Walk a Mile in My Shoes

Evaluation Planning Grant 1292

Walk a Mile in My Shoes: Enhancing Knowledge and Empathetic Understanding of Processing Challenges Experienced by Youth with Mental Health Disorders and Co-occurring Learning Disabilities

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Section A: Executive Summary

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Summary of Project: The manner in which an individual takes in, remembers, works with verbal and visual information, and enacts their knowledge has important consequences for how they navigate their world, their mental health, and their functioning in all aspects of daily life, including peer and family relations and school. Walk a Mile in my Shoes (WAM) is an experiential, interactive workshop for parents, teachers, and service providers designed to enhance knowledge and empathetic understanding of the processing challenges that underlie many of the challenges faced by youth with mental health difficulties and co-occurring Learning Disabilities (LDs). This Planning Grant was undertaken to develop an evaluation framework for WAM, including the development of an innovative online measure of changes that may be associated with mental health literacy programs, such as WAM.

The Purpose

• To develop a mixed method evaluation framework for WAM.
• To develop and pilot an innovative online measure of change that assesses key processes (e.g., empathy, attributions, knowledge of LD and mental health, self-efficacy, and perceived barriers) involved in bringing about helping behaviour, that can be used in the evaluation of WAM.

The Program

Integra is the sole accredited children’s mental health centre in Canada that is committed to addressing the mental health needs of youth (aged 8-18) with LD. We strive to be leaders in this important area of children’s mental health and view program development, evaluation and knowledge translation as pivotal in the attainment of this goal. Integra recognizes the value and importance of evidence-informed practice and is committed to developing and evaluating innovative programs that improve the mental health outcomes for youth with LD.

WAM, originally developed by Integra staff in 1995, is a structured, interactive workshop for parents, teachers, and service providers designed to enhance knowledge and empathetic
understanding of the processing challenges that underlie many of the social, behavioural, and emotional challenges faced by youth with mental health difficulties and co-occurring LDs (see Appendix A for Logic Model). Consistent with pedagogical theories on the value of experiential learning (Niemantsverdriet et. al, 2005; Reilly, 2005), participants in WAM gain knowledge of the nature of processing difficulties and their relation to mental health and an empathic understanding of the experience of the child through interactive activities that simulate processing challenges, such as planning and organization, memory, and visual perceptual abilities. These activities provide participants with a lived experience of what it may feel like to have processing challenges and how it may impact on or contribute to mental health challenges, such as peer relations difficulties, depression, anxiety, and behaviour problems. WAM’s framework is based on models of behaviour change that suggest that empathy is a catalyst in translating knowledge into practice (Kilpatrick, 2005). The presence of an emotional response heightens the ability of individuals to direct attention to important events and facilitates the judgment, memory, decision making, and creative problem-solving needed to change one’s behaviour (Caruso, Mayer, & Salovey, 2002). Participant feedback consistently suggests that participants find the workshop experience leads to profound changes in their understanding of thei experience of a child with LD and heightens their desire to help and be creative in their approach to working with children with LD.

The Plan

The planning grant for WAM focused on the development of a logic model and evaluation framework for a future evaluation. Given that little research has been completed in this area, the planning grant focused on development of a logic model and theoretical framework specifying key processes involved in increasing support and help for children and youth with LD and mental health challenges. Given the paucity of research and associated measures in this area of program evaluation, a second objective of this planning grant was the development of an online measure of processes and outcomes in our theoretical framework. Pilot testing of the online measure with parents
and teachers was used to determine the feasibility and effectiveness of the measure developed and to provide a preliminary test of the logic model and theoretical framework for WAM.

The Product

The first stage of the project involved review of the literature pertaining to theory of behaviour change and education/training approaches. An emphasis was placed on identifying key processes involved in increasing literacy in LD and mental health among parents and teachers and mobilizing knowledge into helping behaviours that promote positive mental health outcomes for children and youth. Given the absence of measures in this area, an online measure reflecting changes in key processes (e.g., empathy, attributions, knowledge) was developed. This process involved significant consultation and qualitative interviews with parents, teachers, and professionals working with children and youth with mental health and learning challenges. Pilot research using the online measure was completed with elementary school teachers (N=13), secondary school teachers (N=9) and parents (N=3). The pilot quantitative and qualitative results suggested that WAM shows promise in being an effective LD and mental health literacy program. The results highlight the impact of the experiential exercises and their impact on teacher empathy (elementary school teachers), attributions (secondary school teachers), knowledge of LD and mental health (elementary and secondary school teachers) and intention to engage in helping behaviours (elementary school teachers). This planning grant has provided Integra staff with the opportunity to build staff capacity in research, to develop an efficient and specific measure to develop processes and outcomes related to one of our cornerstone programs, and to develop a well defined evaluation plan that we hope to implement in the near future.

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The Pilot Results for Tea Parent Qualitative Interview with Parents and Teachers are presented in Section E. This section discusses the challenges in defining and measuring constructs, the development of vignettes and statements, and the evaluation plan. It also presents the evaluation questions for the WAM evaluation and the experiential learning approach that facilitates behavioral change. The purpose of the project is to develop literacy in mental health and learning disabilities. The program, plan, and product are described in Section A. Section B includes the table of contents, while Section C covers the introduction and literature review. Section D focuses on the overall methodology, including the development of the planning grant team and evaluation framework for WAM, challenges in defining and measuring constructs, development of an outcome measure for mental health and LD, and the evaluation plan. Lastly, Section E provides the pilot results for the qualitative interviews with parent and teacher participants of WAM.
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Section C: Introduction and Literature Review

Developing Literacy in Mental Health and Learning Disabilities

Children’s mental health needs have been underserviced in Canada: 14 percent of Canadian children and youth are affected by mental disorders that require professional intervention (Waddell, Offord, Shepherd, Hua & McEwan, 2002) and as few as one in six will access specialty mental health care (Offord, Boyle, Fleming, Munroe Blum, & Rae Grant, 1989).

Improving mental health literacy plays a foundational role in developing an effective system of care and support for children with mental health challenges. Mental health literacy is a term derived from health literacy that refers to “knowledge and beliefs about mental disorders which aid their recognition, management, or prevention”. The Canadian Alliance of Mental Illness and Mental Health (2008) has revised the definition of mental health literacy to be “the knowledge and skills that enable people to access, understand, and apply information for mental health” (p.2), highlighting 

empowerment as a key concept for health. Mental health literacy describes people’s perceptions towards mental illness, understanding and ability to recognize specific disorders, and attitudes and knowledge towards help-seeking and interventions (Canadian Alliance on Mental Illness and Mental Health, 2007). Research from the Canadian Alliance on Mental Illness and Mental Health has shown that generally people have a poor understanding of mental health disorders, stigma and discrimination continue to be problematic, and more education is needed on different mental health treatment options. Improvements in mental health literacy is needed to help individuals understand information related to mental health, seek appropriate and timely treatment, and provide people with the skills and resources to be helpful in their responses to others with mental health issues.

Teachers and parents require mental health literacy to be sensitive and supportive to children and youth. Canadian youth spend more time in school than anywhere else outside the home (Wei & Kutcher, 2011). Knowledgeable school staff are well positioned to identify concerns and to promote mental health prevention strategies. However, approximately two-thirds of regular, elementary school teachers reported feeling “somewhat to very overwhelmed” in supporting mental health needs (Roeser
& Midgley, 1997). Teachers from a diversity of schools reported feeling incompetent in recognizing and managing mental health problems (Rothi, Leavy, & Best, 2008). Students with commonly diagnosed children’s mental health disorders are rated as significantly more stressful to teach, contributing to increased childhood behaviour problems within the classroom setting and higher rates of teacher burnout (Green et al., 2002). Most teachers have had little education and consultation about mental health problems, providing teachers with limited knowledge to support students (Walter, Gouze & Lim, 2006). Teachers have identified the lack of information and training related to mental health as the greatest barrier to addressing students’ mental health needs (Walter et al., 2006). Teaching students with LD and associated behavioural and mental health issues is associated with high levels of job stress, particularly when the student behaviours include a perceived lack of effort in class, inattention and hyperactivity, breaking school rules, and being disruptive (Geving, 2007; Yoon, 2002). High teacher stress may reflect factors such as behavior management, support and workload (Chaplain, 2008) and it is associated with lower job satisfaction (Smilansky, 1984), a more negative attitude toward teaching (Yoon, 2002), and more negative teacher-student relationships (Yoon, 2002). Developing effective and innovative teaching, behavioural and time management strategies has been identified by teachers as a positive method of coping with job-related stress (Zurlo et al., 2007). There is a clear need for training, including advice on identification, referrals, and sources of support, as well as practical training on including students with mental health needs in the classroom (Rothi et al., 2008).

Similarly, research has suggested that parents require an awareness of their children’s state in order to be sympathetic and understand their children’s experiences and the source of that experience (Kilpatrick, 2005). The meaning attributed by parents to their children’s actions impacts on a parent’s emotional response and how parents will respond to the child (Bugental, Johnston, New & Silvester, 1998). Hassall & Rose (2005) have suggested that parents would benefit from interventions that aim to facilitate their understanding of alternative explanations for their children’s behaviour. This
knowledge may lead to more effective management strategies for children’s behaviour and an enhanced emotional quality in parent-child relationships (Hassall & Rose, 2005).

Children whose mental health needs are complicated by LD represent an additional challenge at all levels of our system. Learning Disabilities (LDs) refer to a variety of neurologically-based disorders that affect a person’s ability to take in, understand, remember or express information (LDAC, 2002). LDs are a highly prevalent disorder impacting approximately 8-10 percent of the general population (Vellutino et al., 2004 Lerner & Lerner, 1991). Children and youth with LD represent the largest identified group within special education with 43% of students identified with a LD exceptionality in Ontario (Ontario Ministry of Education, 2011). While difficulties in academics are most commonly associated with LDs, the impact of LDs extend beyond the classroom, with rates of mental health difficulties being 2 to 3 times higher in youth with LDs (LDAC, 2007). One third of youth with a LD have ADHD (Wilcutt & Pennington, 2000) and approximately 10% have significant behaviour problems (Lowe et al., 2007). Peer rejection, neglect, and victimization are experienced by approximately 50% (Wiener, Harris & Shirer, 1990; Mishna, 2003) and friendships tend to be unstable and impoverished (Wiener & Schneider, 2002; Wiener & Sunohara, 1998). LDs can also significantly impact on the quality of parent-child relationships and levels of parental stress (Heiman, Zinck, Heath, 2008).

Training and knowledge in LD and more specifically processing problems and mental health disorders is required in order to correctly identify behaviors of concern and to facilitate appropriate referrals to mental health specialists. Moreover, we know from research on resiliency that mental health outcomes are improved by even just one relationship with an empathic adult, who might be a parent, aunt, teacher or basketball coach, for example (Blum, Kelly & Ireland, 2001). However, training and education to promote knowledge and empathic understanding of LD and mental health has not been readily available or accessible. Parents, teachers and those working with children with learning disabilities need to understand what learning disabilities are and more specifically how challenges in information processing (e.g., memory, processing speed, executive functions) impact on functioning in
and outside of the classroom. This information provides a “roadmap” for how therapy and education can be individualized for a child or youth to maximize success. Developing this literacy is the mission of Integra’s Community Education and Engagement Program and WAM is our flagship program that sets the stage for empowering parents and teachers to bring about positive change in the lives of children and youth with LD and mental health challenges.

Models of Mental Health and LD Literacy

A framework for mental health literacy has been developed by Canadian Alliance on Mental Illness and Mental Health (2007). According to this framework, mental health literacy includes the engagement and collaboration of family members and the community. The framework discusses the importance of normalizing mental health issues and creating an environment in which people speak freely and easily, advocating for community settings, such as schools, to be healthy from a mental health perspective, supporting providers who interact regularly with the public to provide information and resources, and promoting messages of hope and positive components of mental health. In addition, the framework states the need to evaluate the effectiveness of strategies and share best practices.

While this framework is helpful in guiding mental health and LD initiatives and defining target populations, research into specific guidelines or best practices for translating knowledge into practice is still in its infancy. Further, little is known about the key processes of change (e.g., knowledge, skill, attributions, empathy).

Given this gap in knowledge, a thorough literature review was completed to examine key processes that facilitate change in parent/teacher behaviour or intention to engage in behaviour and training/educational approaches (e.g., didactic vs. experiential learning) methods that target these processes.

Key Processes Involved in Changing Parent and Teacher Helping Behaviour

1. Attributions
Attributions are “interpretative filters” through which parents and teachers assign meaning to behaviours and characteristics of children and youth (Bugental, Johnson, New & Silvester, 1998). Theory of Planned Behavior (TPB) was developed by Ajzen (1991) to: (1) predict and understand motivational influences on behavior that is not under the individual’s volitional control; (2) identify how and where to target strategies for changing behavior; and (3) to explain human behaviour.

According to TPB, the most important determinant of a person’s behavior is behavioural intent. Behavioral intent is based, in part, on a person’s attitude about a behaviour and the expected outcome of that behaviour. Attributions or a person’s belief about the causes of a behaviour help to determine attitude. One of the most common complaints of parents and teachers is that children and youth are not trying or are engaging in a challenging behaviour “on purpose.” The work of Ross Greene (Greene & Ablone, 2006) has been influential in shifting the view of parents, teachers, and helping professionals to children and youth will do well if they can and that behaviour problems often reflect underlying challenges or “lagging skills.” When factors outside of a child’s control (e.g., disability or illness) are thought to result in a negative outcome (e.g., not completing school work), parents and teachers are thought to experience more feelings of sympathy, which may in turn foster encouragement of the child or helping behaviours. In contrast, when a behaviour is thought to be within a child’s volitional control (most commonly linked with lack of effort) parents or teachers are more likely to experience anger which may hinder engagement in helping behaviours (Clark, 1998). When a child’s actions pose a challenge or a threat to a caregiver, the meaning assigned to his/her actions influences parental affect and choice of coping or discipline strategies. Research has shown that mothers of children with aggression are more likely to interpret their child’s behaviour in a hostile manner. These behaviours are viewed as pervasive and intentional (Bugental, Johnson, New, & Silvester, 1998). Research into parental cognitions about ADHD suggests that parents need to generate alternative explanations for their child’s behaviour, particularly to include consideration of environmental factors, and to enhance the emotion quality of the parent-child relationship (Bolton et al., 2003 in Hassall & Rose, 2005).
2. Emotional Response and Empathy

While not identified as a specific process in the TPB model, a parent’s or teacher’s emotional response and empathy are intrinsically tied to attributions about mental health and LDs. This connection appears to be bi-directional. The emotional response of a parent or teacher may lead them to be more or less empathetic which may impact their ability to consider a range of factors that may play a role in causing or maintaining a behaviour or mental health challenge. For example, if parents can put themselves in the shoes of a child who is skipping school due to challenges with school work, they are likely to experience sympathy which in turn may help them to search for a range of factors that may be contributing to this behaviour. An emotional response may also be a consequence of a parent or teacher’s attributions or understanding of a behaviour. For example, understanding that challenges with memory can impact on following directions, may make a parent or teacher more sympathetic and more likely to intervene. This view is consistent with emotional intelligence theory.

Caruso, Mayer, and Salovey (2002) suggested that the presence of an emotional response may act as a catalyst in translating knowledge into action. Emotion is thought to heighten the ability of individuals to direct attention to important events and facilitates the judgment, memory, decision making, and creative problem-solving needed to change one’s behaviour.

3. Perceived Barriers, Subjective Norms, and Self-Efficacy

The TPB model also acknowledges the role that Perceived Control, Subjective Norms, and Self-Efficacy play in determining the likelihood of a parent or teacher engaging in a given helping behaviour. This may include how difficult the behaviors are perceived to put into action, how acceptable the behaviours are to others, and the perception of probability of success. If a person holds strong beliefs in these areas, the behaviour is more probable.

Taken together, these processes likely work in an interactive and recursive rather than linear model (Bugental et al., 1998). The following model depicts the key processes in bringing about behaviour change.
Experiential Learning: A Training Approach that Facilitates Behavioural Change

While didactic approaches are commonly used to teach parents and teachers about mental health and learning, these approaches may be less successful in translating knowledge into behavioural change than more active learning approaches (Karns, 2006). Experiential learning theory (ELT) as a model for learning was introduced by Kolb and Fry (1975). ELT is a multilinear model that is learner-centered rather than instructor-centered. Kolb defines ELT as, “… the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience.” ELT, as a learner-centered model, differs from the traditional teacher-centered didactic model in that it focuses on active, participatory, constructive learning rather than the transmission of knowledge from a content expert. ELT views learning as a process rather than an outcome, with an emphasis on the experience as the learning method, with knowledge being gained from assimilating the experience.

Walk A Mile In My Shoes: An Experiential Learning Approach to Facilitating Behaviour Change

Integra is the only accredited children’s mental health centre in Canada dedicated to treating children and youth with LDs and co-occurring mental health issues. *Walk a Mile in My Shoes (WAM)*, originally developed by Integra staff in 1995, is a structured, interactive workshop for parents, teachers, and service providers designed to enhance knowledge and empathetic understanding of the processing challenges that underlie many of the social, behavioural, and emotional challenges faced...
by youth with mental health difficulties and co-occurring LDs. Consistent with pedagogical theories on the value of experiential learning (Niemantsverdriet et. al, 2005; Reilly, 2005), participants in WAM gain knowledge of the nature of processing difficulties and their relation to mental health and an empathic understanding of the experience of the child through interactive activities that simulate processing challenges, such as planning and organization, memory, and visual perceptual abilities. These activities provide participants with a lived experience of what it may feel like to have processing difficulties and how it may impact on or contribute to mental health challenges, such as peer relations difficulties, depression, anxiety, and behaviour problems. WAM’s framework is based on models of behaviour change that suggest that empathy is a catalyst in translating knowledge into practice (Kilpatrick, 2005). It is from this place of empathy, that parents and teachers are able to take in knowledge about mental health and LD and consider alternate explanations (attributions) for behaviour, social, emotional, and academic challenges. Emotion also serves to empower them to find new and creative ways of helping children and youth (See Appendix A: Logic Model).

WAM is tailored to meet the learning needs of diverse groups (e.g., parents, teachers, other helping professionals) in terms of focus of information, length of presentation and structure (e.g. small group, large group, level of facilitation and discussion ). For example, some schools request WAM as a professional development opportunity lasting a full day with time to integrate information covered into daily teaching practices while other groups may chose a shorter time to accommodate an evening presentation for community members after the work day is completed. Integra strives to meet the diverse needs of various participants while maintaining the core knowledge and experiential exercises that elicit empathy and promote understanding. WAM is designed to develop and promote a “multiplier effect” to share knowledge, skills and experience with those in positions to help and advocate for children/youth with LDs who will then in turn, go on to support greater numbers of children and youth than working with individuals. In 2010/11, Integra presented WAM to 1050 participants, with anticipated far-reaching effects as the experience of participants is shared with others.
Evaluation Questions for WAM Evaluation (Appendix B)

1. Does empathy (i.e., understanding of the emotions experienced by child/youth) change from before to after participation in WAM?
2. Do attributions about the causes of behaviour change from before to after participation in WAM?
3. Does LD knowledge change from before to after participation in WAM?
4. Does self-efficacy change from before to after participation in WAM?
5. Does parent/teacher behaviour change or intention to change behaviour change from before to after participation in WAM?
6. Are there process indicators (e.g., target group characteristics, such as group size, elementary or secondary teacher) that moderate change made by participants on process and outcome variables (empathy, attributions, LD knowledge, intention for behaviour change)?

Section D: Overall Methodology

Development of the Planning Grant Team and Evaluation Framework for WAM

Given that Integra is a small agency with 20 employees and that the Community Education and Empowerment Department is comprised of two staff (Director, Dr. Marjory Phillips and Manager, Melissa Rowbotham), all members of the WAM clinical team played an active role in the planning grant process. The team also included members of the Integra Research and Psychology team including Dr. Karen Milligan (Director of Research and Psychology), Dr. Jen Scully (Psychologist), and Priyanka Sharma and Laura Greenberg (Research Assistants). Two University of Toronto students also assisted (Rachelle Cosme & Pei Ying Lin). While not part of the core team, a number of essential stakeholders also contributed to the development of the measure and evaluation framework. This provided us with expertise in a number of key areas such as Ethics, LD and Program Evaluation (Dr. Judy Weiner and Dr. Maggie Toplak, Members, Integra Board of Directors and professors at University of Toronto and York University respectively), mental health literacy (Don Buchanan and the Knowledge Mobilization team at the Hamilton Wentworth District School Board), measurement (Dr. Leslie Atkinson, Professor at Ryerson University, Dr. Chuck Cunningham, Professor at McMaster
University, Dr. Eleanor Allgood, Retired Professor and expert in Q-sort measurement. Integra and Camp Towhee Staff also played a key role in the development of our measure.

The team was lead by Dr. Karen Milligan and regular meetings were held with the team as a whole, as well as individuals, depending on the stage and tasks to be completed. An ethical review and review of the plan for developing the measure and evaluation framework was completed by the Integra Board of Directors Research Committee, including Drs. Milligan, Phillips, Weiner, and Toplak. Valuable feedback on the measure, logic model and evaluation framework was provided by Dr. Marie Josee Emard, Research Associate at the Centre of Excellence in Child and Youth Mental Health.

**Challenges in Defining and Measuring Constructs**

From the outset of our Planning Grant, we were cognizant that one of our greatest challenges would be locating measures for the processes and outcomes defined in our model, such as empathy, attributions, and knowledge of LD and mental health. A thorough literature review was conducted for measures examining empathy, attributions, and knowledge related to learning disabilities, mental health, and Attention Deficit Hyperactivity Disorder. Three main types of measures were located: likert scales about attitudes and helping behaviours and true/false scales typically about knowledge. Measures either had respondents report based on their experience/knowledge or had respondents answer questions associated with vignettes. Parent and Teacher-report questionnaires examining parental empathy and parent and teacher stress (e.g., self-efficacy, perceived barriers) were also examined. While there were general measures of empathy (e.g., Interpersonal Reactivity Index), knowledge of processing (e.g., ADHD Questionnaire, Kos, 2004; Integra Knowledge of LD Questionnaire, Phillips, 2009), attributions (e.g., Brady & Woolfsen, 2008; Clarke, 1998), and teacher and parent stress (Teacher Stress Index, Abindin, Greene, Konold, 2004; Parenting Stress Index, Abidin, 1995), review of these measures suggested that there was no one measure or group of measures that would reflect high levels of face validity and sufficient specificity for the objectives of WAM and our population. Furthermore, many of the measures appeared to be at risk for social desirability bias (i.e., respondent’s providing answers that reflect a normative response vs. their own
feeling/thoughts). This was consistent with feedback from our team and stakeholders. Dr. Marjory Phillips had completed some pilot work using true/false and knowledge-based vignettes measures for evaluating WAM with Youth Justice Personnel and had found that they were not sensitive enough to assess change in knowledge of LD and were at high risk of social desirability bias. Conversations with stakeholder groups evaluating mental health literacy initiatives (e.g., Knowledge Mobilization Team, Hamilton Wellington District School Board) suggested similar challenges. Furthermore, methodological research in the area of attributions has suggested that the use of specific, behavioural events is most likely to provide an optimal measure of a parent or teacher’s stimulus dependent, episodic memory associated with particular child and youth behaviours (Bugental et al., 1998).

Given that measures also needed to be accessible to participants before and after the workshops and the limited time of parents and teachers, we needed a measure that could be easily administered, preferably online. To address these challenges, our research team decided to develop a new measure that would combine the strengths of these different methodologies into an online questionnaire.

**Development of an Outcome Measure for Mental Health and LD**

**Selection of Measure Design**

Development of a measure that would reflect the multiple processes and outcomes of interest involved numerous stages and input from our core team and stakeholders. A literature review of questionnaire formats to be used with the vignettes was completed. Likert scale, Q-sort, and Consumer Preference Modeling/Conjoint analysis were reviewed and considered. Q-sort and conjoint analysis are similar in that they are designed to study subjectivity, including feelings and points of view and to reduce social desirability bias. For both questionnaire formats, respondents sort or choose statements that best reflect their points of view until a final model is reached. Completion of Q-sorts, however, can be time consuming and to make the sort manageable a limited number of processes and outcomes can be examined, ideally two to three (personal communication with Eleanor Allgood on June 22, 2011). Conjoint analysis is much easier for the respondent to complete as they have to
complete a series of forced choice questions to produce a final model rather than sorting statements. The required sample size given the number of processes and outcomes of interest was large. Given the elementary stage of questionnaire design, the need for a brief measure, and our small sample size for the pilot, we decided to begin by using likert scale questions to assess understanding of two picture-based vignettes. To decrease the potential impact of social desirability, all questions were randomized across and within process and outcome area for each participant and at pre- and post-test.

We also felt that it was important that the measure sufficiently activate emotions and prime participants to consider their interactions with their children or children/youth who they taught. As such, we used pictures along with written vignettes and asked parents/teachers to imagine themselves as the parent or teacher in the situation. Questions were then used to examine each of the processes/outcomes in the model (i.e., empathy, attributions, knowledge of LD and mental health, intention to engage in helping behaviour, perceived barriers, self-efficacy).

**Question Development**

*Qualitative Interviews with Parent and Teacher Participants of WAM (Stage 1)*

Given our desire to ensure that our proposed logic model and constructs (outcome variables) was accurate from the perspective of those participating in WAM and to hear in participants’ own words what changes they noticed in relation to the constructs of interest, we completed qualitative interviews. Research by Bugental et al. (1998) has suggested that questionnaires and stimuli generated by stakeholders, such as parents and teachers, is more likely to access responses that reflect the lived experience of parents and teachers. As discussed above, these interviews served three purposes. First, to provide us with an understanding of the workshop and processes of change and outcomes from the perspective of parents and teachers to enable us to ground our logic model in the experience of our participants. Second, to help us understand the language parents and teacher use to lend face validity to the statements to be used in the development of our measure. Lastly, to pilot our questionnaire for use in our future evaluation.
The qualitative evaluation involved individual, in-depth interviews with 3 parents and 2 teachers. Interviews followed a semi-structured guide that was developed by the WAM evaluation team. Parallel forms of the same question were developed for parents and teachers (see Appendix E).

**Qualitative Interview Participants**

In March 2011, a poster inviting families to participate in interviews about their experience in WAM was posted. Melissa Rowbotham, facilitator, also invited parents and teachers to participate and provided them with the contact information of the lead investigator (KM). Participants were contacted by phone and invited to participate. Due to the short length of the interview (20-30 minutes), most parents and teachers participated by phone. Interviews were completed by one of Integra’s psychologists (Dr. Jen Scully or Dr. Karen Milligan) and interviews were audiotaped and transcribed verbatim by a transcription service. The proposed research was reviewed and approved by the Integra Board Research Committee and was in accordance with the Ethical Guidelines of the American Psychological Association. See Appendix F,G,H for poster, consent form, and information letter.

Dr. Karen Milligan and Melissa Rowbotham analyzed all transcripts and identified common themes (e.g., attributions about behaviours seen, knowledge of LD, helping behaviours that they intended to engage in, barriers) and language used by parents and teachers. This information was used to identify common challenges experienced by parents and teachers that could be used for the vignette descriptions and to develop statements that would resonate with parents and teachers and their experience in working with children and youth with mental health and learning challenges.

**Development of Vignettes and Statements (Stage 2)**

1. Selection of Pictorial Image and LD/Mental Health Scenarios

In order to select pictures that would serve evoke emotion and memories of working with children, Integra staff were sent a survey via survey monkey with 29 pictures and asked to rate how strong their emotional response was to the picture and how strongly the picture reflected a child/youth with a Learning Disability. Fifteen staff responded. Based on their responses, the number of pictures was reduced to five and Integra and Camp Towhee (Integra’s summer camp) staff were asked to answer
open-ended questions about each picture, such as What is happening in this picture? How do you think the child is feeling? What do you think may be the cause of these feelings? What would you say to or do with this child? What would you consider doing to make things better or different? What might keep you from being able to make things better or different?

Results of the qualitative interviews, staff surveys and discussions with the WAM Evaluation team highlighted two common experiences for parents and teachers: (1) challenges experienced with homework and school work and (2) behaviour problems in children/youth with LD. This is consistent with research on the experience of teachers with student mental health issues (Walter et al., 2006). Given our need to limit the length of the questionnaire these two situations were chosen to be developed for the online quantitative measure. It was further decided by the WAM evaluation team that given the different experiences and roles of elementary and secondary school teachers and parents of school age and teenage children, different forms of the online questionnaire for these groups were needed. As such, four versions of the questionnaire were created. Statements were kept as consistent as possible between teacher forms and parent forms, however, pictures used to evoke an emotional response and connection to the vignette differed. (Please contact the lead author if interested in viewing a copying of the online measure).

2. Generation of Statement Reflecting Key Processes and Outcomes

Using information gained from the WAM qualitative interviews, the staff surveys, and our review of relevant measures such as the Teacher and Parenting Stress Index, statements were generated to reflect each of the processes and outcomes of interest. A mock version of the questionnaire was then sent to three “expert” raters in the field of mental health and LD who indicated if each item was representative of high, moderate or low understanding mental health and LDs. Based on these ratings and discussion of the Core WAM Evaluation Team, the statements for the questionnaire were selected. For the sake of this pilot questionnaire, we consciously included a larger number of statements than planned in order to narrow which statement best defined each of the constructs through the piloting of the measure. The online questionnaire was programmed in Survey
Monkey. It included information letter, consent, and then a picture with a 2 sentence descriptions about the child and his learning and mental health challenges. Participants were then asked the rate questions (statements) on a 7-point likert scale (Not like me to A lot like me). Statements were programmed to be randomized across participants.

3. Pilot of Teacher Questionnaire

In July 2011, Integra’s Community Education and Empowerment program held its inaugural Integra’s Summer Institute for Teachers and School Staff (ISI). This was a 2-day concentrated professional development experience designed to embed knowledge and practical strategies about Learning Disabilities and Children’s Mental Health into the classroom setting. It is based on WAM and as such provided an ideal opportunity to pilot our online measure with teachers. ISI consisted of two 2-day sessions, one for educators working with students from grades K to 8 and another for those working with students in grades 9 to 12. Participants were asked to complete the online questionnaire during the week before and the week after the training. Given that teachers had just completed the school year and our desire to recognize their time and effort and get a high level of participation, teachers were provided with a $20 gift certificate.

Twenty-three elementary and 25 secondary school teachers registered for ISI. They were contacted by email and invited to complete the online questionnaire before and after the Institute. Of those invited, 12 elementary and 9 secondary teachers completed both the pre- and post-questionnaire. Five elementary and 4 secondary teachers completed only the pre-questionnaire and as such their data were not included in our analyses.

The moderate rates of participation were consistent with our expectation that approximately half of participants would participate. Given all participants who started the questionnaire completed it and that most participants completed the pre- and post-questionnaire suggests that completion of the questionnaire is feasible. Results are presented below in Section E: Pilot Results.

4. Pilot of Parent Measure
Parents who had registered for the WAM at Integra (September 2011) were emailed during the week prior to the workshop and asked to participate in the pilot study. Due to study budget and our inability to provide gift certificates to all participants, parents were told that they would receive a coupon to attend a free workshop at Integra (Value: $10) in recognition of the time and effort required to complete the two questionnaires. Despite excellent parent attendance (N=30), our rate of completion (N=3) was much lower than for the teacher pilot study. We hypothesize that this lower level of participation reflected the lack of a meaningful incentive (as the parents did not know what to expect in terms of quality or content of the workshops prior to attending WAM) and parents being busy at the beginning of the school year. Given the small sample, analyses were not completed.

**Evaluation Plan**

Given the differences in the roles of parents and teachers in working with children and youth with mental health and learning challenges, the WAM evaluation team decided that we would develop separate Evaluation Plans for parents and teachers. Given that our Community Education and Engagement program and the Integra Research team have been increasing our focus on school-based LD and mental health literacy and establishing exciting collaborations with policy makers, administrators, researchers, and front-line staff in this area, we decided to focus our evaluation plan on the WAM for elementary and secondary school personnel.

**Participants:** Participants in the proposed evaluation will include elementary and secondary school teachers participating that include the WAM program. Given that we have established relationships with school boards, such as the Toronto District School Board and the Toronto Catholic District School Board and a number of private schools in Toronto and across Ontario, we anticipate that we will be able to recruit a large sample. Furthermore, in 2010-2011, over 1350 teachers participated in WAM workshops. We anticipate 100 school personnel will serve as participants in the research.

**Procedure:** When schools request to have Integra come and present WAM, they will be asked if they would like to participate in the evaluation. The online questionnaire will then be sent to the school liaison who will email the link to all participants inviting them to participate in the questionnaire. As
indicated in the consent portion of the questionnaire, participation will be voluntary and anonymous and school and Integra staff facilitating the workshop will not know who participated or the content of their responses. Participants who complete the pre-questionnaire will be sent the post-questionnaire the day following the workshop and asked to complete it within one-week. A follow-up questionnaire will be sent 1 month and 3 months following the workshop. Given that we recognize the finite amount of time teachers have to participate in research and our desire to have a high level of participation and retention of participants for follow-up testing, participants will be provided with a $20 gift card upon completion of the pre- and post-test, and a $10 gift card upon completion of each of the follow-up questionnaires.

Qualitative interviews will be completed with 5 elementary school teachers, 5 secondary school teachers, 5 special education teachers, and 5 school administrators (i.e., principal or vice principal). For schools agreeing to participate in our evaluation, an email will be sent to all participants attending WAM inviting them to participate in the interview. Please refer to Appendix E for the semi-structured interview guide. Interviews will be audiotaped and transcribed verbatim.

The moderating impact of process variables, such as length of session, number of participants in each session, elementary or secondary school, type of school personnel, previous mental health and LD workshops attended, years of teaching experience will be examined. School personnel will complete a short demographic survey at the beginning of the online pre-questionnaire and information about session (attendance, length) will be collected by the facilitator. Please refer to the evaluation framework in Appendix C for further details.

**Analysis Plan**

**Quantitative Measure:** Paired sample t-tests and Repeated Measures ANOVAs will be used to explore changes in empathy, attributions, knowledge, self-efficacy and intention to engage in helping behaviours. Barriers, self-efficacy, group size, type of school personnel, and length of workshop will be explored as possible moderators of change scores using Repeated Measures ANCOVA.
**Qualitative Interview**: Using a grounded theory framework, two members of the WAM evaluation team with experience in qualitative analysis will analyze all transcripts and identify common themes. The use of two team members to discuss themes that emerged allows for “investigator triangulation” (i.e., the use of two or more investigators to examine the same phenomenon) in interpreting the data; such collaboration can reduce the risk of biased interpretation that could occur if only one individual were to analyze the data. The goal of the analyses is to extract categories or themes that emerge directly from what the participants have to say and are thus grounded in the data. This will allow for a much richer understanding of the processes being investigated than can be afforded by quantitative data alone. A visual framework will be developed to capture the themes and key processes and will be shared with WAM research/clinical team for feedback and thoughts about interpretation.

**Limitations of Evaluation Framework**

The main limitation of the proposed evaluation framework is the lack of a control group and the associated risk of change based on the passage of time. Given that the length of WAM is brief (contained typically to 1-2 days), we are hopeful that this limitation will not have a significant impact on our findings.

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**Section E: Pilot Results**

**Qualitative Interview with Parents and Teachers** (Appendix J)

Using a grounded theory framework, Dr. Karen Milligan and Melissa Rowbotham analyzed all transcripts and identified common themes. A visual framework was developed to capture the themes and the inter-relations (Appendix). The framework was shared with WAM research/clinical team and feedback and thoughts about interpretation was encouraged and integrated into the model.

**Parent Qualitative Interview Pilot Results**

Results of the parent interviews suggested that parents felt that WAM was very helpful. Most parents learned about WAM through word of mouth or on the Integra website. Parents attended WAM for a range of reasons, typically centered around wanting to connect, share and gain support from a
community of people experiencing similar challenges and increasing their understanding about what their child’s experience with LD is like.

Understanding from both an emotional and knowledge perspective was emphasized. WAM was viewed as a helpful first step in improving their understanding of their child. But they felt that they needed more knowledge and skills to intervene and help their child. There was a recognition that it is a long road. Parents reported that it was helpful to deconstruct the jargon of psychological assessment reports, information processing strengths and weaknesses, and myths of LD (e.g., children with LD are lazy, not smart, output vs. effort, LDs are neurologically based, LDs impact extends beyond the classroom), experiential learning was thought to be the “key” component of WAM and really “brought home” for the parents the child’s experience. When completing the exercises, parents were able to put themselves in the child with LDs’ shoes and reported feeling frustration, incompetence, embarrassment, humiliation and wanting to avoid or disengage. One parent reported that she could not get the answer until it was literally pointed out and typical school accommodations, such as more time, offered by the facilitator did not help. Parents reported thinking about their own children and feeling admiration for their child’s strength and resilience whereas others expressed guilt about past interactions based on not understanding their child’s experience. One mother reported that for the first time she felt like she finally understood her child’s LD.

Parents reported feeling empowered and excited about sharing information. There was a strong theme of all individuals working with a child to feel same empowerment and understanding. Parents spoke about wanting to learn more, to look at their child’s Psychoeducational assessment report or IEP with a new view, to wanting to increase communication with teachers, family members, and their child. Parents felt empowered to consider alternative explanations for challenging behaviours (e.g., homework) and their responses.

**Teacher Qualitative Interview Pilot Results**

Similar to the parents, teachers’ response to the workshop was positive and was viewed as a good first step to creating a community of practice in which all staff had the opportunity to share in the
experience of the child with LD. There was a lot of emphasis placed on understanding how these children and youth “feel” (e.g., frustration) and what it would be like to walk in their shoes. This new empathy was regarded as important to effectively work with students. This was thought to be important for all teachers and school personnel attending the workshop to be on the same page in terms of how to help children and youth with LD. Teachers reported a change in perspective in how they understand behaviour challenges in children and youth with LD and a greater desire to look under the surface of the behaviour to understand what factor may be driving it. One teacher said that she would stop and look at kids differently and not be so quick to judge. More specifically they noted that they noted the idea of lack of effort and care vs, specific learning challenges. One teacher said “You’re good at something so you can’t understand how someone else can’t be. But, they really are trying and no idea how hard they’re trying.” While there was not a lot of time between the workshop and the interviews, one special education teacher noted that after attending WAM more teachers were consulting with the special education department at their monthly meeting. All teachers noted that the emotional experience helped change their perspective and view of challenging behaviour but that they needed more strategies and to remember to use strategies, even in the heat of the moment.

**Pilot Results for Online Quantitative Measure**

**Teacher Questionnaires**

Paired-sample t-tests were completed to examine change from pre- to post-test for the elementary and secondary teacher questionnaires. As can be seen in Appendix K, results differed by grade level taught (elementary/secondary) and the type of situation presented in the vignette. The most significant gains were seen in teachers understanding of vignettes depicting a child/youth with LD and behaviour challenges impacting on peer relations. Elementary teachers showed significant improvements in empathy, knowledge of LD, and intention to engage in helping behaviours. Improvements in self-efficacy also approached significance. No significant changes in empathy, attributions, knowledge, or self-efficacy were noted for the vignette depicting a child with LD experiencing challenges with school work. Secondary teachers showed significant gains in empathy.
and attributions in their responses to the vignette depicting a youth with LD and behaviour challenges impacting on peer relations. They also showed significant gains in knowledge of LD for a youth experiencing challenges with school work. It is interesting to note that secondary teachers reported significantly lower levels of self-efficacy and higher levels of perceived barriers compared to elementary school teachers at pre- and post-test ($F(1,30) = 6.64, p = .01; F(1, 20) = 6.36, p = .02$ and $F(1,30) = 2.93, p = .09; F(1,20) = 7.86, p = .01$, respectively).

**Section F: Conclusion and Recommendations**

**Discussion and Interpretation of Findings**

Taken together, the pilot quantitative and qualitative results suggest that WAM shows promise in being an effective LD and mental health literacy program. The results highlight the impact of the experiential exercises and their impact on teacher empathy (elementary school teachers), attributions (secondary school teachers), knowledge of LD and mental health (elementary and secondary school teachers) and intention to engage in helping behaviours (elementary school teachers). These results are consistent with theoretical models of processes and outcomes associated with behavioural change, such as TPB, emotional intelligence, and attribution theory and suggest that WAM is having an impact on processes that promote positive change in teacher helping behaviour. Given the small sample size for the pilot study, it was not possible to examine the inter-relationships between processes such as knowledge, attributions, and empathy or the moderating role of self-efficacy and perceived barriers on engaging helping behaviour. These results suggest that WAM is a promising approach for mental health and LD literacy. Furthermore, this pilot has moved the field forward in terms of identifying processes of change and an efficient measure of processes and outcomes that typically pose measurement challenge (e.g., social desirability bias, validity).

In addition to results supporting the promise of WAM, the different outcomes for elementary and secondary school teachers were of particular interest. Some possible explanations for secondary teachers reporting significantly lower levels of self-efficacy and higher levels of perceived barriers
compared to elementary school teachers is that secondary school teachers may have less time to get to know students due to rotary schedules, more subject-specific curricular demands, and less training in special education practices than their primary counterparts. There may also be fewer student services offered in secondary schools, such as social work/psychology support.

Taken together, these results underscore the need for teacher training to further the understanding of children and youth with LD and in particular for children and youth experiencing challenges with peers, behaviour or other areas of mental health. Teachers working with elementary and secondary students may need training focused on different aspects of the model given their population, resources and supports, and training/feelings of self-efficacy.

**Recommendations and Next Steps**

Completion of this planning grant was a very positive experience for Integra, both in terms of process and outcome. We had the opportunity to build staff capacity in research and program evaluation capacity. For example, Melissa Rowbotham, Manager of Community Education and Engagement, gained skills in qualitative research design and analysis and in interpretation of quantitative analyses. All members of the core research team gained experience in measure development, including operationalization of difficult to define constructs. Review of the Theory of Planned Behaviour, attribution literature, emotional intelligence and empathy literature and the process of developing the measure has helped us think more clearly about the processes we are trying to target with WAM and the associated outcomes.

The process of engaging stakeholders in all stages of measure development was key to ensuring that the measure would resonate with participants and effectively tap into the processes and outcomes of interest. Qualitative research provided us not only with support for our theoretical model but also assisted us in operationalizing and verbalizing the processes and outcomes in a manner that would reflect the experience of the participant. Qualitative interviews also assisted us in interpreting our findings and better understanding the experience of participants.
One challenge that we faced in the pilot study was recruitment. Given the small size of Integra and the integration of research into all programs at Integra, we have a history of high success with recruitment for and completion of research. We experienced more challenge with WAM than with previous studies. This may be due to the population and the fact that in most cases participants do have an established relationship with Integra. For example, most parents attending WAM have children and youth who are on our waitlist and not yet receiving treatment services. Parents who are not in service may be under more stress and not have time for research. WAM is also the first workshop that many individuals attend. They may not consent to participate in research for a program that is new to them or for which they do not know what to expect. Recruitment of teachers was more successful than parents. It is possible that teachers were under less stress than parents as school was over for the summer. The use of incentives ($20 gift card) also acknowledged and compensated teachers for valuable time and effort spent. Incentives may also encourage individuals with different experiences in WAM to participate in the research, ensuring that results reflect the experiences of all individuals and not those who might self-select due to interest or a positive experience. Providing incentives has been shown to be helpful in recruiting and retaining subjects and is not associated with undue pressure or harm to participants in research studies such as the proposed evaluation (Grant & Sugarman, 2004). As such, we will continue to use incentives as we progress forward in our evaluation.

**Recommendations for Integra’s Community Education and Engagement Program**

1. **The Power of Experiential Activities**

   Findings of the qualitative research highlight the central role of experiential activities in evoking an emotional response from participants and empowering participants to consider alternate explanations of learning and mental health challenges. These findings are complemented by significant results that suggest that these activities are effective in bringing about change in processes and outcomes that are associated with increasing helping behaviour. These findings support continued use of this approach to education with teachers.
2. **WAM lays a Foundation but Further Training is Required**

Across parent and teacher qualitative interviews, participants reported feeling empowered and ready to engage in helping behaviour but felt that there was more they needed to learn. Furthermore, elementary and secondary teacher scores for perceived barriers and secondary teacher scores for self-efficacy did not change. TPB model suggests that change in these processes may need to be facilitated in order to bring about meaningful change in teacher’s helping behaviour. As such, training with school systems (e.g., teachers, support staff, administrators, policy makers) may be necessary to mobilize helping behaviour. Further training, which includes time and opportunity for implementation may also be needed to bring about changes in perceived self-efficacy.
References


Walter, H.J., Gouze, K., & Lim, K.G. (2006). Teachers’ beliefs about mental health needs in inner city


**Goal:** Increase participant knowledge and empathetic understanding of the processing challenges experienced by children and youth with mental health difficulties to promote engagement in helping behaviour.

### Service

**Walk a Mile in My Shoes Group Workshop (N= 20 to 100)**

### Population

Parents and teachers working with children and youth (ages 8-18) with mental health disorders and processing challenges

### Activities

**Knowledge about Processing Challenges & Mental Health**
- Processing challenges (e.g., memory, executive functions, processing speed).
- What processes look like at school/home (academic difficulties, social skills/peer relation difficulties, behaviour problems, anxiety)
- Processes related to common mental health difficulties (e.g., ADHD, peer relation difficulties, anxiety, low self-esteem)

**Experiential Activities & Group Discussion of Experience**
- Simulate processing challenges in youth with mental health difficulties (e.g., stroop task completed to look at challenges in cognitive flexibility)

**Group Process**
- Complete activities within a group setting which simulates social experience of children and youth with mental health and processing challenges.

### Short-Term Outcomes

- Increase ability to empathize with processing challenges in a variety of settings.
- Increase ability to look for cognitive, processing or social emotional factors that may underlie common mental health behaviours.
- Increase knowledge of cognitive, processing or social emotional factors that may underlie common mental health behaviours.

Intention to engage in helpful behaviour that takes into account or may assist with cognitive, processing or social emotional factors that may underlie common mental health behaviours

### Potential Long-Term Outcomes

- Promotes improved relationship between parent/teacher and child
- Promotes development and implementation of new strategies to assist child in a variety of settings
- Promotes child engagement in challenging activities with parent/teacher support which may increase child resilience.
Appendix B: Walk A Mile In My Shoes (WAM): Evaluation Questions

7. Does empathy (i.e., understanding of the emotions experienced by child/youth) change from before to after participation in WAM?

8. Do attributions about the causes of behaviour change from before to after participation in WAM?

9. Does LD knowledge change from before to after participation in WAM?

10. Does self-efficacy change from before to after participation in WAM?

11. Does parent/teacher behaviour change or intention to change behaviour change from before to after participation in WAM?

Are there process indicators (e.g., target group characteristics, such as group size, elementary or secondary teacher) that moderate change made by participants on process
### Appendix C: Walk A Mile In My Shoes (WAM): Outcome Indicators

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicator(s)</th>
<th>Source of Data</th>
<th>Who Collects Data</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>• Empathy score increases from pre- to post-workshop.</td>
<td>• Online Measure (developed as part of planning grant)</td>
<td>Computer administration/ Analyzed by RA</td>
<td>Upon registration for workshop (ideally 2 weeks prior) and immediately following workshop, ideally within 2 weeks.</td>
</tr>
<tr>
<td></td>
<td>• Parents/teachers talk about how they felt and relate their feelings to the experience of children with LD and mental health issues</td>
<td>• Qualitative Interviews</td>
<td>Staff Psychologist/Director of Research</td>
<td>Within 2 weeks following workshop (completed by phone)</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Attributions</td>
<td>• Attribution score increases from pre-to post- workshop. This score indicates that parents/teachers are examining cognitive, processing, learning, or social emotional factors that may be influencing a child’s behaviour vs. viewing behaviour as negative.</td>
<td>• Online measure (developed as part of planning grant)</td>
<td>Computer administration/ Analyzed by RA</td>
<td>Upon registration for workshop (ideally 2 weeks prior) and immediately following workshop, ideally within 2 weeks.</td>
</tr>
<tr>
<td></td>
<td>• Parents/teachers talk about need to examine any cognitive, processing, learning, or social</td>
<td>Qualitative Interviews</td>
<td>Staff Psychologist/Director of Research</td>
<td>Within 2 weeks following workshop (completed by phone)</td>
</tr>
</tbody>
</table>
emotional factors that may be influencing a child’s behaviour vs. viewing behaviour as negative.

| LD Knowledge | • LD Knowledge score increases from pre-to post-test. | • Online measure (developed as part of planning grant) | Computer administration/ Analyzed by RA | Upon registration for workshop (ideally 2 weeks prior) and immediately following workshop, ideally within 2 weeks. |
| • Parents/Teachers provide specific examples of something that they learned about cognitive or processing abilities. | • Qualitative Interviews | Staff Psychologist/Director of Research | Within 2 weeks following workshop (completed by phone) |

<p>| Intention for Behaviour change | • Helping behaviour change score increases from pre-to post-test. | • Online measure (developed as part of planning grant) | Computer administration/ Analyzed by RA | Upon registration for workshop (ideally 2 weeks prior) and immediately following workshop, ideally within 2 weeks. |
| • Parents/Teachers provide specific examples of times that they have acted in a different way with a child/student because of their experience in walk a mile. | • Qualitative Interviews | Staff Psychologist/Director of Research | Within 2 weeks following workshop (completed by phone) |</p>
<table>
<thead>
<tr>
<th>Impact of WAM on quality of relationship with parent/teacher</th>
<th>• Parents/Teacher report that they intend to make a specific behaviour change or engage in a behaviour that will help them assist the child.</th>
<th>• Qualitative Interviews</th>
<th>Staff Psychologist/Director of Research</th>
<th>Within 2 weeks following workshop (completed by phone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If parent/teacher provide a comment that reflects intention towards behavioural change, they will be asked “if you continued to respond to the child in this new way, what impact do you think it would have on your relationship with the child?”</td>
<td>• Qualitative Interviews</td>
<td>Staff Psychologist/Director of Research</td>
<td>Within 2 weeks following workshop (completed by phone)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix D: Process Evaluation Indicators

<table>
<thead>
<tr>
<th>Process</th>
<th>Indicator(s)</th>
<th>Source of Data</th>
<th>Who Collects Data</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of session</td>
<td>• Length of session in minutes</td>
<td>• Length will be examined as a moderator of the outcomes listed above.</td>
<td>• Therapist leading WAM</td>
<td>• At workshop</td>
</tr>
<tr>
<td>Number of participants in session</td>
<td>• Number of participants</td>
<td>• Attendance sheet</td>
<td>• Therapist leading WAM</td>
<td>• At workshop</td>
</tr>
<tr>
<td>Elementary Secondary School</td>
<td>• Indicate HS or EL</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>Special Education Teacher, Regular Stream, or Administration</td>
<td>• Indicate SE or RS or ADM</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>First WAM workshop attended (Y/N)</td>
<td>• Indicate first or attended before</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>Mental Health Status</td>
<td>• Indicate if working with a student mental health challenge and LD.</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>• Self-Efficacy Composite score</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>• Perceived Barriers Composite score</td>
<td>• Online measure</td>
<td>• RA</td>
<td>At pretest</td>
</tr>
<tr>
<td>Experiential Learning</td>
<td>• Helpfulness of exercises?</td>
<td>• WAM Client Satisfaction Questionnaire</td>
<td>• Therapist leading WAM/RA</td>
<td>• Within 2 weeks following workshop (completed by phone)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Qualitative Interviews</td>
<td>• Psychologist/Director of Research</td>
<td></td>
</tr>
<tr>
<td>Participant Satisfaction and Impressions</td>
<td>• Client Satisfaction Questionnaire Score</td>
<td>• WAM Client Satisfaction Questionnaire</td>
<td>• Therapist leading WAM/RA</td>
<td>• At workshop/Booking</td>
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</table>
Appendix E: WAM Qualitative Interview Guide

Thank you for agreeing to complete an interview with us about your experience in WAM. To start, I’d like to find out generally what you thought of the workshop. I will then ask you some more specific questions about your experience.

<table>
<thead>
<tr>
<th>General</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did you hear about WAM?</td>
<td></td>
</tr>
<tr>
<td>Before attending WAM, what did you hope you would get out of this workshop?</td>
<td></td>
</tr>
<tr>
<td>Did you get what you had hoped you would? (Probe for specifics, “tell me more”)</td>
<td></td>
</tr>
<tr>
<td>Did you get anything out of WAM that you were not expecting? (probe for specifics)</td>
<td></td>
</tr>
<tr>
<td>Was there anything about WAM that did not meet your expectations? (Probe for specifics, “tell me more”)</td>
<td></td>
</tr>
</tbody>
</table>

**Question about Specific Model Components**

<table>
<thead>
<tr>
<th>Attributions/Empathy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Some people find that they have an emotional response when participating in WAM, whereas others do not.</td>
<td></td>
</tr>
<tr>
<td>Did you have an emotional response to some of the exercises?</td>
<td></td>
</tr>
<tr>
<td><em>Probes:</em></td>
<td></td>
</tr>
<tr>
<td>Tell me more</td>
<td></td>
</tr>
<tr>
<td>What exercises were most powerful for you?</td>
<td></td>
</tr>
<tr>
<td>How did it make you feel?</td>
<td></td>
</tr>
<tr>
<td>What did it make you think?</td>
<td></td>
</tr>
<tr>
<td>How did you want to respond?</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Were you thinking about a specific child/student during the workshop? (probe)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| *Probes*  
tell me more  
What exercises were most powerful for you in thinking about this child?  
How did it make you feel?  
What did it make you think?  
Were you thinking about your responses or actions towards him/her?  
*Did you see more of his/her strengths or weaknesses?* |
| Did your experience in WAM change the way you think about the behaviors of a child with LD? Tell me more. (e.g., role of processing, can’t vs. won’t) |

<table>
<thead>
<tr>
<th>LD Knowledge</th>
</tr>
</thead>
</table>
| **Has your knowledge or comfort in talking or hearing about aspects of learning disabilities changed since attending WAM?**  
*Probes –*  
Tell me more.  
Are you better able to understand or feel more comfortable with a psychoed report?  
Do you have a better knowledge of language used in psychoed reports? |
<p>| Was there anything about the information provided about LD that was new, surprising to you or that was different from what you thought? <em>Probe for specific example.</em> |
| Is there anything that you learned that you wanted to share with other people? |
| Do you feel like you have more questions now about what things may be happening when a child is struggling with or avoiding a task? |</p>
<table>
<thead>
<tr>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are interested in understanding the impact of WAM on how people think, feel, behave, or intend to behave.</td>
</tr>
</tbody>
</table>

Did you notice anything different about yourself after attending the workshop? (Probe for think, feel, behave, or intend to behave).

Possible Probes:
Did you notice any changes in how you understood your child’s/student’s behaviour (e.g., acting out, inattention, procrastination, speed of completing tasks)?

Has participating in WAM helped you see behaviour differently? Did you think about alternative reasons for the behaviour or that it could be something else?

Did you respond in a different way?

Did you look at an IEP or a psychoed report? Did you advocate on behalf of a child?

Are you still interacting/responding in this new way?

If not, what are the barriers?

Do you feel you have the strategies needed to help your child/student? If no, do you think you will access help in this area? If yes, how?

What information or experience has stayed with you from WAM?
WALK A MILE WORKSHOP EVALUATION
INFORMED CONSENT

√ I understand that Integra staff members are interested in hearing from participants about their impressions of the Walk a Mile Workshop.

√ I understand that I am participating in an interview that will last approximately 30-45 minutes about my experience in the Walk a Mile Workshop. During this interview, I will be asked questions about my impressions of the program, including what information was most meaningful to me, how participation in the workshop may have changed my understanding or way of responding to children with learning disabilities, and what aspects of the program could be improved.

√ I understand that the interview will be held at a time and location of my choosing.

√ I understand that the interview will be digitally audiotaped and transcribed.

√ I understand that the audiofile will be downloaded to a secure computer at Integra after completion of the interview. This file will be deleted upon completion of the study. All information collected will be kept confidential and will be stored in a secure location at Integra. I understand that only the Director of Research and Psychology at Integra, Dr. Karen Milligan, and those directly involved in the research will have access to the information.

√ I understand that if I decide not to participate in this study, it will not impact on the services that my child, family, or children I work with receive at Integra.

√ I understand that I may withdraw my permission at any time.

√ I understand that any information from our interviews that are used for presentations or publications will be presented with all identifying information removed.

√ I understand that if I have any questions or would like additional information, I may contact Dr. Karen Milligan, Director of Research & Psychology (416 486 8055 ext. 232) at any time.

Name of participant: ____________________________

Signature: ____________________________

Witness: ____________________________

Date: ____________________________
 WHEN YOU

WALK A MILE IN THE SHOES

OF KIDS WITH LEARNING DISABILITIES

Does it change...

Your understanding of WHY?
Your knowledge of what to do?
Your belief that you can help?
How you respond?

We are looking for Walk a Mile Participants LIKE YOU to talk to us about their impressions of the program.

- We will book a 30 to 45 minute interview with you at a time and location of your choosing.
- All information is confidential.
- You will be reimbursed $20 to cover transportation costs and will be given a FREE pass to a future Integra workshop

Please call Priyanka Sharma or Dr. Karen Milligan (Director of Research at Integra) at 416-486-8055 to book an interview!
DATE

Dear Walk a Mile Participant,

Thank you for attending the Walk a Mile Workshop. We hope that it was a helpful and enjoyable experience for you.

Integra has been offering Walk a Mile for over a decade and while the content and focus has changed over the years, it has continued to be our most popular workshop for parents, teachers, and other individuals who work with children and youth with learning disabilities.

This year, we were selected for a Provincial Centre of Excellence in Children’s Mental Health Grant to begin an extensive evaluation the Walk a Mile Workshop. We are excited by this opportunity and are particularly interested in questions such as:

- What is it about the Walk a Mile program that makes it so popular?
- Does it change what participants know about learning disabilities?
- After participating, do people look at or respond to children and youth with learning disabilities differently?
- What parts of the program are most and least helpful?

We are interested in hearing your views on these questions. As such, we would like to invite you to complete a short interview with us about your impressions of Walk a Mile. The interview will be approximately 30 to 45 minutes in length and will be conducted in person at a time and location that is convenient for you. We will audiotape the interview. If you are willing, we would appreciate it if you would fill in the form below. We will then contact you in early December. You may also contact the undersigned directly to arrange for an interview time. You will be reimbursed for your time and expenses ($20 an interview) and will receive a free pass to attend a future Integra workshop.

If you decide not to participate, it will not impact on the services that you, your child, or children you work with receive at Integra. You may also decide at any time to withdraw your permission. Your interview and information will be kept confidential and will only be reviewed by those directly involved in the research. Digital audiotapes files will be deleted at the end of the study.

The program evaluation is being headed by Dr. Karen Milligan, Director of Research and Psychology at Integra. If you have any questions or concerns about this project, please do not
hesitate to contact us. You may also direct questions to Melissa Rowbotham who is familiar with our research plans.

Sincerely,

Karen Milligan, Ph.D., C.Psych.
Director of Research & Psychology
416 486 8055 ext. 232
kmilligan@integra.on.ca

Melissa Rowbotham, M.Ed.
Manager of Community Consultation
416 486 8055 ext. 232
mrowbotham@integra.on.ca
Appendix I

TEACHER INSTITUTE EVALUATION FORM

I teach (Circle One)  Elementary  Secondary

What Grade/Subject Area did you teach this past year?
_________________________________________________________

Is this your first training provided by Integra?  YES
NO

Have you attended other workshops on Learning Disabilities?  YES
NO

What did you hope to learn by coming to the Institute?
____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Did the Institute meet these learning objectives?  YES
NO

Comments:
____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Was the timing (length, date, time) convenient?  YES
NO

Comments:
____________________________________________________________________

____________________________________________________________________

For each of the following areas, please tell us what you think:
### Workshop Content

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Needs Improvement</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered useful material</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Practical to my needs</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Well organized</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Presented at the right level</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Effective activities</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Useful visual aids and handouts</td>
<td>[ ]</td>
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### Presentation

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Needs Improvement</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>Instructor’s knowledge</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Instructor’s presentation style</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Instructor covered material clearly</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Instructor responded well to questions</td>
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### OVERALL IMPRESSION

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<th>Excellent</th>
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<th>Needs Improvement</th>
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<tr>
<td></td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**In planning for our next Summer Institute for Teachers, tell us:**

**Three things to keep doing:**

1. ..............................................................................................................

2. ..............................................................................................................

3. ..............................................................................................................

**Three things to stop doing:**

1. ..............................................................................................................

2. ..............................................................................................................

3. ..............................................................................................................
Three things to start doing:

1. 

2. 

3. 

Any other comments or suggestions?

Would you recommend this workshop to fellow teachers?

Yes  

Maybe  

No  

Thank you for taking the time to fill out this evaluation.
Walk a Mile Workshop: Interactive Experiential Exercises and Discussion

Emotional Response
↑Sympathy (Guilt)  ↓Anger, Frustration

Increases Empathetic Understanding
- More questions about what the child’s emotional experience might be.
- More specific descriptions of emotional experience.

Primed for LD knowledge and myth busting
- Increased LD knowledge (e.g., kids with LD are smart)

Attributional Shift
- Can’t vs. won’t
- More questions about what challenges may underlie the behavior
- More specific descriptions of challenges (e.g., hard vs. specific processes)

Empowerment

Intension for Behaviour Change

Behaviour Change
### Appendix K: Quantitative Online Measure Results

#### Table 1

<table>
<thead>
<tr>
<th>Subscale t-score</th>
<th>M (SD)</th>
<th>Pretest</th>
<th>Posttest</th>
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</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>91.58 (13.30)</td>
<td>96.42 (7.51)</td>
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<tr>
<td>Attributions</td>
<td>156.92 (19.76)</td>
<td>167.33 (15.76)</td>
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<tr>
<td>Helping Behaviours</td>
<td>253.42 (18.20)</td>
<td>243.08 (12.86)</td>
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<td>Negative Self-Efficacy</td>
<td>42.25 (15.41)</td>
<td>39.00 (19.86)</td>
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<tr>
<td>Perceived Barriers</td>
<td>24.17 (7.09)</td>
<td>21.42 (8.33)</td>
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<tr>
<td>Knowledge Myths</td>
<td>44.08 (5.00)</td>
<td>47.08 (5.62)</td>
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<table>
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<tr>
<th>Subscale t-score</th>
<th>Pretest</th>
<th>Posttest</th>
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<tbody>
<tr>
<td>Empathy</td>
<td>103.50 (10.37)</td>
<td>115.25 (5.15)*</td>
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<tr>
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<td>72.83 (10.96)</td>
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<tr>
<td>Helping Behaviours</td>
<td>167.75 (17.44)</td>
<td>179.33 (20.88)*</td>
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<td>45.75 (16.80)</td>
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<td>Perceived Barriers</td>
<td>24.75 (8.25)</td>
<td>21.08 (9.30)</td>
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<tr>
<td>Knowledge Myths</td>
<td>42.33 (8.15)</td>
<td>49.17 (4.47)*</td>
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*p<.05
Table 3
Secondary School Teachers - Child Experiencing Challenges with School Work

<table>
<thead>
<tr>
<th>Subscale t-score</th>
<th>M (SD)</th>
<th>Pretest</th>
<th>Posttest</th>
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</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>46.33 (7.31)</td>
<td>49.44 (7.92)</td>
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<tr>
<td>Attributions</td>
<td>82.44 (13.00)</td>
<td>86.00 (8.37)</td>
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<tr>
<td>Helping Behaviours</td>
<td>138.89 (8.05)</td>
<td>143.11 (11.98)</td>
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<tr>
<td>Negative Self-Efficacy</td>
<td>60.33 (20.59)</td>
<td>59.22 (5.43)</td>
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<tr>
<td>Perceived Barriers</td>
<td>30.11 (9.78)</td>
<td>28.67 (5.92)</td>
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<tr>
<td>Knowledge Myths</td>
<td>20.22 (2.54)</td>
<td>24.89 (2.67)*</td>
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*p<.05
Table 4
Secondary School Teachers - Child with LD and Behaviour/Peer Relation Challenges

<table>
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<th>Subscale t-score</th>
<th>Pretest</th>
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<tbody>
<tr>
<td>Empathy</td>
<td>60.78 (9.59)</td>
<td>63.56 (11.17)*</td>
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<td>Attributions</td>
<td>34.44 (5.81)</td>
<td>39.33 (7.07)*</td>
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<tr>
<td>Helping Behaviours</td>
<td>104.67 (10.91)</td>
<td>106.00 (9.38)</td>
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<tr>
<td>Negative Self-Efficacy</td>
<td>60.22 (10.64)</td>
<td>53.89 (16.10)</td>
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<td>Perceived Barriers</td>
<td>31.67 (7.98)</td>
<td>32.44 (6.06)</td>
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<tr>
<td>Knowledge Myths</td>
<td>21.33 (5.10)</td>
<td>23.11 (3.76)</td>
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*p<.05