significant relationship seen, and a rather peculiar one. In Arkansas, it appears that of the clients seen most frequently, 49% had reduced propensity. The finding suggests that, perhaps, in Arkansas clients were seen more frequently when less improvement was perceived by clinicians, with the hope that more contact would have a positive effect.

In order to further substantiate the relationship between service receipt and the summary outcome measure, reduced propensity for maltreatment, multivariate analyses were conducted. (See Appendix J for results.) Such analysis allows one to both assess the combined effects of service receipt and the relative effect of each service when controlling for the others. While the service variables as a group were not found to account for much variance in propensity, certain services--lay therapy and parent education classes--did have significant effects with regard to reduced propensity. When analyzing the service model variables as a group and the summary outcome measure, the lay model was found to have the single greatest effect. Group services were found to have a comparable effect to the social work model. Service models were also analyzed taking into account the different projects. While receiving services from some projects appeared to account more successfully for reduced propensity than any of the service models, the relative effectiveness of the service models (lay, followed by group and social work) remains unchanged.

Having determined the relative effects of each of the discrete services and service models, it becomes interesting to begin to determine whether any service increases in effectiveness when offered in combination with other services. Thus, a service may be a necessary auxiliary service

before some other service can become effective. Or, a service may require some other service as a precondition or complement for being effective. It might be true that individual counseling and the social work model can only be effective when the project is also providing the parent with day care to alleviate some of the pressures in the household, or with transportation help and babysitting so that the parent can attend sessions with counselors (or groups). To test the existence of mix effects, we drew upon theory to specify the most likely mix effects and then created interaction variables designating when clients received both of two or more types of services. A range of mix effects were tested:

- the social work model complemented by services to children (e.g., day care, play therapy, etc.);
- the social work model complemented by multidisciplinary team reviews of the case. This interaction term measures whether team reviews improve the specification of services and the understanding of the case and the appropriate treatment strategy which the clinician brings to counseling;
- the number of different services received, as a general catch-all variable for multiple services. The logic of this variable is that the more services a client receives, the more comprehensive the treatment process, and the more likely that any particular service will be increased in effectiveness.

When these mix effects are included with other service predictors in a multivariate analysis, they emerge either as non-significant and with small effects, or worse, with negative signs, suggesting that receipt of the service mix is associated with an increased propensity for future abuse/neglect. Many different forms of interaction variables and of the overall specification of the set of service variables were tested, but no strong interaction or mix effects emerged. Much more important are the basic service strategies employed--lay, group and individual counseling.

We also explored at length whether it was necessary to get a certain amount of a service or to receive it at regular frequency, before the service would become effective. Most of the service variables used in the regressions presented thus far in this report have taken dummy form and measured the fact of service receipt--did the client receive this service or not? In other analyses, we looked at the amount of the

service the client received when she/he did receive the service and at the frequency over time with which the service was received. In analyses with "amount" and "frequency" forms of variables, we found that the forms had similar effects to each other and the decision was made to use only the "frequency" form, since it was conceptually more complete in combining the amount of service with time in treatment. For most services having sufficient observations for analysis, the inclusion of a frequency term in multivariate analyses did not change the conclusions of the analysis concerning service effectiveness. Consideration of frequency and amount of service only appears to strengthen the general conclusions reached in our earlier analyses with less complex forms of service variables, concerning the relative effectiveness of different services.

3. Combined Relationships of Client Characteristics and Service Provision Variables with Reduction in Propensity for Future Abuse and Neglect

Finally, in order to begin to understand the combined effects of client characteristics and service provision variables on the reduced propensity for abuse and neglect, a series of multivariate analyses were performed for the whole data set. As was indicated in the discussion of these same analyses for improvement in daily functioning, the findings are merely suggestive of the complex relationships between variables and by no means conclusive. They represent the overall demonstration experiences and not necessarily those of any one project. To begin, seriousness of assault was controlled for in multivariate analyses with the service models. The relative effect of the service models remained unchanged. When many of the select service provision and client descriptor variables are considered as a group, absence of substance abuse is the only client descriptor which appears to be significant and its effect is small. In addition to length of time in treatment and frequency of contact, receipt of the following have a significant, positive effect: the lay service model, specialized counseling and individual counseling.[1]

[1]When discriminant functional analysis techniques are used with this set of independent variables, 62% of the cases (a small but significant proportion) are correctly classified with respect to what their predicted and actual scores on the dependent variables are.

As an additional check on the relative effect of select independent varaibles, multivariate analyses were performed using all those independent variables already found to have a significant effect on propensity. As a group, these variables account for 6% of the variance in propensity and all have significant effects on propensity. Receipt of the lay service model has the strongest effect, following by having been in treatment for six months or longer.

4. Relationships Between Client Descriptors, Service Descriptors and Reduced Propensity for Different Types of Maltreaters

Having looked at those client and service descriptor variables which appear to have significant effects on the reduction of propensity, individual groups of clients are studied separately, with respect to type of maltreatment committed, to see if the independent variables remain important in explaining outcome for particular groups of clients. This is a particularly necessary step given the higher proportion of physical abuse cases in the study population than is typically found in protective service agencies.

Potential Abusers and Neglectors. Using most of the select service provision and client characteristic variables in a multivariate analysis, only two variables--receipt of the lay service model and having preschool children--appear as statistically significant (stable) in terms of their effect.[1]

Emotional Maltreaters. When most of the select service provision and client characteristic variables are included in an analysis of just those clients who emotionally maltreated their children, the only variable which is found to have a significant effect is the lay service model.[2]

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[1] Discriminant functional analysis with these variables shows that 70% of the cases can be correctly classified with the lay service model and age of children the most significant variables in discriminating between whether a given case would correctly be predicted as one with (or without) reduced propensity.

[2] Despite this fact, almost 70% of the cases are correctly, and significantly, classified when discriminant functional analysis is used (with both the lay service model and length of time in treatment serving as significant variables in discriminating between whether or not a case has reduced propensity).

Physical Abusers. Only cases in which physical abuse occurred are studied to determine the effects of select client and service descriptors on reduced propensity for this population. In this analysis, the following have significant, but small, effects: length of time in treatment, frequency of contact, lack of receipt of couples or family counseling, and absence of family conflict. The lay, and particularly the group, models show stronger but not stable effects relative to the social work model. These remain significant variables when controlling for the severity of the family situation. For this particular group of maltreaters, it appears that variables describing the nature of service provision (e.g., length of time in treatment) are more important in terms of outcome than the actual types of services provided.[1]

Physical Neglectors. When using most of the select service provision and client descriptor variables for just those cases classified as physical neglectors, the variables with a significant effect include: receipt of the lay service model, length of time in treatment, lack of receipt of the social work service model with children's services, and frequency of receipt of individual counseling.[2]

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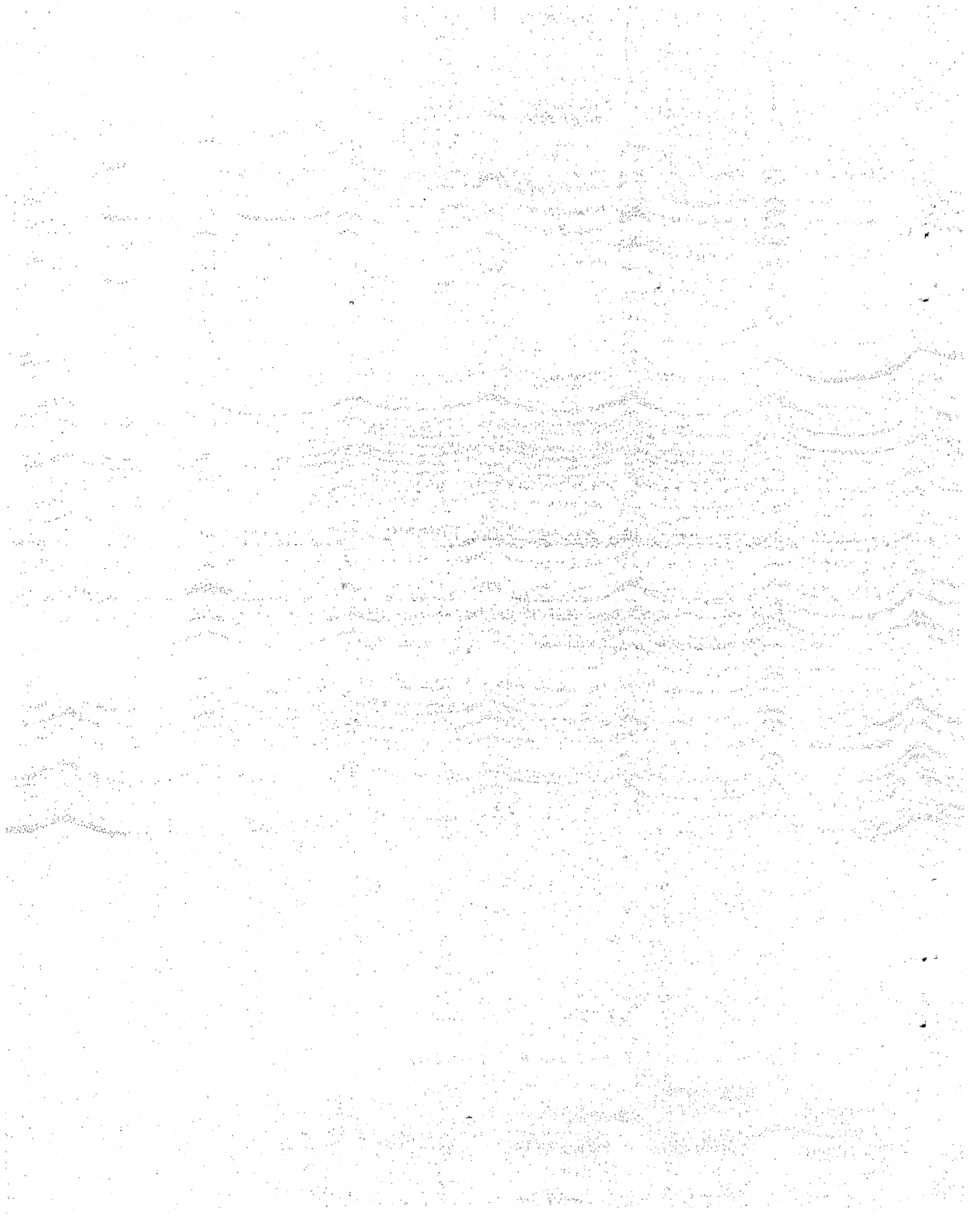
[1]Sixty-two percent of the cases are correctly classified with respect to propensity when discriminant functional analysis is used with these independent variables. Variables which are more significant in discriminating correctly between cases which do and do not have reduced propensity are length of time in treatment, couples/family counseling, family conflict, and the group service model.

[2]Seventy-one percent of the cases are correctly classified in terms of propensity whether this same set of independent variables are used in a discriminant functional analysis. The same variables found to have a significant effect in the regression model were also significant in discriminating between whether or not a case would have reduced propensity. In addition, the group service model appeared as significant.



SECTION IV: DISCUSSION AND IMPLICATIONS

The purpose of this report has been to present, in detail, the analysis of client and service data which leads to increased knowledge about treatment effectiveness. A brief discussion of the findings and their cost and program implications follows. These findings are combined with those from other aspects of the study (notably information gathered on case and project management practices) in the Final Evaluation Report, in which the full implications for the future funding, planning and operation of child abuse and neglect service programs are discussed in detail.

A. Discussion of Outcome Findings and Implications

In this study, it was found that 30% of the clients served by the demonstration projects exhibited severe reincidence of abuse or neglect while they were in treatment and that only 42% who were reported at the beginning of treatment to be likely repeaters (many of whom were reported with severe reincidence) were reported with reduced propensity by the end of treatment. Success was slightly higher with physical abuse (46%) and serious cases (43%) than with other cases (e.g., physical neglect 37%, sexual abuse 38%, emotional abuse/neglect 39%), but the success rate with different kinds of clients based on other descriptors is basically the same in terms of propensity for future problems. With respect to specific aspects of daily functioning, success rates of less than 30% were seen on individual measures, with less than 40% of the clients improving in at least one-third of those areas identified as problems at intake.

On the other hand, there are important variations in success across projects. Several projects -- Arkansas and Tacoma -- had higher overall success rates (56% to 58% of clients with reduced propensity) than other projects (25% to 49%). Arkansas additionally had the highest severe reincidence in treatment rate (51% compared to 13-36% at other projects).[1] The more successful projects were uniquely characterized within the overall

[1] It is theorized that this high reincidence rate in Arkansas is due to the fact that the project accepted more serious cases for treatment than originally planned or anticipated but did not provide these cases with any more intensive intervention at the beginning of treatment than they gave to the less serious cases.

demonstration program by their emphasis on the use of lay and group service strategies to supplement existing social work services. These lay and group services allow for more client contact, and likely more in-depth contact, which may account for their effectiveness. In contrast, those projects which overall had the least success were characterized by an emphasis on the more traditional kinds of service strategies (albeit intensively and comprehensively delivered) normally associated with Protective Services agenices, as well as with large worker caseloads which inhibit the amount of time a worker can devote to any one client.

It is difficult to pass judgment on the demonstration program's overall success, with these statistics in mind. Certainly, the recurrence of severe abuse or neglect, particularly while a client is in treatment, suggests that the child was not being sufficiently protected. That 30% of the clients' children experienced such maltreatment, or lack of protection, does not speak highly of the project's initial intervention strategies, which is additionally a reflection of the lack of sophistication of intervention strategies in general. And, even if the 42% of the cases reported with reduced propensity for future abuse or neglect are indeed clients who will not maltreat their children in the future (indicating that the projects have made a valuable service contribution toward alleviating some child abuse and neglect problems), this is not the kind of success rate many might like to see. It would be useful, given this seemingly disappointing finding, to compare the projects' success rates with those of other programs to see how predictable this outcome was. Comparison data are not easily found, however.

Evaluation of treatment services for abusive and neglectful parents constitutes a major gap in the child abuse and neglect literature. The literature in the field primarily consists of studies concerned with: medically identifying abuse and neglect; distinguishing child abuse from neglect; differentiating both actual and potential abusers and neglectors from non-abusers and non-neglectors; determining the causes of abuse and neglect; assessing the incidence and prevalence of abuse and neglect in the population.[1] As such, the existing literature provides very few

[1] A sampling of these works include: Helfer and Kempe, 1968 and 1972; Light, 1973; Newberger, 1973; Gil, 1970; Cohen, 1974; Spinetta and Rigler, 1972; Silver, 1968; Polansky, et al., 1972; Pavenstedt, 1967; Kadushin, 1974; Zalba, 1967.

benchmarks or comparative points for the current study's findings. A few often cited studies in which the results of treatment programs are discussed do exist. Of these, only a few give any quantitative results.[1]

First, a series of studies were conducted over several years by the faculty and students at the University of Pennsylvania School of Social Welfare assessing the experience of families receiving social work counseling services by the Philadelphia Society to Protect Children (PSPC).[2] The focus of the study was the neglectful parent. Impact was measured by whether or not a family returned for services after termination. This measure of impact is of questionable utility; some clients may have continued to neglect their children, but simply may not have returned to the PSPC. However, the recidivism rate found was close to 60%, and it was additionally found that the families' problems had changed little since their first contact with the agency. This does suggest the program may have had a 40% success rate, comparable to that found in the current study.

Second, a study was done by the Denver, Colorado's Protective Services Program which provides intensive child welfare worker services to abusers and neglectors (including a range of advocacy and counseling services).[3] Social workers, in this study, were asked to describe what kinds of positive changes the parents had gone through during treatment. Impacts were expressed in terms of specific behaviors or problems: 22% of the families

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[1] None of these studies has used a rigorous experimental design, clinical trials, cost-benefit or cost-effectiveness analysis or any other techniques which meet the criteria of rigorous evaluative research, although some of the newer research activities approach this. In addition, these studies are characterized by a number of other problems which limit comparisons, notably: data collection procedures are relaxed, with reliance on clinical judgments rather than standardized measures; sample sizes are small; samples are drawn from specialized populations; clients exhibiting a wide range of behaviors are included without specification of the nature or severity of abuse/neglect committed; and impact is not differentiated on the basis of kind or amount of service received but rather length of time in treatment and a generic description of the service package provided.

[2] Lewis, 1969.

[3] Johnson and Morse, 1968.

were reported as having improved in home care, 39% of the families improved in child care, 80% of the children were no longer in danger of subsequent abuse; this 80% may be contrasted with the 41% figure with reduced propensity in the current study. The amount and type of services and the differentiations between abusive and neglectful families were not specified in this Colorado effort.

Among a number of descriptive case studies of small treatment efforts which begin to consider treatment in an evaluative but non-quantitative way are analyses of programs in Boston, Denver, New York and Chicago. Bean[1] and Gladston[2] both describe the impacts of the Parents Center Project, a treatment program in Boston that provides therapeutic and supportive services including day care, group therapy and social work counseling to a caseload of 30-35 abusive parents and their children. Both studies report impressive program achievements based on clinical observation of cases. The reincidence rate was less than 20%. Parents were said to be more controlled, less isolated and better able to cope with the stresses of daily living. There is, however, no quantitative support for these findings, and thus comparisons with our own findings are not possible.

Davoren[3] and Steele and Pollock[4] describe the results of a multidisciplinary team study of a group of 60 parents in the Denver area. Supportive services such as social worker home visits were offered to the parents, but in addition the program provided a round-the-clock supportive service in the form of a friend to talk to. Members of the team became integral parts of the clients' lives. On the basis of clinical judgments (developed through informal interviews, home visits and psychiatric diagnoses), the researchers determined that the program's major impacts on clients came in reducing their isolation, providing a supportive system in which to function,

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1 Bean, 1971.

2 Galdston, 1970.

3 Davoren, 1968.

4 Steele and Pollock, 1968.

encouraging them to learn how to reach out for help, and aiding them to care better for their children. The study findings, by the researcher's own admission, have questionable applicability:

> Our study group of parents is not to be thought of as useful for statistical proof of any concepts. It was not picked by a valid sampling technique nor is it a "total population." It is representative only of a group of parents who had attacked children and who came by rather "accidental" means under our care.... The duration of our contact (with cases) varied. A few parents were seen for only brief exploratory, diagnostic interviews. Most parents were seen over a period of many months, several for as long as three to five years.
>
> Steele and Pollock, 1968, pp. 104-5.

Fontana and his colleagues at the New York Foundling Hospital's Temporary Shelter Home Program describe their program, which provides residential care for 15 abusive mothers and their children for six months, during which time intensive therapy, child management and homemaking classes and other supportive services are provided.[1] Following this live-in period, services are provided on an outpatient basis for six additional months. After two years of operation, the program was assessed as successful with a near zero reincidence and recidivism rate. This is a marked contrast with the current study's severe reincidence rate of 30% while in treatment.

The Juvenile Protective Association in Chicago reports the results of a million dollar, six year, federally funded program, the Bowen Center Program which demonstrated the use of innovative child protective services for 35 abusive or neglectful families.[2] Prior to describing the project outcomes, the authors state:

> In the major human services--mental health, corrections, child welfare--there are not accepted measurement techniques

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[1] Fontana, et al., unpublished reports.

[2] Juvenile Protective Association, 1975.

> for any of the three factors (which must be studied to determine impact).... The question of "results" must of necessity be answered in terms of clinical judgment and, again, case description.

Following this, case-by-case vignettes are provided describing clinicians' assessments of how families improved in parent functioning and children's progress. Overall, the findings suggest that some families "improved" a lot and others a little, and that these improvements seem to be correlated with length of time in treatment and intensity of service (variables also found to be significant in the current study). Improvements occurred mainly in child care and household management. A follow-up, four years after treatment, was conducted on 13 of the cases. Numbers here are clearly too small for generalization.

The Child Abuse Project at the Presbyterian University of Pennsylvania Medical Center, using behavior modification treatment techniques, studies 41 families in which abuse had occurred or was considered likely, one year after treatment services began. Eighty-four percent of the families were rated by some observable indicator as having improved.[1] In the current study, a comparable percent improved in at least one area determined to be problematic at intake -- however, it is not known whether the percents of clients improving in specific areas were the same, nor what the overall improvement rate among the Pennsylvania clients was.

The work of Dr. Eli Newberger and his colleagues in Boston contributes to knowledge in this area. More than 200 child abuse/neglect cases that have come to the attention of the Boston Children's Hospital have been included in a matched-sample study, in order to clarify the principal problems of the abuser or neglector and their implications for treatment. The research staff included a team of advocates who provided multi-advocacy services to clients over time. Significant changes in client functioning, largely from environmental and sociological perspectives, were measured. Interviews with clients were held at the time the case was identified in the hospital and at some period thereafter. Early research reports indicate

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[1] Tracy, Ballard and Clark, 1975.

that approximately 60% of the clients improved in select aspects of family functioning.[1] Once again, it is not known what the "overall success" rate of this program is.

Parents Anonymous, Redondo Beach, California, has completed a parent evaluation of Parents Anonymous chapters across the country.[2] Parents reported improved self-esteem, reduced isolation and improved ability to cope with stress as a result of participation in Parents Anonymous. The longer a parent participated, the greater the reported improvement. While greater proportions of parents reported improvement in these areas of functioning than was reported for clients receiving Parents Anonymous (or any other treatment) in the current study, the findings do nicely parallel each other, and support the current study's finding of the importance of Parents Anonymous and length of time in treatment.

Finally, Berkeley Planning Associates completed an evaluation in 1975 of the Extended Family Center (EFC) in San Francisco, a federally funded demonstration providing therapeutic and supportive services to both abusive parents and their children.[3] Thirty-nine percent of the clients served by the Extended Family Center were reported with low propensity for future maltreatment; 55% of clients served by San Francisco Protective Services who were included as a comparison group in the study were reported with low propensity. While the measures used in this evaluation were not identical to those used in the current evaluation, they are similar enough for comparative purposes leading to the conclusion that the success rates for the EFC program are the same as those for the projects in the current study.

Conclusions cannot be drawn about the overall success of the demonstration projects relative to most other programs that have been evaluated to date, given the paucity of comparable data. The findings from this current study can, however, be used as benchmarks for future studies. The findings do suggest that child protection programs, working with abusive and neglectful parents, cannot expect to have 100% success rates (indeed, success with close to half of one's clients may be all that a program can look forward to), and that programs must seek ways to more effectively intervene at the

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[1] Daniel and Hyde, 1975.

[2] Lieber and Baker , 1976.

[3] Armstrong, Cohn and Collignon, 1975.

outset of treatment to protect the child in order to avoid severe reincidence during treatment. The study also suggests that the field may find it beneficial to explore in greater depth preventive strategies that might diminish the initial occurrence of maltreatment.

B. Discussion of Treatment Outcome Findings and Cost Implications

Keeping in mind that the findings from this study are suggestive, not conclusive, and not necessarily generalizable to the field, it was learned that relative to any other discrete services or combinations of services, the receipt of lay services -- lay therapy counseling and Parents Anonymous -- as part of a treatment package, appear to be more likely to result in positive treatment outcome. In all cases where these lay services were found to be effective, lay persons were provided with intensive on-the-job training and were provided with professional back-up and supervision. Group services (group therapy, parent education classes) as supplemental services also appear to have a notable positive effect, particularly for the physical abuser. Moreover, these services are relatively equally effective with serious and non-serious cases, and as or more effective with serious cases than other more traditionally oriented services where professionals have intensive one-on-one interactions with clients or seek to provide a wide array of auxiliary services directed toward various client needs without the supplement of lay or group services. Auxiliary services do seem to help increase the effectiveness of lay and group services, however. At the same time, severe reincidence while in treatment is more common with lay services, indicating that there may be a tradeoff between short-run protection of the child and ultimate treatment outcome. Perhaps there are techniques (e.g., careful supervision and review of cases by professionals working with lay workers) which could reduce such reincidence, but this study did not analyze this possibility directly. Also, regardless of the type of service strategy being pursued, this study suggests that the provision of a service for at least six months helps to ensure a positive outcome. These various findings appear to hold irrespective of many client descriptors theorized to influence treatment impact.

The treatment outcome findings bring into question the relevance or appropriateness of the traditional protective services treatment model (based

on provision of services by professionals and the individual counseling approach, without the added use of group services or nonprofessionally delivered services) and thus challenge many of the principles used to date in the formulation of our child protection systems; however, they are really not unexpected. Proponents of self-help treatment groups (Alcoholics Anonymous, Families United, the centers for independent living being created by the severely disabled, and most notably, Parents Anonymous) and of volunteer-based groups in general have long advocated these approaches. They have argued that individuals who actively participate in reducing or at least understanding the stresses in their lives thrive from such participation. Having people "do for you" simply does not help as much as "doing for yourself." Working through problems with others struggling with the same dilemmas helps immeasurably. In addition, they have argued that lay persons (with, of course, sufficient professional backup and supervision) need not be as burdened in their work as are our protective service workers today. Their caseloads can consist of one or two families -- compared to the 15 to 25 that must, for cost reasons, be carried by the professional. Not only does this imply that the lay person (e.g., the person with a small caseload) has more time available for each client, but very likely more energy. In many ways, the argument for lay services has, thus, to do with availability and not with the fact that one lacks a degree or certain credentials. However, some have argued that the lay person is not as tightly bound to particular theoretical approaches as a professional in delivering services and that this allows for more flexibility in helping clients work through their problems.

Despite the fact that the self-help and lay concepts are widely supported, none of the studies extant in the literature compare the relative effectiveness of lay versus other treatment strategies in a systematic, quantitative manner. Indeed, except for the relatively small scale evaluation of the Extended Family Center, previously discussed, none of the studies in the literature compare the relative effects of different interventions.[1] This current study, then, represents a pioneering effort in contrasting different approaches to treating parents with abusive and neglectful behavior. There are no comparisons that can easily be made to determine the general validity

[1]The EFC evaluation sought to compare the relative effectiveness of a public protective services treatment approach and that of a small, family-oriented, therapeutic program with a strong day care component.

of the treatment outcome findings. The findings from this study can serve as useful benchmarks for future studies, provided that all limitations with the findings, cited earlier, are kept in mind.

1. The Cost-Effectiveness of Alternative Service Strategies

A separate Cost Analysis Report analyzes in depth the costs of delivering various kinds of services in each of the projects, and develops generic cost estimates for types of services and service packages (or models) which communities could use in planning their child abuse/neglect intervention programs. In a cost-effectiveness analysis, one takes cost data and compares it with the outcomes achieved by different services. Conceivably, more expensive services may justify their cost by being more effective per dollar of cost in producing desirable outcomes than less expensive services.

In this study, cost-effectiveness analysis simply reinforces the recommendations which would follow from the analysis of treatment outcomes. The services which seem to be more effective also tend to be those services which are the least expensive. This holds true both for particular services and for more general service models. Thus, the study's cost analysis found low average annual costs per client for lay services (lay therapy counseling $377, Parents Anonymous $299) and for group services (group therapy $546, parent education classes $190), as compared with more traditional professional services (e.g., individual counseling $767, individual therapy $1105, couples counseling $884, family counseling $1560). The annual cost for running a community program serving 100 clients and emphasizing the lay therapy model was estimated at $138,035, in contrast to $158,335 for the group treatment model and $169,560 for the individual counselor/social work model. These comparisons assume comparable basic services (e.g., intake, case management, crisis intervention, court case follow-through, and multidisciplinary team reviews) and comparable ancillary services (e.g., child care, transportation help, psychological and other testing) for all three models. At the same time, the cost estimates for the lay therapy model assumed a heavy degree of professional supervision and coordination of the lay workers.

Tables IV.1 and IV.2 depict the relative cost-effectiveness of select services and, most importantly, the overall service models. The first

TABLE IV.1

Cost-Effectiveness of Select Services for the "Average" Demonstration Client

Service	Marginal Increase in Probability of Reduced Propensity for Child Abuse/Neglect, if Client Receives Service[1]	Annual Cost Per Client of Delivering Service[2]	Costs of Securing a 1% Increase in Probability of Reduced Propensity by Providing Service
Individual counseling	.037	$767	$207
Parent aide/lay therapy counseling	.156	377	24
Couples counseling	−.053[a]	884	n
Family counseling	−.053[a]	1,560	n
Alcohol, weight and drug counseling	.063	585	93
Group therapy	.006	546	n
Parents Anonymous	.055	299	54
Parent education classes	.106	190	18
Crisis intervention after intake	−.040	364	n
Day care	.057[c]	2,015	353
Residential care	.057[c]	3,397	596
Crisis Nursery	.057[c]	497	87
Homemaking	−.010	682	n
Babysitting/child care	−.067[b]	364	n
Transportation/waiting	−.067[b]	910	n
Multidisciplinary team reviews	−.014	109	n

a, b, c = indicate services grouped together in analysis because of conceptual similarity and small numbers of clients receiving separate services.

n = service provision was not associated with a 1% increase in probability of reduced propensity, according to results of multivariate analysis.

[1]Regression coefficients from Table J.13, where reduced propensity was regressed upon dummy variables indicating receipt of service. No controls used for type of client.

[2]Taken from Table 3 in Cost Report.

NOTE: Effectiveness, and thus cost-effectiveness, will vary for services with different kinds of clients and perhaps when given in varying combinations with other services.

TABLE IV.2

Cost-Effectiveness of Service Models

Service Model	Probability of Reduced Propensity for Child Abuse/Neglect if a Client Receives Services[1]	Average Costs of Serving 100 Clients with Model[2]	Average Cost Per Successful Family Outcome
Lay model	.533	$138,035	$2,590
Group model	.388	158,335	4,081
Social work model	.380	169,560	4,462

[1]Calculated from Table J.19.

[2]From Table 5 in Cost Report.

table meshes the findings from multivariate analysis of individual service impact with our separate cost analysis. Parent aide and lay therapy counseling ($24), Parents Anonymous ($54) and parent education classes ($18) clearly emerge as more cost-effective in securing a small but significant increase in the probability of a successful family outcome from treatment than does the principal service of the social work model, individual counseling ($207). Table IV.2 provides perhaps a simpler, more intuitively clear picture, by examining the costs per successful outcome using various models or combinations of services. The costs per successful outcome in a project serving 100 clients is $2590 with the Lay Model, as contrasted with $4081 with the Group Model and $4462 with the Social Work Model.

Remembering that these estimates are suggestive only, the lay therapy model appears as the most cost-effective of the three models. It offers the highest rate of success while also requiring the least resources. The group treatment model is more effective than the social work or individual counseling model, and is also marginally less expensive and thus, on the whole, appears to be more cost-effective than the individual counseling or social work model.

Another implication for costs is the finding that effectiveness increases the longer the case is in treatment. While we have not tried to determine the most optimal duration of treatment in terms of cost-effectiveness, it is clear that strategies which seek fast client exits from caseloads and generally maximum client throughputs are not likely to be the most cost-effective strategies in terms of achieving positive outcomes for families with limited public resources. Effective treatment of child abuse and neglect appears to require a lengthy involvement with families. Public policy and program management fares better in terms of cost-effectiveness by shifting the process of service delivery to lay services, than by exhorting professionals to work harder, increase caseloads, or move cases faster through the service process.

2. Final Conclusions on Treatment Strategies

Our analysis does not yield definitive guidelines for how to treat particular abuse or neglect cases. No service strategy worked for all cases or worked with a high level of success (e.g., 80% plus) for particular kinds of clients. No service strategy clearly proved ineffectual; most services show some moderate degree of success with families.

However, our analysis has shown some service strategies to have consistently higher rates of success than other strategies with most clients. In particular, this study suggests that child abuse programs may well want to consider the benefits of the lay model for their particular settings. It appears to be a useful solution to reducing both caseworkers' caseload burdens and case costs, while enhancing the chances of treatment success. At the same time, lay services require careful planning and careful supervision, and take time to implement. The experiences of the eleven demonstration projects in setting up such services, described and analyzed at length in our other evaluation reports, should prove useful to other programs in facilitating this process.

C. Implications for Future Research and Evaluation

This study both provides the field with a data base amenable to many additional and important analyses as well as with directions for future data collection and analysis activities.

1. Additional Study Questions with Existing Data Base

The data base contains the following information which has not yet been analyzed: nature and types of goals of treatment for each client and the extent to which they were accomplished by the end of treatment; amount and type of service receipt for each month in treatment; amount and type of crises in the client's life for each month in treatment; improvement (or lack thereof) on each of the functioning indicators at 1-3 month time intervals during treatment; amount and type of reincidence for each month in treatment. Using these data with that already analyzed, the following questions, which reflect serious concerns of the field about service prescription and the dynamics of the treatment process, could be addressed:

- In addition to a common set of areas in which clients may have exhibited problems at intake, what special or unique problems did different groups of clients exhibit? What services were provided to alleviate these problems? To what extent were these problems resolved by the end of treatment?
- What crises or problems confronted clients during treatment that may have inhibited or altered treatment outcome? To what extent are these problems or crises related to reincidence during treatment? To what extent are they related to regression or lack of improvement in select aspects of functioning during treatment?
- When reincidence occurred during treatment, what services was the client receiving? What services did the client receive as a result of the reincidence?
- At what point in the treatment process does improvement appear to taper off? That is, what appears to be an appropriate length of time in treatment?

2. Questions Requiring Additional Data Collection

A number of issues, of great importance to the field, can only be addressed with the collection of additional information. In the current study, indepth interviews with each clinician concerning each client were not held.[1] Such interviews would have allowed for the collection of information on worker attitudes toward/feelings about the client that may have enhanced or hindered treatment outcome. No interviews with clients were conducted; such interviews could yield important insights into the client's sense of improvement, the client's attitudes towards/feelings about the worker that may have enhanced or hindered treatment outcome, and the client's view of those aspects of service delivery which were the most useful. Finally, follow-up data were not collected to determine the longer term effects of treatment, most particularly to determine whether or not reincidence occurs after service delivery is completed. Additional data

[1] In-depth interviews were conducted with different samples of clinicians for evaluating (a) the impact of management strategies upon worker burn-out and overall project success, and (b) the quality of case management for a sample of clients.

collection in the above areas would allow the following questions to be addressed:

- To what extent do worker attitudes toward a client influence both when and why a case is terminated and outcome? Do client attitudes toward the worker have a comparable effect?
- To what extent do workers and clients agree on treatment outcome? What does each group perceive as the most influential factors in treatment outcome?
- What are the longer term effects of treatment? Which client and service descriptor variables are associated with these longer term effects?

We strongly recommend that agencies within the federal Department of Health, Education and Welfare take the steps toward addressing these important questions.

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APPENDIX A

Listing of Major Evaluation Reports and Papers

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.

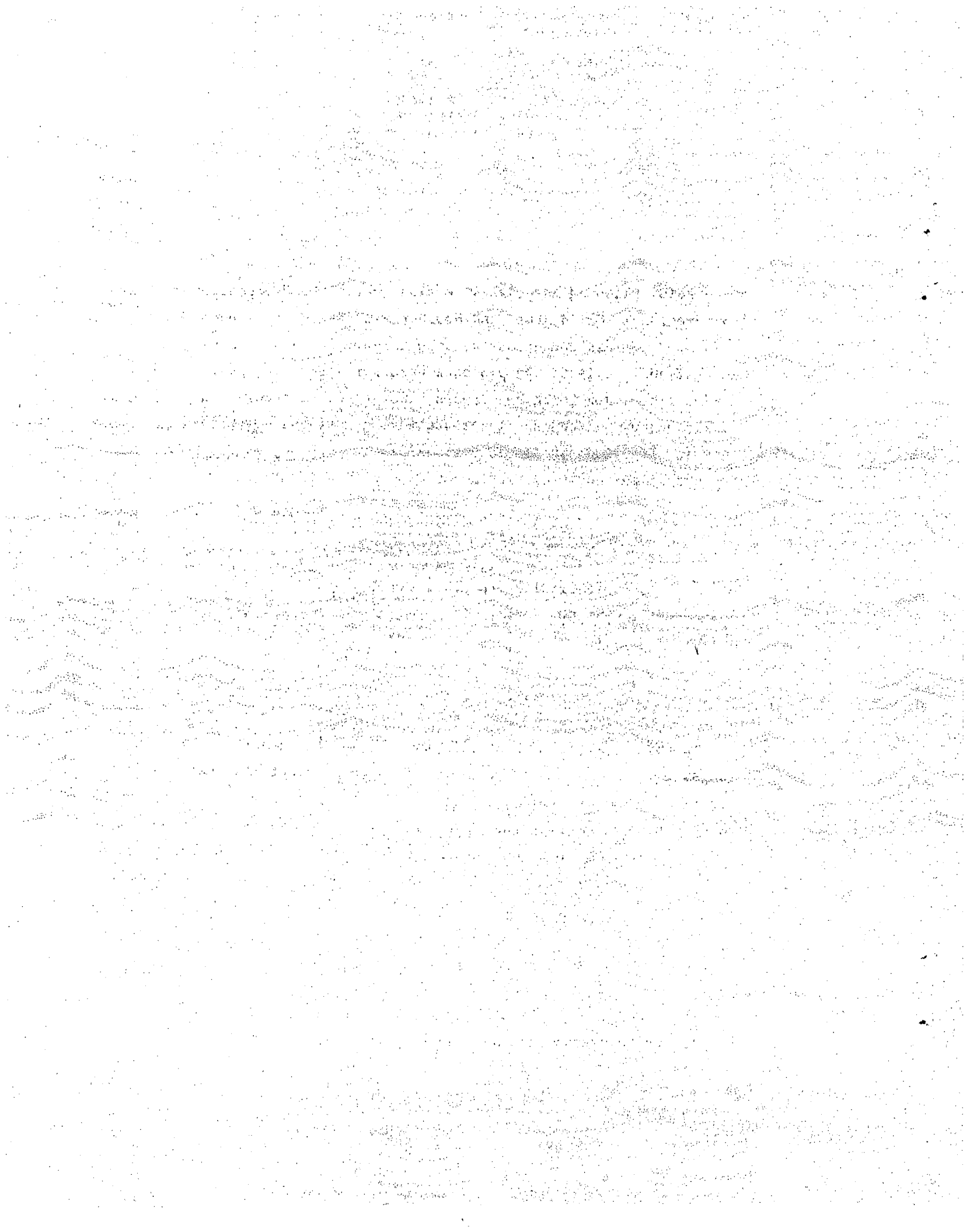
"How Can We Avoid Burnout?", presented by Katherine Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"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.

APPENDIX B

Methodology



Methodology

Introduction

As stated in the main body of this report, an integral component of Berkeley Planning Associates' 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 appendix 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. Related to this methodology, Appendix C presents the data collection instruments and instruction manual; Appendix D presents the results of our reliability tests; and Appendix E presents the results of our efforts to assess the comparability of same-named services across projects.

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 Appendix. 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.

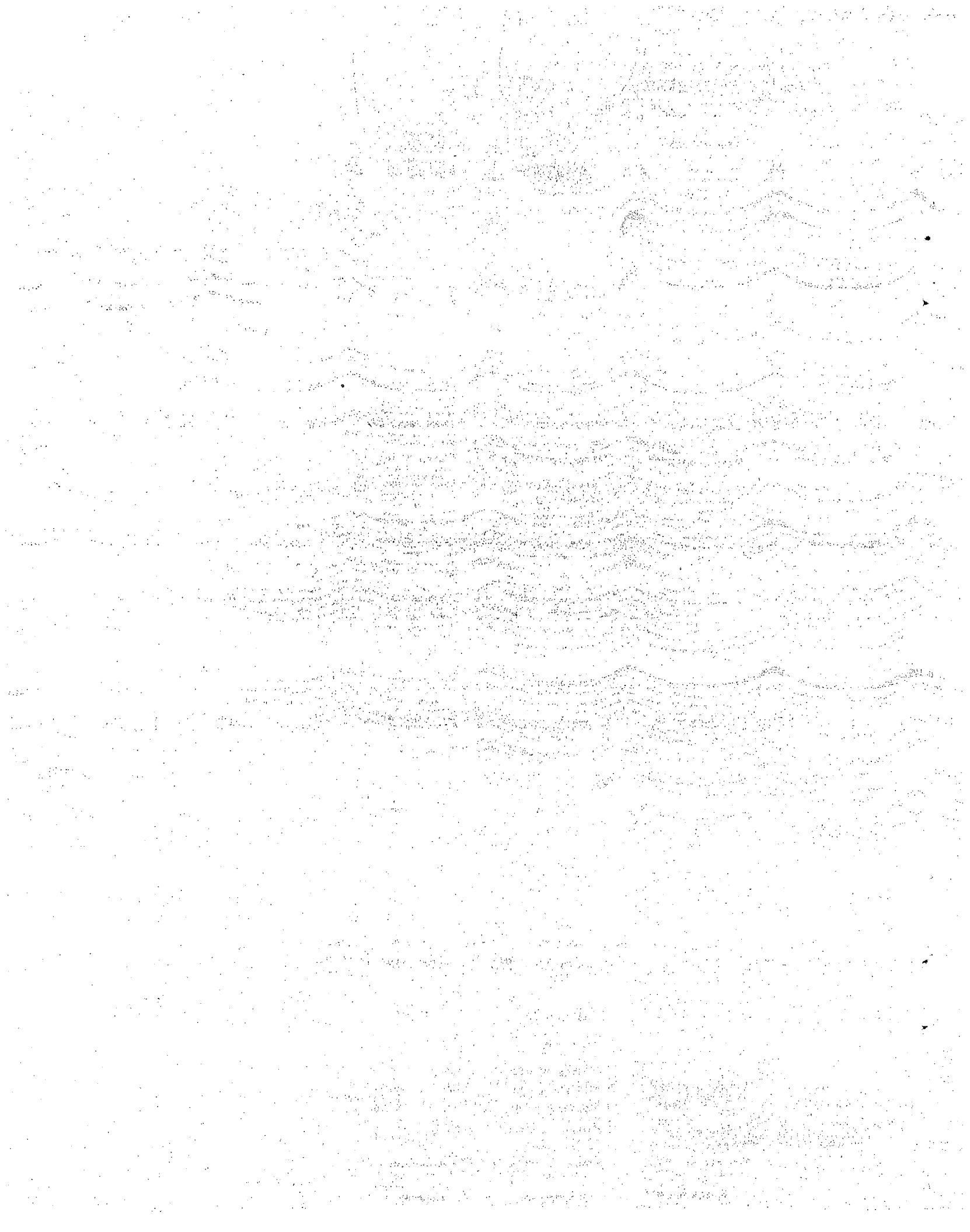
Next, since the coefficient of determination (R-square) provides a weak measure of the power of overall models for prediction when the dependent variable is binary, we converted select regressions into classification functions to test how many of the clients' outcomes could have been correctly predicted 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.

APPENDIX C

Data Collection Forms
and
Instruction Manual with Definitions



CLIENT INTAKE FORM (HOT-120)
BERKELEY PLANNING ASSOCIATES

(08)

PLEASE NOTE THAT THIS FORM IS TO BE COMPLETED BY THE END OF THE INTAKE PROCESS

I.D. No. [ ][ ][ ][ ][ ][ ] (B.P.A. Use Only)

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
38 ☐ No
39 ☐ 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

Adapted from the American Humane Association National Reporting Form

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	25 ☐	evidence of abuse
22 ☐	record of neglect	26 ☐	evidence of neglect
23 ☐	no record of either	27 ☐	no evidence of either
24 ☐	unknown	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 ☐ Unlikked 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)

10-19 [ ][ ] 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	
31 ☐	37 ☐	Less than 8 years education
32 ☐	38 ☐	8-11 years education
33 ☐	39 ☐	High school degree
34 ☐	40 ☐	Some college/vocational training
35 ☐	41 ☐	College graduate
36 ☐	42 ☐	Post graduate
	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)

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	
31 ☐	50 ☐	Taken in for assessment only
32 ☐	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

C.1

GOALS OF TREATMENT FORM (B)
BERKELEY PLANNING ASSOCIATES

I.D. No. _____ (B.P.A. Use Only)

Please Date Each Entry

Client's Name _____

Worker's Name _____

GOALS OF TREATMENT WHEN ENTERED CASELOAD

Please specify and number the goals of treatment for client (i.e., the behavioral, attitudinal and/or situational changes to be accomplished).

(1)

(2)

(3)

(4)

(5)

CHANGES IN GOALS

Specify changes in goals (by specifying number from above) of treatment and intermediate achievement of goals while client is in caseload.

ACCOMPLISHMENTS OF TREATMENT

Please summarize how goals were (and were not) accomplished during the course of treatment (i.e., the behavioral, attitudinal and/or situational changes accomplished).

(1)

(2)

(3)

(4)

(5)

REASONS FOR CLOSING CASE

CLIENT IMPACT FORM (NS2-52B)
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 sca which indicates client's functioni at time client is terminated.
1 2 3 4 5 poor good	GENERAL HEALTH	1 2 3 4 poor goo
1 2 3 4 5 no control control	CONTROL OVER PERSONAL HABITS: (drugs, alcohol, overeating) SPECIFY _____	1 2 3 4 no control contro
1 2 3 4 5 stressful unstressful	STRESS CREATED BY LIVING SITUATION	1 2 3 4 stressful unstressfu
1 2 3 4 5 extension of self separate person	SENSE OF CHILD AS PERSON	1 2 3 4 extension of self separate perso
1 2 3 4 5 inappropriate appropriate	BEHAVIOR TOWARD CHILD	1 2 3 4 inappropriate appropriate
1 2 3 4 5 unaware aware	AWARENESS OF CHILD DEVELOPMENT	1 2 3 4 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 whic indicates your view of client's propensity at time client is terminate
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)

Place an (X) in the box indicating if any of the following occurred in a given month:

Client's Name _____

Worker's Name _____

		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, Death due to Neglect
- [ ] Yes, Moderate physical abuse
- [ ] Yes, Moderate physical neglect
- [ ] Yes, Mild physical abuse
- [ ] Yes, Mild physical neglect
- [ ] Yes, sexual abuse
- [ ] Yes, Failure to thrive
- [ ] Yes, emotional abuse
- [ ] Yes, emotional neglect
- [ ] No
- [ ] Unknown

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

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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 D

Results of the Reliability Tests

Results of the Reliability Tests: Assessment of the Comparability of Select Adult Client Data Across Projects and Workers

Introduction

In order to utilize the adult client data, we had to feel confident about their reliability and validity. Of particular concern was the reliability and validity of certain intake and impact data, i.e., measures of the problem the client had at intake with respect to maltreatment, clients' improvement during treatment on select functioning indicators of the potential for abuse or neglect and reincidence.[1] In this Appendix, we present the results of three reliability tests of these measures.

Methodology

As an ongoing activity in assessing and ensuring the reliability of responses on the impact measures, BPA staff members met with workers completing the BPA adult client forms during each quarterly site visit, going over the definitions of the measures, how the forms were to be used, and any problems project staff were having with the forms. Generic problems identified at a given project were written up in memos and returned to all projects to ensure consistency in input across projects. The numbers of such problems decreased dramatically over the three years. In addition to these forms of informal reliability assessment and ongoing training, which we regarded as critical, we conducted three formal reliability tests of select data items at the projects, during the 5th, 6th and 7th site visits.

The three formal reliability tests consisted of presenting a written, fictionalized child abuse or neglect case history to all workers completing

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[1] Other concerns included the comparability of same-named services across projects, as discussed in Appendix E, Assessment of the Comparability of Adult Client Services Across Projects.

BPA adult client forms in all projects (see end of Appendix for copies of these case histories). After studying the case, each worker completed those relevant BPA forms which contain the select measures, as they would for their own cases. Following this individualized activity, discussions were held on how workers rated the case. The discussions themselves served to highlight problem areas while providing workers with rigorous training in the use of the forms. The forms completed by workers were collected and tabulated. Tables D-1 through D-4 present these results. The results must be considered in light of the cases used, as they did not always present sufficient information to allow workers to make reasonable ratings on certain measures.

Findings

Table D-1 presents the results of the three reliability tests for clinicians' ratings on the severity or nature of the case.[1] Table D-1 suggests that (a) workers do not consistently differentiate moderate from mild physical abuse, but that if these two categories are combined, workers' responses appear very reliable; and (b) workers do not consistently differentiate emotional abuse from emotional neglect and very frequently indicate both for the same cases; and (c) workers may have difficulty consistently differentiating severe from moderate neglect.

[1]Numbers represent the percentage of workers who gave the same score.

TABLE D-1

Results from the Three Reliability Tests: Severity or Nature of Case*

			Case I	Case II	Case III
Abuse	Physical	Severe	1.5%	6.0%	12.0%
		Moderate	44.0% → 93%	64.0% → 94%	64.0% → 92%
		Mild	49.0%	30.0%	28.0%
	Other	Emotional	17.0%	95.0%	56.0%
		Sexual			
		Potential	7.0%	5.0%	2.0%
Neglect	Physical	Severe		48.0%	
		Moderate	3.0%	52.0%	10.0%
		Mild			13.0%
	Other	Emotional	14.0%	97.0%	52.0%
		Failure to Thrive		3.0%	
		Potential	5.0%		6.0%

*Note that each case represented a different set of abuse/neglect problems. Percents add to more than 100% since more than one category may have been checked.

Our conclusions from these three tests are that regardless of the level of specificity of our definitions, the current understanding of abuse and neglect in the field is such that mergings of categories such as ours are necessary for workers to be able to agree on the classifications of clients as to type or severity.

For our own analyses, we decided to combine this measure, severity or type of case, with others to get a more comprehensive definition of "Problem at Intake." These other measures include: whether or not the alleged

maltreatment was in fact substantiated; whether there is a previous history of abuse or neglect; and the degree to which other problems (for example, financial difficulties, heavy, continuous child care responsibilities, spouse abuse) were present in the household at the time of the alleged abuse.

Tables D-2 and D-3 display clinicians' scores on the 13 functioning indicators and the propensity measures for the reliability tests.

The reliability of clinicians' scores at a given point in time -- at intake as shown on Table D-2 -- varies somewhat from case to case on an individual measure, although the average reliability on all but three measures (GENERAL HEALTH, EXTENT OF ISOLATION and ABILITY TO TALK OUT PROBLEMS) is quite high, at over 80%. We thus accepted intake scores on all but these three as reliable. GENERAL HEALTH, at 76% reliability, is lower than our predetermined cut-off point of 80%; but, because we consider physical health an attribute which is easier for clinicians to reliably assess when seeing an individual in person, rather than reading about them, we decided to consider this measure reliable as well. Thus, two measures, EXTENT OF ISOLATION and ABILITY TO TALK OUT PROBLEMS, were dropped from any analysis of the intake data alone.[1]

The dominant analysis of the functioning indicator and propensity data was in terms of direction of change between intake and termination. Did the client improve, stay the same, or regress? As Table D-3 indicates, reliability of clinician ratings or change in functioning and propensity overall is excellent.[2] All measures show at least 80% reliability on at least one of the two tests. Average reliability from both tests is greater than 80% on all but two measures -- CONTROL OVER PERSONAL PROBLEMS and EXTENT OF ISOLATION. These two measures are therefore dropped from any analyses that concern themselves with change scores.

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[1] For certain analyses on the functioning indicators, we looked at change scores on those indicators for which a client received a low or medium rating at intake. Since ABILITY TO TALK OUT PROBLEMS was reliable on the change scores, and since the intake scores are also acceptably reliable when low and medium ratings are merged, this measure was included in such analyses.

[2] Change scores were not sought in the first reliability test.

TABLE D-2

Results From the Three Reliability Tests: Functioning Indicators and Propensity at Intake

Variable		Case I	Case II	Case III	Average Reliability
General Health	Poor	7%	94%	62%	76%
	Somewhat Poor	22	6	28	
	Good	71	--	10	
Control Over Personal Habits	No control	16	100	94	83
	Some control	28	--	6	
	Control	56	--	--	
Stress From Living Situation	Stressful	61	100	94	85
	Some stress	34	--	6	
	Unstressful	5	--	--	
Sense of Child as Person	Extension of self	62	92	92	82
	Mixed	22	8	8	
	Separate person	16	--	--	
Behavior Toward Child	Inappropriate	58	97	100	85
	Somewhat inappropriate	33	3	--	
	Appropriate	9	--	--	
Awareness of Child Development	Unaware	60	97	94	83
	Somewhat unaware	29	3	2	
	Aware	11	--	4	
Extent of Isolation	Isolated	66	60	36	59
	Somewhat isolated	20	29	52	
	Not isolated	14	11	12	
Ability to Talk Out Problems	Unable	91	47	52	63
	Somewhat unable	6	42	24	
	Able	3	11	14	
Reactions to Crisis Situations	Poor	96	97	94	96
	Somewhat poor	4	3	6	
	Good	--	--	--	
Way Anger is Expressed	Inappropriate	84	97	98	93
	Somewhat inappropriate	13	3	2	
	Appropriate	3	--	--	
Sense of Independence	Dependent	91	89	84	88
	Somewhat dependent	4.5	11	14	
	Independent	4.5	--	2	
Understanding of Self	Poor	95	91	86	91
	Somewhat poor	5	6	14	
	Good	--	3	--	
Self Esteem	Low	91	100	92	94
	Somewhat low	9	--	8	
	High	--	--	--	
Potential for Future Abuse	Very likely		100	98	99
	Somewhat likely		--	2	
	Unlikely		--	--	
Potential for Future Neglect	Very likely		100	80	90
	Somewhat likely		--	12	
	Unlikely		--	8	

TABLE D-5

Results from the Second and Third Reliability Tests: Changes in Functioning Indicators and Propensity from Intake to Termination

Variable	Change	Case II	Case III	Average Reliability
General Health	Regressed	--	--	84%
	Stayed the same	2%	30%	
	Progressed	98	70	
Control Over Personal Habits	Regressed	--	--	75
	Stayed the same	--	50	
	Progressed	100	50	
Stress From Living Situation	Regressed	--	--	93
	Stayed the same	--	14	
	Progressed	100	86	
Sense of Child as Person	Regressed	--	--	86
	Stayed the same	2	26	
	Progressed	98	74	
Behavior Toward Child	Regressed	--	--	93
	Stayed the same	--	14	
	Progressed	100	86	
Awareness of Child Development	Regressed	--	--	83
	Stayed the same	2	32	
	Progressed	98	68	
Extent of Isolation	Regressed	--	--	68
	Stayed the same	16	46	
	Progressed	84	52	
Ability to Talk Out Problems	Regressed	--	--	91
	Stayed the same	2	16	
	Progressed	98	84	
Reactions to Crisis Situations	Regressed	--	2	85
	Stayed the same	--	28	
	Progressed	100	70	
Way Anger is Expressed	Regressed	--	--	88
	Stayed the same	2	22	
	Progressed	98	78	
Sense of Independence	Regressed	--	--	92
	Stayed the same	2	14	
	Progressed	98	78	
Understanding of Self	Regressed	--	--	91
	Stayed the same	2	16	
	Progressed	98	84	
Self Esteem	Regressed	--	--	92
	Stayed the same	--	16	
	Progressed	100	84	
Potential for Future Abuse	Regressed	--	--	93
	Stayed the same	2	12	
	Progressed	98	88	
Potential for Future Neglect	Regressed	--	--	89
	Stayed the same	2	20	
	Progressed	98	80	

Reincidence While in Treatment

It was important to understand how reliably clinicians would report reincidence and thus a question pertaining to this was added on the third reliability test. As Table D-4 shows, 80% of the clinicians agreed that "mild abuse" occurred while the client was in treatment, suggesting that we can have confidence in the reincidence data.[1] Smaller percents perceived that emotional abuse (36%) or emotional neglect (42%) had occurred. This strengthens our case that because of the difficulty in differentiating these two forms of emotional maltreatment, they should be combined for analysis.

New Measures

Analysis of client measures to date prompted us to collect some additional data about terminated cases including the difficulty, seriousness, and success of the case which might be useful in future studies (see Table D-4).

(1) Difficulty of case

Clinicians were asked to rate the difficulty of the case in terms of: more difficult than average, average difficulty, less difficult than average. When analyzing outcome data, this variable would be useful in interpreting differences in outcome across cases. Eighty-eight percent of the clinicians agreed that this test case was average difficulty, indicating high reliability on this variable.

(2) Seriousness of case

Clinicians were asked to determine the seriousness of the case in terms of whether it was "a more or less serious case in terms of the child's well-being." Clinicians' responses were split: 48% said it was more serious; 52% said it was less serious. The lack of reliability on this variable not only implies its non-utility in data analysis, but also suggests that, in the

[1] Clearly our confidence cannot be complete, given only one reliability testing of the reincidence data.

field in general, there is little consensus on what constitutes a threatening situation to a child's well being.

(3) Success of case

Finally, clinicians were asked to rate the success of the case: "Given the client's situation at termination, how would you rate the overall program intervention -- a success, uncertain success some progress, clearly not a success?" Ninety-four percent of the clinicians agreed that the case was "uncertain success, some progress." This variable, now shown to be reliable, would be useful as an additional source of program impact.

Conclusions

(1) Severity or type of case

Certain categories on our measure of severity or type of abuse or neglect committed should be merged -- notably "mild" and "moderate" physical abuse and "emotional abuse" and "emotional neglect." Additionally, data from this measure should be combined with others -- whether the alleged incident was established, previous history of abuse or neglect, and number of other problems in the household -- to gain a more useful definition of "problem at intake."

(2) All intake data on the functioning and propensity measures is useful except that on "extent of isolation" and "ability to talk out problems."[1]

(3) All change score data on the functioning and propensity measures is useful except that on "control over personal problems" and "extent of isolation."[2]

(4) Reincidence data is useful if categories are merged as described in (1) above.

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[1]As footnoted earlier, "ability to talk out problems" remained in those analyses for which low and medium intake scores were merged, and change scores were the focus of the analysis.

[2]Given the theoretical importance of the concept of isolation to child abuse and neglect, it is with much regret that we drop this measure.

TABLE D-4

Results from the Third Reliability Test: Additional Measures

Reincidence While in Treatment

--	Severe Abuse	--	Severe Neglect
80%	Moderate Abuse	4%	Moderate Neglect
	Mild Abuse	8%	Mild Neglect
36%	Emotional Abuse	42%	Emotional Neglect
--	Sexual Abuse	--	Failure to Thrive

Difficulty of Case

Overall, how would you rate the difficulty of this case?	
6%	More difficult than average
88%	Average difficulty
6%	Less difficult than average

Seriousness of Case

Was this a more or less serious case in terms of child's well-being?	
48%	More serious
52%	Less serious

Success of Case

Given the client's situation at termination, how would you rate the overall program intervention?	
--	A success
94%	Uncertain success, some progress
6%	Clearly not a success

CASE HISTORY FOR FIRST RELIABILITY TEST*

Initial Report

Tommy J is a three year, four month old caucasian male reported to the policy as a suspected abused child by Ms. Edwards, Head Teacher of the Wind 'n Willows Nursery School.

On 11/14/75, Ms. Phillips, Tommy's teacher, notified Ms. Edwards that she had found bruises and recent belt marks on Tommy's buttocks. She noticed them because Tommy became very upset when pulling his pants down to go to the bathroom. Tommy said, "I got hit cause I peed." He would not say who hit him and was unwilling to talk about the bruises anymore. Police were called according to school procedures and Officer Tom Harrington of the Mission Station took the initial report from Ms. Edwards and transported the child to General Hospital for further investigation. Neither the school nor Officer Harrington were able to reach the parents by telephone to inform them of the school report.

Investigative Reports

Ms. Edwards -- Wind 'n Willows Nursery School

Tommy has attended our school for six months. He is a very attractive, well-kept child who rarely creates a problem at school. If anything, he is perhaps over-obedient, anxious to please and always willing to accommodate the other children or the teachers. He had difficulty separating from his mother and had just recently adjusted to her leaving without tears. He appears quite bright; his development is normal.

Our nursery is a private school which students attend four hours per day. We have had no contact with Mr. J. Mrs. J has normal contact with staff when she leaves or picks up Tommy. During our one scheduled parent conference she was interested and concerned about Tommy's progress and wanted to know how soon we would teach him to count and learn his letters.

Dr. Kramers, Pediatric Resident, County Hospital

Tommy J was seen in pediatric clinic on the request of the police department to evaluate for suspected child abuse. He is a well-nourished child who appeared in good overall health. His overall physical exam was within normal limits. On his right and left buttocks were red welts of a linear nature resolving into discoloration. These marks are consistent with those left by inflicted injuries from an object such as a belt, telephone cord, or ruler. A long bone X-ray survey revealed an old spiral fracture of the right ulna. This fracture is approximately three months old. All other findings were negative. On the basis of the two injuries,

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*This case was developed by Urban and Rural Systems Associates, San Francisco, October 1975.

the child was hospitalized as a suspected battered child for further social investigation. Officer Harrington gave us a 48-hour police hold and authority to admit the child because the parents could not be contacted.

Social Work Report

Ms. Wallace of the Hospital Social Service Department was assigned the case when the child was admitted. She contacted Ms. Edwards who reported that Mrs. J had come to the school to pick up Tommy and had been informed of the report. Mrs. Phillips was bringing her to the hospital now and she was very upset. Ms. Wallace obtained the following information from Mrs. J. The family is intact -- Mrs. J is 24, Mr. J is 40. They have been married five years and are Tommy's natural parents. They have lived in the city six years and are buying their home. Tommy was a wanted child who has been a joy for both parents. They are a happy couple who have "none but the usual problems," which Mrs. J. would not elaborate upon. Mrs J. is 4-1/2 months pregnant, another planned child. Mrs. J denied knowing about the bruises. She stated that the arm was broken three months ago while Tommy was playing with his father. She referred Ms. Wallace to their private pediatrician, Dr. Holloway, who treated the arm. Mrs. J was anxious to "settle all this now" and not get her husband involved. When told they would both have to talk to the Juvenile Authorities she became more upset and insisted on leaving. An appointment for both parents with Inspector Kelly of the Juvenile Division of the Police Department was set up for 4:00 p.m. at the hospital. Mrs. J left without seeing or asking about Tommy.

Inspector Kelly's Report

Interviewed Mr. and Mrs. J at the hospital. They had just visited Tommy and were very upset. Tommy cried a great deal and wanted to go home. Mr. J. did all the talking. Mrs. J cried throughout the interview. He stated he had disciplined Tommy with a belt for wetting the bed. He had hit him four times -- had used this discipline before and only hit Tommy on the buttocks. He stated he was not angry with Tommy; just teaching him proper toilet habits and respect for authority.

Mr. J stated that in August 1975, he and Tommy were in the park. He was pushing Tommy in the swing and the boy began to fall. He grabbed Tommy by the arm to prevent the fall and Tommy's arm twisted. He was taken immediately to Dr. Hollaway who set the arm. Dr. Hollaway is the child's pediatrician and sees him regularly for well-child care. Tommy has no medical problems. The rest of the interview consisted of Mr. J berating the police, the school and the hospital, and threatening suit. After he was informed that the case would be presented to the Hospital Review Board for disposition he left saying his attorney would handle the whole thing. Neither parent saw Tommy before they left. Inspector Kelly confirmed Mr. J's story with Dr. Hollaway. She also stated that this was an upstanding family who took excellent care of Tommy. She knows the family socially and has observed Tommy's care at home. The doctor suggested the police stop harrassing parents who were doing their job raising their kids and go out and catch criminals.

Family Background

This information was obtained from an aunt, Mrs. Perry, who came to visit Tommy on 11/16/75 and asked to speak with Ms. Wallace; she is Mrs. J's sister. Mrs. J called her incoherent last night and she wanted to know what was going on. She gave Ms. Wallace the following family information. Mrs. J is the youngest of three girls. She was a happy, adjusted child who was very attached to her father. She was a tomboy until adolescence and then became a very bright, intense young lady. She attended college where she met Mr. J , a teacher's assistant, and they were married within a year. The J's met soon after the sudden death (a car accident) of Mrs. J's father. Mrs. Perry feels that Mr. J in many ways replaced their father for Mrs. J. She has also been concerned about how Mrs. J has always denied her feelings of loss around their father's death and wonders if Mrs. J's current hysteria is a delayed grief reaction because she keeps talking about how her father would handle everything if he were here.

Mrs. Perry states that Mr. J was an only child raised by his mother. She knows very little about his father except that he left the family when Mr. J was very young. Mr. J is very devoted to his family and treats Mrs. J like a princess. He is attached to Tommy and does a great deal with him alone. Mrs. Perry, mother of six children, feels both parents are a little unrealistic about how much they expect of Tommy in terms of learning and behavior, but feels that things are basically OK at home. Mr. J is enjoying the opportunity to be the father he always wished he had had himself.

While she describes Mr. and Mrs. J as a "healthy, happy couple," she says that they have their fair share of problems. Mr. J was fired from a job last year; she wasn't sure why but maybe it had to do with some attitudinal problems. Mrs. J is often hysterical or incoherent which usually means something is going wrong. (Mrs. Perry gained some of her knowledge about the family problems from Mrs. J's only friend who she has coffee with once a week.) She couldn't imagine Mr. J getting violent too often. If he ever does it's probably because of Mrs. J and her negative feelings about herself. Mr. J is the stronger one of the two; always sure that he is right and always offers a lot of support to Mrs. J.

CASE HISTORY FOR THE SECOND RELIABILITY TEST

Mother: Lu-Ann Johnson, age 26, white

Father: Buddy Johnson, age 27, white

Children: Roxanne (daughter), age 5
Walker (son), age 2-1/2

June 14, 1975. Landlady, Mrs. Purcell, complains to Welfare Department that Lu-Ann Johnson leaves her two children unattended for long periods of time while she has card parties with her girlfriends in the afternoon. Walker, the two-year-old, is left in the care of his sister, five-year-old Roxanne, who pays little attention to him. He cries all the time, gets into fights with his sister, and apparently has recently fallen out of his crib while he was supposed to be taking a nap. Hearing the screams, Mrs. Purcell went upstairs. Roxanne explained that her mother was out playing cards and that she was Walker's Mommy for the afternoon. She was wearing a short dress with no underwear and bare feet and was busy scribbling with crayons on the kitchen table. Walker seemed feverish and to be suffering from a cold. He stopped screaming when he saw Mrs. Purcell and was extremely uncommunicative. Mrs. Purcell stayed with the kids until Mrs. Johnson returned home at 7:30. She was obviously intoxicated. Mrs. Purcell reported that the house was a mess and that there were unwashed diapers in a pail in the bathtub. The refrigerator contained only a few cans of beer and some moldy salad. Roxanne told Mrs. Purcell that she and Walker usually had crackers for lunch.

June 16, 1975. A worker from Child Protective Services, to whom the case was referred, visited the Johnson household at 10:00 a.m. They live in an upstairs flat in a rundown multi-family dwelling in East Oakland. The neighborhood is racially mixed, but predominantly black. Many buildings have been boarded up, and there is a liquor store downstairs. Unemployed men appear to congregate in front of this store drinking from brown paper bags. The hallway to the Johnson flat smells of stale beer and urine.

Lu-Ann Johnson was home. She answered the door wearing a sloppy bathrobe which was half unbuttoned. She had not combed her hair and her lipstick was smeared. She looked older than her 26 years. She apologized for the state of the house, but explained that she suffered from a chronic cough which often developed into bronchitis and that she feels run-down all the time. She said it was hard keeping track of two kids with only an occasional check from their father. She asked if she could make the social worker some instant coffee and if it would be okay if she had a beer, which she said she needed for her nerves. The social worker observed Lu-Ann chain smoked and at one point popped several pills. The social worker asked if they were aspirin, but Lu-Ann laughed and said that aspirin couldn't touch her, the state she was in. She needed "reds," she said, just to keep from going bananas with all the pressure. The television was turned on to a morning soap opera.

The social worker asked about Lu-Ann's family situation. Lu-Ann replied that her husband was a truck driver and often gone for long periods of time. He made good money but he spent a lot of it on the road; in any case she didn't see much of it. She often had to ask her mother for money. Bud came back into town about once every two weeks from his runs. They had been married two years. Walker was Bud's son, but he didn't show much interest in the kid. Roxanne was the child of a previous relationship. When Bud was home, it was mayhem. He wanted his beer and television and tended to knock the kids around when they got noisy. He was grudging about giving her money for rent and food, although he would shell out. She thought he might have another woman in another part of the state to whom he gave money, but she was not sure.

During this visit Roxanne watched television and Walker cried and fussed. Mrs. Johnson excused herself to feed him some Ritz crackers which he refused by gritting his teeth together so she could not put the cracker in his mouth. She swatted him, but then apologized to the social worker. She repeatedly called him, "you little creep."

While the social worker was present, Mrs. Johnson answered the telephone. She laughed a lot and used obscene language and said once, "The S.O.B. better have dough." She apologized again when she hung up and said that she usually met her girlfriends in the afternoon to play cards. It was the only chance she got to get out of the house. She added that Roxanne was perfectly able to take care of Walker, and she expressed resentment of Mrs. Purcell, who she said was "an uptight bitch who couldn't keep her nose out of other people's business." Then she said she had to get ready to go out. The case worker set up a second appointment.

June 17, 1975. Child Protective Services was referred another phone call from Mrs. Purcell. She complained that the children had been locked out of the house for several hours and that she believed Mrs. Johnson was entertaining men and drinking during this time. When the children cried and knocked on the door, a man stuck his head out the window and told the kids to cool it, or he'd come down there and smash their two heads together. She said that the man was definitely not Mr. Johnson, whom she rarely saw, and that she suspected Mrs. Johnson of entertaining men for money at these card games.

June 18, 1975. The case worker set up a morning appointment with Lu-Ann. She giggled and laughed at the case worker's concern that the children were not supervised and that Roxanne should be enrolled in kindergarten. Lu-Ann seemed not to take these things seriously, but said that if Child Protective Services would pay for a babysitter, it would help her a great deal. She said that she had not heard from Bud for over two weeks and if he was going to leave her on her own, she knew what to do with her free time. She said she had once been crazy about the guy but that was over now. During the interview Lu-Ann told Roxie to make some lunch for her brother. When Roxie spilled the soup, pouring it into bowls, Lu-Ann cursed her and slapped her in the presence of the social worker. She apologized, saying that her nerves were shot and that she was worried

about money, and when she's worried she just can't seem to control her temper. The social worker also commented that Walker was covered with scratches and bruises. Lu-Ann said a big dog in the neighborhood had chased him. Both children appeared to have runny noses. Lu-Ann often referred to her son as "the little creep" and said he took after his father who was a moron. She said she wished she had never met the guy and the whole situation was a pain in the neck. She asked whether Child Protective Services could farm the kids out for adoption. The case worker set up another interview.

June 20, 1975. Mrs. Purcell again phoned Child Protective Services. She said that she was going to evict Mrs. Johnson whom she knew was seeing men for money during her husband's absence, but that she was worried about the children. She said the night before there had been an enormous thump on the floor overhead followed by screaming. When she went upstairs to see what was happening, a man's voice told her to keep her nose out of it. Mrs. Johnson refused to open the door. She appeared to be crying hysterically. Mrs. Purcell could hear a record player and several men's voices in the room. The next day she saw Walker in the back yard with a big cut across his forehead. He said a man had hit him. Mrs. Purcell asked if his daddy had hit him and he said no. Mrs. Purcell was very upset about what was going on in her upstairs flat.

A caseworker from Child Protective Services phoned Mrs. Johnson and said that Walker must be taken to the hospital. She asked if Mrs. Johnson was willing to accompany the child. Mrs. Johnson said that if Child Protective Services could arrange a ride, she would go. The child was seen by a doctor, who said the cut required stitches. Formal reports were made to Child Protective Services and the Johnson Case became an open case on their case role.

The caseworker suggested to Mrs. Johnson that she attend some of the group therapy meetings at the Center, explaining that these are designed to help parents who find they have more responsibilities than they can handle. Lu-Ann seemed distraight and upset. She said she didn't like having so many guys around and that Bud was the only man she ever loved, but that he didn't treat her right. She needed money for medical bills for her bronchitis and chronic cough, and for the kids; but instead, when he came back from his runs, he always asked her how much money she had gotten from her mother. She said she would consider going to group therapy meetings but she wanted to talk to Bud about it, who would be back from a trip in a couple of days. In response to questions about Roxanne's scanty dress, she said that the weather was warm and the kid didn't need a lot of clothes.

The caseworker raised the question of Lu-Ann's absences from the house. She said that Bud played around while he was on the road, so she played around while he was gone. She laughed off many of the questions in an hysterical manner, but she became more serious when the social worker said that she didn't perceive Lu-Ann as particularly happy. Mrs. Johnson admitted that she was a nervous wreck and didn't know where to turn. She said she needed reds and booze to keep going, and she hated her house and her family and kids and didn't know how to

get out. She added that she had another kid, Thomas, whom she had had when she was 16. She had had to drop out of high school, and the child had been raised by the mother of Thomas' father. She said her whole life had been one bad man after another and she was sick of it, but what could she do. She'd never done anything right. She had worked at Woolworth's once but they had fired her because she was too slow at the register. She said her two girlfriends had turned her on to the afternoon card games. Sometimes guys they knew showed up, and sometimes they would buy the beer or give Lu-Ann and her friends a little money toward the groceries. They also kept them supplied with downers and reds. They were all a bunch of creeps but what could she do. She was on her own mostly, except when Buddy was in town. Then she didn't play cards with her girlfriends, because Buddy wouldn't stand for it, although he did nothing to help her. She said she would ask Buddy about the group therapy meetings, but she didn't think he would go for it. He didn't trust anyone with a college education.

June 25, 1975. The caseworker called again on Lu-Ann Johnson. They discussed the welfare of Roxie and Walker. Roxie was as usual scantily dressed and Walker had a big scab on his nose. Lu-Ann said that Walker had fallen out of his highchair and his nose had bled for a long time, which was why he had the scar. The social worker asked why she had not considered taking Walker to a doctor. Lu-Ann said: "I get so upset when these things happen that I just can't think. I just can't do anything." She said that Buddy was back and watched television and drank beer all of the time. She said he demanded all of her attention and resented it if she paid any attention to the kids. She allowed as how But often struck her and hit the kids if they cried or made noise while he was watching television.

While the caseworker was there, Buddy Johnson came in. He was a gruff, surly man with a beer belly and a pock-marked face. He ignored the caseworker and went straight to the TV which he turned on full volume. When Lu-Ann complained that they couldn't hear, he said: "Shut your mouth. If you've got something to talk about, take it to the kitchen."

The caseworker observed that Lu-Ann looked run down and seemed to have a bad cold. She coughed a lot and said her bronchitis was getting to her. She chain-smoked during the interview and complained of a headache and took four "downers" while the caseworker was present. As usual she apologized for taking them in front of the caseworker but said she needed them to deal with the tension when Buddy was around. She said she was broke and Buddy hadn't given her any money and her mother couldn't help her out this month. She said she didn't know what to do. She said again that her whole life was a failure and that she'd never done anything right. She said if she asked Buddy for money, he just laughed, and when she demanded to know where it had gone, he hit her.

June 30, 1975. Lu-Ann Johnson attended her first group therapy meeting. At first she seemed uncommunicative and withdrawn. Howard, who was leading the session, asked her about her childhood. She opened up a bit and said that her Dad had left her mother when she was 12 and she had been pretty much on her own since. She had had a "bad" reputation in junior high school. School had bored her. When Howard commented that she showed a high degree of trust in the group to be willing to speak so freely, she appeared to relax a bit more, and volunteered that her relationship with Buddy was lousy. Although he made money, she never saw any of it. However, she said he was the only guy who had ever loved her. He wasn't a jerk, like the guys who came to the card parties. He was a real man. Howard asked her further about this. She said he didn't take gaff from anyone. When the kids hollered, he slapped them down. If the phone rang while he was home, and it was a man, he would slap her around later and call her a whore. She said that Buddy didn't take any shit from anyone.

July 29, 1975. Fourth therapy session. Howard, the group leader, has questioned Lu-Ann further about what constitutes a "real man." He raised the question if caring for his family was not a mark of a real man. Lu-Ann said her own father hadn't paid any attention to his family, so she said she wasn't sure. Howard asked if Lu-Ann had ever considered developing a job skill. He pointed out that there were various community agencies which would help in occupational retraining. Lu-Ann seemed interested but said she doubted anyone would want to train her. Howard said that she seemed to like people and that she might be fairly good working with other people. He suggested several occupations that she might train for. Lu-Ann replied that Buddy would never go for it. He wanted his wife at home; he didn't want a working wife. Howard asked about how much time Buddy spent at home. Wasn't he on the road most of the time? Lu-Ann laughed and said he might have a point.

August 28, 1975. Lu-Ann Johnson has been to four more group therapy meetings. She reports that Bud has left to haul a rig up to Edmonton, Canada and that he will be gone for six weeks. Howard observes that she seems relieved. Her reply is: "Yes, it's a damn good thing that jerk is gone." She added that on her own volition she had gone to the Vocational Training Department and found out that they offered the courses she wanted. They were willing to pay her tuition and she was considering going. Other members of the group supported her interest.

November 20, 1975. Another phone call from the landlady, Mrs. Purcell. She says the house has been in an uproar. There had been some sort of fight the night before and a lamp had been knocked over and a window broken. At three in the morning, a couple of men had staggered out of the Johnson flat, cursing and growling. She assumed that there had been some sort of drunken brawl. Mrs. Purcell reported that Lu-Ann Johnson seemed dazed and distraught and acted as if she didn't know what was happening. "On drugs," had been Mrs. Purcell's observation. Apparently Buddy was back for Thanksgiving and the whole house was a shambles.

November 21, 1975. Another visit to the Johnson household. Lu-Ann Johnson was in tears. She said two of her friends had stopped by unexpectedly and Buddy had gotten out of control and threatened them. He had tried to punch out one guy, but had missed and set the lamp through the living room window. She said she had been on reds, anyway, because having Buddy home was such a strain on her, and she just couldn't deal with the whole thing. Bud had said he would smash her if she called any of the neighbors. She had been frightened because she'd never seen him so bad before and she didn't dare do anything. She said she was sick of the whole damn thing and wished she could leave Buddy, but if she left him, he threatened to follow her and kill her. The social worker suggested a meeting with a counselor for the next day and promised that Child Protective Services would do what they could.

November 22, 1975. Counselor's report. She recommends a separation from Buddy, thinking it would be the best thing for Lu-Ann and the children, and strongly advises that Lu-Ann be given emotional and financial support, if need be, to continue her job training program. She suggests that the next time Buddy leaves for a lengthy truck tour, that Child Protective Services, in conjunction with the Welfare Department, assist Lu-Ann in finding a new place to live in a more secure building. She also recommends that Lu-Ann be given support if she shows any signs of wishing to divorce Buddy. She believes that Buddy is often drunk and violent, but probably will not follow Lu-Ann to a new location.

August 20, 1976 (nine months later). Another visit to the Johnson household. The caseworker noted that Lu-Ann seemed to be taking better care of the house and had made slipcovers for the sofa of which she was quite proud. For the first time Roxie was adequately dressed. At one point, the caseworker noted that Lu-Ann praised Roxie for having put away her toys before the caseworker came. Lu-Ann said that Roxie was a good girl and was trying to help her mother, although she couldn't do everything that her mother could do because she was only a little girl. Lu-Ann also sat with Walker on her lap some of the time. She said that he still reminded her of Bud, but that with Bud gone, it was easier for her. It wasn't his fault he had a jerk for a father. Walker seemed to respond to his mother's affection.

September 20, 1976. Group therapy session. Lu-Ann seems lively and vivacious. She says that she has an important announcement to make: she has finished her job training course and found a job at Associates Ink. The owners are ex-drug abusers and ex-convicts who have gone straight and who have an interest in personality rehabilitation. A condition of employment, however, is no drinking, no smoking, and no drugs. They will be paying her $650 a month and she will be working full-time. She seems very proud of her new job and encourages everyone to drop by Associates Ink and meet her new friends and co-workers.

Also, with the help of the Welfare Department and CPS, she has found a flat in a better part of town and filed for a divorce from Buddy. She reports that Roxie is now in kindergarten--a year behind her age group--but accepted by her classmates. Her mother is taking care of Walker while she works. She is in a position now to pay her mother for this service, out of her earnings. Lu-Ann seems spunky and out-going.

A group member asks her about her card-playing friends. She replies that she doesn't have time for them now, although they still drop by once in a while. She adds that she still takes downers, but not very often. Another group member asks how Buddy will respond to the idea of divorce. Lu-Ann says she doesn't give a hoot. Someone brings up the idea of physical danger from Buddy, but Lu-Ann seem confident that her life has changed and that she is no longer psychologically dependent on him.

November 15, 1976. Case temporarily closed. A caseworker who has visited the new flat reports that Lu-Ann seems to have things well in hand. Walker looks cared for and the house is relatively neat. Lu-Ann has a new steady boyfriend whom she met at Associates Ink, a man in his 30s who works for a pipefitters' union. He has a good job and has taken Lu-Ann's kids on a picnic and to the zoo. There will be a follow-up of this case, but the prognosis is that Lu-Ann has managed to overcome feelings of inadequacy which she acted out through the use of drugs and alcohol. Buddy has apparently visited the house once, but Lu-Ann has told him that it is over, and that she is filing for divorce; he has not been back and does not appear to want to contest it.

CASE HISTORY FOR THIRD RELIABILITY TEST

CHILD: Laura L, 2 years
PARENT: Mrs. L, 22 years

Intake Interview

Mrs. L, a 22-year-old mother of one child, first came into contact with the agency 2-1/2 weeks ago. The report given by Mrs. L's mother indicated a concern over the lack of adequate care being given to her grand-daughter. At that time, Mrs. L's presentation of herself was as a concerned mother interested in the development and welfare of her child. She appeared to disassociate herself from the current state of her daughter Laura, seeing this incident of bruised extremeties as an isolated incident. She saw little difficulty in her relationship with Laura, particularly in parenting skills.

In this interview, I opened our discussion by asking her to talk about her childhood. Initially wary, Mrs. L described her own childhood as relatively "normal." Her parents became separated early in their marriage, shortly after Mrs. L was born. The principle reason for their separation was her father's lack of interest in both mother and daughter. This became obvious in early infancy when Mrs. L developed allergic reactions to milk and cheese. As Mrs. L's father was the sole support of the family, he resented the extra cost of taking Mrs. L to a skin specialist. When the specialist told Mrs. L's mother that the allergies could either disappear or become chronic as Mrs. L got older, her father became incensed, deserting the family soon after. Mrs. L has not had any contact with her father for most of her life.

Her description of her mother is as a firm person, who tended to become depressed over her father at times. Although she feels her mother "loved her very much, making many sacrifices for her," Mrs. L felt herself to be a burden on her mother. This was further complicated when Mrs. L's allergies progressed to an advanced state of asthma. Mrs. L suspects that her mother might have wanted a son rather than a daughter, because of her interest in sports. Consequently, Mrs. L engaged unsuccessfully in competitive sports while in high schools, "letting her mother down." It was also during her adolescence that she met Mr. L. She was reluctant to discuss Mr. L other than superficially, becoming noticeably distraught and anxious, lacking composure during this part of her story. She did say that she became depressed after their separation and has not quite resolved any of her feelings, but has resorted to mild episodes of drinking coupled with a substantial weight gain.

Recently, Mrs. L's mother has remarried, moving to another nearby state. The close relationship between the two continues to exist, as her mother visits once a month. For the first week after her mother moved, Mrs. L "missed her a lot" feeling depressed and expressing fear that their relationship might not be the same when she lived so far away. Apparently, the grand-daughter Laura also misses her grandmother and has verbalized this repeatedly to her mother.

This has caused some ambivalence in Mrs. L's mind regarding the relationship of grandmother, mother (Mrs. L) and daughter (Laura). This most obvious reaction has been to deny any feelings about the triadic relationship, focusing rather on her daughter Laura. Mrs. L has recently felt the need to leave her job as an evening coctail hostess, thinking that she maybe should spend some more time with Laura. At the same time, her current job has been a major source of meeting male friends. She currently leaves Laura with her upstairs neighbor during the evenings while at work, bringing her downstairs each evening when she returns from work. This is a new arrangement, as Mrs. L's mother assumed most child care responsibilities for Laura. Mrs. L felt that taking Laura to her grandmother's during the late afternoon and picking her up at midnight worked out very well. She is apparently unhappy with her added child care responsibilities, and tends to have difficulty in expressing her anger directly when talking about Laura. Mrs. L covers her resentment by laughing immediately after she talks about disciplining Laura.

Usually, Mrs. L spanks Laura for waking up too early and demanding to be fed. At times, Mrs. L will ignore Laura, letting her cry for an hour or so in the morning before disciplining her. Mrs. L perceives discipline to be an integral part of bringing up Laura in the "right way," although her own mother rarely hit her. When Laura becomes sulky and passive after her spanking session, Mrs. L becomes more frustrated. She sees Laura as "no fun to be with" and having little enthusiasm for playing with toys.

Four Month Progress

During our weekly meetings, Mrs. L has begun to explore several familial relationships of the past. She maintains close contact with her mother, calling her several times a month, "just to keep in touch." We have started to talk in more detail about Mr. L and consequently Mrs. L's feelings about their separation. This is extremely anxiety-producing for Mrs. L, as she reports the separation as being part of a confused episode in her life. She speaks of Mr. L in a less ambivalent manner now, citing his lack of responsibility to the family as a major flaw in their marriage. She partially blames her mother for some of the problems, citing her lack of involvement in the way of support as a critical deficit. She sees her own lack of involvement in the marriage as secondary to her husgand's and mother's dominant roles. She has had difficulties in merging her roles of daughter and wife when she thinks about her life. The two seem mutually exclusive to Mrs. L at this time. Consequently, she becomes depressed when attempting to assess her own role; at times she feels that she should have been more dominant in relationships with both her mother and husband. She has expressed some concern over her role as a mother and a wife, and has been unable to fully resolve a way in which to deal with the two roles.

Laura now spends some time in a day care facility which is close to the house. Mrs. L is pleased about this development in some ways, and displeased in other ways. She finds it irritating that she needs to wake up at 7:30 in the morning, so Laura can be ready by 8:00 to be

picked up by a neighbor. Mrs. L perceives Laura as especially "naughty" in the morning and accuses her of purposely antagonizing her. Laura's favorite "trick" is to improperly button her blouse, and forget to zip her trousers. Mrs. L suspects that Laura likes to be "whacked" by her and made to behave. She fears that Laura is intentionally trying to make her look negligent in front of her neighbor. Her concern has mushroomed to an extent where she felt it essential to set early guidelines for Laura's behavior.

Mrs. L appears to constantly test my perceptions of her behavior and interactions with Laura, as well as reaching out to me for support. When she feels that I am not resolving conflicting issues for her, she resorts to a seemingly nonchalant attitude, but later reports of having a depression. During her depressed episodes, Mrs. L exhibits a need to meet men in order to bolster her morale, but is uncomfortable in committing her self to a long-term relationship. She has usually resolved her depressions by engaging in a heavy drinking "binge" for two or three days, calling in sick to her job. During her binges, Mrs. L characterizes Laura as becoming particularly difficult and unfeeling. She finds this very frustrating and easily breaks into tears when relating this to me.

Termination

Mrs. L has decided to change jobs, moving to a nearby town in another county. She feels that she will be able to meet some new people and perhaps become more involved with someone. She recognizes herself as having conflicting feelings about her mother and ex-husband, yet has great difficulty in verbalizing this.

Her drinking has become more commonplace, suggesting that she is depressed much more than she admits to being. She has been reluctant lately to talk about her feelings about Laura. Laura appears to be happy in her day care placement, making new friends. In fact, Laura has asked to bring a friend and her friend's mother over this week. Mrs. L is wary of this, as she feels Laura will only "misbehave," causing her embarrassment. She apparently does not feel comfortable and adequate around the other mothers at the day care facility. She cites Laura's bad behavior as a principle reason, comparing Laura's poor behavior to other "happy, well-behaved" children. I sense that Laura may purposely antagonize her mother, particularly in front of other people, reinforcing her mother's perceptions. During these episodes Mrs. L reports to slapping Laura and telling her "to wait until we get home." When they get home, Mrs. L often will leave Laura alone that night, without feeding her. Usually the next day, Mrs. L feels remorseful and tries to make up to Laura by fixing breakfast for her and spending some time playing with her. Mrs. L says that at times she feels Laura understands her frustration at being a single parent and tries to behave better.

Mrs. L is particularly resistant to continue in therapy at this time, feeling that she will "be able to go it alone." Since she is moving to another county, I have decided to close the case.

APPENDIX E

Assessment of the Comparability of Adult Client Services Across Projects

Assessment of the Comparability of Adult Client Services Across Projects

Section I: Methodology and Findings

Introduction

The adult client analysis called for the pooling of data on clients receiving similarly named services across all of the demonstration projects to provide a sufficient sample size to conduct analyses of the effectiveness of different mixes of services. This required an examination of the extent to which services that are given the same name by different projects are in fact similar services in terms of the way they are provided. This Appendix discusses our analysis of the comparability of same-named services across projects. In general, the approach was to identify a range of critical items which would serve to discriminate between various aspects of service provision. Profiles of such items were developed from questionnaire responses from each worker delivering a particular type of service. These data were complemented by observation of the services by BPA staff members. In this way, a comprehensive picture of the structure, content and process of such services were derived. The resulting profiles were aggregated for all workers in projects delivering certain types of services to identify normative distributions of items. Individual profiles which were significantly outside of the norm on several items were identified and examined to determine the extent to which such departures gave reason to believe that the service should be distinguished from others in the Adult Client Impact Analysis. Overall, the approach provides a way to understand the important dimensions of service provision in making judgments about service similarity both within and between projects -- one basis for pooling data across projects for the Adult Client Impact Analysis.[1]

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[1] Of equal importance is the assessment of the reliability and validity of the clinician-recorded data itself, as discussed in Appendix D: Assessment of the Comparability of Adult Client Data Across Projects.

The scope of the review included the main adult-oriented services provided by the projects: Individual Counseling, Individual Therapy, Group Therapy, Couples/Family Counseling, Parent Education Classes, and Parent Aide or Lay Therapist Counseling.

Methodology and Procedures

The development of the list of critical content areas which distinguish between various aspects of services entailed an extensive process of review, consultation and critical discussion. First, a review of the process analysis literature in the areas of psychotherapy, social work, and small group research was undertaken. Second, experts in the field reviewed and commented on the list and recommended additions or deletions. Finally, an in-house staff review was conducted to synthesize and formulate the final list of dimensions. The list provides a common format for analyzing the process of service provision by individual providers across all services with the use of a single questionnaire while allowing for emphasis on those content areas which were determined to be critical in describing any one type of service. The range of content areas included: aspects of scheduling (length of session), worker considerations (number, education, experience), client considerations (number of clients), focus of the service (verbal, activity-oriented), techniques (supportive, behavioral, verbal, psychoanalytic, eclectic), use of other services simultaneously (within the project or from other agencies), termination considerations (formality of criteria), rules (degree of specificity), service coordination (frequency of contact between providers), and therapeutic goals. Each of these areas was operationalized into one or more items in actually constructing the service provider questionnaire. Extensive in-house review was undertaken to refine the questionnaire. The questionnaire was pretested to determine understandability and revised where appropriate.[1]

[1]The resulting questionnaire is available on request. A slightly revised version, more suitable for use in future similar efforts, appears as Section II of this Appendix.

This questionnaire was administered to projects during the round of BPA site visiting that occurred in January and February of 1976. BPA site liaisons held briefings with project staff to explain the questionnaire. Each worker completed a separate questionnaire for each different service regularly provided, with workers who provided a service together filling out a single questionnaire jointly. Site liaisons were available to answer staff questions and individually check each questionnaire for completeness and logical consistency. At the end of the site visit all questionnaires were collected and checked to assure that all appropriate services and workers had been covered.

Questionnaires were then coded by content area items. Inasmuch as the questionnaire provided for open-ended responses, the construction of rating scales or categorical codes involved a process of content analysis, preliminary formulation of codes, review and comment, revision, pretesting the reliability of coding schemes by use of several independent raters, and final revision. The resulting code formats demonstrated good inter-rater agreement with the exception of the item related to goals, which was subsequently dropped from further inclusion in the analysis.[1] Aside from low rater reliability, the inspection of service goals revealed that they almost exclusively derived from overall project goals such that the goal item in general provided little additional information beyond that provided by the Project Goals Component. Individual questionnaires were then coded by use of the common coding instrument.

Upon completion of the preliminary coding process, the analysis proceeded by first tabulating frequency distributions for each content area within a same-named service. Each type of service was then reviewed to identify normative profiles composed of the modal scores in the content areas appropriate to that type of service. Scores that significantly differed from the modal score within each content area were identified as "deviations." Both the identification of content areas and the determination of deviations relied upon the experience of BPA site liaison observations and discussions

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[1]The coding formats are available upon request.

with individual providers. Individual providers' scores were then reviewed to determine the number of deviations for each provider. Providers with at least two deviations were identified as constituting possible cases of dissimilarity for the Adult Client Impact Analysis. Two content area deviations were considered a conservative estimate of the lower bounds for determining at what point a service was being provided in a way that departed from average practice. These providers were then individually contacted by phone to determine whether there were sufficient grounds for judging their provision of service dissimilar from others. Care was taken not to bias the information provided over the phone by simply restating the original question without intimating what other providers had answered. Following this telephone survey, the final coding process was completed; normative profiles were retabulated and significant deviations identified.

Results

The results of the analysis demonstrates that similarly named services are in general comparably provided in terms of major critical dimensions of care. With few exceptions, the pooling of data on clients across projects and the analysis by types of service units received may proceed with a fair amount of assurance that the variation of service units across projects within a given type of service is within tolerable limits. This means that within the scope of this analysis, the distribution of scores within content areas cluster around identifiable norms, with providers generally falling outside of these norms in no more than one content area. For example, while a provider of individual therapy may deviate from the norm in terms of length of therapy session, no other deviation from the norm would be found among other service dimensions for that provider. The presentations of detailed results for each service category follow. The frequency distribution of scores for the content areas are presented with a narrative explanation of the modal responses as a way to profile the most common way of delivering a particular service. Those scores which constitute a significant deviation from the norm are noted and implications for data pooling are discussed.[1]

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[1]Detailed discussion of the deviations noted in the preliminary coding process and the results of the telephone follow-up survey are available upon request.

Individual Counseling: Table E-1 presents the frequency distributions of content area scores for 42 providers of Individual Counseling at the demonstration projects. In general, individual counseling is a means for providing on-call support to clients for emergent problems. Goals are usually less formalized since the service is not usually considered a long-term venture, but rather as a precursor or as ancillary to other services such as group therapy. Overall, the pattern is for individual counseling to be provided on a one-to-one basis in a variety of locations (home office, phone) to adult clients. The service is generally provided by workers with graduate training or a graduate degree and previous clinical experience directly related to child abuse or neglect problems. Each session generally lasts one to one and one-half hours, although it should be noted that often sessions by phone will be brief, lasting as little as five minutes. The client usually receives minimal orientation or introduction for individual counseling beyond that generally provided at intake into the project. The focus of this service is strictly on verbal interaction of an individualized nature dwelling on individual problems specific to the client. The technique used may be characterized as eclectic, relying on a mix of supportive, directive, behavioral and psychoanalytic modes of counseling as appropriate to the client's needs in a given situation. Clients generally receive one or more other services at the same time from the project and from other agencies (such as AFDC or parent education classes). There is a fair degree of coordination between the provider of this service and other services the client may be receiving simultaneously, with regular contact between providers at least once per month. Usually no formal or explicit criteria for termination are established by the provider; however, implicit criteria, mutually agreed upon, generally operate. The provider and client usually establish loose and implicit rules or agreements in this service, such as when the client may call or when sessions will be scheduled.

The outcome of the analysis of deviations revealed that only one provider was significantly dissimilar from other service providers. The provider differed in four content areas. Beyond this, the review of content areas coupled with onsite observations by BPA staff indicates sufficient comparability in the provision of individual counseling to allow the pooling of data in the Adult Client Impact Analysis. The one provider that was found to be different has been excluded from the analysis.

TABLE E-1

Individual Counseling

Number of clients:

(1) 4

(2) 1

Worker education:

(1) high school 2

(2) college 10

(3) graduate 27

Worker experience:

(1) none 2

(2) unrelated experience 7

(3) direct experience 33

Orientation:

(1) none 28

(2) sometimes 11

(3) always 3

Focus:

(1) individualized verbal 42

(2) other verbal 0

(3) individualized activity 0

(4) other activity 0

(5) other 0

Technique:

(1) supportive 9

(2) behavioral 0

(3) educational 0

(4) psychoanalytic 1

(5) eclectic 34

(6) other 0

Use of other services:

external: (1) none 3

(2) some 16

(3) many 23

internal: (1) none 1

(2) some 10

(3) many 31

Criteria for termination:

(1) none 1

(2) informal 35

(3) formal 4

Specificity of rules:

(1) none 4

(2) informal 27

(3) formal 10

Service coordination:

(1) none 3

(2) irregular 10

(3) regular 29

NOTE: Underlined scores indicate significant deviation from norm.

Individual Therapy: In contrast to Individual Counseling, Individual Therapy is usually considered to be a more intensive and structured therapeutic experience with regular, goal-oriented provider contact. Table E-2 presents the frequency distribution of scores for the content areas within individual therapy. The distribution of scores for the eleven providers of this service indicates a pattern similar to that of individual counseling. Again, one-to-one contact between provider and client, usually of an hour's duration, is the norm, although sessions take place more often in the project's office. Workers almost all have advanced graduate degrees and directly relevant clinican experience. Little orientation beyond intake is given specifically to this service, whose focus is always on individualized verbal interaction. Techniques used are characterized as eclectic with usually more formalized agreements, rules, and even contract-oriented therapy occurring. Criteria for termination is generally loose and implicit, based upon mutually agreed-upon therapeutic goals. Clients are usually simultaneously involved in one or more services, both within and outside of the project, and there is extensive coordination between providers of this service and other services the client may be receiving.

Comparing the profiles for individual counseling and individual therapy, one observes a significant degree of concurrence across content area scores. While certain features distinguish the services, the central difference between these services to client characteristics, such as motivation to engage in therapy. Although this information is not specifically tabulated here, many of the comments made by providers in the questionnaire and observations by BPA site liaisons substantiate this. Given the fact that the Adult Client Impact Analysis takes client characteristics and problems into account, it is not inconsistent with this analysis of comparability to combine individual counseling and individual therapy together as one service for the analytic questions the Adult Client Impact Analysis addresses.

The analysis of deviations indicated that no provider differed in more than one content area. Thus, the variance in the provision of individual therapy across projects is within acceptable bounds. This allows the Adult Client Impact Analysis to proceed in a straightforward manner with respect to the pooling of client data.

TABLE E-2

Individual Therapy

Number of clients:

(1) 11

Worker education:

(1) high school 0
(2) college 1
(3) graduate 10

Worker experience:

(1) none 0
(2) unrelated experience 2
(3) direct experience 9

Length of session in hours:

(1) 10
(1½) 1

Orientation:

(1) none 7
(2) sometimes 3
(3) always 1

Focus:

(1) individualized verbal 11
(2) other verbal 0
(3) individualized activity 0
(4) other activity 0
(5) other 0

Technique:

(1) supportive 1
(2) behavioral 0
(3) educational 0
(4) psychoanalytic 0
(5) eclectic 10
(6) other 0

Use of services:

external: (1) none 0
(2) some 6
(3) many 5

internal: (1) none 0
(2) some 3
(3) many 8

Criteria for termination

(1) none 0
(2) informal 10
(3) formal 1

Specificity of rules:

(1) none 1
(2) informal 7
(3) formal 3

Service coordination:

(1) none 1
(2) irregular 1
(3) regular 9

NOTE: Underlined scores indicate significant deviation from norm.

Group Therapy: Table E-3 shows the frequency distribution of content area scores for eleven cases of group therapy. Group Therapy is generally a more time limited, socialization-oriented experience which has as its focus the verbalization of individualized problems as opposed to generic or group level problems. The clients work on their own problems using the forum of the group to share problems and reduce feelings of isolation. In general, group therapy involves two providers working with at least four or more clients for a series of two hour sessions. Providers typically have advanced graduate degrees and directly relevant clinical experience. There usually is more of a specific orientation or introduction to this service, in contrast to Individual Counseling or Therapy, although the technique employed by providers can once again be characterized as eclectic. Usually, there is greater specificity and formalization of rules or agreements made with clients pertaining to behavior in the group. Loose and informal criteria govern the process of termination from the group. As reported, there is a high degree of coordination between providers of this service and providers of other services the clients may be receiving.

The provision of group therapy does not vary within or between projects sufficiently to prohibit the pooling of client data. The analysis of deviations indicates that no provider deviates from the norm in more than one content area.

TABLE E-3

Group Therapy

Number of clients:

(1) 0
(2) 1
(3) 1
(4) 4
(5) 5

Worker education:

(1) high school	0
(2) college	1
(3) graduate	10

Worker experience:

(1) none	0
(2) unrelated experience	1
(3) direct experience	10

Length of session in hours:

(1) 1
(1½) 4
(2) 5
(2½) 1

Orientation:

(1) none	2
(2) sometimes	2
(3) always	7

Focus:

(1) individualized verbal	11
(2) other verbal	0
(3) individualized activity	0
(4) other activity	0
(5) other	0

Technique:

(1) supportive	0
(2) behavioral	0
(3) educational	0
(4) psychoanalytic	1
(5) eclectic	10
(6) other	0

Criteria for termination

(1) none	2
(2) informal	8
(3) formal	1

Specificity of rules:

(1) none	1
(2) informal	3
(3) formal	7

Service coordination:

(1) none	0
(2) irregular	3
(3) regular	8

NOTE: Underlined scores indicate significant deviation from norm.

Couples/Family Counseling: The provision of counseling to couples and families has been combined in this analysis because many providers did not distinguish between these two services in completing the questionnaire. Thus, as Table E-4 shows, the number of clients served, while generally clustering around two, may range up to five. Likewise, the number of workers providing the service may be either one or two. Education and experience of workers is generally at an advanced level. The length of a session is typically between one and two hours, with the focus of interaction exclusively on individualized verbal activity. There is usually a regular orientation to this service in which workers typically utilize eclectic techniques geared to the clients' needs. Clients typically use other services while in Couples or Family Counseling. Service coordination is reported to involve more than a once a month contact between service providers the client may be seeing. Rules, agreements and even explicit contracts are established in this service, with criteria for termination usually related to the achievement of counseling goals.

The analysis of provider deviations from the norm indicates no situation where more than one deviation in a content area exists. Thus, service comparability is sufficient to allow pooling of data for clients receiving Couples/Family Counseling.

TABLE E-4

Couples/Family Counseling

Number of clients:

(1) 0
(2) 14
(3) 3
(4) 2
(5) 1

Worker education:

(1) high school 0
(2) college 2
(3) graduate 18

Worker experience:

(1) none 0
(2) unrelated experience 1
(3) direct experience 19

Number of workers:

(1) 14
(2) 6

Length of session in hours:

(1) 14
(1½) 5
(2) 1

Orientation:

(1) none 2
(2) sometimes 0
(3) always 18

Service Coordination:

(1) none 0
(2) irregular 3
(3) regular 17

Focus:

(1) individualized verbal 20
(2) other verbal 0
(3) individualized activity 0
(4) other activity 0
(5) other 0

Technique:

(1) supportive 0
(2) behavioral 0
(3) educational 0
(4) psychoanalytic 1
(5) eclectic 19
(6) other 0

Use of other services:

external: (1) none 5
(2) some 10
(3) many 5

internal: (1) none 0
(2) some 4
(3) many 16

Criteria for termination:

(1) none 1
(2) informal 15
(3) formal 4

Specificity of rules:

(1) none 0
(2) informal 11
(3) formal 9

NOTE: Underlined scores indicate significant deviation from norm.

Parent Aide or Lay Therapist Counseling: The use of Parent Aides or Lay Therapists is an auxiliary means of providing loosely structured support to isolated clients. Often the Parent Aide takes the role of a friend or companion, sometimes acting as a role model for the client. Parent Aides are not expected to provide a rigorous systematic schedule of psychotherapy, because of the limited training or experience they are required to have. The Parent Aide-Client relationship involves a voluntary one-to-one interaction, with the Parent Aide employing supportive techniques exclusively. As Table E-5 shows, clients receive many other services in the project while involved in a Parent Aide relationship, with the activities of the Parent Aide being well coordinated with those of other providers. Parent Aides are generally supervised by a professional staff member as well. Rules or agreements between the client and the Parent Aide are typically loose and informal, as are the criteria for termination. Most Parent Aides have little or no clinical experience and/or education beyond high school.

The analysis of deviations from this normative profile reveal five Parent Aides who had more education or experience than the norm. Given that the nature of the tasks that they perform with respect to their clients do not differ from the norm, it does not seem necessary to separate the data on clients receiving service from these Parent Aides from that data for the rest of the providers of Parent Aide or Lay Therapist Counseling.

TABLE E-5

Parent Aide/Lay Therapist Counseling

Number of clients:

(1) 15

Worker education:

(1) high school 10
(2) college 3
(3) graduate 2

Worker experience:

(1) none 7
(2) unrelated experience 6
(3) direct experience 2

Number of workers:

(1) 15

Focus:

(1) individualized verbal 15
(2) other verbal 0
(3) individualized activity 0
(4) other activity 0
(5) other 0

Technique:

(1) supportive 13
(2) behavioral 0
(3) educational 0
(4) psychoanalytic 0
(5) eclectic 2
(6) other 0

Use of services:

internal: (1) none 0
(2) some 10
(3) many 5

Criteria for termination:

(1) none 2
(2) informal 8
(3) formal 0

Specificity of rules:

(1) none 3
(2) informal 12
(3) formal 0

Service coordination:

(1) none 0
(2) irregular 3
(3) regular 12

NOTE: Underlined scores indicate significant deviation from norm.

Parent Education Classes: In the initial tabulation of data on Parent Education Classes, it became that the St. Louis and, in part, the Tacoma pro jects conceive of this service in terms of a significantly different model than other projects. In this model, usually one worker will make a visit to a client to provide in-home parent education, rather than providing parent education in group sessions. Given the differences, our tabulation has excluded those cases from the St. Louis and Tacoma projects; their scores would significantly skew the distribution of scores across all projects for this service. For the Adult Client Impact Analysis we will not pool data on education from St. Louis and the one case in Tacoma with data from the other demonstration projects.

Table E-6 shows the tabulation of content area scores in five instances of parent education for the rest of the projects. In general, sessions of between 1-1/2 to 2 hours are held with groups of greater than five clients, and one or two workers. Workers, usually with advanced education and clinical experience, employ a range of techniques in addition to educational methods; they focus on issues generic to the range of problems experienced by clients in the group. Contracts for achieving certain goal-oriented expectations are often made with explicit criteria established that attempt to relate such contracts with service termination. Usually, regular contact occurs between providers of this service and any other service providers clients may be seeing.

The analysis of deviations for the five cases of parent education classes indicate substantial comparability and thus the data for these cases may be pooled.

TABLE E-6

Parent Education Classes*

Number of clients:

(1) 0
(2) 0
(3) 1
(4) 0
(5) 4

Worker education:

(1) high school 1
(2) college 0
(3) graduate 4

Worker experience:

(1) none 0
(2) unrelated experience 1
(3) direct experience 4

Number of workers:

(1) 1
(2) 4

Length of session in hours:

(1½) 1
(2) 4

Focus:

(1) individualized verbal 0
(2) other verbal 5
(3) individualized activity 0
(4) other activity 0
(5) other 0

Technique:

(1) supportive 0
(2) behavioral 0
(3) educational 1
(4) psychoanalytic 0
(5) eclectic 4
(6) other 0

Criteria for termination:

(1) none 0
(2) informal 1
(3) formal 4

Specificity of rules:

(1) none 0
(2) informal 1
(3) formal 4

Service coordination:

(1) none 0
(2) irregular 3
(3) regular 2

*Excludes St. Louis and one provider in Tacoma.

NOTE: Underlined scores indicate significant deviation from norm.

Conclusion

In general, the analysis has demonstrated that if Individual Counseling and Individual Therapy are merged and if one accepts a minor degree of variation in individual provider practice, most similarly named services are provided in a comparable manner. The degree of comparability must be recognized as a relative judgment. This means that there may not be an identifiable, absolute standard by which one can judge whether a particular form of providing a service is significantly different from other ways of delivering that service. The judgment must be reached by establishing some level of deviation from average practice. In this regard, the methods employed in this analysis of service comparability provide a reasonable means for making such judgments and thereby serve a useful purpose in understanding the extent to which the pooling of client data across projects will yield valid results.

Section II: Provider Questionnaire (revised)

Project _____ Date _____

Worker's name(s) _____ Worker's title(s) _____

_____ _____

1. What BPA service activity category do you use for reporting on this service on the BPA Services Form:

_____ individual counseling	_____ homemaking
_____ individual therapy	_____ recreational therapy
_____ parent aide/lay counseling	_____ other advocacy/supportive services
_____ couples/family counseling	_____ day care
_____ group therapy	_____ residential care for children
_____ parent education classes	_____ child development program
_____ special child therapy	_____ play therapy
_____ crisis nursery	_____ other _____

2. What is your project's name for this service? _____

CIRCLE THE RESPONSE WHICH IS MOST APPROPRIATE:

3. The usual number of clients involved in one session of this service is:

1 2 3 4 5 6 7 more than 7

4. The usual number of workers present is one session of this service is:

1 2 3 more than 4

5. One session of this service usually lasts about:

½ hr. 1 hr. 1½ hrs. 2 hrs. 2½ hrs. more than 2½ hrs.

6. This service involves regularly scheduled sessions:

1	2	3	4	5
always		sometimes		never

7. My educational background is: (check highest)

_____ high school degree

_____ some college

_____ undergraduate degree (specify) _____

_____ graduate training; degree? _____ specify _____

_____ workshops, seminars, etc.

8. I have the following clinical experience: (check all that apply)

_____ experience gained in present position (_____ months)

_____ prior experience <u>indirectly</u> related to present position (_____ yrs)

_____ prior experience <u>directly</u> related to present position (_____ yrs)

9. Introducing a client to this service usually involves:

_____ a formal presentation

_____ an informal orientation

_____ little or no discussion beyond intake into the project

_____ other (describe) _____

10. During a session of this service I tend to focus on: (answer each)

	1	2	3	4	5
a) discussing clients' individual problems with interpersonal relationships	always		sometimes		never
b) discussing clients' individual problems with obtaining resources	always		sometimes		never
c) discussing clients' feelings about him/herself	always		sometimes		never
d) activities or discussion related to the client performing a task (e.g., homemaking)	always		sometimes		never
e) activities or discussion centered on a client sharing problems with others	always		sometimes		never
f) specific behavior the client has problems with	always		sometimes		never
g) clients' attitudes or perceptions of their problems	always		sometimes		never
h) other problems: (describe) _____ _____	always		sometimes		never

11. When working with most clients in this service, I:

	1	2	3	4	5
a) talk openly about myself and my problems					
b) talk freely about my personal feelings					
c) see the client's family or spouse					
d) discuss with the client therapeutic plans and goals					
e) specify the length of our contacts					
f) use educational methods (e.g., reading assignments					
g) give negative reinforcement (e.g., scholding, shock)					
h) let the client do the talking					
i) relabel or reword the clients' problems					
j) use behavioral modification					

11. (continued)

k) role play with the client	1	2	3	4	5
l) use relaxation techniques	1	2	3	4	5
m) directly confront clients with their problems	1	2	3	4	5
n) prefer to conduct intensive rather than goal limited therapy	1	2	3	4	5
o) interpret the clients' thoughts and feelings	1	2	3	4	5
p) give clients my personal opinion about their problems	1	2	3	4	5
q) am sparing and concise in my verbal interventions	1	2	3	4	5
r) consider it most important to have a warm, giving attitude toward the client	1	2	3	4	5
s) vary my techniques from client to client	1	2	3	4	5
t) follow a plan of treatment	1	2	3	4	5
u) use problem solving techniques	1	2	3	4	5
v) interrupt a client while he/she is talking	1	2	3	4	5
w) establish formal rules in conducting a session	1	2	3	4	5
x) use visual aids, toys and other equipment	1	2	3	4	5
y) do whatever the client wants to do	1	2	3	4	5

12. While involved in this service, clients typically receive (0 1 2 3 more than 3) other services simultaneously from other workers <u>in</u> the project.

13. While involved in this service, clients typically receive (0 1 2 3 more than 3) other services simultaneously from workers <u>outside</u> the project.

14. I usually have contact with other providers the client is seeing:

_____ once a week

_____ twice a month

_____ once a month

_____ less than once a month

15. The decision for the client terminating this service involves:

_____ court decision

_____ formal criteria

_____ informal criteria

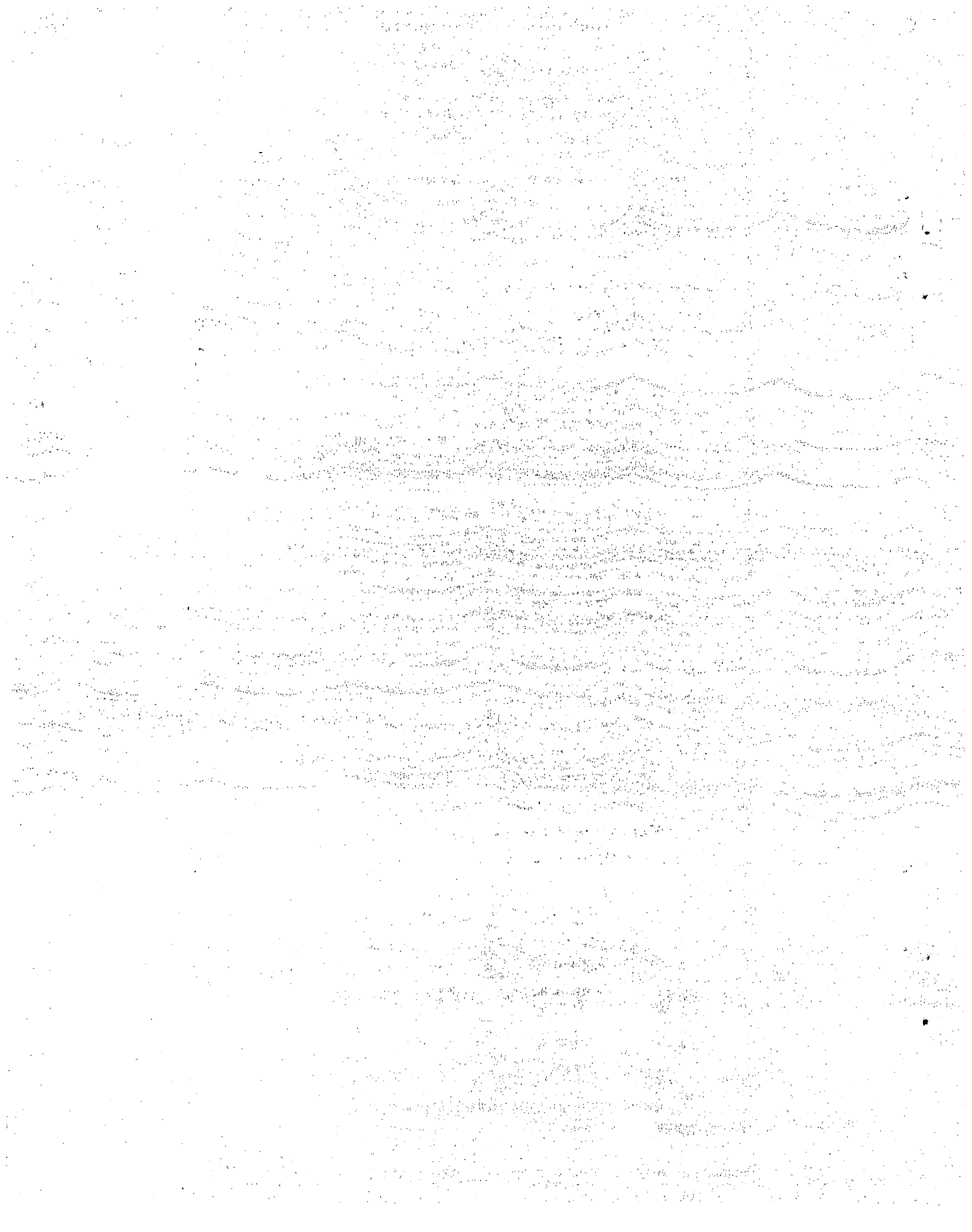
_____ no prior agreements

16. This service could be provided separate from other services the project offers:

1	2	3	4	5
always		sometimes		never

APPENDIX F

Descriptions of Individual Project Caseloads



Individual Project Caseload Descriptions

The Family Center, Adams County, Colorado

The characteristics of the cases described in this section are from data on all the substantiated reports that came through the project's intake process and were opened as ongoing cases either at the project or at protective services. The highest percentage (21%) of the reports were from various schools. Hospitals, agencies other than social service agencies, and social service agencies were also conspicuous public or institutional referral sources (15%, 14%, and 12%, respectively). Acquaintances or neighbors referred 11% of all cases, and self-referrals made up another 11% of the incoming reports.

The project's mandate was to respond to and treat child abuse cases rather than child neglect. Therefore, only 4% of the project's intakes involved actual physical neglect. Whereas 37% of the intakes were physical abuse cases, a full 46% were potential abuse. Less than one-fifth of the cases opened (18%) involved assault (that is, either severe or moderate abuse and neglect or sexual abuse).

For 47% of the project's intakes the mother was responsible for the maltreatment, in contrast to the father being responsible 31% of the time, or both mother and father being responsible in 16% of the cases. No legal action was taken in 40% of the cases opened, but in 11% of the cases a court hearing was held. Foster care was decided upon in 6% of the cases, whereas in only 2% of the cases was the child under court supervision in the home. Criminal charges were pressed in 3% of the cases. Over three-quarters of the cases (77%) had no record of previous abuse or neglect before being reported.

The following household characteristics were represented. In 24% of the cases only one adult was present. Additionally, the project's intakes had an average of 2.3 children in the family, with 12% of the families having four or more children. Families with no minorities present made up 75% of the cases. Neither parent had a high school degree in 48% of the families, and in 23% of the families, no one in the household was employed. Whereas 42% of the families made only $5500 or less per year, only 15% were

receiving public assistance. The average age of the mother of the household was 27 years and the father was on average 31 years. In 36% of the families at least one parent was a teenager.

Among the project's intakes, marital problems were the most often occurring factor leading to child maltreatment, with this an issue in 44% of the cases. Financial problems and a parent having been abused as a child were also critical presenting problems, each showing up in 41% of the cases. Social isolation and heavy, continuous child care responsibilities were seen to be critical problems in about one-third of thd cases (35% and 32%, respectively), and mental health problems were a contributing factor in 29% of the cases.

It is of interest to note that over the course of the project's history some 110 reports were received which did not complete the intake process and were not opened as cases. Sixty-one percent of these complaints were found to be unconfirmed reports and 22% were discovered to have been already open in another relevant agency. For 9% of these reports not subsequently opened as cases, it was not possible to locate the family in question, and 7% of the complaints were outside the project's guidelines.

Pro-Child, Arlington, Virginia

For the Pro-Child project, the largest single source of referrals (22%) is school personnel including teachers, principals and guidance counselors. Acquaintances/neighbors and the Department of Human Resources (of which Pro-Child is a part) referred 17% and 13% of all clients, respectively. Parents, court personnel and self-referrals each accounted for 7% of all other reports. The remainder of the cases were primarily reported from relatives, law enforcement agencies, hospitals, physicians and other agencies. Seventy-one percent of those cases reported had no previous record or evidence of abuse or neglect.

Physical neglect accounted for 31% of all cases, while physical or sexual abuse accounted for 16% of the cases. In contrast, 21% of the cases were ones of emotional maltreatment, while 30% were potential or high risk cases only. The remaining 4% of the reports were cases of combined physical

abuse and neglect. Almost one-quarter (24%) of all categories of cases were severe or moderate cases of abuse or neglect, or were cases of sexual abuse. Seven percent of the cases required a court hearing for a legal disposition to be made. This breakdown both between the types of cases accepted (e.g., abuse or neglect, emotional or physical, actual or potential) and the severity of those cases, is indicative of the project's overall approach to case acceptance. In general, all cases of child abuse/neglect, whether actual or potential, and irrespective of severity, are accepted for at least minimal service provision by the staff. Because resources for these families are scarce in Arlington, there is definitely a philosophy among the staff that if the project does not extend services to referred clients, they will receive no help from other sources. This philosophy is also reflected in the reasons for not accepting certain cases. Of the 238 cases referred to Pro-Child but not provided services, 114 (48%) were unsubstantiated cases, 77 (32%) were cases which could not be located or the clients refused services, and 44 (19%) were cases that were already open in another agency or were referred to another, more appropriate, agency. Only 11 (5%) of the cases were not opened because staff believed the case inappropriate for Pro-Child.

In 54% of the cases mothers were responsible for the maltreatment of the child; in 20% of the cases fathers were so responsible; and in 23% of the cases both parents were involved.

Family composition and socioeconomic characteristics of the Pro-Child cases reflect the general Arlington population. These families, 32% of which were single-parent households, had an average of two children, but almost half (45%) were single-child families. Pre-school children were present in 57% of the households. Half of the families were comprised of adults without a high school degree, although in only 17% of the households were none of the adults employed; all of these families were on public assistance. The average family income was $10,000, reflective of the middle nature of Arlington, but 46% of the families had incomes below $5501 per year. Even though the average age of the mothers was 32 years and that of fathers was 36 years, fully 55% of the families had adolescent parents.

The primary problems of the families, which may have led to, and certainly were at least a factor in the maltreatment of the child, included marital difficulties, financial worries, mental health problems, and social isolation.

Child Abuse and Neglect Unit, Bayamon, Puerto Rico

In Puerto Rico, the project caseload is fairly evenly divided into potential cases (25%), emotional abuse or neglect cases (22%), physical abuse cases (20%), and physical neglect cases (28%). Of these cases, almost all of whom were referred by the social service host agency, somewhat under half (42%) were those in which serious maltreatment occurred, and close to two-thirds of the cases (63%) had a previous record or evidence of maltreatment. Despite the seeming severity of the cases, only 1% had a court hearing; in only 3% were the children removed from the home. The families were relatively large, with an average of 3.3 children; most families had preschool children (83%) and two adults in the household (77%). The families, which were a mixture of native Puerto Ricans and a few other ethnic groups, were not highly educated (63%) had no high school degree), and they were poor (73% had $5500 or less as an annual income). However, these were older parents (fathers' average age was 39 and mothers' was 31) and typically employed (in only 35% of the families was no on employed). The most frequently cited problems in the households in addition to financial ones include: marital problems manifested in arguments and fighting, alcoholism, poor health, and heavy, continuous child care responsibilities. In general, these were difficult cases, multi-problem cases, even though 25% were identified as high risk or potential rather than actual. These cases, close to handpicked by the staff, are the very kinds of cases the project chose to serve.

Child Protection Center, Baton Rouge, Louisiana

The description that follows of the project's caseload is based on data from cases that were both substantiated and accepted for ongoing services. This means that the picture presented here does not include those cases that, after investigation, were found to be unsubstantiated, those for which intake was not completed, and those that were open a month or less.

The largest source of reports to the project by far were from schools (27%). Law enforcement agencies, hospitals, and relatives were the next

most common reporting sources; 18%, 17% and 16%, respectively. Only 2% of the cases were self-referrals.

Almost half (49%) of the Child Protection Center cases involved physical abuse alone, with another 14% sexual abuse cases. Comparatively, the relatively small percentage of physical neglect, emotional maltreatment and potential abuse or neglect reflect the project's evolving acceptance criteria, from taking all abuse and neglect cases initially to limiting their intakes to physical or sexual abuse only. In looking at the project cases in another way, 27% included assault (that is, severe or moderate abuse and/or neglect, including sexual abuse).

The mother or mother substitute was responsible for the maltreatment 50% of the time, with the father responsible 35% of the time, and both father and mother liable in 13% of the cases. No legal action was taken in 25% of the cases; however, formal court hearings were held 10% of the time and the court interceded in other ways, often in informal meetings in the judges' chambers (in-home supervision in 15% of the cases, temporary removal in 15% of the cases, and foster care in 6% of the cases). Criminal action was initiated 4% of the time.

For 28% of the project's cases only one adult was in the household, but in 19% of the cases there were three or more adults living in the same household. The average client family had 2.6 children and 66% of the families had preschool children (six years or younger). The project families had a low level of education; 73% did not have even high school degrees represented. In 59% of the cases there were no ethnic minorities in the families, while in 31% of the cases there were no employed adults in the household. Whereas 57% of the families had incomes under $5500 per year, only 28% of the families were on public assistance. The average age of the mothers in caseload families was 30 years and the fathers 33 years. In 45% of the cases there was at least one teenage parent.

The most prevalent problems in the household leading to maltreatment of the children were financial, marital, and continuous child care responsibilities. Job related and mental health problems also appeared relatively important as contributors to maltreatment.

SCAN, Arkansas

For the client analysis, the cases from Jefferson County and Washington County were pooled, for a total sample of 180 clients from the Arkansas project. Cases were referred to these projects from a variety of sources, most notably the medical community (25%). Cumulatively, other agencies in the community, with the exception of the courts and law enforcement, supplied the bulk of the referrals; however, acquaintances and neighbors as a single referral source provided a significant proportion (17%) of the cases. In 70% of the cases, the SCAN unit reported the case to the mandated agency, i.e., the Division of Social Services. Nearly two-thirds of the cases had record evidence of previous maltreatment.

In half the cases, physical abuse was identified as the presenting problem, with an additional 8% being cases of combined physical abuse and neglect. About 11% of the cases were physical neglect and a similar proportion were emotional maltreatment cases. Fifteen percent of the cases revealed potential only, for abuse or neglect, and a very small proportion were cases of sexual abuse. In over 40% of the cases, the assault was judged to be serious. And in nearly three-quarters of the cases the mother was involved in the maltreatment; she was solely responsible in over half.

The majority of the cases were white, two-adult, uneducated, unemployed, low-income ($5400) households with two children mostly pre-schoolers. While half of the families had teenage parents, the average age of mothers was 25 years; of fathers, 29 years. The largest problem cited in the household as leading to maltreatment was financial (57%), followed by marital (40%), heavy continuous child care (59%), and social isolation (38%).

The problems which typify the project's clients closely reflect those identified as the target population in their goals. It is interesting to look at the disposition, however, of those cases referred to the project but not accepted for treatment. Of the estimated 130 reports received during 1975 and 1976 in Washington County alone and not accepted, over 80% of them were neglect reports and consequently, outside the project's guidelines in most instances (88 of the 130 referrals). Only one case was referred to a more appropriate agency, other than the Division of Social Services to which

the neglect cases were referred. A significant number (24) of the referrals were unconfirmed and occasionally the family could not be located (12 case) or the case was already open in another agency (11 cases). Only two clients refused services.

The Family Resource Center, St. Louis, Missouri

Most of the clients served by the Family Resource Center were referred either by the client him/herself or from a public, social service agency. Sixty percent of the cases were identified as physical abuse; the project also served some number of potential cases (13%) and emotional abuse or neglect cases (17%). Somewhat over one-third of the cases served were those in which a child had been seriously maltreated; in 21% of the cases the child was placed in foster care.

Close to 100% of the families were those with preschool children, and in about half of the families at least one of the adults was a teenage parent. The clients served represented a broad spectrum of families in the St. Louis metropolitan area, with close to half having one or more minorities in the household. Unemployment rates were high for these families -- 44% of the families had no one employed and 73% had an annual income of $5500 or less. In approximately 40% of the families neither adult (and two-thirds of the families had two adults in the home) had a high school degree.

Notable problems of these families included heavy continuous child care responsibilities (56%), social isolation (50%), financial problems (49%) and marital problems (44%).

PACER, St. Petersburg, Florida

In St. Petersburg, cases were referred to the project primarily from three sources: social agencies, self-referral, and the protective services agency. About one-quarter of the cases were potential abuse and neglect, slightly over one-quarter were emotional maltreatment, and slightly more than one-quarter were physical abuse. In a majority of the cases serious

abuse or neglect had occurred, but in one-third of these cases no court hearings were held, and only one-fifth had any court intervention. In a majority of the cases, both the fathers and mothers were abusers of the children; only in one-quarter of the cases was the mother the only known abuser. Most of the cases had had no previous record or evidence of abuse or neglect.

There was an average of 3.4 children per household; over one-third of the families had four or more children in the family. In two-thirds of the cases there were preschoolers, accounting for the nearly 15 families that reported heavy, continuous child care as a serious family problem.

Only a small number of families had only one parent present in the home. The average mother was 32 years of age and the average age of fathers was 33 years. Over one-third of the families were teenage parents. About four-fifths of the parents reported being abused as children.

There were no minority families served in this project's caseload. In nearly one-quarter of the cases there were problems of unemployment. The average yearly salary was $6600, but most of the families lived on $5501 or less. None of the families were on public assistance.

The major presenting problems of the St. Petersburg cases were: marital problems (13), job related (6), alcoholism (5), physical health (8), mental health (8), financial problems (13), heavy continuous child care (15), and, finally, social isolation (12).

Of the 57 families who were referred to PACER but rejected for services, 12 did not comply with project guidelines, eight were unconfirmed reports, five could not be located, two were cases already opened with another agency, and in two cases the families refused services. Twenty-eight of these 57 clients rejected for services were referred to more appropriate agencies.

Panel for Family Living, Tacoma, Washington

In Tacoma, cases were referred to the project from a variety of sources, most notably the medical community and self-referrals. Fewer than one-quarter of the cases had a previous record or evidence of abuse or neglect. The greatest proportion of cases were physical abuse; it is interesting to note that in 38% of the cases parents were said to be abused as children.

Close to one-third of the cases could be categorized as those in which serious maltreatment occurred; appropriately, the same proportion of cases were heard by the courts. These are quite reflective of the project's intake criteria. Mothers were most frequently identified as responsible for the maltreatment, although only 34% of the cases had only one adult (typically the mother) in the household. Two-thirds of the families had preschool age children, reflected in the most frequently cited problem in the household leading to the maltreatment -- heavy, continuous child care responsibilities -- and the fact that one-third of these families had a new baby. Large proportions of these cases had little education (in 70% of the families no one had a high school degree), and low incomes (69% had an annual income of under $5500), although in over half of the families at least one adult was employed. This may in part be explained by the relatively young ages of the parents (60% of the families had at least one teenage parent). In terms of racial/ethnic characteristics, the families were reflective of the county in general -- in 80% of the families there were no minorities. In addition to the above cited problems, 40% of the families experienced marital difficulties, and 36% a recent location.

Union County Protective Services Demonstration, New Jersey

In New Jersey, cases were referred to the project from a variety of sources, most notably hospitals (19%), social service agencies (17%), schools (15%), law enforcement (11%), and other agencies (14%). Private physician referrals accounted for only 1% of project intakes. Thirty-two percent of these referrals had a previous record or evidence of maltreatment. The characteristics of these referrals seem to conform to the project's criteria of serving all physical abuse referrals and extending services to potential abuse/neglect cases when possible. The greatest proportion of the project's caseload was physical abuse (27%) and neglect (28%). About 23% were potential abuse or neglect. Thirty-three percent of the cases were categorized as cases in which serious maltreatment had occurred, but only 5% of the project's cases received court hearings. This seems consistent with the project's goal of working with the families

and reducing court intervention to extreme cases.

In 52% of the cases the mother was the reported abuser; in 22% of the cases both mother and father were thought to be abusers. Only 9% of the abusers reported being abused as children.

In 37% of the cases there is only one adult in the family. The average number of children per family was 2.7, but in nearly 30% of the cases there were four or more children. About two-thirds of the families had preschoolers in the home. Interestingly, only 27% or less than one-third of the families reported heavy, continuous child care as a problem.

Inadequate education and low income were both consistent project caseload characteristics. In almost 75% of the families, neither the mother nor father had a high school degree. The average yearly income was $7500, but 67% of the families had an average income of $5501 or less. In 38% of the cases no one in the household was employed and the family received public assistance.

In addition to the above economic and employment problems, 33% of the families experienced marital difficulties, 29% had mental health problems, 24% experienced social isolation, 15% had physical health problems, 15% experienced alcoholism, and 12% of the families had overcrowded housing.

Most of the cases referred to the project received services. Of those 10 cases rejected for services, five were outside the project guidelines, five were unconfirmed reports, and three could not be located. Only two of these cases were referred to other social agencies.

APPENDIX G

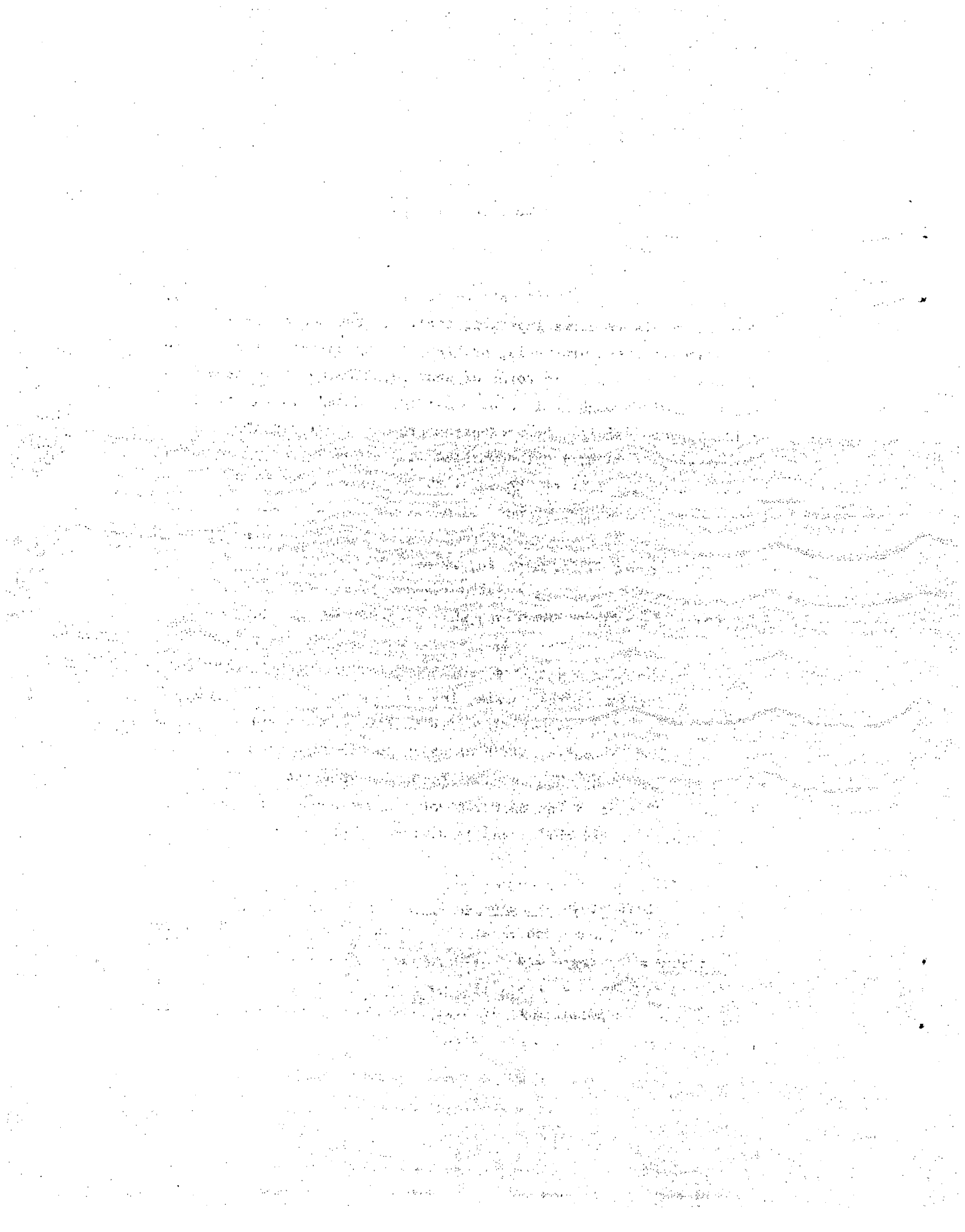
Selection of Intake, Service and Impact Measures

A. Development of a Definition of Problem at Intake

B. Selecting Salient Intake Measures

C. Selecting Salient Service Measures

D. Selecting Salient Impact Measures



A. Development of a Definition of Problem at Intake

Some theories about treatment effectiveness suggest that appropriateness of services provided should be determined by the presenting problem. In medical care, examples are plentiful: appendicitis requires an operation; a bad cold requires modest outpatient care; severe pneumonia requires inpatient care. In the social services area the linkages between presenting problem and appropriate services are much less clear -- both in terms of what services ought to be provided and what services ought not to be provided. Indeed, in the social services, even defining the presenting problem is difficult. Does one look at a particular act committed (e.g., the child was physically abused)? Does one look at the severity of the act committed (e.g., the child was severely injured); or does one look at some constellation of family attributes to define the situation rather than the act (e.g., this is a multi-problem family with a history of physical abuse)?

In our study we were interested in determining relationships between the presenting problems and the effectiveness of alternative services (and thus service planning) could be determined by the presenting problem. In order to do so, we needed first to identify a workable definition of the "presenting problem." Because of existing debates in the field, rather than rely on any singular definition, we decided to develop several, each of which reflected one of the current prevailing schools of thought, and including: problem at intake defined by the nature of the maltreatment; as defined by the severity of the assault on the child; and as defined by the severity of the family situation.

(1) Problem at Intake Defined by Nature of Maltreatment

First we defined "problem at intake" in terms of the generic form of maltreatment of the child. Although a large proportion of the families in our data set committed more than one generic form of maltreatment, it was possible to identify the primary form and categorize families accordingly. The categories include:

Potential abuse and/or neglect	26% of the families
Emotional abuse and/or neglect	14%
Sexual abuse (alone or combined with any other forms)	4%
Physical abuse (alone or combined with any other forms of maltreatment except physical neglect or sexual abuse)	33%
Physical neglect (alone or combined with any other forms of maltreatment except physical or sexual abuse)	19%
Physical abuse and neglect (both occurred as well as any other form of maltreatment except sexual abuse)	4%

As might be predicted, as shown on Table G-1, potential abuse and/or neglect only-families deviate significantly from the entire data set in only two areas: they are less likely to have minority members and they are more likely to have a lower income. Families with emotional abusers and neglectors only, on the other hand, are more likely to have a higher income, to have problems with alcohol, and to have conflict within the household including fighting and marital problems. Families in which there was sexual abuse, a very small percent of the total data set, appear more likely than others to have two adults in the household, to be older parents, to be Caucasian, to be employed and have higher incomes, and to have marital problems. This is very much in keeping with the picture of sexual abusers derived from other studies. Families in which one finds physical abuse and physical neglect, as we had expected, differ from each other (and the overall data set) in a number of ways. The physical abuse family is less likely to have a previous record or evidence of maltreatment, and less likely to have only one adult in the household -- a younger parent, who has not achieved a high school degree, who is unemployed and who has a low income -- than the physical neglector. Minority representation in these two groups is about the same, although substance abuse (alcohol and drugs) is greater among the neglectors, and fighting, marital problems, spouse abuse and a history of abuse as a child is greater among abusers.

(2) Problem at Intake Defined by Severity of Assault on Child

As a second cut at defining "problem at intake" we categorized families on the basis of the severity of the assault on the child, including in the category of serious assault on the child all forms of severe or moderate physical abuse and neglect, and sexual abuse. Families were categorized as follows:

Serious assault	29.5% of the families
No serious assault	70.5%

The ratio of serious assault families to non-serious assault families is about what we expected to see represented in the cases served by the demonstrations, giving us confidence in the differentiation between the two categories. Families categorized as serious assault cases, as shown in Table G-1, are more likely to be: families with a previous record or evidence of abuse or neglect, families with less education, less employment, lower income and minority status, as well as families with alcohol or drug problems and internal family conflict including spouse abuse.

(3) Problem at Intake Defined by Severity of Situation

As a final definition of "problem at intake" we identified a constellation of factors which describe the family situation in general, including: presence or absence of previous record or evidence of abuse or neglect; whether or not the maltreatment bringing the case to the treatment program constituted a serious assault; whether or not that maltreatment had actually been established or was merely suspected; and whether or not six or more identifiable problems (such as heavy, continous child care responsibilities or a new baby) existed in the household and were identified as contributing toward the maltreatment. A five-point scale resulted, corresponding to the presence or absence of each of the above situations. Families were distributed as follows:

Number situations present		Percent of families
0		35%
1		30%
2		23%
3		9%
4	(most severe)	3% (12%)

This index differentiates the most serious cases more finely than the previous one, with 12% of the families here being defined as severe. The relationships between this index and a series of demographic characteristics, shown on Table G-1, are quite strong, revealing the following: the more severe the problem at intake, the more likely the family is to have two adults in the household, minority representation, older parents with less education and a lower income. Families at the highest point on the scale are at least twice as likely as those at the low end of the scale to have alcohol or drug problems, familial conflicts including spouse abuse and other marital problems, a history of abuse as a child, and to be socially isolated.

(4) Correlations Between Three Versions

As shown on Table G-2, the correlations between these three versions of "problem at intake" are fairly high, with a .47 correlation between type of maltreatment and the severity of the situation, a .53 correlation between type of maltreatment and the seriousness of the assault, a .67 correlation between seriousness of the assault and the severity of the situation (this final correlation is not surprisingly high given that seriousness of the assault was one of the four factors used to define the situation). The nature of the correlation suggests that there are conceptual similarities between the three irrespective of the different perspectives or views on how to define problem at intake that they were to reflect. This further suggests that these versions should not be used simultaneously in later analyses.

(5) Summary

Each of the three versions of "problem at intake" appear to have conceptual integrity in that descriptors of cases falling into the

TABLE G-1: Relationship Between the Three Versions of "Problem at Intake" and Other Demographic Data*

	Totals	Preschool Children	Previous Record/ Evidence	One Adult In Household	Young Parents	High School Degree in Family	No Minorities in Household	No Employment in Household	Income Less Than $5,500	Income Greater Than $12,000	Family on Public Assistance	Financial Problems	Alcohol	Drugs	Fights	Spouse Abuse	Marital Problems	History of Abuse as Child	Isolation
A. Type of Maltreatment																			
Potential abuse/neglect	26%	29%	19%	34%	50%	42%	68%	30%	61%	11%	28%	48%	13%	7%	17%	10%	41%	22%	31%
Emotional abuse/neglect	14	12	37	31	44	42	68	28	49	19	22	46	19	3	27	10	47	17	35
Sexual abuse	4	3	30	20	24	37	69	20	53	21	16	34	11	6	11	11	49	17	20
Physical abuse	33	33	26	22	39	41	57	24	55	15	21	41	11	5	25	13	44	30	29
Physical neglect	19	19	43	41	63	28	55	43	67	10	33	57	17	9	15	7	30	10	25
Physical abuse and neglect	4	4	36	21	53	28	60	40	72	5	33	64	14	5	28	22	38	22	36
B. Serious Assault on Child																			
No	70.5	69	24	30	46	41	64	27	55	15	24	44	12	5	18	9	40	19	28
Yes	29.5	31	40	29	50	33	53	37	67	10	27	53	16	8	26	15	41	24	31
C. Severity of Household Situation																			
0	35	33		34	54	44	64	28	57	15	25	37	8	3	11	3	31	11	23
1	30	30		29	46	39	62	28	57	15	23	44	13	6	21	11	42	19	27
2	23	24		27	43	35	59	30	57	14	25	49	15	7	23	11	42	30	31
3	9	10		24	43	31	59	36	62	10	29	68	17	9	33	24	52	33	40
4	3	4		24	38	26	45	48	81	0	31	83	40	17	60	40	69	43	52
Totals		73	29	31	47	39	59	30	56	15	26	46	13	6	20	11	40	21	29

*Numbers for individual variables may not sum to 100% owing to rounding.

TABLE G-2

Significant Correlations of at Least + .200 Between Possible Impact Measures

		Reincidence					Propensity					Functioning Indicators		
		R1	R2	R3	R4	R5	P1	P2	P3	P4	P5	F1	F2	F3
Reincidence	R1	1.000	.519	.478	-	-	-	-	-	-	-	-	-	-
	R2		1.000	.921	-	-	-	-	-	-	-	-	-	-
	R3			1.000	-	-	-	-	-	-	-	-	-	-
	R4				1.000	.869	-	-	-	-	-	-	-	-
	R5					1.000	-	-	-	-	-	-	-	-
Propensity	P1						1.000	.726	-	-	-	-	-	-
	P2							1.000	-	-	-	-	-	-
	P3								1.000	.564	.643	.242	.259	.349
	P4									1.000	.870	.350	.374	.489
	P5										1.000	.395	.403	.438
Functioning Indicators	F1											1.000	.850	.618
	F2												1.000	.578
	F3													1.000

different categories of each of the versions reflect findings of others. Thus, each of the three appear to be useful in later analyses although the relatively high correlations between them suggest that they not be used simultaneously in certain multivariate analyses.

A Note on the Construction of Severity Index

A concern in constructing the severity index is which of the four elements, e.g., number of problems, severity of assault, record of maltreatment, substantiation of maltreatment, accounted for differences in scores (e.g., 0, 1, 2, 3 or 4). Among the elements, our greatest concern is whether our cutoff point of having six problems or more is the appropriate one or whether it would have been better to have used five or fewer as the cutoff. We studied carefully what accounted for differences in scores on the index and found the following:

	Severity Score	0	1	2	3	4
Serious Assault	No	100%	78%	37%	9%	
	Yes		22	63	91	100%
Substantiation	No	100	74	31	10	
	Yes		26	69	90	100
Previous Record	No	100	69	79	31	
	Yes		31	21	69	100
Problems	0-2	43	38	28	11	
	3-4	44	32	32	25	
	5	13	10	12	14	
	6+		20	28	50	100
N=		581	498	392	157	58

The table shows: those people who got a 1 rather than a 0 were only slightly more likely to have a previous record of maltreatment than any other factor; those who got a 2 rather than a 1 were more likely to have had serious assault or substantiation of the case; those who got a 3 rather than a 2 were also more likely to have serious assault and substantiation of the case; and those who got a 3 rather than a 4 were most likely to have five or fewer problems (and more specifically three or four problems), followed by a lack of

previous record of maltreatment. This suggests that the severity of the assault and whether or not it was substantiated play the dominant role in determining the higher scores. This conforms with our expectations.

B. Selecting Salient Intake Measures

There are many different descriptors of clients that may influence or help explain the effectiveness of services, including:

- the presenting problem (type and severity of maltreatment that occurred);
- demographic characteristics of the client and the client's family (age, race/ethnicity, level of income, employment, education, numbers and ages of children);
- the kinds of problems that exist in the household (financial, marital, substance abuse, spouse abuse, child care).

Using the standard questions akin to those on the American Humane's National Reporting Form and supplemental questions of theoretical interest, we collected a wide variety of information concerning each of these three areas on all clients served by the demonstration projects. Because of the number of variables on which data were collected (and because many of these variables may vary together for individuals and thus present statistical problems of multicollinearity in multivariate analysis), we needed to winnow the number of items before proceeding with our analysis of service effectiveness.

In order to reduce the number of client descriptor variables for analysis, a combination of theory, factor analysis and other statistical techniques were used. Our desire was to reduce the number of redundant variables while making sure not to eliminate those with conceptual interest. First, we looked at frequency distributions on all client descriptors to eliminate those with little variation, with questionable data and with little conceptual interest for the effectiveness analysis. Contingency tables for select variables were also studied. Then we ran factor analyses of 35 descriptor variables to see how the descriptors clustered. For the factor analyses, the entire client population was randomly allocated into three non-overlapping subsets of clients. Factor analysis was then conducted separately for each subset.

Table G-3 presents the results of the factor analyses. Variable loadings are shown only for factors having eigen values greater than

1.000 and for variables where the loading was greater than ±.25. In each of the factor analyses, five factors emerged with eigen values greater than 1.000 and the variable loadings on the factors were basically the same for four of these factors in each client subset and highly similar for the fifth factor. The five factors accounted for 72-74% of the total variance in the client descriptor data for each of the client subsets. This emergence of the same five factors and only those five factors in each of three factor analyses with non-overlapping client subsets is a very powerful test of the validity of the underlying dimensions revealed by the factor analyses in the client descriptor data.

The interpretation of the five factors or dimensions underlying the client descriptor data appears straightforward. One dimension is that of the problem presented by the family at intake -- the nature and severity of the abuse/neglect problem. Another dimension or cluster of variables focuses on child-related difficulties, particularly the presence of new or small children with concomitant needs for child care and the bringing of pressure upon the isolated parent. A third dimension focuses on the demographic characteristics of the parents, particularly upon their age and whether both parents are present in the home. A fourth dimension singles out the parents' race/ethnicity with the concomitant problems of poverty, unemployment and family stability. Finally, there is a cluster of variables that highlights particular personal problems of the family such as household conflicts, substance abuse, isolation and the parent's own experience of abuse as a child.

Given these general clusterings of the descriptor data, we selected variables from each cluster to represent the whole cluster or dimension. Variables were selected which were the most highly correlated with the factor, while not being highly correlated with other factors. This basic "hard core" set of descriptor variables included: the severity of the maltreatment that brought the family into treatment -- a dummy variable; a dummy variable designating whether there was a preschool age child in the household; a dummy variable designating whether one of the parents was under 20 years old; a dummy

variable indicating whether or not the family included any minorities; and a dummy variable indicating whether the family was reported as having problems with either arguments and fighting among the parents or physical spouse abuse. A nominal variable describing the maltreatment was included for use in certain analyses.

To these "hard core" variables, we added several additional variables, either (1) because they were correlated highly with a factor in one of the three analyses, yet were not correlated highly with one of the "hard core" variables, and were conceptually distinct from the above selected variables or (2) because they were of high theoretical or policy interest even though correlated in part with variables already selected. In no case did we select a variable where the correlation with another variable being selected was so high (e.g., over .40) that obvious problems of multicollinearity would arise in the statistical analysis. The variables added by this expanded selection process included: a dummy variable designating whether the family at intake was reported as having problems of alcohol or drug abuse; a dummy variable indicating whether the parent was reported as having a history of abuse as a child; a dummy variable indicating whether the family was rated at intake as being socially isolated; a dummy variable indicating that no one in the household was employed at intake; a dummy variable indicating whether the family had a new baby in the household, the mother was currently pregnant or the family otherwise had heavy, continuous child care responsibilities; a dummy variable indicating whether the number of children in the household was greater than three; a dummy variable indicating whether the problem which brought the family into the demonstration project had prompted legal intervention by the courts; and a continuous variable indicating the total family income. These variables, along with the "hard core" set, thus comprised a total set of thirteen descriptor variables, reducing by 22 variables the original set of 35.

As a final test of this set of 13 descriptor variables, we ran another factor analysis, this time on the entire client population. Only one factor emerged with an eigen value greater than 1.000. The

factor accounted for 38% of the total variance in the data. All but two of the variables had loadings on the factor greater than $\pm$ .15. This factor analysis result indicates that the final set of descriptor variables consists of generally unrelated or independent variables, except for perhaps a single weak but common dimension for almost all the variables. Such a common dimension is not surprising since the variables do relate to the overall well-being of families. In some sense, we would expect there to be a weak commonality across a set of descriptors intended to indicate potential sources of family strain and problems. The high degree of independence nevertheless existing among the set of variables suggests that we are measuring different sources of strain and have a useful set of control variables for analyzing service effectiveness and differentiating the clients served by the demonstration projects. This is further shown by Table H-1 in Appendix H, which shows the correlation coefficients between all descriptor values.

TABLE G-3

Results of Factor Analysis on Client Descriptor Variables

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Client Subset #1	Abuse/Neg'l Established (.59) Severity of Situation (.80) Seriousness of Assault (.82) Type of Maltreatment (.61)	One Adult in Home (.69) Young Parents (.68) Unemployed (.38) Legally Married (-.76) Marital Problems (-.33)	No Minorities in Family (.79) Blacks in Family (-.80)	High School Education (-.37) Alcohol Problems (.24) Crowded Housing (.27) Parent Retarded (.30)	Pre-School Children (.26) Mother Pregnant (.43) History of Abuse as Child (.46) Social Isolation (.30)
	E = 3.00	E = 2.93	E = 1.77	E = 1.42	E = 1.06
Client Subset #2	Abuse/Neg'l Established (.69) Severity of Situation (.79) Seriousness of Assault (.76) Type of Maltreatment (.67)	One Adult in Home (.71) Young Parents (.59) Unemployed (.41) Low Income (.24) Legally Married (-.76)	No Minorities in Family (.79) Blacks in Family (-.78)	Young Parents (-.29) Severity of Situation (.27) Marital Problems (.54) Alcohol Problems (.30) Family Arguments (.68) Spouse Abuse (.56)	Pre-School Children (.56) New Baby (.35) Financial Problems (.34) Heavy Child Responsibilities (.38) Recent Relocation (.37) Social Isolation (.31)
	E = 3.34	E = 2.82	E = 1.77	E = 1.21	E = 1.09
Client Subset #3	Abuse/Neg'l Established (.41) Severity of Situation (.65) Seriousness of Assault (.89) Type of Maltreatment (.61)	One Adult in Home (.74) Young Parent (.66) Unemployed (.42) Low Income (.41) High Income (-.30) Legally Married (-.70)	No Minorities in Family (.77) Blacks in Family (-.78)	Young Parents (-.24) Severity of Situation (.26) Marital Problems (.46) Alcohol Problems (.54) Family Arguments (.39) Spouse Abuse (.67)	Pre-School Children (.53) New Baby (.41)
	E = 2.87	E = 3.13	E = 1.70	E = 1.19	E = 1.3

Note: Variables only shown with factor loadings greater than ± .25, as indicated in parentheses.
Eigenvalue (E) for factor shown at bottom of cell.

C. Selecting Salient Service Measures

The analytic plan for this study is somewhat unique in the child abuse/neglect literature for focusing on the relative effectiveness of alternative service and treatment strategies. Such an analytical approach is increasingly being recommended in the evaluation literature as more useful than the traditional concern of researchers with simply documenting the overall outcomes of programs. Unfortunately, analytical methodologies for assessing the effectiveness of services are still emerging and are not yet commonly familiar to program managers or even researchers.

To undertake analysis of service effectiveness, it is essential to determine the forms of the service variables which are most useful and appropriate. In other appendices, we have discussed how we sought to make sure that services were being reliably defined and recorded across demonstration projects. Here, we shall discuss briefly how we selected the final forms of the service variables used in the analyses presented in the text.

The process of selecting service variables was essentially akin to that used in selecting the set of client descriptor variables previously discussed. We conducted factor analysis using the full array of services and found tht there only a few weak underlying dimensions among the service variables. We then sought to reduce the number of service variables by combining services where the numbers of clients receiving them was too small to permit analysis. Such combinations obviously could only be made when the services appeared conceptually similar. The residue became a category of "other" services. Where services to be combined appeared to have very different relationships with ultimate client outcome, we avoided combinations. Next, we explored whether there were important service mix and interaction effects, and whether it was important to control for the amount and frequency of the service received rather than just the fact of the receipt. These complex issues perhaps fortunately proved not to be very important in explaining client outcome, and we were able to use conceptually

simpler models of the service intervention in the analyses presented in the text.

Table G-4 presents the service variable loadings which emerged in the factor analysis. Although over 20 service variables were analyzed, only two factors emerged with eigen values greater than 1.00 and only four factors with eigen values as great as even 0.50. Together, the factors explained 71% of the total variance. Interpretation of the factors is not as clear-cut as with the client descriptor variables. The weak third and fourth factors rather clearly appear to be akin to a traditional social work combination of services (individual therapy, couples counseling, and services to children), and to a lay model of service delivery (lay therapy and Parents Anonymous). The first factor (eigen value = 2.2) appears to represent group service and crisis intervention model of services (group therapy, hotline, crisis intervention, transportation help). The second factor is more vague and captures perhaps an array of special client needs prompting service response (counseling for substance abuse, welfare support, emergency aid, services to children and multidisciplinary team review, with the latter loading negatively). These factors prompted our development of the summary variables connoting general models of service strategy described in the text -- lay, group, social work, and other -- but there is not a simple 1:1 relationship between the model variables and the factors.

We next examined how many clients tended to receive a particular kind of service or combination of services. Table G-5 shows the percentage of clients receiving given combinations of services, and Table G-6 shows the percent of clients receiving one kind of service who also receive various other services. Particular combinations are surprisingly rare and occur at even moderate frequencies (15% or more of all clients) only for clients who receive individual counseling, the most commonly provided service. From this pattern, we concluded that it was generally best to use variables focusing on discrete services rather than creating numerous combination variables.

Nevertheless, we did seek to examine whether any service increases in effectiveness when offered in combination with other services.

Thus, a service may be a necessary auxiliary service before some other service can become effective. Or, a service may require some other service as a precondition or complement for being effective. Thus, it might be true that individual counseling and the social work model can only be effective when the project is also providing the parent with day care to alleviate some of the pressures in the household, or with transportation help and babysitting so that the parent can attend sessions with counselors (or groups). To examine the existence of mix effects, we drew upon theory to specify the most likely mix effects and then created interaction variables designating when clients received both of two or more types of services. Only when enough clients received the combination of services to permit statistical testing, was the interaction variable used, however. Many different forms of interaction variables and of the overall specification of the set of service variables were tested, but no strong interaction or mix effects emerged.

Another approach to testing mix effects was to specify regression models containing both the variables connoting overall service strategies (the lay, group and social work models) and select individual services. The logic here was that a service could have an effect on outcome in addition to the general service strategy being pursued. Thus, for clients receiving a lay service strategy, the additional receipt of individual counseling could increase in theory the probability of successful outcome. In specifying such models, we again sought to avoid using select services which were highly correlated with service models, at least for the models chosen for presentation in the report for analyzing the effect of services with different kinds of clients. Again, the basic conclusions of analysis about the types of service strategies and select services which were most effective, did not change.

We explored at length whether it was necessary to get a certain amount of service or to receive it at a regular frequency, before the service would become effective. Most of the service variables used in the regressions presented in this report have taken dummy form and

measured the fact of service receipt -- did the client receive this service or not? In other analyses, we looked at the amount of the service the client received when he/she did receive the service and at the frequency over time with which the service was received.

Since there is no reason to expect the functional relationship between service amount and client outcome to be a simple linear relationship, we did not use the numeric amount of service units received as a variable. Rather, from the outset, we recognized that it was necessary to classify the amount of services received into categories -- a little, some, a lot. Setting the criteria for classification into categories requires arbitrary judgment given the paucity of observations for statistical classification with techniques like AID. We would also note that experimental analyses with the raw numeric total of service units did show such variable constructions to be useless in explaining client outcome, as anticipated simply on theoretical grounds.

Unfortunately, again because of the small number of clients receiving many of the services, there are not enough observations for clients receiving varying amounts to conduct analysis separately of receipt and amount. For such services, we explored treating clients who received what clearly appeared to be a smaller amount of the service than normal as being akin to clients who never received the service. Analytical conclusions about the effectiveness of the service did not change, however, and the judgment was made not to impose arbitrary criteria as to the necessary amount of a service for having an effect, and instead just to use the "receipt" form of the service variable.

For other services, in analyses with "amount" and "frequency" forms of variables, we found that the forms had similar effects to each other. The decision was made to use only the "frequency" form since it was conceptually more complete in combining amount of service with time in treatment. For most services having sufficient observations for analysis, the inclusion of a frequency term in regression models did not change the conclusions of the analysis concerning

service effectiveness. An overall measure of the frequency of contacts with the service project was also constructed, by adding units of service received across services and treating each unit of service as a separate contact. This variable emerged in some regressions as statistically significant, but with a very small and negative relationship to client outcome.

TABLE G-4

Service Variable Loadings in Factor Analysis

Factor 1		Factor 2	
Group therapy	+.48	Multidisciplinary review	—.25
Hotline	+.49	Special counseling	
Crisis intervention	+.36	(substance abuse)	+.24
Transportation	+.54	Services to children	+.32
		Welfare support	+.65
(E = 2.20)		Emergency aid	+.39
		(E = 1.37)	
Factor 3		**Factor 4**	
Individual therapy	+.38	Lay therapy	+.60
Couples counseling	+.58	Parents Anonymous	+.55
Services to children	+.31	(E = 0.57)	
(E = 0.93)			

TABLE G-5

Combinations of Services Received by 5% or More of All the Clients in the Data Base

	Psychological Testing	MDT Review	One to One Couns.	Lay Therapy	Group Therapy	Couples Couns.	Family Couns.	Crisis Intervention	Medical Care	Child Services	Welfare	Babysitting
MDT Review	6%											
One to One Counseling	10	30%										
Lay Therapy		7	12%									
Group Therapy		6	10									
Couples Counseling	5	11	17									
Family Counseling		10	17			7%						
Special Counseling			6									
Crisis Intervention	5	13	26	8%	5%	9	8%					
Parent Education		5	9					5%				
Homemaking			5									
Medical Care		6	12					7				
Child Services		7	15	5				8	5%			
Welfare		7	21	8				11	7	8%		
Babysitting		5	7									
Transportation		9	18	9	6			12	7	6	10%	5%
Emergency Funds			8					5			5	

TABLE G-6

Percents of Clients Receiving One Service Also Receiving Another Service

Other Services Received by the 611 Clients Provided with Multidisciplinary Team Reviews	
20%	Psychological Teating
88	One to One Counseling
20	Lay Therapy
20	Group Therapy
8	Parents Anonymous
34	Couples Counseling
30	Family Counseling
11	Special Counseling
9	Family Planning
15	Parent Education
4	Job Training
7	Homemaking
18	Medical Care
20	Child Services
21	Welfare

Other Services Received by the 1427 Clients Provided with One to One Counseling	
13%	Psychological Testing
38	MDT Review
16	Lay Therapy
13	Group Therapy
4	Parents Anonymous
22	Couples Counseling
22	Family Counseling
8	Special Counseling
6	Family Planning
5	Hotline Counseling
34	Crisis Intervention
11	Parent Education
28	Job Training
6	Homemaking
15	Medical Care
19	Child Services
27	Welfare
10	Babysitting
24	Transportation
10	Emergency Funds

Other Services Received by the 389 Clients Provided with Lay Therapy	
13%	Psychological Testing
32	MDT Review
59	One to One Counseling
14	Group Therapy
17	Parents Anonymous
13	Couples Counseling
13	Family Counseling
5	Special Counseling
6	Family Planning
5	Hotline Counseling
38	Crisis Intervention
17	Parent Education
2	Job Training
5	Homemaking
21	Medical Care
24	Child Services
41	Welfare
13	Babysitting
41	Transportation
13	Emergency Funds

Other Services Received by the 214 Clients Provided with Group Therapy	
15%	Psychological Testing
57	MDT Review
86	One to One Counseling
26	Lay Therapy
8	Parents Anonymous
26	Couples Counseling
17	Family Counseling
8	Special Counseling
3	Family Planning
11	Hotline Counseling
43	Crisis Intervention
26	Parent Education
3	Job Training
3	Homemaking
14	Medical Care
15	Child Services
29	Welfare
37	Babysitting
48	Transportation
7	Emergency Funds

Table G-6 (continued)

Other Services Received by the 91 Clients Provided with Parents Anonymous	
18%	Psychological Testing
52	MDT Review
60	One to One Counseling
73	Lay Therapy
19	Group Therapy
40	Couples Counseling
22	Family Counseling
12	Special Counseling
5	Family Planning
5	Hotline Counseling
45	Crisis Intervention
25	Parent Education
4	Job Training
5	Homemaking
20	Medical Care
33	Child Services
37	Welfare
19	Babysitting
45	Transportation
11	Emergency Funds

Other Services Received by the 372 Clients Provided with Couples Counseling	
23%	Psychological Testing
56	MDT Review
85	One to One Counseling
14	Lay Therapy
15	Group Therapy
10	Parents Anonymous
35	Family Counseling
16	Special Counseling
7	Family Planning
6	Hotline Counseling
45	Crisis Intervention
17	Parent Education
3	Job Training
6	Homemaking
17	Medical Care
21	Child Services
17	Welfare
9	Babysitting
21	Transportation
11	Emergency Funds

Other Services Received by the 356 Clients Provided with Family Counseling	
17%	Psychological Testing
52	MDT Review
89	One to One Counseling
14	Lay Therapy
10	Group Therapy
6	Parents Anonymous
36	Couples Counseling
15	Special Counseling
10	Family Planning
4	Hotline Counseling
44	Crisis Intervention
10	Parent Education
3	Job Training
7	Homemaking
17	Medical Care
20	Child Services
20	Welfare
6	Babysitting
21	Transportation
13	Emergency Funds

Other Services Received by the 112 Clients Provided with Special Counseling	
26%	Psychological Testing
63	MDT Review
96	One to One Counseling
17	Lay Therapy
15	Group Therapy
10	Parents Anonymous
54	Couples Counseling
46	Family Counseling
21	Family Planning
4	Hotline Counseling
54	Crisis Intervention
12	Parent Education
10	Job Training
6	Homemaking
32	Medical Care
28	Child Services
30	Welfare
9	Babysitting
33	Transportation
8	Emergency Funds

Table G-6 (continued)

Other Services Received by the 88 Clients Provided with Family Planning

22%	Psychological Testing
61	MDT Review
92	One to One Counseling
26	Lay Therapy
7	Group Therapy
6	Parents Anonymous
28	Couples Counseling
39	Family Counseling
27	Special Counseling
16	Parent Education
23	Homemaking
39	Child Services
14	Babysitting

Other Services Received by the 78 Clients Provided with Hotline Counseling

18%	Psychological Testing
88	One to One Counseling
23	Lay Therapy
31	Group Therapy
6	Parents Anonymous
28	Couples Counseling
21	Family Counseling
6	Special Counseling
74	Crisis Intervention
22	Parent Education
36	Babysitting
45	Transportation
14	Emergency Funds

Other Services Received by the 554 Clients Provided with Crisis Intervention

16%	Psychological Testing
88	One to One Counseling
27	Lay Therapy
17	Group Therapy
7	Parents Anonymous
30	Couples Counseling
28	Family Counseling
11	Special Counseling
10	Hotline Counseling
16	Parent Education
3	Job Training
10	Homemaking
24	Medical Care
28	Child Services
37	Welfare
13	Babysitting
39	Transportation
16	Emergency Funds

Other Services Received by the 183 Clients Provided with Parent Education

28%	Psychological Testing
50	MDT Review
86	One to One Counseling
38	Lay Therapy
30	Group Therapy
13	Parents Anonymous
34	Couples Counseling
20	Family Counseling
7	Special Counseling
8	Family Planning
9	Hotline Counseling
48	Crisis Intervention
10	Homemaking
23	Child Services
37	Welfare
32	Babysitting
42	Transportation
13	Emergency Funds

Table G-6 (continued)

Other Services Received by the 40 Clients Provided with Job Training	
22%	Psychological Training
55	MDT Review
100	One to One Counseling
20	Lay Therapy
18	Group Therapy
10	Parents Anonymous
28	Couples Counseling
30	Family Counseling
28	Special Counseling
40	Crisis Intervention
48	Welfare

Other Services Received by the 88 Clients Provided with Homemaking	
18%	Psychological Testing
45	MDT Review
95	One to One Counseling
20	Lay Therapy
7	Group Therapy
6	Parents Anonymous
24	Couples Counseling
28	Family Counseling
8	Special Counseling
23	Family Planning
64	Crisis Intervention
20	Parent Education
44	Medical Care
44	Child Services
57	Welfare
20	Babysitting
45	Transportation
27	Emergency Funds

Other Services Received by the 259 Clients Provided with Medical Care	
26%	Psychological Testing
41	MDT Review
85	One to One Counseling
32	Lay Therapy
11	Group Therapy
7	Parents Anonymous
25	Couples Counseling
23	Family Counseling
12	Special Counseling
52	Crisis Intervention
15	Homemaking

Other Services Received by the 315 Clients Provided with Child Services	
17%	Psychological Testing
39	MDT Review
87	One to One Counseling
30	Lay Therapy
10	Group Therapy
10	Parents Anonymous
25	Couples Counseling
22	Family Counseling
10	Special Counseling
11	Family Planning
49	Crisis Intervention
13	Parent Education
12	Homemaking
46	Welfare
9	Babysitting
36	Transportation
17	Emergency Funds

Table G-6 (continued)

Other Services Received by the 444 Clients Provided with Welfare	
16%	Psychological Testing
29	MDT Review
88	One to One Counseling
36	Lay Therapy
14	Group Therapy
8	Parents Anonymous
15	Couples Counseling
16	Family Counseling
8	Special Counseling
47	Crisis Intervention
15	Parent Education
4	Job Training
11	Homemaking
33	Child Services
13	Babysitting
43	Transportation
21	Emergency Funds

Other Services Received by the 161 Clients Provided with Babysitting	
85%	One to One Counseling
30	Lay Therapy
49	Group Therapy
11	Parents Anonymous
21	Couples Counseling
12	Family Counseling
6	Special Counseling
7	Family Planning
17	Hotline Counseling
46	Crisis Intervention
37	Parent Education
11	Homemaking
17	Child Services
36	Welfare
61	Transportation
11	Emergency Funds

Other Services Received by the 402 Clients Provided with Transportation	
85%	One to One Counseling
40	Lay Therapy
26	Group Therapy
10	Parents Anonymous
19	Couples Counseling
19	Family Counseling
9	Special Counseling
9	Hotline Counseling
53	Crisis Intervention
19	Parent Education
10	Homemaking
28	Child Services
48	Welfare
24	Babysitting
19	Emergency Funds

Other Services Received by the 163 Clients Provided with Emergency Funds	
80%	One to One Counseling
31	Lay Therapy
10	Group Therapy
6	Parents Anonymous
25	Couples Counseling
28	Family Counseling
54	Special Counseling
28	Family Planning
7	Hotline Counseling
56	Crisis Intervention
11	Parent Education
15	Homemaking
32	Child Services
58	Welfare
10	Babysitting
48	Transportation

D. Selecting Salient Impact Measures

Before proceeding with our effectiveness analyses, the most useful versions of our impact measures needed to be identified. First, we created several different versions of the data, then looked at the frequencies of each, the simple relationships between them as well as their correlations and finally we ran a factor analysis to see how they clustered and which version was the strongest variable in each cluster or factor. Based on these data, it seemed desirable to proceed with the following impact measures: severe reincidence of any kind; severe reincidence in problem identified at intake; improvement on either abuse or neglect propensity; and adjusted improvement on select functioning indicators.

(1) Creation of Different Versions of Impact Data

For each of our three sets of impact data we created several versions as follows:

Reincidence:	1.	reincidence of any kind
	2.	severe reincidence of any kind
	3.	amount of severe reincidence of any kind
	4.	reincidence in type of problem identified at intake
	5.	amount of reincidence in type of problem identified at intake
Propensity:	1.	reduced abuse propensity
	2.	reduced neglect propensity
	3.	reduced propensity for both abuse and neglect
	4.	reduced propensity for either abuse or neglect
	5.	reduced propensity in area that corresponds to type of problem identified at intake
Functioning Indicators	1.	adjusted improvement on select functioning indicators (percentage of indicators identified at intake as problems for client on which client improved minus percentage of indicators on which client regressed)
	2.	unadjusted improvement on select functioning indicators (percentage of indicators identified at intake as problems for client on which client improved)

3. summed improvement on all functioning indicators (sum of amount of improvement on each indicator minus any regression).

The frequency distributions on each were carefully studied to identify those that yielded the greatest variations in the data set.

(2) Correlations Among Possible Impact Measures

As a second step in deciding which of the impact measures to use, we explored the correlations between all versions. We were concerned not only with how versions within a given grouping (e.g., reincidence) were correlated, but also what correlations exist across the different groupings. As can be seen on Table G-2 within grouping correlations are found for all three areas, but across grouping correlations are only evident for some of the propensity and functioning indicator measures.

More specifically, relatively high correlations exist between the first three versions of reincidence and between the last two, but none of the reincidence measures are highly correlated with any of the propensity or functioning indicator measures. We conclude that (a) reincidence without respect to problem at intake is a measure different in kind from reincidence in the problem identified at intake and thus it might be fruitful to use both as impact measures, and (b) reincidence in general measures a very different aspect of outcome or treatment impact than do reduced propensity or improvement on the functioning indicators. Presence of reincidence during treatment does not necessarily suggest success or failure as a result of treatment, but it may rather be indicative of client problems during the treatment process. It will be useful as one kind of outcome measure in the analyses.

With respect to the propensity measures, reduced propensity for abuse, if highly correlated with reduced propensity for neglect, but neither of these are highly correlated with the other propensity measures. The other propensity measures are highly correlated with each other, as well as having correlations with each of the functioning indicator measures. Reduced propensity in problem identified at intake is particularly highly correlated with improvement in functioning.

Given that the purpose of the functioning measures was to have them serve as proxies for propensity, we are encouraged by these correlations, but due to the continuing need in the field to determine what the best way to measure outcome is, we used both is our analyses.

Finally, as would be expected given the similarity in their original construction, the functioning indicator measures are themselves highly correlated.

(3) Factor Analysis of All Possible Impact Measures[1]

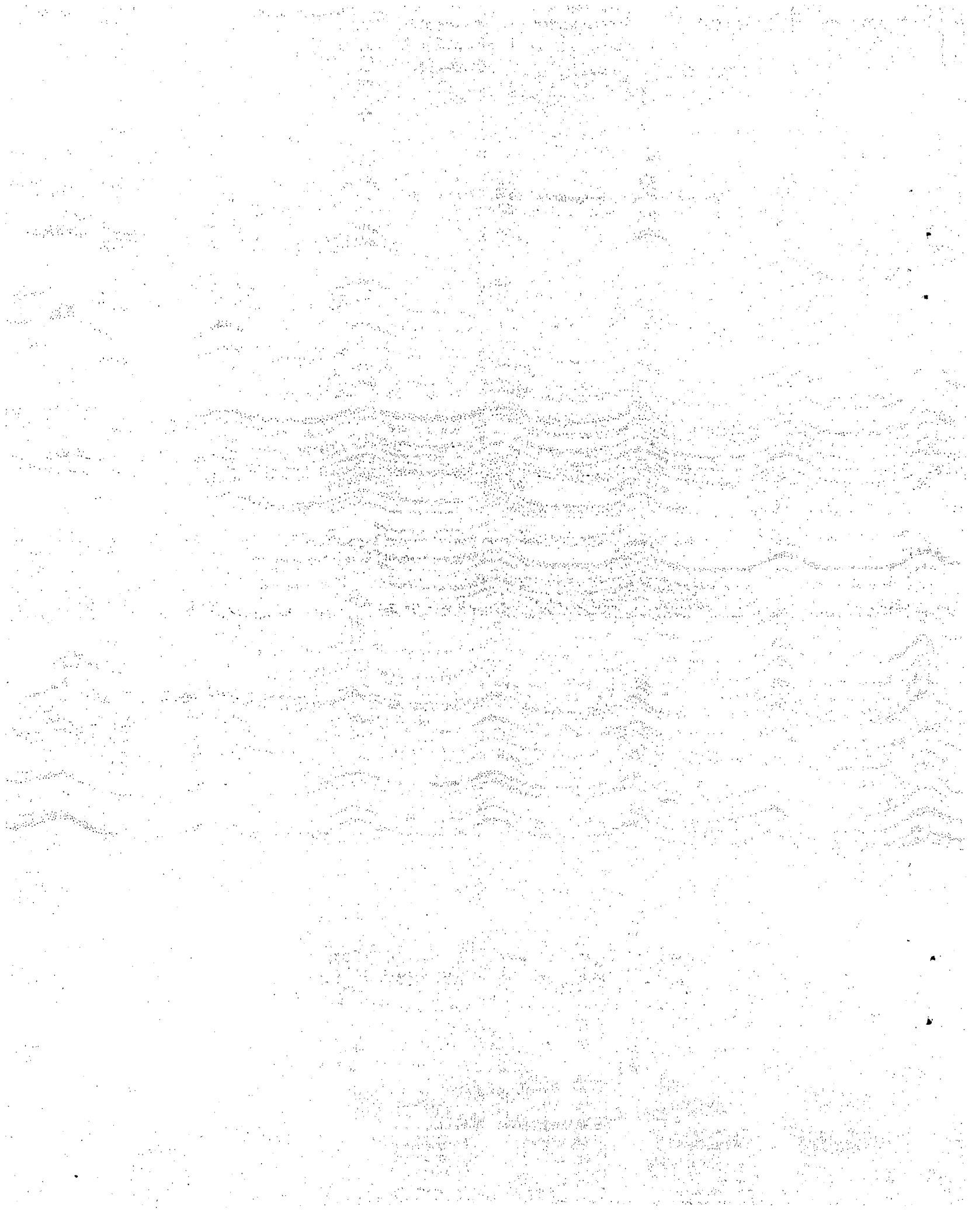
As a final step before selecting the most useful, least redundant impact measures, we ran a factor analysis to determine how the different measures would cluster. As suggested by the simple correlations themselves, we found four factors (three with eigen values over 1.5 and the fourth with a .78), including one representing the propensity measures, one representing severe reincidence, one representing improvement on the functioning indicators, and one representing reincidence of any kind.

(4) Conclusions

Based on the above, we conclude that it is desirable to proceed with the use of four variables:

- severe reincidence;
- reincidence in problem identified at intake;
- unadjusted improvement on select functioning indicators, i.e., percent of indicators on which a client scored a 1, 2 or 3 at intake and improved by the end of treatment;
- reduced propensity for abuse or neglect.

[1]Tables available upon request.



APPENDIX H

Correlations Between Select Variables

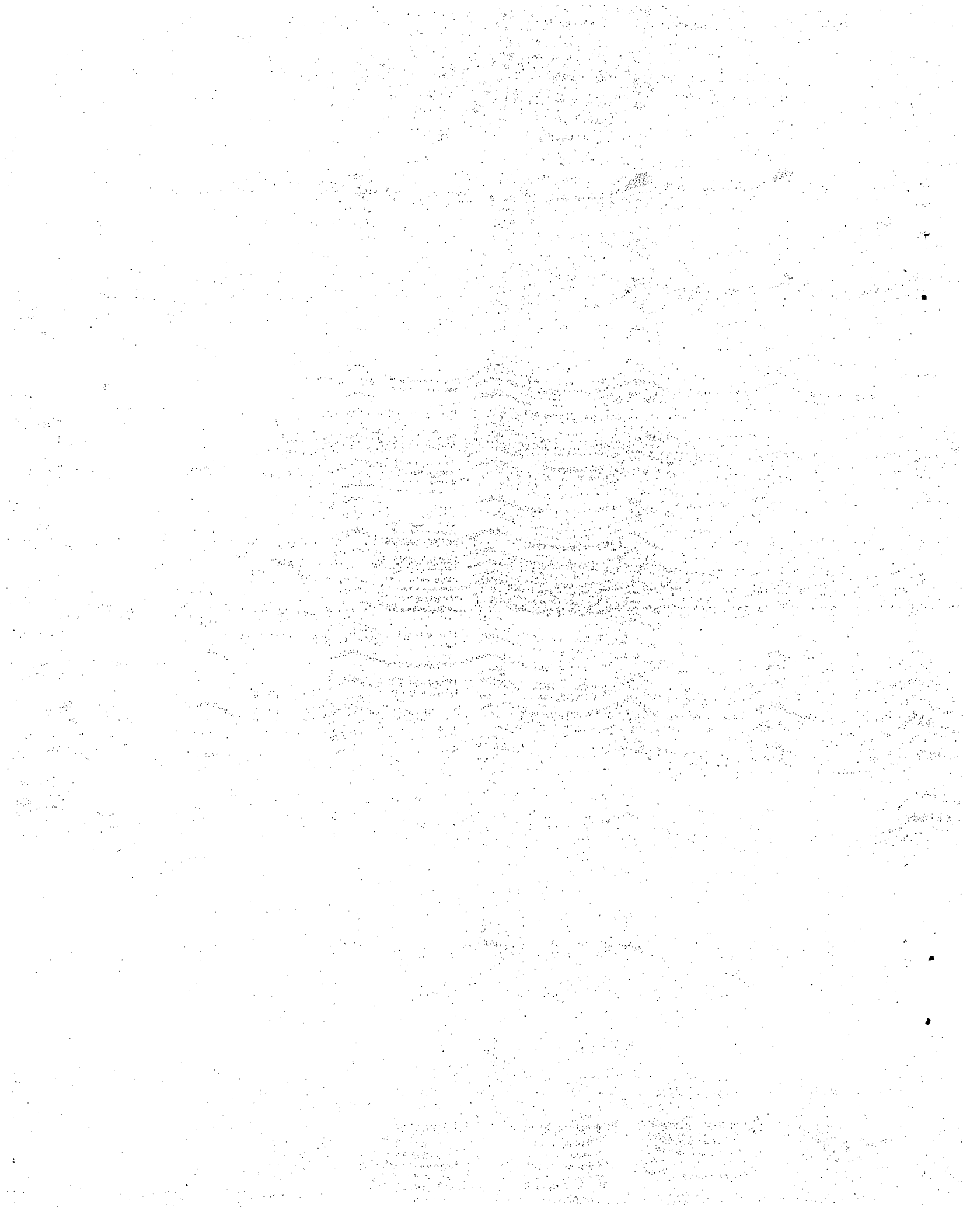


TABLE H-1

Correlations Between Select Client Characteristics (Pearson's Correlation Coefficient)

	Severity Of Assault	Age/ Parents	Ethnicity	Employ- ment	Size/ Family	Age of Children	Family Conflict	Substance Abuse	Isolation	History of Abuse	Child Responsi- bilities	Legal Inter- vention
Severity of Assault	1.000											
Age/Parents	-.107[a]	1.000										
Ethnicity	-.059[b]	-.093[a]	1.000									
Employment	.051[b]	.285[a]	-.099[a]	1.000								
Size/Family	.126[a]	-.162[a]	-.059[b]	.023	1.000							
Age of Children	.055[b]	.065[b]	-.026	.127[a]	-.069[b]	1.000						
Family Conflict	.311[a]	-.266[a]	-.060[b]	-.092[a]	.068[b]	.029	1.000					
Substance Abuse	.212[a]	-.138[a]	-.052[b]	.029	.107[a]	-.066[b]	.273[a]	1.000				
Isolation	.149[a]	.026	.078[a]	.046[c]	-.041[c]	.079[a]	.080[a]	-.015	1.000			
History of Abuse	.252[a]	-.045[c]	.103[a]	-.013	-.033	.097[a]	.143[a]	.010	.180[a]	1.000		
Child Responsibilities	.086[a]	.065[b]	-.002	.036	-.019	.246[a]	.049[c]	-.031	.129[a]	.102[a]	1.000	
Legal Interaction	.120[a]	-.001	.034	.037	.003	.058[b]	-.060[b]	-.027	.028	.084[a]	.054[b]	1.000

a: significant at p = .001; b: signficant at p = .01; c: significant at p = .05.

TABLE II-2

Correlations Between Select Service and Client Variables (Pearson's Correlation Coefficient)

	Age/ Children	Severity Of Assault	Ethnicity	Age/ Parents	Employ- ment	Size/ Family	Family Conflict	Substance Abuse	Isolation	History Of Abuse	Child Responsi- bilities	Legal Inter- vention
Multidisciplinary Team	.098[a]	.175[a]	.014	-.051[b]	-.022	-.038[b]	.116[a]	.030	.089[a]	.141[a]	.044[c]	-.035
Individual Counseling	-.020	-.014	-.064[b]	.029	.037	-.043[c]	.035	.041	-.002	-.002	-.038	-.051[b]
Lay Therapy	.155[a]	.038[c]	.110[a]	.076[a]	.081[a]	-.018	-.048[b]	-.090[a]	.162[a]	.076[a]	.129[a]	.107[a]
Group Therapy	.096[a]	.038[c]	.021	.062[b]	.095[a]	-.061[b]	.006	-.053[b]	.099[a]	.069[a]	-.008	.005
Parents Anonymous	.099[a]	.061[b]	.099[a]	.018	-.036	-.030	.057[b]	-.033	.097[a]	.137[a]	.085	.017
Special Counseling	.029	.144[a]	-.093[a]	-.028	.044	.044[c]	.135[a]	.250[a]	.029	.009	-.007	-.047[c]
Crisis Intervention	.076[a]	.121[a]	-.053[b]	.068[b]	.143	.042[c]	.062[b]	.058[b]	.090[a]	.013	.068[b]	.055[b]
Parent Education	.142[a]	.039[c]	.025	.076[a]	.048[c]	-.061[b]	-.007	-.069[a]	.091[a]	.142	.132[a]	.022
Homemaking	.068[b]	.007	-.059[b]	.066[b]	.127[a]	.004	-.062[b]	-.025	.046[c]	-.057[b]	.090[a]	.065[b]
Child Services	.114[a]	.066[b]	-.023	.066[b]	.048[b]	-.080[a]	-.015	.004	.115[a]	.025	.112[a]	.113[a]
Welfare	.125[a]	.074[a]	-.069[a]	.214[a]	.346[a]	.011	-.089[a]	-.006	.073[a]	.014	.102[a]	.138[a]
Couples/Family Counseling	.041[c]	.094[a]	-.005	-.120[a]	-.030[a]	.016	.101[a]	.014	.002	.019	.040[c]	-.051[b]
Babysitting/ Transportation	.131[a]	.041[c]	-.033	.171[a]	.178[a]	.008	-.042[c]	-.029	.165[a]	.067[b]	.120[a]	.035

TABLE II-3

Correlations Between Select Services (Pearson's Correlation Coefficient)*

	MDT Review	One To One Couns.	Lay Therapy	Group Therapy	Parents Anonymous	Couples/ Family Couns.	Special Couns.	Crisis Inter-vention	Parent Education	Home-making	Child Services	Welfare	Transportation/ Babysitting
MDT Review	1.000												
One to One Counseling	.192[a]	1.000											
Lay Therapy	-.010	-.211[a]	1.000										
Group Therapy	.182[a]	.076[a]	.047[c]	1.000									
Parents Anonymous	.091[a]	-.086[a]	.288	.051[b]	1.000								
Couples/Family Counseling	.261[a]	.153[a]	-.122[a]	.015	.052[b]	1.000							
Special Counseling	.160[a]	.119[a]	-.024	.029	.058[b]	.189[a]	1.000						
Crisis Intervention	.144[a]	.172[a]	.094[a]	.116[a]	.076[a]	.183[a]	.137[a]	1.000					
Parent Education	.123[a]	.093[a]	.137[a]	.192[a]	.118[a]	.082[a]	.015	.133[a]	1.000				
Homemaking	.060[b]	.099[a]	-.002	-.033	.008	.042[c]	.018	.165[a]	.080[a]	1.000			
Child Services	.060[b]	.178[a]	.100[a]	-.014	.097[a]	.055[b]	.079[a]	.186[a]	.053[b]	.163[a]	1.000		
Welfare	-.044[c]	.146[a]	.203	.044[c]	.072[a]	-.067[b]	.039[c]	.207[a]	.103[a]	.172[a]	.239[a]	1.000	
Transportation/Babysitting	.144[a]	.105[a]	.238[a]	.294[a]	.146[a]	-.014	.189[a]	.260[a]	.202[a]	.042[c]	.134[a]	.283[a]	1.000

*Significant at the .01 level.

TABLE II-4

Correlations Between Improvement Scores on the Functioning Indicators (Pearson Correlation Coefficients)*

	General Health	Stress From Living Situation	Sense Of Child As Person	Behavior Toward Child	Awareness Of Child Development	Ability To Talk Out Problems	Reactions To Crises	Way Anger Is Expressed	Inde-pendence	Understanding Of Self	Self Esteem
General Health	1.000										
Stress From Living Situation	.197	1.000									
Sense of Child As Person	.155	.360	1.000								
Behavior Toward Child	.194	.352	.503	1.000							
Awareness of Child Development	.132	.323	.450	.494	1.000						
Ability to Talk Out Problems	.176	.297	.357	.371	.342	1.000					
Reactions to Crises	.141	.387	.361	.457	.371	.432	1.000				
Way Anger is Expressed	.135	.372	.359	.423	.371	.390	.556	1.000			
Independence	.157	.294	.340	.325	.310	.315	.375	.365	1.000		
Understanding of Self	.146	.304	.403	.365	.384	.371	.440	.463	.450	1.000	
Self Esteem	.158	.395	.353	.364	.355	.347	.411	.439	.558	.594	1.000

*All of these correlations are significant at the .001 level.

TABLE H-5

Correlations Between Composite Score of Improvement on the Functioning Indicators and Select Service and Client Characteristic Variables (Pearson's Correlation Coefficient)

Service Variables	
Lay Service Model	.103
Group Service Model	.033
Social Work Service Model	-.087
Social Work Service Model and Children's Services	.071
Social Work Service Model and Multidisciplinary Team Review	-.031
Individual Counseling (frequency)	.025
Lay Therapy Counseling (receipt)	.097
Group Therapy (receipt)	.023
Parents Anonymous (receipt)	.081
Couples/Family Counseling (receipt)	-.080
Specialized Counseling (receipt)	.013
Crisis Intervention (receipt)	-.047
Frequency of Contact	.031
Length of Time in Treatment	.124
Number of Different Services Received	.019
Client Variables	
Seriousness of Assault	-.038
Age of Parents	-.003
Age of Children	.012
Race/Ethnicity	-.031
Employment Status	-.045
Amount of Family Conflict	-.120
Presence of Substance Abuse	-.062
Degree of Social Isolation	-.054

TABLE H-6

Correlation Between Reduced Propensity for Future Abuse or Neglect and Select Service and Client Characteristic Variables (Pearson's Correlation Coefficient)

Service Variables	
Lay Service Model	.140
Group Service Model	-.023
Social Work Model	-.080
Social Work Model and Children's Services	.068
Social Work Model and Multidisciplinary Team Review	-.018
Individual Counseling (frequency)	.020
Lay Therapy Counseling (receipt)	.127
Group Therapy	-.023
Parents Anonymous	.089
Couples/Family Counseling	-.077
Specialized Counseling	.022
Crisis Intervention	-.045
Frequency of Contact	-.002
Length of Time in Treatment	.143
Number of Different Services Received	.028
Client Variables	
Seriousness of Assault	-.039
Age of Parents	-.029
Age of Children	.013
Race/Ethnicity	.048
Employment Status	-.024
Amount of Family Conflict	-.041
Presence of Substance Abuse	-.057
Degree of Social Isolation	.007

APPENDIX I

Interpreting Regression Analyses

Interpreting Regression Analyses

Readers should remember several basic guidelines for how to interpret the statistical findings of multivariate regression analysis which will be presented in the pages which follow. First, most of the regressions use binary (or dummy 0/1) dependent variables. With such dependent variables, the coefficient of determination (R^2) does not have the usual interpretation of percent of variance explained. The F test is still valid for determining the overall level of significance of the regression equation, and R^2s can be used to heuristically judge the worth of models. Thus, an R^2 of .10 indicates more explanatory power than an R^2 of .02, but not five times as much and perhaps only slightly more. Thus, the appropriate indicator of the power of the overall model may not always be the R^2. Often the percent of the sample population (the N) which can be correctly classified using the model is more useful. To estimate this percent, the regression coefficients can either be converted into a discriminant function for classification, or a discriminant functional analysis can be conducted directly.

The results from a discriminant functional analysis (or other classification techniques) differ from regression results and hence should be interpreted differently. It often turns out that even models with low R^2s can correctly classify a high percentage of the observations. For example, we shall later find that models with R^2s of .06 nevertheless correctly classify for 70% of clients whether the client will be judged at the end of treatment to have a reduced propensity for future abuse/neglect. In this example, the low R^2 indicates that the model can only explain a relatively small proportion of the variation between the two groups in the dependent variable (those with a reduced propensity and those without a reduced propensity).[1] The classification results, however, indicate that even though the independent variables do not fully explain outcome, they can correctly

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[1] Further model specification and/or additional information may be needed to fully explain the factors which influence propensity.

classify a high proportion of the observations. Thus, although the model leaves much to be explained, it does fairly well in the simple classification of outcomes.

Indeed, in classifying observations, we have followed the convention of assuming observations would normally divide 50-50 between the two groups. In fact, since only 30-40% of clients have positive outcomes, this classification criterion is very conservative. It reduces (perhaps dramatically) the percent correctly classified that would emerge if we made use of our outcome findings as a priori information (as in Bayesian statistics), and assumed as an expectation that clients divided 30-70 or 40-60 between successful and unsuccessful outcomes. In subsequent analyses, we shall explore the results of alternative classification criteria. When examining classification tables, the reader should also note that 50% of the cases will be correctly classified due to chance.

Second, statistical significance basically measures the stability of a relationship. The regression coefficient measures the size or degree of relationship. The regression coefficient is intuitively the average relationship found between the dependent and the predictor variable. A relationship which is significant at the .05 level intuitively means that the relationship which is found (measured by the regression coefficient) will arise in almost every case. A relationship which is not significant at the .01 or .05 levels may still be important; it simply occurs inconsistently. Thus, the size of the regression coefficient remains important even when not consistently found for every case; a large but nonsignificant coefficient can be more important for providing insight into program planning questions than a small but significant coefficient.

Third, this last point highlights the difference between significance testing in general research and in program evaluation. In general research, we are concerned with knowledge-building. We would rather err on the side of not accepting a valid relationship than on the side of accepting an invalid relationship. Future research may always uncover our mistake and establish the validity of a rejected

relationship. In program evaluation, we are concerned with improving decision making. Managers and clinicians have very different tolerances for uncertainty than scientists. Decisions must be made in spite of uncertainty, and most decision makers will live with information, for example, that has at least a 70% chance of being valid for that particular decision. Thus, in program evaluation, one should use higher levels of significance than in research concerned with general knowledge-building, in deciding what information about relationships revealed by analysis (e.g., regression coefficients) should be given serious consideration. Otherwise, we discard information that can provide much insight and probably improve program performance, simply because we lack the stricter criteria of certainty that we require for what we call "scientific knowledge." What the appropriate levels of significance should be depends on the nature of the decisions being served by the analysis. Economists sometimes live with .30 significance (roughly a t-ratio of 1.00) where inclusion of a variable provides more predictive power than it causes a model to lose by reducing degrees of freedom. Clinicians and managers might well live with less, particularly in child abuse/neglect, where without further information, there is only a 30-40% expectation of success with a client. In this study, we conservatively emphasize variables with a .05 or at most .10 level of significance, because the study is addressed to researchers as well as program managers and service providers. Readers who have the latter roles should therefore examine the data results more liberally.

Fourth, in the case of regressions with binary dependent variables, the coefficient is akin to a conditional probability. Thus, in a regression using reduced propensity for future abuse/neglect, a coefficient of +.10 for a service variable means that receipt of the service is associated across the client population on the average with a 10% increase in the probability of a positive treatment outcome (i.e., reduced propensity for future abuse/neglect). Since probability can only range from .0001 to 1.0000, coefficients are rarely likely to be large unless there is an incredibly strong relationship. In evaluating

coefficients, the reader should use normal logic about betting. With what is only a 5-10% odds favoring the house, gambling casinos still are capable of earning large profits from games of chance. When decisions must be made, even slight gains in predictions can have great value to a program manager or clinician.

Fifth, in regression analysis with binary dependent variables, coefficients are unbiased but variances are inflated. Thus, significance testing at any given level is more conservative than would be the case with a normal, continuous dependent variable. Because of this, we have tended to use .10 levels of significance in considering variables rather than .05. The .10 level, given the binary dependent variable, is more likely to yield conclusions comparable to use of a .05 level in regressions with continuous dependent variables.

APPENDIX J

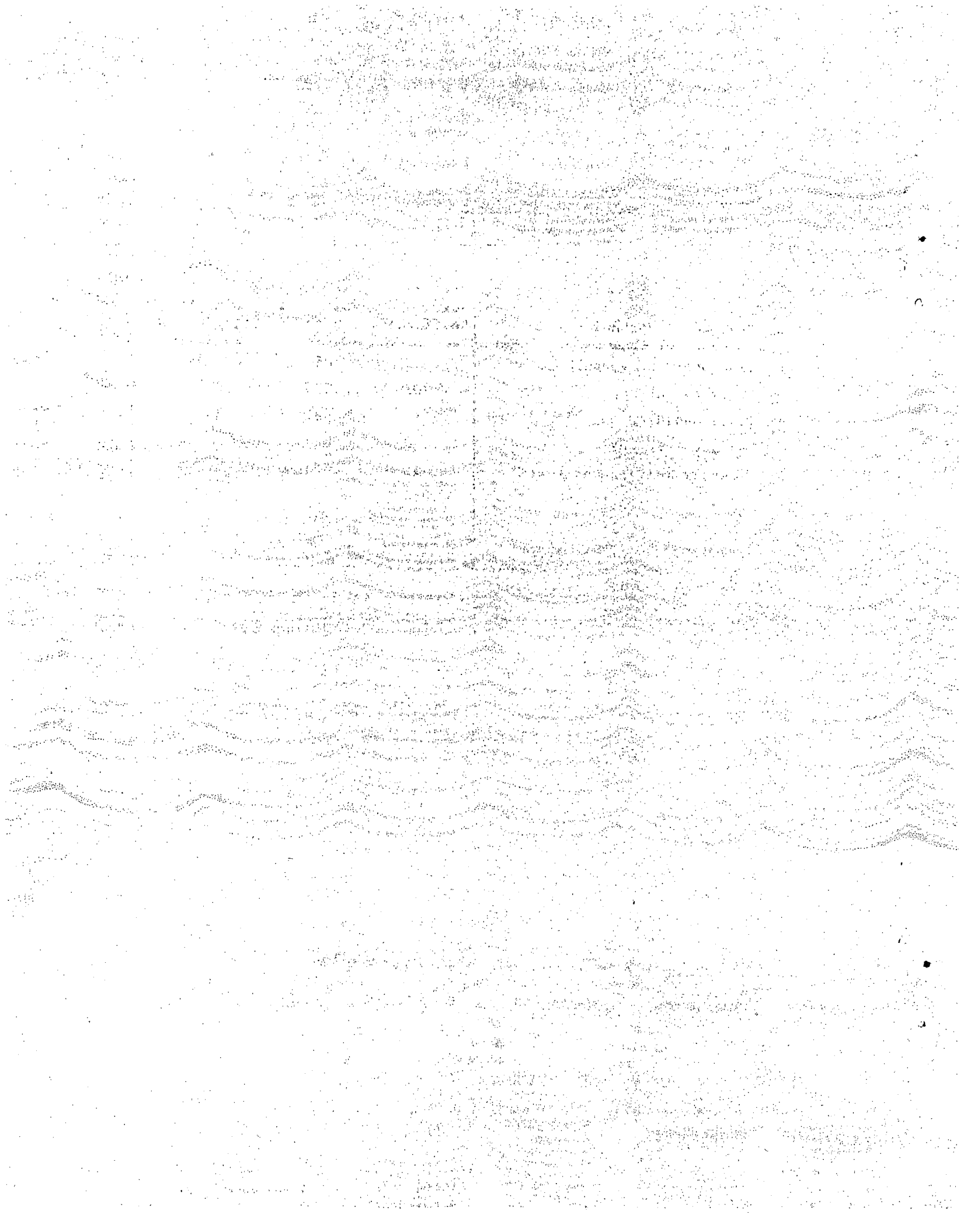

TABLE J.1

Effects of Select Client Characteristics on Severe Reincidence While in Treatment

Independent Variables	Regression Coefficient	Standard Error	Significance
Seriousness of assault	.377	.030	.001
Age of parents	—.006	.030	.85
Age of children	.037	.031	.23
Employment status	.039	.032	.23
Degree of family conflict	.031	.033	.35
Degree of social isolation	—.018	.031	.56
Substance abuse problems	.003	.036	.92
Constant	.133	.032	.001

Adjusted R^2 = .15
Significance of adjusted R^2 = .001

TABLE J.2

Effect of Service Receipt on Severe Reincidence

Independent Variables	Regression Coefficient	Standard Error	Significance
Multidisciplinary team review	.043	.032	.18
Child services	.020	.039	.11
Lay therapy	.092	.040	.02
Homemaking	.003	.068	.96
Special counseling	.235	.061	.001
Group therapy	−.019	.046	.68
Parent education classes	−.123	.049	.01
Crisis intervention	.140	.033	.001
Family planning	.107	.068	.12
Parents Anonymous	−.010	.068	.89
Couples/family counseling	−.023	.032	.47
Individual counseling	−.059	.042	.16
Welfare assistance	.078	.036	.03
Transportation/babysitting	−.001	.037	.97
Other	.038	.035	.29
Constant	.223	.042	.001

Adjusted R^2 = .07

Significance of adjusted R^2 = .001

TABLE J.3

Effect of Service Model Receipt on Severe Reincidence

Independent Variables	Regression Coefficient	Standard Error	Significance
Lay model	.229	.069	.001
Group model	.133	.074	.07
Social work model	.122	.065	.06
Constant	.053	.062	.01

Adjusted R^2 = .01

Significance of adjusted R^2 = .002

TABLE J.4

Effect of Service Model Receipt and Seriousness of Assault on Severe Reincidence

Independent Variables	Regression Coefficient	Standard Error	Significance
Seriousness of assault	.380	.029	.001
Lay model	.178	.064	.005
Group model	.084	.068	.22
Social work model	.101	.060	.09
Constant	.060	.058	.30

Adjusted R^2 = .16

Significance of adjusted R^2 = .001

TABLE J.5

Composite Score of Improvement on the Functioning Indicators and Select Client Characteristics

Independent Variables	Regression Coefficient	Standard Error	Significance
Age of parents	−.012	.021	.56
Age of children	.020	.023	.38
Employment status	−.030	.023	.19
Degree of family conflict	−.080	.024	.001
Degree of social isolation	−.032	.022	.14
Substance abuse problems	−.018	.026	.49
Severity 1 (low)	.063	.054	.24
2	.064	.051	.20
3	.055	.050	.27
4 (high)	.065	.053	.22
Potential maltreatment	.089	.054	.10
Emotional maltreatment	.024	.054	.65
Sexual abuse	.064	.068	.35
Physical abuse	.085	.050	.09
Physical neglect	.051	.052	.32
Constant	.193	.071	.007

Adjusted R^2 = .02

Significance of adjusted R^2 = .002

TABLE J.6

Effects of Service Receipt on the Composite Score of Improvement on the Functioning Indicators

Independent Variables	Regression Coefficient	Standard Error	Significance
Multidisciplinary team review	−.042	.025	.10
Child services	−.008	.031	.80
Lay therapy	.056	.031	.08
Homemaking	−.046	.054	.40
Special counseling	.019	.048	.69
Group therapy	.011	.037	.76
Parent education classes	.061	.039	.11
Crisis intervention	−.056	.026	.03
Family planning	.105	.054	.05
Parents Anonymous	.110	.054	.04
Couples/family counseling	−.058	.026	.02
Individual counseling	.054	.033	.10
Welfare	−.030	.029	.30
Transportation/babysitting	−.006	.029	.85
Other	.016	.028	.57
Constant	.293	.033	.001

Adjusted R^2 = .02

Significance of adjusted R^2 = .006

TABLE J.7

Effects of Service Model Receipt on the Composite Score of Improvement on the Functioning Indicators

Independent Variables	Regression Coefficient	Standard Error	Significance
Lay model	.153	.050	.01
Group model	.121	.053	.02
Social work model	.068	.048	.16
Constant	.188	.046	.001

Adjusted R^2 = .01

Significance of adjusted R^2 = .001

TABLE J.8

Effects of Select Service Delivery Variables Not Including Service Models on the Composite Score of Improvement on the Functioning Indicators

Independent Measures	Regression Coefficient	Standard Error	Significance
Individual counseling (receipt)	−.001	.032	.98
Individual counseling (frequency)	.017	.008	.04
Group counseling	.010	.030	.74
Specialized counseling	.027	.041	.52
Couples/family counseling	−.064	.023	.005
Parents Anonymous	.095	.048	.05
Crisis intervention	−.049	.024	.04
Lay therapy counseling (receipt)	.068	.031	.03
Lay therapy counseling (frequency)	−.000	.003	.89
Frequency of contact	−.001	.002	.73
Length of time in treatment	.100	.022	.001
Number of different services received	−.001	.029	.97

Adjusted R^2 = .03

Significance of adjusted R^2 = .001

TABLE J.9

Effects of Select Service Delivery Variables, Including Service Models, on the Composite Score of Improvement on the Functioning Indicators

Independent Measures	Regression Coefficient	Standard Error	Significance
Lay model	.136	.059	.02
Group model	.083	.056	.14
Social work model	.037	.049	.46
Social work model with children's services	−.027	.042	.53
Social work model with multidisciplinary team review	−.037	.024	.13
Individual counseling	.018	.080	.03
Lay therapy counseling	.000	.003	.96
Specialized counseling	.032	.041	.43
Crisis intervention	−.050	.024	.04
Couples/family counseling	−.051	.023	.03
Frequency of contact	−.001	.002	.84
Length of time in treatment	.105	.022	.001
Number of different services received	.006	.030	.84
Constant	.175	.048	.001

Adjusted R^2 = .03

Significance of adjusted R^2 = .001

TABLE J.10

Effects of Client and Service Provision Variables on Composite Score on Improvement on the Functioning Indicators

Independent Variables	Regression Coefficient	Standard Error	Significance
Service Descriptors			
Lay model	.070	.028	.01
Group model	.052	.030	.09
Social work model with multi-disciplinary team review	−.033	.024	.17
Specialized counseling	.066	.042	.12
Crisis intervention	−.035	.023	.14
Individual counseling	.017	.070	.01
Couples/family counseling	−.063	.023	.007
Parents Anonymous	.078	.049	.11
Length of time in treatment	.112	.022	.001
Number different services received	.088	.029	.76
Client Descriptors			
Seriousness of assault	−.015	.021	.48
Degree of family conflict	−.086	.024	.001
Degree of social isolation	−.057	.023	.01
Employment status	−.047	.023	.05
Age of children	.008	.023	.72
Age of parents	−.024	.022	.27
Presence of substance abuse	−.035	.027	.20
Constant	.266	.030	.001

Adjusted R^2 = .06 (adjusted R^2 without client descriptors = .04)

Significance of adjusted R^2 = .001

TABLE J.11

Effects of Select Client and Service Descriptors, Severity of the Case, and Severe Reincidence on Composite Score of Improvement on the Functioning Indicators

Independent Variables	Regression Coefficient	Standard Error	Significance
Lay service model	.093	.025	.001
Group service model	.051	.069	.06
Individual counseling	.016	.007	.02
Couples/family counseling	−.059	.027	.06
Length of time in treatment	.107	.020	.001
Frequency of contact	.000	.001	.84
Degree of family conflict	−.077	.022	.001
Degree of social isolation	−.055	.021	.01
Employment status	−.052	.021	.01
Severe reincidence	−.040	.022	.07
Severity 1 (low)	.070	.048	.14
2	.074	.047	.11
3	.064	.046	.17
4 (high)	.079	.050	.11
Constant	.179	.052	.001

Adjusted R^2 = .06

Significance of adjusted R^2 = .001

TABLE J.12

Effect of Select Client Characteristics on Reduced Propensity for Future Abuse or Neglect

Independent Variables	Regression Coefficient	Standard Error	Significance
Seriousness of Assault	.021	.034	.54
Age of parents	−.013	.034	.73
Age of children	.016	.036	.64
Employment status	−.004	.037	.91
Degree of family conflict	−.022	.037	.55
Degree of social isolation	.006	.035	.87
Substance abuse problems	−.069	.041	.09
Constant	.364	.037	.001

Adjusted R^2 = −.003

Significance of adjusted R^2 = .73

TABLE J.13

Reduced Propensity and Service Receipt

Independent Variables	Regression Coefficient	Standard Error	Significance
Multidisciplinary team review	.014	.035	.68
Child services	.057	.042	.17
Lay therapy	.156	.043	.001
Homemaking	−.010	.074	.89
Special counseling	.063	.066	.31
Group therapy	.006	.050	.90
Parent education classes	.106	.053	.05
Crisis intervention	−.040	.035	.26
Family planning	.064	.074	.39
Parents Anonymous	.055	.073	.46
Couples/family counseling	−.053	.035	.13
Individual counseling	.037	.045	.41
Welfare	.006	.039	.88
Transportation/babysitting	−.067	.040	.09
Other	.066	.038	.08
Constant	.297	.045	.001

Adjusted R^2 = .02

Significance of adjusted R^2 = .001

TABLE J.14

Reduced Propensity and Service Model Receipt

Independent Variables	Regression Coefficient	Standard Error	Significance
Lay model	.250	.073	.001
Group model	.105	.077	.17
Social work model	.097	.070	.17
Constant	.283	.067	.001

Adjusted R^2 = .02

Significance of adjusted R^2 = .001

TABLE J.15

Reduced Propensity for Abuse and Neglect and Select Service Delivery Variables, Including Service Models

Independent Measures	Regression Coefficient	Standard Error	Significance
Lay model	.305	.085	.001
Group model	.012	.081	.88
Social work model	.026	.071	.72
Social work model with children's services	−.154	.062	.01
Social work model with multi-disciplinary team review	−.032	.035	.37
Individual counseling	.034	.012	.003
Lay therapy counseling	−.003	.005	.53
Specialized counseling	.050	.059	.40
Crisis intervention	−.069	.034	.04
Couples/family counseling	−.084	.033	.01
Frequency of contact	−.005	.003	.13
Length of time in treatment	.172	.032	.001
Number of different services received	.042	.043	.33
Constant	.267	.070	.001

Adjusted R^2 = .05

Significance of adjusted R^2 = .001

TABLE J.16

Reduced Propensity for Abuse and Neglect and Select Service Delivery Variables, Not Including Service Models

Independent Measures	Regression Coefficient	Standard Error	Significance
Individual counseling (receipt)	−.036	.046	.43
Individual counseling (frequency)	.032	.012	.006
Group counseling	−.063	.044	.15
Specialized counseling	.048	.059	.42
Couples/family counseling	−.099	.033	.003
Parents Anonymous	.156	.070	.03
Crisis intervention	−.068	.034	.05
Lay therapy counseling (receipt)	.165	.045	.001
Lay therapy counseling (frequency)	−.003	.005	.47
Frequency of contact	−.005	.003	.11
Length of time in treatment	.165	.032	.001
Number of different services received	−.031	.042	.46
Constant	.338	.045	.001

Adjusted R^2 = .05

Significance of adjusted R^2 = .001

TABLE J.17

Effects of Client and Service Provision Variables on Reduced Propensity for Future Abuse and Neglect

Independent Variables	Regression Coefficient	Standard Error	Significance
Service Descriptors			
Lay model	.249	.057	.001
Group model	.000	.043	.99
Social work model with children's services	−.133	.062	.03
Specialized counseling	.103	.061	.09
Crisis intervention	−.045	.033	.17
Individual counseling	.037	.011	.001
Couples/family counseling	−.095	.033	.004
Parents Anonymous	.075	.073	.30
Length of time in treatment	.178	.032	.001
Frequency of contact	−.005	.002	.03
Client Descriptors			
Seriousness of assault	−.042	.031	.18
Degree of family conflict	−.029	.035	.41
Degree of social isolation	−.015	.033	.65
Employment status	−.022	.034	.52
Age of children	.003	.034	.94
Age of parents	−.043	.032	.17
Presence of substance abuse	−.075	.039	.06
Constant	.342	.044	.001

Adjusted R^2 = .06 (adjusted R^2 without client descriptors = .06)

Significance of adjusted R^2 = .001

TABLE J.18

Effect of Most Salient Independent Variables on Reduced Propensity for Abuse or Neglect

Independent Variables	Regression Coefficient	Standard Error	Significance
Lay service model	.246	.046	.001
Social work service model with children's services	−.169	.058	.01
Couples/family counseling	−.092	.030	.01
Specialized counseling	.117	.059	.05
Individual counseling	.025	.009	.01
Length of time in treatment	.176	.030	.001
Severe reincidence	−.101	.031	.001
Substance abuse	−.075	.036	.04
Constant	.302	.032	.001

Adjusted R^2 = .06

Significance of adjusted R^2 = .001

TABLE J.19: Comparative Effectiveness of Services with Different Types of Maltreatment Problems

Service	Increase in Conditional Probability of Reduced Propensity for Future Abuse/Neglect if Client Received Service				
	Potential Cases	Emotional Abuse/Neglect	Physical Abuse	Physical Neglect	All Clients Combined
Lay service model	.37	.29	.14	.32	.25
Group service model	.06	−.08	−.09	.16	−.002
Social work model with children's services	−.14	−.01	−.04	−.35	−.13
Frequency of individual counseling	.02	.06	.03	.07	.04
Special counseling	.17	.25	.03	.05	.06
Crisis intervention	−.03	−.14	−.06	.000	−.06
Couples/family counseling	−.01	−.02	−.10	−.04	−.09
Parents Anonymous	.12	.04	.11	−.08	.08
Length of time in treatment	.07	.26	.13	.30	.17
Frequency of contact	.03	−.01	−.07	.004	−.05
Constant	.31	.27	.40	.06	.29
Percent correctly classified using above predictors	70%	70%	62%	71%	62%