Evaluation Capacity Building Report

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Mutual Support of the Niagara Region

April 30, 2009

Program Evaluated:
Residential Treatment Program

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The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO
Executive Summary

Description of Program to be Evaluated

Mutual Support of the Niagara Region (Mutual Support) is a residential care and treatment program consisting of four Parent Model group home settings. Each residence is staffed by two live-in House Parents who are replaced by a Relief Team during regular days off. There are two shifts of Child & Youth workers each day to assist the House Parents.

The residential program is supplemented by three specialized classroom settings (Section 23) located in a local school building. The District School Board of Niagara supplies teaching staff to the classrooms. Mutual Support provides Child & Youth Workers, and one supervisor. It is the residential program that this Capacity Building process has focused on.

Clinical treatment and supervision is provided by the firm of Lidkea, Stob, Venema and Associates. Thomas Venema is the lead clinician.

Ongoing research and determination of Outcomes Evaluation instruments used at Mutual Support is provided by Robert J. Fulton. The Outcomes Plan of Care\(^1\) process together with the associated Risk Screening\(^2\) system was developed by David Factor and Robert Fulton in association with the Ontario Association of Residences Treating Youth (OARTY) in 1999. Additional instruments considered for use at Mutual Support are assessed by Mr. Fulton as required. Evaluations of instruments in use are attached to this report.

Summary of Evaluation Capacity Building Activities

The Capacity Building process focussed on developing a framework based on the following components.

Developing Key Questions

The first task in the Capacity Building process was to determine a number of key questions to be answered through a Program Evaluation process. There were several brainstorming sessions held at Mutual Support to determine the questions that were important to management, clinicians and staff. Child & Youth Workers and House Parents were consulted during regularly scheduled weekly meetings. The Admin Team and management held several teleconferences with Susan Kasprzak from the Centre of Excellence. The questions determined by the process are:

\[\text{__________________________}\]

\(^1\) The Plan of Care Model, Measuring the Outcome of Service, 1999, David C. Factor, Ph.D., C.Psych., Robert J. Fulton, M.S.W.

• What is the level of engagement between residents and staff?
• Are relations between residents and staff positive?
• Does this contribute to lasting and positive change within the client population?
• To what extent has there been an improvement in mental health?
• Are residents taking increasing responsibility for their own self-care and physical health?
• Is there a reduction in incidents of acting out?
• Do our policies and practices reflect best practices?
• Is our program being delivered in the intended way?
• Are we providing appropriate and sufficient training to staff?
• What is the level of staff engagement and retention?
• What additional programs should we be providing to our residents?
• What sub-groups within our targeted population are achieving successful outcomes, and what sub-groups within our targeted population are not achieving success?

Program Logic Model

A Program Logic Model was developed through the same consultative process described for identification of Key Questions.

The Program Logic Model (PLM) was designed around the Seven Dimensions of Care utilized in the Ontario Looking After Children (OnLAC) Assessment and Action Record (AAR-C2; Flynn, Ghazal and Lagault, 2006).

Literature Review

The Literature Review was conducted with the assistance of Robert J. Fulton in order to reassess instruments currently in use at Mutual Support, and to determine what additional instruments would be beneficial in answering the key questions outlined in this report. The instruments chosen are outlined in the Evaluation Matrix, and a full assessment for each is attached in the Appendix.

Conclusions

The framework that was developed will be implemented in our existing Residential Treatment programs. Capacity for evaluation of other programs currently under development will be built using the same framework and process.

Instruments that were determined through the literature review to be most valuable were placed in the Evaluation Matrix for use in the Program Evaluation process. One additional instrument was chosen for use, and others have been placed in reserve for future consideration because they were determined to be reliable and appropriate for use at Mutual Support. The evaluation information on the instruments not chosen is attached in the appendices because we believe it may be useful to other residential treatment agencies reviewing this report.
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Introduction

Purpose of Evaluation
The intent of the project was to fully develop an evaluation framework to support ongoing evaluation of program delivery. The framework developed through this project will be linked to the child assessment regime already in place in the program to measure individual child outcomes. The focus is on measuring process and delivery of the program as well as client specific outcomes in order to evaluate program effectiveness in specific areas as well as higher levels, determine areas needing improvement, and measure change in effectiveness over time. Additionally, client satisfaction surveys conducted at discharge, referring agency surveys, staff exit interviews, and other forms of active feedback will be administered to inform delivery of the program. In order to focus the evaluation, evaluation questions were developed through interactive and inclusive brain-storming involving stakeholders. There were two levels of meetings held to develop the questions. Admin Team members and Case Managers met with front line staff and Susan Kasprzak to further develop and refine the evaluation questions.

Mutual Support has been working with the Ontario Association of Residences Treating Youth (OARTY) and the Canadian Outcomes Research Institute (CORI) to develop and refine a set of tools to measure the mental health and wellbeing of children placed in residential care and treatment. These tools are intended to measure changes over time in the strengths, needs and functioning of individual children.

The intent is to use these outcomes in planning for individual children, to evaluate and improve the effectiveness of program delivery, and to inform research regarding best practices in child and youth mental health in relation to provision of residential care and treatment.

As such, this project will strengthen mental health services to children within the MSS program, and through collaboration serve to address child and youth mental health within the larger service delivery system in Ontario.

Evaluation Questions and Methods

- What is the level of engagement between residents and staff?
- Are relations between residents and staff positive?
- Does this contribute to lasting and positive change within the client population?
- To what extent has there been an improvement in mental health?
- Are residents taking increasing responsibility for their own self-care and physical health?
- Is there a reduction in incidents of acting out?
- Do our policies and practices reflect best practices?
- Is our program being delivered in the intended way?
- Are we providing appropriate and sufficient training to staff?
- What is the level of staff engagement and retention?
• What additional programs should we be providing to our residents?
• What sub-groups within our targeted population are achieving successful outcomes, and what sub-groups within our targeted population are not achieving success?

These questions have been laid out in an Evaluation Matrix which describes sources of data and methods of collection. Questions are divided into an Outcome Evaluation matrix and a Process Evaluation matrix. The Matrix is inserted into the Methodology section of this report.

Methods include the following:

• Administration of various clinical tools using a pre-post design over the period of the evaluation;
• Ongoing Review of Literature over term of evaluation;
• Review of files over term of evaluation;
• Annual surveys, conducted during the period of evaluation; and
• Individual interviews with staff

Description of Program

The Mutual Support Systems of the Niagara Region (Mutual Support) residential care and treatment program is a network of four group homes staffed by treatment foster parents, child and youth workers and case managers. The treatment foster parents are employed by MSS to live and work in the home, and are assisted by child and youth workers employed in two shifts per day. Each child in the home is assigned a Case Manager to coordinate planning and support the home. The treatment foster parents receive regularly scheduled days off and are replaced by a relief team during their days off period. MSS operates three low enrollment specialized classrooms in partnership with the District School Board of Niagara for those children who cannot attend regular school due to learning and/or behavioural challenges.

Target Population

Surveys of the client population indicate that these children have histories of physical and sexual abuse and have debilitating emotional and behavioural symptoms of the trauma. For this reason, MSS provides weekly access to psychotherapists working in a separate counseling agency, Lidkea, Stob, Venema and Associates, under the direction of Thomas Venema, MSW. The individual psychotherapy interventions are based on the principle that sexually abused children must learn new ways of thinking about their history, themselves and others in the world. These patterns of thinking, which are often referred to as “inner working models”, affect {a} how and what the child perceives, {b} the strategies he/she selects for problem solving, {c} his/her behavioural response to his current emotional state and {d} his/her orientation towards others and his willingness to accept guidance and affection from care providers, teachers and other important people in his life. The goals of the program are directed at the child’s emotional state, providing an experience of being cared about in a secure social context in which the full range of his feelings can be expressed safely and in which he/she can learn ways to control those feelings and act on them in socially acceptable ways. The group homes work closely with the external psychotherapist to provide the child with social opportunities to learn and practice
social, emotional and communication skills to manage school, community and close personal relationships more effectively.

MSS has been monitoring the behavioural, emotional and social well being of children placed in the program using a set of standardized risk screening and outcome measurement instruments for over six years. Children have been tested in several waves using the Conners Global Index, the Children’s Global Assessment Scale, the FAB-C, the SA-45, the socio demographic checklist and the Parental Bonding Instrument.

**Relevant Stakeholders**

- Mutual Support Management Team
- Mutual Support Clinical Team
- Mutual Support front line staff
- Ministry of Children and Youth Services -
  Miranda Borisenko, Program Supervisor, miranda.borisenko@css.gov.on.ca, (800) 561-0568
  Dave Hopkins, Licensing Officer, dave.hopkins@css.gov.on.ca , (800) 561-0568
- Family and Children’s Services Niagara,
- Hamilton Catholic Children’s Aid Society
- Children’s Aid Society of London and Middlesex
- Children’s Aid Society of Oxford County
- Peel Children’s Aid Society
- Children’s Aid Society of Toronto
- Niagara Child and Youth Services,
  Linda Langston, Executive Director, llangston@ncys.ca, (905) 688-6850
- Ontario Association of Residences Treating Youth,
  Richard Solomon, Executive Director, rsolomon@oarty.net, (905) 475-5437
- Canadian Outcomes Research Institute,
  Casey Boodt, Acting President & Chief Executive Officer/Manager of Research and Evaluation,
  (403) 699-8802
Review of Related Research

A literature review was conducted to inform the project. A summary table has been prepared and is shown here for reference. The literature was used to determine which measurement instruments should be used, the methods to collect the data, and the frequency of collection. Instruments currently in use at Mutual Support were researched, and new instruments were considered. The research documents are attached as appendices.

The Evaluation Matrix outlines the various questions to be addressed through Program Evaluation, together with the instruments that were chosen to inform the evaluation.

The process revealed new instruments that would be valuable for use at Mutual Support, but were not practical for implementation given the number of instruments already in use that provided similar data. The instruments that proved valuable and will be held under consideration for future use include:

- Academic Competence Evaluation Scales (ACES);
- Child & Adolescent Needs & Strengths (CANS-MH);
- Multidimensional Self Concept Scale (MSCS);
- Rosenberg Self-Esteem Scale (RSES); and
- Screen for Childhood Anxiety Related Disorders (SCARED)

Mutual Support will add the Measurement Model of Engagement (Cunningham 2008) to its battery of tests to measure the level of engagement between residents and staff. This instrument will fill a significant gap for us on this important dimension.

Instruments already in use that will be continued are:

- Conners Global Index – Parent Version (CGI-P);
- Children’s Global Assessment Scale (CGAS);
- Feelings, attitudes and behaviour (FAB-C);
- The Symptom Assessment 45 (SA-45);
- Sociodemographic Checklist;
- Indicators of Success; and
• Parental Bonding Index (PBI-1). The PBI did not fit in our existing matrix but may be useful in the future in determining improved quality of relationship between a child/youth and parent/caregiver over time in children at Mutual Support.
### Literature Review Summary Chart

<table>
<thead>
<tr>
<th>Title and publication information</th>
<th>Type of source and approach</th>
<th>Overall goal</th>
<th>Main ideas and conclusion</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>On the Meaning and Measurement of Engagement in Youth Residential Treatment Centres. (March 5, 2002). Wm. Scott Cunningham, Portland State University (<a href="#">see appendix</a>)</td>
<td>The study was conducted at Portland University using data collected at midpoint in placement for 130 youth in 2 residential settings.</td>
<td>To develop an engagement scale for use in Residential Treatment programs.</td>
<td>The authors indicate that the study identified a single underlying factor, engagement, with acceptable reliability and strong validity.</td>
<td>The study produced a set of questions, but no related form or evaluation process. Through interaction with Dr. Cunningham we were able to resolve this and obtain a scoring method.</td>
</tr>
<tr>
<td>Review of “Academic Competence Evaluation Scales (ACES)”, prepared by Robert J. Fulton, 2009, Mutual Support (<a href="#">see appendix</a>)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the ACES tool for possible use at Mutual Support to assess the skills and behaviours necessary to be successful in school</td>
<td>The ACES tool is recommended as suitable for use at Mutual Support or similar residential treatment settings. We chose not to implement the ACES tool at this time because academic functioning is already being measured in the school setting, and success at school is already assessed using the Indicators of Success Questionnaire</td>
<td>The only limitation we determined is the capacity to implement the tool within the program in addition to other tools being used.</td>
</tr>
<tr>
<td>Title</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the BYI-S tool for possible use at Mutual Support to measure a child’s self-concept.</td>
<td>The BYI-S was not recommended as there is no body of evidence to validate its use.</td>
<td>The tool is lacking a body of evidence to validate its use.</td>
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<tr>
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<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Review of “Beck Self Concept Inventory for Youth (BYI-S)”, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the CANS-MH tool for possible use at Mutual Support for assessing the needs and strengths of children and youth.</td>
<td>The CANS-MH tool was determined to be a good instrument for determining which children would be most likely to be successful if returned home, reintegrated into their home community or placed in regular foster care. We chose not to implement the tool at this time due to the number of assessment instruments already in use.</td>
<td>The person using the tool is completely dependent on the quality of file information. There are several key predictors of future success that are not measured by the instrument.</td>
</tr>
<tr>
<td>Review of “Child &amp; Adolescent Needs &amp; Strengths (CANS-MH)”, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the CGI-P tool for continued use at Mutual Support as an indicator of psychological distress.</td>
<td>The CGI-P is a good measure of psychological distress and assessing ADHD. As a result Mutual Support will continue</td>
<td>None determined.</td>
</tr>
<tr>
<td>Review of “Conners Global Index –(CGI-P)”, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the CGI-P tool for continued use at Mutual Support as an indicator of psychological distress.</td>
<td>The CGI-P is a good measure of psychological distress and assessing ADHD. As a result Mutual Support will continue</td>
<td>None determined.</td>
</tr>
<tr>
<td>Review of “Feelings, attitudes and behaviour (FAB-C)” prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the FAB-C tool for continued use at Mutual Support as a means to identify attitudes, feelings and behaviour with peers.</td>
<td>The FAB-C was found to be appropriate for use on a selective basis, in particular for assessing a child’s risk for future anti-social behaviour. Mutual Support will continue using the FAB-C on a selective basis.</td>
<td>The reliability of the tool has not been confirmed by researchers that are independent of the developers. Many children who in particular are victims of trauma may not be able to participate due to their emotional and cognitive functioning.</td>
</tr>
<tr>
<td>Review of “Multidimensional Self Concept Scale (MSCS)”, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the MSCS tool for possible use at Mutual Support to assess children’s self-concept/self-esteem in the areas of social, competence, affect, academic, family and physical.</td>
<td>The MSCS was found to be appropriate for use at Mutual Support for measuring a child’s self-concept. The tool is easy to use and interpret. Mutual Support will not implement the tool at this time due to the number of other measures already in use.</td>
<td>There are no articles by independent reviewers on the MSCS.</td>
</tr>
<tr>
<td>Review of “Rosenberg Review of literature and To determine suitability The tool is a good The tool does not</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Test/Scale</td>
<td>Literature Review</td>
<td>Recommendations</td>
<td>Suitability Determination</td>
<td>Notes</td>
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<tr>
<td>Self-Esteem Scale (RSES)“</td>
<td>prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>recommendations for application at Mutual Support</td>
<td>of the RSES tool for possible use at Mutual Support to measure self-esteem.</td>
<td>measure of change over time and was determined to be suitable for use at Mutual Support. Mutual Support will not implement the tool at this time due to the number of other measures already in use. convey a lot of clinical information.</td>
</tr>
<tr>
<td>Review of “The Symptom Assessment – 45 (SA-45)“, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the SA-45 tool for continued use at Mutual Support in measuring significant psychiatric disorder.</td>
<td>We originally had the SA-45 placed in the indicators of stress and anxiety section of the matrix. The SA-45 is more appropriately an indicator of significant psychiatric disorder, and a section was added to reflect that. Mutual Support will continue to use the SA-45 for that purpose, with children ages 13 to 18. The FAB-C is used for children 12 and under. The tool can only be used as a broad indicator of change in mental health issues.</td>
<td></td>
</tr>
<tr>
<td>Review of “Screen for Childhood Anxiety</td>
<td>Review of literature and recommendations for</td>
<td>To determine suitability of the SCARED tool for</td>
<td>The SCARED tool was found to be appropriate</td>
<td>While there is considerable confidence</td>
</tr>
<tr>
<td>Related Disorders (SCARED)¹, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>application at Mutual Support</td>
<td>possible use to measure general anxiety, separation anxiety, social phobia, school phobia, and physical symptoms of anxiety in children at Mutual Support</td>
<td>for use at Mutual Support, and the parent version of the tool was recommended for instances where the child is unable or unwilling to complete the test. Mutual Support will not implement the tool at this time due to the number of other measures already in use.</td>
<td>in the tool by professionals, there is limited literature available.</td>
</tr>
<tr>
<td>Review of &quot;Children’s Global Assessment Scale (CGAS)¹&quot;, prepared by Robert J. Fulton, 2009, Mutual Support (see appendix)</td>
<td>Review of literature and recommendations for application at Mutual Support</td>
<td>To determine suitability of the CGAS tool for continued use at Mutual Support in measuring significant psychiatric disorder.</td>
<td>The CGAS was found to have substantial reliability and validity in the intensive treatment settings with severely mentally ill children. Mutual Support will continue using this instrument.</td>
<td>Though clinicians show good inter-rater reliabilities, they found poor reliability in rating functional status of children with a history of trauma.</td>
</tr>
</tbody>
</table>
Methodology

*Participation in Development of the Evaluation Framework*

The grant process provided opportunity for several new collaborative processes with internal and external partners. We were able to build on existing internal collaborative consultation processes to gain insight from stakeholders within the program at various levels.

**Internal Participation**

Ten consultation meetings were held during the course of the project involving Mutual Support management and Susan Kasprzak, Research Associate in Program Evaluation with the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. These meetings were used to plan the process and guide the proponents through the capacity building process. These meetings were held on the following dates:

- September 16, 2008
- October 21, 2008
- November 06, 2008
- December 03, 2008
- January 14, 2009
- February 05, 2009
- March 04, 2009
- March 30, 2009
- April 07, 2009

Mutual Support management consulted with front line staff and clinicians through regularly scheduled weekly meetings. Specific meetings were not designated for the consultation; rather the development of the evaluation framework was added to the agenda as required over the term of the grant. Individual groups involved were:

- Admin Team and Managers
- Child and Youth Workers
- House Parents
Program Logic Model
The Program Logic Model (PLM) was designed around the Seven Dimensions of Care utilized in the Ontario Looking After Children (OnLAC) Assessment and Action Record (AAR-C2; Flynn, Ghazal and Lagault, 2006). “OnLAC annually reviews the progress of children and youth in out-of-home care in seven developmental dimensions: health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self-care skills.”

The PLM which appears on the following page demonstrates the design of the program.

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**LONG-TERM GOAL:** Increased emotional well-being and capacity to function independently and successfully within the community

<table>
<thead>
<tr>
<th>Dimension of Care</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Target</th>
<th>Short-Term Outcomes</th>
<th>Intermediate Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCYS funding</td>
<td>8 house parents (4 couples)</td>
<td>Match child/youth to house parents, residents based on personality and functioning</td>
<td>-Goals reviewed every 30 days for 6 months, then every 6 mos.</td>
<td>-Increased awareness of program expectations</td>
<td>-Increased motivation for maintaining healthy lifestyle</td>
<td>-Increased responsibility for own health care</td>
</tr>
<tr>
<td></td>
<td>12 fit child care workers</td>
<td>Establish initial plan of care with CAS worker, case manager, child/youth, and house parents</td>
<td>-Child/youth functioning reviewed every 30 days</td>
<td>-Increased acceptance of program</td>
<td>-Increased physical health</td>
<td>-Increased healthy lifestyle</td>
</tr>
<tr>
<td></td>
<td>4 house parent relief workers (2 couples)</td>
<td>Establish goals with child/youth across 7 key dimensions</td>
<td></td>
<td></td>
<td>-Integration into regular classroom</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 fit school supervisor</td>
<td><strong>Health</strong></td>
<td>-YMCA, 10 kids, 12 hours, 8 sessions</td>
<td></td>
<td></td>
<td>-Integration into regular classroom</td>
</tr>
<tr>
<td></td>
<td>2 fit case managers</td>
<td>-Karate, 400 hours (4 kids)</td>
<td></td>
<td></td>
<td>-Increased incidents of acting-out behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 homes</td>
<td><strong>School or Work Place</strong></td>
<td>-IEP, 24 kids, 194 school days</td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
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<tr>
<td></td>
<td>4 fit senior managers</td>
<td>-Native Activities: 2 kids, 32 hours</td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
<td></td>
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<tr>
<td></td>
<td>1 office manager (0.5)</td>
<td>-Journaling, Life Books, 32 kids, 1800 hours</td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 vans</td>
<td><strong>Identity</strong></td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
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<tr>
<td></td>
<td>4 residences</td>
<td>-Facilitate contact with family of origin or foster family</td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
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<tr>
<td></td>
<td>4 classrooms</td>
<td>-Monitor effects of familial or foster involvement</td>
<td></td>
<td></td>
<td>-Increased self-esteem</td>
<td></td>
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<tr>
<td></td>
<td>1 cottage</td>
<td>-Teach social skills</td>
<td></td>
<td></td>
<td>-Increased social skills</td>
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<tr>
<td></td>
<td>1 management office/training centre</td>
<td>-Facilitate involvement in community activities</td>
<td></td>
<td></td>
<td>-Improved social interaction</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Social Presentation</strong></td>
<td>-Life Skills, Etiquette Course, 12 kids, 62 x 2hr sessions</td>
<td></td>
<td></td>
<td>-Improved social interaction</td>
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<td></td>
<td></td>
<td>-Teach appropriate etiquette and dress for social occasions</td>
<td></td>
<td></td>
<td>-Improved functioning within the community</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Emotional and Behavioural Development</strong></td>
<td>11 psychotherapy 394 hours, SensoryVOT 200hrs</td>
<td></td>
<td></td>
<td>-Reduced incidents of acting-out behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Use appropriate therapeutic tools (cognitive behavioural, artplay therapy, animal therapy, outdoor therapy) to improve behavioural and emotional development</td>
<td>-Sticks, 5820 hrs</td>
<td></td>
<td>-Improved functioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Brain Gym 100hrs</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Self Care</strong></td>
<td>Life Skills, Social Skills, 1248 hrs</td>
<td></td>
<td></td>
<td>-Improved self-care</td>
</tr>
</tbody>
</table>
The proposed sample size includes 28 children and youth residing in 4-parent model residential settings at Mutual Support.

Evaluation Matrix

The Evaluation Matrix shown in the following pages describes the design of the evaluation, the methods for data collection, and sources of information and data.

Data collection instruments include the following. Additional information pertaining to these measures can be found in the Appendices, including who created the measure, what the constructs are, the validity and reliability, and how they were developed.

- **Measurement Model of Engagement** ([Cunningham 2008](#)). The Cunningham consists of symptom agreement scales with a pre-post design to be administered at 6 month intervals during the evaluation period. The source data will come from youth ages 7 to 17, administered by a clinician or case manager.

  The instrument was developed by Wm. Scott Cunningham at Portland State University in conjunction with David E. Duffee, Yufan Huang, Camela M. Steinke and Toni Naccarato. There were 130 youth involved in the study in 2 residential settings. The study identified a single underlying factor, engagement, with acceptable reliability and strong validity.

  The study produced a set of questions, but no related form or evaluation process. Through interaction with Dr. Cunningham we were able to resolve this and obtain a scoring method.

  Each question will be asked using a 7-point scale ranging from strongly disagree to strongly agree. Adding up all of the responses for the 18 items produces a total score. Higher scores indicate higher levels of engagement.

  The test is used at an aggregate program level to determine whether staff expectations of the program are being met.

- **Symptom Assessment – 45 (SA-45)**

- **Feelings, Attitudes and Behaviour (FAB-C)**

- **Indicators of Success** Survey. **Manual** Attached. The Indicators of Success was developed for OARTY by Robert Fulton to measure a child’s functioning based on 7 Visions. The instrument is a strengths based instrument with a pre-post design to be administered at 6 month intervals during the evaluation period. The source data will come from youth ages 7 to 17, administered by a case manager or primary staff member.
The instrument contains a set of questions on a 5-point scale under each Vision to determine the child’s functioning, and is designed to measure change over time.

The instrument is valuable in determining the progress of individuals over time, and to evaluate success of the program in meeting the needs of children in placement.

- Connor’s Global Index (CGI) – Parent Version
- Children’s Global Assessment Scale (CGAS)
- Socio-Demographic Checklist
- Staff Survey. The survey was developed internally based on similar tools used at Mutual Support over time to assist in the annual performance evaluation process, to collect input from staff on policies and procedures, program design and functioning, and training provided.
- Training Records. A record of attendance at training is being developed to ensure that each staff person is receiving regular training in all important areas.
- Staff Retention Records. These statistics are compiled at each year end to track staff retention patterns.
- Client Satisfaction Surveys – one for during placement, one for discharge
- Case Files. Detailed files are kept on each resident, as well as a comprehensive record in the HOMES information system. HOMES is provided under contract by the Canadian Outcomes Research Institute, www.cori.ca.
### Evaluation Matrix: Evaluation of Residential Treatment Program, Mutual Support

#### OUTCOME EVALUATION MATRIX

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Short-Term Outcomes</th>
<th>Indicator(s)</th>
<th>Source of data</th>
<th>Method to Collect Data &amp; Frequency</th>
<th>Who collects data</th>
<th>When collects data (specify month/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the level of engagement between residents and staff?</td>
<td>- Increased awareness of program expectations</td>
<td>Improved overall scores generalized across all participants in the program from pre to post measure.</td>
<td>Measurement Model of Engagement (Cunningham 2008)</td>
<td>Symptom agreement scales. Pre-post design. 6 month interval</td>
<td>Clinician or Case Manager</td>
<td>Pre: Sep 2009 Post: Mar 2010</td>
</tr>
<tr>
<td>Are relations between residents and staff positive?</td>
<td>- Increased acceptance of program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does this contribute to lasting and positive change within the client population?</td>
<td>- Increased acceptance of program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Increase engagement with house parents and staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Increased awareness of program expectations
- Increased acceptance of program
- Increase engagement with house parents and staff
| To what extent has there been an improvement in mental health? | Reduced stress and anxiety | Improved scores on the Global Severity Index (GSI)4 construct between baseline and 6 months. | SA-45 – (The Symptom Assessment – 45) -ages 13 - 18 or FAB-C - (Feelings Attitudes and Behaviour) -ages 6 - 12 | Pre-post design. 6 month interval Source: youth age 13-18. 4 Research Methodology Manual, OARTY Information System, © 1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W. Risk Screening Manual, OARTY Information System, ©1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W. 5 Research Methodology Manual, OARTY Information System, © 1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W. | Clinician or Case Manager Pre: Sep 2009 Post: Mar 2010 |
| Are residents taking increasing responsibility for their own self-care and physical health? | - Increased responsibility for own health care - Increased healthy lifestyle - Increased physical health | Improved scores on the self-care subscale of questionnaire between baseline and 6 months. | Indicators of Success Questionnaire Pre-post design. 6 month interval Administered to both caregiver and teacher | Case Manager Pre: Sep 2009 Post: Mar 2010 |
| Is there a reduction in incidents of acting out? | - Reduced incidents of acting-out behaviour  
- Improved functioning | Improved test scores on the CGI 6 Total construct between baseline and 6 months. | CGI-P: Conners’ Global Index – Parent Version | Behavioral observation rating scale.  
Pre-post design.  
Source: caregiver and teacher.  
6 month interval | Case Manager | Pre: Sep 2009  
Post: Mar 2010 |
|---|---|---|---|---|---|---|
|  |  | Improved test scores on the total score construct between baseline and 6 months. | Children’s Global Assessment Scale | Pre-post design.  
6 month interval, administered to both caregiver and teacher. | Case Manager | Pre: Sep 2009  
Post: Mar 2010 |

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Risk Screening Manual, OARTY Information System, ©1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W.

7 Research Methodology Manual, OARTY Information System, © 1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W.  
Risk Screening Manual, OARTY Information System, ©1999 OARTY, David C. Factor, Ph.D., C. Psych, Robert J. Fulton, M.S.W.
## PROCESS EVALUATION MATRIX

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Inputs/Activities/ Outputs</th>
<th>Indicator(s)</th>
<th>Source of data</th>
<th>Method to Collect Data and/or Frequency</th>
<th>Who collects data</th>
<th>When collects data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do our policies and practices reflect best practices?</td>
<td>Intake/Assessment</td>
<td>Evidence of Best Practices compared to current practices within program</td>
<td>Literature Review</td>
<td>Ongoing Review of Literature over term of evaluation</td>
<td>Admin</td>
<td>Sep 2009 – June 2010</td>
</tr>
<tr>
<td>Is our program being delivered in the intended way?</td>
<td>7 Dimensions of Care Programming</td>
<td>Feedback from staff.</td>
<td>Staff Survey</td>
<td>Annual Survey</td>
<td>Admin</td>
<td>Sep 2009 – June 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comparison of the intended program with the actual delivery of program</td>
<td>Individual Staff Interviews.</td>
<td>Admined at beginning of evaluation to gain staff impressions</td>
<td>Admin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>File Review – Program Documents (Objectives, mission statement, etc.) to develop comprehensive description of intended program.</td>
<td>Interviews Conducted Annually.</td>
<td>Admin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- develop clear description of how program is intended to be delivered</td>
<td>Admin</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Provide feedback and implement necessary changes to program.</td>
<td>Admin</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Staff survey at the end to get impressions of changes</td>
<td>Admin</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Staff</td>
<td>Survey/Review</td>
<td>Admin</td>
<td>Dates</td>
<td></td>
<td></td>
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<tr>
<td>------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------</td>
<td>----------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Are we providing appropriate and sufficient training to staff?</td>
<td>8 house parents (4 couples)</td>
<td>Staff impressions</td>
<td>Admin</td>
<td>Sep 2009 – April 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 f/t child care workers</td>
<td></td>
<td>Level of participation in 36 weekly in-house training sessions per year.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 house parent relief workers (2 couples) - f/t</td>
<td></td>
<td>Staff Survey, Review Training Documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 f/t school supervisor</td>
<td></td>
<td>Participation records for training sessions.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2 f/t case managers</td>
<td></td>
<td>Participation recorded weekly at all 36 training sessions.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>What is the level of staff engagement and retention?</td>
<td>8 house parents (4 couples)</td>
<td>Staff Retention Numbers measured against prior years</td>
<td>Admin</td>
<td>April 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 f/t child care workers</td>
<td></td>
<td>Staff feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 house parent relief workers (2 couples) - f/t</td>
<td></td>
<td>Annual Staff Retention Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 f/t school supervisor</td>
<td></td>
<td>Individual Staff Interviews (Annual Review)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 f/t case managers</td>
<td></td>
<td>Annual Review Checklist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What additional programs should we be providing to our residents?</td>
<td>7 Dimensions of Care Programming</td>
<td>Client impressions of programming and requests for changes on questions 1 - 7 on survey.</td>
<td>Admin</td>
<td>Sep 2009</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| What sub-groups within our targeted population are achieving successful outcomes, and what sub-groups within our targeted population are not achieving success? | Children/Youth, ages 7 to 17 years with severe emotional and behavioural issues; referred by CAS | Analysis of results of client scores on repeat measures (baseline to post intervention) based on client demographic data. | Case Manager   | Pre: Sep 2009  
Post: Mar 2010 |
|                                                                       |                                                                      | Socio-Demographic Checklist                              |                |                     |
|                                                                       |                                                                      | Test score results on the following measures: SA-45/FAB-C, CGI-P, Conners’ Global Index, Children’s Global Assessment Scale |                |                     |
|                                                                       |                                                                      | Chart Review. Source: clinical record 6 month interval  |                |                     |


Discussions and Lessons Learned

The format of the Capacity Building Grant process initiated by the Centre of Excellence was a great improvement over the previous project that Mutual Support was involved in. The focus on building internal capacity is clearly something that will benefit Mutual Support as we move forward to the implementation stage. We have already used lessons learned in developing a new program at Mutual Support. In particular we developed a Program Logic Model for our new transitional home for older youth and are using it now in the Plan of Care process.

A major challenge encountered was that of resourcing time for consultations and input from stakeholders. In order to meet this challenge we used existing regularly scheduled training and consultation meetings as much as possible.

Another challenge was encouraging stakeholders to complete surveys and return them. The only successful way to obtain feedback was arranging face to face meetings and completing the survey questions in person. Some of the problems were technical related to the individual’s ability to understand the process for completing an MS Word form. Future surveys will be conducted using a web based service such as Survey Monkey\(^8\) or the Canadian Outcomes Research Institute’s\(^9\) online survey system.

Throughout the grant period information on the process and results were shared internally with staff and clinicians at regularly scheduled weekly meetings. Input was also gathered at these meetings as the process unfolded.

Our experience in working with the Centre throughout this grant period was much more interactive and supportive than during the 2006 grant period. At that time we were responsible to conduct the Program Evaluation and resulting report with little input or guidance from the Centre. During the current grant period the Centre was in touch on a weekly basis keeping us on track in terms of timelines and providing guidance, consultation, and support as we progressed through a much more structured and defined Capacity Building process. We see this as a much more productive process that has resulted in an internal capacity to conduct ongoing program evaluation.

We have already used the process we have learned in building a new program, a very positive development. A Program Logic Model has been developed for a new transitional program for older youth using the same process learned during the grant period.

\(^8\) http://www.surveymonkey.com/

\(^9\) http://www.cori.ca/
Conclusions & Recommendations / Next Steps
The process which the Centre coached us through provides an excellent framework for development of future evaluation processes. The framework developed will be implemented in our existing Residential Treatment programs. Capacity for evaluation of other programs currently under development will be built using the same framework and process.

Mutual Support plans to apply for an Evaluation Implementation Grant, offered by the Centre of Excellence, in order to implement the evaluation framework we developed. Because Mutual Support is currently undergoing a major program re-design process, application for an implementation grant will likely occur in 2010.

Knowledge Exchange
The grant process provided opportunity for several new collaborative processes with internal and external partners. We were able to build on existing internal collaborative consultation processes to gain insight from stakeholders within the program at various levels. The internal processes involved regularly scheduled weekly meetings and brain-storming sessions. These comprised of the following groups:

- Admin Team, managers staff and clinicians
- Child and Youth Workers
- House Parents

External Participation
Regular e-mail and telephone contacts were conducted between Dave Schulz, project lead at Mutual Support, and Susan Kasprzak during the grant period.

We were connected by Susan Kasprzak with three other organizations who were undertaking similar projects through Evaluation Capacity Building grants. Communications with our external partners were conducted primarily through e-mail.

Sandra Fieber, MSW, RSW, MBA, Craigwood/Community Ventures, London, Ontario

These communications were extremely helpful through shared experience and resources as all three programs were working in similar environments developing a similar evaluation framework.

Contacts and subject matter are listed on the following two pages.
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Subject</th>
<th>Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Schulz</td>
<td>'Michelle Dermenjian'; 'Sandra Fieber'; 'Kasprzak, Susan'</td>
<td>Client Satisfaction Surveys</td>
<td>Mon 2009-03-23 2:47 PM</td>
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<tr>
<td>David Schulz</td>
<td>'Michelle Dermenjian'; 'Sandra Hemming'; 'Sandra Fieber'; 'Kasprzak, Susan'</td>
<td>RE: FW: Measurement - Engagement</td>
<td>Tue 2009-03-10 9:57 AM</td>
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<tr>
<td>Michelle Dermenjian</td>
<td>Sandra Hemming; David Schulz; Sandra Fieber; Kasprzak, Susan</td>
<td>RE: FW: Measurement - Engagement</td>
<td>Fri 2009-03-06 11:41 AM</td>
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<tr>
<td>Michelle Dermenjian</td>
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<td>Fri 2009-03-06 9:31 AM</td>
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<td>Sandra Hemming</td>
<td>Michelle Dermenjian; David Schulz; Sandra Fieber</td>
<td>RE: FW: Measurement - Engagement</td>
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<td>Michelle Dermenjian</td>
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<td>RE: FW: Measurement - Engagement</td>
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<td>Sandra Fieber</td>
<td>Michelle Dermenjian; 'Sandra Fieber'; '<a href="mailto:shemming@craigwood.on.ca">shemming@craigwood.on.ca</a>'</td>
<td>RE: FW: Measurement - Engagement</td>
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<td>Michelle Fieber</td>
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<td>'Sandra Fieber'; 'Kasprzak, Susan'</td>
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<td>Tue 2009-02-17 10:51 A...</td>
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<tr>
<td>Michelle Fieber</td>
<td>'Sandra Fieber'</td>
<td>RE: Evaluation Matrix</td>
<td>Tue 2009-02-17 10:29 A...</td>
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<tr>
<td>Michelle Fieber</td>
<td>'Sandra Fieber'</td>
<td>RE: Evaluation Matrix</td>
<td>Tue 2009-02-17 9:16 AM</td>
</tr>
<tr>
<td>Scott Cunningham</td>
<td>David Schulz</td>
<td>Re: FW: Measurement - Engagement</td>
<td>Mon 2009-02-09 4:33 PM</td>
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<tr>
<td>Michelle Fieber</td>
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<td>Fri 2009-02-06 11:37 AM</td>
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<td>Michelle Fieber</td>
<td>'Sandra Fieber'</td>
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<td>Thu 2009-02-05 10:04 A...</td>
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<tr>
<td>Kasprzak, Susan</td>
<td>Michelle Dermenjian; <a href="mailto:sfieber@craigwood.on.ca">sfieber@craigwood.on.ca</a>; <a href="mailto:dschulz@vaxxine.com">dschulz@vaxxine.com</a></td>
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<tr>
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<tr>
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<td>Michelle Dermenjian; David Schulz</td>
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<tr>
<td>Sandra Fieber</td>
<td>David Schulz; Michelle Dermenjian</td>
<td>RE: Logic Model Residence</td>
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<tr>
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<td>RE: Logic Model Residence</td>
<td>Thu 2009-01-15 4:46 PM</td>
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<td>RE: book</td>
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<td>Tue 2008-12-02 9:53 AM</td>
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<td>Mon 2008-12-01 3:46 PM</td>
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</table>
E-mail consultation was conducted with Dr. Scott Cunningham regarding his paper On the Meaning and Measurement of Engagement in Youth Residential Treatment Centers.

Future Plans for Knowledge Exchange
This report will be made available through the Centre of Excellence, as well as being posted on the Mutual Support web-site. Mutual Support participates in an annual forum conducted by the Center in Hamilton, and will be available to share our experience in that venue in the future.

References & Appendices
The Plan of Care Model, Measuring the Outcome of Service, 1999, David C. Factor, Ph.D., C.Psych., Robert J. Fulton, M.S.W.


On the Meaning and Measurement of Engagement in Youth Residential Treatment Centres. (March 5, 2002). Wm. Scott Cunningham, Portland State University


Diperna, James Clyde (2006), “Academic Enablers and Student Achievement: Implications for Assessment and Intervention Services in the Schools”, Psychology in the Schools, Vol. 43(1), 7-17


Landis, J. R., Koch, G. G. (1977). The measurement of observer agreement for categorical data. Biometrics 33:159-174. The rules for interpreting inter-rater reliability of a continuous numeric variable, such as test scores, are the same as for categorical data.


Sinclair, Ian, Wilson, Kate & Gibbs, Ian (2005), Foster Placements: why they succeed and why they fail, Jessica Kingsley Publishers: London, 272 pages


Wagner et al, 2007, ibid

Hanssen-Bauer, Ketil; Aalen, Odd O.; Ruud, Torleif & Heyerdahl, Sonja (2007), “Inter-rater Reliability of Clinician-rated Outcome Measures in Child and Adolescent Mental Health Services”, Administrative Policy Mental Health, 34:504–512


Rosenberg, Morris (1965), Conceiving the Self, Basic Books: New York


Corcoran, Keven & Fischer, Joel (1996), Measures for Clinical Practice: a Sourcebook, New York: Free Press, page 408

Western Psychiatric Institute and Clinic, University of Pgh.

*Childhood Anxiety Disorders: Lessons From the Literature*, (2000), Canadian Psychiatric Association (author), October special issue

*Childhood Anxiety Disorders: Lessons From the Literature*, (2000), Canadian Psychiatric Association (author), October special issue

Academic Competence Evaluation Scales (ACES)

**Description:**

The ACES test was designed by expert panel to reflect the skills and behaviours necessary to be successful in school. There are versions for the teacher and the student. The test has five scales: **academic skills** consisting of 22 questions, **interpersonal skills** consisting of 10 questions, **academic motivation** consisting of 10 questions, **study skills** consisting of 10 questions and **participation skills** consisting of 8 questions. The test is 50 questions in length.

Each item is rated on a five point scale from (1) never to (5) almost always. Each skill is defined as a behavioural description.

**Method:** behaviour observation rating scale

**Data source:** teacher and youth

**Norms:** based on 1,000 students representative of the USA, including 9% with disabilities and 19% at-risk of failure and drop outs. Norms by gender and age group are available.


- $152 for the initial kit of 25 teacher and student forms and manual or
- $245 for the CD ROM as well
- Manual alone = $87
- 25 student forms = $44.

**OUTPUT:**

There are two major scales and seven subscales produced by the test.
Content:

- **Academic Skills Subscales**
  - Reading/Language Arts
  - Mathematics
  - Critical Thinking

- **Academic Enablers Subscales**
  - Motivation
  - Engagement
  - Study Skills
  - Interpersonal Skills

Evidence Base

The ACES is a new test by the most pre-eminent authorities in academic enablers, Diperna & Elliot\(^\text{10}\). It is a theoretically coherent test of the construct\(^\text{11}\). There are very few references in the literature on this test, apart from the original article which introduced the scale and provided data on its psychometrics.

Reliability:

- Internal consistency coefficients (Cronbach’s alphas) from .94 to .99
- Test-retest stability coefficients from .88 to .97
- Inter-rater correlations from .31 to .65

The ACES test is highly reliable\(^\text{12}\).

Validity:

The ACES was validated with high correlations with tests that measure academic achievement and social skills:

- *Iowa Test Basic Skills Composite* correlations from .66 to .76
- *Social Skills Rating System Academic Competence* correlations from .75 to .80
- *Social Skills Rating System social skills* correlations from .49 to .74


\(^{11}\) Diperna, James Clyde (2006), “Academic Enablers and Student Achievement: Implications for Assessment and Intervention Services in the Schools”, *Psychology in the Schools*, Vol. 43(1), 7-17

\(^{12}\) Publisher information, see Aces Produce Review powerpoint
The ACES has demonstrated solid convergent validity with related measures. Discriminant function analysis with known groups (students with no identified concerns vs. students at-risk or with disabilities) indicated the ACES correctly identified an average of 86% of students across multiple samples.

**Training**

This test is easy to administer and score.

**Recommendation for Mutual Support**

I recommend the ACES instrument. It provides information relevant to treatment planning in the context of programs seeking to integrate children into public school and/or improve their ability to function academically.
Beck Self Concept Inventory for Youth (BYI-S)

Description:

The Beck Self-Concept Inventory for Youth (BYI-S) is part of the Beck Youth Inventory family of scales. The best known of these scales is the Beck Depression Inventory. The BYI-S is a 20 item questionnaire that produces one raw number that is converted into a standard score based on the norms.

Some examples of the questions include: #18 – “I am a good thinker”, #19 – “I like my body” and #20 “I am happy to be me”. Items are written at a second grade level. Item responses are Likert scale options: never=0  sometimes=1  often=2  always=3.

Method: symptom agreement scales

Data source: child and youth ages 7 to 18 years

Norms: 800 children and youth ages 7 to 18 years.

Publisher: Pearson Education Inc.

OUTPUT: one raw score converted to T-scores

Evidence Base

The BYI-S is a recent development of the Beck family assessment measures. There are thousands of articles published using the Beck Depression Inventory, but very few using the BYI-S. Indeed, most of the articles that measured self concept, used the Rosenberg Self Esteem Scale along with the Beck Depression Inventory. The only data on the reliability and validity of the BYI-S comes from the developers.

Reliability:
Steer et al, 2005, (ibid) reported that the internal consistency of the BYI-S was .91, which is excellent. Test re-test reliability for young children is .81 to females and .88 for males. For older children 11 to 14, the test-retest reliability is .86 to .90.

Validity:
A Manova using all five BYI scales with a clinical sample representing 6 different DSM diagnosis showed that the BYI-S had slightly higher scores with normal controls than with the clinical sample. The greatest effect on the BYI-S scores are found in comparing children with Mood Disorders with normal controls.

Training
This scale is very easy to use and interpret.

Critique
The BYI-S does not have a body of independent research to validate its use. In contrast, the Rosenberg Self-esteem Scale had over 2,000 hits in a search of PsychInfo.

Recommendation for Mutual Support
I do not recommend the BYI-S. The option of the RSE will provide as much information and there is more confidence in the validity of the scale.
Child & Adolescent Needs & Strengths (CANS-MH)

**Description:** The CANS-MH is a clinician-rated structured questionnaire for assessing the needs and strengths for children and adolescents. The source of information for the rater is a chart review. The test is a psychometric tool developed on the basis of clinical criteria. The six major areas of the tool were selected because they were regarded as clinically important in treatment planning and measuring outcomes for children receiving mental health service. There are up to 10 individual scales or constructs underneath each of the six major areas of interest.

Each construct is measured on a four point scale. The scales start at zero points representing no problem, no need for action or an area of strength. The scales end at 3 points representing a severe problem, a priority for action or definitely not a strength.

**METHOD:** standardized measurement of specific domains in the clinical record, also referred to as a chart review

**DATA SOURCE:** the clinical record, although the clinician using the instrument may want to speak to other clinicians who contributed primary assessment information

**Norms:** Norms are available from the publisher on request. The CANS-MH is not norm-referenced; the norms referred to by the publisher are the average scores from a large sample of users and the results of this sample may reflect the expected results for different groups.

**Publisher:** in the public domain: download from


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14 The tool may be better named as a *clinimetric* tool, which is the common name in medicine where this method was developed for the Apgar rating system and is used extensively. See Lyons & Weiner, 2004, page 463 for more details on this point in footnote #5)
The cost for the manual, scoring key and the instrument itself is zero dollars. The tool has a copyright and the publisher requests that agencies or jurisdictions that wish to use the tool obtain permission from the publisher.

**OUTPUT**: The CANS-MH produces 42 numbers and average scores for each of 6 scales as well as a total score. These numbers have been subject to research on the reliability and validity of the instrument. They have been used in published reports as a clinical tool.

The CANS-MH has been used in program evaluation studies, within the framework of a pre-post design.

**Content**: The CANS-MH is a set of 42 scales covering the following broad categories:

- Problem Presentation (such as psychosis, depression, anxiety, substance abuse)
- Risk Behaviors (such as danger to self, danger to others, runaway, crime)
- Functioning (such as intellectual, physical, school, sexual)
- Care Intensity & Organization (includes needs for monitoring, transportation)
- Family/Caregiver Needs and Strengths (including physical, supervision, involvement)
- Strengths (including areas such as family, interpersonal, education)

**Evidence Base**

A search on the exact name of the tool as well as the acronym produced 42 references on psychinfo. There are four studies published in 2008, including three dissertations and one peer reviewed journal. These studies have collectively profiled more than 1,000 children in several jurisdictions using the CANS-MH instrument. In a validation study published by the test developers, it was revealed that 27 states in the USA use the CANS-MH to evaluate youth outcomes.

**Reliability**:

The interrater reliability\(^{15}\) (intraclass correlation) between caseworkers and researchers for the total scale was .81. More than 300 children were tested twice, by their caseworker and a second time by a researcher applying the CANS-MH independently on the same clinical record. As expected, there was lots of variation in the total score at the level of individual children as well as between case workers and researchers. A reliability of .81 means that 81% of the scores were scored consistently between caseworkers and researchers. Conversely 19% of the variance in scores are not consistent and must be untrue.

By convention, a reliability of .70 is considered acceptable inter-rater reliability, but this depends highly on the researcher's purpose. Another rule of thumb is that inter-rater reliability

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between 0.40 to 0.59 is moderate; inter-rater reliability between 0.60 to 0.79 is substantial, and anything above 0.80 outstanding\(^\text{16}\) (Landis & Koch, 1977).

Interrater reliabilities were also calculated for each dimension and were .72 for problem presentation, .76 for risk behaviors, .85 for functioning, .75 for care intensity and organization, .75 for caregiver capacity, and .77 for strengths. These values demonstrate that CAN-MH has excellent reliability between users.

**Validity:**

The convergent validity\(^\text{17}\) of the CANS-MH was demonstrated by computing the correlation between the CANS-MH and CAFAS. Lyons found that “items and subscales purporting to measure the same general aspect of functioning generally yielded positive, significant, and moderate to high correlations” (Lyons, 2003, page 10). This method of validation is based on the assumption that the CAFAS is a proven instrument and if the CANS-MH agrees with the CAFAS rating, then the CANS-MH must be measuring accurately.

The predictive validity\(^\text{18}\) of the CANS-MH was demonstrated by correctly classifying 63% of 1,592 children receiving mental health services in a large mid-Eastern state across three levels of care: residential treatment, intensive community based treatment and outpatient treatment. This method of validating an instrument is based on the assumption that a true measure will provide the user with an accurate forecast of the level of care that a child will receive. If it forecast accurately, then the CANS-MH must be measuring something that is important to the level of care decision, assuming of course that level of care decisions are clinically sound in the first place. The fact that 37% of the level of care decisions were not correctly forecast by CANS-MH can be caused by some combination of two forces:

- *An error in the placement decisions*, in which a less disturbed child was assigned to a higher level of care than be/she really needs
- *An error in the instrument*; perhaps the instrument does not measure a crucial factor in the correct placement decision making. Perhaps the CANS-MH doesn’t give sufficient weight to early onset disorders, such as autism or teenage bi-polar

\(^{16}\) Landis, J. R., Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics* 33:159-174. The rules for interpreting inter-rater reliability of a continuous numeric variable, such as test scores, are the same as for categorical data.


that requires rapid response of intensive intervention before the symptoms get worse.

The discriminant validity was demonstrated by a correlation of .54 between the CAFAS (thinking) and the CANS-MH (psychosis). Although the items are similar, the criteria for scoring them is quite distinct between the two scales. The resulting correlation of .54 is moderate as expected. There were higher correlations between CAFAS and CANS-MH on scales where the measurement criteria were more similar. The assumption of discriminant validity is that the CANS-MH will accurately discriminate between two things that look similar on the surface but are in fact different. In this example, the researchers do not want to see a high correlation between CAFAS (thinking scale) and CANS-MH (psychosis scale) because the score should be different but not totally different. This criteria is met by a moderate correlation of .54.

Training

The manual (p. 3) states that “a bachelor's degree with some training or experience with mental health is needed to use the CANS-MH reliably after training.” Formal training and ongoing monitoring ensure the development and maintenance of good reliability. The formal training takes about four hours and consists of an overview, a review of the anchors, and at least two practice vignettes. Most individuals develop reliability above 0.70 with this training format.

Critique

The following positive comments were published by the tool developers:

1. The CANS is a great tool for facilitating the exchange of information about patients because it provides a common language regarding an array of important areas of symptomatology and functioning.

2. Item anchors are relevant to clinical decision-making.

3. Information provided can be closely linked to treatment planning.

4. The item incorporates a solid focus on strengths, consistent with strength-based treatment planning guidelines.

5. The measure makes conceptual sense to clinicians.

Limitations

The principle limitation of the CANS-MH is that the person rating the tool is totally dependent on the quality and completeness of the clinical record, especially diagnostic assessment. Therefore, the tool cannot be used as an initial data collection instrument for intake for children who are new to the service delivery system.
The second area of concern about the CANS-MH is that the tool does not measure or address several key areas that are potent predictors of future adjustment. The areas that are not addressed by CANS-MH include:

1. The vulnerability of the child to be recruited by a negative antisocial peer group and the corresponding lack of refusal skills within the child. This area was identified by O’Donnell in a 3.5 year longitudinal study of boys who scored about 70T on the CBCL at age 11. More than half were in the normal range on aggression and did not develop other problems by age 14. Those that recovered from earlier aggression problems were able to resist associating with antisocial peers. 19

2. The areas of family functioning that have a potentially devastating effect on child outcomes are not measured by CANS-MH. These areas were identified by Rutter20
   a. parental behaviour management practices
   b. the child’s attachment to his parents beyond infancy
   c. triangulation effects
   d. scapegoating
   e. stressors

3. The CANS-MH does not cover a number of developmentally critical conditions, such as autism, FASD and dual diagnosis

4. The CANS-MH does not include critical biographical data on the child, including:
   a. Aboriginal ancestry
   b. Other ethnic identities
   c. History of abuse
   d. History of parental disorder (including suicide, psychiatric illness, substance abuse disorder, criminality, domestic violence)

**Recommendation for Mutual Support**

The CANS-MH provides a structured, consistent and probably valid measure of the needs and strengths of children with mental health concerns on condition that MSS already has good individualized information on clinical records. The tool would identify children most likely to succeed if repatriated, sent home and replaced into regular foster care. The scientific criteria for determining who is likely to succeed in foster care was recently demonstrated through a longitudinal study in England21.

The CANS-MH provides a good basis for pre-post outcome evaluations of service.

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Conners Global Index –(CGI-P)

Description:

The Conners’ Global Index is a 10-question behavior checklist completed by either or both the parent and teacher. The term “parent” refers to his current caregiver. This form is named, CGI-P. This could be a foster parent, adoptive parent or child care worker. You may read the ten questions over the telephone to the caregiver or the child’s teacher (e.g. “the child is excitable, impulsive”) and ask the caregiver or teacher to rate the behavior as “Not True at All”, “Just a Little True”, “Pretty Much True”, or “Very Much True”.

Foster parents and residential child care workers who have a parenting role in the child’s life may complete the Conners’ Global Index - Parent. Teachers and day treatment staff should use the Conners’ Global Index -Teacher. The face sheet of the two versions are almost identical except that the order of questions is different. More substantial differences exist between the teacher and parent versions in the normative scores.

Method: behaviour observation rating scale

Data source: parent and teacher

Norms: The developers have more than 8,000 subjects that have completed the CGI from their normative data is derived.

Publisher: Multi-Health Systems, Inc., www.mhs.com

The manual and 25 sets of parent, teacher and self report booklets is $169. Additional booklets for parents, teachers and children cost $1.72 each.

OUTPUT:

The CGI is sold as a multi-part form, with the scoring key and standardized table readily accessible. Standard scores exist for the Global Index and two scales: restless/impulsive and emotional lability.

Content:

The CGI has 10 questions that measure aspects of ADHD.
Evidence Base
The Conners Global Index has 30 references in the literature under the name of this scale which is within the family of Conners Rating scales. The CGI has been used in studies of populations including ADHD, FASD, ASD, intellectual deficits and general emotional and behaviour disorders.

Reliability:
The Conners’ Global Index is very reliable. Cronbach’s Alpha measuring the internal consistency for the Conners’ Global Index was 0.89. (Conners’ Manual, 1999, page 111).

Validity:
The Total Index T-score from the Conners’ is highly correlated (r = 0.82) with the Total Problems T-score from the Achenbach22. (Achenbach, 1991, page 85). Secondly, the Conners’ Global Index was highly correlated with the total score of the Kovacs Children’s Depression Inventory (CDI) at .71 (Conners’ Manual, page 131). These findings demonstrate convergent validity.

The average scores of the CGI for children with no disorder (52.7), those diagnosed with ADHD (69.8) and those diagnosed with some other disorder (66.7) demonstrate discriminant validity. The F-ratio between no disorder and either group of children with diagnosis is 16.18 and p < .007. This finding23 does suggest that the CGI may not do as well as expected in identifying children with ADHD among a population of disturbed children. It does, however, clearly distinguish disturbed and not disturbed. The CGI may be a measure of psychological distress as well as hyperactivity and inattentiveness according to Sullivan & Riccio (2007).

Training
It takes less than ½ hours to train a worker on the CGI.

Critique
The CGI is a rapid assessment device that is very useful in specific purposes in a system of screening and assessment. The two roles the CGI is valid for: measuring ADHD symptoms especially as short term outcome measure and risk screening, because it the CGI is a reliable and valid indicator of psychological distress.


Double-click icon to view sample CGI-P document.
Children’s Global Assessment Scale (CGAS)

Description:

The CGAS is a clinician-rated criterion referenced scale for assessing the functioning of children and adolescents. Youth are assessed relative to how they perform their roles at home, school and community in the month prior to the test. The clinician must gather the information necessary to score the test from open ended assessment interviews with the child, parent and school as well information in prior assessments.

The CGAS rating scale was constructed from ten exemplars or generic clinical profiles. Each exemplar are progressively worse from superior functioning to severe impairment. The worker matches the child’s level of functioning to the exemplar best matched to the child’s role performance. The manual instructs the worker to rate the child according to his/her worst level of functioning in the past month.

The CGAS is an adaptation of axis 5 of the DSM-IV in order to apply to children. Another adaptation of axis 5 has been constructed for children with developmental handicaps, the DH-CGAS. The underlying construct for the CGAS was developed by a consensus panel of the developers of DSM-IV and represents the best expert advice on the subject.

Method: rating client in reference to exemplars based on symptoms and social consequences

Data source: clinician

Norms: The CGAS is not norm-referenced.


OUTPUT: The output from the CGAS is one number between 1 and 99.

Content: The CGAS fits on one page and has one dimension or underlying construct, the child’s lowest level of functioning in his/her roles at home, school and community. There are ten exemplars representing ten levels of functioning. The worker must first locate the subject on the band which most closely matches the child’s clinical profile. Once a band has been selected, the worker assigns a number from a 10 point range identifying where the child fits within the band.

Evidence Base

A search on the CGAS produced 127 references on psychinfo. Haugen Schorre & Vandvik (2004) found 243 references to the CGAS on PubMed26. The single number has been used across the world in a triage function as gating criteria for admission to psychiatric hospital27. The CGAS score can also be used as part of an assessment battery to determine the severity of the child’s mental health needs28. In this way, the CGAS supports formulation and treatment planning. The number has been used to profile a population of children receiving service. It is also been used as a pre-post measure of outcomes.

The scientific basis for the CGAS comes from the research in developmental psychopathology. Stroufe & Rutter (1984) found that the strongest predictors29 in childhood for later dysfunction (violence, mental disorder and inability to cope) “appear to be adaptational failures, defined in age-appropriate terms”. The underlying question in all functional assessments is “how well is the child adapting to environment”.

Reliability:

Clinicians had good interrater reliability30 when rating vignettes of children without trauma histories on the CGAS (r = .73). In contrast, clinicians displayed poor reliability using the CGAS in rating functional status of children with a history of trauma (r = .38).


Publisher: in the public domain
Other independent studies, reviewed in the Haugen Schorre & Vandvik meta-analytic study, 2004, ibid) have found fair inter-rater reliabilities from .40 to .61. These authors notes that low inter-rater reliability occurs when there is no standardized and mandatory training for raters. The average test-retest reliability was excellent, ICC = 87.2.

The inter-rater reliability for the DH-CGAS was calculated. The ICC (intra class correlations) for the 13 raters across all 16 vignettes was .79 (p = .001). The ICCs between test and re-test ratings for all eight raters varied from .66 to .97 and averaged .86. All ICCs were significant at the p = .001 level.

There has also been criticism of the CGAS on the grounds that its inter-rater reliability is less reliable than the common finding reported above. Specifically, researchers in Norway found that the inter-class correlation for different raters was 0.61 rather than the average of 0.86 across several other studies.

Validity:

The DD-CGAS was significantly and positively correlated with measures of functioning: the VABS Composite \( r = .50, p = .001 \), ABLLS total score \( r = .52, p = .001 \), SB-5 Composite Score \( r = .47, p = .001 \), and Leiter-R Full Scale IQ \( r = .49, p = .001 \). Of the measures of symptom severity, the DD-CGAS was significantly and negatively correlated with the ABC-I \( r = .30, p = .006 \), the CY-BOCS total score \( r = -.29, p = .008 \), mean HSQ severity score \( r = -.26, p = .016 \), ADI-R Social Domain \( r = -.30, p = .005 \), ADI-R Communication Domain–Nonverbal \( r = -.45, p = .037 \), and CGI-S \( r = -.48, p = .001 \). It did not correlate significantly with the ADI-R Communication Domain–Verbal or the ADI-R Repetitive Behavior Domain. This clearly demonstrates convergent validity. (Wagner et al, 2007, ibid)

The correlations between the Columbia Impairment Scale (CIS) and the CGAS scores with the other measures of psychological dysfunction provide support for the concurrent validity of the impairment measures. Discriminant validity was demonstrated by the fact that the scores were significantly different for referred (mean = 61.8 ± 13.5) and non-referred children (mean = 85.6 ± 6.6). A CGAS score>71 is probably “non-cases”, CGAS ≥ 61 but < 71 is “probable cases” and CGAS<61 is “definite cases”

31 Wagner et al, 2007, ibid
32 Hanssen-Bauer, Ketil; Aalen, Odd O.; Ruud, Torleif & Heyerdahl, Sonja (2007), “Inter-rater Reliability of Clinician-rated Outcome Measures in Child and Adolescent Mental Health Services”, Administrative Policy Mental Health, 34:504–512
There was also a strong gender effect, with girls showing much more functional impairment than boys even with the same diagnosis. This finding by Steinhausen and Metzke (ibid) suggests girls suffer more severe social consequences of psychiatric disorders. They conclude “If replicated, the marked gender differences for thresholds on all impairment scores make it mandatory to use these thresholds separately when calculating prevalence figures in epidemiological surveys.” Furthermore, Steinhausen and Metzke (ibid) go on to assert that only a measure of functional impairment can determine “caseness” or clinical significance.

Secondly, they conclude: “If the present findings were to be replicated in clinical samples, clinicians must also be aware of these gender differences: girls, in general, need to be more impaired than boys in order to receive a psychiatric diagnosis.”

Predictive validity was shown by the fact that the CGAS is sensitive to change and predicts response to treatment. At study by Gold et al., reviewed in Steinhausen & Metzke (Ibid) found that CGAS alone accounted for 30.7% of the variance of the logarithm of length of stay in residential treatment. The CGAS and the Achenbach CBCL was used on 105 patients admitted to a 4 month inpatient program in a psychiatric hospital34. In their study, both the CBCL and the CGAS showed significant improvement over the four months period.

At discharge, the ward psychiatrist rated 83% of the adolescents as having improved 10 or more points on the CGAS (mean increase 20.5 points, SD 14.5). A total of 16% improved 0 to 10 points, with 1 patient having a decrease of 16 points. When change was examined according to primary diagnosis, patients with psychosis or mood disorder showed the most improvement.

Although learning disability was not the principal reason for admission, the 15 patients who were diagnosed with learning disability were seen as having fared worst of all, with a mean CGAS increase of only 9.6 (SD 4.3).

The CGAS is now regarded as valid for clients of ages 0 to 23 years. Steinhausen & Metzke (Ibid) conclude:

“Findings indicate that a unidimensional scale like CGAS is a better measure of change and predictor of outcome than diagnoses and multidimensional scales.”

Training

Training on the CGAS is important to ensure reliability. Instructions for proper interpretation of the exemplars and scoring are readily available.

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Critique

The CGAS has been subject to extensive independent evaluation of its psychometric properties and useability from sources across many cultures. Using the APA criteria (Holmbeck et al, previously cited), the CGAS is a well established evidence based test. The scale does appear to have substantial reliability (inter-rater and test-retest all above .80). However, the reliability is only fair (.61) with certain groups (trauma) and with poorly trained raters.

The CGAS shows excellent results with various tests of validity and in the context of intensive treatment settings with severely mentally ill children.

Recommendation for Mutual Support

I recommend that CGAS for use as an outcome measurement device at MSS. It is an evidence based tool that has been used successfully in many different setting for outcome data.
Feelings, attitudes and behaviour (FAB-C)

**Description:**

The FAB-C consists of 48 yes/no questions that ask the child to rate whether the statement describes him or her. The FAB-C is appropriate for children ages 6 to 13 years of age. For younger children and those with little reading ability, the FAB-C can be administered by reading the questions to the child and recording his response on the form. Children with a first grade reading level can complete the test.

The FAB-C is not designed to map directly to DSM disorders. It is designed to identify the attitudes and feelings of school age children. In addition, it examines the child’s behaviour with peers, a critical area for assessment. The FAB-C also has a lie scale. Higher scores indicate increasing severity of emotional and behavioral problems. An overall Problem Index helps identify children whose symptoms may merit further investigation with a more targeted assessment.

**Method:** symptom agreement scales for young children.

**Data source:** children 6 to 13 years

**Norms:** The FAB-C questionnaire was developed using a normative sample of 1,988 children—1,074 males and 914 females. The mean age for males was 9.62 (SD = 2.08) years and 9.65 (SD = 2.04) years for females. The normative sample for the FAB-C represents basic variables such as socioeconomic status, family structure, and cultural background. Separate norms are available for boys and girls in 2-year age intervals.

**Publisher:** Multi-health at https://www.mhs.com/ecom/(hr2sfte3dlt2ffr3iffeed55)/product.aspx?RptGrpID=FAC

$95.00 for the complete kit, manual and 25 forms. Additional packages of forms cost $46.00
OUTPUT:
The FAB-C produces t-scores for seven problem areas.

Content:
There are seven norm referenced scales produced:

- Conduct Problems (11 items)
- Self-Image (7 items)
- Worry (7 items)
- Negative Peer Relations (5 items)
- Antisocial attitudes and beliefs (6 items)
- Lie (8 items)
  - Problem Index

Evidence Base
The developer, Dr. J.H. Beitchman has published four articles attesting to the reliability, validity and usefulness of the instrument. There are no other references to the FAB-C in the literature. This instrument would be classified as promising on a scale of EBA.

Reliability: The internal consistency ranges from .62 to .78 across the scales. The 28 day test-retest reliability varies from .48 (self esteem)) to .68 (worry)

Validity: The ability of the FAB-C to correctly classify children in a clinical sample using the problem index score was tested. The false positive rate was 27% meaning that these children were classified as in the clinic sample when they were not considered in need. The false negative rate was 37% meaning that these children were classified as normal when they were in the clinic sample.

The FAB-C shows strong convergent and discriminant validity with both the Conners Rating System, the CBCL parent rated instruments, the Child Depression Inventory and clinician ratings of the same child. Indeed, the pattern of correlations appear to be more suggestive of validity than the self report versions that are internal to the ASEB and Conners Rating systems. For example, the correlation between somatic complaints on the CBCL and the self esteem scale of the FAB-C is .42. The self esteem scale was also correlated (.59) with the CDI total score.

Associating with negative peers on the FAB-C is inversely correlated with social activities on the CBCL (-.27) and positively correlated with the clinician’s rating of negative peer relations. The FAB-C conduct scale was correlated with aggression (.40) and antisocial behaviour (.49). There are at least 100 significant correlations between the FAB-C scales and the battery of tests described above.
The internal validation studies for the FAB-C demonstrate excellent psychometric properties.

**Training**

The FAB-C is very easy to administer and score. It will take ½ hour to train someone who has never administered a test before.

**Critique**

The FAB-C is unique in that it offers an opportunity for children as young as 6 years to provide self-report data to the clinician. The language of the test is very non-threatening and natural.

**Pros:**

1) The FAB-C includes a lie scale
2) The FAB-C includes a measure of negative peer relations which is one of the most potent risk factors for future problems.
3) The FAB-C has excellent psychometric properties
4) The FAB-C is comprised of non-threatening language that does not provoke emotional responses from the children or leave them with the feeling that they are disturbed.

**Cons:**

1) The reliability and validity of the FAB-C has not been confirmed by researchers that are independent of the developers.

**Recommendation by Robert Fulton**

There are very few instruments that are appropriate for school age children and that measure negative peer relationships and have a lie scale. That makes the FAB-C very useful for these reasons alone. The test appears to be valid based on the test manual.

I recommend that Mutual Support use the FAB-C for school age children on a selective basis. The FAB-C is appropriate when the clinician want to assess the child’s risk factors for future antisocial behaviour.

**Limitations**

Many disturbed children of this age group are not able to participate in testing because of their emotional and cognitive problems. This may be true for children who are victims of trauma.
Multidimensional Self Concept Scale (MSCS)

**Description:**

The MSCS is a standardized clinical instrument with 150 items on a 4-point scale that assess global self-concept and six context-dependent self-concept domains. The six domains assessed by the MSCS are social, competence, affect, academic, family and physical.

The MSCS can be administered either to individuals or to groups in approximately 20 minutes. The scale is simple to score; interpretation allows for both norm-referenced and inter-child comparisons across each of the six scales. Scores are reported as standard scores ($M = 100, SD = 15$) or as $T$ scores ($M = 50, SD = 10$) and can be graphically displayed for ease of interpretation.

**Method:** symptom agreement scales

**Data source:** child and youth ages 9 to 19 years

**Norms:** 2501 ages 9 to 19 years.

**Publisher:** Psychological Assessment Resources


The kit, including manual and 50 booklets cost $134.00US. An additional 50 booklets cost $72.00 or $1.44 per test per child.

**OUTPUT:** raw scores converted to T-scores which are converted by a table into DSM indicators
**SCORING:**

The scales produced by MSCS are as follows:

- **Total** – Overall self-concept/self-esteem
- **Social** – ability to achieve goals and objectives through successful social interactions
- **Competence** - ability to succeed in attempts to solve problems, attain goals, and function effectively
- **Affect** – One’s self-view of their emotional life
- **Academic** – Child’s evaluation of academic achievement and expectations of school-related situations
- **Family** – child’s view of home, family relationships, and influence of family on own life
- **Physical** – Child’s perceived physical attractiveness

**Evidence Base**

The scale has been used in numerous dissertations. In addition, there are about 12 articles in peer reviewed journals that have used the MSCS. There are no articles by independent reviewers confirming the reliability and validity of the instrument. The MSCS was originally published in 1991. The original validation study provided evidence of outstanding psychometric properties. Scime, Melinda & Cook-Cottone, Catherine (2008) used the MSCS in a study of body image related to eating disorders. The MSCS was reviewed in the current issue of Mental Measures Yearbook, but the copy was not available in time for this review.

The MSCS has been criticized in the dissertation literature. The MSCS failed to find any abnormal scores on any dimension of self concept with children of parents who were incarcerated, despite a significant number of studies that demonstrate that there is an effect on the child’s self concept. The failure to demonstrate an effect with the MSCS in at-risk population may be due to a methodological problem with the sample but it may also mean that the MSCS is not sensitive to the real “effect” on children of parents going to jail. That may have an impact on the ability of this instrument to provide outcome data to MSS.

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**Reliability:**

Each MSCS subscale evidences very high reliability related to internal consistency (a >.90); the Total scale score reliability exceeds .97 for the total sample\(^{38}\).

**Validity:**

The MSCS correlates very strongly with other measures of self-concept and self-esteem and has been shown empirically to identify clients who were previously identified as being low in self-concept. Specifically, the Coopersmith Self-Esteem Inventory Scale is correlated with MSCS scales and total scores ranging from .57 to .73; the Piers-Harris Self-Concept subscales are correlated ranging from .66 to .77 for theoretically similar scales and the Self-Description Questionnaire-II is correlated for similar scales ranging from .40 to .74. (Scime, Melinda & Cook-Cottone, Catherine, 2008, ibid)

**Training**

This scale is very easy to use and interpret.

**Critique**

There is a small amount of literature featuring this scale; indeed, the APA, division 54, (Holmbeck et al, 2007) did not consider the MSCS worthy of review, based on a consensus panel of experts from the APA. Nevertheless, the scales produced are theoretically coherent and relevant to the work of MSS. The data on reliability and validity is outstanding, particularly the scale’s internal consistency.

**Recommendation for Mutual Support**

I recommend the use of the MSCS in addition to SCARED. The information between the two instruments are quite distinct.

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Rosenberg Self-Esteem Scale (RSES)

Description:

The RSES\(^{39}\) is a 10 item self report symptom agreement scale for assessing the global self esteem of adolescents. The RSES\(^{40}\) has been used in thousands of research studies across the world for both adolescents and adults and for all groups of people.

The 10 questions include 5 positively worded statements of self worth (I feel that I have a number of good qualities) and 5 negatively worded statement of self worth (I certainly feel useless at times). The adolescent indicates his/her agreement to the scales by using a scale ranging from “strongly agree = 1” to “strongly disagree = 4”. In order to score the RSES, the worker must use a scoring key in which the negatively worded questions are reversed scored (i.e. 4 becomes 1 and so on). When the scores are converted appropriately, the score for all question is added together. The total number measures global self esteem.

Method: symptom agreement rating scale

Data source: youth

Norms: The original research on teh RSES was completed on 5,000 high school students across teh USA. Subsequently many different groups were tested. Normative values for different groups are available. The interpretive table on the next page are the norms by gender.

Publisher: in the public domain, download from

http://www.bsos.umd.edu/socy/Research/rosenberg.htm

\(^{39}\) Rosenberg, Morris (1965), Conceiving the Self, Basic Books: New York

\(^{40}\) Rosenberg, Morris (1965), Society and the Adolescent Self-image, Princeton university press: Princeton, New Jersey
OUTPUT: The output from the RSES is one number between 1 and 40.

Evidence Base

There is a very large number of research studies that have evaluated the RSES. A search of the RSES on psychinfo produced 2,069 hits. Many of the articles feature the RSES as a criteria for the validation of another self esteem instrument. Many studies use the RSES to compare groups on self esteem, such people with medical conditions compared to healthy individuals, etc. The RSES has also been used extensively as an outcome measure. The RSES was reviewed by Holmbeck\(^{41}\) and the APA. It is regarded as a well established, evidence based instrument.

Reliability:

Reliability coefficients\(^{42}\) (Cronbach’s alpha) for the 414 adolescent and 900 adults, participating in a study of the factor structure of the RSES, were similar in this sample (.81 and .83, respectively). In either case, this represents substantial reliability. The RSES\(^{43}\) has a Gutman scale coefficient of .92 indicating good internal consistency. Two studies of two week test-retest reliability of .85 and .88, indicating excellent stability.

Validity:

Whiteside-Mansell & Corwyn (2003, ibid) were able to rule out the possibility of an age-related bias contained in the RSES. The bias or “falsehood” that the researchers studied could invalidate the RSES when comparing scores between adults and teens. There is a potential for different scores obtained by a particular test between two groups (e.g. adults and adolescents, or mainstream Canadians and native Canadians) to mean that the same test is measuring two different constructs rather than the usual interpretation that the two groups are really different on the same construct.

The outcome of the research by Whiteside-Mansell & Corwyn provided strong support for the validity of the RSES when testing adults and adolescents.


\(^{43}\) Corcoran, Keven & Fischer, Joel (1996), Measures for Clinical Practice: a Sourcebook, New York: Free Press, page 408
Hagborg (1993) found significant differences between males and females on global self esteem, but difference by grade level. The RSES was highly correlated with the Harter Self-Perception Profile for Adolescents (SPPA), global self worth scale (r = .76) and the SPPA physical appearance scale (r = .55).

The RSES predicts delinquent behaviour, school failure and drop-out and substance abuse. (Holmbeck, 2007, page 9, ibid)

**Training**

The RSES is very easy to administer and interpret.

**Critique**

The RSES in a unidimensional scale measuring global self concept. As a result, it does not convey a lot of clinical information. Nevertheless, differences in scores within a single person over time are highly reliable and valid and reflect a critical developmental asset.

**Recommendation for Mutual Support**

I recommend the RSES for mutual support as an outcome measure of changes in self concept during residential care.
The Symptom Assessment – 45 (SA-45)

**Description:**

The SA-45 is a one page form with 45 questions completed by the teenager. The longer version (SCL-90R by Derogatis) is the major epidemiological instrument for adult mental health. The SA-45 is a revision of the 53 item BSI by Derogatis. This family of instruments reword psychiatric symptoms into *statements of self* to represent the DSM diagnostic criteria. The teenager responds by rating *how much the problem has bothered or distressed you during the last 7 days including today* on a five point scale: not at all (1), a little bit (2) ... extremely (5).

The questions are evidently linked to psychiatric symptoms. For example, “feeling afraid to travel on buses, subways or trains”, “feeling tense or keyed up”, “shouting and throwing things” and “the idea that you should be punished for your sins”. The content is clearly about thoughts and feelings. It does not have a lie scale.

**Method:** symptom agreement scales

**Data source:** technically youth 13 to 18, although it may be better for youth 15 up.

**Norms:** The SA-45 is scored relative to a normative database of over 18,000 subjects.


The manual and 25 forms can be purchased for $84.00 retail and an additional 25 forms for $43.00.

**OUTPUT:**

The SA-45 produces t-scores for 9 scales and two composite scales, a positive symptoms index and a global severity index. The positive symptoms index indicates the degree to which the youth is symptom free.

**Content:**

The scale are produced from five items in each category:

- Anxiety
- Depression
- Hostility

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Mutual Supports Program logic model: SA-45
• Interpersonal Sensitivity
• Obsessive-Compulsive
• Paranoid Ideation
• Phobic Anxiety
• Psychoticism
• Somatization
  o Global Severity Index
  o Positive Symptom Index

Evidence Base

The original instrument, the SCL-90, was assessed by the APA as a well established on its rating scale of evidence based assessments\textsuperscript{44}. The entire family of assessments have been used in hundreds of publications. This is an evidence based assessment instrument.

Reliability:

The internal consistency of each of its scales has been established with Cronbach’s alpha ranging from 0.71 to .87. Test-retest reliability over a two week interval are in the 80’s for most scales, except for anxiety which is .43. (SA-45 manual, reliability summary, page 49)

Validity:

The SA-45 scales are correlated at .95 or higher with their predecessors (SCL-90 and BSI). In addition, the SA-45 has very low false positive and false negative rates of 10% each for identifying inpatient versus outpatient samples.

Borduin et al (1995) found that the Global Severity Index of the SA-45 “represents the best single indicator of the respondent’s psychiatric functioning” (page 572)\textsuperscript{45}

Training

This is a multi-part form and scoring is fairly straightforward. The problem of managing missing values is a little complex.


Mutual Supports Program logic model: SA-45
Critique

The SA-45 provides a fast, valid snapshot of the degree of DSM symptomatology that the teenager acknowledges in relation to him/herself. The individual scales are not as predictive of “caseness” as the global severity index. The GSI is a measure of comorbidity and as such it is a valid indicator of clinical significance.

Pros:

(1) The SA-45 provides a valid measure of the degree of symptomatology in a broad sense of the word, which is an important risk factor for current and worsening mental disorder

(2) The content of the SA-45 cannot be assessed by behaviour observation since it is clearly about explicit thoughts and feelings

Cons:

(1) The individual scales (depression) are measured by only five items. This is totally inadequate to assess the construct of depression. Therefore, you cannot use the individual scales except as broad indicators of the probable direction of the mental health issues.

Recommendation for Mutual Support

I cannot recommend that use of the SA-45 for the logic model as an indicator of stress and anxiety. If that is the purpose, then MSS should use SCARED. The SA-45 is more useful as a risk screening tool for a significant psychiatric disorder

Double-click icon to view sample SA-45 document.
Screen for Childhood Anxiety Related Disorders (SCARED)

**Description:**

This tool screens children and adolescents age 8 and older for anxiety disorders. Both SCARED versions contain 41 items that measure five factors: general anxiety, separation anxiety, social phobia, school phobia, and physical symptoms of anxiety.

There are two versions for child and parent. Each version fits on two pages. Each version has identical questions, phrased differently to fit the respondent. For example, the following questions, which are symptoms of anxiety, are put to the parents:

15. When he/she gets frightened, he/she feels like things are not real.
16. My child has nightmares about something bad happening to his/her parents.
17. My child worries about going to school.
18. When my child gets frightened, his/her heart beats fast.

The child questionnaire mirrors the same questions as the parent:

15. When I get frightened, I feel like things are not real.
16. I have nightmares about something bad happening to my parents.
17. I worry about going to school.
18. When I get frightened, my heart beats fast.

The parent and child are asked to rate how true these statements are: not true, sometimes true and very true.

**Method:** symptom agreement scales

**Data source:** child and parent

**Norms:** none

**Publisher:** in the public domain: download from

[http://www.wpic.pitt.edu/research/](http://www.wpic.pitt.edu/research/)
**OUTPUT**: raw scores which are converted by a table into DSM indicators

**SCORING:**

- A total score of $\geq 25$ may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.
- A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.
- A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.
- A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.
- A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.
- A score of 3 for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**Evidence Base**

The SCARED instruments have been reviewed by the APA, division 54, on evidence based assessment and classified as well established. The Canadian Psychiatric Association recommended SCARED in its review of anxiety disorders, as the instrument with the “best evidence for reliability and validity”.

**Reliability:**

The internal consistency for the total score ranges from .90 to .96. The individual scales show alpha values from .55 to .92. The test-retest reliability ranges from .70 to .90. The parent-child inter-rater reliability ($r = .33$) and the individual scales range from .20 to .47, which are much higher than seen in the behaviour observation rating scales. (Holmbeck et al, 2007)

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46 Western Psychiatric Institute and Clinic, University of Pgh.


48 *Childhood Anxiety Disorders: Lessons From the Literature*, (2000), Canadian Psychiatric Association (author), October special issue

Validity:

The SCARED clearly differentiates children with or without diagnosed anxiety, anxiety vs depression and other DSM categories (according to the APA, division 54). It is highly correlated with a number of other anxiety scales, demonstrating convergent validity: SCAS (r = .85), YSR-anxiety-depression scale (r = .73), STAIC-trait (r = .73), STAIC-state (r = .65) and RCMAS (r = .86). (Holmbeck et al, 2007)

Training

This scale is very easy to use and interpret. It will need a few hours to prepare a manual.

Critique

There is a considerable amount of confidence in this scale from eminent authorities. (Holmbeck et al, 2007) Despite this, there are still very few references in the literature. This is partly because the SCARED is in the public domain and there is no profit motive to conduct research on the scale.

Recommendation for Mutual Support

I recommend the use of the SCARED parent report if the child is unwilling or unable to participate in testing. Using both versions would provide better assessment information, although there will be many differences in the scores from children as opposed to parents.
On the Meaning and Measurement of Engagement in Youth Residential Treatment Centers

Wm. Scott Cunningham
Portland State University

David E. Duffee
Yufan Huang
Camela M. Steinke
Toni Naccarato
University at Albany

Objective: This study describes the development of an engagement scale for use with youth in residential treatment centers. Engagement includes attitudes about treatment, bond with providers, and participation in treatment activities. Method: Interview data were collected at the midpoint in residence of 130 youth in two centers. Items were selected to capture practitioners’ description of three related concepts in a logic model. The authors conducted confirmatory factor analysis and examined interitem reliability. Results: Results indicate a single underlying factor, which the authors label engagement, an acceptable level of reliability, and strong content validity. Conclusion: The scale integrates several concepts in the treatment process literature and might serve to assess youth engagement in residential settings. Additional study should examine construct validity.

Keywords: client engagement; residential treatment centers; treatment process

The centrality of client engagement to the therapeutic process has long been recognized in many different forms of therapy. For instance, Roberts and Nee (1974) noted that the concept of engagement in social work practice dates to the 1950s. In psychotherapy, Rogers (1951) argued that therapy works through the therapeutic relationship. In discussing cognitive-behavioral treatment, Beck (1976) stressed the importance of therapist–client collaboration. More recently, Reid (1987, 1990) recognized that clients could actively contribute to the treatment process. Broadly conceived, engagement refers to a client’s commitment to and active participation in the treatment process. In the case of youth in residential treatment, in addition to participation in treatment activities, engaged clients have established a working relationship with their adult service providers, and they express a level of commitment to working on problems, which they acknowledge and for which they accept some responsibility. Despite the presumed importance of engagement in treatment, well-developed measures of engagement appropriate for use with youth are rare (Dore & Alexander, 1996; Reid, 1990; Shirk & Karver, 2003).

Two major justifications for measuring client engagement exist. First, practitioners often describe client engagement as a prerequisite to effective intervention. For example, a core feature of task-centered social work is the agreement between therapist and client concerning the goals of therapy (Reid, 1996). Likewise, the functional approach to casework emphasizes the relationship that develops between therapist and client (Smalley, 1967). Dawson and Berry (2002) and Yatchnenoff (2005) viewed engagement of family members as a critical element in many forms of service delivery in the child welfare system. In a recent meta-analysis of 23 studies, Shirk and Karver (2003) reported a positive association between therapeutic relationship variables and measures of treatment outcome in child and adolescent therapy, suggesting that engagement...
Sociodemographic Checklist

Child’s birth date: ____/____/____ (D/M/Y) gender: _______ (M or F) Name: _______________________

Check the box if the child has a history of any of the following:

☐ years of hardship and deprivation including poverty (e.g., family dependent on welfare or FBA all their childhood ... do not check off if family’s dependence on welfare is episodic or recent)

☐ sexual abuse ............................................................................................................. specify age when started _____

☐ physical abuse ................................................................................................. specify age when started _____

☐ suicide of a family member * ............................................ specify Mom     Dad     other _______

☐ incarceration of a family member * ..................................... specify     Mom    Dad    other _______

☐ hospitalisation of a family member *
  for psychiatric reasons ...................................... specify     Mom    Dad    other _______

☐ family member * has cognitive deficits (MR) ............... specify     Mom    Dad    other _______

☐ abuse of drugs or alcohol by a family member * .......... specify     Mom    Dad    other _______

☐ rape or sexual assault of family member * .................. specify     Mom    Dad    other _______

* “family member” means someone who has actually lived with the child in the past or currently

☐ The child has a history of abusing (not including experimenting with) drugs or alcohol.

☐ The child has someone living with him(her) currently who is violent toward other family members

☐ The child has someone living with him(her) currently who sexually assaults others in family

☐ The child has been diagnosed as brain damaged including specific brain related medical conditions such as epilepsy.

☐ The child displays learning problems or frustrations in school achievement dating from elementary school.

☐ The child’s mother was in her teens when the child was born.

☐ The child is medically fragile

☐ The child has a diagnosis of autism

☐ The child has been diagnosed with a developmental disability of mild or lower
Indicators of Success Questionnaire

Double-click icon to open document.

Plan of Care Model, Measuring the Outcome of Service
1999, David C. Factor, Ph.D., C.Psych., Robert J. Fulton, M.S.W.

Double-click icon to open document

Research Methodology Manual, Risk Screening and Outcome Evaluation for OARTY,
1999, David C. Factor, Ph.D., C.Psych., Robert J. Fulton, M.S.W.

Double-click icon to open document
Parental Bonding Index

Double-click icon to open document.
CLIENT SATISFACTION QUESTIONNAIRE – during placement

Child/Youth: _____ Date of Birth: _____
Agency: _____ Phone No.: _____
Social Worker: _____
Date: _____
Mutual Support placement: _____

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How do you rate the quality of care you are receiving at Mutual Support?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
</tbody>
</table>

2. Are you getting the kind of care you want?

<table>
<thead>
<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>

3. To what extent is our program meeting your needs?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Almost all of my needs have been met</td>
<td>Most of my needs have been met</td>
<td>Only a few of my needs have been met</td>
<td>None of my needs have been met</td>
</tr>
</tbody>
</table>

4. If a friend were in need of similar help, would you recommend our program to him or her?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>
5. How satisfied are you with the amount of help you are receiving?

<table>
<thead>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

6. Have the services you have received so far helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, they helped a great deal</td>
<td>Yes, they helped</td>
<td>No, they really didn’t help</td>
<td>No, they seemed to make things worse</td>
</tr>
</tbody>
</table>

7. In an overall, general sense, how satisfied are you with the services you are receiving?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Very satisfied</td>
<td>Mostly satisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Quite dissatisfied</td>
</tr>
</tbody>
</table>

8. What do you like about your placement at Mutual Support?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

9. What do you not like at Mutual Support?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

10. What would make the services at Mutual Support better?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
CLIENT SATISFACTION QUESTIONNAIRE – discharge

Child/Youth: _____ Date of Birth: _____
Agency: _____ Phone No.: _____
Social Worker: _____
Current Placement: _____
Date: _____
Mutual Support placement: _____

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

8. How do you rate the quality of care you received at Mutual Support?

<table>
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<tr>
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<th>4</th>
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<tr>
<td></td>
<td>Excellent</td>
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<td>Fair</td>
<td>Poor</td>
</tr>
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</table>

9. Did you get the kind of care you wanted?

<table>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>

10. To what extent has our program met your needs?

<table>
<thead>
<tr>
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<th>1</th>
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<td>Almost all of my needs have been met</td>
<td>Most of my needs have been met</td>
<td>Only a few of my needs have been met</td>
<td>None of my needs have been met</td>
</tr>
</tbody>
</table>

11. If a friend were in need of similar help, would you recommend our program to him or her?

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<tr>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>
12. How satisfied are you with the amount of help you have received?

<table>
<thead>
<tr>
<th></th>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

13. Have the services you received helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
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<tbody>
<tr>
<td></td>
<td>Yes, they helped a great deal</td>
<td>Yes, they helped</td>
<td>No, they really didn’t help</td>
<td>No, they seemed to make things worse</td>
</tr>
</tbody>
</table>

14. In an overall, general sense, how satisfied are you with the service you have received?

<table>
<thead>
<tr>
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<th>1</th>
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<tbody>
<tr>
<td></td>
<td>Very satisfied</td>
<td>Mostly satisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Quite dissatisfied</td>
</tr>
</tbody>
</table>

8. What did you like about your placement at Mutual Support?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

9. What did you not like at Mutual Support?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

10. If another child/youth were placed at Mutual Support, what would make it better?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Stakeholder Survey

Double-click icon to open document.

Annual Staff Interview Survey

Double-click icon to open document.