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INTRODUCING INTERNAL EVALUATION IN A RESIDENTIAL TREATMENT CENTRE

Julia Paré
Shawbridge Youth Centre
Montreal, Quebec

Abstract: This article describes a process by which internal evaluation was introduced in a residential treatment centre for adolescents in Quebec. The historical development, purpose, and philosophy of program evaluation at the centre are presented. A unique program for "multiple handicapped youth" collaboratively designed by the centre, a hospital, and a social service agency, as well as the methods of evaluation selected to examine the program's efficiency and effectiveness, are described. Lastly, comments about the process of evaluation and some final results of the evaluation are reported.

Résumé: Cet article décrit le processus par lequel une évaluation interne a été introduite dans un centre de réadaptation en résidence pour adolescents dans la province de Québec. Le développement historique de l'évaluation des programmes ainsi que la mission et la philosophie du centre sont présentés. Un programme unique pour "les jeunes handicapés multiples", conçu in collaboration avec le centre, un hôpital et un centre de services sociaux, en plus des méthodes d'évaluation choisies pour examiner l'efficacité du programme, sont aussi décrites. Enfin, des commentaires concernant le processus d'évaluation ainsi que des résultats finaux de l'évaluation sont inclus.

Shawbridge Youth Centre is a residential treatment centre for anglophone adolescents, aged 12 to 18, referred through the courts under the federal Young Offenders' Act and Quebec's Youth Protection Act. The adolescents are placed in cottage-like settings in a rural community 80 kilometers from Montreal, or in group homes in the Montreal area. Programs range from secure care and highly structured open units on the campus to community-based group homes and after-care programs in the city. The centre's program includes special education, recreation, life skills training, and individual, group, and family counseling. Specialized services offered on a limited basis include medical, psychiatric, and psychological services, art therapy, drug counseling, religious services, and specific services for clients from different cultural backgrounds (e.g., translation, diet).

The centre, through its specialized programs, aims to provide the adolescents with experiences by which their awareness of both themselves and their situation is broadened and from which they learn skills that enhance their personal development as well as prepare them for a return to family and community living. The centre's philosophy is evolving toward a systems approach to treatment, with primary emphasis on each adolescent's particular family and community situation and its relationship to the court-ordered reasons for placement. To that end, a highly individualized treatment plan for each adolescent and his or her family is the instrument used to ensure a therapeutic focus throughout placement.

HISTORICAL BACKGROUND

Over its 80-year history, the centre has operated with a wide variety of philosophies and approaches. Throughout that time, but more frequently over the past two decades, the centre has made sporadic attempts to evaluate both its efficiency and its effectiveness. External and internal evaluators have been enlisted to do evaluative research that focused on particular aspects or several facets of the centre's functioning.

In 1975 the centre completed its first major internal evaluation project, of the effectiveness of the centre's treatment model. The study evaluated, functionally and theoretically, the interactions between client characteristics, treatment environments, treatment settings, and treater characteristics.

In 1978 a two-year research project conducted by a university group, and funded by the Ministry of Social Affairs of Quebec and the centre's private foundation, was completed. This study looked at the impact of institutional policies, structures, and staff on residential children, with particular emphasis on evaluation from a model of community-oriented institutional care.

Since the mid-1970s, the centre has been regularly involved in carrying out internal evaluation studies focused on tracking program process. At that time, the centre began to make use of data collection and analysis through a computerized system. The three areas that have had fairly consistent monitoring are client demographics, budget, and staffing issues such as allocation and trends.

Evaluation through analysis of statistics has been conducted by each of the centre's three departments: Treatment Services, Administrative

Services, and Professional Services. The centre's executive committee, with representatives from each of these departments, decides on both the choice and priority of any particular study. All internal research-focused studies or outcome studies are approved, coordinated, and supervised by the Department of Professional Services.

The data gathered from the research efforts were used to substantiate requests for increased funding, to modify programs, and to develop new ones. Program evaluation as an integral and ongoing internal process has not, to date, been a part of the centre's practices.

Over the past several years, as the child welfare field has become increasingly aware of the need for a systematic method of providing accountability, the centre has moved to introduce internal evaluation as a component of all new programs being developed.

The centre has become increasingly sophisticated in its ability to present clear and current statistics on clients, budgets, staffing, and resources. This valuable information has led the board of directors and executive of the centre to request further information that can provide a clearer analysis of context and outcome. In particular, the board of directors, influenced in part by its members representing parents, have requested that outcome studies conducted by internal evaluators and focusing on quality of treatment services be an objective for this year. And finally, the Ministry of Social Affairs, which finances the centre, has shown growing interest in and expectations of the centre's ability to provide data about the population being served and the value of the programs offered.

PLANNING FOR PROGRAM EVALUATION

Two part-time managers were relieved of their supervisory responsibilities to devote their time to researching the status of program evaluation in the current child welfare literature and to develop pilot projects for the evaluation of new programs in the centre. It was hoped that these goals could be achieved within a period of one year and that their outcome would assist the centre in determining the approach to and the extent of further internal evaluation.

The two program evaluators worked within the Department of Professional Services and were directly accountable to the director of that department; at the same time they worked closely with the line staff of the programs being evaluated.The director of Professional Services had been given the mandate to have all new treatment programs evaluated.

One of the centre's programs, a group home in the community, had recently opened with a new mandate. The program's goals, objectives, and design had been developed with program evaluation in mind; thus, the essential prerequisites were in place to proceed with an internal evaluation as a pilot project.

The program was the result of a collaborative effort by three separate agencies in the hospital and psychosocial network. The program evaluator had previously assumed the leadership role in developing the unit's new mandate. She had been a member of the committee that met over the course of a year to form both a conceptual and an organizational framework, and she eventually chaired the committee that formulated the program's admission criteria and collaborative procedures. Thus, the program evaluator had actively participated in developing the program's goals, objectives, and design, although she had not had any direct involvement in the program itself. Situated at the head office, she had been responsible for supervision of the program's supervisor.

THE PILOT PROJECT: PROGRAM DESIGN

The group home in question is an eight-bed, community-based program developed to meet the needs of adolescents who require placement in a treatment setting, but who do not meet the admission criteria of either the treatment centres or the psychiatric hospital units in the anglophone Montreal community. These clients are often described as "multiple handicapped" youth who have a psychiatric and/or medical component to their psychosocial problems.

In the past, when the need for placement arose, these adolescents fell between the cracks of the psychosocial network, which provides foster and residential care, and the hospital (psychiatric) network, which provides short-term and crisis intervention inpatient treatment. Although the psychosocial network (treatment centre) was able to provide a stable and even long-term environment with adequate care, structure, and supervision as well as a treatment plan that integrated the family and the community, it was not equipped to provide specialized medical and psychiatric treatment to meet the acute needs of these adolescents when they were in crisis. The hospital network, on the other hand, was able to successfully intervene in the crisis situation but unable to provide the longer-term environment that these adolescents needed to deal with the other, more general problems they and their families were experiencing at the time of the crisis. As a result of a hospital/treatment centre initiative, a search for the creation of a new program began.

The project's mandate was developed by a committee of professionals representing the hospital (Montreal Children's Hospital), the social service centre (Ville-Marie Social Service Centre), and the treatment centre (Shawbridge Youth Centre). The committee was unanimous in seeing the need for such a unit and defining its purpose: to provide a short-term intensive therapeutic milieu that offers education and recreation, individual, family, and group counseling, and nursing services from the treatment centre; medical and psychiatric consultation, short-term (crisis) inpatient backup services, and outpatient services from the hospital; and screening and referral through the social service centre.

Admission criteria and collaborative procedures were developed to ensure consistent and integrated practice for intake, treatment planning, backup, and discharge. The time frames and the person(s) responsible (from each of the three agencies) for completing each task within these stages of placement are outlined in detail in the procedures. Ongoing, specialized in-service training is jointly offered as needed by the reception centre and hospital for the program's staff and the personnel of the reception centre.

The goal of this intensive therapeutic program is to correct the situation that led to the need for placement so that the adolescent can return to a more "normal" environment (i.e., home, group home, or residential setting). It is not a setting for long-term placement, where goals are related to adolescent adjustment to family or community living and independent functioning.

The objective of the program is to provide an intensive therapeutic program that focuses on the biopsychosocial problems presented at referral. The program is geared to clients who:

1. are multiple handicapped, as defined by our admission criteria;
2. are in need of placements of short duration, between three and nine months;
3. are male and female adolescents between the ages of 12 and 18;
4. are referred from Montreal Children's Hospital and the social service agencies;
5. are referred with a medical/psychiatric assessment that includes a medical/psychiatric diagnosis;
6. are likely to require medication or other medical interventions;
7. would, on occasion, require short-term hospital admissions during times of crisis; and

8. would in most cases be followed by a medical, psychiatric, or other specialist from outside the group home who could actively develop and participate in the treatment plan.

In addition to the therapeutic aspects of this group life situation, individual treatment plans for each adolescent and his or her family are the instruments used to ensure the most intensive part of the placement experience. The treatment plan includes:

1. a description of the presenting problem as understood, through discussion and consensus-building, by the adolescent, the parents, and the group home staff;
2. clear and concise treatment goals developed and agreed to by the adolescent, the parents and the group home staff; and
3. specific and goal-focused strategic interventions for staff and, depending on the case, the adolescent and/or parents.

THE PILOT PROJECT: EVALUATION DESIGN

An evaluation component was added to the program design to determine if (a) the program was serving the intended population and (b) the program was effective in its service delivery. The evaluation design was selected by the evaluator with the approval of the director of Professional Services.

A process evaluation method was designed to determine the "population being served." An outcome evaluation method that focused on goal attainment using multiple indicators and a client satisfaction questionnaire/interview was developed to examine effectiveness.

The process evaluation involved gathering referral and admission data on each client in order to determine if the actual client population served was similar to that expected. Data on each of the clients referred to the program were gathered for one year. The results are described below. The other two evaluations are still in progress as of this writing, and hence their results are not available; their content and process will be described below.

PROCESS EVALUATION: RESULTS

The "anticipated" client profile comprised eight characteristics that, viewed as a whole, distinguish these clients from the rest of the population at the centre.

The object of the process evaluation was to collect and retain referral and admission data related to these eight characteristics for each client referred to the program during a one-year period. The goal was to compare the profiles of the actual clients to those of the speculative ones in order to determine if we were serving the population we intended to serve.

The findings, categorized by the eight characteristics, are summarized here:

1. Of the 33 clients referred, 18 met the admission criteria; of these, 15 were admitted.
2. The range of stay was one to nine months, with an average of five months. These results are close to the three-to-nine-month stay that was predicted.
3. Six of the clients were male and nine were female. They ranged in age from 12 to 18 years, with an average of 16 years. Again, these results were as anticipated.
4. As expected, approximately half of the clients admitted were referred from the hospital (7 of the 15) and the other half were referred from the sources we had predicted.
5. Of the 15 clients admitted to the program, 13 did indeed have a psychiatric diagnosis as part of their assessment profile, and 3 had a medical diagnosis.
6. Five clients were on psychotropic medication, three on prescribed medication for medical conditions. These numbers are slightly smaller than was anticipated. Several clients were weaned from their psychotropic medication prior to their admission to the program.
7. Five clients were admitted to the hospital for short-term crisis intervention. The frequency of hospital admissions and the process of intervention and reintegration into the program followed the approach envisioned in the planning stage.
8. Eleven clients were being followed by specialists from outside the program, and as anticipated, most of these specialists have a specified role in the treatment plan.

Thus, the actual client profile was remarkably similar to the speculative one. The client profile in this program differed significantly from that of clients in other programs within the centre. The psychiatric/medical nature of clients' problems distinguished them most clearly. For example, 86% of the clients had a psychiatric diagnosis, and 73% of these clients were seeing a psychiatric or medical specialist. In contrast, less than 20% of clients in the centre's other units either had a psychiatric diagnosis or were seeing a specialist. The results assured the centre that,

within its first year, the program was indeed serving the population that it had been designed to serve.

OUTCOME EVALUATION: CONTENT AND PROCESS

In order to examine the question of effectiveness, the individual treatment plans were isolated from other interventions for evaluative scrutiny. Of the number of variables involved in the intensive therapeutic approach, the treatment plan was seen as the most clearly designed and goal-oriented intervention.

The treatment plan describes the presenting problem, the goals of treatment, and the interventions necessary to achieve the goals. The definition of the problem, the choice of goals, and, in some cases, the type of intervention are described and decided on by the adolescent and his or her family. The plan is developed during the intake interview(s) with the professional staff assisting the family to formulate its content. It uses the client's own words and is not acted upon until it has received the client's approval. Although the treatment goals would be considered "subjective," they represent the client's position as much as is possible and are therefore considered to be valuable for measuring progress.

Once the treatment plan has been written and approved, indicators of progress are defined for each goal. The goals most often describe a dynamic personal or interpersonal change; the indicators describe behaviors that show whether progress has been made toward each goal. The indicators are used as guidelines for the content of each client's daily log. Every client's treatment plan is reviewed on a quarterly basis to ensure that clients and staff continue to perceive their relevance, and to reassess commitment to the plan. Treatment goals are occasionally modified at these times.

It was decided that this practice would continue within the program despite the evaluation process because our clinical obligations were seen as being more important than the evaluation considerations. However, if a treatment goal is modified, the indicators are also adjusted and all goals, including those that were adjusted, are evaluated. The primary concern, post-discharge, is whether there is a perception of goal achievement regardless of whether there were adjustments made.

Within a month after an adolescent's discharge from the program, the adolescent, the parents, the family's social worker, and the adolescent's primary child care worker are interviewed separately to determine the

extent of achievement of the treatment goals. The interview involves the evaluator in (a) reading each of the treatment goals that was developed throughout the placement, (b) asking whether the interviewee thinks the goal was achieved, and (c) having the interviewee describe, in behavioral terms, why he or she thinks the goal was or was not achieved. The evaluator writes down the responses in the interviewee's own words. In addition to providing quantitative data on achievement of treatment goals, this interview provides qualitative findings, which are compared to the pre-treatment indicators of change.

At this time, the sample size is too small to provide any useful information about the program's effectiveness. However, as more clients are discharged and the data accumulates, the evaluators hope to examine the information from several different points of view, such as:

1. What percentage of each client's treatment goals are considered to be achieved (a) by each of the interviewees and (b) with consensus among the interviewees?
2. How do the interviewees' descriptive indicators of achievement of goals compare to the pre-treatment indicators?
3. What percentage of all the clients' treatment goals were considered to be achieved (a) from the client's perspective and (b) from the staff's perspective?
4. How do the clients' (adolescent and parents) views on achievement of the treatment goals compare to the professional's views (both quantitatively and qualitatively)?

Although the sample size is at this time too small to support any conclusions, the process did yield some unexpected and interesting outcomes. Of foremost importance, the indicators proved to be of great practical and therapeutic value to the program staff. By using the indicators and guidelines for each client's daily log, the childcare staff became much more focused on treatment goals in their daily exchanges and interventions with clients, and their log entries became more purposeful and informative. A second finding was that, although the parents had agreed on the description of the goals, they did not always agree between themselves on the achievement of the goal.

The client satisfaction questionnaire/interview is divided into eight categories: pre-admission process, intake process, treatment planning process, specialized services in the program, respect for client rights, receptiveness and respectfulness of program staff, frequency and privacy of contact between the adolescent and the family, and discharge process. Within

each category are an average of six questions designed to explore clients' personal satisfaction with their experience in the program. Both the degree and the quality of their involvement with the programs are evaluated, as well as their satisfaction with the services and personnel. The questionnaire was developed by the program evaluator in collaboration with the program's treatment staff. The centre's treatment philosophy and its procedures for intake, treatment, and discharge were used as references in generating the content of the questionnaire.

Within a month of discharge from the program, the evaluator interviews the adolescent and parents separately, noting whether they were or were not satisfied with their experience within each category and asking for their comments about that experience. Again, their remarks are written in their own words.

It is hoped that the clients' responses will help the centre assess both its strengths and its weaknesses in the delivery of services from pre-admission to discharge. The questionnaire results will also help us to examine the process by which we engage and involve the adolescent and the family, and to gauge the quality of that process.

CONCLUSIONS

Because the evaluation project is still in progress, no final recommendations have been presented to the executive and board at the centre. However, the evaluators have reached some preliminary conclusions about the evaluation process, which include suggestions for future internal evaluation.

The process of determining whether a program is serving the population it was designed to serve is a simple and manageable one, provided that the program's goals and objectives are clearly defined. The centre could integrate an ongoing process evaluation into each of its programs for this purpose once clear goals and objectives were defined within each program design.

A client satisfaction interview designed to look at both the quality of services and the process by which the services are delivered can provide the centre with valuable information about clients' perceptions of their experience during placement. By incorporating this interview into the discharge procedures, the centre could ensure ongoing assessment of the client population's reaction to the placement experience.

The evaluation design for assessing the centre's effectiveness of treatment is not practical as an ongoing process. Attempting to scrutinize each client's treatment goals using the multiple indicators made it necessary to accumulate an abundance of data through a lengthy interviewing process. However, the notion of assessing clients' perceptions of progress on the goals they helped define is worth pursuing. Thus, evaluators are recommending that the agency continue to seek an evaluation design to assess progress on treatment goals using the individual treatment plans for each client in the centre.