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16. Abstracts
This report describes the development of a methodology for determining the quality of the case management process in child abuse and neglect service programs as well as the application of this method to nine of eleven demonstration child abuse and neglect service projects. Included in the report are: a detailed discussion of the methodology; an assessment of the feasibility of collecting reliable data on this subject in the child abuse field; a description of the case management process at the demonstration projects; and an analysis of the factors associated with high quality case management. Suggested minimal standards of case management for the field are presented as well. The method used is adapted from the medical care quality assessment field.

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PREFACE

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

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

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

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

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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 demonstration child abuse and neglect projects to develop and test alternative strategies of treating abusive and neglectful parents and their children, and alternative models for coordinating community-wide child abuse and neglect systems.

The projects, located around the country and in Puerto Rico differed in size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. In order to document the context of the different service interventions being tested and to determine their relative effectiveness and cost-effectiveness, the Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the demonstration effort. This Quality of the Case Management Process Report presents the findings from that evaluation related to the identification of the most essential elements of quality case management.

I. Methodology

In the interest of identifying standards for case management and understanding the relationship between case management and client and program outcomes, a number of child abuse and medical case audit specialists were consulted to identify both the elements of and methods for assessing the quality of the case management process. The procedures developed were adapted from those used in conducting audits of medical care delivery. The methodology, pre-tested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects to review a random sample of case records from each of the treatment workers and to interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. The relationships between case management and client outcome were also identified. Care must be used in generalizing from the findings of this study; the projects studied were demonstrations selected because of their differences. As such, they are not necessarily representative of other child abuse and neglect programs. This is the first known attempt to develop quality of care measures for the child abuse field using the medical model, and considerable refinement of the approached developed is encouraged.

II. Judging Case Management Quality

Extensive reliability tests of the data were conducted by having more than one reviewer assess a subsample of cases. It was found that reviewers can reliably collect factual information about case handling and, that while acknowledge experts in the field generally rate quality in the same way as persons knowledgeable about child abuse but not "clinical experts," judgments about quality cannot be finely distinguished by anyone. At this point in the development of the field, usually judgments can only reliably be made between "poor practice" and "better than poor practice."

III. How Cases Were Managed in the Demonstration Projects

More than one-half of the cases were contacted within three days of the initial report. Before coming to a decision on the plan of treatment for a client, usually at least one more meeting with the client in addition to the first contact was made; treatment services, then, would typically begin within two weeks of the first contact with the client. Despite the interest and attention in the field to multidisciplinary review of cases, the typical case in the sample was not reviewed by a multidisciplinary review team at any time in the process. Use of outside consultants on the management of the case also was not the norm. On the other hand, whereas case conferences or staffings usually were not used on the case at intake or termination, there was a likelihood that such a conference was held sometime during the treatment phase of the case. The current manager of the case was usually the person who also carried out the intake, and further, the typical case had only one case manager. Other than the primary case manager there was likely to be at least one other person in the project working with the client and, at the same time, the client usually also received services from an outside agency. Evidence of communication and coordination with the source of the report and with outside treatment providers (if the client was receiving such services) was also the norm, but active client participation in treatment planning and reassessment was not the usual practice. On average, throughout the history of the case, the case manager would meet with the client about once or twice a month. The typical case was open no more than one year and, after a case was terminated, usually a follow-up contact was made either with the client or with another service provider still working with the client.

IV. Factors Associated with High Quality Intakes

The factors most highly associated with expert-judged quality intake include: use of a multidisciplinary review team; minimal time between the report and first client contact; use of outside consultation; and use of the same case manager for conducting the intake and managing ongoing treatment. The more education and experience the case manager has, the more likely that the intake will be rated of higher quality. Responsiveness of clients is also a factor in quality intake.

V. Factors Associated with High Overall Quality Case Management Process

The factors most highly associated with expert-judged overall quality are: minimal time between the report and first client contact; use of outside consultants; frequent contact with client during the history of the case; a longer time in process; a difference in ethnicity between the client and the manager. Responsive clients are more likely to receive high quality ratings on overall case management. Factors with less stable, but substantively interesting effects on quality include: recontacting the reporting source for further background information on the case; using multidisciplinary review teams; and following up on clients after termination.

VI. The Relationship Between Quality Case Management and Client Outcome

Based on the data collected and analyzed from this developmental phase in assessing case management practices and client outcome, there is little appreciable relationship between quality case management and positive client outcomes. Of all the case management processes studied, the two with some association to client outcome were found to be: smaller caseload size (under 20) and longer time in process (over 6 months). Whereas in this evaluation study case handling practices do not predict client outcome, quality case management does serve to protect clients' interests, support case manager efficiency and program cost-efficiency, and improve system-wide coordination of services to clients.

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 research and demonstration projects. A substantial portion of that allotment, approximately three million dollars, was to be spent jointly by the Office of Child Development's (OCD) Children's Bureau, and Social and Rehabilitation Services (SRS) on a set of demonstration treatment programs. On May 1, 1974, after review of over 100 applications, OCD and SRS jointly selected and funded eleven three-year projects.[1] The projects, spread throughout the country, 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 their clients and their local communities.

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

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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: 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.

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.

As a group, the projects embraced the federal goals for this demonstration effort, which included:

(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;

(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 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, included:

- 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?

Throughout the demonstration period, numerous documents describing project activities and preliminary findings were prepared by the evaluators. For a listing of major study reports and papers see Appendix A.

Project Profiles

As a group, the projects demonstrated diversified 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 several 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 service-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 an interdisciplinary 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. These workers, with the back-up of professional consultants, provided 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 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 Quality Case Management Component of the Evaluation

At the outset of the demonstration evaluation, the proposed study design called for extensive analysis of the impact of the eleven participating demonstration projects on their clients and on the communities in which they resided. However, within a few months of the evaluation's inception, it became evident that the projects' processes of service delivery could not be ignored and development of a systematic method to describe variation in the quality of the delivery of treatment services was initiated.

Two primary purposes for the study presented here emerged. Given the limited nature of previous research on evaluating the process of social services delivery, it seemed that an important contribution could be made toward development of standards of service delivery for child abuse and neglect programs in particular and the social services field in general. And secondly, because of the demonstration evaluation's simultaneous study of client outcome following service intervention, it would be possible to test if case management practices make a difference in terms of successful outcome for clients.

The following report presents the rationale for being concerned with case management, and discusses the development of the methodology used to assess case management practices, the norms of case management found in the projects, the elements of case management most often associated with judgments of quality, and the relationship of quality case management practices to client outcome. This study was carried out in demonstration projects selected because they represented new and different approaches to child abuse and neglect treatment. They are not necessarily representative of other child abuse and neglect programs across the country and thus care must be used in interpreting and generalizing from the findings. The methodology used, adapted from the medical care/medical audit field, is largely developmental, further limiting the conclusiveness of the findings.

SECTION I: DEVELOPMENT OF THE APPROACH FOR STUDYING THE QUALITY OF THE CASE MANAGEMENT PROCESS

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

A. A Survey of Medical Quality Assessment

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

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

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

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

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

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

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

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

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

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

B. Focusing on Case Management

To map out an approach for a process-related quality assessment of the child abuse/neglect projects, a two-day workshop was used to elicit specific suggestions from experts in both medical quality assessment and in child abuse and neglect service delivery. Various alternative

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

approaches were considered, but by consensus from the participants it was decided that a project's case management function, because it involved a wide range of process activities and also appeared to be amenable to assessment within the scope of the overall evaluation, would be the focus of the quality assessment.[1]

"Case management is best understood as a process made up of a series of interconnected steps. . .[that] constitute a framework for activities and tasks in the agency/worker/client relationship."[2] Case management in a child abuse and neglect service agency includes phases of service delivery from intake through diagnosis, development of a treatment plan, management of service delivery and referral, to case termination and follow-up after termination. Good case management, which is important for successful service delivery, implies continuity of service provision, planfulness (i.e., rational decision-making) in designing and executing a treatment package, coordination among all providers of services, effective involvement of the client, timeliness in moving clients through the process and maintenance of an informative and useful case record.

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[1]For further detail on the range of approaches considered, see Report on the Quality Assessment Workshop, Berkeley Planning Associates, April 1975.

[2]Adapted from "The Case Management Model," Volume I, Regional Institute of Social Welfare Research, Inc., Athens, Georgia, 1977, p. 5.

SECTION II: METHODOLOGY[1]

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

A. Selecting Criteria and Measurement Tools

Given that the focus of this effort was to identify the essential elements of case management, the first step was to develop criteria by which to judge the adequacy of this process in each of the eleven demonstration projects. An initial list of criteria was developed by the participants at the Quality Assessment Workshop and refined through consultation with others experienced in child abuse/neglect and general social service delivery. Appendix B1 contains this complete criteria list along with necessary measurements and potential data sources.

Several means for measuring the case management practices of the demonstration projects against these criteria were considered, including record reviews, observation of worker-client interaction, self-

[1]For a more detailed description of sections of the methodology, see Appendices B1 through B4.

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

With the decision on a general approach, it was then possible to translate those criteria considered to be measurable by means of a case audit into data collection instruments. A pre-test of the draft instruments and procedures was conducted at four abuse/neglect programs in mid-1975. Appendix B2 details the methods and results of the pre-test.

B. Data Collection

Following refinement of the methods and instruments as a result of the pre-test, primary data was collected during site visits to nine demonstration projects.[1] Reviews of a sample of cases at each project provided the quantifiable data. Unstructured interviews, using a

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[1] Included were the projects in Adams County, Colorado; Arlington, Virginia; Baton Rouge, Louisiana; Bayamon, Puerto Rico; Fayetteville, Arkansas; Los Angeles, California; St. Louis, Missouri; Tacoma, Washington; and Union County, New Jersey. The projects in Neah Bay, Washington and St. Petersburg, Florida were not included due to an insufficient number of cases.

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

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

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

The Orientation Checklist (see Appendix B3) elicits project-wide information to provide sufficient background for the assessors to conduct their case reviews. The checklist includes 26 topics that the quality assessment team should cover at the beginning of each site visit. The topics range from organizational structure and political context to caseload per worker. The information covered in this instrument was primarily for the assessor's use and was not tabulated.

The Case Review Instrument (see Appendix B3) was designed to obtain, for a sample of cases, information on case management practices as well as ratings by the assessor on the quality of case management provided for each case. The information collected in the case review instrument is obtained from both the written case record and through interview with the case manager. First, assessors reviewing the case record search for the information asked for in the instrument. This abstracting process takes between 30-45 minutes. Following the record

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

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

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

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

The use of case reviews as the major data source for the quality assessment necessitated a sampling procedure, since not all cases could be reviewed within time and budget constraints. The sampling procedure addressed the need to draw conclusions in which we could have reasonable confidence of representativeness across the total pool of cases. With this condition in mind, a sampling strategy was devised which called for selecting a portion of terminated cases from those projects with large caseloads or all cases (terminated and active) from those projects with smaller caseloads. A stratified sample was drawn from each project's list of cases that were opened between January 1975 and January 1976, using the case manager as the stratum, and randomly drawing from each stratum (that is, each case manager's caseload) a number of cases proportional to the size of his or her caseload to the total project caseload. A minimum of two cases was selected for each caseworker. Stratification on the basis of case managers ensured representation in our sample of the range of case practices and would enable us to perform analyses focusing on the importance of the case manager in determining the quality of case management.[1]

C. The Data Base

The two rounds of site visits to the demonstration projects yielded a review of 354 cases. As shown in Table II-1, the number of cases per project ranged from a high of 51 in Union County to a low of 13 in Los Angeles. Appendix C presents a description of the cases and case managers in the total sample.

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[1] For a more detailed description of the sample design, see Appendix B4.

TABLE II-1

Number of Cases Reviewed, by Project

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

D. Quality Controls and Data Processing

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

E. Data Analysis

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

As indicated earlier, the data gathered and analyzed is from a set of projects selected because of the strategies they proposed to test out, not because they were representative of child abuse and neglect programs in general. Findings must, therefore, be regarded as reflective of the experiences of these demonstration projects, and not necessarily other child abuse and neglect programs.

Table II-2 displays the total set of case management data items used throughout the analysis. For portions of the analysis these items were integrated with data on client outcome and program characteristics collected for other components of the evaluation.

TABLE II-2: Quality Case Management Data Items[1]

Case Descriptors

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

Case Handling Descriptors

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

Case Handling Descriptors (continued)

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

Case Manager Descriptors

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

TABLE II-2 (Continued)

Case Manager Descriptors (continued)

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

Quality Measurement Descriptors

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

Quality Measurement Descriptors (continued)

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

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

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

SECTION III: IS IT POSSIBLE TO RELIABLY JUDGE CASE MANAGEMENT QUALITY?

It is important, before beginning extensive analysis of the information collected during the case management assessment site visits, to examine the reliability of the data in order to determine how much confidence we can place in the measures of quality case management. In looking at the reliability of the case review instrument, we are interested in the degree to which people with the same information available to them make the same observations and interpretations.

There are three purposes for establishing the reliability of the collected data. The first is to determine whether two reviewers can be consistent in ascertaining so-called factual information on a given case. The second purpose is to shed light on whether reviewers, either "expert" social workers who are acknowledged as such by their colleagues in the field, or trained, but "non-expert" staff can agree on judgments about good or poor quality in handling cases. The third purpose is to determine, based on these tests for reliability, to what extent one can use the data already in hand to make generalizations about case management practices for the field.

A. Pre-Test Results

In pursuing the question of instrument and methodology reliability, we conducted a test of reviewer agreement on a pre-test version of the current case review form in the summer of 1975. At that time, all case reviews were performed independently by two expert assessors, and one-half of the cases were additionally reviewed by a non-expert BPA staff member. Analysis revealed a high percentage of agreement across the reviewers who carried out the pre-test. It is of interest that analysis of agreement between types of reviewers showed no pattern of expert versus non-expert differences. Disagreements across reviewers were

equally likely to be between the two experts as between expert and non-expert. Appendix B2 details the results of the pre-test.

B. Further Testing of Inter-Rater Reliability

The instrument was refined following the pre-test, but the need to further document reliability remained. Thus, certain reliability checks were built into the case management assessment site visits. The most extensive analysis of reliability occurred during the first round of data collection in the spring of 1976. At seven sites, five or six cases from the total sample for each site were selected at random for independent review by the two or three expert reviewers present at the site. Thirty-six reliability cases were sampled in this manner from a total sample of 245 cases. The procedure for collecting case data for the reliability sample of cases required that each reviewer separately abstract the record and complete as much of the questionnaire as possible. Then, in the interest of efficiency, the primary case worker for each reliability case was interviewed jointly by both reviewers. One reviewer was designated as the lead questioner, but the other was free to ask any necessary further questions. The portion of the questionnaire which called for ratings was then completed independently by each reviewer.

To determine reliability, the number of times there was agreement between two reviewers for each variable or instrument item was tallied. The measure of reliability, then, was the percentage of cases with agreement. Because of the exploratory nature of this study, it was decided that all items with agreement of over 70% would be acceptable for use in future analysis. For those items for which there was less than 70% agreement on an absolute basis (that is, two reviewers agreeing exactly on an answer or rating) an adjusted agreement percentage was calculated, collapsing the scale or range of choices in the original questionnaire.

The detailed reliability test results are presented in Appendix D. In summary, the items of the instrument were divided into four groups of variables: (1) descriptors of the case, the client and the

case worker; (2) descriptions of case handling practices; (3) judgments about the case record; and (4) judgments on the management of the case.

Since responses to the first group of items, describing the case, client and caseworker, were usually determined by referring to record forms of routinely collected information, with no interpretation involved, the data would be expected to be highly reliable.[1] Most of these items showed 90% or more absolute agreement.

For the second grouping of questionnaire items (description of case handling practices) there was a wider range of absolute agreement, from a high of 100% to a low of 57%. This was due to the fact that much of the needed information was not clearly recorded in the record, and in many cases interpreting various clues was called for. In general, the greater the number of choices for a given question, the less absolute agreement. However, when the responses to scales and multiple choice items were collapsed into fewer, yet logical and analytically useful categories, at least 70% agreement was achieved for all items and most items have 80% or more inter-rater agreement.

For those items in the original questionnaire calling for judgment of the adequacy of the written record, there was very low reliability in terms of absolute agreement, and even with an adjusted two-point scale the level of agreement was still low, with an average percentage of agreement of only 60%. Apparently the reviewers (and perhaps other experts in the field also) could not agree on what was the necessary content of a record for adequate case management. Because of the low percentage of agreement across this group of variables, they were eliminated from use in the data analysis.[2]

As was predictable, for quality judgments (ratings) on various aspects or elements of case management, there was poor absolute reliability using a five-point scale. In general, there was little improvement in agreement when moving from a five-point to a three-point scale;

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[1] Instrument numbers 1-14, 16, 37-40, 58, and A-K.

[2] Also, because of their lack of reliability, these questions were not included in the final version of the case review instrument, as presented in Appendix B3.

certainly not enough, in most cases, to consider collapsing and using the data in this way. In attempting to find the best way to make use of the reviewer assessment items of the case review instrument, given low reliability on five-point and three-point scales, it was decided to look at the data on a binary scale. To do this, rather than having a predetermined breakpoint for dividing the five-point scale, the data itself revealed how the reviewers used the scales and the extent to which there was reliability. For fifteen of the seventeen judgment items, the reviewers reliably differentiated the poorest managed cases; for the remaining two items they agreed on the best handled cases. This level of agreement suggests that, while the state-of-the-art in the management in child abuse and neglect cases does not allow for fine distinctions of poor and good quality, there is some agreement on what is poor quality or on what is good quality.[1]

C. Reliability of Data Between Experts and Non-Experts

Because of interest in determining the usefulness and the transferability of the case management assessment methodology, the final round of site visits conducted in late 1976 and early 1977 included a check on reliability between expert and non-expert assessors to see if the use of expert social workers is critical for conducting this type of evaluation.[2] Can a person well-trained in the use of the instruments and familiar with the field, but not experienced in delivering services to child abusers/neglectors, abstract records, interview workers and make quality judgments just as reliably as an expert?

In summary, as might be expected, there was no difference in the percentage of absolute agreement for instrument items on case handling practices. Both experts and non-experts can collect the facts of case

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[1] An alternative approach for using the reviewer ratings of quality would have been to disregard the reliability data, and use a five-point scale or a predetermined breakpoint consistently for each item. Given that this is an exploratory study, attempting to learn how to maximize reliability in this as yet unexplored area, this alternative was felt to be less desirable.

[2] Appendix D presents a breakdown of expert and non-expert inter-rater agreement.

management with a similar degree of reliability--in some cases the two experts did better and in other cases the expert and non-expert agreed more often. While acknowledging the use of a small comparative sample, it is particularly interesting to note that for ratings on the quality of various aspects of case management, in fact, the expert and non-expert apparently agreed more often that did two experts. The conclusion, then, is that while use of experts is perceived as more legitimate by those being evaluated, the empirical evidence does not support the need to use highly experienced people who have personally worked with child abuse/neglect cases.

D. Use of the Data in Analysis

Based on the testing that took place, it was demonstrated that the data describing the case and case manager are highly reliable and, therefore, useful for analysis. While not as clear-cut, the items on case handling practices also have important analytic utility. With the responses collapsed in such a manner as to establish their reliability, they, in fact, distinguish critical management practices in the cases reviewed. Those items which elicit judgments or ratings of quality can only be applied as two-point scales, discriminating between higher and lower quality. Even at that, some of the individual ratings, while worthwhile at this pioneering stage in pointing toward factors associated with case management quality, are acknowledged to be tentative.

SECTION IV: HOW CASES WERE MANAGED IN THE DEMONSTRATION PROJECTS

Tables IV-1 through IV-16 (at the end of this section) present the case management practices found in the nine demonstration projects that participated in the quality assessment. The variables of case handling explored were those suggested by experts in the field as important in defining quality case management. Included are items on case management responsibility and continuity; timeliness of the process; amount and type of contact between manager and client, between treatment provider and client, and between manager and other agencies; planful decision-making as exhibited by use of consultants, staffings and multidisciplinary reviews; coordination of information on cases; and client participation.

These data portray a pattern of case management in nine diverse child abuse and neglect programs. The composite picture of the case handling experiences in these projects contributes to an understanding of the elements of good case management that are applicable to other child abuse and neglect programs.[1]

A. Case Management Norms

The combined project data on how cases are handled can then be viewed as current norms of case management. While no empirical values are attributed to these management practices at this point, they are still important as minimum standards or benchmarks of case management practices in the field. These norms should not be taken as tantamount to optimum practice. Rather, they are discussed as minimums against which other case management reviews might take place. In order to

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[1] For a description of the project-by-project differences in case management practices, see Appendix E.

proceed with making comparative judgments on quality, some standard must be applied. While the standard of measurement could be "perfection," even if there was agreement on what constitutes the best practice, this is not realistic and, therefore, using the combined experience of several programs is useful. Because of the demonstration nature of the projects which participated in the assessment, they are assumed to be well equipped to provide better than average, if not exceptional management of cases.[1]

Depending on one's experience, there may be surprise or disappointment with the practices of case management as found across these projects. Some dismay is certainly in order, particularly with practices that are in general agreed to be most critical. The fact that in almost one-half of the cases, four or more days elapsed until an initial contact was made, or that in more than one-fourth of the cases there was no further exploration with a client, after the first contact, before a treatment plan was determined, or that if a client was receiving outside services from another agency or individual, for 15% of the cases there was no evidence of coordination and communication between the project and the other agency, are all cause for criticism. However, it should be kept in mind that the participating projects represent a wide range of service delivery models, from large, urban protective services units to free-standing, voluntary agencies. The norms are based on the averages and ranges found across all the programs, including those which have the best possibility for optimum case management and those that struggle, even with demonstration money, under the acknowledged handicaps of being the public, legally mandated agencies.

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[1] The National Center on Child Abuse and Neglect is currently proposing federal standards of practice for prevention and treatment. Most of the proposed standards apply to organization and services at the system level, but a few are suggested on the case management level. These case management standards, developed on the basis of expert judgment, will be discussed individually in relation to the data collected for this study.

B. A Case Management Profile

The collective information on how all the demonstration projects handled their cases of abuse and neglect profiles the way in which a typical case might be managed (typical is defined as the mode of practice). More than one-half of the cases were contacted within three days of the initial report. Before coming to a decision on a plan of treatment for a client, usually at least one more meeting with the client, in addition to the first contact, is made; treatment services then would typically begin within two weeks of initial contact with the client. Despite the interest and attention in the field to multidisciplinary review of cases, the typical case in the sample was not reviewed by a multidisciplinary review team at any time in the process. Use of outside consultants on the management of the case also was not the norm. On the other hand, whereas case conferences or staffings usually were not used on the case at intake or termination, there was a likelihood that such a conference was held sometime during the treatment phase of the case. The current manager of the case was usually the person who also carried out the intake, and further, the typical case had only one case manager. Other than the primary case manager there was likely to be at least one other person in the project working with the client and, at the same time, the client usually also received services from an outside agency. Evidence of communication and coordination with the source of the report and with outside treatment providers (if the client was receiving such services) was also the norm, but active client participation in treatment planning and reassessment was not the usual practice. On average, throughout the history of the case, the case manager would meet with the client about once or twice a month. The typical case was open no more than one year and, after a case was terminated, usually a follow-up contact was made either with the client or with another service provider still working with the client.

C. The Sixteen Key Case Handling Practices

The following is a discussion of each of the case handling practices or variables for which data was collected. The practices are critiqued both as the norms found across all of the projects combined, and as they vary by differentiating case characteristics. Many case characteristics might have been analyzed, but the eight case, client, case manager and site attributes that were selected are theorized by the field to be important in influencing how cases can and should be handled.

The characteristics that are analyzed as to their impact on case management practices are:

- large bureaucratic projects vs. smaller, less bureaucratic settings;
- serious incidents of abuse/neglect vs. less serious incidents;
- court involvement vs. no court intervention;
- difficult cases vs. less difficult cases;
- male clients vs. female clients;
- unresponsive clients vs. responsive clients;
- professionally trained case managers vs. those without professional training;
- managers with larger caseloads vs. managers with smaller caseloads.

Large, bureaucratic social service agencies[1] are expected to be more encumbered with heavy workloads and restrictive regulations, but at the same time are required by law to respond to certain mandated case management standards and procedures (e.g., response to incoming reports within 24 or 48 hours). Serious cases (those that involve

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[1]Two of the nine demonstration projects were located in large, urban public social service agencies -- Arlington, Virginia and Union County, New Jersey.

severe and moderate abuse or neglect and sexual abuse), it is expected, need specialized, more intensive attention. The court (most often with these cases this means the family or juvenile court), one might suppose, would pressure for more and better response to clients under its jurisdiction. Difficult cases (that is, all cases rated by the case manager as more difficult than average on a five-point scale), while in need of comprehensive, timely management, may well get less adequate intervention due to problems of cooperation or complexity. Male clients are thought to be more difficult to manage because of their unavailability and often hostile demeanor. Unresponsive clients (all cases ranked by the case manager as either somewhat or very unresponsive on a five-point scale) are not rewarding to work with and may adversely influence the case management process. A case manager without professional training (lacking a post-graduate degree) might be expected to be less acquainted with and/or less prepared to carry out optimum case management, and case managers with larger caseloads (over 20 cases) theoretically are precluded from thorough intervention with clients.

1. Time Between Report and First Client Contact (any type) -- Table IV-1[1]

Whereas more than one-half of all the cases (52%) were contacted in some manner within three days of the initial report, 8% were not responded to until one to two months from the first report and 4% were not contacted until over two months from the initial report. There was no significant difference in response time between serious and less serious cases; only 35% of the serious cases were investigated within 24 hours and 27% of the less serious cases (mild, emotional or potential abuse or neglect) were investigated within 24 hours. It is notable that male clients are less likely to be contacted immediately and more likely to not be contacted until one to two months or more after the initial report.

The federal standard as proposed by the National Center on Child Abuse and Neglect suggests that "the intake worker should intervene

[1]Tables for the 16 key case handling practices follow Section IV, pp. 44-59.

immediately if a report is considered an emergency; otherwise intervention should take place within 72 hours."[1] Minimal compliance with federal standards by the projects might in some way be explained by the often time-consuming process of locating and tracking down reported cases. Certainly the fact that male clients are not contacted as quickly substantiates the reported difficulty that many workers have in locating and investigating men. Also, workers might attempt to contact clients, but are unsuccessful because of inadequate referral information. This finding suggests that several of the projects had poor structures for responding immediately to incoming reports. The fact that there were no differences in response time to serious cases further suggests that many of the projects had not implemented criteria for screening incoming calls and giving priority to more severe problems of abuse and neglect.

2. Number of Contacts (following the first contact) Prior to Decision on Treatment Plan -- Table IV-2

A proposed federal standard states that "the treatment services worker should develop an individualized treatment plan for each family and each family member."[2] Acceptable practice in the field for most situations and for a majority of clients suggests that certain information is necessary before a client-centered plan can be established. This is not to suggest that services should not be provided prior to a treatment plan, but rather to affirm that mutually agreed upon treatment requires time for a completed assessment and engagement of the client in a working relationship. While 18% of all clients in the sample had between three to five contacts before a decision was made on a plan of treatment, and 7% had over five such contacts, 27% of the clients were not contacted at all after the initial meeting before a plan for treatment was decided upon. The mode or norm across all cases for number of contacts before deciding on a treatment plan was two -- the initial contact and one additional one.

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[1] Report on Recommendations for Revisions to Standards, National Institute for Advanced Studies, July 1977, p. III-42.

[2] Ibid, p. III-46.

There were significant differences in the number of contacts before developing a treatment plan when looking at some variations in client and worker characteristics. Difficult cases more often had three or more contacts following the initial contact than did less difficult cases, whereas unresponsive clients more often had no further contact after the first contact than did responsive clients. Case managers in smaller, less bureaucratic agencies, and professionally trained case managers, tended to contact the client more frequently prior to treatment planning.

The data seems to support the perception that many workers do not develop formal treatment plans or client contracts, but rather informally set up non-specific service schedules based on cursory assessments. Setting up realistic treatment plans and agreements with clients often requires more than two client contacts.

3. Time Between First Contact and First Treatment Service -- Table IV-3

Timely provision of treatment services is critical to establishing a positive working relationship with the client and to protecting the child. Sixty-three percent of all clients began treatment (defined as discrete therapeutic services which are not part of intake) within two weeks of their first contact with the project. But for 13% of all cases reviewed, it took over one month for clients to begin treatment, and almost 9% had no treatment provided at all. Male clients, unresponsive clients and clients in large, bureaucratic agencies were less likely to receive services within the first two weeks after first contact than were female clients, responsive clients and clients in small, less bureaucratic settings.

Whereas for the majority of cases the start of treatment was timely, for many cases the delay would appear to be unacceptable case management practice in light of the potential for serious consequences. If children are still in the home, it is dangerous to open a case for investigation and management and then delay or provide no treatment services. On the other hand, if no treatment services are needed for the client, it is usually in the best interest of the family and more

efficient for the agency to close cases promptly after intake rather than maintaining them without provision of treatment services.

4. Use of Multidisciplinary Review Team -- Table IV-4

One of the proposed federal standards states that "the local unit . . .should establish a multidisciplinary child abuse and neglect case consultation team."[1] A multidisciplinary team serves an important function in assisting staff to take a multi-dimensional approach to their cases. It is not necessarily essential that all cases be reviewed, but that the more serious and complex cases be presented for team assessment.

The norm across all cases was not to use multidisciplinary review teams. Only about one-third of all the cases reviewed had multidisciplinary team reviews at some time during the course of services. Of those which did have team reviews, most often they were during intake or treatment (about 21% of all cases); very few team reviews were carried out at termination (7% of the cases). Use of multidisciplinary team review varied significantly with different types of cases. Serious and difficult cases were more likely to be reviewed than were less serious and less difficult cases. If the court was involved with the case, it was also much more likely to be reviewed by a multidisciplinary team, as it was if the case was found in a smaller, less bureaucratic project setting. Education and caseload size of the case manager seemed to make a difference in whether a case was brought to a team review; professionally trained workers and workers with smaller caseloads (20 or less) more often had their cases reviewed by a multidisciplinary team.

These findings suggest that of the cases presented for team review, workers are tending to select out more of the difficult and serious cases, which seems appropriate. However, there is some indication that despite the fact that all the projects had operating multidisciplinary

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[1] Ibid, p. III-38

review teams, workers who are not professionally trained and workers in large bureaucracies may be more reluctant to present their cases. Also, probably because the use of multidisciplinary teams can be time consuming (i.e., preparation of cases, attending the review, etc.), workers with large caseloads are less likely to utilize team input. Since projects and workers who do not use multidisciplinary review extensively may be missing helpful assistance and opportunities to explore other avenues of case management and treatment that could improve work performance, it is suggested that efforts be made to make review teams more accessible and attractive.

5. Use of Case Conferences (staffings) -- Table VI-5

While the proposed federal standard guideline suggesting a review of the family's use of treatment services and resources every three months[1] does not specifically suggest a mode of review, case conferences or staffings are one such approach. Further, case conferences provide an important support structure to workers and offer one channel for internal quality review of worker performance.

In contrast to multidisciplinary team reviews, 60% of the cases had case conferences sometime during their history. About 38% of the cases were discussed at a case conference or staffing at intake. During treatment, the number of cases with conferences rises to 55%. Case conferences were typically not held at termination, but still about 30% of the cases had them. There was a general tendency for more serious and difficult cases to be assessed in case conferences than their counterparts. In contrast to what one might expect, cases of responsive clients more than unresponsive clients were likely to be discussed in staffings. As was found with multidisciplinary team reviews, professionally trained workers, workers with smaller caseloads and workers in less bureaucratic agencies were more likely to have their cases reviewed in case conferences.

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[1] Ibid, p. III-49

While these data might suggest that the projects did not adequately monitor client flow-through for some number of cases, we do not know if, in addition to the case conferences, other mechanisms were employed to periodically review and reassess cases. Many workers complain that they do not receive enough input and support regarding their case handling and in making important client decisions on such aspects as child placement and court action. In these findings, workers who might best benefit from case conferences (i.e., those not professionally educated, those with heavy caseload duties, and those in large, bureaucratic organizations) are less likely to have their cases systematically reviewed and, therefore, are not receiving needed feedback on their work.

6. Use of Outside Consultants -- Table IV-6

Working with child abusing families can be very challenging and difficult work. To make many of the decisions regarding removing a child, diagnosing the client, family and home environment, and selecting among treatment options often requires special expertise and an outside perspective and viewpoint. For this reason, workers need to have access to a range of consultants, such as lawyers, doctors, psychologists and other social workers, to assist in these sensitive problem-solving areas. While management of the majority of cases (62%) did not include the use of outside consultants, it is not known which percentage of the remaining cases had multidisciplinary team reviews (a measure of another type of outside input into case decision-making). About 25% of the cases did use three or more outside consultants. It appears there was a perceived need to use either extensive consultation on a case or almost none at all.

Serious cases, and those involving court intervention, more often used over five consultations than did less serious cases or cases in which the court was not involved. Difficult cases and cases of workers with smaller caseloads were less likely to have used no consultants. Education of the case manager also meant significant differences in the use of outside consultants, in that professionally trained workers tended more often to use at least some consultation, and also to heavily use consultation (three times or more per case).

These results may reflect to some extent variation in project policies and procedures; i.e., since outside consultants are often expensive or difficult to arrange for, they may not be available at will to all workers. It is suspected, for example, that those projects with less professionally trained workers or those with larger caseloads might be less likely to have extensive access to outside consultants. However, some manner of outside consultation was available in all the demonstration projects and the data point out underutilization of these resources, for whatever the reason.

7. Responsibility for Intake -- Table IV-7

For 58% of the cases, intake was handled by the ongoing case manager interviewed for the assessment, with the remainder provided intake by another staff member. There was no significant difference between cases in larger, bureaucratic projects and those in smaller, less bureaucratic projects. Intake responsibility may have differed from ongoing management responsibility because of staff turnover; however, it is the belief, based on knowledge of the sites, that most of the difference is accounted for by agency policy regarding separate intake units.

It is difficult to judge this norm because of the debate in the field about the advisability of intake units. The proposed federal standards on abuse and neglect clearly distinguish between intake and treatment workers.[1] The argument is that abuse and neglect cases need intake by specialized workers and that it is critical to distinguish in the clients' minds between the investigatory role of the intake worker and the ongoing, supporting role of the treatment worker. On the other side of the debate, however, is the belief that a good worker can and should assume both the intake and ongoing treatment responsibilities, to ensure a sense of continuity with the client. Further, intake units are usually staffed by the newest, least experienced staff

[1] Ibid, pp. III-45 through III-48.

who burn out quickly, often negating the desirability of the intake unit model.

8. Number of Primary Case Managers -- Table IV-8

To ensure continuity of service, minimal transferring of cases from one case manager to another seems advisable. The obvious exceptions to this standard would be when the client and the worker are unable to establish a working relationship or when continued worker involvement with the client is interfering with treatment objectives. Seventy-eight percent of the cases reviewed had a single case manager following the intake process.[1] The projects, despite more expected staff turnover by the time of the case management assessment site visits, managed to maintain reasonable manager continuity, with only 4% of the cases having more than two primary managers.

The only significant difference in number of primary case managers was between serious and less serious cases: serious cases more often had at least two primary case managers than did less serious cases, indicating that these cases might well turn over due to the drain on the case manager. This is disturbing because these cases more likely cannot tolerate case management disruption.

9. Number of Treatment Providers (other than case manager) -- Table IV-9

The belief is that good case management includes involving the client in other direct treatment services, either within or outside the agency. The majority of cases (62%) reviewed involved more than one treatment provider from within the project. The number of project treatment providers varied significantly across the several types of cases. Cases found in less bureaucratic projects had more treatment providers than did their counterparts. Male clients more often had no

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[1]Of the 63 cases where there was more than one case manager, the primary reason (in 40% of the cases) was staff turnover. Joint involvement of more than one manager, temporary staff absence, lack of success by the original case manager, and other such reasons accounted for the remainder of these cases.

project treatment providers other than the case manager, cases with court involvement tended less often to have no other treatment providers and more often to have three or more such treatment providers. Despite the fact that a high percentage of clients did not receive services from other than the case manager (38%), it is of interest to note that at least serious cases tended to get more intensive intervention from within the project. Cases of workers with smaller caseloads more often had no other treatment providers. This suggests that workers with fewer cases to work with often believe that they can spend enough time with the client to preclude the need for other treatment, whereas workers with larger caseloads more often turn to at least one other person to share case responsibilities.

10. Services From Other Agencies/Individuals -- Table IV-10

One of the proposed federal standard guidelines states that a worker should "arrange or help clients arrange for services provided by another agency, organization or individual."[1] Many child abuse clients present multi-problems requiring assistance with financial, housing, mental health and child care needs. Usually a full package of these services is not available within one agency, necessitating a coordinated approach among agencies to meet the full range of client demands. The extent to which clients receive services from other agencies is one indicator of how well the various needs of the clients are being met by the project and the case manager.

Of the projects' clients, 66% received one or more services from other community agencies. Cases with court involvement tended to receive more outside services than cases without court involvement, probably reflecting more extensive use of court-ordered placement. Consistent with previous findings, female clients are more likely to receive services from other community agencies than male clients.

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[1] Report on Recommendations for Revisions to Standards, op. cit p. III-48.

11. Communication with Other Service Providers -- Table IV-11

Communication among community agencies serving joint clients is crucial in providing continuity of care and decreasing duplication of services. Of the 224 cases actually receiving outside services, 85% showed evidence of some communication between the project and the other agency providers. There was a greater likelihood of communication between project and other agency personnel in cases involving court action than in non-court involved cases, perhaps reflecting the need for workers to more thoroughly prepare their cases and gather information for court hearings and reviews.

A comprehensive treatment approach that meets the various needs of clients requires that there always be some communication among all providers serving mutual clients. The norm as established by the projects is minimal compliance with the ideal, but is above average when compared to usual interagency communication habits, which experience has shown tend to be very limited unless strongly encouraged and supported by formal coordination agreements.

12. Contacts with the Reporting Source -- Table IV-12

Another aspect of case management coordination includes establishing lines of communication with reporting sources. Recontacting the sources of incoming reports for more background information is important for thorough intake, but it also sets up a linkage with another agency and builds trust and confidence between reporting agencies and abuse/neglect programs. This confidence can be maintained if communication continues during the course of treatment.

The data show that it was the usual practice to recontact the reporting sources to obtain further background information and case history; this happened in 84% of the cases. Contact with the reporting source later in the treatment process to discuss the client's progress happened somewhat less often, but still in the majority of cases (68%). Again, as with the previous norm on communication with outside treatment providers, if the court was involved with the case there was more evidence of contacts with the source of reports, both at the outset

and during the history of the case. In contrast to what might be expected, there was a significant difference in contacts with the reporting source on clients' progress while in treatment between large, bureaucratic projects and smaller, less bureaucratic projects -- bureaucratic projects more often contacted reporting sources than did less bureaucratic projects. The implication of this pattern is that workers in smaller projects tend to be more self-contained, a detriment when working with cases that need strong inter-agency coordination.

13. Client Participation -- Table IV-13

Participation in their own treatment planning might well be the ultimate motivating factor for clients in accomplishment of their treatment goals. When clients have voiced their own needs and directed the development of their own treatment plans, they have a greater investment in working on these goals and are more likely to take responsibility for their accomplishment. The one direct measure of client participation in this review -- presence of the client either at multidisciplinary team reviews or at case conferences -- showed that there was very little direct participation, at least in these particularly visible aspects of the case management process. Only 14% of all reviewed cases had the client present during either a multidisciplinary team review or a conference. There were very few variations in the amount of client participation when looking at project, client and caseworker characteristics. There was a tendency for responsive clients to participate more than non-responsive clients, and for workers with smaller caseloads to directly involve their clients in the treatment process more than workers with large caseloads.

The low percentage of client participation is surprising. However, many workers are caught in a double-bind. In their work with clients they are representing authority, imposing demands on families and, at the same time, trying to motivate and encourage clients to respond to treatment intervention. In this kind of environment, workers may find it difficult to understand how to involve clients and elicit their participation. These findings suggest more attention be directed towards including clients directly in their own service provision.

14. Frequency of Contact by Case Manager, Over History of Case -- Table IV-14

Frequency of case manager contact with the clients is determined by the treatment plan and the degree to which the client needs to be supervised, as well as the length of the treatment process. But, frequency of client contact is also constrained by demands placed on the worker from other clients and administrative duties.

Most cases reviewed fell into two categories of contact frequency, with 40% of the cases contacted by the case manager once a week or more and another 33% contacted about once or twice a month. Smaller proportions of the cases were seen less than once a month, once or twice only during the entire course of treatment, or with a wide variation of frequency (This latter category usually refers to cases where contact was at least weekly in the early phases, but was reduced to less than monthly once the case was stabilized). Difficult cases and responsive clients tended to have more intensive contact than did their counterparts. Clients served by less bureaucratic organizations and those who were under court supervision were also seen more intensively (once a week or more) than clients in bureaucratic organizations.

The data show that at least 14% of all cases sampled were either underserved, or were not promptly and appropriately terminated when services and worker contact were no longer indicated (i.e., those cases seen less than once a month or once or twice only). Given the generally serious nature of child abuse/neglect cases and the demand for services to those who really need them, it is incumbent that programs seek remedies for this situation.

15. Length of Time in Treatment -- Table IV-15

It might be assumed that most child maltreatment cases need several months of services before they are considered ready for termination. However, the actual time in treatment would be expected to vary depending on the case characteristics. It is somewhat surprising that by far most cases (69%) were in the projects' caseloads only

between four and twelve months. Thirteen percent were very short-term cases (three months or less), and almost one-fifth (18%) were active between one and two years. Serious cases, more than less serious cases, tended to be kept active for over a year, indicating their greater need for longer-term services.

16. Follow-Up Contacts -- Table IV-16

Follow-up contacts with the client or another agency working with the client are important for abuse/neglect cases in order to prevent new crises that might provoke reincidence. One of the proposed federal standards states that follow-up on terminated cases should occur within 45 days by direct contact with the family.[1] Project-initiated contacts after termination occurred in 56% of the cases. There was no significant variation seen in follow-up among cases when looking at site, client and worker characteristics.

The projects did not comply with the suggested federal standards in over 40% of the cases. Further, the lack of differentiation in follow-up among types of clients suggests that follow-up efforts are not discriminating between clients who are thought most to need it. More effort is indicated in assuring that terminated clients are provided a measure of ongoing support through routine follow-up.

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[1] Ibid, p. III.50.

TABLE IV-1[a]

Time Between Report and First Client Contact (Any Type)

Time	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Same Day	33%	28%	34%	35%	27%	39%	29%	38%	28%
One to Three Days	19	16	20	17	20	18	19	13	23
Four to Seven Days	12	14	12	12	15	15	12	12	13
Eight to Fourteen Days	11	10	11	10	13	10	11	12	10
Fifteen to Thirty Days	14	16	13	18	12	11	15	15	13
One to Two Months	8	13	7	4	12	5	10	6	10
Over Two Months	4	4	4	4	2	3	4	5	3
	(n = 337)	(n = 337; not significant)		(n = 284; not signif.)		(n = 327; not signif.)		(n = 329; signif. at p<.1)	

Time	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤ 20)
Same Day	25%	35%	29%	35%	30%	36%	34%	32%
One to Three Days	17	20	15	21	20	16	16	20
Four to Seven Days	9	13	11	13	14	8	12	12
Eight to Fourteen Days	11	11	14	8	10	12	9	12
Fifteen to Thirty Days	13	15	15	14	14	14	15	14
One to Two Months	14	6	11	6	8	11	7	9
Over Two Months	11	1	5	3	4	3	7	2
	(n = 334; signif. at p < .01)		(n = 328; not significant)		(n = 332; not significant)		(n = 335; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-2[a]

Number of Contacts (Following First Contact) Prior to Decision on Treatment Plan

Contacts	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
None	27%	32%	25%	26%	29%	27%	27%	24%	27%
One	31	36	29	28	34	22	35	26	36
Two	17	19	16	18	16	20	16	13	21
Three to Five	18	6	22	18	15	19	17	30	10
Over Five	7	7	8	10	6	12	5	8	8
	(n = 325)	(n = 325; significant at p<.01)		(n = 279; not signif.)		(n = 319; not signif.)		(n = 319; signif. at p<.01)	

Contacts	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
None	31%	25%	35%	19%	22%	41%	33%	24%
One	28	32	26	36	32	30	33	30
Two	19	16	18	17	18	14	16	18
Three to Five	15	19	15	20	22	9	13	20
Over Five	7	7	6	9	7	7	6	8
	(n = 325; not significant)		(n = 319; signif. at p<.05)		(n = 323; signif. at p<.05)		(n = 323; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-3[a]

Time Between First Contact and First Treatment Service

Time	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Within 2 Weeks	63%	55%	66%	66%	65%	70%	60%	65%	62%
2 Weeks to 1 Month	16	14	17	17	17	11	18	18	15
Over 1 Month	13	17	11	11	13	14	12	11	14
No Treatment Given	9	14	6	3	7	6	10	6	9
	(n = 338)	(n = 338; signif. at p<.01)		(n = 290; not signif.)		(n = 331; not signif.)		(n = 329; not signif.)	

Time	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Within 2 Weeks	54%	66%	56%	68%	62%	65%	63%	63%
2 Weeks to 1 Month	16	16	22	13	16	18	12	19
Over 1 Month	17	11	13	13	13	9	12	12
No Treatment Given	13	7	8	6	9	8	13	6
	(n = 338; signif. at p<.1)		(n = 330; signif. at p<.1)		(n = 336; not significant)		(n = 336; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-4[a]

Use of Multidisciplinary Review Team

Reviews	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
None	65%	86%	58%	58%	69%	48%	72%	54%	74%
At Least One	35	14	42	42	31	52	28	47	26
	(n = 345)	(n = 354; signif. at p<.01)		(n = 297; signif. at p<.1)		(n = 346; signif. at p<.01)		(n = 343; signif. at p<.01)	
At Least One Review During Intake	21%(n = 345)								
At Least One Review During Treatment	21%(n = 342)								
At Least One Review at Termination*	7%(n = 270)								

*Terminated cases only

Reviews	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
None	64%	67%	66	66%	57%	87%	84%	56%
At Least One	36	33	35	34	43	13	16	44
	(n = 354; not significant)		(n = 345; not significant)		(n = 352; signif. at p<.01)		(n = 352; signif. at p<.01)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-5[a]

Use of Case Conferences (Staffings)

Reviews	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
None	40%	60%	32%	27%	39%	33%	42%	31%	45%
At Least One	60	40	68	73	61	67	58	69	55
	(n = 354)	(n = 354; signif. at p<.01)		(n = 297; signif. at p<.05)		(n = 346; not signif.)		(n = 343; significant at p<.05)	

At Least One Review During Intake	38%	(n = 343)
At Least One Review During Treatment	55%	(n = 343)
At Least One Review at Termination*	30%	(n = 265)

*Terminated cases only

Reviews	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (<20)
None	34%	41%	46%	35%	36%	49%	62%	28%
At Least One	66	59%	54	65	64	52	38	72
	(n = 354; not significant)		(n = 345; signif. at p<.1)		(n = 352; signif. at p<.05)		(n = 352; signif. at p<.01)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-6[a]

Use of Outside Consultants

Number	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
None	62%	67%	61%	56%	60%	63%	64%	56%	67%
Once	7	6	7	4	10	3	8	7	4
Twice	6	7	6	9	6	6	6	10	3
Three-Five Times	13	12	14	11	18	10	14	13	13
Over Five Times	11	8	13	20	7	18	9	14	10
	(n = 350)	(n = 350; not significant)		(n = 294; signif. at p<.01)		(n = 344; signif. at p<.1)		(n = 341; signif. at p<.1)	

Number	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Client	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
None	64%	62%	68%	59%	55%	80%	68%	59%
Once	6	8	6	8	7	7	9	6
Twice	5	6	7	6	7	5	7	6
Three-Five Times	16	12	13	13	17	5	9	16
Over Five Times	9	12	7	14	14	4	7	14
	(n = 350; not significant)		(n = 342; not significant)		(n = 348; signif. at p<.01)		(n = 348; signif. at p<.1)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-7[a]

Responsibility for Intake

Responsibility	All Cases	In Large Bureaucratic Project	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic
Current Case Manager	58%	51%	60%
Other Project Staff Person	42	49	40
	(n = 352)	(n = 352; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-8[a]

Number of Primary Case Managers

Number	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
One	78%	85%	76%	70%	81%	79%	77%	79%	79%
Two	18	12	20	25	14	19	18	19	17
More Than 2	4	4	4	5	5	2	5	2	5
	(n = 350)	(n = 350; not significant)		(n = 295; signif. at p<.1)		(n = 343; not signif.)		(n = 341; not significant)	

Number	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
One	78%	78%	79%	79%	80%	76%	82%	77%
Two	16	19	18	17	17	20	14	20
More Than 2	6	3	3	4	3	5	4	3
	(n = 350; not significant)		(n = 343; not significant)		(n = 348; not significant)		(n = 348; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-9[a]

Number of Project Treatment Providers (Other than Case Manager)

Number	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
None	38%	50%	33%	30%	45%	28%	42%	33%	41%
One	24	33	20	18	22	20	25	22	24
Two	19	12	22	26	17	20	19	18	20
Three to Five	18	5	23	24	16	30	13	24	15
More Than Five	1	1	2	3	1	2	1	2	1
	(n = 351)	(n = 351; signif. at p<.01)		(n = 295; signif. at p<.05)		(n = 344; signif. at p<.01)		(n = 341; not significant)	

Number	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (<20)
None	45%	35%	37%	37%	40%	34%	31%	42%
One	27	22	26	22	23	27	32	20
Two	11	23	13	23	21	15	16	21
Three to Five	17	18	22	16	15	23	19	16
More Than Five	0	2	2	1	1	2	2	1
	(n = 351; signif. at p<.05)		(n = 343; not significant)		(n = 349; not significant)		(n = 349; significant at p<.1)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-10[a]

Services from Other Agencies (or Individuals)

Receipt of Services	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Yes	66%	69%	66%	72%	62%	78%	62%	71%	62%
No	34	31	35	28	38	22	38	29	38
	(n = 347)	(n = 347; not significant)		(n = 291; not signif.)		(n = 341; significant at p<.01)		(n = 338; not significant)	

Receipt of Services	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Yes	58%	69%	63%	68%	64%	72%	69%	65%
No	42	31	37	32	36	28	31	35
	(n = 347; signif. at p<.1)		(n = 339; not significant)		(n = 345; not significant)		(n = 345; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-11[a]

Communication with Other Service Providers

Evidence of Communication	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Yes	85%	89%	84%	86%	84%	93%	81%	90%	82%
No	15	11	16	14	16	7	19	10	18
	(n = 224; only cases that received outside services)	(n = 224; not significant)		(n = 189; not signif.)		(n =219; significant at p<.05)		(n = 220; not significant)	

Evidence of Communication	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Yes	79%	87%	81%	88%	88%	82%	89%	84%
No	21	13	19	12	12	18	11	16
	(n = 224; not significant)		(n = 218; not significant)		(n = 222; not significant)		(n = 222; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-12[a]

Contacts with the Reporting Source

Type of Contact	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
For Further Background Information: Yes	84%	89%	82%	86%	83%	93%	81%	83%	85%
No	16	11	18	14	18	7	19	17	15
	(n = 306)	(n = 306; not significant)		(n = 254; not significant)		(n = 299; significant at p<.1)		(n = 297; not significant)	
Regarding Client's Progress While in Treatment: Yes	68%	82%	63%	67%	71%	76%	65%	67%	70%
No	32	18	37	33	29	24	35	33	31
	(n = 304)	(n = 304; significant at p<.01)		(n = 255; not significant)		(n = 300; significant at p<.1)		(n = 298; not significant)	

Type of Contact	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (<20)
For Further Background Information: Yes	82%	85%	83%	85%	86%	81%	84%	84%
No	18	15	18	15	15	19	16	16
	(n = 304; not significant)		(n = 296; not significant)		(n = 304; not significant)		(n=304; not significant)	
Regarding Client's Progress While in Treatment: Yes	71	67	70	68	68	69	72	66
No	29	33	30	32	32	31	28	34
	(n = 305; not significant)		(n = 297; not significant)		(n = 305; not significant)		(n = 305; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-13[a]

Client Participation

Client Presence	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Yes	14%	13%	15%	18%	14%	19%	12%	17%	13%
No	86	87	85	82	86	81	88	83	87
	(n = 354)	(n = 354; not significant)		(n = 297; not signif.)		(n = 346; not signif.)		(n = 343; not significant)	

Client Presence	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Yes	19%	12%	10%	18%	15%	11%	9%	17%
No	81	88	90	82	85	89	91	84
	(n = 354; not significant)		(n = 345; signif. at p<.1)		(n = 352; not significant)		(n = 352; significant at p<.1)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-14[a]

Frequency of Contact by Case Manager--Over History of Case

Number	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
About Once a Week or More	40%	15%	45%	41%	38%	52%	34%	41%	37%
About Once or Twice a Month	33	43	29	29	37	24	37	32	34
Less Than Once a Month	7	13	5	7	6	6	7	8	6
Once or Twice Only	7	9	7	6	7	6	8	2	12
Varied Over Time	13	10	14	17	12	11	14	16	11
	(n = 343)	(n = 343; signif. at p<.01)		(n = 289; not signif.)		(n = 337; significant at p<.05)		(n = 339; signif. at p<.05)	

Number	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
About Once a Week or More	39%	40%	29%	46%	37%	45%	33%	43%
About Once or Twice a Month	30	34	36	31	37	24	35	32
Less Than Once a Month	11	5	12	4	5	11	8	6
Once or Twice Only	10	7	10	5	7	8	7	8
Varied Over Time	11	14	13	14	14	12	16	12
	(n = 343; not significant)		(n = 339; signif. at p<.01)		(n = 341; not significant)		(n = 341; not significant)	

[a] Percentages may not sum to 100% due to rounding.

TABLE IV-15[a]

Length of Time in Treatment

Time	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Involved	Difficult Cases	Less Difficult Cases
Through 3 Months	13%	13%	12%	8%	11%	12%	13%	11%	14%
Four to 12 Months	69	72	67	62	76	66	70	63	72
One to Two Years	18	15	19	28	13	22	16	24	13
Over Two Years	1	0	2	3	4	0	1	1	1
	(n = 272)	(n = 272; not significant)		(n = 224; significant at p<.05)		(n = 266; not signif.)		(n = 261; not significant)	

Time	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Through 3 Months	10%	13%	12%	13%	10%	16%	13%	12%
Four to 12 Months	74	68	74	64	70	68	72	67
One to Two Years	15	18	14	20	18	16	15	19
Over Two Years	1	1	0	2	2	0	0	2
	(n = 271; not significant)		(n = 263; not significant)		(n = 271; not significant)		(n = 272; not significant)	

[a]Percentages may not sum to 100% due to rounding.

TABLE IV-16

Follow-up Contacts

Evidence of Contact	All Cases	In Large Bureaucratic Project		Seriousness of Case		With Court Involvement		Difficulty of Case	
		Highly Bureaucratic	Less Bureaucratic; Non-Bureaucratic	Serious Cases	Less Serious Cases	Court Involved	Court Not Invovled	Difficult Cases	Less Difficult Cases
Yes	56%	61%	54%	53%	57%	22%	18%	60%	55%
No	44	39	46	47	43	78	82	40	45
	(n = 279)	(n = 279; not significant)		(n = 231; not signif.)		(n = 273; not signif.)		(n = 269; not significant)	

Evidence of Contact	With Male Client		Responsiveness of Client		Education of Case Manager		Caseload Size of Case Manager	
	Male Clients	Female Clients	Unresponsive Clients	More Responsive Clients	Professionally Trained	Not Professionally Trained	Larger Caseloads (>20)	Smaller Caseloads (≤20)
Yes	52%	57%	52%	60%	57%	54%	57%	55%
No	48	43	48	40	43	46	43	45
	(n = 279; not significant)		(n = 270; not significant)		(n = 278; not significant)		(n = 278; not significant)	

[a]Percentages may not sum to 100% due to rounding.

SECTION V: FACTORS ASSOCIATED WITH HIGH QUALITY CASE MANAGEMENT

In addition to collecting data on the case handling practices, qualitative judgments were also made by the assessors on 17 aspects of the case management process. Most of the individual judgment items are discrete parts or elements suggested by the field as necessary for a complete process; three of the items are attempts to capture an overall "gestalt" of case management. As mentioned in Section III, the quality judgments or ratings are somewhat problematic because, in most cases, they are only considered reliable as two-point scales, discriminating between higher and lower quality. However, in combination, they do give measures of the quality of case management as perceived by those who reviewed the cases and, in that sense, are useful for indicating those practices and case characteristics that are associated with high quality ratings.

In order to proceed with analysis on what variables appear to be associated with ratings of quality case management, composite measures of quality were constructed. A combination of theory and factor analysis[1] was used, resulting in two measures: an intake measure, compiled from the averages of the three intake rating items, and an overall measure, devised from the average of all the rating items. One of the 17 rating items captured a unique dimension of case management, the extent to which a client participates in the case management process, which, because of its inherent interest to the field, is used in a limited way as a third measure of quality.

A. Steps in Determining the Important Characteristics Associated with Judgments of High Quality

In determining which factors or characteristics appeared to influence the assessors' judgments and, thereby, were critical for ratings of higher

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[1] See Appendix F for factor analysis results.

quality, several analytic steps were undertaken. Each of the quality measures were looked at with respect to three groupings of case characteristics or inputs:[1] a) case handling practices; b) case manager characteristics; and c) case descriptors.

Before exploring the complex and interactive relationships between the independent variables (or individual and distinguishing characteristics of the case) and high quality ratings, using bivariate analysis, each characteristic singly was analyzed with respect to the quality measures of case management. Following review of the cross-tabulations and correlations, certain of the case handling, case management and case characteristics were selected for multivariate analysis, first separately by each of the three groupings of characteristics and, then, using an even more select number of variables, across all case characteristics.

B. Predictors of High Quality Intake

In considering those case handling practices which are part of the intake process in relation to the quality of intake, as shown in Table V-1, a pattern emerges. Forty-two percent of the high quality cases were contacted the same day as the incoming report, compared to 26% of those cases with low quality ratings. A higher percentage of cases with high quality ratings had more meetings between case manager and client before a treatment plan was developed, than did those with lower ratings. Multidisciplinary review teams were used much more frequently on cases with high quality ratings, as was the use of outside consultants. Recontacts with the reporting source for further background information occurred more frequently with high quality cases. While getting the client into treatment services in a shorter amount of time (indicating a faster intake process) tended to mean higher quality ratings, this was not a statistically significant difference. It is also interesting

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[1]Because of problems of interpretation due to use of different time frames, assignment of project-wide values to individual cases and high intercorrelation between variables, site management descriptors were not used in the in-depth analysis of the factors associated with quality case management. However, for the interested reader, Appendix G presents cross-tabs of the intake and overall quality measures and certain site characteristics.

to note that cases in which the current case manager also handled the intake received higher quality ratings, pointing out the perceived negative effects of worker turnover, either from resignation or from use of an intake unit, on quality case management.

TABLE V-1

Quality Intake Rating and Certain Case Handling Characteristics[a]

	Lower Rating	Higher Rating
Time Between Report and First Contact (Any Type)		
Same Day	26%	42%
1-3 Days	17	23
4-7 Days	12	14
8-14 Days	12	9
15-30 Days	15	11
1-2 Months	13	2
Over 2 Months	6	0
(n = 331; significant at p<.01)		
Number of Contacts (Following First Contact) Prior to Decision on Treatment Plan		
None	31	19
One	32	31
2	14	22
3-5	17	19
Over 5	6	10
(n = 317; significant at p<.1)		
Time Between First Contact and First Treatment Service		
Within 2 Weeks	65	74
2 Weeks to 1 Month	19	17
Over 1 Month	17	9
(n = 300; not significant)		
Use of Multidisciplinary Review Team		
None	75	49
At Least Once	19	36
At Least Twice	6	15
(n = 339; significant at p<.01)		

(Table V-1 continued on following page)

Table V-1 (continued)

	Lower Rating	Higher Rating
Use of Outside Consultants		
None	72%	47%
One	6	9
2	5	8
3-5	10	18
Over 5	6	19
(n = 340; significant at p<.01)		
Responsibility for Intake		
Current Case Manager	51	70
Other Staff Member	49	30
(n = 341; significant at p<.01)		
Contacts with Reporting Source For Further Background Information		
Yes	80	91
No	20	9
(n = 302; significant at p<.05)		

[a]Percentages may not sum to 100% due to rounding.

Several characteristics of the case manager, when looked at independently, appear to be important for high quality intake management. Table V-2 shows that a more formally educated case manager and one with more intensive training in abuse/neglect are factors associated with higher quality intake performance. Less strongly associated with higher quality, but worthy of note, are more years of experience in working with abuse and neglect cases, the age of the case manager (30 years old or younger) and differences in ethnicity between client and case manager. This last variable most often involves white workers with black clients or black workers with white clients; however, there are also sizeable numbers of non-matches between Asian, Spanish and white clients and workers.

TABLE V-2

Intake Assessment and Case Manager Characteristics[a]

	Lower Rating	Higher Rating
Same Ethnicity as Client		
Yes	68%	56%
No	32	44
(n = 340; significant at p<.05)		
Similar Socio-Economic Experience		
Very Similar	3	12
Somewhat Similar	36	24
Not Very Similar	61	64
(n = 101; not significant)		
Same Sex as Client		
Yes	63	69
No	37	31
(n = 343; not significant)		
Similarity of Case Manager and Client Age		
Manager More Than 10 Years Older	26	18
Manager 3 to 10 Years Older	24	25
Manager Same Age (Within 2 Years)	17	19
Manager 3 to 10 Years Younger	21	22
Manager More Than 10 Years Younger	12	16
(n = 333; not significant)		
Age		
22-25	14	12
26-30	46	63
31-40	21	14
Over 40	19	11
(n = 341; significant at p<.05)		
Formal Education		
Professionally Trained	65	81
Not Professionally Trained	35	20
(n = 341; significant at p<.01)		
Training in Abuse and Neglect		
At Least Once	43	21
At Least Twice	25	35
At Least Three Times	16	25
At Least Four Times	15	19
(n = 341; significant at p<.01)		

(Table V-2 continued on following page)

Table V-2 (continued)

	Lower Rating	Higher Rating
Years Experience in Abuse and Neglect Treatment		
One Year or Less	24%	14%
Two Years	34	24
Three Years	27	35
Four Years or More	15	28
(n = 333; significant at p<.05)		
Months Employed with the Project		
0-2 months	20	15
3-4 months	22	21
5-7 months	20	20
8-10 months	16	14
over 10 months	22	30
(n = 258; not significant)		
Caseload Size		
0-20 Cases	62	71
Over 20 Cases	38	29
(n = 341; not significant)		

[a]Percentages may not sum to 100% due to rounding.

Most case descriptors, as illustrated in Table V-3, did not significantly affect the intake quality ratings. For example, the seriousness of the abuse or neglect incident was not important in influencing how a case was rated. The difficulty of the case, either as perceived by the case manager or the assessor, did not effect the quality rating. These findings lead to the assumption that quality intake can be performed and judged as such, despite the complexity of the case. However, the client's interest and responsiveness were statistically significant in generating a high quality rating, indicating that it is difficult to carry out adequate intake if the client is uncooperative.

TABLE V-3

Intake Assessment and Case Characteristics[a]

	Lower Rating	Higher Rating
Seriousness of Abuse and Neglect		
Serious	39%	41%
Less Serious	61	59
(n = 287; not significant)		
Court Involvement		
Yes	24	32
No	76	68
(n = 336; not significant)		
Start of Case		
Before 1975	17	13
First Half of 1975	40	43
Second Half of 1975	37	38
After 1975	6	6
(n = 340; not significant)		
Type of Referral to the Project		
Self Referral	11	11
Referred from Other Agency or Individual	89	89
(n = 322; not significant)		
Responsibility for Case Management		
Project Primarily Responsible	86	85
Project Not Primarily Responsible	14	15
(n = 338; not significant)		
Difficulty of Case--Manager View		
Most Difficult	19	22
More Difficult	24	21
Average Difficulty	32	30
Less Difficult	12	17
Least Difficult	14	11
(n = 336; not significant)		
Client's Interest in Treatment		
Very Uninterested	16	13
Somewhat Uninterested	12	9
Neutral	19	6
Somewhat Interested	26	29
Very Interested	27	43
(n = 335; significant at p<.01)		

(Table V-3 continued on following page)

Table V-3 (continued)

	Lower Rating	Higher Rating
Client's Responsiveness to Treatment		
Very Unresponsive	18%	12%
Somewhat Unresponsive	13	8
Neutral	16	7
Somewhat Responsive	31	32
Very Responsive	22	41
(n = 336; significant at p<.01)		
Difficulty of Case--Assessor View		
More Difficult	86	83
Less Difficult	14	17
(n = 326; not significant)		

[a]Percentages may not sum to 100% due to rounding.

As a more complete and thorough investigation of the relationships between case handling practices, case manager characteristics and case descriptors, and quality intake, multiple regression techniques were used. This analysis allows for understanding the combined effects of the independent variables.[1] Tables V-4, V-5 and V-6 display the results of the first set of intake quality regressions, using a limited number of variables selected because they were considered theoretically more important and, for the most part, were statistically significant following bivariate analyses.[2]

Table V-4 illustrates that almost fifteen percent of the variance in intake quality was accounted for by a select group of case handling practice variables. Recontacting the reporting source for further background information had the largest effect on whether or not there is a high quality rating; if recontact with the referral source occurred, the conditional probability of a higher intake rating is increased by .10 (however, it was an unstable

[1]See Appendix H for a discussion of how to interpret regression analyses.

[2]Correlation coefficients for all the independent variables with the dependent variables (quality measures) are presented in Appendix I.

relationship, with a significance of .159). Of the remaining significant case handling variables used in this regression equation, the conditional probabilities ranged from ± .04 to .09. Only the number of contacts prior to determination of a treatment plan had too small an effect to be insignificantly different from zero and, therefore, was the sole case handling characteristic in this grouping that did not predict higher quality intake.

TABLE V-4

Effects of Select Case Handling Practices on the Quality of the Intake Process

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Time between report and first client contact	-.058	.013	.000
Contacts with reporting source for further background information	.095	.067	.159
Number of contacts prior to decision on the treatment plan	.007	.014	.617
Use of multidisciplinary team review	.088	.036	.015
Use of outside consultants	.035	.012	.005
Case manager also responsible for intake	.065	.025	.009
Constant	.133	.141	.000

Adjusted R^2 = .148

Significance of Adjusted R^2 = .001

[a]Means were substituted for missing values in the independent variables.

While only 4.7% of the variance in the dependent variables (intake quality) is accounted for by case manager characteristics as a grouping, as Table V-5 shows, this variance is significant. Taken separately, increased years experience in working with abuse and neglect cases is statistically significant at $p < .1$ (the conditional probability of quality intake was .04 greater for those with more experience), while more formal education of the case manager, which tended to increase the conditional probability of higher quality intake by .05, was significant at .101.

TABLE V-5

Effects of Select Case Manager Characteristics on the Quality of the Intake Process

Independent Variables [a]	Regression Coefficient	Standard Error	Significance
Same ethnicity as client	-.088	.055	.112
Similar socio-economic experience	.010	.405	.810
Same sex as client	.058	.055	.290
Similar age as client	.002	.002	.448
Formal education	.050	.030	.101
Training in abuse & neglect	.017	.027	.528
Years experience in abuse/ neglect treatment	.037	.022	.095
Caseload size	-.002	.001	.136
Constant	-.058	.278	.001

Adjusted R^2 = .047

Significance of Adjusted R^2 = .002

[a] Means were substituted for missing values in the independent variables.

Table V-6 shows that select case descriptors as a group account for only 2.6% of the variance in quality intake. Responsiveness of the client in question, however, has a significant effect, tending to increase the conditional probability of higher quality intake by .07.

TABLE V-6

Effects of Select Case Descriptors
on the Quality of the Intake Process

Independent Variable[a]	Regression Coefficient	Standard Error	Significance
Seriousness of the Abuse or Neglect Incident	.003	.054	.961
Court Involvement in the Case	.087	.062	.161
Project Primarily Responsible for the Case Management	.008	.077	.919
Difficulty of the Case--Manager View	.025	.023	.270
Difficulty of the Case--Assessor View	-.024	.077	.761
Responsiveness of the Client	.067	.019	.001
Constant	.007	.199	.000

Adjusted R^2 = .026

Significance of Adjusted R^2 = .022

[a]Means were substituted for missing values in the independent variables.

In order to better understand the association between the case variables thought to be the most salient and quality intake, a final multiple regression analysis was studied. Table V-7 shows that 19% of the variance in quality intake is accounted for by these select characteristics. Use of a multidisciplinary team review has the greatest effect on (or relationship with) a higher quality rating, with a conditional probability of .09. Other characteristics or variables with stable effects

(significant at p<.1 or better) include reduced time between report and first client contact, use of more outside consultation, case manager also handling the intake, more formal education of the case manager, more years of case manager experience in working with abuse/neglect cases, and more responsive clients.

TABLE V-7

Effects of the Most Salient Variables on the Quality of the Intake Process

Independent Variable[a]	Regression Coefficient	Standard Error	Significance
Time Between Report and First Client Contact	-.053	.013	.000
Contacts with Reporting Source for Further Background Information	.074	.066	.261
Use of Multidisciplinary Team Review	.090	.036	.012
Use of Outside Consultants	.030	.012	.012
Case Manager Also Responsible for Intake	.055	.024	.025
Formal Education of Case Manager	.041	.025	.097
Years Experience of Case Manager in Abuse/Neglect Treatment	.043	.017	.012
Responsiveness of the Client	.048	.017	.005
(Constant)	-.264	.167	.000

Adjusted R^2 = .186

Significance of Adjusted R^2 = .001

[a]Means were substituted for missing values in the independent variables.

Using seven of the eight variables found in the last regression equation (eliminating contacts with the reporting source for further background informationa because of its less stable relationship, .261), another statistical technique, discriminant functional analysis, was applied to determine if the final selection of key case handling, case manager and other case characteristics will withstand additional testing. Given information only on these items, will it be possible to correctly classify cases as to their higher or lower quality intake? The result is that by determining the values for these seven particular variables, one can correctly classify 72.1% of the cases in the total data set, a high percentage given the state-of-the-art.

C. Predictors of High Overall Case Management Quality

As shown in Table V-8, several of the case handling characteristics, when looked at independently using cross-tabulations, are related to high overall quality. Forty-six percent of those cases with higher quality ratings were seen the same day as the initial report, whereas only 27% of those cases with lower ratings were seen within 24 hours of the report. Multidisciplinary team reviews occurred more often in high quality cases, as did the use of outside case consultation. More intense contact between client and case manager was associated with higher rated cases, and more follow-up contact after termination was also related to a rating of high overall case management quality. Further, cases open for six months or less, more often received lower quality ratings, whereas cases open over 12 months tended to more often receive higher quality ratings. Other variables that are statistically significant in their association with higher overall quality are the number of project treatment providers (more often having two or more providers received a higher rating), and contacts with the reporting source for further background information on the client and case (more often the high quality cases had more evidence of this type of contact than did the low quality cases). With the other case handling practices, while the direction might be what would be expected -- for example, more cases that get into treatment services within two weeks have high quality -- they appear not to be strongly enough associated with the high overall quality ratings to have significant impact.

TABLE V-8

Overall Quality Rating and Case Handling Characteristics[a]

	Lower Rating	Higher Rating
Time Between Report and First Client Contact (Any Type)		
Same Day	27%	46%
1-3 Days	19	19
4-7 Days	13	11
8-14 Days	11	9
15-30 Days	14	13
1-2 Months	11	1
Over 2 Months	5	1
(n = 332; significant at p<.01)		
Number of Contacts (Following First Contact) Prior to Decision on Treatment Plan		
None	30	19
One	30	35
2	17	17
3-5	17	21
Over 5	7	9
(n = 319; not significant)		
Time Between First Contact and First Treatment Service		
Within 2 Weeks	67	72
2 Weeks to 1 Month	20	13
Over 1 Month	14	15
(n = 304; not significant)		
Use of Multidisciplinary Review Team		
None	71	51
At Least Once	23	32
At Least Twice	6	17
(n = 342; significant at p<.01)		
Use of Case Conferences (Staffings)		
None	40	33
At Least Once	23	25
At Least Twice	23	26
At Least 3 Times	14	16
(n = 341; not significant)		

(Table V-8 continued on following page)

Table V-8 (continued)

	Lower Rating	Higher Rating
Use of Outside Consultants		
None	69%	45%
Once	8	6
Twice	4	13
3-5 times	11	19
Over 5 times	8	20
(n = 344; significant at p<.01)		
Responsibility for Intake		
Current Case Manager	56	62
Other Staff Member	43	38
(n = 345; not significant)		
Number of Primary Case Managers		
One	78	78
Two	17	19
More Than 2	4	3
(n = 343; not significant)		
Number of Project Treatment Providers (Other Than Case Manager)		
None	40	34
1	25	19
2	17	26
3-5	18	21
More Than 5	1	1
(n = 344; significant at p<.1)		
Services Received from Other Agencies (or Individual)		
Yes	65	71
No	35	29
(n = 341; not significant)		
Communication with Other Service Providers		
Yes	82	91
No	18	9
(n = 221; not significant)		
Contacts with Reporting Source		
For Further Background		
Yes	80	93
No	20	7
(n = 302; significant at p<.05)		
Regarding Client's Progress		
Yes	65	74
No	35	26
(n = 300; not significant)		

(Table V-8 continued on following page)

Table V-8 (continued)

	Lower Rating	Higher Rating
Client Participation		
None	87%	81%
At Least Once	10	14
At Least Twice	2	5
At Least 3 Times	2	0
(n = 347; not significant)		
Frequency of Contact by Case Manager		
About Once a Week or More	36	50
About Once or Twice a Month	33	33
Less Than Once a Month	9	0
Once, Twice Only	9	2
Varied Over Time	12	15
(n = 339; significant at p<.01)		
Time in Process		
Through 3 Months	11	8
4 Through 6 Months	31	16
7 Through 9 Months	24	30
10 Through 12 Months	17	12
Over 12 Months	16	34
(n = 338; significant at p<.01)		
Follow-up Contacts		
None	54	31
One	34	32
Two	9	23
More Than 2	4	14
(n = 199; significant at p<.01)		

[a]Percentages may not sum to 100% due to rounding.

Using bivariate analysis, certain case manager characteristics are also significantly related to overall quality. Table V-9 shows that smaller caseloads and more experience in working with child abuse and neglect cases are positively associated with high quality. Professionally trained case managers and those managers with more training specifically in child abuse tend to get higher quality ratings on their cases. As with intake quality, a difference in ethnicity between case manager and client is associated with higher quality.

TABLE V-9

Overall Quality and Case Manager Characteristics[a]

	Lower Rating	Higher Rating
Same Ethnicity as Client		
Yes	68%	52%
No	32	49
(n = 344; significant at p<.01)		
Similar Socio-Economic Experience		
Very Similar	5	12
Somewhat Similar	34	25
Not Very Similar	61	63
(n = 103; not significant)		
Same Sex as Client		
Yes	64	69
No	36	31
(n = 347; not significant)		
Similarity of Case Manager and Client Age		
Manager More Than 10 Years Older	23	21
Manager 3 to 10 Years Older	23	29
Manager Same Age (Within 2 Years)	19	17
Manager 3 to 10 Years Younger	20	23
Manager More Than 10 Years Younger	14	13
(n = 337; not significant)		
Age		
22-25	15	11
26-30	51	62
31-40	20	14
Over 40	16	15
(n = 345; not significant)		
Formal Education		
Professionally Trained	68	80
Not Professionally Trained	32	20
(n = 345; significant at p<.05)		
Training in Abuse and Neglect		
At Least Once	39	22
At Least Twice	26	38
At Least Three Times	20	18
At Least Four Times	15	21
(n = 345; significant at p<.05)		

(Table V-9 continued on following page)

Table V-9 (continued)

	Lower Rating	Higher Rating
Years Experience in Abuse and Neglect Treatment		
One Year or Less	23%	12%
Two Years	33	21
Three Years	31	30
Four Years or More	14	37
(n = 336; significant at p<.01)		
Months Employed with the Project		
0-2 Months	16	20
3-4 Months	25	15
5-7 Months	23	16
8-10 Months	15	17
Over 10 Months	22	33
(n = 261; not significant)		
Caseload Size		
0-20 Cases	61	79
Over 20 Cases	39	21
(n = 345; significant at p<.01)		

[a]Percentages may not sum to 100% due to rounding.

Again, as was the finding with case descriptors and their association to high intake quality, cases of interested and responsive clients received higher overall quality case management. Table V-10 illustrates that no other characteristics describing dimensions and facets of the case were significant in indicating higher rather than lower quality performance.

TABLE V-10

Overall Quality Rating and Case Characteristics[a]

	Lower Rating	Higher Rating
Seriousness of Abuse and Neglect		
Serious	41%	36%
Less Serious	59	64
(n = 291; not significant)		
Court Involvement in Case		
Yes	27	28
No	73	72
(n = 340; not significant)		
Children Living Out of the Home		
Yes	29	33
No	71	67
(n = 335; not significant)		
Start of Case		
Before 1975	18	10
First Half of 1975	41	40
Second Half of 1975	36	42
After 1975	5	8
(n = 344; not significant)		
Type of Referral to the Project		
Self Referral	11	14
Referral from Other Agency or Individual	89	86
(n = 325; not significant)		
Responsibility for Case Management		
Project Primarily Responsible	86	84
Project Not Primarily Responsible	14	16
(n = 341; not significant)		
Difficulty of Case--Manager View		
Most Difficult	20	19
More Difficult	23	22
Average Difficulty	32	30
Less Difficult	13	17
Least Difficult	13	12
(n = 339; not significant)		

(Table V-10 continued on following page)

Table V-10 (continued)

	Lower Rating	Higher Rating
Client's Interest in Treatment		
Very Uninterested	18%	6%
Somewhat Uninterested	12	10
Neutral	15	10
Somewhat Interested	25	33
Very Interested	30	41
(n = 339; significant at p<.05)		
Client's Responsiveness to Treatment		
Very Unresponsive	19	7
Somewhat Unresponsive	12	8
Neutral	15	7
Somewhat Responsive	29	41
Very Responsive	26	38
(n = 340; significant at p<.01)		
Difficulty of Case--Assessor View		
More Difficult	85	84
Less Difficult	15	16
(n = 331; not significant)		

[a]Percentages may not sum to 100% due to rounding.

As was done with the analysis of intake quality, multiple regressions were run to illuminate the relative effects on high overall quality of the variables within the same three groupings of variables: case handling practices, case manager characteristics and case descriptors. Table V-11, displaying the regression using select case handling practices, shows that the percent variation in the dependent variable is modest (accounting for only 11%), but significant. Of all the case handling practices, the largest effect on high overall quality was recontacting the reporting source for further background information on the case (increasing the conditional probability of high quality by .12). Other variables with significant, albeit small, predictive value are the time between report and first client contact (more time between report and first contact decreases the probability of a high quality rating by .04), use of multidisciplinary team review (with each review the conditional probability of a high rating is increased by .05), follow-up contacts after termination (the conditional probability of a higher rating is increased by .05 for each additional contact), use of outside consultants (increasing the conditional probability of a high rating by .02), and frequency of case manager contact with the client

throughout the history of the case (more contact increases the conditional probability of high quality by .03). Longer time in process as an open case is also statistically significant in terms of its effects on high overall quality.

TABLE V-11

Effects of Select Case Handling Practices on the Quality of the Overall Case Management Process

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Time Between Report and 1st Client Contact	-.044	.013	.001
Contacts with Reporting Source for Further Background Information	.124	.064	.052
Time Between 1st Contact and 1st Treatment Service	-.005	.017	.765
Use of Multidisciplinary Team Review	.048	.035	.170
Use of Case Conferences (Staffings)	-.009	.023	.695
Use of Outside Consultants	.024	.012	.048
Case Manager also Responsible for Intake	.022	.024	.373
Number of Project Treatment Providers	-.025	.016	.140
Frequency of Contact with Client	.029	.015	.049
Communication with other Service Providers	.001	.016	.963
Follow-up Contacts after Termination	.048	.026	.066
Time in Process	.001	.000	.004
Constant	.133	.170	.000

Adjusted R^2 = .114

Significance of Adjusted R^2 = .001

[a] Means were substituted for missing values in the independent variables.

Table V-12 reveals that as a group, key case manager characteristics account for only 6% of the variance in ratings of high overall quality. The case manager characteristics that have the most significant relative effect on high quality of overall case management are: more years of experience in abuse and neglect treatment; a smaller caseload size of the manager handling the case; and a difference in the ethnicity between manager and client. With an increase in the years of manager experience in working with abuse/neglect cases, the conditional probability that the case is rated high quality is increased by .06. While caseload size is significant for higher overall quality, there is a very minor effect when accounting for a decrease of a single case. Again, there is an effect of a non-match on ethnicity between client and case manager. For all the remaining case manager characteristics used in this regression, the conditional probability is not significant.

TABLE V-12

Effects of Select Case Manager Characteristics
on the Quality of the Overall Case Management Process

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Same Ethnicity as Client	-.147	.051	.004
Same Sex as Client	.030	.051	.554
Similar Age as Client	-.001	.002	.626
Professional Education	.008	.028	.766
Training in Abuse & Neglect	-.013	.024	.582
Years Experience in Abuse/ Neglect Treatment	.063	.020	.002
Caseload Size	-.003	.001	.010
Constant	.424	.253	.001

Adjusted R^2 = .057

Significance of Adjusted R^2 = .001

[a] Means were substituted for missing values in the independent variables.

The regression shown in Table V-13 of key case descriptor variables and the overall quality measure is statistically significant, but accounts for only 2.5% of the variance in high overall quality ratings. Of all the case descriptors, only responsiveness of the client has a noteworthy effect; a responsive client increases the conditional probability of a higher quality rating by .07.

TABLE V-13

Effects of Select Case Descriptors on the Quality of the Overall Case Management Process

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Seriousness of the Abuse or Neglect Incident	-.043	.051	.393
Court Involvement in the Case	.006	.074	.935
Children Living Out of the Home	.019	.071	.785
Project Primarily Responsible for the Case Management	-.025	.071	.731
Difficulty of Case--Manager View	.015	.021	.468
Difficulty of Case--Assessor View	.028	.072	.699
Responsiveness of the Client	.068	.018	.001
Constant	-.048	.186	.001

Adjusted R^2 = .025

Significance of Adjusted R^2 = .029

[a]Means were substituted for missing values in the independent variables.

In seeking to further discern the relative effectiveness of select case variables, another multiple regression analysis was carried out. Table V-14 shows the relationships between the most salient case handling, case manager and case characteristics on judgments of overall quality of case management. Eighteen percent of the variance in the dependent measure (overall case management quality) was accounted for by this group of variables. Several characteristics stand out as statistically significant ($p<.1$) in predicting a high rating of overall quality: reduced time between report and first client contact (with a regression coefficient of -.04), increase in the use of outside consultation (.02), more contact with the client during the history of the case (.03), longer time in process (.0003), difference in ethnicity between client and manager (-.13), and responsiveness on the part of the client (.04). While not as statistically significant, but having notable effects on the conditional probability of a higher quality rating are contacts with the reporting source for further background information on the case and client (.08), use of multidisciplinary team reviews (.05), and follow-up contacts regarding the client's situation after case termination (.04).

TABLE V-14

Effects of the Most Salient Case Variables on the Quality of Overall Case Management

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Time Between Report and 1st Client Contact	-.036	.012	.004
Contacts with Reporting Source for Further Background Information	.080	.062	.198
Use of Multidisciplinary Team Reviews	.051	.034	.129

(Table V-14 continued on following page)

Table V-14 (continued)

Independent Variables[a]	Regression Coefficient	Standard Error	Significance
Use of Outside Consultants	.023	.011	.047
Frequency of Contact Between Manager and Client	.027	.015	.064
Number of Project Staff Delivering Treatment	-.012	.017	.478
Follow-up Contacts	.038	.025	.137
Time in Process	.0003	.0002	.027
Years Experience of Case Manager in Abuse/Neglect Treatment	.052	.016	.001
Caseload Size of Manager	-.001	.001	.209
Same Ethnicity between Client and Manager	-.131	.047	.006
Responsiveness of the Client	.042	.016	.011
(Constant)	-.103	.186	.000

Adjusted R^2 = .177

Significance of Adjusted R^2 = .001

[a]Means were substituted for missing values in the independent variables.

As with quality intake, discriminant functional analysis was used to test the final set of key characteristics on overall quality case management. The variables used in this analysis included all those in the last regression with the exception of caseload size of the case manager and number of project staff providing services. With values for the 10 select variables one can correctly classify 74.8% of all the cases, an even higher percentage than the group of variables used to predict intake quality.

D. Predictors of High Quality Client Participation

Only a few of the case handling characteristics are theoretically directly related to client participation. Table V-15 shows that three of these variables are indeed associated with judgments of higher quality client participation. Having one or more meetings with the client (after the first contact) before deciding on a treatment plan more often led to higher quality ratings than if there were no such meetings. More often direct client participation in case conferences or multidisciplinary team reviews predicted higher quality judgments (although not as conclusively as would be expected). Finally, 45% of the cases with client contact of once a week or more received higher ratings on client participation compared to only 29% of the cases with lower quality ratings.

TABLE V-15

Client Participation Assessment and Some Case Handling Characteristics[a]

	Lower Rating	Higher Rating
Number of Contacts (Following First Contact) Prior to Decision on Treatment Plan		
None	39%	20%
One	23	35
2	16	18
3-5	18	18
Over 5	4	9
(n = 315; significant at p<.01)		
Client Participation		
None	95	81
At Least Once	4	14
At Least Twice	0	4
At Least 3 Times	1	1
(n = 341; significant at p<.05)		
Frequency of Contact by Case Manager		
About Once a Week or More	29	45
About Once or Twice a Month	37	32
Less Than Once a Month	15	3
Once, Twice Only	7	7
Varied Over Time	12	13
(n = 339; significant at p<.01)		

(Table V-15 continued on following page)

Table V-15 (continued)

	Lower Rating	Higher Rating
Follow-up Contacts		
None	47%	50%
One	40	30
Two	10	14
More Than 2	4	7
(n = 196; not significant)		

[a]Percentages may not sum to 100% due to rounding.

As seen in Table V-16, certain case manager characteristics appear to influence quality client participation. The amount of training in abuse and neglect and years of experience in working with abuse/neglect cases were associated with higher quality ratings. The age of the case manager was also significant, but the direction of the relationship is not clear.

TABLE V-16

Client Participation and Case Manager Characteristics[a]

	Lower Rating	Higher Rating
Same Ethnicity as Client		
Yes	65%	63%
No	35	37
(n = 338; not significant)		
Similarity of Case Manager and Client Age		
Manager More Than 10 Years Older	22	22
Manager 3 to 10 Years Older	21	26
Manager Same Age (Within 2 Years)	16	19
Manager 3 to 10 Years Younger	26	18
Manager More Than 10 Years Younger	15	14
(n = 331 ; not significant)		
Similar Socio-Economic Experience		
Very Similar	0	10
newhat Similar	26	32
Not Very Similar	75	58
(n = 101; not significant)		

(Table V-16 continued on following page)

Table V-16 (continued)

	Lower Rating	Higher Rating
Same Sex as Client		
Yes	60%	67%
No	40	33
(n = 341; not significant)		
Age		
22-25	16	12
26-30	45	57
31-40	19	18
Over 40	20	13
(n = 339; significant at p<.01)		
Formal Education		
Professionally Trained	66	74
Not Professionally Trained	34	26
(n = 339; not significant)		
Training in Abuse and Neglect		
At Least Once	50	27
At Least Twice	20	33
At Least Three Times	15	22
At Least Four Times	16	18
(n = 339; significant at p<.01)		
Years Experience in Abuse and Neglect Treatment		
One Year or Less	25	17
Two Years	32	29
Three Years	34	28
Four Years of More	10	26
(n = 330; significant at p<.01)		
Months Employed with the Project		
0-2 months	18	17
3-4 months	25	20
5-7 months	25	19
8-10 months	10	18
Over 10 months	23	25
(n = 257; not significant)		
Caseload Size		
0-20 Cases	69	66
Over 20 Cases	31	34
(n = 339; not significant)		

[a]Percentages may not sum to 100% due to rounding.

As with higher quality intake and overall case management, client interest and responsiveness had a positive influence on quality ratings for client participation. Table V-17 shows that, additionally, the difficulty of the case (whether determined by the case manager or the quality assessor) was critical; difficult cases more often tended to get lower quality ratings on this item, implying that these types of cases include dimensions that preclude active client involvement, either due to the worker's reluctance or the client's predeliction.

TABLE V-17

Client Participation Assessment and Case Characteristics[a]

	Lower Rating	Higher Rating
Seriousness of Abuse and Neglect		
Serious	40%	39%
Less Serious	60	61
(n = 286; not significant)		
Court Involvement in Case		
Yes	27	27
No	73	73
(n = 334; not significant)		
Children Living Out of the Home		
Yes	30	30
No	70	70
(n = 329; not significant)		
Start of Case		
Before 1975	16	15
First Half of 1975	39	42
Second Half of 1975	42	35
After 1975	3	7
(n = 338; not significant)		
Type of Referral to the Project		
Self-Referral	11	12
Referral from Other Agency or Individual	89	88
(n = 319; not significant)		

(Table V-17 continued on following page)

Table V-17 (continued)

	Lower Rating	Higher Rating
Difficulty of Case--Manager View		
Most Difficult	26%	17%
More Difficult	29	20
Average Difficulty	30	32
Less Difficult	7	17
Least Difficult	9	15
(n = 334; significant at p<.05)		
Client's Interest in Treatment		
Very Uninterested	25	10
Somewhat Uninterested	10	12
Neutral	17	12
Somewhat Interested	23	30
Very Interested	26	36
(n = 334; significant at p<.01)		
Client's Responsiveness to Treatment		
Very Unresponsive	26	10
Somewhat Unresponsive	16	9
Neutral	14	12
Somewhat Responsive	26	35
Very Responsive	18	34
(n = 336; significant at p<.01)		
Difficulty of Case--Assessor View		
More Difficult	92	81
Less Difficult	8	19
(n = 325; significant at p<.05)		

[a]Percentages may not sum to 100% due to rounding.

Regression analyses shed further light on the interactive effects of key case and case manager characteristics on quality client participation. Table V-18 shows that with a set of key independent variables, selected because they were theorized to be strongly associated with higher quality, 13% of the variance in quality of client participation is accounted for. All the five select characteristics are statistically significant, with the number of times the client participated having the strongest effect on the rating (increasing the conditional probability by .12). Three of the remaining variables, frequency of contact throughout the history of the case, experience of the case manager in working with abuse and neglect cases, and responsiveness of the client, increased the conditional probability of higher quality by .05, .06 and .06 respectively. And finally, a lesser degree of difficulty with case increased the conditional probability of higher quality client participation by .05.

TABLE V-18

Effects of the Most Salient Case Variables on the Quality of Client Participation

Independent Variables [a]	Regression Coefficient	Standard Error	Significance
Amount of Client Participation	.118	.044	.007
Frequency of Client Contact Between Manager and Client	.045	.015	.002
Years Experience of Case Manager in Abuse/Neglect Treatment	.058	.016	.000
Responsiveness of Client	.057	.018	.001
Difficulty of Case	.054	.020	.006
Constant	.267	.124	.000

Adjusted R^2 = .132

Significance of Adjusted R^2 = .001

[a]Means were substituted for missing values in the independent variables.

E. Discussion and Implications of the Findings

The various analyses and tests that have been carried out on the data collected for the quality case management study have led to determinations of the most critical case handling and case manager characteristics for predicting professional judgments of high quality. None of the variables had large effects individually on high quality, and many and overlapping considerations entered into the assessors' ratings of the quality of the case management process for each case; however, several specific characteristics clearly emerge as associated with their decision-making. Case managers and program administrators, while they should not abandon the full range of accepted procedures and standards of case management, might do well to focus their attention and strive to improve upon those aspects of practice that are most cogent to a high quality management process.

1. Case Handling Characteristics and High Quality

In summary, the following case handling practices appear to be the strongest in positively influencing quality case management:

a. Immediacy of response to incoming reports. A minimal time lapse between report and first contact with the client is one of the most powerful predictors of both high quality intake and high overall quality case management. Those case managers who respond to incoming reports with a sense of urgency, in order to intervene in a crisis or potential crisis situation, set the tone for their future case management interactions with the client. While it seems evident that child maltreatment cases need immediate response, this is an area in which many agencies fall seriously short and programs should press harder to make early contact with prospective clients a high priority.

b. Recontacting the reporting source for further background information. This variable is associated with both quality intake and overall management, although it has a somewhat unstable predictive value. Contacting the reporting source for background information on the case dynamics is an indicator of both thoroughness of intake and communication with another service. Whether or not the reporting agency maintains an association with the client, this linkage is potentially useful in future management of other cases. Agencies with formal

interagency agreements around management of cases encourage workers to open and maintain communication and, thereby, strengthen service delivery to clients.

c. Intensity of contact between client and case manager throughout the history of the case. With abuse and neglect cases, where the potential for crisis is high, routine interaction between client and case manager must be established and continued. Maintaining frequent contact with the client, one of the strongest indicators of high overall quality case management, suggests that the case manager is monitoring the client's progress in a systematic manner. Case managers should seek ways to maximize ongoing contact with the client and supervisors should encourage regular meetings between client and worker.

d. Use of multidisciplinary team reviews. The child abuse and neglect field has for some time been encouraging the use of multidisciplinary reviews as a formal means for introducing a range of perspectives on diagnosis and treatment planning. It is interesting to note that the use of such team reviews on a case is a statistically significant predictor of high quality intake and a somewhat lesser predictor of high overall quality case management. Multidisciplinary team reviews are important for case management because a sole worker or even a single agency cannot be expected to know all there is about managing many of the cases; such a team provides needed interdisciplinary input. At the same time, presenting cases to a multidisciplinary team encourages workers to thoroughly prepare their treatment plans and/or reassess their client's progress.

e. Use of outside consultation. Again, both intake and overall quality are very positively associated with the use of consultants. Abuse and neglect cases are complex and often difficult to handle, and a case manager who recognizes this and uses available consultation, as necessary, is indicating awareness of the need to turn to other experts for assistance. Despite limited budgets, agencies should arrange for a panel of outside consultants to work with case managers and should encourages workers to use these resources.

f. Ongoing case manager also conducting the intake. Acknowledging that the field is divided over the issue of separation of intake and ongoing treatment, the data presented here supports, significantly, having the intake and ongoing treatment managed by the same person. Intake units appear to inject enough discontinuity in treatment provision so as to adversely effect quality case management. If intake workers were more

highly trained and experienced, and the transfer process more efficient, perhaps these adverse effects could be mitigated.

g. A longer time in process. Cases that were only opened for short periods of time more often received lower ratings on the quality of overall case management. The inference is that short-term cases were handled too hastily and without rationally systematic procedures and practices. This is not to say that all cases should be open for longer periods, but that for those cases which appropriately should be closed after a short time, more care and attention is required.

h. Follow-up contacts after termination of the case. Completing the case management process by following-up after case closure, either by making a personal contact with the client or by contacting another agency still in touch with the client is an important aspect of overall quality case management. Many abuse and neglect agencies, while exhibiting strong case management practices for open cases, have been remiss in encouraging workers to make contact within a short period of time after termination, to assure that no new problems have emerged which require further intervention.

2. Case Manager Characteristics and High Quality

A few case manager characteristics are also significantly associated with judgments of high quality case management. This does not mean that these attributes in and of themselves cause higher quality, but that certain types of managers more often had cases which were rated of higher quality. The assumption is that these manager qualities lead to better management practices in those areas that are most associated with quality case management.

a. Years of experience in abuse/neglect treatment. This case manager characteristic has a very strong association with both high quality intake and overall case management, leading to the conclusion that problem-specific experience is critical in working with these difficult cases that have multiproblems and diverse needs. The implication of this finding for program managers is that, while it is not possible to hire only highly

experienced workers (because of a severe shortage of this type of worker), and while other personal qualifications should enter into hiring decisions, looking for those with more direct experience is important.

b. Formal education of the case manager. It is clear that advanced formal education is not important for many aspects of working with abuse and neglect clients, such as for delivering certain treatment services. However, it appears that increased formal education better prepares a person for the demands of case management (or, perhaps, the same personality traits that cause one to seek more education make a person a better case manager.) Working with these cases can be learned, as evidenced by the strong association between experience and high case management quality, but many of the aspects of case planning, including diagnosis, and knowledge and coordination of alternative intervention strategies and resources, can often be more efficiently learned in school. Again, in searching out workers who will be good case managers, programs should strongly consider formal training, along with the range of other personal attributes.

c. Difference in ethnicity between client and case manager. Contrary to popular belief, workers managing abuse/neglect cases do not have to be the same ethnicity as their client in order to carry out good case management. In fact, it appears that a non-match in ethnicity, such as, black worker and white client or white worker and hispanic client, is best for overall quality. The possibilities are that either the client, because of an inculcated sense of deference is more cooperative with a worker of a different ethnicity, affecting case management practices, or a case manager of the same ethnicity as the client makes stronger demands, thus weakening the client/worker relationship.

d. Smaller caseload sizes. Smaller caseload sizes tend to effect the quality of overall case management. This finding supports the contention from those who have worked with abuse and neglect cases that there is a need to maintain smaller work loads than with other social service or protective services cases. Program administrators must continuously strive to keep caseloads of a reasonable size.

3. Variables Not Associated with Higher Quality

In contrast to those case practices and case manager characteristics that were shown to be relevant to ratings of higher quality case management, several variables or characteristics, which are thought by many in the field to be critical, did not prove to be associated (using both bivariate and multivariate analyses) with judgments of quality intake or of overall case management quality. This does not mean that these characteristics or attributes might not have been a factor in ratings of one or more of the seventeen individual measures of quality from which the composite quality measures were constructed, but they were not associated enough to be meaningful when looking at the whole of intake or overall case management. The following are the variables which were <u>not</u> useful in predicting judgments of high quality:

- Time between first contact and first treatment service;
- Receipt of service from outside agencies or individuals;
- Communication with other service providers;
- Use of case conferences;
- Recontacts with the reporting source regarding client's progress in treatment;
- Client participation in treatment planning;
- Number of primary case managers;
- Agency responsibility for case management;
- Seriousness of the abuse/neglect;
- Whether the child was out of the home during treatment;
- Type of referral (self-referral vs. not self-referral)
- Having the case manager the same sex or of a similar age as the client;
- Case manager's length of employment with the project.

SECTION VI: THE RELATIONSHIP BETWEEN QUALITY CASE MANAGEMENT AND CLIENT OUTCOME

It is important to determine whether or not the case mangement practices that are related to perceptions of quality case management are related to treatment outcomes, and also whether, in general, quality case management is associated with and thus is predictive of positive client outcome. To this end, the measure of overall case management quality and those case handling practices found to be related to judgments of quality case management (and others of substantive interest) were studied in terms of their relationships to clients' reduced propensity for future abuse or neglect by the end of treatment--the evaluation's primary treatment outcome measure.[1] This evaluation has been an exploratory study and the methodology is largely developmental. While the measures used require refinement before any conclusive judgments can be drawn about the relationship between case management process and client outcome, it is instructive to see what suggestive relationships exist in the study's data base.

Upon analysis, the ratings of the overall quality of case management were not found to be related to a reduction in propensity to abuse or neglect. This suggests that the judgments of quality used in this study do not predict client improvement while in treatment as measured in this study. Only two factors found to be associated with quality case management were also found to have strong relationships to client outcome: length of time in treatment and caseload size. As Table VI-1 shows, the smaller the manager's caseload, the more likely his/her client improved with treatment. Also, clients who were in treatment longer (over 6 monhts) more often tended to improve (that is, reduce their propensity for abuse/neglect). The remainder of the case handling practices as described in the previous section were not found to be significantly associated with positive client outcome.

[1] See the Adult Client Report for a detailed discussion of this measure.

TABLE VI-1

Case Management Characteristics and Positive Client Outcome

(Reduced Propensity for Future Abuse/Neglect)

Time in Treatment	Reduced Propensity for Future Abuse/Neglect	
	Low	High
Time in Treatment (N=260)		
Up through 6 months	78%	22%
7 months or more	54	46
Caseload Size (N=258)		
20 cases or less	60	40
Over 20 cases	70	30

This suggests, then, that what is considered "good practice" in handling or managing cases for this data base does not appreciably influence a client's improvement. This is not surprising; treatment outcome may be more related to other factors, such as the content of the worker/client interation, the type of treatment service provided, the client's environment and his/her constellation of problems.

This lack of a clear-cut relationship between case management and outcome can best be understood by looking at examples. The amount of time that elapses between receipt of a report and the first contact with a client is a strong predictor of the quality of case management. A quick response time is considered essential to ensure that a child receives any needed protection and that immediate family crises are alleviated. However, it seems that any negative effects of a slower response to an incoming report may well be mitigated over the course of treatment by the nature of the services received and the client's receptivity to intervention.

Another example which illuminates the reason for nonassociation between case management and client outcome is the practice of recontacting a reporting source to elicit further information about a case. Such contacts reduce duplication of effort and maximize the efficiency of the intake process, and, thus, are regarded as an important aspect of quality case management. However, because the proportion of clients with a reduced propensity to abuse and neglect by the end of treatment is not affected by whether or not such contacts occurred, the implication is, again, that other factors about the services and the client are more critical for improvement in the client.

Discussion of Findings

The question arises when faced with the apparent noneffect of superior case management and positive client outcome: should concern with the quality of case management be dismissed as unimportant in child abuse/neglect service agencies? The answer is no. While one should understand that quality case management may not be a proxy measure for determination of the direction of client outcome, it does serve many other purposes.

Good case management protects the interest of the client. Clients will not have the opportunity to receive and retain the effects of treatment unless they are brought into services and moved through the period of time in which they are receiving treatment in an efficient and equitable manner. Securing the safety of the child in question by quick response and thorough investigation, and monitoring the client's progress while in treatment are two examples of indirect, but necessary adjuncts to provision of effective treatment.

Quality management practices also serve to support case managers, allowing them to maintain control over their workload. A well-managed caseload, using rational and systematic decision-making, can reduce work pressures and, thereby help to prevent burnout in what is otherwise a very stressful work environment.

Another reason to value quality case management is directly relevant to the agency as a whole. As shown in Appendix G (Table G-2) judgments of higher overall quality case management are positively related to cost-efficiency, meaning that there is a tendency for cases managed in a quality manner to contribute to delivery of services for a more reduced cost than less well-managed cases. While acknowledging that the two composite measures cited are only very generally applicable for cross comparison purposes, this relationship is an important consideration to program managers.

Finally, quality case management serves a purpose beyond the individual client, the manager and the agency. It serves to improve coordination across the community system. By setting up communication and referrals, by using outside service providers--all part of good case handling practice--interagency cooperation is maximized and duplication of effort is reduced.

APPENDIX A

Listing of Major Evaluation Reports and Papers

Listing of Major Evaluation Reports and Papers

Reports

(1) Comparative Descriptions of Projects Report; June 1977.

(2) Historical Case Studies of the Eleven Demonstration Projects; June 1977.

(3) Final Cost Analysis Report; July 1977.

(4) Final Community Systems Impact Report; August 1977.

(5) Final Adult Client Impact Report; September 1977.

(6) Final Child Impact Report; September 1977.

(7) Final Quality Case Management Report; September 1977.

(8) Final Evaluation Report; September 1977.

(9) Methodology for Evaluating Child Abuse and Neglect Programs; October 1977.

(10) Handbook for Planning and Implementing Child Abuse and Neglect Programs; October 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 Kathy Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas, April 1977.

"Evaluating Case Management," presented by Beverly DeGraaf, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas, April 1977.

"Quality Assurance in Social Services: What Can Be Learned from the Medical Field?" presented by Beverly DeGraaf, National Conference on Social Welfare, Chicago, Illinois, May 1977.

Appendix B

Methodology

B 1. Case Management Criteria

Table B 1-1 displays the full set of criteria for quality case management as suggested by a wide range of experts.

TABLE B 1-1

Suggested Case Management Criteria and Measures

Criteria	Type of Measure	Data Source
Initial Intake		
Existence of case acceptance criteria	presence/absence	Director/staff interview
Adherence to acceptance criteria	qualitative	Case review
Time between report and first contact	quantifiable	Case review
Communicate helping philosophy	qualitative	Case review
Amount of face-face contact prior to completed intake and diagnosis	quantifiable	Case review
Amount of other contact prior to completed intake and diagnosis -- with client by phone -- with other agencies -- with other household members	quantifiable	Case review
Diagnosis/Prescription of Services		
Operational goals established	qualitative	Case review
Service-specific treatment plan	presence/absence	Case review
Multidisciplinary review	presence/absence, quantifiable	Case review
Length of waiting lists for services	quantifiable	Director/staff interview
Time between first contact and start of treatment	quantifiable	Case review
Treatment Process		
Existence of minimum contact standards	qualitative	Director/staff interview

TABLE B 1.1 (Continued)

Criteria	Type of Measure	Data Source
Frequency of contact with: -- mother -- father -- abused/neglected child(ren) -- household member(s) -- other	quantifiable	Case review
Client utilization of services	quantifiable	Case review
Existence of criteria for staffing and case conference	qualitative	Director/staff interview
Frequency of client and family staffing and case conference	quantifiable	Case review
Staff/caseload ratio	quantifiable	Director interview
Frequency of contact with referral agencies -- re: initial referral -- re: receipt of services/ progress, status	quantifiable	Case review
Client drop-out rate from services	quantifiable	Director interview
Termination/Stabilization		
Existence of operational termination/stabilization criteria	presence/absence	Director/staff interview
Adherence to termination/stabilization criteria	qualitative	Case review
Time between first contact and termination	quantifiable	Case review
Follow-Up		
Existence of standard follow-up policy	qualitative	Director/staff interview
Frequency and types of follow-up	quantifiable	Case review
Assessment of client functioning during follow-up	presence/absence	Case review

TABLE B1.1 (Continued)

Criteria	Type of Measure	Data Source
Information Needs		
Story of abuse/neglect incident and circumstances	presence/absence	Case review
Basic demographic socio-economic information	presence/absence	Case review
Parent's view of abuse/neglect incident and circumstances	presence/absence	Case review
Child's view of abuse/neglect incident and circumstances	presence/absence	Case review
Childhood experience of mother, father	presence/absence	Case review
Family stress factors and conditions	presence/absence	Case review
Evaluation of parent-child interactions -- mother -- father	presence/absence	Case review
Rating parent(s) on critical characteristics related to abuse/neglect	presence/absence	Case review
Elaboration of parent status on critical characteristics related to abuse/neglect -- mother -- father	presence/absence	Case review
Key people in family's life	presence/absence	Case review
Other agencies involved in case	presence/absence	Case review
Measures of child's development -- physical -- developmental -- psychological-social-emotional	presence/absence	Case review

TABLE B1.1 (Continued)

Criteria	Type of Measure	Data Source
Changes in goals	presence/absence	Case review
Changes in treatment plan	presence/absence	Case review
Client's progress	presence/absence	Case review
Provider Continuity		
Amount of turnover of case managers	quantifiable	Case review
Staff turnover -- administrative -- casework -- other paid staff -- volunteer	quantifiable	Director interview
Coordination		
Mechanics for internal communication on cases	qualitative	Director/staff interview
Planfulness		
Explicitness of rationale given for links between -- case intake information and goals -- goals and treatment plans -- progress and changes in plan -- progress and termination	qualitative	Case review
Client Involvement		
Existence of client participation policy	qualitative	Director/staff interview
Client participation	presence/absence; quantifiable	Case review
Program Priorities		
Time staff spend with client vs. time spend in managing case	quantifiable	Cost analysis
[illegible]quality criteria not being met, what action is being taken?	qualitative	Interviews and general observation
Internal quality review procedures	qualitative	Director interview

B 2. Results of the Pretest

The Teams and Sites

Visits to selected projects were made prior to a full-scale assessment in order to test the applicability and appropriateness of the criteria and instruments for assessing the quality of case management. In the summer of 1975 four projects were visited by teams composed of persons from outside the BPA national evaluation staff. They were selected to represent a range of perspectives on abuse and neglect service delivery as well as some commonality of experience with respect to family and children's services.

Two teams, each made up of two "experts," were accompanied to two of the sites by a member of BPA's staff or the evaluation's project officer from Health Resources Administration. Team 1 consisted of Eli Newberger, M.D., a staff physician at Children's Hospital in Boston and Director of the Family Development Study service project for abusive families, and Katherine Armstrong, MSW, MPH, an experienced treatment provider who is on the staff of BPA with responsibilities at that time outside the national evaluation. This team visited the Union County Protective Services Project in New Jersey and the Family Resource Center in St. Louis, Missouri. In Union County, this team was augmented by the evaluation project officer; in St. Louis a BPA staff member was added to the team. Elsa TenBroeck, MSW, past director of the Extended Family Center in San Francisco, and Marilyn Rymer, MSW, a social services and evaluation specialist with a Cambridge, Massachusetts, consulting firm, made up Team 2. Another BPA staff member joined this team in Adams County, Colorado.

Team 1 visited the project in Union County, New Jersey, July 1 and 2, and the project in St. Louis, July 7 and 8. Also July 7 and 8, Team 2 went to Adams County, Colorado, and then on July 9 and 10, they visited the Arkansas project at its Jefferson County office.

Training

Previous to the site visits, the team members were provided a half-day of training in the use of the data collection instruments and were provided copies of the Preliminary Quality Assessment Design Report. The training consisted of a brief review of the design and its purpose and a thorough review of each instrument, in which all questions were clarified. Each of the team members was assigned responsibility for directing interviews at one of the four sites.

The Results

Analysis of the data collected during the site visits provided a basis for selecting the most reliable, valid and important criteria to be used in actual assessment of the demonstration projects and assisted in determining what the respective roles of outside experts and BPA staff should be.

Following is an analysis of the reliability of the case review instrument used. A compacted version of the form is shown, listing every review data item. For each question for which all team members (either two out of two, if there were only two team members, or three out of three, if there were three) recorded the same response from reviewing the same case, this is counted as a case of 100% agreement. Where three team members participated in an interview, agreement by two of three interviewers is separately noted. If none of the team members agreed on a response, this is recorded as 'no agreement.'

Table B 2-1, pages B 2.5 to B 2.9, indicates that of the total of 87 items in the case review,[1] there was only one item, "Date Entered Caseload," for which all reviewers agreed on all cases. Fourteen cases were reviewed, and the table indicates by a double asterisk (**) those items on which all reviewers agreed for 75% or more of the cases (11 or more cases). A single asterisk (*) indicates those items on which all reviewers agreed in 50% or more cases (7 or more cases). Nineteen of

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[1] The record review and interview schedule contained 80 items. However, some had multiple parts, and these were tabulated separately.

the items received double asterisks and an additional 38 items single asterisks. Thus, 57 items (or about 65%) showed reviewer consensus in at least half of the cases reviewed.

The case review instrument used a number of different types of items: scales, in which reviewers rated some aspects of case management on a scale from very poor to very good; counts of number of contacts during different phases of case management; dates of critical events or recording of critical information; yes/no items; and basic identifying information. Analysis of inter-rater agreement for the different types of items indicates the highest reliability is for scaled items. Items 64 through 80, for example, which call for summary ratings on 17 aspects of case management, all received either single or double asterisks.[2] Items calling for counts of the number of contacts had the lowest inter-rater agreement, and items calling for recording of precise dates also had low agreement. These items appear to have called for a level of precision beyond what can be obtained in a one to one-and-a-half hour review of a complex case record.

Most of the reasons for reviewer disagreement on items are apparent on analysis. Differences in reviewers recording numbers of contacts and dates were usually fairly small and due to a lack of precision which is probably not critical to the purpose of the case review. Conflicts on items calling for reviewers to determine whether critical information has been placed in the record appeared to be based on different standards and expectations among reviewers for case records: some reviewers were satisfied with a minimal notation in the record on a given question, others considered such a notation to be so minimal as to be useless. Thus, most of the disagreements, and thus lack of reliability on items, could be resolved by moving to more scaled items. Items calling for actual counts of contacts and dates could be revised to provide frequency ranges for reviewers to check. Items assessing the content of the record might ask not whether certain information is recorded

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[2] With the exception of the three items related to terminated cases (there were only 3 terminated cases among the fourteen reviewed, and thus these items were not rated with asterisks).

at all, but whether the record contains no information, minimal information, adequate information, or extensive information.

Of course, inter-rater reliability measures were not the only factor to be considered in assessing the usefulness of the pre-test instruments. Some of the items which showed high reliability were nevertheless problematic. Reviewers agreed in over half the cases, for example, on both the date of first telephone contact with client and the date on the record of the child's view of the abuse or neglect incident. However, their agreement was usually on the fact that neither of these items were recorded at all. Revisions of the instrument took into account not only reliability factors but also usefulness of the data obtained.

In general, the participants in the preliminary quality assessment concluded that the basic approach used, intensive site visits to projects to interview staff and review case records, was a workable method for assessing the degree to which a program is meeting basic standards of good case management. Analysis of the assessor responses and ratings indicated levels of inter-rater consistency which showed promise for further development of the quality assessment methodology. Thus, the preliminary assessment experience provided encouragement to proceed in the development of a quality assessment technique.

TABLE B 2-1

CASE REVIEW

	No. Cases with 100% Agreement
No. of Interviews: 14[a]	
Identifying Information	
* A. Case Status (terminated/active)	7
** B. Caseworker Name	12
* C. Client Sex	6
* D. Severity of Case	8
Intake & Plan	
** 1. Date Initial Report Received ___/___/___	12
** 2. Type of report: Self-referral: in person ___ by phone ___ report by agency ___ report by other individual ___	11
* 3. First in-person contact with client (after initial report) ___/___/___	9
* 4. First telephone contact with client (after initial report) ___/___/___	8
** 5. Date entered caseload ___/___/___	14
6. Date Treatment Plan recorded ___/___/___ None recorded ___	5
** 7. Date Intake and Diagnosis Completed ___/___/___	11
* 8. Number of face to face contacts with client prior to date of 7. ___	8
* 9. Number of telephone contacts with client prior to date of 7. ___	7
10. Number of contacts with other household members prior to date of 7. ___	6
* 11. Number of contacts with other agencies or individuals prior to date of 7. ___	9
Record of Critical Information	
Is the following information: in the record? (first date recorded) ___/___/___ if not recorded, known to worker? ___	
* 12. Description of abuse/ neglect incident & circumstances	9[c]
* 13. parent's view of abuse/ neglect incident & circumstances	7[c]
* 14. child's view of abuse/neglect incident & circumstances	10[c]

Table B2-1 (Continued)

	first date?	known to worker?	100%
* 15. Childhood experience of mother	↓	↓	8[c]
* 16. Childhood experience of father			9[c]
* 17. Family stress factors/conditions			10[c]
* 18. Evaluation of mother-child interaction			9[c]
19. Evaluation of father-child interaction			5[c]
20. Discussion of mother's status on critical abuse/neglect characteristics			4[c]
21. Discussion of father's status on critical abuse/neglect characteristics			6[c]
22. Measures of child's physical health			4[c]
23. Measures of child's developmental status			4[c]
24. Measures of child's psych-social-emotional health			6[c]
* 25. Are the following BPA forms completed: Partially; Fully (to date); Not at All. Intake; Goals of Treatment; Client Impact; Client Functioning; Services to Parent; Services to Child			8
Planfulness/Treatment Process			
26. Date 1st treatment service provided ___/___/___ (Note: includes any service of the type listed on BPA Services form; excludes initial intake interview.)			2
* 27. Please indicate, by rating on a scale of 1-5, whether the goals listed are operational and measurable, or are either too broad or too procedural. 1 overly procedural or broad... 2 3 4 5 operational...			10[b]
28. Record for all staffings, case conferences, and multi-disciplinary team reviews: Date(s)			4
Whether Client Present			4
No. of Other Household Members Present			3
* 29. Number of contacts, by project, during 1st 2 weeks in caseload, with: Mother ___ Father ___ A/N child(ren) ___ Other Other Household Members ___			8[d]
* 30. Number of contacts, by project, from 3rd week to date, with: Mother ___ Father ___ A/N child(ren) ___ Other Household Members ___			8[d]

Table B2-1 (Continued)

	100%
Coordination of Information From All Sources	
31. Number of contacts to date with agency or individual referring client to project re initial referral ___ re receipt of services/status & progress	5[d]
32. Number of contacts to date with agencies or individuals to which client referred for services by project re initial referral ___ re receipt of services/status & progress ___	4[d]
* 33. Extent to which case record provides information on client's progress 1 Very poor — 2 Poor — 3 Adequate — 4 Good — 5 Very Good	9[b]
Termination & Follow-Up	
34. Date case closed ___/___/___	1[a]
35. Follow-up contacts with client after case closed/stabilized Face to face with client ___/___/___ ___/___/___ ___/___/___ Telephone with client Letter to client With other agencies/indi.	1[a]
36. Was there assessment of client functioning as part of these follow-ups, i.e., record shows some consideration of client functioning indicators used by BPA or similar items? Number "yes" _____ Number "no" ____	1[a]
Basic Information on Case	
* 37. Number family members in household (adult and child)	10
38. Age of abused/neglected child(ren) _____ _____ _____	2
39. Relationship of project's client(s) to abused/neglected child(ren) Mother ____ Father ____ Grandparent ____ Other ____, specify _____	6
** 40. Does this case meet the project's case acceptance criteria? Yes ____ No ____ Comment:	13
41. If terminated (or stabilized), did this case meet the project's termination/stabilization criteria? Yes ___ No ___ Comment:	1[a]

Table B2-1 (Continued)

	100%
Reviewer Assessment of Case: Based on Case Record Only	
Very Poor / Poor / Adequate / Good / Very Good / No Record Information	
* 42. Intake - timing	9[b]
* 43. Intake - thoroughness	10[b]
* 44. Intake - helping approach	10[b]
* 45. Record of critical information	7[b]
* 46. Planfulness in case handling	8[b]
* 47. Frequency of contact during treatment	10[b]
* 48. Reassessment of case during treatment	7[b]
** 49. Appropriateness of case for project	13[b]
50. Appropriateness of decision to terminate case	2[a,b]
51. Coordination of information from all providers	6[b]
52. Handling of follow-up after termination	2[a,b]
* 53. Explicitness of rationale given for links between intake information & goals	8[b]
* 54. Explicitness of rationale given for links between goals & treatment plan	7[b]
* 55. Explicitness of rationale given for links between progress & changes in goals & in plan	7[b]
56. Explicitness of rationale given for links between progress & termination	2[b]
Note: Items 57 & 58 not tabulated, procedural questions only.	
Worker Interview Supplement to Record Review (refer worker to case record, as necessary)	
* 59. What other agencies are involved in this case? (Probe to determine if this is known to worker) known to worker ___ not known ___	9
* 60. Who are the key people in the client's life? (Probe to determine if this is known to worker.)	10
61. Did anyone other than you have primary responsibility for intake in this case? Yes ___ No ___ If yes, was there more than one person responsible for intake? Yes___ No___	6
* 62. Did anyone other than you ever have primary case management responsibility on this case? Yes ___ No ___	7
63. Worker characteristics:	
** Age	12
* Sex	8
* Race	7
** Degree	12

Table B2-1 (Continued)

		100%
	Reviewer Assessment of Case: Based on Worker Interview and Record	
	Very Poor / Poor / Adequate / Good / Very Good	
**	64. Intake - timing	12[b]
*	65. Intake - throughness	10[b]
**	66. Intake - helping approach	12[b]
**	67. Record of critical information	11[b]
*	68. Knowledge and record of critical information	10[b]
**	69. Planfulness in case handling	13[b]
**	70. Frequency of contact during treatment	13[b]
**	71. Reassessment of case during treatment	12[b]
**	72. Appropriateness of case for project	11[b]
	73. Appropriateness of decision to terminate case	2[b]
*	74. Coordination of information from all providers	9[b]
	75. Handling of follow-up after termination	0[a]
*	76. Explicitness of rationale given for links between intake information and goals	10[b] 10[b]
**	77. Explicitness of rationale given for links between goals & treatment plan	11[b]
**	78. Explicitness of rationale given for links between progress & changes in goals & in plan	11[b]
	79. Explicitness of rationale given for links between progress & termination	2[b]
**	80. Rate this worker as a case manager	13[b]

NOTES for Table II-c

** Items for which total agreement occurred in 75% or more of the cases.

* Items for which total agreement occurred in 50% or more of the cases.

[a] For termination & follow-up questions, N = 3.

[b] For scale items, reviewers were counted as in agreement if responses were within cne scale point of each other.

[c] For items requiring notation of date recorded, reviewers were counted as in agreement if responses were within 2 weeks of each other.

[d] For those items requiring counts of number of contacts throughout treatment, responses were grouped into the following frequencies:
0, 1, 2-5, 6-10, 11-20, over 20.
Reviewers were counted as in agreement if responses were within the same frequency grouping.

B.3. Case Management Assessment Instrument

Following are the two forms used for collecting the data necessary for the quality review: the Orientation Checklist and the Case Review Instrument, parts A and B.

ORIENTATION CHECKLIST

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

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

ORIENTATION CHECKLIST (Continued)

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

CASE REVIEW INSTRUMENT (Part A)

Berkeley Planning Associates
2320 Channing Way
Berkeley, California 94704

Column

CARD NUMBER 1 [1]

Client name _____

Project ID No. _____

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

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

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

Date of Review: / / / / / / [13-18]
mo dy yr

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

[20]**

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

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

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

**These card columns are to be left blank.

Basic Information

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

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

[39-40]**

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

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

[59-60]**

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

		Column
5. Number of children in household:	/ / / Unknown 99	[73,74]
6. Total number of children in family, whether or not in household: *(BPA Intake)*	/ / / Unknown 99	[75,76]
END OF CARD 1		[77-80]**

		Column
	CARD NUMBER 2	[1]
	ID and Reviewer	[2-10]
		[11]**

7. Identification of client for this review:

Mother	1	[12]
Mother substitute	2	
Father	3	
Father substitute	4	
Other (specify) _____	5	
Unknown	9	

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

9. Ethnicity of client: *(BPA Intake)*

White	1	[15]
Black	2	
Spanish	3	
American Indian	4	
Asian	5	
Other (specify) _____	6	
Unknown	9	

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

Less than 8 years	1	[16]
8-11 years	2	
High school diploma	3	
Some college/vocational training	4	
College graduate	5	
Post college graduate	6	
Unknown	9	

Column

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

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

[18-20]**

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

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

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

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

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

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

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

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

[38-40]**

Intake and Plan

15. Date initial referral received: / / / / / / [41-46]
mo dy yr
Unknown 999999

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

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

17. Date of first contact with client (any type of contact, i.e., telephone, in-person, or other): / / / / / / [48-53]
mo dy yr
Unknown 999999

18. Date of first in-person contact with client: / / / / / / [54-59]
mo dy yr
Unknown 999999

[60]**

Column

19. Number of contacts (any type) with client, following first contact, prior to decision on treatment plan (circle one):

		Column
None	0	[61]
One	1	
Two	2	
Three	3	
Four	4	
Five	5	
Over five	6	
Not applicable (no treatment plan)	8	
Unknown	9	

20. Time between first contact with client and provision of first treatment service by project (concerns only services on BPA Services Form; does not include services specific to intake):

		Column
Within one day	1	[62]
Within one week	2	
Within two weeks	3	
Within one month	4	
Over one month	5	
Not applicable (no services given)	8	
Unknown	9	

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

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

22. How many times have outside consultants, other than MDT, been used on the management (not treatment) of this case?

		Column
None	0	[66]
Once	1	
Twice	2	
Three times	3	
Four times	4	
Five times	5	
More than five times	6	
Unknown	9	

Column

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

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

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

(Write in code from list):

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

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

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

Coordination of Case Information

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

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

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

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

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

END OF CARD 2 [79-80]**

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

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

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

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

Termination and Follow-Up

34. Date case terminated (or stabilized) *(BPA Impact)*: ___/___/___ (mo dy yr) [22-27]

NA (case not closed) 888888

Unknown 999999

35. How many follow-up contacts have there been with the client after case was closed (or stabilized (verify by interview)?	None	0	[28]
	One	1	
	Two	2	
	Three-five	3	
	More than five	4	
	NA (case not closed)	8	
	Unknown	9	

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

INTERVIEW CHECKLIST

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

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

Reviewer Assessment of Case: Based on Worker Interview and Record

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

	Among the most difficult	More difficult than average	Average	Less difficult than average	Among the least difficult	Column
58. Rate the difficulty of this case, from your perspective. . . .	1	2	3	4	5	[58]
						[59-80]**

CASE REVIEW INSTRUMENT (Part B)

Case Manager Information

Berkeley Planning Associates
2320 Channing Way
Berkeley, California 94704

Column

CARD NUMBER 4 [1]

Project Number / / / [2,3]

[4-11]**

A. Case Manager Name: _____

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

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

Unknown 99

C. Sex:
- Male . . . . . 1 [16]
- Female 2

D. Ethnicity:
- White. . . . . 1 [17]
- Black. 2
- Spanish. 3
- American Indian. 4
- Asian. 5
- Other. 7
- Unknown. 9

E. Degree (circle highest attained):
- High school. . . . . 1 [18]
- AA 2
- BA 3
- MSW. 4
- Other Master's 5
- RN 6
- Other (specify) _____ 7
- Unknown. 9

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

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

**These card columns are to be left blank.

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

B 4. Sampling Design

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

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

Projects were asked to submit lists of all their cases opened between January 1975 and January 1976*. These lists identified the active or terminated status of each case, as well as its most current primary case manager. A stratified random sample was then drawn from each project's caseload using the case managers as the strata, and selecting from each stratum (or each case manager's caseload) a number of cases proportional to the size of his or her caseload, up to a total of usually between 40 and 50 per project. A minimum of two cases were drawn per

* Due to oversight a few sites included some cases opened prior to January 1975. These cases were allowed to remain in the sample.

every worker. Thus, in a project with five workers usually eight or nine cases were selected from each; in a project with 15 workers, at least two cases were reviewed from each, but some would have proportionally more.

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

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

APPENDIX C

Description of the Quality Case Management Assessment Sample

Table C-1

Case Characteristics

Severity of Case[1]	
For Abuse	
Death due to abuse	1.0%
Severe abuse	7.4
Moderate abuse	17.7
Mild abuse	19.7
Emotional abuse	20.1
Sexual abuse	5.4
Potential abuse	31.3
For Neglect	
Death due to neglect	1.3%
Severe neglect	6.7
Moderate neglect	9.5
Mild neglect	7.4
Emotional neglect	12.3
Failure to thrive	4.3
Potential neglect	12.5
(N = 354)	
Seriousness of Abuse or Neglect	
Serious	40.0%
Less Serious	60.0
(N = 297)	
Sex of Client	
Female	72.9%
Male	27.1
(N = 354)	

[1] More than one category may have been checked for any given case; therefore, the sums can be more than 100%.

Table C-1 (continued)

Age of Clients	
Mother/Mother Substitute	
19 or under	9.2%
20 - 24	28.3
25 - 29	23.8
30 - 34	18.6
35 - 39	11.0
40 - 44	4.0
45 - 49	4.0
50+	1.2
(N = 250)	
Father/Father Substitute	
19 or under	4.2%
20 - 24	18.4
25 - 29	21.1
30 - 34	16.3
35 - 39	19.5
40 - 44	9.5
45 - 49	4.7
50+	6.3
(N = 95)	
Ethnicity of Client	
White	69.2
Black	19.6
Spanish[1]	6.4
American Indian	0.7
Asian	0.3
Other[2]	3.4
(N = 348)	

[1]This category has a different meaning across sites and, therefore, is not strictly comparable. In the West (California and Colorado) it usually refers to Spanish surname; in the remainder of the country it means Spanish language as the mother tongue; in Puerto Rico it means that the person is from Spain.

[2]Most people in this category are trigueno; this is a Puerto Rican classification for persons of a mixture of Caucasian, Indian and Spanish.

Table C-1 (continued)

Number of Children in Household	
Zero	1.0%
One	23.6
Two	31.2
Three	22.3
Four	10.2
Five or more	11.7
(N = 351)	
Family Had Child of Preschool Age	
Yes	76.0%
No	24.0%
(N = 229)	
All Known Parents Are Unemployed	
Yes	27.7%
No	72.3
(N = 260)	
Family Conflict at Intake	
Yes	28.8%
No	71.2
(N = 260)	
Substance of Abuse at Intake	
Some	16.2%
None	83.8
(N = 260)	

Table C-1 (continued)

Type of Referral	
Self referral	12.2%
Agency or individual	87.8
(N = 331)	
Agency Responsibility for Case Management	
Demonstration Project had primary responsibility	85.9%
Other agency had primary responsibility	3.5
Joint responsibility between project and other agency	10.6
(N = 347)	
Court Supervision of Children During Parent's Treatment	
No	73.2%
Yes	26.8
(N = 346)	
Abused/Negelcted Children Out-of-Home During Parent Treatment	
No	70.3%
Yes	29.7
(N = 341)	
Assessor's View of Difficulty of Case	
Less difficult	84.4%
More difficult	15.6
(N = 335)	

Table C-1 (continued)

Manager's View Regarding Difficulty of Cases	
Very difficult	19.5%
Above average difficulty	22.4
Average	31.6
Below average difficulty	14.0
Not difficult	12.5
(N = 343)	
Manager's View Regarding Client's Interest In Treatment	
Very uninterested	15.2%
Somewhat uninterested	11.0
Neutral	13.8
Somewhat interested	27.6
Very interested	32.4
(N = 344)	
Manager's View Regarding Client's Responsiveness	
Very unresponsive	16.2%
Somewhat unresponsive	11.1
Neutral	12.6
Somewhat responsive	31.5
Very responsive	28.6
(N = 345)	

Table C-2

Case Manager Characteristics

Case Managers: Age	
20 - 24	8.8%
25 - 29	45.6
30 - 34	12.3
35 - 39	15.8
40 - 44	12.3
45+	5.3
(N = 57)	
Mean Age, 32.6	
Case Managers: Ethnicity	
White	74.1%
Black	17.2
Spanish	1.7
Other	6.9
(N = 58)	
Case Managers: Sex	
Male	20.7%
Female	79.3
(N = 58)	
Case Managers: Degree	
High School	15.79%
Associate	1.75
Bachelors	24.56
Professional[1]	57.90
(N = 57)	

[1] Master's or Professional Nursing Degree

Table C-2 (continued)

Case Managers: Training in Child Abuse and Neglect[1]	
M.S.W. coursework	29.82%
Post Graduate; Cont. Ed.	17.54
Workshops	66.67
In-service	78.95
Other	22.81
(N = 57)	

Case Managers: Years Experience	
Experience in Family Treatment:	
Less than one year	10.7%
1 - 2 years	23.2
3 - 5 years	35.7
More than five years	30.4
(N = 56)	
Experience in Child Abuse/ Neglect:	
Less than one year	12.5%
1 - 2 years	37.5
3 - 5 years	44.6
More than five years	5.4
(N = 56)	

Case Managers: Caseload Size	
2 - 3 cases	26.3%
4 - 9 cases	12.3
10 - 19 cases	29.8
20 - 29 cases	24.6
30 - 39 cases	0.0
40 or more cases	7.0
(N = 57)	
Mean Caseload, 17	
Median Caseload, 15	

[1]Because a case manager could have received training in more than one setting, this will not sum to 100%.

Table C-2 (continued)

Case Manager Same Age as Client	
Manager more than 10 years older than client	23.0%
Manager 3 to 10 years older than client	24.0
Manager and client same age (within 2 years)	18.2
Manager 3 to 10 years younger than client	21.5
Manager more than 10 years younger than client	13.6
(N = 343)	
Caseworker Same Ethnicity as Client	
Different	37.0%
Same	63.0
(N = 350)	
Case Manager of Similar Socio-Economic Status as Client	
Very similar	7.7%
Somewhat similar	30.3
Not very similar	62.0
(N = 109)	
Case Manager Same Sex as Client	
No	34.7%
Yes	65.3
(N = 354)	

APPENDIX D

TESTING INTER-RATER RELIABILITY

COMPARABILITY OF THE RELIABILITY SAMPLE

Table D-1 illustrates key case and client characteristics, comparing the case management assessment sample drawn in the Spring of 1976 and the corresponding reliability sample. The reliability cases were selected randomly after the total sample was also randomly drawn. While there were some variations, none of these differences were striking enough to conclude that the reliability sample was not representative of the total sample.

Table D-1

RELIABILITY TEST SAMPLE COMPARED TO TOTAL CASE MANAGEMENT ASSESSMENT SAMPLE

	Reliability Sample (N=36)	Total Sample (N=274)
Case Status:		
Terminated	75.0%	65.3%
Active	25.0	34.7
Severity of Case for Abuse:		
Death due to abuse	0.0%	0.0%
Severely injured	0.0	5.5
Moderately injured	5.6	14.5
Mildly injured	22.2	16.4
Emotional abuse	13.9	15.7
Sexual abuse	8.3	4.0
Potential abuse	33.3	22.4
Severity of Case for Neglect:		
Death due to neglect	0.0%	0.4%
Severely neglected	5.6	4.9
Moderately neglected	5.6	6.9
Mildly neglected	5.6	6.0
Emotional neglect	13.9	9.9
Failure to thrive	2.8	2.9
Potential neglect	11.1	8.6
Number of Children in Household:		
One	16.7%	23.0%
Two	27.8	31.6
Three	25.0	22.1
Four	19.4	9.9
Five	5.6	7.3
More than five	5.6	5.6
Number of Adults in Household:		
One	38.9%	28.5%
Two	55.6	65.1
Three	5.6	4.9
More than three	0.0	1.5
Identification and Age of Client (for this review):		
Mother/mother substitute:	72.2%	72.4%
less than 20 years	2.8	6.1
20-24 years	30.5	19.5
25-29 years	19.5	17.4
30-34 years	11.2	11.9
35-39 years	2.8	8.4
40-44 years	2.8	3.1
45-49 years	2.8	3.5
50 years+	0.0	0.4

Table D-1 (continued)

	Reliability Sample (N=36)	Total Sample (N=274)
Identification and Age of Client (for this review):		
Father/father substitute:	27.7%	27.5%
Less than 20 years	0.0	1.1
20-24 years	2.8	5.6
25-29 years	0.0	5.9
30-34 years	8.4	4.5
35-39 years	8.4	4.8
40-44 years	2.8	2.3
45-49 years	0.0	1.3
50 years+	5.6	2.3
Ethnicity of Client:		
White	75.0%	69.3%
Black	25.0	21.9
Spanish	0.0	4.1
American Indian	0.0	1.1
Other	0.0	4.0
Type of Referral to the Project:		
Self-referral	9.1	11.4
Report by other agency or individual	90.9	89.0

Results of the Reliability Tests

Tables D-2, D-3, and D-4 display inter-rater agreement from the reliability tests conducted in the Spring of 1976. Tables D-5 and D-6 show the percentage of agreement between an expert and a non-expert assessor. This second reliability check occurred following the data collection round of December 1976 and January and February 1977.

Table D-2

AGREEMENT ON VARIABLES OF CASE HANDLING PROCEDURES

N = 46 cases

Questions	Absolute Agreement	Adjusted Agreement
Date of first contact with client (any type): / / / / mo day yr	91%	
Time between initial referral and first in-person contact with client (circle closest category): Within one day Within one week Within two weeks Within one month Over one month Unknown	59%	70% Within one week Within one month Over one month Unknown
Number of contacts with client, following first contact, prior to decision on treatment plan (circle one): None One Two Three - five Over five Unknown Not applicable	76%	76% None (including NA) One - two Three - five Over five Unknown
Time between first contact with client and provision of first treatment service by project (concerns only services on blue services form, not intake) (circle one): Within one day Within one week Within two weeks Within one month Over one month Unknown Not applicable	57%	72% Within two weeks Two weeks to one month Over one month Unknown Not applicable

Table D-2 (continued)

Questions	Absolute Agreement	Adjusted Agreement
Have there been multidisciplinary team (MDT) reviews of this case? Yes, client present / Yes, client not present / No / NA / Unknown		
At intake/treatment planning	91%	
During treatment	93%	
At termination	88%*	
How many times have outside consultants, other than MDT, been used on the management (not treatment) of this case? None / Once / Twice / Three - five times / Over five times / Unknown	91%	
Have there been case conferences or staffings of this case? Yes, client present / Yes, client not present / No / NA / Unknown		
At intake/treatment planning	85%	
During treatment	87%	
At termination	88%*	

Table D-2 (continued)

Questions	Absolute Agreement	Adjusted Agreement
Approximate frequency of contact by case manager with client, while in treatment (circle one) (verify by interview): None Once/twice only More than once a week About once a week About twice a month About once a month Less than once a month Varied over time Other Unknown	61%	72% None Once a week or more Once or twice a month Less than once a month Once/twice only Varied over time Other Unknown
Was there contact with the agency or individual who referred client to project?		
To obtain background, history, other recorded information	96%	
To discuss client's status and progress	87%	
Did this case manager do the intake on this case? (verify by interview) Yes, alone Yes, with other project staff No Unknown	74%	85% Yes No Unknown

Table D-2 (continued)

Questions	Absolute Agreement	Adjusted Agreement
After intake, how many case managers have there been for this client? One Two More than two Unknown	98%	
(If more than one case manager) were these different case managers involved jointly with the case or were there changes from one to another? Involved jointly Changed, due to staff turnover Changed, at request of client Changed, other reason Not applicable Unknown	89%	
How many people in this project have provided direct treatment to this client (other than case manager)? None One Two Three Four Five More than five Unknown	63%	73% None One Two Three - five Over five Unknown
Have any agencies (or individuals) outside of the project provided direct treatment to this client (while the client was in the project's caseload)? Yes No Unknown	89%	

Table D-2 (continued)

Questions	Absolute Agreement	Adjusted Agreement
How much contact has there been with other agencies or individuals from whom client received services to discuss client's status and progress (verify by interview)? None One Two Three - five Over five Unknown Not applicable	57%	74% None Some Unknown
Does this project have primary case management responsibility for this client, or does some other agency have primary responsibility? This project is primary Other agency is primary (specify agency) Joint responsibility between this project and other agency (specify agency) Unknown	100%	
Date case terminated (or stabilized): / / / / mo day yr NA (case not closed)	82%*	
How many follow-up contacts have there been with the client after case was closed (or stabilized) (verify by interview)? None One - two Three - five Over five NA (case not closed) Unknown	68%	91% Two or less Three - five Over five NA (case not closed) Unknown

Table D-2 (continued)

Questions	Absolute Agreement	Adjusted Agreement
How many follow-up contacts have there been with other agencies working with the client after case was closed/stabilized (verify by interview)? None One - two Three - five Over five NA (case not closed) Unknown	85%*	

* Because 12 of the reliability test cases were still active, for these, N=34.

Table D-3

AGREEMENT ON VARIABLES OF ASSESSMENT OF THE RECORD

N=46

Questions					Absolute Agreement	Adjusted Agreement*
Is information on the following:	in the record? no	minimal	adequate	good	Average agreement=36%	Average agreement=60%
circumstances of abuse/negelct incident	0	1	2	3	50%	63%
family stress conditions	0	1	2	3	39	65
interaction between child and client . .	0	1	2	3	35	52
client's functioning on characteristics associated with abuse/neglect. . . .	0	1	2	3	20	48
child's mental and physical health, and development standards	0	1	2	3	35	83
goals of treatment for the client . . .	0	1	2	3	24	54
the treatment plan .	0	1	2	3	33	54
client's progress during treatment . .	0	1	2	3	43	65
services received by client.	0	1	2	3	46	59

*Minimal or none (0-1); adequate or better (2-3).

Table D-4

AGREEMENT ON VARIABLES JUDGING THE CASE MANAGEMENT PROCESS

Ratings	Very Poor	Poor	Adequate	Good	Very Good	NA	Absolute Agreement	3-Point Scale Agreement (1-2, 3, 4-5)	2-Point Scale Agreement (1,2):(3,4,5)	2-Point Scale Agreement (1,2,3):(4,5)
intake -- timing	1	2	3	4	5		26%	52%	87%	63%
intake -- thoroughness	1	2	3	4	5		52	52	67	78
intake -- helping approach	1	2	3	4	5		46	52	87	59
record of critical information	1	2	3	4	5		39	50	70	74
knowledge of critical information	1	2	3	4	5		43	50	74	63
planfulness in case handling	1	2	3	4	5		46	48	67	63
frequency of case manager's contact with client during treatment	1	2	3	4	5		22	26	61	50
reassessment of case during treatment	1	2	3	4	5		24	35	63	59
coordination of information from all providers	1	2	3	4	5		52	59	76	80
goals: understandable, feasible, being worked on	1	2	3	4	5		37	43	85	52
client opportunity to participate in case decisions	1	2	3	4	5		39	41	78	65
appropriateness of decision to maintain or terminate case	1	2	3	4	5	7	47	47	88	62
follow-up after termination	1	2	3	4	5	7	38	44	50	82
supervision of case manager on the case	1	2	3	4	5		70	76	87	87
overall management of this case	1	2	3	4	5		57	57	72	72
worker's attitudes toward the client	1	2	3	4	5		59	61	85	76
worker as a case manager	1	2	3	4	5		65	67	96	72

Table D-5

EXPERT/NON-EXPERT AGREEMENT ON VARIABLES OF CASE HANDLING PROCEDURES

Questions	Absolute Agreement
Date of first contact with client (any type): / / / / mo day yr	89%
Time between initial referral and first in-person contact with client (circle closets category): Within one day Within one week Within two weeks Within one month Over one month Unknown	89%
Number of contacts with client following first contact, prior to decision on treatment plan (circle one): None One Two Three - five Over five Unknown Not applicable	78%
Time between first contact with client and provision of first treatment service by project (concerns only services on blue services form, not intake) (circle one): Within one day Within one week Within two weeks Within one month Over one month Unknown Not applicable	89%

Table D-5 (continued)

Questions	Absolute Agreement
Have there been multidisciplinary team (MDT) reviews of this case? Yes, client present / Yes, client not present / No / NA / Unknown At intake/treatment planning During treatment At termination	100%
How many times had outside consultants, other than MDT, been used on the management (not treatment) of this case? None Once Twice Three - five times Over five times Unknown	100%
Have there been case conferences or staffings of this case? Yes, client present / Yes, client not present / No / NA / Unknown At intake/treatment planning During treatment At termination	67%
Approximate frequency of contact by case manager with client while in treatment (circle one) (verify by interview): None Once/twice only More than once a week About once a week About twice a month About once a month Less than once a month Varied over time Other Unknown	56%

Table D-5 (continued)

Questions	Absolute Agreement
Was there contact with the agency or individual who referred client to project? Yes / No / NA (self-referral) / Unknown To obtain background, history other recorded information To discuss client's status and progress	78%
Did this case manager do the intake on this case? (verify by interview) Yes, alone Yes, with other project staff No Unknown	100%
After intake, how many case managers have there been for this client? One / More than two Two / Unknown	78%
(If more than one case manager) were these different case managers involved jointly with the case or were there changes from one to another? Involved jointly Changed, due to staff turnover Changed, at request of client Changed, other reason Not applicable Unknown	67%
How many people in this project have provided direct treatment to this client (other than case manager)? None / Five One / More than five Two / Unknown Three Four	89%

Table D-5 (continued)

Questions	Absolute Agreement
Have any agencies (or individuals) outside of the project provided direct treatment to this client (while the client was in the project's caseload)? Yes No Unknown	89%
How much contact has there been with other agencies or individuals from whom client received services to discuss client's status and progress (verify by interview)? None One Two Three - five Over five Unknown Not applicable	78%
Does this project have primary case management responsibility for this client, or does some other agency have primary responsibility? This project is primary Other agency is primary (specify agency Joint responsibility between this project and other agency (specify agency) Unknown	89%
Date case terminated (or stabilized): / / / / mo day yr NA (case not closed)	78%
How many follow-contacts have there been with the client after case was closed (or stabilized) (verify by interview)? None One - two Three - five Over five NA (case not closed) Unknown	67%
How many follow-up contacts have there been with other agencies working with the client after case was closed/ stabilized (verify by interview)? None One - two Three - five Over five NA (case not closed) Unknown	78%

Table D-6

EXPERT/NON-EXPERT AGREEMENT ON VARIABLES JUDGING THE CASE MANAGEMENT PROCESS

N = 11

Question	Agreement within one point on five point scale
intake -- timing	91%
intake -- thoroughness	100%
intake -- helping approach	45%
record or critical information	100%
knowledge of critical information	82%
planfulness in case handling	82%
frequency of case manager's contact with client during treatment	82%
reassessment of case during treatment	82%
coordination of information from all providers	91%
goals: understandable, feasible, being worked on	64%
client opportunity to participate in case decisions	73%
appropriateness of decision to maintain or terminate case	82%
follow-up after termination	73%
supervision of case manager on the case	100%
rate the overall management of this case	91%
rate the worker's attitudes toward the client	82%
rate this worker as a case manager	91%

Appendix E

Descriptions of the Projects' Case Managements Practices

Descriptions of the Projects' Case Management Practices

Table E-1 illustrates the case management practices found in the demonstration projects. Below are brief descriptions of each site which participated in the assessment.

Adams County, Colorado

The case management process of the project was assessed during two rounds of site visits conducted in 1976 and 1977. Such aspects of case management as timeliness, the amount of contact between case manager and client, case diagnosis and regular review, referral mechanisms, coordination of information, service continuity, and client participation were reviewed.

Sixty-three percent of the randomly sampled cases for the assessment showed that the potential client was contacted the same day as the incoming report was made. Another 30% were contacted no later than the third day after the initial report. One-third of the cases had at least one more client contact prior to the decision on a treatment plan, and a full 61% had two or more such contacts, reflecting the project's comparatively thorough intake process. Almost two-thirds of the cases reviewed (65%) indicated that the clients in question received treatment services within two weeks of their first contact with the project, whereas 26% waited no more than a month to start treatment services.

The project made extensive use of multidisciplinary team reviews, with 100% of its cases having at least one such review. As indicated in Table E.1, these reviews most often occurred during intake. Case conferences or staffings were not used as often -- less than one-half of the cases (47%) had any case conferences during their history. Consultants, on the other hand, were used often. In 58% of the cases at least one consultant was called in, and in 36% of the cases three or more consultants were used. Client participation, as measured by the client's presence at a multidisciplinary team review or at a case conference, was not the norm at the project, with the clients present only 10% of the time.

For over three-quarters of the cases (78%) the current case manager also carried out the intake, and in 72% of the cases there was only one primary case manager over time. It was the usual practice to have at least one other project staff member providing treatment to Center clients -- 61% had one or more other providers from within the project. Just over one-half (56%) of the clients also were receiving services from outside agencies.

While an open case, 48% of the cases were contacted in some manner once a week or more, with another 38% contacted once or twice a month. After termination from the project's caseload (which occurred 59% of the time in 4-12 months and 41% of the time in 12-24 months) almost two-thirds

of the cases (65%) showed evidence of a follow-up contact to determine the client's status.

Arlington, Virginia

In general, the case management practices at the project, evidenced in the reviews undertaken, were adequate. On most quality of case management measures, the project scores were within the average range of all projects' averages. Most cases (58%) were seen within seven days of referral, slightly lower than the average across all projects, and 71% of the clients received services within two weeks of the initial contact. Very few cases (15%) are reviewed by the multicisciplinary team compared to a 34% average for the group as a whole, and only 28% of the cases ever receive a case conference (staffing) at all, compared to 60% in the total demonstration group. Clients rarely participate in the service planning process, but this tended to be true for all projects. Most cases (95%) had only one case manager (compared to 78% of the demonstration group as a whole), and extensive contacts were made with referral sources for both background and progress information. In over half of the cases (54%), the clients received services from only the primary case manager, and in another 33% of the cases, only one other treatment provider was involved in the case, indicating perhaps a lack of service options or inadequate use of existing resources. Slightly better than half (59%) of all clients received some services from outside agencies, again indicating a lack of options or inadequate use of existing resources. Most cases (89%) remained in treatment from one to 12 months, with 13% of the cases terminated within three months.

Other observations of the review teams were that enough attention is given to meeting parents' treatment needs; the multidisciplinary team is not used to optimum capacity, and termination is probably occurring too quickly (in order to handle the flow of new cases) to be considered good practice.

Baton Rouge, Louisiana

The information collected for the case management assessment indicates that the project provided, in most instances, better than average intake compared to the norm of all the demonstrations combined. Thirty-three percent of the cases sampled for the assessment were contacted within the same day as the report; an additional 24% were contacted within three days. However, 19% of the cases reviewed were not contacted until over one month from the date of the incoming report. Many of the cases not responded to until over a month later turned out to be suspected mild neglect reports that had been transferred all together to the project early in its operation, after being backlogged at the Protective Services Unit -- they continued to be backlogged at the Center. Thirty-eight percent of the sampled cases showed at least one additional contact with the client before a treatment plan was completed, and a full 50% had two or more such client contacts. This compares favorably with the norm across the demonstration projects of 42% of the cases seen

two or more times after the initial contact before a treatment plan was determined.

In 61% of the cases reviewed, treatment services began within two weeks of the first contact between project and client. On the other hand, a full 25% of the clients received no therapeutic treatment services at all. A portion of the project's cases were formally assessed and reassessed, either by a multidisciplinary review team and/or staffings; 27% had at least one multidisciplinary team review and 42% were reviewed in case conferences or staffings at least once. For one-third of the reviewed cases, an outside consultant (e.g., lawyer, psychologist, etc.) was used. There was only minimal direct client participation (7%) in the case management process, as measured by client presence at a multidisciplinary review or a case conference.

For 84% of the cases, the primary case manager interviewed for the assessment also carried out the intake. This reflects the fact that the project's intake unit was short-lived. Whereas 32% of the clients had no other project staff member working with them besides the case manager, the remaining 68% did. In most cases this meant that the project's homemaker was one of the other project staff members assigned during the course of treatment and often the project supervisor provided temporary counseling and crisis intervention to clients as well as the case manager. Some short-term therapeutic groups also included some of the clients. Of the clients in the sampled cases, 64% were also receiving services from outside agencies. Of these, there was evidence of communication with these agencies regarding the client and his/her progress 93% of the time.

Twenty percent of the project's cases were active for three months or less. About two-thirds were open 4-12 months, and 13% were open between 1-2 years. Following termination, in 56% of the cases at least one follow-up contact was made either with the client or with another agency from which the client was receiving services.

Bayamon, Puerto Rico

In general, with few exceptions, the Bayamon project used excellent case management practices. Intakes were thorough; records were well kept; contact with clients was intense and continuous; and reviews occurred frequently.

Cases were referred to the project from the social services department. Although the time between actual referral and first in-person contact with the client was often one month, during this month project staff conducted extensive review of the cases, collected background information, and talked with the referral source. The number of contacts with the client prior to the development of a full treatment plan varied from one to five, depending upon the complexity of the case, although some treatment services were offered within two weeks of the first contact. More than two-thirds of the cases were reviewed by a multidisciplinary team and all cases were reviewed in case conferences. While consultants were rarely used for case management issues, and clients never participated in thier own case reviews, referral agents were used extensively in

providing information about the case. Typically, the person performing the case management function also performed the intake (deviations from this were due to turnover in one staff position), and was the primary treatment provider as well. The project tended to provide clients with all needed services rather than refer them elsewhere.

Fayetteville, Arkansas

The case management process of the project was assessed during two rounds of site visits conducted in 1976 and 1977. Such aspects of case management as timeliness, the amount of contact between case manager and client, case diagnosis and regular review, referral mechanisms, coordination of information, service continuity, and client participation were reviewed.

Sixteen percent of the randomly sampled cases for the assessment showed that the potential client was contacted the same day as the incoming report was made. Another 25% were contacted no later than the third day after the initial report, and another 14% were contacted within 4-7 days. This means that nearly half of the clients in the sample were first contacted after a week or more had elapsed since the referral.

In over a third of the cases, the decision on the treatment plan was made without any additional contact with the client. However, 38% of the cases had at least one more client contact and 26% had two or more such contacts prior to the treatment plan decision. In 80% of the cases reviewed, treatment services were initiated within two weeks of the first contact with the project, reflecting the immediacy of the lay therapist's assumption of responsibility upon assignment of a case.

The project made extensive use of multidisciplinary team reviews, with 71% of its cases having at least one such review. As indicated in Table E.1, these reviews most often occurred during treatment. Case conferences or staffings were used even more frequently -- 93% of the cases had case conferences during their history. Consultants, on the other hand, were not used often -- only 20% of the cases called in one or more consultants. Client participation, as measured by the client's participation at a multidisciplinary team review or at a case conference, was below the norm with clients present only 5% of the time.

Reflecting the project's specialization of intake and initial evaluation being conducted by a staff member (the director or assistant director) and subsequently assigned to a lay therapist for service delivery, 89% of the cases had a different current case manager from the one who carried out the intake. In 73% of the cases there was only one primary case manager over time. Due to the supervisory role provided in most cases by the director and/or assistant director, 43% of the cases had one or more other service provider from within the project. Nearly two-thirds (63%) of the clients were receiving services from outside agencies.

While an open case, 51% of the cases were contacted by the case manager once a week or more, with another 24% contacted once or twice a month. Termination from the project's caseload occurred within 3

months in 15% of the cases, within 4-12 months in 77% of the cases and within 12-24 months in 9% of the cases. Over half (57%) of the terminated cases showed evidence of a follow-up contact to determine the client's status.

Los Angeles, California

Thirteen cases were reviewed at the Family Care Center to determine the quality of the case management practices. In 12 of these cases, less than one week elapsed between referral and the first contact with the client, and all but one client began receiving treatment services within two weeks after the first contact. Ten of the thirteen cases had the benefit of a multidisciplinary team review and all but one case had both intake and treatment conferences (general staffing) to provide input into decision-making about the case. Extensive use of consultants (more than 4) were used in 10 cases, and in all 13 cases, contact was made with the referral source to elicit background information. There was little turnover in case managers and only in rare cases (2) did the case manager change during the treatment process. One-third of the cases had only one treatment provider, one-third had three, and one-third had 4-6 different treatment providers. Contact with other agencies, including provision of outside services, was made in most cases (11 of 13). At least two follow-up contact were made with every client, following an average of 4-12 months in treatment.

Despite these relatively effective case management practices, some serious problems were uncovered by the quality reviewer. The project's emphasis clearly is on the child who is in residence and few services are actually provided to the parents. It was felt that the multidisciplinary team was not functioning effectively and treatment goals were set too quickly and without client input. All evidence pointed to a punitive approach to treatment with severe demands placed on parents to comply with numerous rules and regulations.

Little supervision was provided to the professional staff, house parents, or the numerous volunteers. Concern was also expressed about the clients' records which, overall, were incomplete and disorganized. There were few social histories, information on the abuse incident, or evaluation of the child in the records, and little assessment of the family's functioning or the information about treatment plans in relation to observed familial problems.

St. Louis, Missouri

A review of case management practices of the Family Resource Center showed that almost a third of the cases were contacted the same day as referred, and almost 60% within the first three days, comparing favorably with the total demonstration effort cases. Somewhat longer times elapsed, however, for this project than others between first contact and first treatment service -- 42% of the cases received treatment within 2 weeks, but 26% not until after one month.

Multidisciplinary reviews were not heavily used, with only 16% of the cases having this service. However, over 90% of the cases were provided "staffing" or case conferences, with the client present 50% of the time. Both of these figures exceeded the average across projects.

The project had separate intake and treatment staff in many cases and almost 40% of the cases had more than one case manager during the period of treatment, often due to staff turnover. The project usually involved several staff in each client's treatment program, with over 40% being treated by three or more staff. Seventy-two percent of the cases were also receiving services from outside agencies.

Tacoma, Washington

In general, the Panel's case management practices were adequate. As shown on Table E.1, for almost half the cases, the first contact occurred on the same day as the referral. And in close to 90% of the cases, contact was made with the referral source to obtain background information about the case, and almost as frequently to provide reports on case progress. Treatment plans were developed at that time and treatment services began within two weeks. Multidisciplinary team reviews were provided to only one-fifth of the cases, however, and case conferences were used for less than half the cases (typically during treatment). Consultants were rarely used for case management purposes although in one-fifth of the cases the client participated in either treatment planning or progress review. Although three-quarters of the cases had the same case manager throughout treatment, in close to half of the cases a person other than the case manager took primary responsibility for intake. Clients typically received services from three to five Panel staff members and from other agencies as well. The Panel, unlike many projects, systematically conducted at least one follow-up visit with terminated cases.

The major problems in the case management practices were the relatively inadequate records kept by the project and the lack of interdisciplinary input into treatment planning for most of the cases.

Union County, New Jersey

In general, the project's case management practices were adequate. As shown on Table E.1, for almost 40% of the cases the first contact occurred on the same day as the referral. And in close to 90% of the cases, contacts were made with the referral source to obtain background information about the case, and almost as frequently to provide reports on case progress. In almost 30% of the cases no contact was made with the referred client for at least a month. In a majority of the cases, the treatment plan was begun after the first or second contact. Less than one-quarter of the cases received a multidisciplinary review, but 34% of the cases received a case conference at least once, typically during treatment. In a majority of the cases no consultant was used to develop the treatment plan. In about one-fifth of the cases clients participated in the multidisciplinary team review or case conference.

For most of the cases reviewed (75%), there was only one case manager throughout treatment, but in close to half of the cases a person other than the case manager took primary responsibility for intake. In 45% of the cases, only the case manager provided services to the client, but in 32% of the cases at least one extra worker provided treatment services, and in 21% there were two extra workers providing treatment to the family. Eighty-eight percent of the clients received two or less follow-up visits or contacts after termination.

The quality case reviewers reported that the Union County project is doing a good job of case management in light of bureaucratic requirements and large caseloads. Many cases are being carried that are not really protective service in nature, but are preventive or potential abuse and neglect cases that are so designated in order to qualify for necessary purchased services. Consequently, workers tend to be overwhelmed by large caseload sizes. Despite this, the project maintains well written, coherent records (although BPA forms are often not completed); the response to referrals is quick, and service information from outside providers are well coordinated by project workers. Follow-up after termination is carried out by many workers, but is an individual decision since the agency has no follow-up policy.

There were a number of specific problem areas in the project's case management. The sample of cases indicated a long time lag between completion of intake and transfer to services. However, the recent project reorganization is designed to improve this problem. The diagnostic team is not being used to its full potential, nor are outside consultants being used. Cases are often terminated without an evaluation as to the appropriateness of such action. Some of these case management problems are due to the lack of scheduled formal meetings for supervision and communication problems. As a result, social workers often must rely on themselves or peers for support and consultation.

TABLE E-1

Case Management Practices: The Experience of the Joint Demonstrations*

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Fayetteville	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Time Between Referral and First Contact										
Same Day	63%	15%	33%	6%	16%	39%	31%	47%	38%	32%
1-3 Days	30%	17%	24%	6%	25%	23%	28%	5%	15%	19%
4-7 Days	3%	26%	9%	21%	14%	23%	7%	14%	2%	12%
Within 2 Weeks	3%	13%	9%	13%	23%	8%	12%	9%	6%	11%
Within 1 Month	3%	22%	6%	40%	10%	0	10%	20%	11%	14%
Over 1 Month	0	7%	19%	15%	13%	8%	12%	5%	28%	12%
Number of Client Contacts (After Initial Contact) Before Treatment Plan										
None	8%	36%	13%	22%	36%	8%	17%	59%	28%	27%
One	33%	36%	38%	28%	38%	0	37%	15%	36%	31%
Two	23%	16%	13%	27%	3%	39%	3%	18%	23%	17%
Three-Five	35%	9%	30%	21%	18%	15%	23%	8%	4%	18%
Over Five	3%	4%	7%	3%	5%	39%	20%	0	9%	7%
Time Between First Client Contact and First Treatment Service										
Within 2 Weeks	65%	71%	61%	68%	79%	92%	42%	69%	41%	63%
2 Weeks to 1 Month	27%	9%	3%	18%	17%	0	24%	22%	18%	16%
Over 1 Month	7%	18%	11%	15%	3%	8%	26%	5%	16%	13%
No Treatment Given	0	2%	25%	0	1%	0	8%	5%	25%	9%
Use of Multidisciplinary Review Team										
At Least 1 Review	100%	15%	27%	71%	18%	85%	17%	20%	14%	35%
Review During Intake	98%	3%	4%	13%	5%	77%	14%	16%	5%	21%
Review During Treatment	13%	12%	22%	64%	15%	75%	6%	16%	13%	21%
Review at Termination**	23%	1%	0	27%	6%	67%	0	2%	9%	7%

TABLE E-1 (Continued)

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Fayetteville	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Use of Case Conferences (Staffings)										
At Least 1 Conference	47%	28%	42%	100%	93%	92%	95%	47%	54%	62%
Conference During Intake	5%	18%	20%	63%	64%	92%	79%	21%	31%	38%
Conference During Treatment	45%	17%	24%	97%	91%	92%	84%	43%	45%	55%
Conference at Termination**	19%	4%	16%	100%	61%	67%	35%	12%	41%	30%
Use of Consultants										
None	42%	57%	67%	37%	80%	8%	73%	77%	77%	62%
One	10%	9%	13%	12%	3%	0	4%	5%	4%	7%
Two	13%	15%	2%	9%	5%	0	5%	2%	0	6%
Three-Five	18%	12%	11%	24%	12%	8%	8%	14%	12%	13%
Over Five	18%	8%	7%	19%	0	85%	10%	2%	8%	11%
Client Participation										
Client Presence at MDT's and for Case Conferences	10%	9%	7%	0	5%	0	50%	22%	20%	14%
Contact with Referral Source										
For Background Information	93%	89%	84%	93%	73%	100%	55%	81%	89%	84%
For Progress Reports	72%	81%	49%	62%	45%	92%	63%	76%	82%	68%
Responsibility for Intake										
Current Case Manager	78%	47%	84%	62%	11%	85%	37%	77%	55%	58%
Other Staff Member	23%	53%	16%	38%	89%	15%	63%	23%	45%	42%
Number of Case Managers										
One	72%	95%	87%	75%	73%	85%	61%	80%	76%	78%
Two	23%	5%	13%	25%	21%	15%	26%	18%	17%	18%
More than Two	5%	0	0	0	6%	0	13%	2%	7%	4%
Reason for Two of More Case Managers										
Joint Management	N= 4	N= 0	N= 1	N= 0	N= 3	N= 1	N= 2	N= 0	N= 2	N= 12 (15%)
Staff Turnover	N= 5	N= 1	N= 2	N= 9	N= 2	N= 0	N= 8	N= 4	N= 5	N= 36 (40%)
Staff Unavailability	N= 0	N= 2	N= 3	N= 0	N= 3	N= 1	N= 0	N= 2	N= 2	N= 13 (15%)
Lack of Success with Client	N= 2	N= 0	N= 0	N= 0	N= 2	N= 0	N= 1	N= 1	N= 4	N= 10 (11%)
Other	N= 1	N= 0	N= 3	N= 0	N= 2	N= 0	N= 5	N= 1	N= 3	N= 15 (19%)

TABLE E-1 (Continued)

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Fayetteville	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Number of Treatment Providers in Project (Other than Case Manager)										
None	39%	54%	32%	62%	57%	31%	15%	2%	45%	38%
One	30%	33%	27%	22%	10%	0	11%	27%	32%	24%
Two	22%	2%	21%	13%	21%	39%	32%	19%	21%	19%
Three-Five	10%	9%	20%	0	12%	23%	39%	50%	2%	18%
Over Five	0	2%	0	3%	0	8%	3%	2%	0	1%
Services from Outside Agencies	56%	59%	64%	46%	63%	85%	72%	80%	78%	66%
Evidence of Communication with Outside Agencies	86% (N= 22)	89% (N= 27)	93% (N= 28)	100% (N= 16)	65% (N= 26)	91% (N= 11)	78% (N= 25)	82% (N= 32)	89% (N= 38)	85% (N= 224)
Frequency of Contact by Case Managers										
About Once Per Week or More	48%	26%	36%	24%	51%	69%	62%	41%	22%	40%
About Once or Twice Per Month	38%	57%	22%	59%	24%	15%	16%	27%	25%	33%
Less Than Once Per Month	3%	11%	2%	9%	5%	8%	3%	7%	14%	7%
Once/Twice Only	8%	4%	4%	3%	5%	8%	3%	14%	12%	7%
Varied Over Time	5%	2%	33%	6%	15%	0	14%	9%	18%	13%
None	0	0	2%	0	0	0%	3%	2%	10%	2%
Follow-Up Contacts**										
At Least One Contact	65%	61%	56%	60%	57%	67%	65%	34%	60%	56%
Contacts With Client										
Two or Less	78%	94%	93%	79%	90%	67%	92%	93%	88%	90%
Three to Five	13%	4%	4%	21%	9%	33%	8%	2%	12%	8%
Over Five	9%	2%	2%	0	1%	0	0	5%	0	2%
Length of Time in Treatment**										
Through 3 Months	0	13%	20%	0	15%	33%	8%	12%	12%	12%
4-12 Months	59%	76%	67%	54%	77%	67%	60%	74%	70%	69%
1-2 Years	41%	11%	13%	46%	9%	0	20%	14%	18%	18%
Over 2 Years	0	0	0	0	0	0	12%	0	0	1%
Total No. Cases Reviewed	40	46	45	35	41	13	38	45	51	354
Total No. Terminated Cases Reviewed	22	46	45	12	34	3	25	42	44	272

*Throughout, percentages may not sum to 100% owing to rounding.
**Terminated cases only.

APPENDIX F

Factor Analysis Results

Table F-1

Results of Factor Analysis on Ratings of Quality Case Management[1]

Factor 1		Factor 2	
Record of critical information	(.42)	Intake -- timing	(.50)
Knowledge of critical information	(.58)	Intake -- thoroughness	(.49)
Planfulness in case handling	(.59)	Intake -- helping approach	(.42)
Frequency of case manager contact	(.27)	Record of critical information	(.34)
Reassessment of case during treatment	(.51)	Knowledge of critical information	(.27)
Coordination of information from all providers	(.38)	Planfulness in case handling	(.34)
Understandable, feasible goals	(.54)		
Supervision on case	(.41)		
Overall management	(.63)		
Worker's attitude	(.35)		
Worker as case manager	(.73)		

[1] Note: Variables only shown with factor loadings greater than ± .25, as indicated in parentheses.

APPENDIX G

Quality Ratings and Site Characteristics

Quality Ratings and Site Characteristics

The following are the definitions of the management variables which were developed for other aspects of the evaluation. Values for these characteristics have been assigned to each of the sites participating in the quality case management assessment. Tables G-1 and G-2 display bivariate analysis between the quality ratings on intake and overall case management and the site management characteristics.

- Cost-efficiency. The extent to which a given package of services is developed at a lesser cost.
- Span of Control. The average number of personnel directly responsible to each first-line supervisor in the project.
- Formalization: Rule observation. The degree to which workers feel monitored and constrained to obey the organization's rules.
- Formalization: Specificity of job description. The degree to which job expectations are specified and explicit.
- Centralization: Job decisions. The extent to which decisions about an individual's job or case management responsibilities (daily work schedules, interview appointments, delivery of services) are dictated by a supervisor, coordinator, or director.
- Leadership Level. The extent to which project director provides structure and support; the degree to which the director provides direction and emotional support, enhancing the feelings of personal worth and importance of the staff.
- Level of Communication. The extent to which information provided to workers is timely, adequate, and appropriate.
- Task orientation. The extent to which the climate emphasizes good planning, efficiency and encourages workers "to get the job done."

- Amount of Autonomy on Job. The extent to which workers are encouraged to be self-sufficient and to make their own decisions (includes items related to personal development and growth).

- Level of Staff Support. The extent to which supervisors are supportive of workers and encourage workers to be supportive of each other.

TABLE G-1

Intake Rating and Site Characteristics

	Lower Rating	Higher Rating
Span of Control (Supervisory Level)		
Low	32%	30%
Medium	41	57
High	27	13
(n = 343; significant at p<.01)		
Formalization--Rule Observation		
Lower	76	61
Higher	24	39
(n = 343; significant at p<.01)		
Formalization--Specificity of Job		
Lower	58	39
Higher	42	61
(n = 343; significant at p<.01)		
Centralization--Job Decisions		
Low	34	23
Medium	34	41
High	33	36
(n = 343; significant at p<.1)		
Leadership Level		
Lower	36	44
Higher	64	56
(n = 343; not significant)		
Level of Communication		
Lower	34	25
Higher	66	75
(n = 343; not significant)		
Level of Task Orientation		
Lower	24	39
Higher	76	61
(n = 343; significant at p<.01)		
Amount of Autonomy on Job		
Lower	36	44
Higher	64	56
(n = 343; not significant)		
Level of Staff Support		
Lower	57	67
Higher	43	33
(n = 343; significant at p<.1)		

TABLE G-2

Overall Rating and Site Characteristics

	Lower Rating	Higher Rating
Cost-Efficiency		
Low	39%	31%
Medium	31	25
High	30	44
(n = 347; significant at p<.01)		
Span of Control (Supervisory Level)		
Low	35	22
Medium	41	60
High	24	18
(n = 347; significant at p<.01)		
Formalization--Rule Observation		
Lower	76	55
Higher	24	45
(n = 347; significant at p<.01)		
Formalization--Specificity of Job		
Lower	58	30
Higher	42	70
(n = 347; significant at p<.01)		
Centralization--Job Decisions		
Low	35	15
Medium	33	46
High	32	39
(n = 347; significant at p<.01)		
Leadership Level		
Lower	33	57
Higher	67	43
(n = 347; significant at p<.01)		
Level of Communication		
Lower	32	25
Higher	68	75
(n = 347; not significant)		
Level of Task Orientation		
Lower	24	45
Higher	76	55
(n = 347; significant at p<.01)		

TABLE G-2 (Continued)

	Lower Rating	Higher Rating
Amount of Autonomy on Job		
Lower	33%	57%
Higher	67	43
(n = 347; significant at p<.01)		
Level of Staff Support		
Lower	56	76
Higher	44	24
(n = 347; significant at p<.01)		

APPENDIX H

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, 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.

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 dan 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.

Fourth, in the case of regressions with binary dependent variables, the coefficient is akin to a conditional probability. Thus, in a regression using overall quality case management, a coefficient of +.10 for a case handling variable means that the practice is associated across the cases on the average with a 10% increase in the probability of a higher rating of quality. 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, signifi-

cance 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 significant or stable. 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 I

Correlation Coefficients:

Independent with Dependent Variables

TABLE I-1

Correlation Coefficients: Case Handling Characteristics and Quality Measures

	Overall*	General*	Intake*	Client Participation	Worker Attitude
Time Between Report and First Contact	-.019	.009	-.138[a]	.061	.049
Number of Contacts Prior to Treatment Plan	.154[a]	.154[a]	.077[c]	.122[b]	.052
Time Between First Contact and First Treatment Service	-.149[a]	-.142[a]	-.090[c]	.017	.096[b]
Use of Multidisciplinary Review Team	.200[a]	.174[a]	.223[a]	.047	.046
Use of Case Conferences	.093[b]	.094[b]	.047	.027	-.008
Use of Outside Consultants	.218[a]	.203[a]	.190[a]	.128[a]	.014
Responsibility for Intake	.063	.040	.132[a]	.003	.014
Number of Case Managers	-.017	.010	-.128[a]	.031	-.091[b]
Number of Project Treatment Providers	.135[a]	.146[a]	.037	.095[b]	.028
Receipt of Outside Services	.006	.002	.015	.079[c]	-.006
Communication with Outside Service Providers	.332[a]	.344[a]	.159[b]	.101[c]	.040
Contacts with Referral Source--Intake Information	.242[a]	.238[a]	.152[a]	.104[b]	.031
Contacts with Referral Source--Client's Progress	.155[a]	.160[a]	.080[c]	.111[b]	.004
Client Participation	.148[a]	.164[a]	.020	.155[a]	.142[a]
Frequency of Contact with Client	.279[a]	.286[a]	.153[a]	.224[a]	.118[b]
Time in Process	.057	.049	.063	-.012	.031
Follow-up Contacts	.267[a]	.248[a]	.253[a]	.035	.129[b]

*Based on continuous values between 1.00 and 2.00

[a]Significant at p<.01

[b]Significant at p<.05

[c]Significant at p<.1

TABLE I-2

Correlation Coefficients: Case Manager Characteristics and Quality Measures

	Overall*	General*	Intake*	Client Participation	Worker Attitude
Same Ethnicity as Client	-.223[a]	-.223[a]	-.142[a]	-.024	-.119[b]
Similar Socio-Economic Experience	.054	.069	.005	.177[b]	.108
Same Gender as Client	.072[c]	.056	.112[b]	.069	.026
Same Age as Client	.190[a]	.188[a]	.116[b]	-.000	-.014
Age of Manager	-.320[a]	-.320[a]	-.173[a]	-.142[a]	-.129[a]
Formal Training of Manager	.299[a]	.295[a]	.183[a]	.125[b]	.030
Training in Child Abuse and Neglect	.109[b]	.080[c]	.177[a]	.115[b]	-.037
Years Experience in Abuse and Neglect Treatment	.137[a]	.117[b]	.167[a]	.170[a]	-.005
Months with Project	.043	.020	.103[b]	.070	.095[c]
Caseload Size of Manager	-.050	-.042	-.061	.020	-.090[b]

*Based on continuous values between 1.00 and 2.00

[a]Significant at p<.01

[b]Significant at p<.05

[c]Significant at p<.1

TABLE I-3

Correlation Coefficients: Case Characteristics and Quality Measures

	Overall*	General*	Intake*	Client Participation	Worker Attitude
Seriousness of Case	-.084[c]	-.095[c]	-.003	-.014	-.053
Court Involvement with Case	.028	.014	.071[c]	-.001	.031
Child Living Out of Home	.091[b]	.094[b]	.041	-.004	.068
Start of Case	.071[c]	.062	.075[c]	.009	.109[b]
Type of Referral	-.075[c]	-.080[c]	-.009	-.017	.026
Difficulty--Assessor View	-.165[a]	-.173[a]	-.066	-.140[a]	-.193[a]
Difficulty--Manager View	-.074[c]	-.079[c]	-.032	-.172[a]	-.174[a]
Interest of Client	.312[a]	.309[a]	.213[a]	.186[a]	.314[a]
Responsiveness of Client	.353[a]	.351[a]	.224[a]	.259[a]	.392[a]
Responsibility for Case Management--Project	-.107[b]	-.108[b]	-.054	-.015	-.055
Responsibility for Case Management--Other Agency	-.056	-.048	-.060	-.048	.087[c]

*Based on continuous values between 1.00 and 2.00

[a]Significant at p<.01

[b]Significant at p<.05

[c]Significant at p<.1