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INTERNAL EVALUATION FOR DECISION-MAKING IN A CHILDREN'S MENTAL HEALTH CENTRE

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Abstract: This article presents an approach to ongoing internal evaluation in a children's mental health agency. Some examples of evaluation activities that have taken place are given. Program evaluation is integrated into the management functions of the agency and assists managers to plan, implement, and determine the efficiency and effectiveness of programs. The quality of decision-making is enhanced through a systematic approach to program evaluation.

Résumé: Cet article présente une approche de l'évaluation interne en cours dans un centre de santé mentale pour enfants. Quelques-unes des évaluations faites sont données en exemple. L'évaluation de programme est intégrée dans les fonctions de gestion du centre et aide les directeurs à planifier, appliquer et déterminer l'efficacité et l'effectivité des programmes. La qualité de la prise de décision est améliorée au moyen d'une approche systématique de l'évaluation de programme.

Madame Vanier Children's Services is a mental health centre for children up to 16 years of age and their families. We offer the normal range of outpatient counseling, home-based family support interventions, day treatment in a school setting, short- to medium-term residential treatment, and prevention/outreach programs. The centre is in an urban location, and we serve principally the urban district and surrounding rural area, with a total population of about 350,000. There are approximately 70 clinical staff. We have multidisciplinary staffing, with social work, counseling, child care, clinical psychology, child psychiatry, and speech and occupational therapy represented. The centre is well known for its systemic and strategic therapeutic approaches, although a variety of individual, group, family, and milieu approaches are utilized according to individual treatment plans.

In this article we describe the approach to internal evaluation that has evolved within this agency and the practical uses of evaluation there. We present examples of the various components of evaluation to illustrate an approach to ongoing internal evaluation. It is difficult to capture all the various types of evaluation activity that occur within the agency; the examples given are illustrative. The approach to evaluation in the agency follows a program development model (cf. Pancer & Westhues, 1989). The examples given specifically exclude some categories of evaluation, such as case-specific reviews and audits.

Program evaluation is integrated into the management functions, and this is reflected in the structure. There is no program evaluation department. The treatment director is responsible for overseeing the program evaluation function in the agency, although in practice evaluation is dispersed throughout the agency. The treatment director reports to the executive director and is part of a three-member senior management team that also includes the business manager. Three senior program managers in the agency who are responsible for the direct operation of the clinical programs (outpatient, intensive, and community services) report to the treatment director. The second author is the information system coordinator, responsible for producing regular information system reports and providing consultation and support to managers. It is also important to note that the agency has for several years had an excellent computerized information system. During the last few years, however, a change in systems has occurred. We previously used a university-based mainframe computer accessed through a remote terminal onsite at the agency; we now use an in-house microcomputer-based network.

Evaluation activities are initiated in response to specific questions raised primarily by management, but also by other program staff. A treatment subcommittee composed of both front-line staff and management of the agency reviews new program plans and evaluation data. The program committee of the board of directors reviews major program changes and monitors ongoing program effectiveness. Any new program proposal submitted to the treatment subcommittee for approval must have an evaluation component. Even though there are few direct external demands for evaluation, the agency as a whole recognizes that evaluation is essential for its long-term health as a service provider. Management training for all management and supervisory staff of the agency has recently focused on the importance of evaluation.

Examples of the types of evaluation activity that take place in the agency include:

- *Needs assessment*: periodic needs assessment using surveys and available indicators.
- *Program efficacy studies*: ad hoc systematic experimental or quasi-experimental designs that address specific questions about efficacy of agency programs.
- *Process or input analysis*: systematic collection of service or input data (utilization of service indicators); use of systematic indicators.
- *Goal analysis*: goal analysis and goal attainment scaling (Kiresuk & Sherman, 1968).
- *Consumer feedback*: client satisfaction measures (e.g., Larsen, Atkisson, Hargreaves, & Nguyen, 1979).
- *Client outcome evaluation*: pre- and post-testing with the Achenbach Child Behaviour Checklist (Achenbach & Edelbrock, 1983) at the time of admission to and discharge from the agency to determine the impact of services on clients.

NEEDS ASSESSMENT

Periodic needs assessments are undertaken on an ad hoc basis. For example, a study was recently undertaken to account for the large number of drop-outs following referral and prior to assessment. The drop-out rate had been documented by the agency information system and the trend over several years showed a drop-out rate between 32.5% and 44.5%. The survey was a needs assessment of a specific group of "consumers" whose needs had presumably not been met by the agency. An interviewer/research assistant was hired for three months and conducted a telephone survey of all available referrals who had not come for service during the previous year. A report summarized the findings, and the recommendations were reviewed by internal committees. The resulting report was also presented to a children's mental health association conference (Evans, 1988).

Results from the drop-out sample indicated that 70% felt the service was not required: either the child had improved or the problem was no longer considered severe. Another 14% chose an alternative service route, and 16% cited agency-specific factors that deterred them from completing the referral process. For example, we found that long waiting periods accounted for a significant number of drop-outs. The majority of survey respondents expected to be seen within four weeks, which was unrealistic given the waiting lists. We also received information about preferred appointment times. As a result of these findings, a decision was made to open the agency for evening clinics and to reorganize the Intake

Department with increased staffing to provide a more responsive service. We have set an evaluable goal: Each client referred to the agency will receive a clinical intake interview either face to face or by telephone within 24 hours of referral. The data pertinent to this goal can be obtained directly from the information system by comparing referral date to date of first clinical contact.

PROGRAM EFFICACY STUDIES

We conduct ad hoc efficacy studies to determine which of a number of different possible program alternatives might best achieve the goals of treatment. Occasionally a question will arise as to whether to continue a particular program activity given concerns about dubious benefits, excessive costs, or potential risks. One such study was conducted to examine the relative risks and benefits to our clients of "wilderness" camping experiences. The goal of the wilderness experience was to enhance the children's self-esteem and feelings of competence. The only available information about the program's success in attaining this result consisted of anecdotal reports. Therefore, we implemented a pre- and post-measure of self-concept and perceived self-competence (Harter, 1982) and daily behavioral measures to evaluate goal achievement.

The results from several trips consistently yielded no significant pre- and post-differences in self-concept measures. The self-concept data were useful, however, in profiling the children who participated in the groups, and the daily behavioral results were useful in clarifying the objectives of the program. The results were reviewed internally, and a decision was made to (a) reconceptualize the goals and (b) select program alternatives that would meet these goals. The new goals focused on the residents having an enjoyable time in a different environment from the cottages and the staff teaching residents basic outdoor skills. Programming alternatives included shorter and less risky camping trips. It was therefore no longer necessary to find elaborate justifications of the camping experience in terms of purported benefits.

SYSTEMATIC INPUT ANALYSIS

A major goal of this agency has been to improve the efficiency of operations and thus to improve the cost-efficiency ratio. Efficiency is measured by means of a time-based clinical contact information system that requires clinicians to track all time spent in "face-to-face" or "ear-to-ear" clinical contact. We did track nonclinical activities when the system was

first introduced, but found that time "overheads," such as conferencing time and paperwork, were relatively invariant from month to month. We are able to track individual clinician's time distribution across programs, total clinical input time by service, and various modalities of clinical input, such as group, parent, family, and individual therapy. We are also able to track "no shows" and "cancellations."

In our service plan we set objectives for direct service time. For example, in the outpatient counseling program, we have set a target goal of 360 direct service hours per month. This is tracked, and management personnel receive a monthly report with current month and year-to-date statistics. Clinicians also receive a personal record of their time. Policy decisions regarding the provision, for example, of increased service of a particular type (e.g., group treatment), or the need for more clinical resourcing in a particular area, can be evaluated with reference to the service-tracking information.

We also track specific procedures such as "physical restraints" that require monitoring as an intrusive procedure (in accordance with government regulations). These data can also be used as a systemic indicator of the environment within a milieu program. Following a prescribed definition of a physical restraint, each incident of physical restraint is recorded with information about the client, location, staff, duration, and precipitating events and is entered on a computerized database. Monthly data over a period of about two years will allow us to do a time-series analysis to assess the impact of agency-wide crisis prevention training on patterns of usage of physical restraint.

GOAL ANALYSIS AND GOAL ATTAINMENT SCALING

Goal analysis and goal attainment scaling is a developmental area for the agency. The clinical case management approach to date has included the setting of treatment goals for clients. This has served some function in individual case management, although aggregate information has not been available from casebooks to serve a more global evaluation function. It appears that although the goals formulated often have clinical relevance, they are also often vague and do not contain specific indicators or timeframes, nor is there a systematic evaluation of whether or not the goals are met. We recently did an inductive analysis of goals that were set by examining a representative sample of recent casebooks. We classified goals by looking at the language content of the goals and resolving minor wording differences, and we arrived at a list that appears to have some relevance to the agency. The goals have been coded into

the following goal areas: process, developmental, symptom reduction, family structure/role, parenting skills, child cognitive understanding, family cognitive understanding, and school-related behaviours.

The next step is for clinicians to use the goal attainment scale format (Kiresuk & Sherman, 1968) to develop case-specific indicators. Clinical staff will then be required to submit a periodic evaluation of progress utilizing a five-point scale. The information regarding types of goals and attainment levels will be entered on the clinical information system database and analyzed by a range of variables.

CONSUMER FEEDBACK

The agency recently adopted the CSQ-8, the eight-question client satisfaction questionnaire of Larsen, Attkisson, Hargreaves, and Nguyen (1979), which is also used by several other children's mental health agencies in Ontario. Introduction of the questionnaire resulted in staff resistance, low return rates, and recognition of the need to address both of these issues. Feedback to front-line staff was perceived to be a means of overcoming resistance. We have been able to provide recognition and reinforcement to specific staff based on client comments. Negative comments, to have some validity, must be specific; in a number of such cases we have been able to take remedial action. There are many advantages to a client satisfaction questionnaire, and, whether one adopts the CSQ-8 scale or some other, consumer feedback should be considered as an essential component of evaluation.

CLIENT OUTCOME EVALUATION

For several years we have routinely used the Child Behaviour Checklist (CBCL) to collect data from parents/guardians regarding the child's behavioral and emotional problems on admission to and on discharge from the agency (cf., Achenbach & Edelbrock, 1983). We have had less success in collecting similar information from teachers using the Teacher Report Form of the scale, although we routinely ask for it. The CBCL is completed before we proceed with our assessment, and the parents are offered assistance in completing the forms; as a result, we have a fairly complete database on clients at intake. There are some occasions when forms are found to be spoiled or unscorable; in other cases clinical judgement regarding the nature of the case overrides the requirement to complete all the forms.

The illustrative data reported here are taken from two years, January 1983 to December 1984. In 1983–84 we had 526 and 564 referrals respectively, and 324 and 349 clients who completed the intake and assessment process, for a total of 673. Of this total number, we collected 561 Child Behaviour Checklists (83.4% of the possible sample) at the intake level. Of the 561, we were also able to collect 117 (20.9%) at discharge. The group means and standard deviations for the total sample of 561 and the sub-sample of 117 did not differ significantly. This provided some justification for using the subsample for which post-test scores were available.

Using the subsample of 117 cases, the pre- and post-test scores for four summary measures—sum T (a standard score overall pathology), externalizing T (a standard score reflecting "conduct" problems), internalizing T (a standard score reflecting "neurotic" problems), and social competence scores—were all significantly different, and all in the expected direction. The percentage of children in the normal range (using the criteria of Achenbach & Edelbrock [1983]) also significantly increased from 23.5% to 42.2% (sum T), 26.1% to 44.8% (externalizing T), and 26.1% to 50.0% (internalizing T). Outcome evaluation studies of this type are important, although imperfect in design. They are often the only type of design that is feasible, and they do provide a qualified answer to the question, How many children get better? For example, we can state that in the group of children for whom we have information on overall adjustment before treatment and after treatment, there was an increase in children falling within the normal range, from 23.5% to 42.2%. This information has proved to be useful in presentations to board members, ministry officials, and members of the service community network. The feedback also had an important impact on front-line staff, in two ways: It demonstrated that the data were being used purposefully, and it focused attention on the importance of outcome measurement, giving a positive but realistic view of the impact of our service.

In conclusion, we have in this article given several illustrations of ongoing internal evaluation and the practical applications of evaluation in relation to managerial decision-making. It is the firm belief of the agency that evaluation is an integral part of agency management. This principle is not restricted to management, but extends to all levels of the organization. Evaluation is a reflective exercise that helps us to keep on track in doing the best job we are able to do with the scarce resources that we have available.

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