

Women Mental Health Consumers
and Their Children Multi-Site Outcome Study

Case File Extraction Form
Documentation Manual

Prepared by:
Pamela Steigman, M.A. and Judith A. Cook, Ph.D.
University of Illinois at Chicago
National Research and Training Center on Psychiatric Disability

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The Case File Extraction Protocol: An Overview

The Case File Extraction Protocol (CFEP) was developed to guide researchers in extracting case file information for a multi-site research project called the Women Mental Health Consumers and their Children Study. This study is part of a five-year program of research and training activities conducted as part of the University of Illinois at Chicago, National Research and Training Center on Psychiatric Disability. Data gathered via the CFEP will be used to evaluate the outcomes of mothers with severe mental illness and their pre-school aged children (0-6 years) who were served for at least a year in one of four comprehensive mental health and rehabilitative programs around the country. The extraction protocol is designed for use by trained abstracters to collect information, retrospectively, from the case files of former or current clients of these programs.

Inclusion Criteria. Files should be extracted if they meet the following study inclusion criteria: 1) the client began receiving services on or after January 1, 1996; 2) the client was enrolled in the program for at least one year; and 3) the client had at least one pre-school aged child enrolled in the program with her. The treatment outcomes that are being assessed in this study include custody status, employment and education status, psychiatric hospitalization, substance abuse status, health status of mother and child(ren), legal status, and independent living status. Descriptive information, such as marital status, social support network, living situation, diagnostic information, etc., will be collected, as well.

Use of the Manual. The intent of this manual is to provide guidelines and instructions for data extraction using the Case File Extraction Protocol (CFEP). During the case file extractor training, you will have gained experience in completing the CFEP, using the manual as a reference. Inevitably, issues will arise once the real work begins. The manual has been designed to be the source to which you turn first when dealing with questions about study procedures. You often will find within it the answers to your questions about when or how to complete a CFEP item. In addition, you should document all questions or problems in writing for discussion with UIC project staff (Dr. Judith Cook, Study Principal Investigator; Pamela Steigman, Study Coordinator; or Alexandra Laris, Research Data Analyst), or during the study's weekly conference calls.

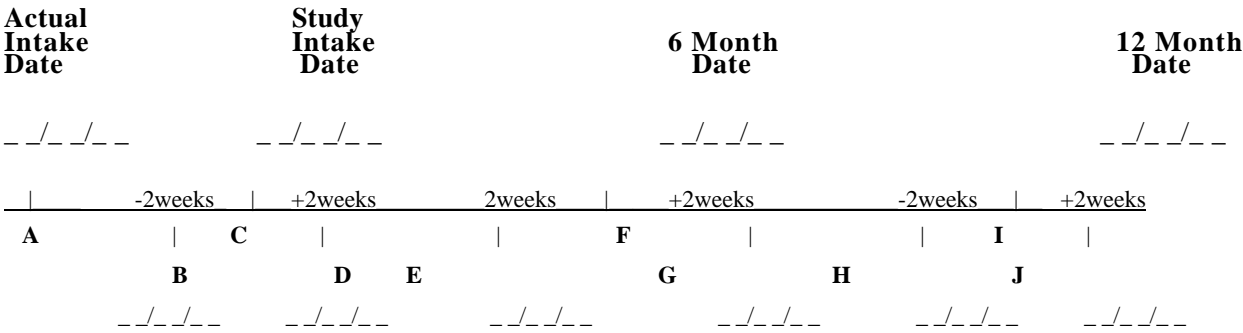
Organization of the Protocol. The Case File Extraction Protocol (CFEP) consists of three major sections: the *Intake Review*, the *6 Month Review*, and the *12 Month Review*. In the Intake Review section, questions refer to the study intake date (plus or minus 2 weeks), as well as a defined period of time prior to enrolling in the program, (i.e., 6 months prior to intake). The 6 Month Review covers two specific times: 1) the *time point* at 6 months after intake, with a 2 week window of time on either side of the date; and 2) the *time interval* between intake and 6 months (consisting of the time period from 2 weeks after intake to 2 weeks before the 6 month anniversary date). Similarly, the 12 Month Review covers two time periods: 1) information at the 12 month post-intake date, again with a 2 week window of time on either side of the date, and 2) the time between 6 and 12 month anniversaries, (consisting of the time from 2 weeks after the 6 month date until 2 weeks before the 12 month date).

Setting the Time Frame. It is critically important that the study time frame be applied accurately and consistently both within and across sites. Since charts vary considerably from program to program, all extractors must use identical criteria when deciding on each research subject's study time line. This is likely to be complicated by the fact that many charts will be

poorly organized and not clearly dated, and some will contain information from time periods beyond the first year of service delivery. On the following page is a diagram which provides a visual representation of the time line you should have clearly fixed in your mind before beginning to extract information from any particular case file. There are 6 time segments to keep in mind. First, the **Program Intake Date** (marked A on the time line) is the date at which the program formally accepted the woman and her child(ren) as clients. Because some program admit a woman into a program and then do not begin providing services for a period of time, the **Program Intake Date** may or may not differ from the **Study Intake Date** you apply in your abstraction time line for a particular case. (You will learn more about this later in the manual). Second, the **Study Intake Date** is a time point at which regular services were initiated for the woman and her child(ren) on an ongoing basis; you may collect information for this time point from 2 weeks before the **Study Intake Date** through 2 weeks after the **Study Intake Date** (marked B,C,D on the time line). Third, the **Intake to 6-month Interval** is the period of time from 2 weeks after the Intake Date to 2 weeks before the **6 Month Date** (between D and E on the time line). Fourth, the **6 Month Date** is a time point exactly 6 months *after* the **Study Intake Date**, with a time period which encompasses 2 weeks before and 2 weeks after the date itself (E,F,G on the time line). Fifth, the **6 Month to 12 Month Interval** includes the period of time stretching from 2 weeks after the actual 6 Month Date to 2 weeks before the actual **12 Month Date**, (between G and H on the time line). Finally, the **12 Month Date** is a time point exactly 6 months after the **Six Month Date**; you can gather information pertaining to this date for a time period beginning 2 weeks before the actual 12 month date and ending 2 weeks after. Thus, the abstraction time line consist of *3 time points (intake, 6-month, 12-month) and two intervals (intake-to-6-month, and 6-month-to-12-month)*. It is critically important that abstractors understand how these dates are defined and how to establish them accurately and consistently for every protocol that is abstracted. To assist you in this process

the time line will be part of each protocol, and you will set the time line *only after* you have read through the file once and *before* beginning to record any information in the CFEP.

Time Line



General Instructions for Completing the Case File Extraction Protocol

Familiarizing Yourself with the CFEP

Prior to starting case file extractions at your site, you should become very familiar with the CFEP and with this Documentation Manual. In addition to the work you do with the CFEP and manual during the Extractor Training in Chicago, you should read both documents over several times before attempting your first case file extraction. In particular, pay close attention to the way in which the Extraction Protocol is organized and color-coded for the three different time periods: intake, 6 month and 12 month. It will be especially helpful for you to be familiar with the different sets of information that are called-for (e.g., Income, Household Composition, Background on Children) and where they are located within each section of the protocol.

Getting Started with Each Case File

Once you are ready to begin extracting a particular case file, you should read the file in its entirety before beginning to complete the CFEP. Be sure to read all of the progress notes which often contain relevant information. While an agency's summary forms (e.g., intake form, staffing reports) may be useful in your abstraction, often it is the progress notes that contain the most pertinent and useful information. In order to establish chronological order, it will be necessary for you to organize the case file in sequential order, starting with the agency's official date of intake (note: establishing the study intake date is discussed in the section on Intake Review). Use the colored tabs, with colors matched to the different protocol time frames, to mark the dates of information that appears in the file. By following this method you will avoid disrupting the chart and creating problems for the agency that is allowing you access to the information. While this step may seem time consuming, preparing the chart in this manner will save you time in the end and will yield more consistent and accurate data.

Protocol Completion

Following is a general list of things to keep in mind while completing the CFEP. First, be sure to ***use black ink only*** and ***print legibly***, as your handwriting will have to be read and understood by others, including the UIC project staff back in Chicago. When checking boxes, be sure to ***check one box only*** and take care to make it clear which box you are marking (i.e., don't let your checks span 2 boxes). Third, make sure to ***avoid recording*** the same piece of information ***in more than one place*** unless the information being recorded actually occurred at more than one time point (e.g., the woman held a job that spanned the entire time line). Fourth, please ***be specific*** by providing as much information as possible to clarify anything you report on the CFEP, especially any unusual or confusing situations. Fifth, if there is not adequate space on the CFEP for the amount of information you wish to record, ***add details in the margins or on the back*** of the page. Remember, if you do write on the back of a page, ***mark the page clearly with an asterisk so that you remember to copy both sides before sending it to UIC***. Sixth, if you have **any** coding questions or concerns, ***read this Documentation Manual first***, then contact the staff at UIC/NRTC for clarification and feedback. Seventh, always copy and ***send the original*** CFEP to project staff at UIC, reserving a ***complete and legible copy*** for your files in case the original is lost in the mail. Eighth and very important, ***always send your original CFEP via Fed-Ex*** with a recipient ***signature required***. You will be supplied with Fed-Ex mailing labels and a project account number and trained in how to forward the materials safely and confidentially.

Dealing with Discrepancies in the Case File

One of the challenges in conducting chart review studies is to establish consistency in the manner in which information is gathered and contradictions in the chart are resolved. For example, a client's racial/ethnic group may be recorded as African American on one form and as Hispanic in another section of the chart. Should you come across a similar situation, always search thoroughly through the chart before you come to a conclusion, since relevant information may appear in more

than one section of a case file. If you are unable to confirm information after searching through other areas of the chart, you may check with the program staff to see if they can provide clarification. In the example above, the extractor could ask the staff if anyone knew the client's race/ethnicity. If the discrepancy is preventing you from moving forward, call project staff at UIC to discuss the matter. If the problem is not urgent, the discrepant matter should be raised during the study's weekly conference call, discussed further in a later section of the manual.

Missing Information

Remember that client case files are not inherently prepared for the purposes of extraction of research information. Typically, the file is used for Medicaid or other insurance reimbursement or for storage of agency forms and progress notes. Be aware that much of the information requested by the CFEP may be missing from a file. The danger of employing case file extractions as a research methodology is the large amount of missing data which can result. This leads, in turn, to the temptation to "read too much into" case file information. You should be appropriately conservative about supplying information about which you are unsure. If you doubt the veracity of anything you record you should note this in the margins of the CFEP and explain why. Try to think of creative ways to obtain missing data or verify information accuracy when there are discrepancies (i.e., ask a staff member or seek additional documents). Prior to making use of additional methods, however, we ask that you obtain feedback about your plans from project staff at UIC.

Section I:

Intake Review

As mentioned earlier, you should begin by reading the file in its entirety, marking pages with colored tabs to help you code the file chronologically. Once you have done this and are ready to complete the **Intake Review** section of the CFEP, you should record your full name in the space provided for "abstracter's name," the client's ID number, the date on which the chart review took place, and the dates of the abstraction time line for that file. The time line (described earlier) refers to the specific dates of study time points and study intervals. Make sure you understand the instructions for setting the time line before trying to abstract the file. Assign a consecutive number to each case file you abstract, starting with 001 and preceded by your site code (Invisible Children Project=1, Thresholds Mothers Project=2, Center for Mental Health=3, and Parent Infant Program=4). You will need to keep a running list of the ID numbers and the corresponding names of the clients whose files you have abstracted. Since this list will contain highly confidential information, it must be kept in a locked file cabinet at the agency where you do your work. Do not leave the list where others can see it or will have access to it. This will come in handy should it be necessary for you to refer back to the case file. It will also help to ensure that you do not use the same ID# for 2 clients. *Before beginning the review of a new chart, log the name of the client on your list and assign this individual the next sequential ID#. Only after completing this step should you continue with the Intake Review.*

"Intake" refers to the time at which the client officially entered the program. It is crucial for you to **establish the intake date** prior to starting the extraction process. You need to be aware that the intake date recorded in the file may not be reflective of when service delivery actually started for a particular client. Often, a lapse in service may occur after the intake process. For the study

purposes, the intake date listed in the chart is to be employed only if the intake process is followed by ongoing services (i.e., at least weekly) to the client in person (i.e., not on the phone) within one month after the recorded intake date. A gap of 1 month is acceptable. If the gap extends past 1 month, consult with project staff about how to set the file's time line. ***If the actual intake date is undeterminable, but you can determine the month and year, you should record the first day of the month as the intake date.***

As mentioned previously, Section I of the CFEP, the Intake Review, concentrates on client information as of the Intake date, plus or minus 2 weeks (B-D in the time line shown at the beginning of the manual). In a few cases, this section also includes some questions about time periods *prior* to intake (6 months before intake, at any time in client's life before intake). The Intake Review is comprised of 19 sub-sections. The following summary provides descriptions and instructions for completing each section.

Background Information: This section contains items requesting general demographic features of the client, such as date of birth, ethnicity, marital status, education, employment status, income, and insurance coverage. For ethnicity, if the client is biracial or multi-racial, record the information in the space allocated for "other". For marital status, if the client was single (never married) **and** living with partner (unmarried), mark 6 - living with partner. In the education section, aside from inquiring about education level, information regarding classes the client may have been enrolled in is asked about, as well. Question 5 asks if the client was enrolled in any **academic classes**, which is self-explanatory. Question 5b asks if the client had enrolled in any **non-academic classes**. ***Non-academic classes refer to structured classes which may have been program-based, such as classes pertaining to pharmacology, parenting skills, money management, or psycho-social education. It is important to make sure these are in fact structured classes as opposed to support groups. The goal of this question is to capture education received by the client within the service of treatment.***

For the income section, question 10 asks for the “total monthly income”. Make sure that this total equals the amounts that are listed for items 9a through 9g (sources of income).

Housing and Household Composition: This section covers where and with whom the client lives, as well as any episodes of homelessness. It begins by asking for information about whether the client had a regular place to live at intake. For purposes of this project, a “regular” place to live is defined as a place where the client spends at least 5 out of 7 nights per week. Questions 15-16 ask about the client’s living situation at intake. You should check only one response for this question. *Remember, living in a shelter is equivalent to being homeless.* The next question, (#17), elicits information on whether the client had ever been homeless at the time of intake. **By homeless, we mean that the client had nowhere to stay for at least one night.** If the response to question 17 is “yes”, you will go to the following items regarding the number of nights the client was homeless in her lifetime. These questions are then re-phrased to record homelessness in the 6 months prior to intake. The last question in this section asks about the people with whom the client was living at the time of intake. You are instructed to check all categories of people that apply, as well as provide a number for some of the categories (e.g., number of children). Also, for some of the responses, you will notice sub-categories in parentheses (e.g., for children, they could be birth, adopted, or step). Underline the appropriate category, if one applies.

Background on Children: This section elicits the number of children born to the client as well as the gender and age of each child, and includes questions related to child(ren)’s living situation, custody issues, and involuntary removal of children from the home. For the question that elicits information on the number of children ever born to the client (Q.22), in addition to the number of live children, include any children who were deceased before intake.

You will notice that each child (currently living) is assigned a number (child #1-#6) . If client has more than 6 children, record information for the additional children on the backside of the page using the same format (and remember to put an asterisk on the front of the page). **Child #1 refers**

to the oldest child, child #2 refers to the second oldest, and so on. Consistency is crucial when referring to the children from this section onward.

Tip: Using a separate sheet of paper, record children's names and their corresponding #s. For example, John (oldest) = child #1; Kathy (second oldest) = child #2. When you see references to Kathy in the case file that are relevant to particular questions, refer to your list of children and record the information in the space allocated for child #2.

Item 22b inquires about which of the client's children were enrolled in the program with her and the dates in which each child was enrolled. For study purposes, it is necessary for **at least one** of the client's children to have been receiving services during the time period in which the mother was enrolled in the program. **It is acceptable if the child began receiving services up to 6 months after the mother's intake date. However, if the child's intake date is more than 6 months after the mother's, the chart will not be eligible for the study.**

Items 23 through 36a constitute a series of questions asking about four types of situations: 1) when the client does not have parental rights of her child(ren); 2) when the client does not have legal custody of her child(ren); 3) when the child(ren) was removed from client's care; and 4) when an informal care taking arrangement was in place for client's child(ren). It is important not to confuse the second and third kinds of situations. Custody loss should only be recorded if the parent's custody was terminated by the court system in official legal proceedings. Question 27 asks with whom the client's children were living, if not with the client, at the time of intake. The responses for this question are in terms of the **child's** relationship to the individual(s) with whom s/he was living (e.g., grandmother, foster parent). The following question asks, for each child who lived away from the parent, when this occurred. In responding to item 28, you should record the dates (or length of time if only that is available) and any other information available, such as the days of the week (e.g., the child may have lived with the mother on weekends but spent weekdays with another individual

such as a grandparent or aunt). This section continues with items regarding the reasons any child(ren) were not living with the client. Check all of the reasons that apply for all of the children, if more than one child was not residing with the client. Question 30 asks how many days the child had not lived with the respondent *at the intake date*. Item 32 asks for the frequency with which the client had contact with each of her children at intake, regardless of the child(ren)'s residential or custody status. Keep in mind that, even though a mother may have lost custody of a child, she still may have contact with that child. Items 33 through 36 repeat the series of questions regarding the 4 types of custody situations (i.e., loss of parental rights, custody, removal of children, informal care taking arrangement) in terms of the period of time before intake. Finally, item 36a asks whether the Department of Family Services was monitoring the client and her children while children in the care of the client before intake.

Social Support: This section concentrates on the client's social support network, consisting of family and/or friends, at the time of intake. You are first instructed to indicate whether or not the client has contact with relatives at intake and, if so, how often, using the frequency codes used in item 37a. Be sure to list only the individuals' relationship to the client but be very specific (e.g., "maternal grandmother" rather than "grandmother"). **Do not record the names of the individuals** who comprise the social support network of the client, as this would be a breach of confidentiality. Items then ask about support from the women's friends, neighbors, and significant others, as well as whether or not they were involved in the program intake process. If client has a supportive boyfriend/girlfriend, he/she should be recorded in this section (q. 39). Finally, item 40 asks whom the client listed as a person to contact in an emergency by noting their relationship to the client. Again, please be very specific, if possible, in what you record (e.g., "maternal aunt" rather than aunt).

Legal History: The information collected in the legal history section centers on the client's involvement with the criminal justice system prior to and at the intake time point. More specifically,

the items inquire about any previously charged offenses, convictions, and the time period of incarceration(s), as well as probation/parole. If the client had more than 3 offenses reported in the chart, record information on additional offenses on the back side of the page using the same format (and remembering to put an asterisk on the front of the page).

Substance Use: This segment of the Intake Review focuses on whether the client used any drugs and/or alcohol in the past and/or at intake, and if so, which specific substances were used. We are interested in any type of “use” mentioned in the chart at the time of intake. This section also focuses on substance use among others living with the client and her child(ren). In addition, we are interested in knowing whether the client’s children were exposed to someone other than the client who had been abusing alcohol or street drugs.

Diagnosis: In this section, you will be recording whatever information about the client’s DSM-IV diagnosis on Axes I-V **at the time of intake** is summarized in the chart. You should record the date of the diagnosis, diagnostic code, as well as the corresponding DSM-IV name for each numerical code, as they appear in the case file. Axis I reports clinical disorders, such as schizophrenia, mood and anxiety disorders; Axis II is used to denote personality disorders, including obsessive-compulsive personality and borderline personality disorders and mental retardation; Axis III should be used to report general medical conditions that may be relevant to managing the client’s mental disorder; Axis IV is used to account for psychosocial and environmental problems. Unlike Axes I-III, Axis IV contains a check list of problems that, if checked, require specification. Axis V is for reporting the results of the Global Assessment of Functioning Scale (GAF, sometimes known as the GAS). The GAF Scale assesses the client’s overall level of functioning. You are instructed to record the client’s score in the allocated space. Only record the GAF score if it is reflective of a recent administration.

Other codes, known as “V” codes, are commonly used in conjunction with the DSM-IV codes to report on problems such as those related to abuse or neglect, relationships, noncompliance

with treatment, bereavement, and acculturation. A “V” code also is noted when no diagnosis or condition is present on a particular axis. During your abstractor training you will have received detailed information on how to code this section of the CFEP, so be sure to refer back to your notes from the training frequently, to refresh your memory and clarify coding procedures.

Remember: You should try to record the diagnostic information exactly as it is specified in the chart. You do not need to ascertain codes or DSM-IV names if they are not supplied in the file. Also, be sure to record all information related to V codes.

Psychiatric Medication: This section of the CFEP addresses whether the client was taking any psychotropic medications before intake and whether the program staff prescribed any psychotropic medications at intake, and if so, which ones. Be aware that we are asking about *psychiatric medication only*, in this section. If you are not sure whether or not a medication named in the chart is a psychotropic drug, record it anyway and put a question mark next to it with an explanation. The last item asks about the client’s medication compliance at the intake time point.

Inpatient History: This section covers *inpatient* hospitalizations the client may have had *prior* to intake into the program. Specifically, this information includes the total number of hospitalizations in the client’s lifetime, as well as the name of the hospital, admission and discharge dates, and reason for admission. For reason for admission, indicate whether the hospitalization was for medical or psychiatric reasons. This information is to be collected for each hospitalization, starting with the most recent admission. If the client had experienced more than 10 hospitalizations, record the information for additional inpatient hospitalizations on the back of the page (with an asterisk on the front).

Family History: These questions inquire about whether the client’s family has a history of psychiatric disorders and/or substance abuse. If there is a family history of mental illness or substance abuse, you should check all of the family relationship categories that apply and record

each diagnosis or a description of the family member's mental health problem, if present in the chart. If any of the categories of family members include more than one person, please indicate the number of persons in that category (i.e., for the categories of “sibling” and “grandparents,” if the client has more than one relative in these categories with psychiatric disorders or problems, record the number and their individual diagnoses or problem descriptions).

Traumatic Events: In this section, the questions pertain to sexual/physical abuse, neglect, and emotional/verbal abuse of the client and/or her children. First, the questions inquire about childhood abuse/neglect of the client, as well as adult abuse of the client **prior to intake**. Then, they ask about abuse/neglect inflicted upon the **client’s children prior to intake**. The same questions regarding abuse are then asked about the client and her child(ren) in reference to the **intake time point (plus or minus 2 weeks)**.

Diagnostic Information: Here, you will gather information on different developmental problems the client may have had, such as low intelligence, head injury, seizures, vision and hearing impairment, and/or speech/language impairment, if any of the problems listed are mentioned in the client’s chart **at the time of intake**. If there is no mention of a problem in the case file, be sure to check the box for “no”. **Do not skip** any of the questions.

Medical: This section of the protocol elicits information on “active” medical problems that the client may have had at the time of intake. “Active” implies a medical problem that was unresolved at the intake time point. This is in reference to medical problems only; do not include problems related to mental illness.

Developmental: In this section, information about the client's psychiatric symptoms during, before, and after pregnancy, and any medications she may have taken during pregnancy are recorded. For medications taken during pregnancy, you should include both any street drugs and any prescribed medications that the client took while she was pregnant.

Child(ren)'s Health: Information about child(ren)'s physical and mental health are recorded in this section. Additionally, information is requested for children's hospitalizations (including general and psychiatric) prior to intake and any medications taken at the time of intake. Also requested is information on child care and educational status for each child. Again, if the client has more than six children, record the information for additional children on the back side of the page. **Remember to refer to your list of children in order to maintain consistency.**

Services: In this short section, the questions elicit information regarding child care services client may have been receiving at intake. There are 3 types of services on which you will be collecting information. The first type of service pertains to homemaker/child care assistance and refers to someone who assists the mother in caring for her child(ren) and teaches her parenting skills in the process. The second service refers to respite care. Respite services are generally temporary and involve someone from the agency caring for the children in an emergency/stressful situation while the mother is out of the home. The third type of service is babysitting services. Babysitting services must be arranged for by the agency for non-emergency purposes.

Treatment Plan: If available in the case file, you will collect information from the client's treatment plan about treatment goals and the specific plans outlined to help the client achieve these goals. Often these are formulated with the client at intake or soon after but they may not appear in the chart until a later date. If so, code this as missing for the Intake Review section of the CFRP. This is **VERY** important information, as significant progress can only be noted if appropriate detail is recorded by the abstractor.

First, record whether there was evidence in the chart that program staff had educated the client about the nature of her illness within one month following intake. If there is no evidence of this in the chart, be sure to check "NO". Then, you will list and number all treatment goals identified in the client's treatment plan in the chart.

Note: If information about the Treatment Plan is dated more than 1 month after intake, you should include it in the 6 Month Review section of the protocol, NOT in the Intake Review section.

When listing the goals you also are asked to provide a description of the treatment plan for that goal (i.e., the steps involved in attempting to achieve the stated goal). Some agency's treatment plans may be organized or stated slightly differently than the format used in the CFEP, so you should check with project staff at UIC if you are unsure about treatment plans or goals.

Section II:

6 Month Review

The 6 Month Review includes many of the same sub-sections that comprise the Intake Review. This section of the protocol gathers information pertaining to two reference points. One is the intake-to-6-month time interval and covers events that may have occurred at any time from 2 weeks after the intake date until 2 weeks before the 6 month date (**between D and E on the time frame described earlier in the manual**). Be sure to have completed the CFEP time line before completing this section. The second reference point is to the date six months after intake plus or minus 2 weeks (F on the time frame). We incorporate a 2 week window of time to account for information in the client's chart that may be recorded as occurring *near* but not exactly *on* the 6 month date. The goal for this section is two-fold. First, you are recording information about outcomes that occurred at (or very near to) the 6 month anniversary date of intake. Second, you are obtaining information about experiences and outcomes that occurred in the interval between the intake and 6 month time point. Be sure you are clear about the dates that define both the *time point* and the *interval*, before you complete this section. It is quite possible that, while you are searching for information related to the 6 Month Review, you will discover information pertinent to the Intake Review section. If this is the case, be sure to refer back to the Intake Review and make necessary changes, additions, or clarifications to earlier information.

Background Information: The first question asks about the client's marital status. If it has changed at all since intake, you should record the status as of the 6 month date as well as any change in status that occurred during the intake-to-six month interval, but has ended by the six month time point. For example, a client who was "single" at intake may have begun and ended a "living with partner, unmarried" relationship during the interval, and be back to "single" status at the 6 month

time point. Be sure not to miss this and any other changes in marital status that clients may experience between time points. The next series of questions relates to the client's educational experiences and status between intake and 6 months and at the six months time point (enrollment in classes, earning a new degree). Question 2 asks if the client was enrolled in any **academic classes**, which is self-explanatory. Question 3 asks if the client had enrolled in any **non-academic classes**. *Non-academic classes refer to structured classes which may have been program-based, such as classes pertaining to pharmacology, parenting skills, money management, or psycho-social education. It is important to make sure these are in fact structured classes as opposed to support groups. The goal of this question is to capture education received by the client within the service of treatment.*

Next, information regarding employment status is requested. First, you will need to determine the client's employment status at the 6 month date (plus or minus 2 weeks). If the client was working, you should record a very detailed description about the woman's job, if available. Getting as detailed a job description as possible is important because UIC staff will be coding job descriptions into the U.S. Department of Labor's Dictionary of Occupational Titles categories, requiring knowledge of job title, job tasks, qualifications, and responsibilities. You also will record the number of hours worked in a typical week, and the client's hourly salary. The next series of questions ask for information about employment during the intake-to-six-month time interval. If the client held more than 3 different jobs between time points, record information for additional positions on the back of the page (with an asterisk on the front).

Information about income is asked for next. You are asked to record the monthly income the client was receiving at this time point. As you did with the Intake Review, make sure the "total monthly income" corresponds to the sum of items 11a-11g.

Housing/Household Composition: The first portion of this section assesses the client's housing situation. You are asked to categorize the nature of the client's residence as of the 6 month

date (plus or minus 2 weeks). The next question asks whether the client had been homeless at any point during the intake-to-six-month interval, and, if so, for how many nights during this time period. The next item asks about the quality of the client's housing as assessed by program staff. If program staff ascertained conditions of the client's housing and recorded information between the intake date and 6 month time point, you will complete the next section related to quality of housing. The last question asks about household composition. You should record information about all of the people living with the client at the 6 month date (plus or minus 2 weeks).

Background on Children: This section begins by asking whether the client was pregnant at the 6 month date (plus or minus 2 weeks). It then asks if the client had given birth since the intake date. If so, you are asked to record information about the client's newborn(s). The next set of items inquire about the client's psychiatric status during her pregnancy between intake and the 6 month time point, and whether she had been taking any medications or street drugs during this time. Following this are a series of questions are a set of items addressing custody status at the 6 month date (plus or minus 2 weeks). Custody issues are then addressed in reference to the period between 2 weeks post intake and 2 weeks before the 6 month date. **Use the list of children and corresponding numbers to keep information consistent.**

Social Support: The items in this sub-section inquire about the client's social support network. First, the questions are framed in terms of the 6 month time point, after which they are repeated using the intake-to-six-month interval. This is done to enable us to assess whether the support network had changed at all between time points. You are instructed to only record the relationships of the individuals to the client. **Again, do not record any names of any individuals mentioned in the client's file.**

Legal History: In this section, you record any involvement of the client with the criminal justice system between intake and the 6 month time point. You should record any dates of arrest, charged offenses, whether the client was convicted and, if so, the time period of the incarceration. If the client has had more than 3 arrests,

record this information on the back of the page. Also of interest is whether the client was on parole/probation at any time between the intake and 6 month date.

Substance Use: The items in this section pertain to substance use of the client, and of others living with client, *at the 6 month date* (plus or minus 2 weeks). In order to capture any substance use that may have occurred prior to the 6 month date, this series of questions is repeated for the period *between 2 weeks post intake and 2 weeks before the 6 month date*.

Diagnosis: Here, we are interested in knowing whether there was any change in the client's diagnosis since the intake date. If the diagnosis had changed, you should record the diagnosis listed in the chart as of the 6 month date, following instructions provided earlier in the Intake Review section of this manual.

Psychiatric Medication: In this section, the questions elicit information concerning any prescribed medication used by the client at the 6 month date (plus or minus 2 weeks). You should record all prescribed medication, including psychotropics, that the client was taking *at the 6 month date*. The items are then repeated asking about medications prescribed for the time period *between the 2 weeks post intake and the 2 weeks before the 6 month date*. Again, if you are unsure about whether a medication was prescribed for psychiatric reasons record, its name along with a question mark and an explanation.

Inpatient Hospitalizations: Begin this section by recording the number of hospitalizations (for either medical **or** psychiatric reasons) that occurred during the intake-to-six-month time interval **AND including any hospitalizations that were occurring at the intake time point or the six month time point**. For this interval, starting with the most recent hospitalization, indicate the hospital, date of admission, date of discharge, and reason for hospitalization as either medical or mental health-related. **Please note that, unlike other parts of the CFEP, this time frame for this question is inclusive of the intake time point all the way through to the 6 month time point.** You should be sure to include any hospitalizations that may have occurred at the intake time

or at the 6 month date (plus 2 weeks). If more than 10 hospitalizations occurred, record additional information on the backside of the page.

Traumatic Events: This section captures information on physical/sexual abuse and neglect/emotional abuse experienced by the client and her child(ren). The questions are phrased first in terms of occurrences at the 6 month date (plus or minus 2 weeks), and then repeated to inquire about any occurrences during the intake-to-six-month time interval.

Diagnostic Information: Here, record whether there was any mention in the clients' chart of developmental problems (e.g., mental retardation) or disabilities (e.g., hearing impairment) in the period of time since intake. As in the Intake Review, you must check "yes" if there is mention of any of the listed problems, and "no" if there is no evidence in the chart, making sure to provide responses to **all items**.

Medical: If medical problems are identified in the client's file between the 2 weeks post intake and the 2 weeks before the 6 month date, describe the problems in detail on the review form. If any medical problems were identified, the next question asks, if at the 6 month date (plus or minus 2 weeks), any of the medical problems were unresolved.

Child(ren)'s Health: In this section, for each child (**remember to refer to the list of children and their corresponding numbers used in the Intake Review**), you should indicate whether any medical problems existed between the intake and 6 month time point. If the response is yes, you should then provide a description of the problem for each child. The next question asks, for each child, if any of the medical problems persisted at the 6 month date. The following item requests information on hospitalizations for the children between the 2 weeks post intake and the 2 weeks before the 6 month date. You should record hospitalizations for psychiatric and physical problems, and then describe the mental health of each of the client's children. Be sure to record all relevant information, such as diagnoses, symptoms, behavioral problems, etc. Also in this subsection, record detailed information on all medications (including psychotropics) prescribed for each

child at the 6 month date (plus or minus 2 weeks). The next item requests the same information based on the period *between the 2 weeks post intake and the 2 weeks before the 6 month time point*.

Services: As in the intake section, you will record information on the 3 types of child care assistance received by the client at 6 months and for the interval between the 2 weeks post intake and the 2 weeks before the 6 month time point. The 3 types of assistance are described in the “services” sub-section in the Intake portion of the manual.

Treatment Plan: The last sub-section of the 6 month Review concentrates on the client's Treatment Plan. If goals were identified from the Plan in the Intake Review, those goals should be listed in item #122, along with their corresponding goal number (assigned by the extractor during the Intake Review) and indicate the level of attainment of all numbered goals. Rate each goal in terms of achievement by the client, using the attainment scale: fully attained, partially attained, not at all attained. *You should be conservative when rating the goals.* Also, be sure to add a brief explanation for each rating you provide. If you are unable to ascertain the level of attainment of a goal because of inadequate information in the chart, please indicate this next to the particular goal. If there was no Treatment Plan abstracted from the client's file within the first month after intake (during the Intake Review), these items are not applicable and should be left blank. Item 123 asks for any "new" Treatment Plan goals, where "new" is defined as either goals added to the original Treatment Plan developed at intake or goals from a Treatment Plan developed some time in the intake-to-six-month interval. Describe and number each "new" goal in item 123 and then describe the plans to help the client reach each goal in the following section, if that information is available from the case file. In most cases, the Treatment Plan goals should be identified by the client's 6 month anniversary but, if they still are not named, this section also is not applicable and should be left blank.

Section III:

12 Month Review

The 12 Month Review is identical to the 6 Month Review, except that questions are framed around the 12 month time point (the date exactly 12 months after intake, plus or minus 2 weeks) and the interval of time between the 6 month date and 12 month time points (i.e., 2 weeks after the 6 month date to 2 weeks before the 12 month date). The same instructions and guidelines outlined in the 6 month Review apply to the 12 month Review. To recap, in this section the *time point* is two weeks before and after the client's twelve month anniversary and the *time interval* is two weeks after the 6 month time point to 2 weeks before the 12 month date. For clarification about recording information in the 12 Month Review, you should refer back to the corresponding sections of the 6 Month Review. As before, when completing the 12 month review, you may discover information which supplements (or even contradicts) information recorded about earlier time points or their intervals. If so, be sure to return to earlier sections of the CFEP and add or correct information (or note conflicting information if you are unable to resolve the discrepancy).

You will notice two additional questions at the end of the protocol. For question 125, you will rate the accuracy, in your opinion, of the information recorded in the CFEP. Using a scale from 1-10, with 1 being not at all accurate and 10 being extremely accurate, select a value that comes closes to your perception of the level of accuracy reflected in the CFEP. Make sure you indicate in the margins on the form which specific information was unreliable. For question 126, you will record any additional information you feel we should know about the client and her child(ren) that was not captured by any of the questions in the CFEP.

Section IV

Conclusion

This documentation manual has been designed to provide guidance to researchers engaged in a case file abstraction process for a research study. Thus, an attempt has been made to be as detailed and as comprehensive as possible. However, while many potential situations and problems are addressed in the manual, there are other possible coding and extraction dilemmas that are not covered. These are most appropriately raised and discussed among the study's extractors and UIC project staff on a regular basis. This fact points to the importance of the study's weekly teleconference call, lasting for one hour. These calls, which are *mandatory*, are attended by all extractors, project staff at UIC, and program site representatives who wish to participate. Topics of the calls include abstraction difficulties, development and adoption of decision rules, and resolving logistical problems. These calls are an important way to develop a common set of procedures and standards that will enhance study rigor and the value of the information that is collected. Remember, however, that any difficulties which prevent you from moving on with your work should be reported immediately to the UIC project staff in Chicago. In these cases, you should *not wait* until the weekly study conference call before seeking clarification. However, even after the problem has been resolved, it may be helpful to the other abstractors to bring it up and discuss it so that other sites are aware of how it was handled.

In conclusion, the extraction of case files can be a difficult and time consuming process, as you no doubt realize after reading this manual and becoming familiar with the client records at your agency. However, the benefits of obtaining the information about program process and effectiveness are many, especially for this tremendously underserved group of families. Hopefully, the information you gather will be used by programs and service designers around the country, to improve and replicate programs that are effective in improving outcomes for women mental health consumers, their children, and families.