A program evaluation of the inter-organizational family violence service project in Kent County, 1989.

Judith Marguerite Dunlop

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A Program Evaluation of the Inter-Organizational Family Violence Service Project in Kent County, 1989

by

Judith Marguerite Dunlop

A Thesis Submitted to the Faculty of Graduate Studies and Research through the School of Social Work in Partial Fulfillment for the Degree of Master of Social Work at the University of Windsor

Windsor, Ontario, Canada 1989
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Abstract

A Program Evaluation of the Inter-Organizational Family Violence Project in Kent County, 1989

The purpose of this study was to conduct a comprehensive evaluation of the Family Violence Service Project in Kent County. The program evaluation design included both formative and summative evaluation components and was conducted from August 1, 1988 to August 1, 1989. The main objectives of the evaluation were to: 1) assess the effectiveness of the unique inter-agency approach to the delivery of service; and, 2) to determine whether the project made a difference in serving clients with problems related to domestic violence in this community.

Data were collected by means of structured interview questionnaires with key informants in the community as well as project staff. Client data were collected using a standardized client data intake form, standardized assessment instruments and a client satisfaction survey. One of the main data sources for the formative aspect of the study was the administrative chronology. The Treatment Process descriptions provided a further formative data source for this aspect of the evaluation.

The analyses of data indicated that the original concept for the inter-agency service co-ordination model which included three organizations was still the model of choice for both the community and project staff. Further, the data suggested that the
target group for this intervention are in fact utilizing the 
service. The long-term nature of the therapeutic intervention 
however, raised concerns about the time-limited funding commitment 
for this project. As well, the need for a more comprehensive 
domestic response team for Kent County was demonstrated in the 
evaluation.

The study concluded that more developmental work needs to be 
done at a community planning level to further refine the 
inter-agency model which can meet the needs of both clients and 
service providers in Kent County. Recommendations were made in 
the areas of organizational structure/functioning, resource 
development, program planning, evaluation, prevention/education 
and further inter-agency collaboration.
Acknowledgements

Many people have made a contribution to enable the completion of this research and the opportunity to acknowledge them gives me great pleasure.

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My fellow students in the part-time program who created a caring and supportive network for all of us. Thank you for letting me "beat the drums" for community practice.

Finally the research is dedicated to all the families whose lives are marred by violence. May you find a place of peace in your relationships. . .
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List of Abbreviations

A.A. - Alcoholics Anonymous
A.I.R.S. - Assessment Integration Resource Service
C.B.C.L. - Child Behavior Checklist (Achenbach)
C.K.C. & F.S. - Chatham-Kent Community and Family Service
C.K.W.C. - Chatham-Kent Women's Centre
C.O.M.S.O.C. - Ministry of Community and Social Services
F.V.S. - Family Violence Services
ISA-P - Index of Spouse Abuse (Physical)
ISA-NP - Index of Spouse Abuse (Non-physical)
K.C.C.A.S. - Kent County Children's Aid Society
K.C.T.F.F.V. - Kent County Task Force on Family Violence
L.B.P.C. - Lester B. Pearson Centre for Children and Youth
M.H.C. - Mental Health Clinic (Kent County)
O.C.P.A. - Ontario Centre for Prevention of Child Abuse
S.P.S.S. - Scales of Perceived Social Support (Macdonald)
A PROGRAM EVALUATION OF THE INTER-ORGANIZATIONAL
FAMILY VIOLENCE PROJECT IN KENT COUNTY, 1989

In the current economic climate of resource scarcity, human
service organizations are being required to examine their service
delivery and administrative structures to assess the
cost-effectiveness of their systems. While service co-ordination
and integration concepts have been touted as the wave of future
planning for services, the de facto application of these
principles is both difficult to find and evaluate. While recent
policy documents from the Ontario Ministry of Community and
Social Services identify the need to move toward more agency
accountability, the reality is that usually the guidelines for
effective service co-ordination are left to the discretion of
individual service providers. The planning process necessary to
develop reciprocal relationships is a complex, political
environment to be negotiated by stakeholders at the local
community level.

Historically, community-based service delivery systems have
been fragmented with no process to assure that services are
comprehensive, and/or compatible with client needs. The field of
domestic violence has received increasing attention during the
past two decades as North American feminists have made gains in
lobbying effectively for more policy and legislative changes as
well as increased public awareness. Family violence issues which
include child, sexual, elder and spouse abuse have all come to the attention of the therapeutic community. Based on interviews with a large, representative national sample of American adults, it is "estimated that in any given year at least one in six couples, married and unmarried, will experience a violent incident" (Carlson, 1987, p. 16-23). Indeed, the evidence suggests that violence in the family has always existed and that we are now only beginning to see the end of the societal denial which has sanctioned violence in the family "behind closed doors".

In recent years, a variety of policy and legislative changes have occurred along with the development of a wide range of intervention techniques which cover a wide range of punitive and therapeutic modalities including: incarceration; mandated counselling; accountability; education; supervised self-help groups; anger control treatment; and, family therapy (Gondolf, 1987, pp. 335-349). The recognition that couples involved in marital violence generally choose to remain together, as well as concern that both partners be involved in constructive change, has led to the development of more integrated interventions for all family members (Finn, 1987, pp. 154-165). The Family Violence Service Project in Kent County reflects a unique, specialized form of program development for family violence. An examination of the inter-organizational nature of the Family Violence Project and its impact on the community, staff and clients is the focus of this research study.
The foremost unique characteristic of the Family Violence Project is its inter-organizational component. This is not to say that the transition from separate agency to inter-agency has been a smooth one, for as Aiken, Dewar, DiThomaso, Hage and Zeitz (1975) stated, co-ordination is "an idea that is overworked, under-achieved and seldom defined". While the most important objective of any co-ordination effort is improved service to clients, this commitment to clients in itself will not ensure that co-ordination is effected. Agencies must also have proof that the co-ordination effort will not interfere with their core programs and services already being delivered.

Further, agencies must be convinced that a co-ordination effort does not dramatically threaten the continued survival or expansion of their own organizations. The appeal of integrated service delivery is obvious to funding bodies as they are forced to make the best use of scarce resources to avoid duplication of service. However, as Goering and Rogers (1986) suggested it is "easier to define the target population of clients than it is to define which services are to be co-ordinated" (p. 6).

Currently, it is recognized that organizations operate under many environmental constraints and that other organizations are among the most important elements in an organization's environment. In the inter-relationships between organizations are a series of exchanges which can either result in a positive structural change at the community level or a conflictual mode of interaction which may detract from building the collaborative
community. Rogers (1974) developed a sequential scale which described the stages of Inter-Organizational relations (IOR) as they proceeded from director acquaintance to director interaction, information exchange, resource exchange, overlapping boards and finally written agreement.

As well, contingency theory has contributed a great deal to an understanding of inter-organizational relations. With its focus on the development of an organizational structure required for effectiveness, this theory suggests that there is no best way for structuring an organization (Mulford, 1984). The concept that the internal structure requisite to be effective depends on the nature of the organization's environment lends itself to the developmental nature of the family violence service administrative structure. It is in the pragmatics of operating family violence services that information can be collected which will guide the further development of the structure. To date, the Family Violence Project has remained remarkably open and flexible in terms of its structure which has been its hallmark in establishing its identity, sensitivity to client needs and organizational survival.

Further discussion of inter-organizational relations must include the concept of resource exchange. Levine and White (1961) have defined exchange as any voluntary activity between two organizations that has consequences for their respective goals and objectives.

Specifically, three determinants of exchange have been specified by Levine and White (1961): 1) lack of accessibility
of organizations to necessary elements from outside the local system; 2) the objectives of each organization and functions to which it allocated the elements that it controls; and, 3) the degree to which domain consensus exists among the various organizations. Although Levine and White (1961) do not discuss whether organizations with dissimilar or similar goals are more likely to exchange, the assumption is made that compatibility of goals would allow for more collaboration as each organization would both understand and have a stake in the goal attainment of the other. As well, Paulson (1976) found that perceived co-operation and perceived competition are positively related to goal similarity. It appears that the premise that organizational similarity will be positively correlated with resource exchange relationships can be borne out by examining whether administrators of agencies that are similar find it easier to relate to each other and have less conflict. An examination of these inter-organizational relations of the 
Family Violence Service Project and its impact on the community, staff and clients is the primary focus of this evaluation research study. The secondary focus was to evaluate the administrative elements of the project to try to determine the efficacy of its development and service delivery.

Statement of Purpose

On July 1 of 1988, the Family Violence Services demonstration project was initiated under the organizational umbrella of the Chatham-Kent Women's Centre Inc. The
Chatham-Kent Women’s Centre entered into a contract with the Ministry of Community and Social Services to be accountable for the overall services of the Family Violence Service Project and the financial reporting of the project for the period of July 1, 1988 to October 31, 1989. The Chatham-Kent Women’s Centre was directly responsible for the crisis response/education component, the intake/assessment and referral service and its portion of the children's groups. The Lester B. Pearson Centre had co-sponsored the Family Violence Service Project and was directly responsible for child and family therapy and its portion of the children’s groups. The Chatham-Kent Women’s Centre Inc. has entered into a contract to purchase the services of the Lester B. Pearson Centre’s two program components.

The purpose of the Family Violence Project is to provide a unified, inter-agency approach to responding and treating women, children and men experiencing violence in their lives. The Family Violence Service Project includes: an educational and crisis response component; individual assessment and referral services for women, children and men; individual and group counselling for women and children; and, family therapy. Individual and group counselling for men and marital counselling are provided through existing services in the community and on a fee for service basis when necessary.

The purpose of this research study was to evaluate the effectiveness of the Family Violence Service Project. The emphasis was on evaluating its impact on service delivery to
clients and the effectiveness of intervention on individual clients and various client systems.

The move toward a co-ordinated and integrated approach to intervention services in family violence has been a major accomplishment for service providers in Kent County and it is hoped that this evaluation of the demonstration project will yield valuable information for further research and development of this inter-agency collaborative model of service delivery.

This evaluation will address the process of inter-agency collaboration undertaken in this community and hopefully will contribute new research knowledge in the areas of inter-agency planning and co-ordinating and in the development of integrated service delivery systems to clients experiencing family violence. Finally, this evaluation has implications for funders and the community at large as the scarcity of resources in the environment call for an examination of integrated mechanisms for avoiding duplication of services. The results of this study will be utilized as: 1) a decision-making and administrative tool; 2) to assess the appropriateness of program development; and, 3) to identify ways to improve the service delivery of the project. The conclusions drawn from the data will provide the basis for recommendations for program modifications.

The rationale. The evaluation of the Family Violence Service Project was mandated by the funder, the Ministry of Community and Social Services. As part of the negotiated
contract for funding of the demonstration project, COMSOC required an independent evaluation be carried out which would address: 1) the effectiveness of service delivery; 2) whether the goals and objectives of the project were met; and, 3) whether the inter-agency collaborative model had been successful. While initially conceptualized as the Trinity Project which brought together three separate organizations, it has become operational as a two-agency project namely Family Violence Services. The Trinity Project was originally suggested by the Ministry of Community and Social Services as a project which could offer an integration of service to families where violence was an identified problem. The three agencies comprising the Trinity Project were brought together in a strategic planning process which proved to be more time-consuming than originally envisioned. Further, the process of developing a collaborative model for co-ordination proved to be more difficult to attain than expected and resulted in a unique co-ordinated service delivery structure developed by the Chatham-Kent Women’s Centre and the Lester B. Pearson Centre.

The Concepts

Family violence clients - Include those families where at least one incident of physical abuse has occurred between the partners; there is at least one child under 16 years of age in the family; and, they wish to reside in Kent County.

Organizational domains - The claims that the organization stakes out for itself in terms of human problems or needs
covered, populations served and services rendered (Hasenfeld, 1983, p. 61).

**Task environment** - The set of all external groups and organizations controlling access to potential and actual resources for the organization (Hasenfeld, 1983, p. 61).

**Providers of fiscal resources** - Federal, provincial and local agencies from whom an organization obtains financial resources (Hasenfeld, 1983, p. 61).

**Providers of legitimation and authority** - Organizations and groups that delegate some of their vested authority to an organization or who lend social support based on their prestige and status (Hasenfeld, 1983, p. 61).

**Providers of clients** - Groups and organizations that refer clients to an organization as well as individuals and families who may directly seek out the services of that organization (Hasenfeld, 1983, p. 61).

**Providers of complementary services** - Human service organizations whose activities are needed by an organization to assure successful client services (Hasenfeld, 1983, p. 61).

**Consumers and recipients of an organization’s products** - All the external units upon which an organization depends for the disposal of its products (Hasenfeld, 1983, p. 62).

**Competing organizations** - Organizations that may be competing with an organization for clients or other resources and can, therefore, influence the organization’s access to them (Hasenfeld, 1983, p. 62).
As was previously indicated, the unique characteristic of the Family Violence Service Project is its development as an inter-organizational project. In order to understand the relationships between organizations as they seek to integrate at service delivery levels, the literature on inter-organizational relations will be reviewed. The first section of the literature review synthesizes the relevant research on the determinants of inter-organizational collaboration. The second section of the literature review will address the issues of family violence with a specific focus on the historical development of service systems which may reduce the fragmentation of providing treatment services to clients experiencing family violence problems. Traditionally, treatment systems have involved a diversity of services provided by numerous agencies with inconsistent and conflicting policies, separate administrative and information-gathering structures and services offered in isolation from each other and relevant facilities (Goering and Rogers, 1986). The movement to integrated domestic response systems for victims of family violence is the culmination of many years of policy, legislation and attitude change.

I. Inter-Organizational Relations

Effective inter-organizational collaboration requires amongst other things, knowledge of the complexities of political
processes. Further, designing optimal conditions for collaboration depends on the ability of the stakeholders involved to engage in a planning process which identifies the uniqueness of each organization involved, the barriers to co-operation which may impede consensus on collaborative problem-solving, and the commitment of each participant to make a commitment to work through the difficult, conflictual process. As well, the literature is clear that a well-developed planning process needs to precede any attempt to implement an inter-agency program, as a lack of acknowledgment by stakeholders that some interdependence exists is a critical barrier to any collaborative effort.

Inter-organizational coordination and cooperation. Gans and Horton (1975) identified three models of co-ordination for the delivery of services have been described including voluntary, mediated and directed co-ordination. An examination of these concepts will provide a clearer understanding of the type of inter-organizational relationships which form the basis of the family violence service project. The integration models refers to the organizational entity (board, staff or person) charged with co-ordinating the services of autonomous organizations. With voluntary co-ordination, the integrator provides services and also tries to encourage co-ordination. With mediated co-ordination, the integrator is charged with the development of linkages between providers. When directed co-ordination is used the integrator has the authority
to mandate the development of linkages. Gans and Horton (1975) identified that these models tend to have different kinds of impact with mediated co-ordination helping to reduce service duplication and to standardize delivery procedures. In addition, Gans (1975) stated that when voluntary co-ordination occurs, more clients receive services and that clients are aided through the provision of multiple services. Directed co-ordination in Gans and Horton's (1975) opinion holds more promise for the development of a better planning capacity to assess needs and resources, eliminating overlap and duplication and feeling service gaps.

Gans and Horton (1975) further identifies two categories of linkages: administrative and direct service. The major contributions of Gans (1975) have been the identification of the major facilitators and barriers to co-ordination.

Consistent with the research of Gans and Horton (1975) was the concurrent development by Schmerhorn (1975) of the determinants of inter-organizational co-operation. Schmerhorn identified these major motivators as: 1) resource scarcity or performance distress; 2) the existence of positive values that stress co-operation; and, 3) powerful extra-organizational factors that demand co-operation. The barriers to co-operation identified by Schmerhorn (1975) included: 1) a fear of loss of autonomy; 2) fears that organizational participation will have unfavourable ramifications for image or identity; and, 3) fears that participation will require the direct expenditure of scarce resources. Mulford (1984) stated that organizations that accept each other's domain as legitimate, have goals that are similar
and administrators comparable in social status are more likely to exchange a variety of resources with each other.

Goering and Rogers (1986) further illuminates these potential organizational dilemmas (to coordination and cooperation) by reporting that "agencies must also have some evidence that the co-ordination effort will not conflict with another goal they all share in common: the continued survival and growth of their own organizations" (p. 5). Goering and Rogers (1986) contributes much insight into inter-organizational problems by further indicating that establishing and maintaining inter-organizational networks requires a great deal of formal and informal communication. While the benefits of improved and more efficient service to clients should outweigh the costs of inter-organizational co-ordination, Goering and Rogers (1986) stated that it is not evitable that they will.

A further identification of collective strategy dysfunctions is provided by Bresser and Harl (1986, pp. 408-427). These authors (1986) posit that organizational collectives have at their disposal two strategic coping mechanisms namely: 1) removing dysfunctions by abandoning collective strategies; or, 2) using buffering techniques to ameliorate undesired consequences. The ability to discern unproductive collaborative arrangements is described by Bresser and Harl (1986) as the ability to perceive "the potential for undesired developments which are appreciated early so that a commitment to reinforce explosive processes leading to uptight situations is forestalled" (p. 419). Further, in this
regard, Schmidt and Kachon (1972) posits that conflict is inherent when participants perceive that they have incompatible goals and when they realize that they have both the opportunity and capacity to block each other’s resource acquisition and goal attainment.

With regard to the presence of conflict in inter-organizational relations, Morrisey, Tausig and Lindsey (1985) noted that in one form or another, the fragmentation of human services has been attributed to the excessive "autonomy" of service agencies and their attempts to control definitions about problem statements, intervention strategies and client disposition. As well, Warren (1976) identified that the experience with voluntary co-ordination mechanisms in the human services area has proven to be disappointing.

**Implementation issues.** While the basic concept of inter-organizational service delivery as an optimum way to deliver services is not disputed by government or service providers, it is the lack of implementation strategies which is problematic. More specifically, Van de Ven and Ferry (1980) developed a theoretical framework for the emergence and maintenance of formalized inter-organizational relationships (I.O.R.) which provides a valuable perspective for the assessment of I.O.R. networks. Morrisey et al. (1985) stated that "the framework consists of the situational preconditions that facilitate or inhibit the development of inter-agency relationships, the resultant structure and co-ordination of resource flows or interdependencies among agencies and the extent of system articulation within inter-organizational networks" (p.
704). Subsequently, Morrisey, et al. (1985) utilized this framework in a study of community mental health systems, and discussed the possibility that it is assumed that co-ordination is effective when based on mutual adjustment, and alliances. Further, it may be that some types of co-ordination which lack the properties of formal inter-organizational systems may be more effective alternatives to highly formalized singular structures.

Another element in managing conflict in inter-organizational relations is the issue of power imbalance. Gray and Hay (1986) proposed that a necessary pre-condition for collaboration is mutual recognition of interdependence. Gray and Hay (1986) further described this dimension of the inter-organizational collaborative process by stating that "powerful stakeholders who perceive they have little or no interdependence with others will undoubtedly try to preserve their individual control over the domain and will resist collaborative interventions that aim to balance power among the stakeholders" (p. 99).

Once the stakeholders of a collaborative process are identified and implementation strategies have commenced, the individual agencies involved then begin a period of boundary adjustments in the process. Maypole (1982, p. 15) described three forms of boundary adjustments: expansion; maintenance; or, contraction. Maypole (1982) further described the boundary adjustment model and stated that boundary adjustments reflect the "after-the-fact" accommodations to agency policies and strategies, in relation to internal values and capacities and external relationships with collateral agencies, funders, regulators and clients.
Certainly, the uniqueness of each organization and the uniqueness of each inter-agency collaborative effort are the important factors to be considered when examining any inter-organizational effort. Specifically, each organization must choose its method of adaptation to the needs of the project whether this is in structure, function, collaboration, resources, service-technology or ideology. In this context, Hasenfeld (1983) pointed out that such collaborative strategies are not necessarily rational and effective from the clients' or consumers standpoint. Most germane to this research study however, may be Hasenfeld's contention that the network of services is likely to be characterized by redundancy together with major service gaps, limited cooperation, contradictory or inconsistent service delivery patterns, multiple inter-organizational links and contracts but no overall rational and effective service network. The outcomes of the inter-organizational collaborative process may affect the realities of the theoretical constructs of inter-organizational relations and need to be interpreted within this context. The challenge of inter-organizational relations may be as D'Aunno and Price (1985) asserted that "adaptation to environmental demands often requires non-trivial, relatively enduring changes in the structure, technology and ideology of organizations" (p. 674).

Barriers to inter-organizational relations. It also seems important to identify the barriers to co-ordination which usually impact on inter-organizational efforts. It is a given that no explicit mandate requires organizations to co-ordinate their
services or even to recognize the target group as a distinct
client group with special needs. The basic tenet of
inter-organizational collaboration is that it must be voluntary,
even though it is recognized that this is difficult to bring
about in the human service arena.

Bacharach (1981) outlined several barriers to co-ordination
including: confusion resulting from the separation of funding
streams; the lack of a mandate to conduct inter-organizational
planning; and, budget constraints. Other factors which
discourage co-ordination in human service systems are:
competition for resources; multiple network memberships and
consequent conflicting obligations felt by constituent
organizations; and, a lack of complementary goals and role
expectations and differences in organizational activities and
client target groups (Baker, 1973; Molnar, 1978).

Finally, the formative issues of voluntary
inter-organizational relationships need to be briefly identified
in this context. The work of Schopler (1987) provided insight
into the developmental processes of inter-organizational groups.
She indicated that the performance of inter-organizational groups
is of particular concern in the health and human services, when
the group evolves from the demands and needs of external
constitutencies, such as special interest groups or community
coalitions. In groups with a low degree of externally imposed
task structure, an external agent or constituency indicates a
general purpose for the group, but offers little guidance on
structuring group activities (Schopler, 1987, p. 703). In
discussing the efficiency of group development, Schopler stated that "the length of time required to resolve formative issues and to develop an operative consensus is directly affected by the group's origin and external requirements" (p. 707). Further, she identified that members of voluntary groups that shape their own structure are likely to develop more personal ties and spend more time on maintenance activities and decision-making, and may be delayed when interpersonal differences arise. The reality of the current environment reflects that public money and organizational resources are spent on task forces, advisory committees and co-ordinating councils that, at times, either are unable to reach consensus or provide only a ritual response to external requirements (Rubin & Fry, 1974; Scott, 1984). Schopler (1987) differentiated inter-organizational groups from other linking mechanisms through the following definition:

Inter-organizational groups are composed of members, representing parent organizations and community constituencies, who meet periodically to make decisions relevant to their common concerns and whose behaviour is regulated by a common set of expectations (p. 703).

Jones (1978) and Tucker (1981) expressed the opinion that particularly when group decisions have significant implications for the members' organizations, controversies may be prolonged and heated.

In order to move from a discussion of inter-organizational relations to service co-ordination (for understanding family violence), it seems helpful to examine the work of McCann (1983). McCann (1983) stated that inter-organizational domains
develop through three sequential phases: problem-setting; direction-setting; and, structuring. Further, he suggested that internal and external forces can interrupt, enhance or impede the cycle, and that collaboration will be enhanced when there is a mutual agreement as to what the problems are and when there is a collaborative process undertaken to create a mutually acceptable regulative framework. In this regard, it is important to note how the philosophical commitment to co-ordination of services does not ensure that co-ordination will be effected. The most important objective for any inter-agency service delivery project is to provide improved service to clients. However, as has been identified previously, the experience with voluntary co-ordination mechanisms in human services has been disappointing.

II. Family Violence: Case Management Approaches

The issue of domestic violence has received increasing attention over the past twenty years in North America and has moved from denial that the problem existed to a commitment to provide comprehensive case management service delivery. In the identification of family violence as a distinct problem, there have been four distinct phases of service delivery development. The first phase was the recognition that violence within the family was in fact occurring. Historically, the societal response up to this point was to deny, condone by omission, or to aid in the concealment of this aspect of dysfunctional family systems. The women’s movement of the 1970’s has had a major
impact on bringing this problem into the open and in demanding that the legal system protect women from spousal abuse. The founding of women's shelters over the past fifteen years represents the second phase of the societal response to domestic violence.

The development of specialized interventions for women including the provision of a safe environment heralded the recognition that this was indeed a social problem which required major policy, legislative and economic changes at structural levels in society.

Following the development of women's shelters which were essentially geared to providing short term intervention to battered women, the next phase of development addressed the needs of the men and children who were part of these families. The beginning of an integrated domestic response system can be seen when the inclusion of specialized services to men and children began to be included in the programmatic response of women's shelters themselves, as well as other human service agencies. These services were mainly treatment or support groups for male batterers and children whose main objective was anger control and social adjustment. This phase also saw the beginning of court mandated treatment for males charged with domestic violence. The court referral process has strengthened the treatment process for men who had been difficult to motivate voluntarily.

The final phase of program response to domestic violence is the current move toward a comprehensive community based case management service delivery system. The development of an integrated service delivery system for family violence addresses
the fundamental issue of the case management role for human service agencies. In examining the organizational context within which these services are developed, a framework is provided which describes both the inter-organizational dimensions and the complexities of case management.

The implementation of the F.V.S. project moved the inter-organizational relations of the agencies in Kent County from a planning mode to a service delivery mode. The basic vehicle for delivery of the service technology is the use of a case management system. Case management is defined by Weil and Karls (1985) as a "set of logical steps and a process of interaction within a service network which assures that a client receives needed services in a supportive, effective, efficient and cost-effective manner" (p. 2). The case management role includes a liaison role for the direct service worker. Bradfield and Dame (1982) suggested that the case manager may have to use both formal and informal mechanisms. Examples of formal mechanisms include inter-agency agreements and admission criteria while informal mechanisms include agreements between staff of different programs.

The concept of community wide co-ordination to deal with family violence is gaining in acceptance with more communities across North America thinking about co-ordinated inter-disciplinary solutions. It appears that the F.V.S. project represents the beginnings of a model for co-ordination of a family violence community based response, and as such, has demonstrated that a management team can provide a support system
for professionals as well as providing high quality service through mutual planning and problem-solving (Weil and Karls, 1985).

The organizational aspects of case management activities are complex as case management activities occur between formal systems that are independent of each other. Mayer (1972) used three variables to analyze organizational system arrangements: 1) system level, which refers to the unit of analysis; 2) structure, which indicates how the elements are arranged to interact; and, 3) integrative mechanisms which refer to what holds the system together. While these variables may be helpful in defining a case management system, equally important in determining differences of case management approaches are client needs. Clearly, because the target group's needs will significantly shape the types of service and the membership of the service network, there will be no single most efficient form of organization appropriate for managing all resources and services (Weil and Karls, 1985). This shaping of case management technology offers a challenge to any integrated service delivery system as not only joint problem-solving must take place, but at the same time collaboration is needed "at the community level to ensure that all resources are tapped and that needed resources are generated" (Weil and Karls, 1985, p. 92).

Domestic violence treatment has been gradually evolving toward an integrated response and the case management models which have been developed provide valuable research into the politics of this interagency intervention. Hasenfeld (1983)
perhaps best describes the operational realities of case
management systems as follows:

In order to function, a case management program
must be able to cross boundaries between agencies,
intervene in the internal workings of other
organizations and have the sanction to do so. To
carry out its functions, the case management program
must convince agencies in the service network that
they and their clients will benefit from its
activities. The service network agencies will be more
accepting of case management if they share a service
philosophy and if the case management program can
provide demonstrable benefits, such as smoothing the
operations of the service system, strengthening the
expertise and domain of participating agencies,
sharing the work with especially difficult clients,
increasing collaboration, and reducing competition
with other network agencies and adding new resources
or increasing access to existing resources (p. 202).

Thus, case management could not only assist specific
families but is also an essential function in the community to
identify gaps in service to the specific target group.

In sum, the complexity of operationalizing inter-
organizational service delivery projects has been identified
through the presentation of this sub-section of the literature
review. The exchange relationships necessary to develop service
mechanisms which are integrated, functional and receptive to
client needs require a high level of political skills. Further,
the strategies necessary to achieve consensus and mediate the
destructive dimensions of conflict are difficult to assess. By
examining modes of co-ordination, it is possible to structure a
conceptual framework for defining the nature of the interactions
between organizations. Further, by reviewing the implementation
issues (previously identified in the literature), a clearer
pathway to identifying this process seems possible. Perhaps, the
most crucial dimension in managing inter-organizational relations is an understanding of the barriers to co-ordination as outlined by Bacharach (1981), McCann (1983) and Schopler (1987). While these theoretical constructs have illuminated the complex reality of this process, there is little empirical research reported in the literature on the successful implementation of inter-organizational service delivery projects. Further research which identifies program pathways for effective service co-ordination would be valuable for all human service delivery systems. Most importantly, the fragmentation of services to families where violence is present is a crucial issue which demonstrates clearly the need to effect this aspect of inter-organizational development.

Finally, until further models of service co-ordination are developed which differentiate effective and non-effective organizational strategies, services to this population will not be delivered by a comprehensive mechanism which links all the key elements of the service network.

Case management systems, given the level of collaborative problem-solving necessary to be effective, require an overriding treatment philosophy which can serve as the value base for professional practice by all staff. This is an essential ingredient whether the organizational context is inter-agency or a single agency. The F.V.S. project has addressed this issue by its commitment to developing a treatment philosophy which seeks to integrate feminist therapy principles with family systems theory. In addressing the integration of feminist and family
therapy, Luepnitz (1988) cautions practitioners that when working with the family's unconscious, the family's projective system and the family's transference to the therapist, as feminists, one must be careful not to transform these concepts into a re-affirmation of patriarchal relationships (p. 173). Clearly, Luepnitz (1988) defines the feminist/family therapy controversy in the following statement:

The feminist therapist with an object-relationships orientation does not stop at analyzing the family, but leads the patient to action, making suggestions, stirring up debate and sometimes giving advice. The feminist therapist is definitely concerned with helping the family achieve symptom relief, not in just any possible way but in ways that allow the family to be less patriarchal, less father absent and more connected to the community than before. Needless to say, these changes are more plausible with some families than others, and therapists must, of course acquire sensitivity for the kinds and degrees of transformation that can be hoped for. Such limits are part of any therapeutic orientation, no more or less relevant to feminist than to conventional therapy (p. 193).

The service delivery issues of the F.V.S. project reflect the issues which are currently indicated in the literature. First, the integration of a feminist position within a family systems approach produces a struggle for conceptual clarity. Bern and Bern (1984) stated that because spouse abuse is so directly related to sexism, any program aimed at dealing with this problem must be non-sexist in its structure. The work of Luepnitz (1988) makes a valuable contribution to the understanding of the feminist family therapy dilemma. Any understanding of this therapeutic mode must begin with a critical and historical understanding of the family. Luepnitz
(1988) stated that "it is doubtful that a feminist therapy could follow the structural-functionalist model because the latter takes too little account of the family's personal history and treats problems largely as they appear in the present" (p. 68).

The examination of the literature on inter-organizational relations illustrates the complex and political nature of this type of inter-agency development. Further, the discussion of a case management system which could be utilized as a service delivery mechanism at a community level further illuminates the arduous development tasks that participants must be willing to take on to operationalize this type of service delivery project. Finally, the issue of melding a feminist and family therapy perspective is germane to this evaluation, as these two separate operating philosophies comprise the actual working relationships between the two sponsoring organizations of the F.V.S. project. The issues identified throughout the literature provide a conceptual framework for both the theoretical and practical aspects of this inter-agency initiative.
METHOD

An evaluation of this scope and magnitude required an elaborate multi-faceted design using a variety of research strategies, data sources and variables. This evaluation method was developed based on models used elsewhere with success (Holosko, 1987, Holosko and Anderson, 1988; Holosko and Metcalf, 1988). The evaluation method of this study, as is the case with any evaluation, tailored its design and methodology consistent with the purpose of this study.

Research Design

The evaluation design included both formative and summative evaluation components as shown in Figure 1. Formative evaluation refers to assessing the conduct of programs (Rossi and Freeman, 1985, p. 79). The formative evaluation for the project specifically focussed on how the project was developed and how it was operationalized.

One of the main data sources for the formative aspect of the study was the administrative chronology (Exhibit A). The administrative chronology has two purposes: 1) it provides the history of the program’s growth and development; and, 2) it builds in the potential for other programs to generalize (Holosko, 1987, p. 282). It basically provided a running record of the major developmental aspects of the project. The description of the Treatment Process provided a further formative data source for this aspect of the evaluation.
### Figure 1

**Evaluation Design**

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<th>Evaluation Strategy Used</th>
<th>Data Sources</th>
<th>Formative/Summative</th>
<th>Steps in Process</th>
<th>Variables</th>
<th>Documentation</th>
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**Client Satisfaction Survey**

1. Outcomes of therapy as perceived by the respondent
2. Respondent's attitude toward therapist
3. Respondent's attitude toward factors affecting outcomes
4. Respondent's attitude toward family violence project in general
### Evaluation Strategy Used

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<th>Data Sources</th>
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<th>Steps in Process</th>
<th>Variables</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>1. Literature on Assessment Instruments</td>
<td>Formative/Summative</td>
<td>2. Meetings with staff for 3 month period to consult re intake/assessment package &amp; procedures</td>
<td>2. Social support scale</td>
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<td>2. Client Data Form</td>
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<td>3. Development of client data intake forms</td>
<td>3. Conflict Tactics scale</td>
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<td>4. Test Scores from Intake/Assessment Instruments</td>
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<td>5. Training for staff on use of intake/assessment package</td>
<td>5. Child behavior ratings</td>
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<td>2. Training Materials on Staff Development</td>
<td>2. Literature review regarding treatment interventions</td>
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<td>3. Interviews with Staff</td>
<td>2. Secondary treatment objectives</td>
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<td>5. Treatment contracts</td>
<td>4. Interviews with staff to define treatment interventions using definitive matrix</td>
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<td>6. Literature on Treatment Interventions</td>
<td>5. Roles</td>
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<td>6. Time-frame</td>
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<td>7. Appendices a) instruments</td>
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<td>b) group outlines</td>
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<tr>
<td>5. Inter-Organisational Survey Results</td>
<td>1. Inter-Organisational Map of Task Environment of Project</td>
<td>Formative/Summative</td>
<td>1. Review of literature on inter-organisational relations identifying framework for analysis analysis</td>
<td>1. Task Environment Domains a) providers of fiscal resources b) providers of legitimisation &amp; authority c) provider of clients d) providers of complementary services e) consumers &amp; recipients f) competing organisations</td>
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<td></td>
<td>2. Inter-Organisational Survey Interviews of Key Informants (N=14)</td>
<td></td>
<td>2. Analysis of task environment of family family violence project project</td>
<td>3. Identification of key informants in each in each domain of task of task environment</td>
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<td></td>
<td>3. Literature review of inter-organisational relations</td>
<td></td>
<td>3. Identification of key variables for development of Inter-Organisational survey questionnaire</td>
<td>5. Development of inter-organisational survey questionnaire a) joint activities b) formal agreements c) board members d) operating conflict e) domain consensus f) goal similarity g) perception of service utilisation h) structural perception i) resource scarcity j) written agreements k) perceived mutual dependence l) frequency of interaction</td>
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The other relevant data sources as shown in Figure 1 provided both formative and summative evaluation components and included: Client Profile Data; Intake/Assessment Data Analysis; Inter-organizational Survey Results; and, Project Staff Survey Results.

The Setting

Kent County fronts off Lake Erie, lying west of Elgin and Middlesex Counties, south of Lambton County and east of Essex County (Figure 2).

The population of Kent County has remained fairly stable from 1981 to 1986; from 107,022 in 1981 to 105,996 in 1986; compared with an overall provincial growth rate of 4.82% over this same period (Holosko, White and Anderson, 1989). Currently the population of Chatham comprises approximately 40% of the total population of Kent County. The 1986 Census data shows that the 0-24 age group is decreasing in number, while the 25-44 age group is increasing. Kent County's population has a projected annual growth rate of 0-0.4% up until 1991. By comparison, the population of Southern Ontario is expected to grow by 6% during the same period (Holosko et al. 1989, p. 12).

The two sponsoring organizations, the Chatham Kent Women's Centre and the L.B. Pearson Centre, are part of the service network of Kent County. The C.K.W.C. provides temporary shelter and services for women, with or without children, who are suffering physical and/or emotional abuse. The C.K.W.C. has taken a leadership role on issues of family violence in Kent County over the past ten years.
The L.B.P.C. is a children’s mental health centre funded primarily by COMSOC and operating under provincial legislation governing the provision of children’s mental health services in Ontario. The L.B.P.C. has been instrumental in providing valuable counselling and parenting services for children and their families in Kent County since 1976.
Sample Sources and Data Collection

Figure 1 presents the data sources and data collection methods used in the study. Information about the various program components was obtained from a combination of data sources.

The procedure. The Administrative Chronology was completed with data obtained from the Chatham-Kent Women's Centre and the Lester B. Pearson Centre project files which included: project correspondence; proposals; contracts; consultation reports; media announcements and the Kent County Task Force on Family Violence Research Report.

The Client Profile Data was obtained by developing the Client Data Intake Form for females, males and children with the identified socio-demographic and other relevant variables as shown in Figure 1. The Client Satisfaction Survey (Appendix A) described further in the instrument section of the report, was developed around the variables as shown in Figure 1.

The Intake/Assessment Data Analysis was developed by reviewing the literature on intake/assessment procedures and through a consultative process. An intake/assessment package was developed (Appendix B).

The Project staff were interviewed for the section on descriptions of treatment process utilizing a standardized format for obtaining descriptions of the various project components. The detailed description of these components are provided in Appendix C.
A unique characteristic of the family violence service is its development as an inter-organizational project. This relationship between organizations in the task environment of the family violence project was explored utilizing an inter-organizational survey questionnaire (Appendix D). A map of the task environment (Figure 3) identified key informants in each domain and a personal face-to-face interview was conducted with each of the identified stakeholders (Appendix D). One of the key informants contacted did not respond to the request to be included on the inter-organizational survey.

The project staff of family violence services were interviewed in a face-to-face interview utilizing a survey questionnaire (Appendix F) developed from the data collected in the inter-organizational survey as well as the variables of supervision, the physical environment and program outcomes.

The Instruments

There were three main questionnaires developed for this evaluation:

Inter-Organizational Survey Questionnaire (Appendix D). In order to assess the resource exchange relationships which exist for the Family Violence Project in Kent County, the key exchange variables of inter-organizational relations were identified. Mulford (1984) in a study of 136 dyadic relationships has identified the following variables which may be useful in an analysis of inter-organizational relationships: information exchange; resource exchange; joint activities; written
agreements; board members; compatibility of operating philosophy; operating conflict; resource scarcity; domain consensus; lack of alternative sources of resources; goal similarity; mutual dependence; asymmetric dependence; frequency of interaction; differences in professionalism; difference in degree of social status; and, differences in formalization.

After examining the variables, eight were developed which would allow for the gathering of data for the particular purposes of the family violence project. In examining the inter-organizational network in Kent County, these variables were selected to form the base of an inter-organizational survey questionnaire whose purpose was to gain information to help to define the essential network properties of this project. Further, the perceptions regarding program goals, activities and resource base were key concepts which could be investigated by interviewing key stakeholders in the community.

The general survey questionnaire was developed from the identification of the following variables: joint activities, formal agreements, board members, operating conflict, domain consensus, goal similarity, perception of service utilization and structure perception. The specific sections of the survey were developed using key variables for each specific section.

The framework for the development of the analyses of the community network was the task environment map of the family violence project. Hasenfeld (1983) defines the task environment as a "set of all external groups and organizations useful in
controlling access to potential and actual resources for the organization" (p. 61). The mapping of the task environment provides a conceptual framework for identifying the potential resource exchange relationships which could have an impact on the family violence project (Figure 3). Hasenfeld (1983) identified six major sectors in the task environment:

1. Providers of fiscal resources
2. Providers of legitimation and authority
3. Providers of clients
4. Providers of complementary services
5. Consumers and recipients of an organization's products
6. Competing organizations

Within the six major sectors outlined above, key stakeholders were identified and were interviewed accessing information from the general survey instrument and from the specific survey questions developed for each sector (Appendix D). The variables identified for each sector included:

1) Providers of Fiscal Resources
   1. Resource Scarcity
   2. Written Agreements
   3. Structural Perception

2) Providers of Legitimation and Authority
   1. Domain Consensus
   2. Board Members
   3. Structural Perception

3) Providers of Clients
   1. Service Utilization
2. Perceived Mutual Dependence
3. Formal Agreements

4) Providers of Complementary Services
   1. Service Utilization
   2. Formal Agreements
   3. Domain Consensus

5) Recipients and Consumers
   1. Service Utilization
   2. Operating Conflict
   3. Domain Consensus

6) Competing Organizations
   1. Goal Similarity
   2. Frequency of Interaction
   3. Joint Activities
   4. Operating Conflict

Within each of these domains, key stakeholders in the environment were selected for a personal interview.

Project Staff Survey Questionnaire (Appendix F). The questionnaire was designed to elicit information on the following dimensions of the family violence project: Part I 1) Expansion of Family Violence Project; 2) Prevention Activities; 3) Consultation/Staff Training; 4) Formal Policies and Procedures; 5) Integration of Services; 6) Future of the Project; and Part II 7) Supervision; 8) Physical Environment; and, 9) Program Outcomes.
Client Satisfaction Survey Questionnaire (Appendix A). The questionnaire was developed to assess client satisfaction designed around the following dimensions of client outcome: 1) Outcome of therapy as perceived by the respondents; 2) Respondent's attitudes towards factors affecting outcomes; and, 3) Respondent's attitude toward family violence project in general.

Questionnaires were mailed to clients with a self-addressed, stamped envelope provided along with the covering letter assuring the respondents of the confidentiality of their responses (Appendix A). The questionnaires were sent to clients who had terminated their therapeutic contract with Family Violence Services. A telephone call was made to respondents advising them one week before that the questionnaire would be sent. At the time of completion of this report, no follow-up data has been obtained through the Client Satisfaction Survey Questionnaire to date. Subsequent to this evaluation, it is expected that some 20-25 clients eventually will respond to this survey.
PROJECT DESCRIPTION

The Family Violence Service Project will be described according to the following five sub-headings: 1) Education and Crisis Response Component; 2) Intake/Assessment Process; 3) The Intake Package; 4) Assessment Instruments; and, 5) Descriptions of Treatment Process. A discussion occurs after sub-section (4) (Assessment Instruments) and after sub-section (5) (Descriptions of Treatment Process). As previously indicated in the method section (see Figure 1), data for this part of the evaluation were more formative than summative and essentially describe in detail the main components of the Family Violence Services Project.

1. Education and Crisis Response Component

The crisis response component provides service by telephone and/or personal interviews. Crisis response services address safety, legal and housing issues, information and referral services as well as problem-solving processes. The Crisis Response Process is shown in Figure 4. The community education component is carried out by the Chatham-Kent Women's Centre crisis worker and these two projects are part of the C.K.W.C. service delivery system. These two components are funded and administered separately from the Family Violence Service Project. The Chatham-Kent Women's Centre Education Program provides community education or family violence in general.
Figure 4

PROCESS CHART - CRISIS RESPONSE

Referral In

Crisis Worker

Referral Out

Other Community Service

Family Violence Service
There is no specific family violence project educational program or crisis response service. For families who meet the following criteria a referral is made to Family Violence Services: 1) at least one incident of physical abuse has occurred between partners; 2) at least one child under the age of 16 years; and, 3) clients reside in Kent County. For families and individuals who do not meet these entrance criteria, referral to other community services is made.

2. Intake/Assessment Process

Referral process. It is important to note that there are two avenues by which clients may arrive at Family Violence Services. These two pathways are: 1) they may enter the crisis response process as shown in Figure 4, or; 2) use the referral mechanism of Family Violence Services. As indicated, families are primarily referred to Family Violence Services by other community agencies or they refer themselves. During the initial contact with the family, the intake/assessment worker seeks to ascertain whether there has been physical violence present in the family system. The eligibility criteria for the F.V.S. Project states that physical violence must be present in the family to be considered for inclusion in the program. If the intake/assessment worker obtains information that physical
violence is not a problem for the family, then appropriate referrals are made to other community agencies.

**Intake process.** During the initial phone contact, if the family meets the eligibility criteria, an orientation to the program is carried out and appointments are scheduled for both the adults and children. Each adult in the family is seen twice during which time a complete orientation to the program is carried out, appropriate consent forms are signed, and the intake/assessment package is administered. Intake/assessment interviews with family members are conducted individually to assess and ensure safety.

The children of the family are interviewed once during which time the children's intake form is completed. As well, instruments are administered either to parents for their children or to the children themselves.

The instruments are then scored by the Intake/Assessment worker and a family profile is developed. An intake report (Appendix F) is then prepared for the case disposition meeting. The outline of this report contains; presenting request, family history, present family situations and presenting problems. The time interval between the intake/assessment interviews and presentation of the case at a disposition meeting is approximately three weeks.

During the disposition meeting, the case is discussed by the inter-agency intervention team and a primary therapist is
designated to co-ordinate and monitor the implementation of the treatment plan. The intake/assessment worker then contacts the family to advise them of the primary therapist’s name and advises that the therapist will be contacting them to set up an interview within the next week. The intake/assessment worker then transfers the file to the primary therapist while at the same time retaining a separate intake/assessment file with primary data housed within the family violence service office. The intake/assessment procedure was developed in consultation with the Family Violence team and the evaluation consultant (Dr. M. Holosko). The assessment instruments have been chosen because of their applicability to the treatment intervention offered.

3. The Intake Package

The items which comprise the Family Violence Project Intake/Assessment package are administered in the following order: (Appendix B)

1) Information Pamphlet - "Pathways Through Treatment"
2) Acceptance of Referral
3) Intake Contract
4) Access and Disclosure of Records
5) Client Non-Disclosure Agreement
6) Informed Consent Form (Research)
7) Release of Information and/or Form 14 (Mental Health Act)
8) File Summary Sheet
The intake/assessment package has been designed to meet both legal and program requirements in a comprehensive and concise fashion. The items and their suitability for the project are briefly described in the following sub-section.

I Intake

1) Information Pamphlet - "Pathways Through Treatment"

This brochure outlines for families the process they will encounter upon entering the program. Information is communicated in a step-by-step fashion which addresses the referral criteria, intake appointment, consent forms to be signed, the data to be collected during intake interviews, the counselling sessions, treatment planning, course of therapy, termination and re-referral and participation in the evaluation of the program.

2) Acceptance of Referral

The consent form defines acceptance of referral into the program. The participant signifies acceptance of the knowledge that information on the family will be shared between the two sponsoring organizations. Further, the participant acknowledges that the goal of the program is to ensure safety of family members and that the police will be notified if there is a suspicion that a person's safety is in jeopardy.

3) Intake Contract

The intake contract outlines the individual/family rights in regard to confidentiality, disclosure and access of records under Bill 77, The Child & Family Services Act. The right to appeal to the Children's Services Review Board is explained within the intake contract.
4) **Access and Disclosure of Records**

The **Child and Family Services Act of Ontario** in Part VIII, Bill 77 contains detailed provisions that clarify who does and who does not have the right of access to records and when an agency can and cannot disclose records without the consent of the child or parent. The relevant sections of this Act which pertain to confidentiality and access are explained to clients of the family violence service during the intake interview. As well, the procedures available for appeal are outlined. This information is shared both verbally and in writing with clients receiving the disclaimer pamphlet for their further review.

5) **Client Non-Disclosure Agreement**

The family agrees not to release information regarding the assessment, and/or treatment of the family, and/or children without first obtaining the written consent of Family Violence Services administration. The consent would be withheld where in the opinion of Family Services administration, the disclosure would be detrimental to the treatment of the family, and/or children, and/or the effective operation of the Family Violence Services Project.

6) **Informed Consent Form**

The agreement to participate in the project's research component identifies the voluntary nature of participation and assures the confidentiality and anonymity of information collected. During the administration of the consent form, the individual/family member is made aware that no penalty or risk is
involved should they choose not to participate in the research component.

7) **Release of Information**

The individual/family agrees to allow Family Violence Services to access information from other specific agencies and to release information to other specific agencies about specific members of their family for a three month period following the signing of the consent. The purpose of the Release of Information form is to determine eligibility for, and/or enhance the individual/families treatment program with Family Violence Services. Form 14: - *(Consent to the Disclosure, Transmittal or Examination of a Clinical Record under Section 29 of The Mental Health Act)* is also used as a release of information consent form where necessary.

8) **File Sheet**

A summary sheet of contents of the case file contains the following: name, I.D.#, date of intake and disposition meetings, name of primary therapist and presenting problem identified at intake. The names of all assessment instruments and the dates instruments were administered are available for all members of the family. This summary sheet provides an easily accessible review of the file contents and the present status of the file.
4. Assessment Instruments

Adult. The assessment instruments are administered by the intake/assessment worker during the intake/assessment interviews. A more complete description of the intake/assessment package is provided in Exhibit B. The adult section of the assessment package contains: a) Client Data Form which gathers basic socio-demographic data and data on the background of abuse, legal involvement and alcohol and drug use; b) Social Contacts Questions which attempt to assess the frequency of the social contacts of the client; c) Scales of Perceived Social Support (Macdonald, 1987) which focus on perceived support availability in the individual client's network; d) Index of Spouse Abuse (Hudson and McIntosh, 1981) which measures the degree or severity of physical and non-physical abuse inflicted on a woman by her spouse or partner and which is administered only to females; e) Conflict Tactics Scale (Straus, 1979) which measures intra-family conflict and the techniques used by family members in conflict situations.

Children. The assessment instruments for children are administered to the parents for the children or where appropriate to the children themselves by the intake/assessment worker during the intake/assessment interviews. A more descriptive account of the child section of the assessment package is provided in Exhibit B. The child section of the assessment package contains: a) Children's Intake Form which gathers information in three ways (description of the family, attitudes and responses to anger, and safety skills); b) Child Behavior Checklists For Ages 2-3
(Achenbach, 1981) which assesses parent's perceptions of child behavior problems; c) Child Behavior Checklist For Ages 4-16 (Achenbach, 1981) which obtains parent's descriptions of their child's behaviors and social competence; d) Youth Self-Report for ages 11-18 years which is designed to obtain self-ratings on social competence and behavior problem items; and, e) Self Perception Profile for Children (Harter, 1985) which is designed to measure children's domain specific competence as well as a global perception of their self-esteem. [The latter instrument was introduced to the treatment team as a result of the author's consultation with the team in October of 1988].

**Discussion**

The original design of the F.V.S. project included a crisis response and education component which was to be administered through the C.K.W.C. Although structurally, this program component was an integral part of the organizational design it has somehow not become operational at a program level. As indicated, the two pathways to the F.V.S. are through the crisis response component, or through referral to intake. While the crisis response component structurally appears to be the centralized funnel for domestic response calls; in fact, very few referrals from the crisis response component were made to F.V.S. This lack of integration of the crisis response component was identified by key informants as an area that required further development. As well, the education component has continued to be carried out under the auspices of the C.K.W.C. It is not clear however, how specific messages about F.V.S. are communicated since this education about F.V.S.
is carried out by the C.K.W.C. as a part of a general public education program. This lack of clarity surrounding the educational component needs to be addressed if the project is to continue. It is deemed important that the F.V.S. project have thematic consistency in its social marketing messages.

The intake/assessment package was developed over a three month period in consultation with the project staff and administrators. The original intake/assessment package was then streamlined, and standardized instruments were chosen for their relevance to family violence parameters. The choice of instruments for both the adults and children reflects the need to assess physical safety and marital interaction but perhaps, more importantly, the instruments chosen reflect the current move toward social support indicators, social competence indicators and measures of individual and family empowerment.

5. **Descriptions of Treatment**

**Descriptions of Treatment Process**

The process of the treatment intervention is shown in Figure 5. The intervention component of Family Violence Service is anchored by the designation of a primary therapist at the disposition meeting. It is the responsibility of the primary therapist to develop a treatment contract and to guide the family members to the appropriate program component. A description of
Figure 5
PROCESS CHART - TREATMENT PROCESS
these program components is presented as well as a description of
the systemic family therapy model developed by Bross and Benjamin
(1982) which has provided the overriding theoretical framework
for the intervention team. A discussion of the philosophical and
practice issues which have evolved from the process evaluation of
the family violence service project is also presented.

The treatment program components of the Family Violence
Service project are as follows:

I) The Women's Group Component

II) The Children's Group Component
   - a) Pre-School (3 1/2 - 6 years)
   - b) School Age (6 - 8 years)
   - c) Older School Age (8 - 10 years)
   - d) Young Adolescents (10 - 13 years)
   - e) Older Adolescents (13 - 16 years)

III) The Individual Counselling Component

IV) The Family Counselling Component
   - 1) Family Therapy
   - 2) Parenting Counselling
   - 3) Child Psychotherapy

The Disposition/Treatment team is composed of:

1) Crisis Response Worker
2) Intake/Assessment Worker
3) Women's Group & Individual Counsellor
4) Child Care Worker
5) Children's Group and Individual Counsellor
6) Family Therapist
7) Administrator of the Women's Centre
8) Executive Director of the Pearson Centre

The Intake Report is presented to the case disposition meeting. The case is discussed by the inter-agency Disposition/Treatment team and a primary therapist is then designated. It is the responsibility of the primary therapist to develop a treatment contract with the members of the family which clearly delineates both individual and family treatment goals, the strategy for achieving these goals, methodology for evaluating changes and a schedule for evaluation. In cases where no change is noted, the primary therapist will return to the treatment team to revise problem formulation and intervention strategy. Termination occurs when treatment goals have been achieved as determined by family members and the counsellor.

The primary therapist will then also liaise with counsellors at other agencies providing service for members of participating families.

Descriptive summaries of the various Project components were developed by interviewing members of the Family Violence Services Project team utilizing the format shown below. A complete description of each program component is shown in Appendix C.

DEFINITIONS: Objective - How the target population will be changed.

Indicators - Measure to determine whether objectives have been met.
Activities - Tasks staff will perform to achieve outcome objectives.

FORMAT:

1. Objectives -
   a) Primary
   b) Secondary
   1  2  3  4

2. Indicators -
   a) Primary
   b) Secondary
   1  2  3  4

3. Activities -
   a) Primary
   b) Secondary
   1  2  3  4

4. Staff Role -
   Staff Role

5. Time-Frame -
   a) - how many sessions
   b) - how many hours
   c) - how many people

6. Appendices

Staff Training

The training for intervention team members was carried out at the beginning of the employment of intervention team members by Allon Bross, M.S.W., Director of Ontario Family Guidance Centre Inc. The model of family therapy practice developed by Bross is called the Recursive Model of Strategic Practice. Bross and Benjamin (1982) defined this model as one which "demonstrates an explicit linkage between assessment, diagnosis and intervention, is recursive in design and which explicitly attends to the issue of therapist error" (p. 3). This model is sub-divided into six major phases which together comprise the therapeutic process.
Bross and Benjamin (1982) stated that the model is "explicitly recursive in the sense that it consists of a series of nested feedback loops" (p. 3). The six major divisions of the therapeutic process are outlined by Bross and Benjamin (1982) as follows: (pp. 8-29)

**Phase One**

- **Family Assessment includes:**
  1) demographic data
  2) substantive information including treatment history
  3) interactional data pertaining to family rules and history

**Phase Two**

- **Development of a Family Problem Formulation**
  - a statement which includes:
    a) a description of the problem in systems terms which describes interactional processes and system maintenance issues
    b) a description of the systemic pattern changes that will indicate problem resolution

**Phase Three**

- **The Maintenance of Therapeutic Contract**
  - supportive operations of the therapist which include:
    1) attentive listening
    2) empathy
    3) reinforcing strengths
    4) imitation
    5) respecting differentiation
Phase Four - Intervention
- selection of a therapeutic task includes:
  a) the particular family
  b) the case formulation
  c) the therapist's preferential style

Phase Five - Evaluation
- possible outcomes of evaluation include:
  a) not successful
  b) partially successful
  c) completely successful

Phase Six - Termination
- case termination includes:
  a) recognition that no problem exists
  b) intervention may be contraindicated where members of family are evidencing organic problem or learning disability
  c) client withdraws from therapy
  d) intervention has failed to produce any significant movements in the case
  e) client withdraws following partial success
  f) a logical and welcome outcome of successful intervention

Intervention Team members received training in assessment and treatment using this conceptual framework. This model provides the base for clinical practice carried out by team members and allows for the treatment interventions to be structured utilizing a family systems approach. The application of this model has
allowed for the operationalization of comprehensive assessment and treatment techniques which are understood and practiced by all intervention team members.

Finally, intervention team members received training from Deborah Sinclair, M.S.W. a private practice therapist. The content of the training session consisted of feminist theory and its applications in family violence. As well, Ms. Sinclair provided training on the nature of inter-organizational relations as applied to family violence interventions. Having a common theoretical framework and developing a common language with which to discuss respective cases has provided the intervention team members with a solid base for their clinical practice.

Discussion

The development of the intervention strategies for the Family Violence Project reflect the strengths of the project’s administrators. As previously discussed in the literature review, the differing philosophical approaches to family violence of the two organizations were negotiated by the administrators to allow for an overriding treatment philosophy to emerge. This framework (for intervention) was the focus of the training provided to staff at the initiation of employment and proved to be an integrating mechanism for the strengthening of the team. The whole area of professional growth and development of the intervention team is one which the project
has developed to reflect a credible standard of practice. The staff themselves have recognized and appreciated the wealth of training provided and the commitment to see this theoretical knowledge integrated into their professional practice.

As well, the community has recognized the expertise developed by the family violence practitioners and has identified their needs for consultation and training from the family violence project. The development of the program components has not occurred as consistently as was originally envisioned. The range of services necessary to provide comprehensive intervention to families of violence was originally designed to include services for men such as anger control groups. The lack of inclusion of this valuable program component is a serious deficit in the array of treatment services.

As well, the program components for children did not appear to be as well defined as some other components. The children's groups that were proposed were delivered but the process and outcome variables of these groups were not as well defined as they needed to be to accurately assess the effects of this intervention. The data suggest that the children's group component needs to be bolstered when the planning for future development occurs and should include definitive descriptions of goals, objectives, outcome indicators and activities. The inclusion of more highly specialized, standardized instruments for pre-test and post-test measures should be included in the children's group component.
One of the most important findings in the analyses of the treatment interventions is the overwhelming time dimension of this therapeutic intervention. Initially, the treatment contract for these families was set at twelve weeks. Through the process of working extensively with these families, it has become abundantly clear that clients need to be constantly re-cycled back through the service delivery system for additional therapeutic intervention. The issues which arose in therapy included a large number of sexual abuse victims who are also battered women as well as the inclusion of substantial alcohol and drug problems within these families. These problems do not allow for a definitive short-term contract to be feasible. The present clinical judgement of the family violence team is that these families require at least one year of intensive clinical work to see any meaningful change.

The knowledge that the clinical needs of the families are better suited for long-term therapy has been an important finding from the project. The dilemma this presents is a serious matter when one considers the present needs of the clients in an economic reality which threatens to remove the funding for this (their only) therapeutic intervention. Further, since clients did not finish the therapeutic contract but continually re-cycled it was impossible to post-test clients and obtain any post intervention outcome data. The standardization of the intake/assessment package however, does provide baseline data on these families and provides a mechanism for the post intervention data collection which will be collected in the future.
RESULTS AND DISCUSSION

The results and discussion have been organized according to the information outlined in the evaluation strategies (Figure 1). These sub-sections are as follows: I. Administrative Chronology, II. Client Profile Data, III. Intake Assessment Data Analysis, IV. Inter-Organizational Survey, and V. Project Staff Survey. In each of these sub-sections, a presentation of the results will precede a discussion of these results in an analytic context.

I. Administrative Chronology

In February, 1981 the Kent County Task Force on Family Violence (K.C.T.F.F.V.) was established to be the local co-ordinating committee for family violence in Kent County. In July of 1983, the K.C.T.F.F.V. received federal funding to launch a nine month family violence research project on family violence. The results of this project were released in April, 1984 with the following recommendations: 1) to develop public and professional education program; and, 2) to develop a pilot project to provide immediate assistance to families in Kent County experiencing family violence. A detailed description of the Administrative Chronology is provided in Exhibit A.

The Social Planning Council of United Way Chatham-Kent in October 1984, after receiving a request from the Chatham-Kent Women’s Centre for a full-time child care worker, sought a joint proposal from the C.K.W.C. and the L. B. Pearson Centre. The Family Violence Program proposal was submitted to United Way in
October, 1984 by the Women's Centre and the Pearson Centre requesting funding for a program with a child care component and a child and family treatment component. In February of 1985, United Way was unable to commit funds for the family violence program but provided a letter of support for the agencies to the Area Manager, Ministry of Community and Social Services.

The Ministry of Community and Social Services announced in February of 1985 that monies had been budgeted for services to children of violent families and in March of 1985, an amended Family Violence Program proposal was submitted to COMSOC by the C.K.W.C. and the L.B.P.C. After submission of this proposal, in March of 1985, COMSOC asked the two sponsoring agencies to include a third agency, the Chatham-Kent Community and Family Services. The service component of this proposal was expanded to include marriage and separation counselling and individual and group therapy for both women and men. The addition of this third agency was the conception of the Trinity Project in April, 1985 at which time the Family Violence Program proposal was re-written and re-submitted under the Trinity name to COMSOC by the three sponsoring organizations: the L. B. Pearson Centre; C. K. Women's Centre; and, the Chatham-Kent Community and Family Services. The stated objectives of the Trinity proposal were to provide an integrated system of service to families experiencing violence. The submission of this proposal reflected the recommendations of the K.C.T.F.F.V. report issues which arose in April of 1984. Upon receipt of this proposal in 1985, the Area office of COMSOC submitted this proposal to the Ontario Centre
for Prevention of Child Abuse for funding consideration under their child abuse prevention program. The OCPCA was interested in the Trinity Project, especially the inter-agency aspect of the project; however, OCPCA required the addition of an extensive evaluation component to the project in order to consider the submission for funding approval.

In May of 1985, Dr. Ian Smith was engaged on behalf of the Strategic Planning Team of Trinity to develop a research proposal. The research design proposal for the Trinity Proposal was submitted to COMSOC in July of 1985. The proposed budget was $42,200 over two years with the proposal calling for validation of the efficacy of intervention as well as the effectiveness of the inter-agency co-operation. Modifications to this proposal were re-submitted in September of 1985.

During this time the C.K.W.C. and the L.B.P.C. jointly provided children's groups from 1986-1987 in collaboration with research undertaken by Dr. Peter Jaffe of the London Family Court Clinic. Also during this time, the Kent County Task Force on Family Violence provided on a voluntary basis from 1986 to 1987, a treatment group for men identified as perpetrators of family violence.

In January of 1986, a Phase I design grant proposal prepared by Dr. Ian Smith was submitted to COMSOC with a budget of $10,175. The principal applicants were the L.B.P.C., C.K.W.C. and C.K.C. and F.S. The proposal was for the establishment of a model for an integrated multi-agency approach toward developing, implementing and evaluating a strategic systems approach to the delivery of intervention services to children and families of
domestic violence. In January of 1986, the Communications Branch of COMSOC issued a news release that the funding for the Trinity Project had been approved in principle for a two year project for $357,462. John Sweeney, Minister of Community and Social Services announced the details of the Trinity Project Funding in Chatham. In February of 1986, the OCPA provided notice of approval of funding for the Phase I - Developmental Phase of the project.

Dr. Ian Smith was hired in March of 1986 to lead the Trinity Management Team through a strategic planning process to develop a consensual model for the implementation phase of the project. During this time, the C.K.W.C. hired a staff person to continue the children's program within the shelter and the C.K.C. and F.S. hired a worker to provide services to the Trinity Program.

After completion of eighteen days of planning during April to September, 1986 to develop the co-ordinated inter-agency model, the full project proposal for Phase II - Implementation entitled 'Trinity - A Systemic Community-Based Approach to Reducing Violence Within the Family' was submitted to OCPA in September of 1986.

In December of 1986, the Trinity S.S.P.T. contacted the OCPA to inquire as to the status of the proposal as the one year anniversary date of the announcement of funding was imminent. A response was received in January 1987 from OCPA that there were concerns regarding the program components, research components, philosophy, and budget submission. During the period from February, 1987 to April, 1987 funding was obtained both from
COMSOC and the Ministry of Corrections to carry out the men's group component and as well the C.K.W.C. children's program was funded by COMSOC.

Negotiations between the Operations Branch of COMSOC and the local Area Office of COMSOC resulted in a decision being made in June 1987, that: 1) the project be pursued as a service project rather than a research project; 2) the project be funded and monitored through the Area Office; and, 3) the Budget needed to be reduced. The Trinity Proposal was returned by OCPA to COMSOC Area Office and in July, 1987, COMSOC requested that for their funding purposes the proposal be re-written deleting the Research Component, the Child Care Component and the Men's Group Component. The Trinity Project Proposal was re-written and re-submitted to COMSOC Area Office in August of 1987.

Approval for funding for the Trinity Project was given in a letter from the Area Manager of COMSOC in September of 1987. This approval was to be effective November, 1987 for a two year period with a caveat that there was no commitment for funding beyond two years and that a program evaluation would be conducted. Budget approval for two years was in the amount of $80,000 for 1987/88 and $174,000 for 1988/89.

From the period September 1987 to March 1988, the S.S.P.T. planning team met to develop the protocol for administration of the Trinity Project. The Intake/Assessment package and purchase of service agreements were also developed during this time. In March of 1988, Dr. Michael Holosko of the University of Windsor, School of Social Work, was hired as the Research Consultant to carry out the program evaluation. The previous Research
Consultant, Dr. Ian Smith, had become terminally ill and had passed away during the previous months.

The formal announcement of the launching of the Trinity Project was prepared with the official starting date of April 19, 1988 to be announced at a press conference held at the Women's Centre for the press and community agencies.

During the month of March and part of April, the S.S.P.T. had been experiencing great difficulty gaining consensus on decisions regarding the operation of the project. In April of 1988, before the official announcement launching the Trinity Project, the board of directors decided that the C.K.W.C. would have to withdraw from the project due to serious conflicts with the C.K.C. and F.S. A letter informing COMSOC of the Centre's decision was sent to the Area Manager of COMSOC by the President of the Women's Centre, Board of Directors. On April 30, 1988 the official 60 day notice of Termination of Contract was sent to the Area Manager of COMSOC by the President of the Board of Directors of the L.B. Pearson Centre. This letter specifically stated that the "continuing deterioration of inter-agency relationships had reached a point of impasse where our participation in the project under its present structure is no longer possible".

A joint proposal by the C.K.W.C. and the L.B.P.C. was submitted to COMSOC Area Office for a project entitled, "Family Violence Services". This proposal sought to incorporate the Family Violence Project under the umbrella of the C.K.W.C. with a fee-for-service contract developed with the L.B.P.C. The
proposal identified the following personnel requirements: Intake/Assessment Worker; Individual Women and Women's Group Worker; Children's Group Counsellor and a Child and Family Counsellor. By also utilizing the present staffing complement of the C.K.W.C., the proposed service delivery system for the project included: 1) Education and Crisis Component; 2) Direct Services, a) Intake/Assessment, b) Individual and Group Counselling, c) Family Therapy; and, 3) Referral and Co-ordination.

Funding for the Family Violence Project was approved in July of 1988 in a letter from the Area Manager of COMSOC to the President, Board of Directors, C.K.W.C. The program officially opened on September 1, 1988, in an office at 10 Third Street, Chatham. An Open House was held at the Family Violence Services office and letters were sent to community agencies announcing the family violence services project.

Discussion

The development of the present Family Violence Services Project is the culmination of years of inter-agency planning for family violence in Kent County. The initial recommendation of the Chatham-Kent Women's Centre who saw the need for services for children from violent homes in 1984, led to the development of a joint proposal for a family violence program sponsored by the L.B.P.C. and the C.K.W.C. whose mandate at that time included only the inclusion of a child care component.

This proposal was first submitted to Chatham-Kent United Way and subsequently to COMSOC when monies were not available from
United Way allocations. It appears that provincial monies had been made available for services to children of violent families and in this regard, the Area Office of COMSOC requested of these two sponsoring agencies that they include a third agency, C.K.C. and F.S. and expand the program proposal to include marriage and separation counselling, and individual and group therapy for women and men. It is at this juncture that the nature of the inter-agency collaborative process became more complex. The respective histories and relationships of the L.B.P.C. and the C.K.W.C. coupled with the previously negotiated co-operative relationship between the administrators of these agencies allowed for an effective inter-agency process to be carried out. The inclusion of a third agency with a separate philosophy and mandate produced many challenges to effective collaboration and communication. While it appeared that it was a cumbersome and difficult process to reach a consensus regarding philosophical and operational matters, the three agencies did in fact develop a proposal which was submitted to COMSOC Area Office and which identified their mutual objective of providing an integrated system of services to families experiencing violence.

Since COMSOC, upon receipt of the Trinity Proposal, sent the proposal to the Ontario Centre for Prevention of Child Abuse, the assumption is made that this was in fact the source of provincial monies which COMSOC had identified before the proposal was developed. The specific funding criteria for OCPA necessitated that an extensive evaluation research component be
added to the proposal with a further identification that OCPA was most interested in the inter-agency aspect of the program which was the unique dimension of the program which one assumes they thought would yield the most valuable research data for future programming in family violence.

In order to effect the development of this evaluation component, a research consultant, Dr. Ian Smith, was hired and a research design proposal was developed and submitted to COMSOC Area Office in July of 1985. Modifications to this proposal were requested and in January of 1986, a design grant proposal with a budget of $10,175 was submitted whose stated objective was to establish a model for the integrated service delivery approach to family violence.

In a somewhat confusing turn of events, the Communications Branch of COMSOC through its Queen's Park offices released an official news release in January, 1986 that the Trinity Project had been funded in principle to actually implement the service delivery system as a two year project with a budget of $357,462. Concurrently, the Minister of Community and Social Services along with local politicians announced the details of the project while visiting the Chatham-Kent Women's Centre in Chatham. Subsequent to this, in the next month the OCPA approved a Child Abuse Prevention Grant for the developmental phase of the project to actually design the project so that a detailed proposal which outlined the model could be submitted at a later date. It was at this point that a serious communication problem appears to have occurred between the
COMSOC Area Office in Windsor, the COMSOC Communications Branch in Toronto and the OCPA in Toronto. The design proposal submitted for Trinity was for funding for research to develop the model not for implementation of a service delivery project. The approval by OCPA allowed the Trinity Project to hire Dr. Ian Smith as a consultant to lead the Trinity Management team, comprised of Board Members and Administrators of the three agencies, through a strategic planning process to develop a co-ordinated inter-agency model. Between March of 1986 and August of 1986, the Strategic Planning Team for the Trinity Project spent eighteen full days trying to work out a consensual model for implementation. The problems inherent in this process can be attributed to a number of factors.

First, no clear guidelines were provided by either COMSOC or OCPA as to how to operationalize such a project. Second, the choice of a business-oriented planning model by the consultant did not appear to facilitate the process of planning for a human service delivery system. Third, while a quasi-organization (SSPT) to administer and monitor the functions of the project appears to be a de jure solution to inter-organizational conflict, the de-facto reality is that this type of organizational structure is not suited to a direct service delivery project but would be more appropriate for a voluntary planning and co-ordinating body who were to act in an advisory capacity not in an administrative capacity.

Organizationally, the accountability, decision-making and dispute resolution mechanisms for a service delivery project
employing practitioners need to be incorporated into the hierarchy of an organizational structure with a voluntary advisory committee reporting to the Board of Directors of one agency. The decision to create an administrative body not linked structurally to an organization is a crucial factor in the inter-personal conflict experienced by the Trinity management team. Fourth, it appears that the unique properties of this project were not considered vis a vis the issue of family violence and the need for family violence practitioners to have a clear reporting relationship where crucial policy and procedural decisions could be made immediately when the seriousness of the practice issue necessitated such a decision. Last, given the complexity of inter-organizational relations where organizational dimensions such as comparative structure, size and philosophy determine the success or failure or organizations being able to engage in a collaborative process, it appears that the emergent issues in the relationships between the three agencies were not resolved during the strategic planning process.

Although the project was approved for funding and transferred back to the Area Office of COMSOC for implementation, the lack of conflict resolution among the parties finally resulted in a withdrawal of the C.K.W.C. and the subsequent termination of the contract by the L.B.P.C.

The project has been implemented as Family Violence Services with sponsorship by the C.K.W.C. and the L.B.P.C. as a fee for service contract entity, however the lack of integration of the
which is provided by CKC & FS has produced a less than successful service delivery system for the clients it seeks to serve.

The scarcity of resources for families in this community who are involved in violent interaction necessitates that agencies interact in the external environment as more open systems. The process and outcome of the development of this inter-organizational project, while successful with the two agencies involved, illuminates the need for careful planning for integrated service delivery systems.
II. Client Profile Data

Socio-demographic data. During the period of operation of the Family Violence Project from September, 1988, to the end of the data collection for research purposes on May 30, 1988, thirty-nine female clients and twenty-five male clients were seen. The referral sources for males were: L.B. Pearson Centre - 28%; Women's Centre - 28%; Crisis Component Family Violence Service - 12%; self - 12%; and, "Other" - 20%. For females, the referral sources were: L.B.P.C. - 41%; W.C. - 33%; Crisis Component - 8%; Self - 8%; and, "Other" - 10%.

The mean age of male clients was 30.8 years while the mean age for female clients was 31.9 years. The age range for male clients was 23-44 years and for female clients the range was 19-41 years. Fifty-five percent of the male client group were married with: 32% reported living common-law; 12% reported being separated; and, 1% reported being divorced. The marital status of female clients was reported as: 38% were married; 31% reported living common-law; 21% reported that they were separated; and, 10% reported being divorced.

The gross income of the client group revealed that for male clients: 32% reported incomes of 0-$15,000; 40% reported income of $15-30,000; and 28% reported incomes of $30-50,000. The data for female clients indicated that 54% of females earned 0-$15,000; 33% earned between $15-30,000; and, 13% earned between $30-50,000. Some of the female client data were reported as overall family income not individual income.
The ethnic background of the client group was identified as Canadian for 28% of men and 37% of women. Further, 40% of men reported French/Canadian, French/Belgian backgrounds, while 23% of women reported the same ethnic groups. The remaining 32% of males and 40% of females reported ethnic backgrounds as Dutch/Canadian, German, Scottish, Irish, Yugoslavian, Polish, Native and American.

The identified religious affiliation of 65% of the male clients was reported to be Roman Catholic with 53% of women reporting this same affiliation. Twenty-two percent of males and 16% of females reported they were Anglicans. Thirty-one percent of females reported other denominations such as Jehovah's Witness, Baptist and United, while 13% of males reported other religions as Baptist, United and Presbyterian.

When asked about levels of education, 92% of the females reported they had attended high school, 5% had completed grade school education and 3% had post-secondary education. For males, 92% reported they had attended high school, with 4% reporting grade school and 4% reporting post-secondary education.

The occupations of the male family violence clients were as follows: labourers 56%; 32% classified as "other", including skilled trades, self-employment, farming and managerial; and 12% reported they were unemployed. The female clients reported that: 38% were in clerical or semi-skilled occupations; 30% were labourers; 22% were homemakers; 5% in managerial; and, 5% were in skilled trades.
When asked if they were involved with any other agencies, 20% of males said they were involved with C.K.C. & F.S., compared to 11% of female clients. Specific agency involvement for males was: 20% - M.H.C.; 15% - C.A.S.; 15% - L.B.P.C.; and, 30% - "Other", including, Probation & Parole, Brentwood Alcohol and Drug Treatment Centre and the Women’s Centre. Female clients reported agency involvement as: 17% - C.K.W.C.; 14% - L.B.P.C.; 14% - C.A.S.; 9% - M.H.C.; and 35% - other, including Southwestern Regional Centre, Chatham Kent Health Unit, The Inn, Brentwood and Probation & Parole.

Family data. In examining data on the families who are clients of F.V.S., it was discovered that the mean age of the 89 children who were part of F.V.S. was 7.2 years. Further, natural mothers comprised 95% of client groups with step-mothers representing 4%, and "other" comprising 1%. The father's relationship to the children yielded data which showed: 68% of males were natural fathers; 30% identified themselves as step-fathers; and, "other" relationships to the children represented 2% of the male client group.

History of abuse. Information on the background of abuse was gathered from the clients of family violence service at intake. In examining the ages of clients at the beginning of their relationships, the age ranges for men were from 14 to 39 with a mean age for beginning of 21.5 years. Similarly, females had an age range from 13 to 34 years with a mean age of beginning their relationship as 20.6 years.
When asked the ages when they got married: males responded a mean of 23.3 years; and, females responded with a mean of 22.5 years. Further, when asked their ages when they started living together: males reported a mean age of 23.8 years; and, females reported a mean of 21.8 years.

Clients were then asked whether there was any physical violence between their parents, or between the parents and children in their own families of origin. Forty-nine percent of the males reported physical violence between their parents and 55% of males reported physical violence between parents and kids. Further, 55% of females reported physical violence between their parents and 45% reported violence between the parents and children in their families.

When asked if there was any physical abuse in any previous relationships, 27% of males and 39% of females reported that there had been physical abuse. When asked if they abused or were abused before getting married/started living together, 77% of the males reported "no"; and, 13% of males stated "yes". As well, 31% of the females reported "yes" to abuse before marriage/living together, and 60% stated "no" to this question. In another dimension of abuse, female clients were asked if they were assaulted during pregnancy: and 53% of females replied "yes"; and, 47% stated "no" to this question.

Further, 43% of the males stated that the first abuse incident occurred from 0-6 months after getting married/living together, with 40% of females reporting this as the same time of first abuse. Fourteen percent of males and 23% of females stated
that the time of first abuse occurred from 6 months to one year after getting married/living together. Finally, in this regard, 43% of males and 37% of females reported the first abuse as occurring after one to five years of habitation.

When questioned about the number of times they had abused or been abused since getting married/lived together: 58% of males reported from 1 to 10 abuse incidents; with 42% of males reporting more than 15 abuse incidents. Similarly, 53% of the females reported from 1 to 15 abuse occurrences, and 47% of the females reported more than 15 such abuses. When asked how long it was between abuse incidents, 29% of the males reported from 1 to 7 years, and 6% of the females reported this same time interval. Fifty-two percent of the males said the time between abuses was from 1 to 6 months, and 70% of the females reported this same time period. Fifteen percent of females reported abuse incidents weekly, with 9% of males stating this also. Finally, 9% of females reported abuse incidents occurring within 3-5, days with 9% of males reporting this same time period between abuse incidents.

When asked when the last incident of abuse occurred, 30% of males and 24% of females reported 1989. For 1988, 65% of males and 56% of females identified this as the last incident of abuse. Further, 15% of female clients reported the last abuse as 1987 with 5% of males stating this also. When asked if they had been separated from their current partner before, 62% of males said "yes", and 80% of the females reported previous physical separation.
Next, clients were asked questions about the involvement of the legal system with their family violence problems. Sixty-eight percent of the men stated that the police had not been called at the time of the abuse, with 54% of females similarly reporting no police involvement. When asked if charges were laid for an abuse incident, 64% of men said "no", and 71% of the women said "no". Clients were asked if there were charges pending, and 73% of males and 80% of females said "no".

The sample's responses to the question of having a criminal record revealed that 43% of the male clients and 26% of the female clients had a criminal record. When asked if their partner had a criminal record, 19% of the males said "yes" and 46% of the females identified that their partners had a criminal record.

Finally in this context, clients were asked if they had ever been treated medically for injuries from abuse. Ten percent of the males stated "yes" to this, and 34% of females stated they had been treated in this regard. When asked if their children had seen or heard the violence, 100% of males reported "yes", and 80% of the females stated "yes". Further, 59% of the males and 66% of females reported that their children had tried to interfere in violence episodes.

Clients were questioned about the seriousness of the violence in their relationships. Males responded as follows: 20% - 'not at all'; 45% - 'somewhat of a problem'; and, 35% - 'a serious problem'. Females reported the seriousness of the violence as follows: 3% - 'not at all'; 20% - 'somewhat of a problem' and, 77% - 'a serious problem'. 
Alcohol and drug involvement. When asked if they thought they had a drinking problem, 32% of males and 9% of females said they did. Males described the seriousness of their drinking as "somewhat of a problem" (57%), and 43% indicated a serious problem". When asked if they thought their partner had a drinking problem, 18% of males said "yes", with 75% of those responding "yes" describing the problem as a serious one. Fifty-three per cent of female clients of F.V.S. stated that their partner had a drinking problem, and 33% stated that it was a serious problem.

Finally, when asked if they had a drug problem, 14% of the males reported "yes", with 67% stating that this was a serious problem. Female clients reported that 3% thought they had a drug problem. When asked if they perceived their partner had a drug problem, 86% of male clients said "no". Of those 14% stating "yes", 67% described the drug problem as serious. When females were asked if they thought their partner's had a drug problem, 29% stated "yes" with 70% of these indicating that the drug problem was indeed serious.

Discussion

The finding of a mean age of 30.8 years for males and 31.9 years for females was somewhat surprising as one might have expected the population to perhaps be younger on the whole. Also, given the findings that the age of beginning of relationships was approximately 21 years and that abuse occurred before getting married for 31% of females, the question of how people have been dealing with the issue of long term family
violence in this community previous to the inception of the F.V.S. Project needs to be assessed.

As well, the occupational data reflected a group designated as "labourers" for males and clerical or semi-skilled for females. The religious affiliations for both the majority of males and females was Roman Catholic. It is of interest that this religious background is over-represented when compared to the general population in this community. One may speculate that involvement of a priest in these families has influenced marital partners to seek help to maintain their marriages reflecting the Catholic church’s position on marriage and divorce.

The family data revealed that natural mothers and natural fathers comprised the majority of the population, although there were more reported step-fathers than step-mothers. The mean age of the children in this population was 7.2 years reflecting the previously mentioned older age of their parents than one would have expected. In general, the clients were older than expected given the reported young ages of beginning the relationships.

In regard to the literature on family violence which describes the cycle of violence from generation to generation in such families, this population reported that for 49% of the males and 50% of the females, there had been violence between their parents. Further, 55% of the males and 45% of the females reported violence between the parents and children in their families of origin. There was a great deal of congruence in these responses between males and females. It may be that violence as a family coping style is a learned behaviour which
violence as a family coping style is a learned behaviour which people from similar backgrounds tolerate in each other when they begin a marital relationship. Further, it could be assumed that when people from violent families interact with people from non-violent families, the relationship may end quickly as the partner from a non-violent background cannot or will not generally tolerate physical abuse. Indeed, this population further reported similar percentages of male to female abuse when asked about abuse in previous relationships, establishing a viewpoint again which suggested that physical violence was tolerated both before and during the relationship for many in this group. As well, 31% of females reported that there was violence before getting married/living together.

Perhaps one of the most dismaying findings was the reporting by both males (43%) and females (40%) that the first abuse incident occurred from 0 to 6 months after getting married/living together. Given the age of the population and the young age of the beginning of their relationships, the finding suggested a long history of physical violence in the relationship and adds further credence to the argument that this population can only be helped by long-term therapy. Further, it was of great concern that 53% of the female clients replied that they had been assaulted during pregnancy. This finding was troubling by itself but takes on more importance when juxtaposed against the finding
that there were no referrals from physicians to family violence services. The assumption could be made that these female clients are receiving pre-natal care and if this is so, the medical community needs to be alerted to this dimension of abuse.

The population also reported some disturbing trends in describing the violence in their families with a large number of them reporting more than fifteen abuse occurrences, and also that the abuse incidents happened between one and six month intervals. The dysfunction in these families is further illuminated by both males (62%) and females (80%) reporting previous separations. More specifically, family breakdowns appear to be occurring in these violence families with their attendant stresses both on the parents and perhaps more importantly on the children. The lack of stability, safety and security these separations produced may be assumed to have a major negative impact on the developmental stages of these children.

Further, the client data revealed that parents overwhelmingly stated that their children had seen or heard the violence and the majority reported that their children had tried to interfere in the violence episodes. This information is troubling to human service professionals who are knowledgeable about the family systems which are responsible for the healthy growth and development of children. It may be that preventative services for children need to be highlighted as the next wave of family violence intervention. The type of educational programming for child sexual abuse which has created an awareness of the impact of this problem on children's emotional functioning could be developed for children from violent homes thereby developing
a societal awareness of the impact of this dysfunctional relationship style. It is hoped that this awareness would lead to community advocacy for changes in policy, legislation and funding to protect children and their rights.

The changes in legislation and policy which have seen the involvement of the judicial system in this problem in the larger society are not reflected in the findings on the population in this study. More specifically, the majority of males and females with a disturbing degree of congruence stated that the police were not called at the time of the abuse, nor were charges laid, nor were charges pending. Interestingly enough, while males and females similarly reported information on no police involvement, when asked if they had a criminal record, 43% of the males said "yes" and 26% of females said "yes". It may be valuable at some time in the future to further assess the nature of these criminal records to see if there is extra-familial violence present. While the police apparently are not being called in these cases, medical attention was sought by 34% of the females. Again, this finding is of serious concern given the lack of referrals by physicians to the project as a whole. Both of these findings are important in the development of future family violence services and add further weight to the proposed domestic response team concept with structural linkages to the emergency rooms of the hospitals, the police, the crown attorneys office and the court system.
The findings related to alcohol and drug involvement substantiate the assumption that these are multi-problem families with addiction problems contributing to or exacerbating the family violence problem. Alcohol was seen as a more serious problem for males than drugs. Fifty-three per cent of the female clients of the F.V.S. stated that their partners had a "drinking problem". This finding is congruent with what is known about alcohol abuse and family violence. The implications for treatment in this regard are crucial and may require a better integration of multiple community based services to deal concurrently with the abusive behaviour and the addictive behaviour. The coordination of programs between the addictions program in Kent County and the F.V.S. may need to be more fully developed and defined in order to offer this population the most appropriate treatment milieu.

Finally, the responses of the males and females to the question of how they would rate the seriousness of the violence in their relationship provided a chilling documentation on male and female perceptions of violence. Specifically, the majority of females (77%) reported that violence was 'a serious problem'; conversely only 35% of the males reported violence was 'a serious problem' with 45% stating it was somewhat of a problem, and 20% stating it was not a problem at all. This minimizing of the seriousness of family violence by males holds significance for treatment implications. It may be that the type of confrontational therapy used in alcohol and drug treatment may be useful with this population. The alcohol and drug problems of
this population are clearer to males and females when they reported on levels of seriousness of this problem.

The seriousness of the violence behaviour, however, is perceived radically differently by males and females. The motivation and commitment to long term therapy may be seen to be lacking in males whose belief system minimizes the seriousness of the problem. The recent public education campaign on family violence carried out through the television media may need to be augmented in order to create an awareness among men who batter than family violence will no longer be tolerated by the legal system or the society at large.

III. Intake/Assessment Data

During intake and assessment the clients received the intake/assessment package previously described in pages 48-51. The assessment instruments were chosen in consultation with the Family Violence Services team and the evaluation consultant (Dr. M. Holosko). The instruments which are contained in this intake/assessment package were utilized by project staff at intake and provided standardized measurements of the dimensions of family violence thought to be applicable to the treatment intervention. The average length of time to administer the intake/assessment package was four hours over the time period of two intake visits.

The presentation of these results and discussions are confined to only those intake/assessment data sources which had a meaningful sample size and from which descriptive statistics
could be extrapolated. These included the following scales: 1) Scales of Perceived Social Support (Macdonald, 1987); 2) Index of Spouse Abuse (Hudson and McIntosh, 1981); 3) Child Behaviour Checklist for Ages 2-3 (Achenbach, 1979); 4) Child Behaviour Checklist for Ages 4-16 (Achenbach, 1979); and, 5) Self-Perception Profile for Children (Harter, 1985). Excluded were: 1) Social Contacts Questions; 2) Conflict Tactics Scale (Straus, 1979); 3) Youth Self-Report for Ages 11-18 (Achenbach, 1981). The presentation of the scores upon intake precedes a discussion of these findings.

**Presentation of Test Scores**

1. **Perceived Social Support.** As was previously indicated in the description of the intake/assessment process, a number of scales and instruments were sought out and used to determine assessment data.

   One of the main issues derived from the literature and treatment experience with this population has to do with perceived social support by family members and friends. This variable was assessed by Macdonald's (1987) Scale of Perceived Social Support (see Appendix B) which was administered to all females and males who entered the project. It assessed the extent of external social support in two primary dimensions; family and friends. Table 1 indicates the test scores received by females and males in the sample.
TABLE 1

Scales of Perceived Social Support (MacDonald, 1987)
Mean Scores (x) Male and Female at Intake (N = 42)

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
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<tbody>
<tr>
<td>Family</td>
<td>Friends</td>
</tr>
<tr>
<td>Mean Scores</td>
<td></td>
</tr>
</tbody>
</table>

High scores in each of the dichotomous networks reflects high levels of perceived support. The mean scores for male and female clients are shown in Table 1. Males reported a mean score of 106 on the social support scale by family and a mean of 102 on the scale for friends. Females in this population scored a mean of 99 on the scale for family and a mean of 102 on the scale for social support by friends. The mean scores for a mixed normal sample of males and females reported by Macdonald (1987) were a mean of 115 on the social support scale by family and 112.5 on the scale for support by friends. In comparing the results of
this population against the scores for a normal population, 69% of males and 73% of females are below the mean of 115 reported for family support. Further, 69% of males and 62% of females fall below the mean of 112.5 reported by Macdonald for social support by friends. It is interesting to note that the mean scores for support in a population of alcoholics were 109.9 for family support and 104.4 for friend support. Both of these mean scores are higher than the mean scores reported by the population served by family violence services.

2. Spouse Abuse. Obviously, the designers and practitioners of the project were very concerned about the extent and nature of spousal abuse amongst this population. The literature has very few empirical assessments of this phenomenon; however, one measure which has excellent reliability and validity for adult populations is the Index of Spouse Abuse (Hudson and McIntosh, 1981) (see Appendix B). As indicated in the previous sub-section, this measure was only administered to female clients and upon administration, scores could be analyzed in terms of a non-physical abuse dimension as well as a physical abuse dimension. Table 2 presents the scores for the 30 females who completed this index.
TABLE 2

Index of Spouse Abuse (Hudson & McIntosh, 1981)
Mean Scores of Female Clients at Intake (N = 30)

<table>
<thead>
<tr>
<th></th>
<th>Non-physical</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>47</td>
<td>33</td>
</tr>
</tbody>
</table>

This instrument was designed to measure the degree of severity of physical or non-physical abuse inflicted on a woman by her spouse or partner. The Index of Spouse Abuse contains two clinical cutting scores: for the ISA-P scores above 10 indicate the respondent is likely to be a victim of serious physical abuse and for the ISA-NP scores above 25 indicate the respondent is likely a victim of serious non-physical abuse. Females in this population scores a mean of 47 on the non-physical abuse dimension and 33 on the physical abuse dimension. Forty-seven per cent of female clients scores above the clinical cutting.
score of 47 on the non-physical abuse dimension with scores ranging from 21.3 to 87.2. Further, 97% of the clients scored above the clinical cutting score of 10 on the physical abuse dimension with scores ranging from 6.8 to 73.5. Hudson and McIntosh (1981) reports mean scores on the ISA for a group identified by others as abused as 45.2 on the ISA-P and 58.9 on the ISA-NP while for the non-abused group mean scores were only 3.8 on the ISA-P and 8.3 on the ISA-NP. The mean scores for females in the family violence services population are much closer to the mean scores of the clinical sample reported by Hudson and McIntosh (1981) of 107 women who were involved with social agencies and protective shelters. This data suggests that as a measure for clinical evaluations of spouse abuse, the ISA is serving as an important instrument for assessment of the population served by F.V.S.

3. Child Behaviour. Given the understanding both from the literature and from direct clinical experience that familial violence has a dramatic effect on the lives and behaviour of children, the need for a behavioural assessment instrument for children was crucial to the assessment component of the project. In order to assess whether the spousal violence of their parents was a factor in the empowerment of the educational and/or social functioning of the children in these families, a decision was made to use the Child Behavior Checklists (Achenbach, 1981) (see Appendix B). These instruments had been used successfully at the L.B. Pearson Centre for Children and Youth and were adopted by the F.V.S. as an assessment tool. The instrument obtains
competence and are designed to be self-explanatory for parents with reading skills as low as the fifth grade. Table 3 indicates the mean scores for children 2-3 years on the behaviour problem scale and the mean scores for children from 4-16 years on the behaviour problem scales and social competence scales.

**TABLE 3**

Achenbach Child Behavior Profile (Achenbach, 1979)
Mean Scores of Children at Intake (N = 60)

(Age - 2 to 3 years)  (Age - 4 to 16 years)

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Child Behavior Checklist for Ages 2-3 (Achenbach, 1981). This profile allows the comparison of a parent's description of his or her child with what other parents report at different points in time. T scores range from 55 to 100 on the problem scales, high scores (above T = 70) on the problem scales are considered deviant. The mean score for children tested by Family Violence Service was 61.7 on the behavior problem scale with 20%
considered deviant. The mean score for children tested by Family Violence Service was 61.7 on the behavior problem scale with 20% of children being above the T score of 70 and the range of T scores for this age group being 41 to 87.

**Child Behavior Checklist for Ages 4-16** (Achenbach, 1979). The checklist for this age group consists of behaviour problem items and social competence items. T scores range from 55 to 100 on the problem scales with high scores (above T = 70) on the problem scales being considered deviant. The T scores range from 10-55 on the social competence scales with low scores (below T = 30) being considered deviant. The mean scores reported for children from Family Violence Services were 58.3 on the behaviour problems scale and 39.6 on the social competence scales with 48% of children being above the T score of 70 for the behaviour problems scale and 2% of children being below the T scores of 30 for the social competence scale.

While the children in this sample achieved mean T scores below the T score of 70 reported as deviant by Achenbach, the mean scores are close enough to the cutting score of 70 to suggest that these children are exhibiting behavioural problems closely approximating those of children referred to mental health services. Further, while the mean T scores are below 70, in the age group 2-3 years, 20% of the children were above the cutting score. Similarly, in the age group 4-16 years, 48% of the children were above the cutting score considered deviant. Finally, on the social competence scale, the mean score of 39.6
is above the cutting score of 30 for this age group. The scores they received are close to the population of children referred to children's mental health services as reported by Achenbach (1979).

Self-Concepts of Children. In order to assess further the adaptation of children to their experience of living in families where violence is present, it was deemed important to try to ascertain the strengths of these children as well as their problems. In this regard, the author sought instruments which would assess the competency and skills of children. During the evaluation process, the author discovered the Self-Perception Profile for Children (Harter, 1985). This instrument is suitable for children 8 to 14 years. The profile contains six separate sub-scales examining five specific domains as well as global self-worth: 1) Scholastic Competence; 2) Social Acceptance; 3) Athletic Competence; 4) Physical Appearance; 5) Behavioural Conduct; and, 6) Global Self-Worth. The actual questionnaire filled out by the child is entitled "WHAT I AM LIKE" (see Appendix B). This instrument which has reliability and validity for these sub-populations was presented to the team for inclusion in the intake/assessment package. Table 4 shows the sub-scale means for the F.V.S. child population.
TABLE 4
Self-Perception Profile for Children (Harter, 1985)
Mean Scores of Children at Intake (N=20)
(Ages 8 to 14 years)

![Bar chart showing mean scores for SC, SA, AC, PA, BC, and GSW]

*NOTE: Sub-scale definitions
SC = scholastic competence
SA = social acceptance
AC = athletic competence
PA = physical appearance
BC = behavioral conduct
GSW = global self-worth

The mean scores represent the total mean for both males and females in the population and were representative of the scores for twenty children who received the questionnaire. Mean scores reported by Family Violence Services clients on the subscales...
were: Scholastic Competence - 2.7; Social Acceptance - 2.9; Athletic Competence - 2.7; Physical Appearance - 2.3; Behavioural Conduct, 2.8; and Global Self-Worth - 3.1.

Mean scores reported by Harter (1985) for sub-scale means for grade 6 boys and girls were: Scholastic Competence - 2.9; Social Acceptance - 2.9; Athletic Competence - 3.0; Physical Appearance - 2.8; Behavioural Conduct - 2.9; and, Global Self-Worth - 3.1.

The mean scores of the children involved with the Family Violence Project are congruent with the grade six sub-scale means of a normal population of 1,527 children in Colorado. This finding may reflect the limited sample size available through the F.V.S. project and suggests that as this instrument continues to be used by the F.V.S. project, further data should be collected which would allow for a better comparison with the normative scores reported by Harter (1985). The small sample size from F.V.S. does not allow any inference to be made regarding the competencies and global self-worth of these children at the time of this report.

Discussion

A discussion of the data collected through the assessment instruments yields much information that is valuable in both understanding and treating this population. The test results of the Index of Spouse Abuse reflect the severity of the physical abuse experienced by the female clients of F.V.S. Given that the criteria for inclusion in F.V.S. was one instance of physical abuse, the finding that 47% of clients are experiencing serious
physical abuse adds weight to the gravity of this problem in Kent County. Indeed, the impact of this finding suggests the necessity for further continuation and development of this specialized intervention.

Although the mean scores for this population on the social support scale are close to the normative scores, the findings do reflect that this population does in fact score lower on the social support scale. Females especially have a mean score of 99 on the scale for family support as contrasted to males whose mean score for family support was 106. This may suggest some isolation of females from their support systems. It may further reflect the tendency for women who are abused to hide their imperfect marriages or relationships from their families, and/or friends. Further, the provision of the women’s group component to these clients may have a major impact on their social support networks in the future.

Similarly, the T scores reported for children on the Achenbach are close enough to the identified deviant T scores of the Achenbach on both the problem scales and social competence scales, should be of concern to practitioners responsible for the treatment interventions provided to the families through this project. The stress on the family which is dealing with behaviour problems of children as well as the marital violence of the spouses necessitates the continued therapeutic involvement of the F.V.S. project. Further, the ability to prevent problems for the children of these domestic violence families requires that early intervention take place, and the findings from the
Achenbach profiles suggests the consequences of marital violence are manifesting in the behaviour of these children.

Interestingly, the mean scores for the children on the Harter scales are close to the mean scores reported by Harter (1985) for a normal population of grade school children in Colorado.

The normative scores reported for children may in fact only represent an artifact of the small sample size and should not be construed in any way to suggest that the domain competencies, and/or global self-worth of these children are that approaching a normal sample. Harter (1985) stated that this instrument may not be suitable for specialized populations and further utilization of this instrument will yield valuable information for the project on its usefulness as an assessment tool.

Finally, the assessment instruments have shown themselves to be useful as clinical tools in working with families of violence and their continued use and monitoring will provide F.V.S. with helpful documentation regarding the identified variables they seek to assess.
IV. Inter-O rganizational Survey

The inter-organizational survey was conducted with a number of key community informants (see Appendix D) in Kent County. Respondents were asked a series of questions which yielded general information based on identified inter-organizational variables. Further, informants in each domain were asked questions concerning variables specific to their respective domains. The synthesis of the qualitative data gained from these interviews is shown in Exhibit C. The presentation of these data is broken down into general inter-organizational information which includes: 1) joint activities; 2) formal agreements; 3) board members; 4) operating conflict; 5) domain consensus; 6) goal similarity; 7) service utilization; and, 8) structural perception and specific inter-organization domain data including information about: 1) providers of complementary services; 2) recipients and consumers; 3) competing organizations; 4) providers of legitimation and authority; 5) providers of fiscal resources; and, 6) providers of clients. The presentation of these data is followed by a discussion.

I. General Section

1. Joint Activities

The majority of community respondents indicated that their organizations had been involved in working co-operatively with the F.V.S. in either planning or implementing activities. Activities mentioned included: planning to develop the project; joint training sessions; case-planning activities; and the
provision of resources. Further, a number of respondents stated that they had been directly involved in the K.C.T.F.F.V. and saw this as a key involvement in the development of the project.

2. Formal Agreements

Respondents generally perceived that formal agreements per se were only as valuable as the informal relationships between parties to honour them. It was also expressed that if a model for an integrated service delivery system for family violence was going to be developed, there could be a need for the model to be clearly outlined so that other programs would have the benefit of the developmental process experienced by this project. It appears that the majority of respondents stated that at a practical level, the system is operating well without formalized written agreements but, should other organizations become integrated into the model, there would be a need to move from the individualized approach to a more formalized approach.

3. Board Members

The most frequently reported participation in this area was involvement of the respondents with the K.C.T.F.F.V. Since F.V.S. no longer has a strategic planning team or advisory committee which could incorporate representation from these agencies; the linkages with the sponsoring organization were only minimal. The inclusion of the K.C.T.F.F.V. in the responses of those being interviewed suggested that there may not be clarity about the actual structural and unique properties of the F.V.S.
4. Operating Conflict

A major philosophical difference among community respondents appeared to be related to the concept of victimization, with some stating that systemic family therapy modes of practice do not adequately address the issues of violence. Organizationally, it appears that each agency's operating philosophy may be different, but with a focus on the primacy of service to the public. In short, the respondents appeared to have negotiated any serious philosophical differences between themselves and the F.V.S.

5. Domain Consensus

The respondents expressed a desire to see more integration of services to include men's groups, and to increase the amount of co-ordination and collaboration at a community level. Further, the increasing of a resource base which would allow for a better physical environment, for an identified project co-ordinator and more community education was identified by a number of respondents. An important dimension for future consideration was more liaison with emergency rooms of hospitals, police and the court system. Finally, the majority of respondents stated that they are committed to supporting and advocating continuation of the service.

6. Goal Similarity

Respondents were asked how they perceived the family violence project being modified to their organization's service delivery needs. In general, they stated that they would like to see: 1) an expansion of the CKC & FS batterers group from 10
weeks to 30 weeks; 2) centralized intake and assessment for all domestic response calls; 3) a clearer role clarification about what other agencies are offering to families where violence is present; and, 4) an expansion of eligibility criteria to include other forms of family violence.

7. Service Utilization

The informants stated that these specialized services were needed and that the termination of funding for the project would create an ethical problem for some agencies who would be then forced to handle family violence problems because there would be no services in the community to refer clients to. In short, they would have to stretch their service mandates to include such clients. However, the respondents stated that if funding were discontinued, perhaps clients would be forced into isolation with the resultant "hiding" of the problem. The responses to questions regarding service utilization are shown in Table 5.

<table>
<thead>
<tr>
<th>Table 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Ratings of Importance of Family Violence Services (N=13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Grouping</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Service</td>
<td>76.9</td>
</tr>
<tr>
<td>Consultation</td>
<td>46.1</td>
</tr>
<tr>
<td>Training</td>
<td>38.4</td>
</tr>
<tr>
<td>Community Education</td>
<td>23.3</td>
</tr>
</tbody>
</table>
The responses to the question of which services have been of most benefit to the organization are shown in Table 6.

Table 6

Importance Ratings of Services Provided by Family Violence Project (N=8)

<table>
<thead>
<tr>
<th>Service Utilization</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Individual Counselling</td>
<td>5</td>
</tr>
<tr>
<td>Women's Groups</td>
<td>3</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>5</td>
</tr>
<tr>
<td>Parenting Counselling</td>
<td>5</td>
</tr>
<tr>
<td>Child Psychotherapy</td>
<td>2</td>
</tr>
<tr>
<td>Pre-School Children's Group (3 1/2 - 6 yrs.)</td>
<td>2</td>
</tr>
<tr>
<td>School-Age Children's Group (6 - 8 yrs.)</td>
<td>3</td>
</tr>
<tr>
<td>Older School-Age Group (8 - 10 yrs.)</td>
<td>3</td>
</tr>
<tr>
<td>Young Adolescent Group</td>
<td>3</td>
</tr>
<tr>
<td>Older Adolescent Group</td>
<td>3</td>
</tr>
<tr>
<td>Parent Group</td>
<td>1</td>
</tr>
<tr>
<td>Community Education</td>
<td>3</td>
</tr>
<tr>
<td>Consultation</td>
<td>3</td>
</tr>
<tr>
<td>Staff Training</td>
<td>3</td>
</tr>
<tr>
<td>Case-Sharing</td>
<td>3</td>
</tr>
</tbody>
</table>
8. Structural Perception

Respondents were finally asked whether they saw the Family Violence Project as a separate and distinct entity. The majority of informants did not see the project as a distinct entity, but as a form of service provided by the two sponsoring organizations. As well, some respondents stated that the project needed to be separate and integrated into the police system in the form of a domestic response team which co-ordinates all services to work together within the family violence domain. Further, a number of respondents expressed the opinion that the project exists as a result of the K.C.T.F.F.V., and that this organization would be an effective advocate for funding for F.V.S. Finally, respondents were asked what was the primary goal of F.V.S. The two main findings resulting from this question were: a) to stop the violence within the family; and, b) to provide a co-ordinated approach to services to families who are victims of violence.

II. Specific Domains

1. Providers of Complementary Services

Respondents were asked how the service offered by their organization complemented the work of family violence services. They indicated that they acted as a referral service back and forth, and provided treatment resources and consultation to the project in their specific areas of service delivery. Respondents were then asked whether better administrative or service linkages could be developed. The respondents stated
that it would be advantageous to have a liaison between agency directors and board members of F.V.S. for additional information sharing. Informants were asked in what ways they saw their organization continuing to be involved with F.V.S. They stated that although they were interested in making referrals to F.V.S., and in seeing the community education component continue; their own needs to address their organization's service delivery needs were the primary focus of involvement.

2. Recipients and Consumers

When asked how Family Violence Services had affected programs in their organization, respondents replied that the Project had provided services which allowed them to render services to clients who would otherwise have to be put on a waiting list. The respondents stated that family violence services were an important contribution to the community both in direct service programming and in training for others in clinical practice related to family violence.

Respondents were also asked about possible resources they could provide, and in this regard stated that they were prepared to work in a collaborative way with other agencies and mentioned such resources as: space, secretarial support, supervision, shared training, consultation, psychological assessment services and support groups. The respondents were also interested in sharing training among agencies and were prepared to commit resources to the process of problem sharing for the maintenance of the project.

3. Competing Organizations

The major service provided in this domain is counselling;
individual, couple, children, adolescents and family therapy. In this regard, there was little or no contact and joint activities between the organization and F.V.S. project. In fact, one of the identified organizations in this domain did not make themselves available for inclusion in the survey despite repeated attempts to provide this opportunity.

4. Providers of Legitimation and Authority

Respondents were questioned regarding their involvement with F.V.S. at the board and committee levels. Most respondents stated that they had been involved with the development of the collaborative model and were prepared to offer their consultation in inter-agency collaboration. In response to a question regarding overlapping board membership between sponsoring agencies and the respondents organizations, it appears that there are established linkages between these bodies. Most importantly however, respondents perceived their linkage with the K.C.T.F.P.V. as a crucial linkage to the F.V.S. Project. Finally, those interviewed in this area were asked to provide input into how the F.V.S. could be modified. Modification suggestions included: ensure the K.C.T.F.P.V. knows what is going on; more public education on how to access services; and, better co-ordination and re-structuring of boards of directors of sponsoring organizations in order to provide an advisory committee to family violence services with citizen representation.

5. Providers of Fiscal Resources

Respondents were asked the extent to which the sponsoring organizations had provided adequate resources to them. Some
respondents stated that personnel resources had been developed very well. Others stated that the project had provided a good way of meeting client needs with staff being neither overburdened nor underburdened. Those interviewed were then asked about their knowledge of written financial agreements. Some respondents stated that at one time, there was a plan for an inter-agency agreement regarding finances, but presently the primary contract was between C.K.W.C. and COMSOC with a fee-for-service contract between the C.K.W.C. and L.B.P.C.

Finally, in questioning key informants in this area about their commitment to providing financial resources in the future, they stated that they had committed substantial resources, and would re-consider their commitment after the evaluation of the project was produced.

6. Providers of Clients

Responses to the question regarding the services used and their possible benefit to clients is shown in Table 7. Respondents were further asked how important their contacts with the F.V.S. were to the work of their respective organizations on a scale from one to five, with five being designated high. respondents rated their contacts as 4.5, suggesting that the Family Violence Project is providing an important addition to the service network in this community. Finally, when respondents were asked if their organization had any written agreements with the Family Violence Project regarding specific programs or activities, personnel commitments, client referrals or procedures for working together, one respondent stated that they did have a written agreement.
Table 7  
Importance Ratings of Services and Benefits of the Family Violence Service Project (N=6)  

<table>
<thead>
<tr>
<th>Services</th>
<th>Organization</th>
<th>Clients How Beneficial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very</td>
<td>Somewhat</td>
</tr>
<tr>
<td>Direct</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Community Education</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Consultation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Staff Training</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Discussion  
The inter-organizational interviews conducted with key informants in Kent County were a valuable source of data. Indeed, respondents were very familiar with the development of the F.V.S. Project and appeared to have invested in providing information for research purposes. In general, respondents perceived that this was in fact a community-based initiative not just a project developed by the two sponsoring organizations. The stakeholders involved also stated clearly that they saw the F.V.S. project as an outcome of the work of the K.C.T.F.F.V. It appears that the linkage between the F.V.S. Project and the K.C.T.F.F.V. is confusing to the community and the formalization of this linkage will need to be addressed at some future time.
Respondents indicated that the degree of formalization in the project was appropriate for the two particular agencies involved but said that more formalization would be required if expansion was to be considered.

Individuals interviewed clearly were aware of the philosophical differences which existed among service providers involved with the project. The majority of respondents did believe however, that major philosophical differences had been resolved and that the on-going conceptualization for the project would include a commitment to developing a more integrated feminist-family therapy orientation. The work of Luepnitz (1988) as discussed in the review of the literature in this study provides a theoretical framework for this on-going resolution of philosophical differences.

Perhaps the most important finding from these data was the overwhelming support for an expanded domestic response team in Kent County. More specifically, respondents identified that further integration should be planned which would include men's groups, more liaison with police, hospital emergency rooms and the court system. A number of respondents identified the development of a domestic response team integrated into the police system as a direction of choice for F.V.S.

Finally, key informants addressed the serious reality of ending the funding for F.V.S. and its direct implications in the community. Specifically, respondents stated that F.V.S. had provided a valuable service to the community, and the expertise
they had developed needed to continue both to exist for the client group and to provide consultation to other service providers. Finally, respondents were concerned that the ending of F.V.S. would result in the problem being hidden with families remaining isolated as they had been before in this community. While those interviewed did state clearly that the work of their organizations was of primary concern, they were more than aware that the client needs would not be met if the funding for the F.V.S. were cut. Finally, all respondents were prepared to make a commitment to advocate for this service being continued and expanded in Kent County as they saw it as: a) needed; b) meaningful; and, c) creditable.
V. Project Staff Survey

The survey for the project personnel was designed to elicit information from those involved in operationalizing the family violence project at a direct service level (N=5) (Appendix F). In the general section of the questionnaire, project staff were asked questions which paralleled data previously collected in the inter-organizational survey. In the remainder of the questionnaire, project staff were asked specific questions about staff supervision, the physical environment and program outcomes. A detailed account of the results of data collected from project staff is shown in Exhibit D.

I. General Section

1. Expansion of the Family Violence Project

Project staff were asked if they saw the family violence project being expanded to include elder abuse, sexual assault and incest survivors. Staff were generally supportive in principle of the need to expand the family violence criteria, however, they stated that program expansion would require more resources in order to be operationalized. The observation was universally made that the family violence criteria should be expanded to include: 1) those families who don’t have children; 2) the issue of children physically abusing their parents; and, 3) elder abuse.

2. Prevention Activities

Staff reported that they believed the project should be involved in prevention activities such as public education to stop
the cycle of violence. Respondents indicated that the present levels of public education should be maintained with resources committed to upgrading the clinical program. Finally, some staff responded that if any move to public education was chosen, a valuable response would be to publish information and materials on the Family Violence Project's experience to date.

3. Consultation/Staff Training

Staff suggested various ways of providing to the community the family violence expertise they had gained including: development of manuals, videos or articles, public and professional education and consultation to health, education and social service agencies. In general, project staff stated that they had learned a great deal about the families of violence, children's groups and treatment modalities and that networking in the community would allow this expertise to be shared.

4. Formal Policies and Procedures

With regard to policies and procedures, there was universal agreement among staff that the development of more policy and procedural guidelines would be helpful in delivering direct services to clients. Respondents reported that stronger policies would help to mediate the complexity of having several people administer the project which at a practice level necessitates treatment decisions around safety issues.
5. **Integration of Services**

All project staff stated that the project needed more co-ordination especially to integrate the men's group. Specifically, respondents stated that a twenty-four hour service with increased specialization of workers would be valuable. Respondents also reported that they were essentially working in isolation from the crisis component and indicated that a more effective service could be delivered if there was a comprehensive crisis response component fully integrated within the intake/assessment/intervention component.

6. **Future of Project**

Respondents stated that they would like to see continued funding as well as program expansion to include the men's group and more formal linkages with the police, the court system and the Kent County Children's Aid Society. Other respondents said they would like to see all staff housed under the same roof and with one central phone number. Project staff also all identified the need for further integration of the crisis response component and clarification of the administrative parameters of the project. Finally, some respondents indicated that the project should include a community worker to carry out community development activities and advocate for more social, political and environmental changes.
II. Issue-Specific Section

1. Supervision

Staff responded that they were aware of the complexities of managing an inter-agency project, but would have liked more explicit guidelines regarding clinical supervision and a more defined mechanism for bridging their relationships with the staff of their employing agency. Despite this, all project staff responded that they found the clinical supervision they received to be excellent. Staff further indicated that they were all provided with the most current information on treatment modalities and family violence issues by both organizational administrators.

Respondents reported that individual supervision was the major contributor to their professional development as a family violence practitioner, although (as indicated), it did not occur as frequently as they would have liked. Further, respondents stated that they enjoyed the group supervision and found it helpful to have both agencies' perspectives and to bring the team together. Peer supervision was reported to be an unstructured activity with some respondents stating that a structured activity sanctioned by administration would make the peer supervision component more effective. When staff were questioned about the staff training provided to them, they stated that the staff development component had been excellent and commented on the foresight shown by administrators to effect this level of staff training.

In response to a question whether a team leader position should be integrated into the structure of F.V.S., there was a
consensus among staff that while the team leader position would be useful, this would be difficult to implement. However, the respondents identified the following functions which they perceived the team leader's position fulfilling as: facilitating information flow between administrators and staff; co-ordination of service; and team building.

2. Physical Environment

Most respondents replied that there had been difficulties with the physical environment which were identified as follows: space at F.V.S. office was not adequate for working with families; secretary was in a different building; phone lines were different so not all phones answered family violence services; the thinness of walls in the F.V. office; hours were different for each organization; problems with secretarial space at F.V.S. office were not conducive to confidentiality; crisis component was sharing the F.V.S. office but was not integrated with intervention team; and, problems with air conditioning and heating.

When asked if they perceived the physical environment had been conducive to protecting confidentiality, staff who said confidentiality was a concern identified the following: F.V.S. office with its designation posted on the outside of the building; letters to clients on F.V.S. letterhead; and, carrying files back and forth from office to office.

Staff were further asked if the physical environment had encouraged clients to feel comfortable and respected. The
majority of staff stated that there were definite problems with the F.V.S. office given its location next to the police station, lack of space, heating and air-conditioning problems, lack of supervised play room for children and the openness (too open) of the secretarial space.

In response to a question about what modifications could be made to provide better service, respondents suggested the following: that the team be housed within the same facility; to ensure one secretary was co-ordinating calls; staff access to files, resource material and each other; and, to facilitate clients knowing in which of the three offices they would be seen.

Staff also reported the following client comments on the physical environment: visibility of computer screen in waiting room; lack of air conditioning; having to call to find out where they were being seen; furniture not comfortable; no room for children to play in, and smoking/non-smoking differences among the various offices.

The majority of staff stated that it would be advantageous for all family members to be seen within the same facility; however, the security issues were of primary concern to team members. Staff stated that in order to see families within the same facility, specific steps would have to be taken to insure that safety is maintained.

Finally, staff were asked if the physical space provided had allowed for interaction with fellow team members. Staff responded that ideally, they would like to be housed together with secretarial resources, information resources and other team members easily accessible within the physical structure.
3. **Program Outcomes**

Project staff were interviewed about various dimensions of program outcomes which included: contracting, support services, identified gaps in service, client outcomes and clinical dilemmas. All staff reported that family violence clients require long-term intervention and do not fit within the model of 12 week contracts and re-contracts. Further, all staff reported that they had had to re-contract with all clients. Further, when respondents were asked what community support services they had planned for clients, they identified the following services: C.K.C. and F.S., L.B.P.C., C.K.W.C., C.A.S., Health Unit, A.I.R.S. Program, Big Brothers, Big Sisters, Probation, Mental Health Clinic, Separated and Divorced Groups both Catholic and Protestant, Self-help groups for non-custodial parents, Sexual Assault Centre, Crossroads program of C.K.C. and F.S., private therapists, Al-Anon, Alateen, A.A. Addictions Program-Mental Health Clinic, camps and playground groups at L.B.P.C. and Windsor Western Hospital.

Project staff also identified the gaps in service to this population as lack of: integration of men’s group with F.V.S.; support groups; drop-in programs for children; linkage between C.A.S. and F.V.S.; treatment groups for women; incest survivors groups; partners of incest survivors group; services to adolescents 15 years to 18 years. They would like more integration of services between F.V.S. and police and crown attorneys; and, more treatment groups to develop inter-personal skills for adults who have experienced physical abuse as children.
Staff were further asked what support services they would like to see developed in the community for family violence clients. Service priorities identified were: more integration with the men's group component; protocol development between C.A.S. and F.V.S.; a crisis response team with trained counsellors; on-going groups for children; community resource drop-in centre; incest survivors group with strong clinical focus; and, groups for partners of incest survivors.

In terms of client outcomes they would like to see, all respondents replied that they would like the family violence to stop. Further, staff identified that they would like to see changes in the children's attitudes and behaviours especially in problem-solving and coping skills. Finally, staff identified that they hoped for an increase in the social skills of children to avoid a repetition of the cycle of violence in the future relationships of the children.

In an effort to determine further program outcomes, project staff were asked what kinds of gains they perceived their clients to have made during their involvement with family violence services. Respondents reported the following perceived gains: insight into dynamics of family violence; improvements in mother-child interactions and reductions in children's inappropriate behaviours; women's empowerment as individuals and parents; children empowered around safety issues; more realistic gender belief systems; and, couples had examined their relationship and had made a commitment to stay, leave or change.
Finally, staff were asked to identify the clinical dilemmas that clients of the Family Violence Services had presented them with. Respondents outlined the following clinical dilemmas: balancing the therapeutic relationship with men with the safety concerns of women; changing a therapeutic style which is nurturing to a confrontive style when appropriate; balancing the therapeutic relationship with the legislative mandate to report child abuse to the C.A.S., and the necessity to be a generalist as opposed to a specialist. Finally, respondents identified some pragmatic concerns regarding clients such as the need for transportation services for children's groups, a safe, supervised play area for children, providing for the child care needs of families to enable them to engage in counselling, and the provision of concrete supports to enable clients to meet their basic survival needs.

**Discussion**

Personal face-to-face interviews were conducted with the five staff members of the F.V.S. project team who had been responsible for actually implementing the service. Staff responded to a series of questions about expansion of the service to include other family violence populations, issues of implementation and program outcomes.

The respondents in the inter-organizational survey were all in agreement that the project needed to be expanded to include elder abuse, sexual assault victims and incest survivors. While staff were philosophically supportive of the need to expand the criteria, there was consensus that resources would need to be expanded to include these other areas. There was also concern
expressed that resources could be applied to prevention activities, which while seen as important, should not compromise the upgrading of the basic care clinical program. There was however, an interesting suggestion offered that the project include a community worker who could be responsible for a range of community development activities necessary to fully operationalize an inter-agency model. This role was perceived as being different from the team leader's role, and further research on case management models as described in the literature section of this study may be helpful in further defining this position.

In addition, all staff identified the complexities of being part of an inter-agency project administered by two agencies and reported that the difficulties of the model included: the need for clearer policies and procedures to aid in treatment decisions; the need to fully integrate the crisis response component with the intake/assessment/intervention component; the need for a centralized office for all staff; and, the need for a bridging mechanism to facilitate relationships with the staff of their employing agency. As well, staff readily identified the strengths of the project as the supervision and training component and were very appreciative of the attention and concern which was paid to their overall professional growth and development.

In the area of program outcomes, staff generally replied that basically stopping the physical violence was their major goal and it was the easiest outcome to achieve. They identified however, the intricacies and multi-dimensional aspects of working with these females as issues of sexual abuse, alcohol and drug
involvement surfaced during treatment. As a result, the limited
time-frame treatment contract of 12 weeks does not nearly appear
to be long enough to meet many of the needs of this client group,
and staff have determined their clients as generally being in need
of more long-term therapeutic intervention.

Finally, staff reported, as did the respondents in the
inter-organizational survey, that the integration of the men's
groups was a crucial component to successful interventions with
the family violence clients.
CONCLUSIONS AND RECOMMENDATIONS

The findings of this study have been organized according to: 1) conclusions derived from the literature review; 2) conclusions related to the administrative chronology; 3) conclusions related to client profile data; 4) conclusions related to the intake/assessment data; 5) conclusions related to the treatment process; 6) conclusions related to the inter-organizational survey; 7) conclusions related to the project staff survey; 8) overall study limitations; and, 9) overall study recommendations.

Conclusions Derived from the Literature Review

1. The determinants of inter-organizational co-operation are: 1) resource scarcity or performance distress; 2) existence of values that stress co-operation as a positive thing to do; and, 3) powerful extra-organizational factors that demand co-operation. The lack of implementation of the original three-agency Family Violence Services Project, when viewed using the above criteria, becomes clearly a problem of organizational relations not of individuals.

2. The barriers to co-operation identified in the literature were as follows: 1) fear of a loss of autonomy; 2) fears that organizational participation will have unfavourable ramifications for image or identity; and, 3) fears that participation will require the direct expenditure of scarce
resources. These barriers need to be explored among the three organizations who attempted to develop this integrated service approach. They may be useful as a starting point to discuss the future development of the project. Clearly, the community wants to see a resolution of the conflict experienced by these organizations in order to deliver the service as originally planned.

3. Any inter-organizational model because of the multi-faceted dimensions of the developmental process of inter-agency collaboration requires a comprehensive planning process which addresses planning issues from the conception of the model to its actual implementation.

4. As indicated in the literature, despite the best of inter-organizational efforts and intentions, agencies have trouble thinking outside of their own self interest or organizational domains even though they may develop certain co-operative structures among themselves.

Conclusions Related to the Administrative Chronology

1. Although the three agencies involved in the project went through a strategic planning process facilitated by an outside consultant, the fundamental philosophical differences which existed between them were never fully resolved to allow for a consensual decision regarding the development of the proposed inter-agency model.
2. Although the Ministry of Community and Social Services (COMSOC) funded the project, there were no clear-cut guidelines provided to the planning team which identified the type of model for integrated services which COMSOC wished to see developed.

3. Lines of communication between the three sponsoring organizations, the Area Office of COMSOC, Operations Branch of COMSOC, Communications Branch of COMSOC and the OCPA were initially unclear. This lack of clarity in the communication system produced confusion about decision-making and lines of authority and hindered the implementation of the project.

4. The incremental nature of the funding for the project contributed to the incremental planning that characterized the project. Due to sporadic funding decisions, no long-term continuous or rational planning process was possible.

5. While a bureaucratic decision was made to fund the project on a demonstration project basis, the constant threat of the program eventually closing trickled down and affected staff and eventually clients.

6. The evaluation component of the project was never fully launched until the program had been operational for a year, and was essentially post hoc rather than thoughtfully built-in to the project from the beginning.
7. Despite all of the inter-organizational rhetoric and expectations, what made the project actually functional was the determined efforts of the two focal organizations who made an overwhelming commitment to see that this project would become operational.

Conclusions Related to Client Profile Data

1. The data clearly show that these families were much older than expected on the average, 30 plus years. They had also had long periods of abuse and came from families of origin where there had been abuse between their parents and their parents and the children.

2. The data show there were a large number of Roman Catholic families; a larger number of children per family than the average; abuse occurred in these families with high frequency during pregnancy. Further, abuse did not occur as a singular episode in these families but was frequent with a large number reporting abuse episodes of more than 15.

3. The findings clearly showed that parents were aware that their children were seeing and hearing the violence between them. Further, children were in some cases trying to intervene to stop the violence. Preventative programs need to be developed to reach children in violent homes in order to teach them how to protect themselves and to prevent trauma to the children.
4. The problems of alcohol and drug involvement and past history of sexual abuse in these families supports the argument that a more comprehensive community-based service delivery system needs to be developed. Specifically, the involvement of the legal system could be aided by developing a domestic response team with linkages to the police and hospitals.

5. The lack of referrals by physicians suggests that a public education campaign directed at the medical community needs to be developed in order to increase awareness of family violence.

6. The lack of charges being laid, or in fact police even being called in to these domestic assault cases is of concern, and should be explored more in depth between the F.V.S. project and the local police to determine the reasons for this lack of police involvement.

Conclusions Related to the Intake/Assessment Data

1. The inter-organizational nature of the project was not fully operationalized as an integrated program. Although structurally, the crisis response and education components were part of the organizational design, they were not fully integrated into the service delivery system.

2. The intake/assessment package will allow for the collection of baseline data on clients which can be used for further program evaluation. The instruments seem to be addressing the outcome variables identified.
3. Although it was refined in the past year, the intake/assessment procedure may need to be further streamlined. Given the information which appears to be forthcoming during the therapy sessions regarding alcohol and drug use, sexual abuse and abuse in the family of origin, it may be more expedient to limit the intake procedure to a more general gathering of information. It is assumed that a more honest disclosure will occur once a trusting relationship has developed.

4. The intake/assessment package will need to be continuously evaluated and monitored to ensure that the client variables which manifest themselves through therapy are correctly addressed by the instruments.

5. Further research needs to be done on developing standardized instruments for family violence clients and the F.V.S. could be a population sample for this research.

6. The client profile data collected at intake should be computerized for accessibility and analyses.

**Conclusions Related to the Treatment Process**

1. The staff training provided to the intervention team has had a major impact on the development of an overriding clinical framework as well as increasing the credibility of the intervention team at a community level.

2. The intervention model needs to be structured to include a companion case co-ordination role which is organized around clients as well as a treatment role.
3. While there is an overriding theoretical framework, the treatment approach is still eclectic and needs to be co-ordinated among team members and other service providers.

4. The hiring of an experienced clinician as team leader to perform a clinical supervision and case management function would improve treatment intervention in the program.

5. The development of a singular theoretical framework for intervention which integrates both a feminist therapy approach and a family systems approach would be an important undertaking for F.V.S. in the future.

6. Although the project had been designed for more short-term intervention, the realities of treating this group of clients precluded this notion. More specifically, effective treatment for this group of clients requires a more long-term interventive approach and should include a mechanism for review every 12 weeks.

7. Of the entire range of interventions offered to these clients, although the children's groups were seen as integral to the F.V.S., they were the most difficult to implement and determine their effectiveness.

Conclusions Related to the Inter-Organizational Survey

1. The findings clearly revealed that the community has a commitment to the on-going funding and expansion of the Family Violence Service project, and is concerned that the problem will be hidden if the project is discontinued.
2. The community perception is that the F.V.S. project and the Kent County Task Force on Family Violence are inexorably linked and this linkage should become more formalized.

3. The development of a domestic response team with stronger linkages with the police, hospitals and court system is the model of choice for family violence services in Kent County.

4. The resolution of the on-going philosophical debates around family violence issues is a major developmental task to be carried out by the community.

Conclusions Related to the Project Staff Survey

1. Project staff have identified both the need for a further integration of services for family violence and the need to provide a more structured and centralized program.

2. Project staff reported that the physical environment did not meet the requirements of either clients or staff. Staff identified that they would like to be physically housed together to allow for better interaction with other team members.

3. Staff reported that the training and supervision aspects of their employment with family violence services were most rewarding to their professional growth.

4. Staff identified that the crisis response component of the F.V.S. project needs to be integrated more comprehensively into the project's range of services. Staff perceived that they were working in isolation from the program component, and concurred with the key informants who saw a more
comprehensive domestic response team for the future of the program.

6. The inclusion of a team leader position was seen as difficult to implement by staff but one which could provide administrative and case management functions. The team further identified the functions of the position as: facilitating information flow between administrators, co-ordination of service and team building.

Study Limitations

First, there is the nature of program evaluation itself. Program evaluation is not to be confused with social science basic or applied research. Basic research concerns questions of theoretical interest without regard to immediate needs of people or organizations. By contrast, program evaluation tries to help human service programs improve their effectiveness, assist administrators to make program-level decisions and make it possible for programs to be accountable to the public. Second, the Strategic Systems Planning Team, which had been responsible for the development of the inter-agency model had disbanded midway through the project. Third, the defined geographical area with a small number of clients limits extrapolation to more general populations or communities. Fourth, the long-term therapy needs of this client population did not allow for the collection of post-intervention data. Fifth, the time-limited funding for the project was a factor which influenced both the community's perceptions and staff perceptions when conducting the surveys with these groups.
Finally, the nature of the funding for this demonstration project did not allow for the evaluation component to be fully launched until the program had been operational for a year which resulted in the design of the evaluation being essentially post hoc rather than appropriately integrated from conception to completion.

Recommendations

The following recommendations have been developed from the evaluation of the Family Violence Project in Kent County.

1. The uniqueness of each agency involved in an inter-agency project needs to be explored before beginning this type of project. A strategic planning process should be carried out which identifies the, commitment and ability to develop a collaborative model for each of the respective agencies involved in any such inter-agency project.

2. The accountability for administration of the inter-agency project needs to be invested in one organization with formalized letters of agreement with each agency which define the parameters of decision-making and dispute resolution.

3. The person with the designated administrative responsibility should be given the mandate to communicate with the ministry system at all levels and to co-ordinate the flow of information from government to the inter-agency project.

4. An inter-agency committee comprised of agency representatives and key stakeholders should be struck to act
in an advisory capacity to the project. This inter-agency advisory committee should report to the board of directors of the administering agency.

5. The Kent County Task Force on Family Violence should be more closely allied with the family violence service project and should advocate for future funding at both a community and government level.

6. A mechanism for proposing the integration of the men's groups should be identified and implemented by the appropriate agencies.

7. The further development of family violence services in Kent County should be the focus of further inter-agency collaboration to explore the concept of a domestic response team with strong linkages to police, hospitals and court systems.

8. The administrators of the project need to address the issue of policy and procedural development for program issues.

9. The physical location of the project needs to be assessed using criteria such as the confidentiality of client interaction and the facilitation of team interaction.

10. The crisis response component of the F.V.S. needs to be operationalized as a comprehensive domestic response system as originally conceptualized in the program design.

11. The inclusion of a team leader position should be made to the staffing complement with this position taking over administrative and case management functions and reporting to the administration team of the F.V.S. project.
12. A further inter-organizational planning mechanism needs to be developed for family violence services integration. An external facilitator whose specific expertise is in inter-organizational relations should be hired to resolve some of the conflictual issues between organizations which now exist.

13. The three organizations which originally comprised the Trinity Project need to examine their current organizational mandates and structures to ascertain whether in fact they can or are willing to respond to the community's demands that the services for family violence clients be integrated in a more comprehensive way.

14. A preventative educational component of the program needs to be developed to increase the awareness, of children who live in violent homes, that there is help available.

15. There needs to be increased linkages with service providers who work with addictions and issues of adult survivors of incest.

16. A professional education program needs to be developed for police and physicians to increase their ability to identify this problem and to make appropriate referrals.

17. The crisis response component and education component need to be fully integrated into the project to provide a comprehensive service for family violence in the community.

18. There should be on-going monitoring of treatment issues which are brought to light during therapy with the families with a subsequent re-definition of the assessment process to include measurement of the relevant variables.
19. Based on the knowledge that clients require more long-term therapy than was eventually envisioned, it may be prudent to streamline the intake/assessment process further to enable the primary therapist to gather the relevant data.

20. There needs to be a commitment to provide on-going training for staff including the commitment to melding the feminist therapy and family therapy positions into a unique approach suitable for family violence clients.

21. A case management process needs to be developed which is appropriate for family violence clients and for the service network in Kent County.

22. There needs to be a team leader’s position structured into the organization of the intervention team. This person who would be responsible for service co-ordination should have skills in group facilitation and decision-making as well as clinical and technical skills.

23. An evaluation component for the project needs to be continued. The focus of the evaluation should be on the key issues which arose in this project, namely: 1) the strategic planning process for inter-agency collaboration; 2) the organizational accountability issues; 3) the flow of communication from administration to government, community and staff; 4) the formation of an inter-agency advisory committee to the F.V.S.; 5) an information retrievability system for effecting in-house decisions; and, 6) more assessment of client outcomes.
Appendix A

1. CLIENT SATISFACTION SURVEY QUESTIONNAIRE

2. COVERING LETTER
FAMILY VIOLENCE PROJECT

CLIENT SATISFACTION SURVEY

The purpose of this study is to find out information about services you received from the family violence project. We would appreciate you answering all the questions and assure you that all of your responses will be confidential. Your help in taking the time to complete this survey will allow us to improve the family violence services we are offering to the community. There are no right or wrong answers. We are interested in your honest opinion only. Thank you once again.

1. Sex
   1. Male ___  2. Female ___

2. Are You Presently Employed (Circle Number)
   1. Employed?  3. Full-Time Homemaker?
   2. Unemployed?  4. Student?

3. Your present age? _____ Years

4. Your present marital status? (Circle Number)
   1. Never Married  4. Divorced
   2. Married  5. Separated
   3. Living Together  6. Widowed

5. Number of children living in your home in each age group? (If None, Write 0)

NUMBER OF CHILDREN PRESENTLY LIVING IN THE HOME
   ___ Under 5 years of age
   ___ 5 to 13 years
   ___ 14 to 18 years
   ___ 19 to 24 years
6. Please describe the usual occupation of the principal wage earner in your household.

Usual occupation __________________________

What kind of work do you do? ________________

Kind of Company or Business ________________

In this section, we are interested in what services you actually received.

A) Individual Counselling for Yourself

Did you receive this service? Yes ____  No ____

If yes, how many sessions did you receive?

   a) 3 per week ____
   b) 2 per week ____
   c) 1 per week ____
   d) once every 2 weeks ____
   e) other ____

For about how many weeks? ______

Total # of Sessions ______

B) Individual Counselling for the Children

Did your child(ren) receive this service? Yes ____  No ____

If yes, how many children received the service? ______

Child 1

If yes, how many sessions did he/she (they) receive?

   a) 3 per week ____
   b) 2 per week ____
   c) 1 per week ____
   d) once every 2 weeks ____
   e) other ____

For about how many weeks? ______

Total # of Sessions ______
CHILD 2
If yes, how many sessions did he/she (they) receive?
   a) 3 per week ____
   b) 2 per week ____
   c) 1 per week ____
   d) once every 2 weeks ____
   e) other ____
   For about how many weeks? ______
   Total # of Sessions ______

Child 3
If yes, how many sessions did he/she (they) receive?
   a) 3 per week ____
   b) 2 per week ____
   c) 1 per week ____
   d) once every 2 weeks ____
   e) other ____
   For about how many weeks? ______
   Total # of Sessions ______

C) Women's Groups
Did you receive this service? Yes ____ No ____
If yes, how many sessions did you receive?
   a) 3 per week ____
   b) 2 per week ____
   c) 1 per week ____
   d) once every 2 weeks ____
   e) other ____
   For about how many weeks? ______
   Total # of Sessions ______
D) **Children's Groups**

Did your child(ren) receive this service?

Yes ___  No ___

If yes, how many sessions did he/she (they) receive?

a) 3 per week ___

b) 2 per week ___

c) 1 per week ___

d) once every 2 weeks ___

e) other ___

For about how many weeks? _____

Total # of Sessions _____

---

E) **Family Therapy**

Did you receive this service?  Yes ___  No ___

If yes, how many sessions did he/she (they) receive?

a) 3 per week ___

b) 2 per week ___

c) 1 per week ___

d) once every 2 weeks ___

e) other ___

For about how many weeks? _____

Total # of Sessions _____
For the rest of the questionnaire, we would like you to answer the following questions by checking off (√) whether you strongly agree (1), agree (2), disagree (3), or strongly disagree (4).

1. I understand issues about family violence better much better than I used to.

2. I am now better able to cope with issues of family violence.

3. I have a better understanding of where I would go to get help for a personal problem.

4. I am better able to cope with personal problems.

5. I feel better about myself as a person because of the family violence services I received.

6. My children(s) behaviour is better because of the services I received.

7. I feel my child understands his/her problems better.

8. I feel my child is completing his/her chores more often since going through this program.

9. I feel my child is better able to cope with his/her problems.

10. I feel my child’s relationships with his/her friends have improved.
11. I feel better about my friends and family after participating in this program.

12. I feel that my partner and I are able to discuss our problems better.

13. Whatever family violence was going on in our family has been reduced.

14. I thought that the primary therapist tried to find ways to help me.

15. I thought the primary therapist understood the problem I had.

16. I thought the primary therapist provided very competent service.

17. I thought the goals of the family violence project were made clear to me.

18. I thought the intake procedure was appropriate.

19. After intake, I felt the intake worker really understood my problem.

20. I felt that throughout the program, confidentiality was respected by the staff.

21. I felt that the appointment times were flexible enough for me to attend my sessions.

22. I thought there were an adequate number of sessions.
23. I was uncomfortable in the place where most sessions were held.

24. I thought that the time spent during the sessions was time well spent.

25. I felt throughout the project that I was treated with respect as an individual.

26. I feel we are much better off as a family because of our participation in this project.

27. I felt that the project was worthwhile.

28. I would recommend this service to my family or friends.
Finally, we would like to give you the chance to tell us what you would like to see improved in this service.

29. If I had to give three suggestions to help improve the family violence project, I would say:

1. 

2. 

3. 

30. Any other comments?

__________________________

__________________________

__________________________

__________________________

Thank you for completing these questions. Please return to Family Violence Services in the envelope provided.

If you wish to give your name and address, please do so in the space provided. If not, thank you once again.

NAME: ____________________________________________

ADDRESS: _________________________________________

__________________________________
Dear

We are interested in the service you recently received from Family Violence Services. As you remember, during the intake process, you were asked to sign a consent form which gave us permission to contact you after you received the service.

Attached is a questionnaire which we would appreciate you filling out to the best of your ability. A stamped, self-addressed envelope is also enclosed for your convenience. Your answers will be confidential and will be used with answers from other people like yourself who received services to help us understand how we can give better service in the future. Please do not put your name anywhere on this questionnaire if you don’t want to.

Thank you for taking the time to complete and return the questionnaire.

Joy Pyymaki  
Administrator  
Chatham Kent Women's Centre

Julie Farrell, M.S.W.  
Executive Director  
Lester B. Pearson Centre
Appendix B

INTAKE ASSESSMENT PACKAGE

Intake Section

1. Information Pamphlet
   "Pathways Through Treatment"

2. Acceptance of Referral

3. Intake Contract

4. Access and Disclosure of Records

5. Client Non-Disclosure Agreement

6. Informed Consent Form (Research)

7. Release of Information and/or Form 14
   (Mental Health Act)

8. File Summary Sheet
Individual, marital and family counselling will be carried out by your primary therapist. When group counselling is decided upon, the primary therapist will enrol you or your family members in the appropriate group. The group leader will telephone you to make arrangements.

Course of Therapy

As you and your family move through the course of therapy, your progress toward your treatment goals will be evaluated with you by your primary therapist on a regular basis. If you are dissatisfied with your progress, you may ask your primary therapist to change your treatment plan.

Termination

When you and your family have reached your treatment goals, your primary therapist will recommend that treatment end and your file be closed. You will be asked to complete some simple pencil-and-paper testing to determine the extent of change that has occurred during treatment. You will also be asked to complete a Client Satisfaction Survey that will help us determine to what extent you are satisfied with the counselling process you have undergone.

Research Interview

Following termination of your case, you will be contacted by a member of the project's research team who in one interview will collect the information from you about your experience in the program that will enable us to (1) improve our service and (2) apply for continued funding for the project.

Re-referral

If, following termination, you find that violent behaviour patterns re-occur, we urge you to call the Family Violence Service to re-referr your family for further counselling services.
FAMILY VIOLENCE SERVICE
Pathways Through Treatment

Referral

The Family Violence Service is available to all families meeting the following criteria:

* At least one incident of physical abuse has occurred between the partners.
* At least one child under the age of 16.
* Residing in Kent County.

You may call to refer your family yourself or the referral may be made by a third party such as the police or another social service agency. If the referral is made by a third party, you will be contacted to inquire whether you wish to schedule an intake appointment.

Intake appointment

It is preferable for the whole family to attend the intake appointment, although family members will usually be interviewed separately. The counsellor conducting the intake appointment will inform you of your rights as a client and obtain your consent to participate in this counselling program, take pertinent information and administer simple tests which will enable your counsellor(s) to determine your counselling needs.

Consent to Treatment

The following forms will be explained to you and your signature requested to insure that your rights as a client are maintained:

* Informed consent form - agreement to participate in this project's research component. You have the right to say "no" without jeopardizing your counselling rights.

* Intake contract - agreement that you have been informed of your rights regarding confidentiality of your records, disclosure of information and access to your file.

* Release of Information - allows the Family Violence Service to give and/or receive information about your family.

* Client Non-disclosure Agreement - You agree not to release information regarding the treatment of your family for legal purposes without the consent of the Family Violence Project.

* Use of Client Information - You agree that family records, case material and video may be used in training.

* Acceptance of referral - Terms for accepting referral into the Family Violence Service.

Collection of Information

The information that the intake counsellor will need to determine your and your family's counselling needs will be collected in three ways.

(1) You and your family members will be asked to complete a Client Data Sheet, (2) interviews will be held with various family members (separately if advisable), and (3) simple pencil-and-paper tests will be administered to both adults and children. This intake appointment should take from 1 1/2 to 2 hours to complete.

First Counselling Session

Following the intake appointment, your case will be assigned to a primary therapist who will telephone you to set up the first counselling session with your family. During this session the counsellor will set treatment goals with you (the Treatment Contract) and will recommend an individualized treatment plan for you and your family. This plan may include any combination of the following:

* Individual counselling for adults and/or children

* Group programs for husband, wife and/or children.

* Marital therapy (only when abuse has ceased)

* Family therapy

Once the treatment plan has been agreed upon, treatment may begin.
Acceptance of Referral

DATE: ____________________

I/We accept referral into the Family Violence Services and by doing so I consent to and understand that: two agencies are involved and these agencies namely Chatham-Kent Women's Centre and the Lester B. Pearson Centre will share pertinent information so that service co-ordination and delivery can occur as this program serves all family members. Upon acceptance to this referral, I understand that the goal of the Family Violence Service Program is to stop the violence and ensure the safety of all family members. If the counsellors have any reason to suspect that a person's safety is in jeopardy, the potential victim and/or police department will be notified.

_____________________________  ______________________________

_____________________________  ______________________________

_____________________________  ______________________________

Witness

PARTICIPATING AGENCIES: CHATHAM-KENT WOMEN'S CENTRE INC./LESTER B. PEARSON CENTRE FOR CHILDREN AND YOUTH
INTAKE CONTRACT

I/we, having sought the counselling service of the Family Violence Services have been advised of my/our rights in regard to confidentiality, disclosure of the access to records, under Bill 77, The Child & Family Services Act. It has been explained to me/us that:

1. No information from said records may be released to, or sought from other agencies or involved persons without my/our valid, signed consent, except as in Section 166, Page 137 of the Act.

2. I/we may designate areas in the record which may not be disclosed to other agencies or persons, not to my/our children under 16 years of age and the service worker shall so indicate.

3. All persons 12 or over are entitled upon request, to access within 30 days, to:
   a) their own records
   b) records of their children or legal wards under the age of 16, except as in Section 168, Page 139 of the Act.

4. If there are errors or omissions in these records, I/we may request corrections to be made in the original and in any copies which have been disclosed.

5. I/we can expect that service workers will behave ethically at all times in regard to confidentiality, disclosure and access, sharing information only in such a way as to be helpful to me/my family.

6. If I/we have complaints in regard to confidentiality, disclosure of and access to said records, I/we may appeal to the Children’s Services Review Board.

I/we do hereby state that I/we understand these rights and their exceptions, as explained to me/us ___________________________ ___________________________ ___________________________.

Day  Month  Year

Family Signatures: ___________________________ ___________________________ ___________________________.

Witness: ___________________________ ___________________________

Father   ___________________________ ___________________________

Mother   ___________________________ ___________________________
ACCESS AND DISCLOSURE OF RECORDS

If children and parents are to participate in the decisions that affect their rights and interests - a right guaranteed under this law - they must have access to their records kept by service agencies. They must know that the information contained in their records is protected from inappropriate distribution. Part VII of the Act contains detailed provisions that clarify who does and who does not have the right of access to records and when an agency can and cannot disclose records without the consent of the child or parent.

What Records are Included?

A record is considered to be all recorded information, (except for that noted below), that is under the control of a service provider and that was recorded in connection with a service being provided.

The following are exempt from the provisions of this section:

- records obtained during a child investigation;
- the child abuse register;
- records relating to adoption;
- the voluntary adoption disclosure registry;
- clinical records as defined in the Mental Health Act;
- medical records as defined in the Public Hospitals Act;
- records relating to a patient as defined by the Health Disciplines Act.

Also exempt is information recorded prior to this Act becoming law. (Section 163).
Access Rights

The Act gives parents and children 12 years of age or over the right, with some exceptions, to see their complete record kept by the service agency. But records created while counselling a child 12 or older as provided for in the Act, can only be disclosed to that child's parents with the child's permission. At the same time, parents also have the right, if their child is under 16, to designate specific information in the child's record that relates to the parent as restricted, and not to be disclosed to the child. (Section 167).

Once a person has requested access to record, the agency has 30 days to release the information or explain why it has been withheld. (Section 169(1)).

Not all records have to be released. The new Act provides some flexibility to service providers in deciding whether access to information should be granted. Specifically, information can be denied:

- if the child is under 16 and the information could cause physical or emotional harm;
- if the record contains the name of another person and the disclosure is likely to cause physical or emotional harm to that person;
- if the name of a person who provided information is in the record but that person is not engaged in providing services.

In addition, medical, emotional, developmental, psychological, educational or social assessment results can also be withheld. (Section 168)
A person who is denied the right to see his or her record may appeal to the Children's Services Review Board within 20 days. The Board may uphold the refusal; order that access to all or part of the record be granted, or order that corrections be made to the record. (Section 171)

Disclosure

In most instances the new Act provides that no person's record shall be released to a third party without consent of the child's parent or the society or the individual if 16 years or older. There are cases, however, where disclosure without consent is permitted. Those to whom information may be released outside include:

- service providers who need the information to carry out their duties, including foster parents;
- a children's aid society if the child is under that society's care on a child protection order or a temporary care or special needs agreement;
- a peace officer or medical personnel if the need is urgent and failure to disclose the information could cause the person harm;
- members of a child abuse review team. (Section 165, 166).
- if records are subpoenaed by the court
Client Non-Disclosure Agreement

NAME OF CLIENT: ________________________________

I/We, the undersigned, hereby acknowledge that we are voluntarily entering this diagnostic assessment and/or treatment agreement with the Family Violence Services solely for the benefit of my/our family. As a condition precedent to the Family Violence Services entering with this Agreement, I/We promise that I/We will not unilaterally or together disclose any information whatsoever pertaining to the diagnostic assessment and/or treatment of the family and/or children without first obtaining the written consent of the Family Violence Services Administration to do so. Such consent shall be withheld where, in the opinion of the Family Violence Services Administrative Team, any disclosure would be detrimental to the treatment of the family and/or children and/or the effective operation of the Family Violence Services.

DATED THE ___________________ DAY ____________________, 19__.

WITNESS:

_________________________________________  ______________________________

_________________________________________  ______________________________

_________________________________________  ______________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

Participating Agencies: Chatham-Kent Women’s Centre Inc./Lester B. Pearson Centre for Children and Youth
Informed Consent Form
For
Family Violence Project Clients

I, the undersigned agree to participate in the following study of assessment and treatment of persons who have experienced physical abuse in a partner relationship. I understand that participation in the study is completely voluntary and that information collected from me will remain anonymous and confidential.

I understand that the study will involve a personal interview and/or a follow-up by telephone or by mail after treatment. All information collected from myself and other individuals will be reported in group numerical or statistical form only. No names will be used in this study. The consent sheet will be detached from the questionnaire upon its receipt.

I understand that the purpose of this study is to collect information which will aid in understanding family violence and help people like myself.

Signature __________________________
Date _______________________________
Witness ___________________________
As a matter of policy the Family Violence Services does not give out information except as required by law relating to you or your children without your consent.

Date: ____________________

CONSENT FOR THE RELEASE OF INFORMATION

I/We do hereby consent for a three month period to the release of:

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by: ____________________

Agency: ____________________

to: ____________________

Agency: ____________________

in regard to: ____________________

Client's Name: ____________________

born: ____________________

Date of Birth: ____________________

for the purpose of determining eligibility for, and/or enhancing said client's treatment program with the Family Violence Services.

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<tr>
<th>Family Signatures</th>
<th>Relationship to Client</th>
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Consent to the Disclosure, Transmittal or Examination of a Clinical Record under Section 29 of the Act

I, ____________________________________________________________________________ (print full name of person)

of ____________________________________________________________________________ (address)

hereby consent to the disclosure or transmittal to or the examination by ____________________________________________________________________________ (print name)

of the clinical record compiled in ____________________________________________________________________________ (name of psychiatric facility)

in respect of ____________________________________________________________________________ (name of patient) - (date of birth, where available)

See Notes 4 and 5.

__________________________________________________________________________ (signature)

See (if other than the patient, state relationship to the patient)

__________________________________________________________________________ (witness)

Dated the ___________ day of ____________________________________________________________________________ , 19______.

NOTES:

1. Consent to the disclosure, transmittal or examination of a clinical record may be given by the patient where mentally competent or, where the patient is not mentally competent, by the person authorized under section 1a of the Act to consent on behalf of the patient. See subsection 29(3) of the Act.

2. Clause 29(1)(b) of the Act provides, "(b) 'patient' includes former patient, out-patient, former out-patient and anyone who is or has been detained in a psychiatric facility."

3. Clause 1(g) of the Act provides, "(g) 'mentally competent' means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent."

4. Subsection 1a(1) of the Act provides, "1a.- (1) A person may give or refuse consent on behalf of a patient who is not mentally competent if the person has attained the age of sixteen years, is apparently mentally competent, is available and willing to give or refuse consent and is described in one of the following paragraphs:
   1. The committee of the person appointed for the patient under the Mental Incompetency Act.
   2. The patient's representative appointed under section 1b or 1c.
   3. The person to whom the patient is married or the person of the opposite sex with whom the patient is living outside marriage in a conjugal relationship or was living outside marriage in a conjugal relationship immediately before being admitted to the psychiatric facility, if in the case of unmarried persons they,
      i. have cohabited for at least one year,
      ii. are together the parents of a child, or
      iii. have together entered into a cohabitation agreement under section 53 of the Family Law Act, 1986.
   5. A parent of the patient or a person who has lawful custody of the patient.
   6. A brother or sister of the patient.
   7. Any other next of kin of the patient.
   8. The Official Guardian."

See sections 1b and 1c of the Act regarding patients' representatives.
**File Sheet**

Name: ____________________________  I.D. #: __________________

Date of Intake Interview: ____________________________

**Inventory of Tests Administered:**

**Adult**

1) Scales of Perceived Social Support (MacDonald)  __________________

2) Conflict Tactics Scale (Strauss)  __________________

3) Index of Spouse Abuse (Hudson)  __________________

4) Social Contacts Questions (Ragg)  __________________

**Children**

1) Child Behavior Checklist (2-3 years) (Achenbach)  __________________

2) Child Behavior Checklist (4-16 years) (Achenbach)  __________________

3) Youth Self-Report (11-18 years) (Achenbach)  __________________

4) Self-Perception Profile for Children (8-14 years) (Harter)  __________________

Presenting Problem: ______________________________________

Date of Disposition Meeting: ____________________________

Primary Therapist Assigned: ____________________________
Appendix B

INTAKE/ASSESSMENT PACKAGE

Assessment Package

Adult

1. Client Data Form – Male
2. Client Data Form – Female
3. Social Contacts Questions
4. Scales of Perceived Social Support
   (Macdonald, 1987)
5. Index of Spouse Abuse (Hudson and McIntosh, 1981)
6. Conflict Tactics Scale (Straus, 1979)

Children

7. Children's Intake Form
   (Achenbach, 1979)
9. Child Behavior Checklist for Ages 4-16
   (Achenbach, 1979)
10. Youth Self-Report for Ages 11-18
    (Achenbach, 1981)
11. Self-Perception Profile for Children
    (Harter, 1985)
CLIENT DATA FORM

(Male)

Date: ___________________________  I.D. Number ________

Referred by: ______________________

A. Client Data

1. Name: ________________________  S.I.N.: ______________

2. Age: _______________________

3. Date of Birth: ________________

4. Address: ______________________

5. Telephone: ____________________

6. Marital Status:
   Married ___  Single ___  Widowed ___
   Separated ___  Common-law ___  Divorced ___

7. Education: (last grade completed)
   Grade School ___  High-School ___  Post-Secondary ___

8. Occupation: (most recent)
   Where: ________________________________
   How Long: ________________________________

9. Gross Income: (0-15,000) ___  (15,000-30,000) ___
   (30,000-50,000) ___  (over 50,000) ___

10. Ethnic Background: ________________________________

11. Religion: __________________________

12. Family Doctor: ______________________
13. Are you or your family involved with other agencies?

No ____ Yes ____

If yes, agency names/contact person ________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

Total Number of Agencies ______

B. Children Data

<table>
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<tr>
<th>Family Name</th>
<th>First Name</th>
<th>Age</th>
<th>D.O.B.</th>
<th>School</th>
<th>Grade</th>
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*Scoring Key for this (use # and place above)*

Mother
1) Natural Mother
2) Step-Mother
3) Adoptive Mother
4) Foster Mother
5) Other

Father
1) Natural Father
2) Step-Father
3) Adoptive Father
4) Foster Father
5) Other
C. Background of Abuse

1. Age at beginning of relationship
   Client ____  Partner ____

2. When did you get married?  ____
   start living together?  ____

3. Was there physical violence between:
   your parents ____
   parents & kids in your family ____

4. Was there physical abuse in any previous relationship?
   Yes ____  No ____

5. Did you abuse or were you abused by your partner before you
got married/started living together?
   Yes ____  No ____
   If yes, when? ________________________________________

6. When was the first time you abused or were abused by your
   partner after getting married/living together?
   (0-6 mos.) ____  (6 mos.-1 yr.) ____  (1-5 yrs.) ____

7. How many times would you say you abused or were abused by
   your partner since married/living together?
   (1-5) ____  (5-10) ____  (10-15) ____  (15-20) ____  (20+) ____

8. How long would you say it was between abuses?
   No. of days ____  No. of weeks ____
   No. of months ____  No. of years ____

9. When was the last incident of abuse?  ________________

10. Have you been separated from your current partner before?
    Yes ____  No ____
    If yes, how many times? ____
11. Were the police called at the time of the abuse?
   Yes ___    No ___

12. Were charges laid for this incident?
   Yes ___    No ___

13. Are there charges pending?
   Yes ___    No ___

14. Do you have a criminal record?
   Yes ___    No ___

15. Does your partner have a criminal record?
   Yes ___    No ___

16. Were you ever treated medically for injuries from abuse?
   Yes ___    No ___

17. Have your children seen or heard the violence?
   Yes ___    No ___

18. Did the children try to interfere in the violence?
   Yes ___    No ___

19. How serious do you think the violence was in your relationship?

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<th>not at all</th>
<th>somewhat of a problem</th>
<th>a serious problem</th>
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D. Other

1. Do you think you have a drinking problem?
   Yes ___    No ___

   If yes, on the following scale, circle the number that best describes your problem.

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<th>not at all</th>
<th>somewhat of a problem</th>
<th>a serious problem</th>
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<td>7</td>
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</table>
2. Do you think your partner has a drinking problem?

Yes ___  No ___

If yes, on the following scale, circle the number that best describes your partner's problem.

not at all  somewhat of a problem  a serious problem

1  2  3  4  5  6  7

3. Do you think you have a drug problem?

Yes ___  No ___

If yes, on the following scale, circle the number that best describes your problem.

not at all  somewhat of a problem  a serious problem

1  2  3  4  5  6  7

4. Do you think your partner has a drug problem?

Yes ___  No ___

If yes, on the following scale, circle the number that best describes your partner's problem.

not at all  somewhat of a problem  a serious problem

1  2  3  4  5  6  7
CLIENT DATA FORM

(Female)

Date: ___________________________ I.D. Number ______

Referred by: _______________________

A. Client Data

1. Name: _________________________ S.I.N.: ____________

2. Age: __________________________

3. Date of Birth: _________________

4. Address: __________________________

5. Telephone: _______________________

6. Marital Status:

   Married ____  Single ____  Widowed ____
   Separated ____  Common-law ____  Divorced ____

7. Education: (last grade completed)

   Grade School ____  High-School ____  Post-Secondary ____

8. Occupation: (most recent)

   Where: ____________________________________________________________________

   How Long: __________________________________________________________________

9. Gross Income: (0-15,000) ____ (15,000-30,000) ____ (30,000-50,000) ____ (over 50,000) ____

10. Ethnic Background: ________________________________________________________

11. Religion: ______________________________

12. Family Doctor: ________________________
13. Are you or your family involved with other agencies?

No ______ Yes ______

If yes, agency names/contact person _____________________________

________________________

________________________

________________________

Total Number of Agencies ________

B. Children Data

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<th>School</th>
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<th>*Relationship To Child</th>
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* Scoring Key for this (use # and place above)

**Mother**

1) Natural Mother
2) Step-Mother
3) Adoptive Mother
4) Foster Mother
5) Other

**Father**

1) Natural Father
2) Step-Father
3) Adoptive Father
4) Foster Father
5) Other
C. Background of Abuse

1. Age at beginning of relationship
   
   Client ___ Partner ___

2. When did you get married? ___ 
   start living together? ___

3. Was there physical violence between:
   
   your parents ___
   parents & kids in your family ___

4. Was there physical abuse in any previous relationship?
   
   Yes ___ No ___

5. Did you abuse or were you abused by your partner before you got married/started living together?
   
   Yes ___ No ___
   If yes, when? ___________________________

6. Were you assaulted during pregnancy?
   
   Yes ___ No ___

7. When was the first time you abused or were abused by your partner after getting married/living together?
   
   (0-6 mos.) ___ (6 mos.-1 yr.) ___ (1-5 yrs.) ___

8. How many times would you say you abused or were abused by your partner since married/living together?
   
   (1-5) ___ (5-10) ___ (10-15) ___ (15-20) ___ (20+) ___

9. How long would you say it was between abuses?
   
   No. of days ___ No. of weeks ___
   No. of months ___ No. of years ___

10. When was the last incident of abuse? ____________________________

11. Have you been separated from your current partner before?
   
   Yes ___ No ___
   If yes, how many times? _____
12. Were the police called at the time of the abuse?
   Yes ___     No ___

13. Were charges laid for this incident?
   Yes ___     No ___

14. Are there charges pending?
   Yes ___     No ___

15. Do you have a criminal record?
   Yes ___     No ___

16. Does your partner have a criminal record?
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17. Were you ever treated medically for injuries from abuse?
   Yes ___     No ___

18. Have your children seen or heard the violence?
   Yes ___     No ___

19. Did the children try to interfere in the violence?
   Yes ___     No ___

20. How serious do you think the violence was in your relationship?
    not at all    somewhat of a problem    a serious problem
    1           2                       3                       4                       5                       6                       7

D. Other

1. Do you think you have a drinking problem?
   Yes ___     No ___

   If yes, on the following scale, circle the number that best describes your problem.

   not at all    somewhat of a problem    a serious problem
   1           2                       3                       4                       5                       6                       7
2. Do you think your partner has a drinking problem?

Yes ___  No ___

If yes, on the following scale, circle the number that best describes your partner's problem.

not at all  somewhat of a problem  a serious problem

1    2    3    4    5    6    7

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If yes, on the following scale, circle the number that best describes your problem.

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1    2    3    4    5    6    7

4. Do you think your partner has a drug problem?

Yes ___  No ___

If yes, on the following scale, circle the number that best describes your partner's problem.

not at all  somewhat of a problem  a serious problem

1    2    3    4    5    6    7
Social Contacts

Name: ___________________________ Date: ________________

1. How many friends do you see outside of the family?

2. How often do you see these friends in an average month?

3. On a scale of 1 - 5 (with 5 being most severe) rate the level of difficulty your spouse exhibits regarding these contacts.

   1 - 2 - 3 - 4 - 5
   Least Most

4. How many family members do you see outside of the family you live with?

5. How often do you see these people in an average month?

6. On a scale of 1 - 5 (with 5 being most severe) rate the level of difficulty your spouse exhibits regarding these contacts.

   1 - 2 - 3 - 4 - 5
   Least Most

7. How many other social contacts (i.e. clubs etc.) do you have outside of the above?

8. How often do you attend these contacts in the average month?

9. On a scale of 1 - 5 (with 5 being most severe) rate the level of difficulty your spouse exhibits regarding these contacts.

   1 - 2 - 3 - 4 - 5
   Least Most
Scales of Perceived SOCIAL SUPPORT

INSTRUCTIONS
The following are statements about your family and friends. By family we mean those people in your life whom you consider to be part of your family. They may be your parents, children, spouse or common-law partner, or other relatives. In the space to the left of each item, indicate with the appropriate number the degree to which you agree or disagree with each statement. Please use the scale at the top of the next page.

NAME: __________________________ DATE: /__/__/ AGES: ___ years SEX: [ ]Male; [ ]Female.
EDUCATION: ___ years OCCUPATION (Please be specific): _________________________
MARITAL STATUS: [ ]Single; [ ]Married; [ ]Separated; [ ]Divorced; [ ]Widowed
ITEMS ABOUT YOUR FAMILY

[ ] 1. I feel very close to my family.

[ ] 2. If I needed to borrow 50 dollars, I feel I could count on a loan from a member of my family.

[ ] 3. My family is overly critical of me.

[ ] 4. My family gives me guidance and support when I need it.

[ ] 5. I sometimes feel that my family doesn't really like me.

[ ] 6. My family gives me practical kinds of help.

[ ] 7. My family recognizes the importance of the things I do for them.

[ ] 8. When I have personal problems, I can count on my family to help.

[ ] 9. There is at least one family member to whom I can tell my intimate feelings.

[ ] 10. If I was short of cash, my family would help me out.

[ ] 11. I often feel better about myself after talking with members of my family.

[ ] 12. My family advises me when I have to make a difficult decision.

[ ] 13. My family understands me.

[ ] 14. If my car broke down, I could not count on someone from my family to come to my aid.

[ ] 15. There is at least one family member who shows me his/her appreciation.

[ ] 16. My family gives me good advice when I have personal problems.

[ ] 17. My family shows that they care about me.

[ ] 18. I can count on my family for practical help in an emergency.

[ ] 19. I often get complaints from my family.

[ ] 20. My family is not helpful when I have a personal problem.

[ ] 21. I feel that my family loves me.

[ ] 22. There is at least one family member who would offer me his/her assistance even without being asked.

[ ] 23. I often feel that my family puts down my efforts.

[ ] 24. I can go to my family when I need advice.

[ ] 25. I talk to my family about things that are really important to me.

[ ] 26. I could stay with my family if I ran into difficulty.

[ ] 27. My family praises me when I do well.

[ ] 28. There is at least one family member who helps me cope with life's everyday problems.
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<tr>
<th>Items About Your Friends</th>
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<tbody>
<tr>
<td>1. I feel very close to my friends.</td>
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COPYIES OF THIS SCALE MAY BE OBTAINED FROM:

J. Grant Macdonald, Ph.D.
Atkinson College
York University
4700 Keele Street
North York, Ontario
M3J 1P4

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Atkinson College, York University, Toronto, Canada.
## SCALES OF PERCEIVED SOCIAL SUPPORT

(Ages 14 yrs. +
Self Report )

(Dr. J. G. MacDonald, York University)

### Scoring Sheet

| Name: ___________________ | Date: ___________________ |

### Items About Family

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<th>Appraisal</th>
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<td>56.</td>
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</tbody>
</table>

| TOTAL | TOTAL | TOTAL | TOTAL |

* Reverse Scored
INDEX OF SPUSE ABUSE (ISA)

This questionnaire is designed to measure the degree of abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Never
2. Rarely
3. Occasionally
4. Frequently
5. Very frequently

Please begin.

1. My partner belittles me.
2. My partner demands obedience to his whims.
3. My partner becomes surly and angry if I tell him he is drinking too much.
4. My partner makes me perform sex acts that I do not enjoy or like.
5. My partner becomes very upset if dinner, housework, or laundry is not done when he thinks it should be.
6. My partner is jealous and suspicious of my friends.
7. My partner punches me with his fists.
8. My partner tells me I am ugly and unattractive.
9. My partner tells me I really couldn't manage or take care of myself without him.
10. My partner acts like I am his personal servant.
11. My partner insults or shames me in front of others.
12. My partner becomes very angry if I disagree with his point of view.
13. My partner threatens me with a weapon.
14. My partner is stingy in giving me enough money to run our home.
15. My partner belittles me intellectually.
16. My partner demands that I stay home to take care of the children.
17. My partner beats me so badly that I must seek medical help.
18. My partner feels that I should not work or go to school.
19. My partner is not a kind person.
20. My partner does not want me to socialize with my female friends.
21. My partner demands sex whether I want it or not.
22. My partner screams and yells at me.
23. My partner slaps me around my face and head.
24. My partner becomes abusive when he drinks.
25. My partner orders me around.
26. My partner has no respect for my feelings.
27. My partner acts like a bully towards me.
28. My partner frightens me.
29. My partner treats me like a dunce.
30. My partner acts like he would like to kill me.

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---

## INDEX OF SPOUSE ABUSE

*(Hudson & McIntosh, 1981)*

---

### SCORING SHEET

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Non-Physical Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>16.</td>
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<td>17.</td>
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<tr>
<td>18.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Non-Physical Abuse</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>20.</td>
<td></td>
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<td>21.</td>
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<td>26.</td>
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<td>28.</td>
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<td>29.</td>
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<td>30.</td>
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</tbody>
</table>

**SCORE** ___  **SCORE** ___
Conflict Tactics Scale  
(M. A. Straus) (1979)

78. No matter how well a couple gets along, there are times when they disagree on major decisions, get angry about something the other person does, or just have spells or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that you and your (wife/partner) might have done when you had a dispute, and would first like you to tell me for each one how often you did it in the past year.

<table>
<thead>
<tr>
<th>RESIDENT-IN-PAST YEAR</th>
<th>WIFE/PARTNER-IN-PAST YEAR</th>
<th>HAPPENED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>TIMES</td>
</tr>
<tr>
<td></td>
<td>ONCE</td>
<td>TWICE</td>
</tr>
<tr>
<td></td>
<td>TWICE</td>
<td>ĐO NOT DONE</td>
</tr>
<tr>
<td></td>
<td>ĐO NOT DONE</td>
<td>ĐO NOT DONE</td>
</tr>
</tbody>
</table>

a. Discussed the issue calmly  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

b. Got information to back up (your/her) side of things  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

c. Brought in or tried to bring in someone to help settle things  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

d. Insulted or swore at the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

e. Sulked and/or refused to talk about it  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

f. Stumped out of the room or house (or yard)  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

g. Cried  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

h. Did or said something to spite the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

i. Threatened to hit or throw something at the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

j. Threw or smashed or hit or kicked something  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

k. Threw something at the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

l. Punched, grabbed, or shoved the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

m. Slapped the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

n. Kicked, bit, or hit with a fist  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

o. Hit or tried to hit with something  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

p. Beat up the other one  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

q. Threatened with a knife or gun  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

r. Used a knife or gun  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

s. Other (PROBE):  
0  1  2  3  4  5  6  x  0  1  2  3  4  5  6  x  1  2  x

79. And what about your (wife/partner)? Tell me how often she (HE) in the past year.  

For each item circled either "NEVER" or "DON'T KNOW" for BOTH RESPONDENT AND PARTNER. Ask:  

GO. Did you or your (wife/partner) ever (ITEM)?
### Conflict Tactics Scale Scoring Summary

(M.A. Straus, 1979)

(University of New Hampshire)

<table>
<thead>
<tr>
<th></th>
<th>Respondent Score</th>
<th>Partner Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Reasoning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add items a+b+c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>R: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>P: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Verbal Aggression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add items d+e+f+g+h+i+j)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>R: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>P: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Violence Score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add items k+l+m+n+o+p+q+r)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>R: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>P: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>4. TOTAL (Raw Scores)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add 1+2+3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Average Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(divided by 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Severe Violence Scale</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add n+o+p+q+r)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>R: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>P: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Frequency of Occurrence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>R: Yes ___ No ___</td>
<td></td>
</tr>
<tr>
<td>P: Yes ___ No ___</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Children's Intake Form

Name: ___________________________  Date: __________________

Client I.D.#: ____________________

I. 1) Description of Family

Who: ______________________________________________________

________________________________________________________

What do they do: __________________________________________

________________________________________________________

Pets: ______________________________________________________

Fun things: ________________________________________________

Three Favorite T.V. Shows: ________________________________

II. Attitudes and Responses to Anger

1) What kinds of things make you really mad?

________________________________________________________

________________________________________________________

ii) Have you ever felt really mad at someone in your family?
   - When, What did you do?

________________________________________________________

________________________________________________________
iii) Have you ever felt really mad at one of your friends?
   - When, What did you do?

III. Safety Skills

i) What do you do if mom and dad are arguing?
   - Do you ever . . .

<table>
<thead>
<tr>
<th></th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>stay in the same room</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>leave the area or hide</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>phone someone</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>go to get help</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>go to siblings (in safe place)</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>ask parents to stop</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>interrupt parents</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>do something to draw attention to yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Score: __________

ii) Can you tell when arguing will lead to dad hitting mom? (Check off all that apply)

- volume __________
- threats __________
- non-verbal __________
- time of day __________
- gestures __________
- topic areas __________
- drinking __________
- others __________

Score: __________

iii) Can you tell when arguing will lead to mom hitting dad? How? (Check off all that apply)

- volume __________
- threats __________
- non-verbal __________
- time of day __________
- gestures __________
- topic areas __________
- drinking __________
- others __________

Score: __________
IV. Do you feel like you should do something to stop the fighting.

Do you try . . .

<table>
<thead>
<tr>
<th>Action</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. interrupting before they fight</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. getting into trouble</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. asking them not to fight</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. getting someone else into trouble</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. crying or some other change the subject</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Score: 

V. Can you name 5 places or people that you can go to help for if there was an emergency for you or your mother.

<table>
<thead>
<tr>
<th>Who/Where</th>
<th>Phone # or Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</table>

Score: ___
Children's Intake - Scoring Sheet

<table>
<thead>
<tr>
<th>Item</th>
<th>Focus</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>III i</td>
<td>Safety during verbal fight.</td>
<td>/16</td>
</tr>
<tr>
<td>III ii</td>
<td>Cuing for male to female violence.</td>
<td>/8</td>
</tr>
<tr>
<td>i:i</td>
<td>Cuing for female to male violence.</td>
<td>/8</td>
</tr>
<tr>
<td></td>
<td>Total for identifying potential violence.</td>
<td>/16</td>
</tr>
<tr>
<td>IV</td>
<td>Child responsibility for stopping the violence.</td>
<td>/10</td>
</tr>
<tr>
<td>V</td>
<td>Sources of safety/help.</td>
<td>/10</td>
</tr>
</tbody>
</table>
# Child Behavior Checklist for Ages 2-3

**Child's Name**

- **Sex**: [ ] Boy  [ ] Girl
- **Age**:
- **Ethnic Group or Race**:

**Today's Date**

- **Month**:  [ ]  [ ]  [ ]
- **Day**:  [ ]  [ ]
- **Year**:  [ ]  [ ]

**Child's Birthdate**

- **Month**:  [ ]  [ ]  [ ]
- **Day**:  [ ]  [ ]
- **Year**:  [ ]  [ ]

Please fill out this form to reflect your view of the child's behavior even if other people might not agree about the behavior.

Below is a list of items that describe children. For each item that describes the child now or within the past 2 months, please circle the 2 if the item is very true or often true of the child. Circle the 1 if the item is somewhat or sometimes true of the child. Circle the 0 if the item is not true of the child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to the child.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aches or pains (without medical cause)</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Acts too young for age</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Afraid to try new things</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Avoids looking others in the eye</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Can't concentrate, can't pay attention for long</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Can't sit still or restless</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Can't stand having things out of place</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Can't stand waiting; wants everything now</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Chews on things that aren't edible</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Clings to adults or too dependent</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Constantly seeks help</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Constipated, doesn't move bowels</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Cries a lot</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Cruel to animals</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Defiant</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Demands must be met immediately</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Destroys his/her own things</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Destroys things belonging to his/her family or other children</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Diarrhea or loose bowels when not sick</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Disobedient</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Disturbed by any change in routine</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Doesn't want to sleep alone</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Doesn't answer when people talk to him/her</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Doesn't eat well (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Doesn't get along with other children</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Doesn't know how to have fun, acts like a little adult</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Doesn't seem to feel guilty after misbehaving</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Doesn't want to go out of home</td>
<td>0 1 2</td>
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<tr>
<td>29</td>
<td>Easily frustrated</td>
<td>0 1 2</td>
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<tr>
<td>30</td>
<td>Easily jealous</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>31</td>
<td>Eats or drinks things that are not food (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>32</td>
<td>Fears certain animals, situations, or places (describe):</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>33</td>
<td>Feelings are easily hurt</td>
<td>0 1 2</td>
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<tr>
<td>34</td>
<td>Gets hurt a lot, accident-prone</td>
<td>0 1 2</td>
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<tr>
<td>35</td>
<td>Gets in many fights</td>
<td>0 1 2</td>
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<tr>
<td>36</td>
<td>Gets into everything</td>
<td>0 1 2</td>
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<td></td>
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<tr>
<td>37</td>
<td>Gets too upset when separated from parents</td>
<td>0 1 2</td>
<td></td>
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</tr>
<tr>
<td>38</td>
<td>Has trouble getting to sleep</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>39</td>
<td>Headaches (without medical cause)</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>40</td>
<td>Hits others</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>41</td>
<td>Holds his/her breath</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>42</td>
<td>Hurts animals or people without meaning to</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>43</td>
<td>Looks unhappy without good reason</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>44</td>
<td>Angry moods</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>45</td>
<td>Nausea, feels sick (without medical cause)</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>46</td>
<td>Nervous movements or twitching (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>47</td>
<td>Nervous, high-strung, or tense</td>
<td>0 1 2</td>
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<td>48</td>
<td>Nightmares</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Overtaking</td>
<td>0 1 2</td>
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<tr>
<td>50</td>
<td>Overlaid</td>
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<td>51</td>
<td>Overweight</td>
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<tr>
<td>52</td>
<td>Painful bowel movements</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>53</td>
<td>Physically attacks people</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>54</td>
<td>Picks nose, skin, or other parts of body (describe):</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>55</td>
<td>Plays with own sex parts too much</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>56</td>
<td>Poorly coordinated or clumsy</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>57</td>
<td>Problems with eyes without medical cause (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>58</td>
<td>Punishment doesn't change his/her behavior</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>59</td>
<td>Quickly shifts from one activity to another</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Rashes or other skin problems (without medical cause)</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>61</td>
<td>Refuses to eat</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>62</td>
<td>Refuses to play active games</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>63</td>
<td>Repeatedly rocks head or body</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>64</td>
<td>Resists going to bed at night</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please see other side
### Child Behavior Checklist for Ages 4-16

**Child's Name**

- **Sex:**
  - [ ] Boy
  - [ ] Girl

- **Age:**
- **Race:**

- **Today's Date:**
  - Mo.
  - Day
  - Yr.

- **Child's Birthday:**
  - Mo.
  - Day
  - Yr.

- **Grade in School:**

---

#### I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

- [ ] None
  - a.
  - b.
  - c.

- Compared to other children of the same age, about how much time does he/she spend in each?
  - Don't Know
  - Less Than Average
  - Average
  - More Than Average

- Compared to other children of the same age, how well does he/she do each one?
  - Don't Know
  - Below Average
  - Average
  - Above Average

---

#### II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.)

- [ ] None
  - a.
  - b.
  - c.

- Compared to other children of the same age, about how much time does he/she spend in each?
  - Don't Know
  - Less Than Average
  - Average
  - More Than Average

- Compared to other children of the same age, how well does he/she do each one?
  - Don't Know
  - Below Average
  - Average
  - Above Average

---

#### III. Please list any organizations, clubs, teams, or groups your child belongs to.

- [ ] None
  - a.
  - b.
  - c.

- Compared to other children of the same age, how active is he/she in each?
  - Don't Know
  - Less Active
  - Average
  - More Active

---

#### IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.

- [ ] None
  - a.
  - b.
  - c.

- Compared to other children of the same age, how well does he/she carry them out?
  - Don't Know
  - Below Average
  - Average
  - Above Average

---

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V. 1. About how many close friends does your child have? □ None □ 1 □ 2 or 3 □ 4 or more

2. About how many times a week does your child do things with them? □ less than 1 □ 1 or 2 □ 3 or more

VI. Compared to other children of his/her age, how well does your child:

   a. Get along with his/her brothers & sisters? □ Worse □ About the same □ Better
   b. Get along with other children? □ □ □
   c. Behave with his/her parents? □ □ □
   d. Play and work by himself/herself? □ □ □

VII. 1. Current school performance — for children aged 6 and older:

□ Does not go to school
   a. Reading or English □ □ □ □
   b. Writing □ □ □ □
   c. Arithmetic or Math □ □ □ □
   d. Spelling □ □ □ □
   e. ____________________________ □ □ □ □
   f. ____________________________ □ □ □ □
   g. ____________________________ □ □ □ □

   Other academic subjects — for example: history, science, foreign language, geography.

2. Is your child in a special class?
   □ No □ Yes — what kind?

3. Has your child ever repeated a grade?
   □ No □ Yes — grade and reason

4. Has your child had any academic or other problems in school?
   □ No □ Yes — please describe

When did these problems start?

Have these problems ended?
   □ No □ Yes — when?
<table>
<thead>
<tr>
<th>Number</th>
<th>Item Description</th>
<th>Checkmark</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2</td>
<td>Acts too young for his/her age</td>
<td>CHECKBOX</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 1 2</td>
<td>Allergy (describe):</td>
<td></td>
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<tr>
<td>3 1 2</td>
<td>Argues a lot</td>
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<tr>
<td>4 1 2</td>
<td>Asthma</td>
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<tr>
<td>5 1 2</td>
<td>Behaves like opposite sex</td>
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<tr>
<td>6 1 2</td>
<td>Bowel movements outside toilet</td>
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<tr>
<td>7 1 2</td>
<td>Braggling, boastful</td>
<td></td>
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<tr>
<td>8 1 2</td>
<td>Can't concentrate, can't pay attention for long</td>
<td></td>
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<tr>
<td>9 1 2</td>
<td>Can't get his/her mind off certain thoughts; obsessions (describe):</td>
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<tr>
<td>10 1 2</td>
<td>Can't sit still, restless, or hyperactive</td>
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<tr>
<td>11 1 2</td>
<td>Clings to adults or too dependent</td>
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<tr>
<td>12 1 2</td>
<td>Complains of loneliness</td>
<td></td>
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<tr>
<td>13 1 2</td>
<td>Confused or seems to be in a fog</td>
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<tr>
<td>14 1 2</td>
<td>Cries a lot</td>
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<tr>
<td>15 1 2</td>
<td>Cruel to animals</td>
<td></td>
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<tr>
<td>16 1 2</td>
<td>Cruelty, bullying, or meanness to others</td>
<td></td>
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<tr>
<td>17 1 2</td>
<td>Day-dreams or gets lost in his/her thoughts</td>
<td></td>
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<tr>
<td>18 1 2</td>
<td>Deliberately harms self or attempts suicide</td>
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<tr>
<td>19 1 2</td>
<td>Demands a lot of attention</td>
<td></td>
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<tr>
<td>20 1 2</td>
<td>Destroys his/her own things</td>
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<tr>
<td>21 1 2</td>
<td>Destroys things belonging to his/her family or other children</td>
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<tr>
<td>22 1 2</td>
<td>Disobedient at home</td>
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<tr>
<td>23 1 2</td>
<td>Disobedient at school</td>
<td></td>
<td></td>
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<tr>
<td>24 1 2</td>
<td>Doesn't eat well</td>
<td></td>
<td></td>
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<tr>
<td>25 1 2</td>
<td>Doesn't get along with other children</td>
<td></td>
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<tr>
<td>26 1 2</td>
<td>Doesn't seem to feel guilty after misbehaving</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>27 1 2</td>
<td>Easily jealous</td>
<td></td>
<td></td>
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<tr>
<td>28 1 2</td>
<td>Eats or drinks things that are not food (describe):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>29 1 2</td>
<td>Fears certain animals, situations, or places, other than school (describe):</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>30 1 2</td>
<td>Fears going to school</td>
<td></td>
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<tr>
<td>31 1 2</td>
<td>Fears he/she might think or do something bad</td>
<td></td>
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<tr>
<td>32 1 2</td>
<td>Feels he/she has to be perfect</td>
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<tr>
<td>33 1 2</td>
<td>Feels or complains that no one loves him/her</td>
<td></td>
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<tr>
<td>34 1 2</td>
<td>Feels others are out to get him/her</td>
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<tr>
<td>35 1 2</td>
<td>Feels worthless or inferior</td>
<td></td>
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<tr>
<td>36 1 2</td>
<td>Gets hurt a lot, accident-prone</td>
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<tr>
<td>37 1 2</td>
<td>Gets in many fights</td>
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<tr>
<td>38 1 2</td>
<td>Gets teased a lot</td>
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<tr>
<td>39 1 2</td>
<td>Hangs around with children who get in trouble</td>
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<tr>
<td>40 1 2</td>
<td>Hears things that aren't there (describe):</td>
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<tr>
<td>41 1 2</td>
<td>Impulsive or acts without thinking</td>
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<tr>
<td>42 1 2</td>
<td>Likes to be alone</td>
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<tr>
<td>43 1 2</td>
<td>Lying or cheating</td>
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<tr>
<td>44 1 2</td>
<td>Bites fingernails</td>
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<tr>
<td>45 1 2</td>
<td>Nervous, highstrung, or tense</td>
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<tr>
<td>46 1 2</td>
<td>Nervous movements or twitching (describe):</td>
<td></td>
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<tr>
<td>47 1 2</td>
<td>Nightmares</td>
<td></td>
<td></td>
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<tr>
<td>48 1 2</td>
<td>Not liked by other children</td>
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<tr>
<td>49 1 2</td>
<td>Constipated, doesn't move bowels</td>
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<tr>
<td>50 1 2</td>
<td>Too fearful or anxious</td>
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<tr>
<td>51 1 2</td>
<td>Feels dizzy</td>
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<tr>
<td>52 1 2</td>
<td>Feels too guilty</td>
<td></td>
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<tr>
<td>53 1 2</td>
<td>Overeating</td>
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<tr>
<td>54 1 2</td>
<td>Overtired</td>
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<tr>
<td>55 1 2</td>
<td>Overweight</td>
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<tr>
<td>56 1 2</td>
<td>Physical problems without known medical cause:</td>
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<tr>
<td>56 a 1</td>
<td>Aches or pains</td>
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<tr>
<td>56 b 1</td>
<td>Headaches</td>
<td></td>
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<td></td>
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<tr>
<td>56 c 1</td>
<td>Nausea, feels sick</td>
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<tr>
<td>56 d 1</td>
<td>Problems with eyes (describe):</td>
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<td></td>
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<tr>
<td>56 e 1</td>
<td>Rashes or other skin problems</td>
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<tr>
<td>56 f 1</td>
<td>Stomachaches or cramps</td>
<td></td>
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<tr>
<td>56 g 1</td>
<td>Vomiting, throwing up</td>
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<tr>
<td>56 h 1</td>
<td>Other (describe):</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>0 = Not True (as far as you know)</td>
<td>1 = Somewhat or Sometimes True</td>
<td>2 = Very True or Often True</td>
<td></td>
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<tr>
<td>0 1 2 57. Physically attacks people</td>
<td>0 1 2 84. Strange behavior (describe):</td>
<td>0 1 2 85. Strange ideas (describe):</td>
<td></td>
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<tr>
<td>0 1 2 58. Picks nose, skin, or other parts of body (describe):</td>
<td></td>
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</tr>
<tr>
<td>0 1 2 59. Plays with own sex parts in public</td>
<td>0 1 2 86. Stubborn, sullen, or irritable</td>
<td>0 1 2 87. Sudden changes in mood or feelings</td>
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<tr>
<td>0 1 2 60. Plays with own sex parts too much</td>
<td>0 1 2 88. Sulks a lot</td>
<td>0 1 2 61. Poor school work</td>
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<tr>
<td>0 1 2 62. Poorly coordinated or clumsy</td>
<td>0 1 2 89. Suspicious</td>
<td>0 1 2 90. Swearing or obscene language</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 1 2 63. Prefers playing with older children</td>
<td>0 1 2 91. Talks about killing self</td>
<td>0 1 2 92. Talks or walks in sleep (describe):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 1 2 64. Prefers playing with younger children</td>
<td>0 1 2 93. Talks too much</td>
<td>0 1 2 94. Teases a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 65. Refuses to talk</td>
<td>0 1 2 95. Temper tantrums or hot temper</td>
<td>0 1 2 96. Thinks about sex too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 66. Repeats certain acts over and over, compulsions (describe):</td>
<td>0 1 2 97. Threatens people</td>
<td>0 1 2 98. Thumb-sucking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 67. Runs away from home</td>
<td>0 1 2 99. Too concerned with neatness or cleanliness</td>
<td>0 1 2 100. Trouble sleeping (describe):</td>
<td></td>
<td></td>
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<tr>
<td>0 1 2 68. Screams a lot</td>
<td></td>
<td></td>
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<tr>
<td>0 1 2 69. Secretive, keeps things to self</td>
<td>0 1 2 101. Truancy, skips school</td>
<td>0 1 2 102. Underactive, slow moving, or lacks energy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 70. Sees things that aren’t there (describe):</td>
<td>0 1 2 103. Unhappy, sad, or depressed</td>
<td>0 1 2 104. Unusually loud</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 71. Self-conscious or easily embarrassed</td>
<td>0 1 2 105. Uses alcohol or drugs (describe):</td>
<td>0 1 2 106. Vandalism</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 72. Sets fires</td>
<td></td>
<td>0 1 2 107. Wets self during the day</td>
<td></td>
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</tr>
<tr>
<td>0 1 2 73. Sexual problems (describe):</td>
<td>0 1 2 108. Wets the bed</td>
<td>0 1 2 109. Whining</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 74. Showing off or clowning</td>
<td>0 1 2 110. Wishes to be of opposite sex</td>
<td>0 1 2 111. Withdrawn, doesn’t get involved with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 75. Shy or timid</td>
<td>0 1 2 112. Worrying</td>
<td>0 1 2 113. Please write in any problems your child has that were not listed above:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 76. Sleeps less than most children</td>
<td></td>
<td>0 1 2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 77. Sleeps more than most children during day and/or night (describe):</td>
<td></td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 78. Smears or plays with bowel movements</td>
<td></td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2 79. Speech problem (describe):</td>
<td></td>
<td>0 1 2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 80. Stares blankly</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0 1 2 81. Steals at home</td>
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<tr>
<td>0 1 2 82. Steals outside the home</td>
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</tr>
<tr>
<td>0 1 2 83. Stores up things he/she doesn’t need (describe):</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.**

**UNDERLINE ANY YOU ARE CONCERNED ABOUT.**
# YOUTH SELF-REPORT FOR AGES 11-18

<table>
<thead>
<tr>
<th>YOUR AGE</th>
<th>YOUR SEX</th>
<th>GRADE IN SCHOOL</th>
<th>YOUR NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YOUR RACE</th>
<th>TODAY'S DATE</th>
<th>PARENTS' TYPE OF WORK (Please be specific — for example: auto mechanic, high school teacher, homemaker, laborer, taxi driver, shoe salesman, fireman, accountant)</th>
<th>FATHER'S TYPE OF WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Black</td>
<td>□ White</td>
<td>□ Other (specify)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ma. _______</td>
<td>Date _______ Yr.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>PARENT'S TYPE OF WORK</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>FATHER'S TYPE OF WORK</th>
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<tr>
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<table>
<thead>
<tr>
<th></th>
<th>MOTHER'S TYPE OF WORK</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skateboarding, bike riding, fishing, etc.

- □ None
  - a. ______________________
  - b. ______________________
  - c. ______________________

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, crafts, etc. (Do not include TV)

- □ None
  - a. ______________________
  - b. ______________________
  - c. ______________________

III. Please list any organization, clubs, teams or groups you belong to.

- □ None
  - a. ______________________
  - b. ______________________
  - c. ______________________

IV. Please list any jobs or chores you have. For example: Paper route, babysitting, making bed, etc.

- □ None
  - a. ______________________
  - b. ______________________
  - c. ______________________

- Compared to others of your age, how well do you do each one?
  - Compared to others of your age, about how much time do you spend in each?
    - Less Than Average: □
    - Average: □
    - More Than Average: □
    - Below Average: □
    - Average: □
    - Above Average: □

- Compared to others of your age, about how much time do you spend in each?
  - Less Than Average: □
  - Average: □
  - More Than Average: □
  - Below Average: □
  - Average: □
  - Above Average: □

- Compared to others of your age, how active are you in each?
  - Less Active: □
  - Average: □
  - More Active: □

- Compared to others of your age, how well do you carry them out?
  - Below Average: □
  - Average: □
  - Above Average: □

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Thomas M. Achenbach, Ph.D., U. of Vermont, 1 So. Prospect St., Burlington, VT 05401
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VIII. Below is a list of items that describe kids. For each item that describes you now or within the past 6 months, please circle the 2 if the item is very true or often true of you. Circle the 1 if the item is somewhat or sometimes true of you. If the item is not true of you, circle the 0.

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I act too young for my age</td>
<td></td>
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<tr>
<td>2. I have an allergy (describe):</td>
<td></td>
<td></td>
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<tr>
<td>3. I argue a lot</td>
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<td></td>
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<tr>
<td>4. I have asthma</td>
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<tr>
<td>5. I act like the opposite sex</td>
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<tr>
<td>6. I like animals</td>
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<tr>
<td>7. I brag</td>
<td></td>
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<tr>
<td>8. I have trouble concentrating or paying attention</td>
<td></td>
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<tr>
<td>9. I can't get my mind off certain thoughts (describe):</td>
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<tr>
<td>10. I have trouble sitting still</td>
<td></td>
<td></td>
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<tr>
<td>11. I'm too dependent on adults</td>
<td></td>
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<tr>
<td>12. I feel lonely</td>
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<tr>
<td>13. I feel confused or in a fog</td>
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<tr>
<td>14. I cry a lot</td>
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<tr>
<td>15. I am pretty honest</td>
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<td></td>
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<tr>
<td>16. I am mean to others</td>
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<tr>
<td>17. I daydream a lot</td>
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<tr>
<td>18. I deliberately try to hurt or kill myself</td>
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<tr>
<td>19. I try to get a lot of attention</td>
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<tr>
<td>20. I destroy my things</td>
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<tr>
<td>21. I destroy things belonging to others</td>
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<tr>
<td>22. I disobey my parents</td>
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<tr>
<td>23. I disobey at school</td>
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<tr>
<td>24. I don't eat as well as I should</td>
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<tr>
<td>25. I don't get along with other kids</td>
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<tr>
<td>26. I don't feel guilty after doing something I shouldn't</td>
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<tr>
<td>27. I am jealous of others</td>
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<tr>
<td>28. I am willing to help others when they need help</td>
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<tr>
<td>29. I am afraid of certain animals, situations, or places, other</td>
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<tr>
<td>than school (describe):</td>
<td></td>
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<tr>
<td>30. I am afraid of going to school</td>
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<tr>
<td>31. I am afraid I might think or do something bad</td>
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<tr>
<td>32. I feel that I have to be perfect</td>
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<tr>
<td>33. I feel that no one loves me</td>
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<tr>
<td>34. I feel that others are out to get me</td>
<td></td>
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<tr>
<td>35. I feel worthless or inferior</td>
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<tr>
<td>36. I accidentally get hurt a lot</td>
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<tr>
<td>37. I get in many fights</td>
<td></td>
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<tr>
<td>38. I get teased a lot</td>
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<tr>
<td>39. I hang around with kids who get in trouble</td>
<td></td>
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<tr>
<td>40. I hear things that nobody else seems able to hear (describe):</td>
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<tr>
<td>41. I act without stopping to think</td>
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<tr>
<td>42. I like to be alone</td>
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<tr>
<td>43. I lie or cheat</td>
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<td></td>
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<tr>
<td>44. I bite my fingernails</td>
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<tr>
<td>45. I am nervous or tense</td>
<td></td>
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<tr>
<td>46. Parts of my body twitch or make nervous movements (describe):</td>
<td></td>
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<tr>
<td>47. I have nightmares</td>
<td></td>
<td></td>
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<tr>
<td>48. I am not liked by other kids</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>49. I can do certain things better than most kids</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>50. I am too fearful or anxious</td>
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<tr>
<td>51. I feel dizzy</td>
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<td></td>
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<tr>
<td>52. I feel too guilty</td>
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<td></td>
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<tr>
<td>53. I eat too much</td>
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<td></td>
<td></td>
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<tr>
<td>54. I feel overstimulated</td>
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<td></td>
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<tr>
<td>55. I am overweight</td>
<td></td>
<td></td>
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<tr>
<td>56. Physical problems without known medical causes:</td>
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<td></td>
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</tr>
<tr>
<td>a. Aches or pains</td>
<td></td>
<td></td>
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<tr>
<td>b. Headaches</td>
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<td></td>
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<tr>
<td>c. Nausea, feel sick</td>
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<tr>
<td>d. Problems with eyes (describe):</td>
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<tr>
<td>57. I physically attack people</td>
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<tr>
<td>58. I pick my skin or other parts of my body (describe):</td>
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<tr>
<td>59. I can be pretty friendly</td>
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<tr>
<td>60. I like to try new things</td>
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<tr>
<td>61. My school work is poor</td>
<td></td>
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<tr>
<td>62. I am poorly coordinated or clumsy</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>63. I would rather be with older kids than with kids my own age</td>
<td></td>
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</tbody>
</table>
SELF-PERCEPTION PROFILE FOR CHILDREN

Instructions to the Child (8 - 14 years)

We have some sentences here and each sentence describes how kids see themselves. Some kids see themselves like kids on the right. Some kids see themselves like kids on the left. First decide which kid you are like. Check whether this is really true or sort of true. Make sure you only have one checkmark in the boxes.

Sample Sentences

<table>
<thead>
<tr>
<th>Really True for me</th>
<th>Sort of True for me</th>
<th>Sort of True for me</th>
<th>Really True for me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Some kids like french BUT fries</td>
<td>Other kids like yoghurt and fruit</td>
<td></td>
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<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
## What I Am Like

**Name**

**Sex**

**Age**

**Birthdate**

### SELF-PERCEPTION PROFILE FOR CHILDREN

*(Revision of the Perceived Competence Scale for Children)*

_Susan Harter, Ph.D., University of Denver, 1985*

<table>
<thead>
<tr>
<th>Really True for me</th>
<th>Sort of True for me</th>
<th>Sort of True for me</th>
<th>Really True for me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Some kids feel that they are very good at their school work</td>
<td>BUT Other kids worry about whether they can do the school work assigned to them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Some kids find it hard to make friends</td>
<td>BUT Other kids find it's pretty easy to make friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Some kids do very well at all kinds of sports</td>
<td>BUT Other kids don't feel that they are very good when it comes to sports.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Some kids are happy with the way they look</td>
<td>BUT Other kids are not happy with the way they look.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Some kids often do not like the way they behave</td>
<td>BUT Other kids usually like the way they behave.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Some kids are often unhappy with themselves</td>
<td>BUT Other kids are pretty pleased with themselves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Some kids feel like they are just as smart as as other kids their age</td>
<td>BUT Other kids aren't so sure and wonder if they are as smart.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Some kids have alot of friends</td>
<td>BUT Other kids don't have very many friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Really True for me</td>
<td>Sort of True for me</td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>9.</td>
<td>Some kids wish they could be alot better at sports</td>
<td>BUT Other kids feel they are good enough at sports.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Some kids are happy with their height and weight</td>
<td>BUT Other kids wish their height or weight were different.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Some kids usually do the right thing</td>
<td>BUT Other kids often don't do the right thing.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Some kids don't like the way they are leading their life</td>
<td>BUT Other kids do like the way they are leading their life.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Some kids are pretty slow in finishing their school work</td>
<td>BUT Other kids can do their school work quickly.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Some kids would like to have alot more friends</td>
<td>BUT Other kids have as many friends as they want.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Some kids think they could do well at just about any new sports activity they haven't tried before</td>
<td>BUT Other kids are afraid they might not do well at sports they haven't ever tried.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Some kids wish their body was different</td>
<td>BUT Other kids like their body the way it is.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Some kids usually act the way they know they are supposed to</td>
<td>BUT Other kids often don't act the way they are supposed to.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Some kids are happy with themselves as a person</td>
<td>BUT Other kids are often not happy with themselves.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Some kids often forget what they learn</td>
<td>BUT Other kids can remember things easily.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Some kids are always doing things with aloot of kids</td>
<td>BUT Other kids usually do things by themselves.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Really True for me</td>
<td>Sort of True for me</td>
<td>BUT</td>
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<tr>
<td>21</td>
<td></td>
<td>Some kids feel that they are better than others their age at sports</td>
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<tr>
<td>22</td>
<td></td>
<td>Some kids wish their physical appearance (how they look) was different</td>
<td></td>
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<tr>
<td>23</td>
<td></td>
<td>Some kids usually get in trouble because of things they do</td>
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<td>24</td>
<td></td>
<td>Some kids like the kind of person they are</td>
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<td>25</td>
<td></td>
<td>Some kids do very well at their classwork</td>
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<tr>
<td>26</td>
<td></td>
<td>Some kids wish that more people their age liked them</td>
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<tr>
<td>27</td>
<td></td>
<td>In games and sports some kids usually watch instead of play</td>
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<td>28</td>
<td></td>
<td>Some kids wish something about their face or hair looked different</td>
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<td>29</td>
<td></td>
<td>Some kids do things they know they shouldn’t do</td>
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<tr>
<td>30</td>
<td></td>
<td>Some kids are very happy being the way they are</td>
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<tr>
<td>31</td>
<td></td>
<td>Some kids have trouble figuring out the answers in school</td>
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<tr>
<td>32</td>
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<td>Some kids are popular with others their age</td>
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<tr>
<td></td>
<td>Really True for me</td>
<td>Sort of True for me</td>
<td>Really True for me</td>
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<td>36.</td>
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Susan Harter, Ph.D., University of Denver, 1985
<table>
<thead>
<tr>
<th>Mean: Items (6)</th>
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<tr>
<td>SUM 36</td>
<td>SUM 35</td>
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<td>30 (R)</td>
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**DOMAINS:**
- Global Self-Worth
- Conduct
- Behavioral Appearance
- Physical Competence
- Athletic Competence
- Social Acceptance
- Competence
-Scholastic

**SCORING SHEET:** Each response quantified as follows:
- 1 if True
- 2 if True and Sort
- 3 if True and Sort Really
- 4 if True, Sort, and Really

**REVISED SELF-PERCEPTION PROFILE FOR CHILDREN**
Appendix C

DESCRIPTIONS OF TREATMENT PROCESS
# Description of Treatment Process

## I. The Women's Group Component

<table>
<thead>
<tr>
<th>Description</th>
<th>Primary Objective</th>
<th>Secondary Objective</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provision of support groups to battered women</td>
<td>1. To increase knowledge of resources and safety skills to insure women are able to take action on safety concerns.</td>
<td></td>
<td>Weekly Report</td>
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<tr>
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<tr>
<td></td>
<td>2. To empower women to take responsibility for decision making and asserting control over their own lives</td>
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<td>K-M</td>
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<tr>
<td>Secondary Objective</td>
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<tr>
<td></td>
<td>3. To reduce isolation by increasing social support and knowledge of available resources</td>
<td></td>
<td>Locus of Control Scale</td>
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<td></td>
<td>4. Exploration of gender belief system with resulting disenfranchisement of these beliefs</td>
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<td>Fibro-B Test</td>
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<td></td>
<td>Adult SSAT</td>
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<td>K-K</td>
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<td>Description</td>
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<td>Secondary Objective</td>
<td>Indicator</td>
<td>Activities</td>
<td>Resources</td>
<td>Staff Roles</td>
<td>Time-Frame</td>
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</tr>
<tr>
<td>Activities</td>
<td>Women's Group</td>
<td>Outline</td>
<td></td>
<td>Activities: Ice Breakers Large Group Discussion Small Group Discussion Brainstorming Self-Disclosure Activities AV Resources Handouts</td>
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<td>E - P</td>
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<td>Resources</td>
<td>Co-facilitators</td>
<td></td>
<td></td>
<td>Educators</td>
<td>Enablers</td>
<td>Advocacy</td>
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<tr>
<td>Staff Roles</td>
<td>Group Therapists</td>
<td></td>
<td></td>
<td>Role Models</td>
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<tr>
<td>Time-Frame</td>
<td>12 sessions</td>
<td>6 sessions Educational Focus</td>
<td></td>
<td>6 sessions Therapeutic Focus</td>
<td>2.5 hrs./wk.</td>
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II. The Children's Group Component

<table>
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<th>Secondary Objective</th>
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<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
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</thead>
<tbody>
<tr>
<td>The provision of children's groups offers an opportunity to mediate the impact of violence in the home and to develop safety skills and social skills.</td>
<td>Ensure safety/well-being</td>
<td>Teach safety skills</td>
<td>Pre/Post - Pre/Post interview - Pre/Post Parent Reports</td>
<td>1. Teach sources of safety 2. Facilitator of safety 3. Coach Encourage non-interference 4. Challenger Enforce self responsibility 5. Assign appropriate responsibility for violence</td>
<td>Educator 3 sessions</td>
<td>K - H</td>
<td>K - L</td>
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</tbody>
</table>

Children's Groups Components

1. Pre-School (3 1/2-6 yrs.)
2. School-Age (6-8 yrs.)
3. Older School-Aged (8-10 yrs.)
4. Young Adolescent Group (10-13 yrs.)
5. Older Adolescent Group (13-16 yrs.)

<table>
<thead>
<tr>
<th>Description</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
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</thead>
<tbody>
<tr>
<td>Description</td>
<td>Primary Objective</td>
<td>Secondary Objective</td>
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<td>Activities</td>
<td>Staff Roles</td>
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<td>4. Affective disclosure</td>
<td>4. Challenger</td>
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<td>5. Delegitimizing violence</td>
<td>5. Process</td>
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<td>6. Assertion training</td>
<td>Illuminator</td>
</tr>
<tr>
<td>Redress belief systems re: male,</td>
<td></td>
<td></td>
<td>1. SISAT</td>
<td>1. Group exercises</td>
<td>1. Facilitator</td>
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<td></td>
<td>Illuminator</td>
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</table>
### III. The Individual Counselling Component - Women

<table>
<thead>
<tr>
<th>Description</th>
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<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendix/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provision of individual counselling to increase women's social support and self-esteem to enable the development of problem-solving and decision-making skills.</td>
<td>1. To increase knowledge of safety skills to insure women are able to take action on safety concerns.</td>
<td></td>
<td>Index of Spouse Abuse (Hudson and McIntosh)</td>
<td>Conflict Tactics Scale (Strauss)</td>
<td>A - B</td>
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<tr>
<td>Primary Objective</td>
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</tr>
<tr>
<td>2. To insure the basic material needs of the women and her family are being met.</td>
<td>Process Recording - Primary Therapist</td>
<td></td>
<td></td>
<td></td>
<td>A - B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Objectives</td>
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</tr>
<tr>
<td>3. To empower women to: a) increase problem-solving &amp; decision-making skills b) decrease isolation by increasing social support c) increase level of assertiveness d) increase self-confidence</td>
<td>Scales of Perceived Social Support (MacDonald)</td>
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<tr>
<td>Description</td>
<td>Primary Objective</td>
<td>Secondary Objective</td>
<td>Indicator</td>
<td>Activities</td>
<td>Staff Roles</td>
<td>Time-Frame</td>
<td>Appendices/Exhibits</td>
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<tr>
<td>4. Education regarding dynamics of violence in the family</td>
<td></td>
<td></td>
<td>Process Recording of Primary Therapist</td>
<td>Adult SISAT</td>
<td></td>
<td>K - K</td>
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</tbody>
</table>

**Activities**

1. Systemic Analysis & Strategic Family Interaction

2. Empowering women to take an active role in goal setting, decision-making & action planning utilizing role play techniques and a feminist therapy approach
<table>
<thead>
<tr>
<th>Description</th>
<th>Primary Objective</th>
<th>Secondary Objective</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Challenger</td>
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<td></td>
<td></td>
<td>Supporter</td>
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<td></td>
<td>Confronter</td>
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<td></td>
<td>Enabler</td>
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<td></td>
<td>Educator</td>
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<td></td>
<td>Therapist</td>
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<td>Advocacy Role</td>
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<td></td>
<td>6 sessions</td>
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<td>1 1/2 hrs.</td>
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<td>per session</td>
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20
### IV. The Family Therapy Counselling Component

#### 1) Family Therapy

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<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provision of therapy to members of a violence prone family - either the whole family or parts thereof to remedy the impact of violence on the children</td>
<td>- stop violence</td>
<td>- ensure safety</td>
<td>- Verbal Reports</td>
<td>1. Individual sessions with family members</td>
<td>Coach Conscience Educator Monitor Enforcer Confronter Informer Coordinator</td>
<td>- minimum 6 months</td>
<td>A - B</td>
</tr>
<tr>
<td>- to prevent relapse of violence</td>
<td></td>
<td></td>
<td>- Verbal Reports</td>
<td>2. Conjoint sessions (after violence stops)</td>
<td>Counsellor Coach Monitor Enforcer Mediator Educator</td>
<td>- 6 to 8 months</td>
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</tr>
<tr>
<td>Description</td>
<td>Primary Objective</td>
<td>Secondary Objective</td>
<td>Indicator</td>
<td>Activities</td>
<td>Staff Roles</td>
<td>Time-Frame</td>
<td>Appendices/Exhibits</td>
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<tr>
<td>stop violence</td>
<td>- family subsystem</td>
<td>functioning</td>
<td>- Clinical Assessment</td>
<td>1. Reestablish hierarchy</td>
<td>Therapist</td>
<td>- 4 to 6 months</td>
<td>A - B</td>
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<td></td>
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<td></td>
<td>- Client Reports</td>
<td>- support parents</td>
<td>Coach</td>
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<td></td>
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<td>- Team Reports</td>
<td>- team building</td>
<td>Instigator</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- Achenbach Observation</td>
<td>- shift power coalitions</td>
<td>Illuminator</td>
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<td></td>
<td></td>
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<td>- Goal Attainment Scaling</td>
<td>- dysfunctional</td>
<td>Motivator</td>
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<td>- parental spousal sibling</td>
<td>Support</td>
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<td>3. Redress coalitions and alliances</td>
<td>Strategist</td>
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<td>Team Member</td>
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<td>Coordinator</td>
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<td></td>
<td>Director</td>
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### 2. Parenting Counselling

(Women)

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<th>Description</th>
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<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendixes/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Objective</strong></td>
<td>1. To insure safety needs of women are met by increasing knowledge of social support network available to them as an alternative to staying in a violent home.</td>
<td></td>
<td>Perceived Scale of Social Support (MacDonald)</td>
<td>Index of Spouse Abuse (Hudson and McIntosh) Conflict Tactics Scale (Strauss)</td>
<td></td>
<td>A - B</td>
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<tr>
<td>2. Clarifying roles of wife and mother for clients to address issues of role differentiation/individuation</td>
<td></td>
<td>Process Recording of Primary Therapist</td>
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<td>A - B</td>
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<tr>
<td>3. Empowerment of parent to set appropriate boundaries to enhance family functioning.</td>
<td></td>
<td>Process Recording of Primary Therapist</td>
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<td>A - B</td>
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<tr>
<td>4. To increase skill in recognising indicators of escalating tension in the cycle of family violence.</td>
<td></td>
<td>Conflict Tactics Scale (Strauss)</td>
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<tr>
<td>Description</td>
<td>Primary Objective</td>
<td>Secondary Objective</td>
<td>Indicator</td>
<td>Activities</td>
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<tr>
<td>Activities</td>
<td>Strategic Family Therapy - 1) systemic analysis and intervention to restructure family interactions (Bross and Benjamin)</td>
<td></td>
<td>Enabler, Advocate, Therapist, Educator (Parenting Issues)</td>
<td></td>
<td>E - F Contract</td>
<td>E - F Contract</td>
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<tr>
<td>Staff Roles</td>
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<tr>
<td>Time-Frame</td>
<td>- Treatment - 12 wks X 1 1/2 hrs/wk</td>
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<td>- After 6 wks intervention - evaluation - termination or continuation</td>
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<td>- After 12 wks intervention - evaluation - termination or re-contract for another 12 wks.</td>
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<td></td>
<td>- Termination</td>
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</table>
## 2. Parenting Counselling

### (Men)

<table>
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<th>Secondary Objective</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Objective</strong></td>
<td>1. To change parental behavior using a systemic intervention.</td>
<td></td>
<td>Process Recording</td>
<td>Primary Therapist</td>
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</tr>
<tr>
<td><strong>Secondary Objective</strong></td>
<td>2. To challenge and reframe belief systems regarding sexual stereotyping of male/female roles.</td>
<td></td>
<td>Process Recording</td>
<td>Primary Therapist</td>
<td></td>
<td></td>
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<tr>
<td><strong>Activities</strong></td>
<td></td>
<td></td>
<td>Systemic analysis and strategic intervention to restructure family interactions</td>
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<tr>
<td><strong>Staff Roles</strong></td>
<td></td>
<td></td>
<td>Enabler Advocate Therapist Educator Parenting Issues</td>
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<tr>
<td><strong>Time-Frame</strong></td>
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<td></td>
<td>Treatment K–K Contract 6 evaluation re-contract or termination</td>
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<td>12 week I I 1 1/2 hrs./wk.</td>
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</table>
### 3. Child Psychotherapy

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<thead>
<tr>
<th>Description</th>
<th>Primary Objective</th>
<th>Secondary Objective</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
<th>Time-Frame</th>
<th>Appendices/Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children ages 3 1/2 to 16 years.</td>
<td><strong>Primary Objective</strong></td>
<td>1. To increase knowledge of safety skills to insure children are able to take action on safety concerns.</td>
<td>Children's Intake Form (Safety Screen)</td>
<td></td>
<td></td>
<td>A - B</td>
<td></td>
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<tr>
<td></td>
<td><strong>Secondary Objective</strong></td>
<td>2. To increase the ability to identify and express feelings regarding self and family.</td>
<td>Process Recording - Primary Therapist</td>
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<td>3. To increase knowledge of child's role in family and appropriate functioning re sub-system issues.</td>
<td>Process Recording - Primary Therapist</td>
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<td>4. To increase incidence of age-appropriate expressions of feelings.</td>
<td>Adult for the Child (Achenbach) -Structured Learning Skill Checklist (Survey Place)</td>
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<td>A - B, E - G</td>
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<tr>
<td>Description</td>
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<td>Child</td>
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<td>A - B</td>
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<td>-Piers-Harris</td>
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</table>

**Activities**

- Play Therapy (3 1/2-6 yrs)
- Individual Therapy (7-16 yrs)
- Role Modelling

**Staff Roles**

- Facilitator
- Therapist
- Educator
<table>
<thead>
<tr>
<th>Description</th>
<th>Primary Objective</th>
<th>Secondary Objective</th>
<th>Indicator</th>
<th>Activities</th>
<th>Staff Roles</th>
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<th>Appendices/Exhibits</th>
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<td><em>Time-Frame</em></td>
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<td>Treatment</td>
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Appendix D

1. INTER-ORGANIZATIONAL INTERVIEW QUESTIONNAIRE

2. KEY INFORMANT INTERVIEW LIST
Family Violence Project

Inter/Organizational Interview Questionnaire

Section I - General

1. Within the last three years, has your organization worked jointly in planning and/or implementing activities with the Family Violence Project?

2. To what extent would developing more formal procedures, such as written agreements, help link your organization's service delivery to the services provided by the Family Violence Project?

3. Does anyone from your organization (staff or board member) serve on the board or committees of the Family Violence Project or its sponsoring organizations - the Lester B. Pearson Centre or the Chatham-Kent Women's Centre?

4. Does your organization and the Family Violence Project have differences in assumptions regarding the causes of family violence and the way services to families of violence should be delivered?

5. Where do you see the family violence project going in the future?

6. What would you like to see happen to the Family Violence Project in the future?

7. How do you see yourself being involved in the family violence project in the future?

8. How could you see the Family Violence Project being modified to suit your organization's service delivery needs?

9. In the event the Family Violence Project does not get funded in the future, would it make a difference to your organization?

10. What impact would it have on your organization if the Family Violence Project was not funded in the future?
11. Which of the following services have you had to use in the past year? How important are the contacts with Family Violence services to the work of your organization?

<table>
<thead>
<tr>
<th>Services</th>
<th>check (✔)</th>
<th>check (✔)</th>
<th>How Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Don't Know</td>
</tr>
<tr>
<td>a) Individual Counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Women's Groups</td>
<td></td>
<td></td>
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<tr>
<td>c) Family Therapy</td>
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<tr>
<td>d) Parenting Counselling</td>
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<tr>
<td>e) Child Psychotherapy</td>
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<td>f) Pre-School Children's Group</td>
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<td>g) School-Age Children's Group</td>
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<td>h) Latency Age Children's Group</td>
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<tr>
<td>i) Young Adolescent Group</td>
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<tr>
<td>j) Older Adolescent Group</td>
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<td></td>
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<tr>
<td>k) Parent Group</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>l) Community Education</td>
<td></td>
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<tr>
<td>m) Consultation on Family Violence</td>
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<td></td>
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<tr>
<td>n) Staff Training</td>
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<td></td>
<td></td>
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<tr>
<td>o) Case-sharing</td>
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</tr>
</tbody>
</table>
12. Which services do you think have been of most benefit to your organization?

Direct Services
Community Education
Consultation on Family Violence
Staff Training

13. Do you see the Family Violence Project as a separate and distinct entity from the two sponsoring organizations?

14. In your perception, what is the primary goal of the Family Violence Project?

Section II - Providers of Complementary Service

15. How does the service offered by your organization complement the Family Violence Project?

16. In what ways could a better administrative and service linkage mechanism be established?

17. In what ways do you see your organizations continuing to be involved with the Family Violence Project?

Section III - Recipients and Consumers

18. How has the family violence project affected the programs and services provided by your organization?

19. In the event the project was not funded in the future, could you incorporate the Family Violence Project within your organization's present operating philosophy?

20. How would you describe the extent to which you are willing to provided needed resources to the Family Violence Project to help them accomplish their objectives?

Section IV - Competing Organizations

21. What is the major service provided directly by your organization?

22. How often does your organization have contact with the Family Violence Project?
23. Has your organization worked jointly with the Family Violence Project in planning and/or implementing any case management activities?

24. To what extent do disagreements or disputes characterize the relationship between your organization and the Family Violence Project?

Section V - Providers of Legitimation and Authority

25. If the Family Violence Project continues, do you think you should be involved at a board or committee level?

26. Does anyone from the Family Violence Project or its sponsoring organizations - the Lester B. Pearson Centre or the Chatham-Kent Women's Centre serve on boards, committees, councils or commissions of your organization?

27. How do you see the Family Violence Project being modified to provide better co-ordination of family violence services in Kent County?

Section VI - Providers of Fiscal Resources

28. How would you describe the extent to which the organization’s involved have provided adequate resources for facilities and personnel?

29. To what extent do written financial agreements exist between the funder and sponsoring organizations? How were these agreements negotiated and agreed upon?

30. How would you describe the extent of your commitment to provide financial resources to the Family Violence Project as a separate entity in the future?
Section VII - Providers of Clients

31. Which services of the Family Violence Project has your organization utilized over the past year? Which have been most beneficial to your a) organization b) clients?

<table>
<thead>
<tr>
<th>Services</th>
<th>A Organization How Beneficial</th>
<th>B Clients How Beneficial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Services</td>
<td>Very</td>
<td>Somewhat</td>
</tr>
<tr>
<td>Community Education</td>
<td></td>
<td></td>
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<tr>
<td>Consultation on Family Violence</td>
<td></td>
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<tr>
<td>Staff Training</td>
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</tbody>
</table>

32. How important are the contacts with Family Violence Service to the work of your organization? LOW 1 2 3 4 5 HIGH

33. Does your organization have any written agreements with the Family Violence Project regarding specific programs or activities, personnel commitments, client referrals or procedures for working together?
Family Violence Project
Inter-Organizational Survey

Key Informant Interviews

A. Providers of Fiscal Resources

1) Mike Byrne, Program Supervisor, Ministry of Community & Social Services

2) Dr. John Leigh, Past President, Board of Directors, Lester B. Pearson Centre

3) Cathy Cottingham, President, Board of Directors, Chatham-Kent Women's Centre

B. Providers of Legitimation & Authority

1) Nelson Somerset, Assistant Deputy Chief, Chatham Police Department

2) Jamie Snyder, President, United Way
   Isabel Cimolino, Past Executive Director, Kent County Task Force on Family Violence
   Nan Stuckey, Past Board Member, Chatham-Kent Women’s Centre

C. Competing Organizations

1) Sam Hershenhorn, Executive Director, Chatham-Kent Community and Family Services

2) Paul Szeps, Private Therapist

D. Recipients & Consumers

1) Joy Pyymaki, Administrator, Chatham-Kent Women's Centre

2) Julie Farrell, Executive Director, Lester B. Pearson Centre

E. Providers of Clients

1) John Bloxam, Public Relations Co-ordinator, Chatham O.P.P.

2) Joy Pyymaki, Administrator, Chatham-Kent Women's Centre
F. Providers of Complementary Services

1) Larry Quinlan, Supervisor, Family Service Team, Kent Children's Aid Society

2) Bruce McCubbin, Addictions Program, Mental Health Clinic
Appendix E

PROJECT STAFF SURVEY QUESTIONNAIRE
Family Violence Project

Staff Interview Questionnaire

Part I
General

1. Do you see the family violence project being expanded to include elder abuse, sexual assault and incest survivors?

2. Do you believe the family violence service should expand its mandate to include more prevention services such as a more intensive public education program?

3. Could the expertise you have developed in the family violence service be utilized at a consultative and/or staff training level for other community agencies?

4. To what extent would developing more formal policies and procedures help your work with clients?

5. Do you perceive the need for further integration of services for family violence such as a domestic response team to respond to police calls and emergency room calls?

6. Where would you like to see the family violence project going in the future?

Part II
Supervision

7. How has the organizational structure of the family violence project impacted on your relationship to your employing agency?

8. Has the clinical supervision provided to you been an effective component in your development as a family violence practitioner? Has the frequency and duration of supervision been adequate?

9. How have the methods of supervision outlined below contributed to your development as a family violence practitioner?

   a) Individual
   b) Group
   c) Peer

10. Has the staff training provided to you as a family violence practitioner been an important component of your employment with family violence services? How has this training been integrated into your practice?
11. Would the position of team leader be an effective staff position to incorporate into the family violence project? What functions do you see this position fulfilling?

**Physical Environment**

12. Has the physical environment provided by family violence services been conducive to your work with clients?

13. Do you feel the physical environment has been conducive to protecting the confidentiality of your clients?

14. Has the physical environment, in your opinion, encouraged your clients to feel comfortable and respected during client sessions?

15. How could the physical environment be modified to provide better service to the clients you have seen?

16. Have your clients commented on the physical environment of family violence services? If Yes, What was the content of these comments?

17. Do you feel it is important for family violence services to provide a physical environment where all members of the family could be seen within the same facility?

18. How has the physical environment allowed for interaction with your team members of the family violence project? If Yes, How does this occur? If No, What would improve this?

**Program Outcomes**

19. Did the majority of clients complete the treatment contract set up during the first session? Did you find that re-contracting for further intervention was needed beyond the initial treatment contract?

20. What community support services have you planned for clients during their involvement with family violence services and upon leaving the project?

21. What are the identified gaps in service to this population that you have discovered in your practice?

22. What support services would you like to see developed in the community for these families?

23. What would you like the outcome of your client's involvement with family violence services to be?
24. What kind of gains did you perceive your clients to have made during their involvement with family violence services?

25. What clinical dilemmas have the clients of the family violence project presented you with?
Appendix F

INTAKE REPORT OUTLINE
INTAKE REPORT OUTLINE

Family Members: names

Genogram:

Date(s) of Assessment: ____________________________
Date Assessment Dictated: ________________________

PRESENTING REQUEST: -who referred the family
- their perception of the problem
- precipitating events
- what is the family asking for
- how do they define the problem

FAMILY HISTORY: - individual histories for both partners
up to the time of dating each other
- families of origin
- existence of violence or
child abuse
- relationships with other members
- social behaviors as a child
- nature of other intimate relationships
- relationship history of the partners
- how they met
- what they did together
- family acceptance of the relationship
- existence and profile of any violence
- decision to marry:
- nature of the early marriage i.e., rules, rules, insecurities, dreams, stressors
- violence dynamics i.e., when did it begin,
changes over time, patterns,
complimentary vs. symmetrical
- family development with children
- births of the children and their development
- changes in the relationship associated
with the parental responsibilities
- changes in violence dynamics
- child involvement in the violence
- nature of parent/child relationships
- problems exhibited by the children
over time
PRESENT FAMILY SITUATION:

- nature of relationships in the present
  - how has the violence changed i.e. has it changed from complimentary to symmetrical, frequency, intensity, nature etc.
  - how do the family members feel about each other and the family
  - what kind of dysfunctions are obvious in the individual members
  - how are these exhibited in the family

- motivating forces at this time i.e. is there court involvement, are there threats to leave, are the children too badly impacted/level and perceived power of these motivators

- what are the members willing to work on and admit to as being problematic
- what are the members still avoiding or minimizing

*note: in this section, the psychometric results can be integrated to reinforce and illustrate clinical impressions. For example, "At this time there appears to be an increasing problem with physical abuse, this has been reported by LB and is also reflected by high scores on the Index of Spouse Abuse (physical abuse scale)."

PRESENTING PROBLEMS:

In this section, list the most prevalent problems and recommendations for the family. Back up these concerns with the text of the report and the measurement results. For example:

1. "Safety concerns appear to be important for the children in the family. Both parents report their involvement in the conflicts, and the Children's Intake Screening indicates that they feel that they must do something to stop their parent's fighting"

2. ..................
REFERENCES


*Due to the extensiveness of the supporting documents, they have not been included with this report. A file containing this additional documentation is available for review at the following location:

School of Social Work
University of Windsor
Windsor, Ontario
N9B 3P4
(519)253-4232 Ext. 3064
Vita Auctoris

Judith Marguerite Dunlop was born in Windsor, Ontario on February 7, 1949. She attended J.L. Forster Collegiate in Windsor, Ontario and Sheridan College in Oakville, Ontario. She received her Bachelor of Social Work Degree from the University of Regina in Regina, Saskatchewan in 1981. Since that time, she has practiced as a social worker in the provinces of British Columbia, Saskatchewan and Ontario.
TO: Alison Samson  
Academic Assistant to the Dean  
Faculty of Graduate Studies  

FROM: Dr. M. J. Holosko, School of Social Work  

SUBJECT:  

DATE: August 22, 1989  

As per your request, I received permission in 1988 from both Dr. Grant Macdonald and Dr. Walter W. Hudson to use their scales for the conduct of the inter-organizational evaluation of the Family Violence Services Project. These scales include the Perceived Social Support Scale (Macdonald, 1987) and the Index of Spouse Abuse (Hudson, 1978) and are used in Judith Dunlop's graduate thesis "A Program Evaluation of the Inter-Organizational Family Violence Project in Kent County, 1989", School of Social Work.