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EVALUATION AS MANAGEMENT SUPPORT: THE ROLE OF THE EVALUATOR

Pat Reavy
Linda Littell
Gail Gonda
Irene O'Neill
Thistletown Regional Centre
Rexdale, Ontario

Abstract: This article provides an overview of an internal evaluation model in a children's mental health center as well as practical examples of evaluation activities. The overview includes a rationale for the positioning of evaluation within the organization's structure; the primary approaches to evaluation; and the application of three major approaches to evaluation and their operational implications. In summary, internal evaluation is seen to be an integral management support function directed at the planning, development, and assessment of program operations and outcomes.

Résumé: Cet article donne une vue d'ensemble d'un modèle d'évaluation interne appliqué dans un centre de santé mentale pour enfants et des exemples pratiques d'évaluation interne. Cette vue d'ensemble justifie l'inclusion de l'évaluation dans la structure de l'organisation; les approches primaires vers l'évaluation, l'application des trois principales approches vers l'évaluation et leurs implications pratiques. En bref, l'évaluation interne est considérée comme une fonction intégrale du soutien de gestion visant la planification, le développement et l'examen des opérations de programme et des résultats.

Thistletown Regional Centre was originally designed as a children's convalescent hospital, and from 1927 to 1956 operated as a branch of the Hospital for Sick Children in Toronto. In 1957 it became a provincial residential facility for emotionally disturbed children. In 1967 the Ontario Ministry of Health established Thistletown as one of its regional children's mental health centres. Ten years later, a major shift in the Ontario government's corporate organization resulted in most children's mental health centres being moved from the authority of the Ministry of Health to the Ministry of Community and Social Services (MCSS). Thistletown thus became a directly operated centre under MCSS.

With this ministerial-level change of responsibility, the centre shifted from a medical model approach to a community-based, less "institutionalized" treatment facility. However, evaluation activities were still based on a research model. The major focus was on one-time, in-depth studies looking at individual client progress rather than organizational issues or program processes. Almost all projects were limited to evaluative research or outcome studies and were funded through external grants. Within these structural and operational parameters, evaluation had little effect on policy development or program management at the centre.

One example of an evaluative research study carried out at that time was Gardner, Shamsie, and O'Neill's (1984) examination of selection differences in demographic, pre-treatment adjustment variables and treatment outcomes of children admitted to four types of clinical programs at Thistletown. Data were collected over a five-year period, from 1977 to 1982. Three external funding bodies assisted in sponsoring this study: Ontario Ministry of Health, National Health and Welfare, and the Hospital for Sick Children Foundation (Toronto). As with many large, longitudinal studies, the project was affected by changes in clinical and evaluation personnel and several shifts in organizational climate and structure. When data collection was completed, the centre was in the midst of a major reorganization, and the study had little impact on these changes.

The major focus of the 1981–82 reorganization at Thistletown was the service delivery model. Where programs had previously been structured on the basis of *type of service* provided (e.g., day treatment, outpatient), the post-reorganization service model was based on the types of *client group* receiving service (e.g., adolescents, autistic clients). Responsibility for providing these services was decentralized, devolving to program directors. As well, there was a move away from the matrix model. The various professional disciplines, such as psychiatry, psychology, and social work, no longer constituted separate departments, as clinical staff were integrated into the clinical program areas.

Today, Thistletown is composed of seven client programs on two geographically distinct campuses. The main offices for four of our programs are located at the Rexdale campus. These are Adolescent Services, whose clientele include mildly retarded to average-functioning disturbed adolescents; Interface (Integrated Resources for Family Assessment, Consultation and Education), which provides service to children up to age 13 and their families; the Safe-T program, which provides clinical support to sexually abused or abusing children and adolescents and their families; and TRE-ADD (Treatment, Research and Education of Autism and

Developmental Disorders). Our secure programs are located in Oakville, 40 kilometers away. They include the Secure Detention Program, for juveniles who have committed a range of offenses and are charged under the Young Offenders Act, but are still awaiting a disposition by the court; the Secure Custody Program, for juveniles who have been charged and placed in a secure setting under the Young Offenders Act; and the Secure Treatment Program, which is a clinically intensive program for severely emotionally disturbed adolescents.

Currently, the Information and Evaluation Department is responsible for developing and maintaining management information systems and for program evaluation activities. Organizationally, the department reports directly to the centre administrator. However, evaluation activities are negotiated with each of the program directors. In this way, evaluation in a program is very much determined by the individual program director's needs. This heightens the usefulness and acceptance of evaluation, and also means that evaluation activities are at different stages in the different programs.

The evaluation group itself consists of three program evaluators who function in a management support role and, as such, are involved in program planning, implementation, and monitoring. Each evaluator has primary responsibility for evaluation within assigned clinical program areas. Consequently, the evaluator becomes very familiar with the program, its history, and the needs of its management. However, as the evaluator is a centre employee rather than a program employee, objectivity is maintained and conflict of interest reduced. This arrangement maximizes the advantages and minimizes the disadvantages of an internal evaluator. In addition, members of the evaluation group keep informed through team meetings about issues in programs other than the ones to which they are assigned, as well as overall centre issues, and the workload gets shared when it is particularly heavy or when there are methodological reasons for doing so (e.g., interrater consistency on the coding of interview data). This peer support, review, and consultation is a unique feature of our structure. We believe that it increases objectivity, enhances an organizational systems perspective, and increases our effectiveness as well as the quality and usefulness of the evaluations.

Also included in the department are two staff working on the development and maintenance of management information systems. Working closely with program evaluators, these staff design clinical, financial, and administrative databases that can be used to answer evaluation questions. The coordination of evaluation and information functions is another unique aspect of the Thistletown model.

To summarize, then, program evaluators have direct access to management of individual programs as well as direct links to major decision-making and policy formulation in the centre. They also have a direct effect on the design of management information systems. Unlike clinical researchers, they are not encumbered with the difficulty of trying to wear two hats, that of clinician and that of researcher. Unlike most program evaluators, they not only have formal and direct links to decision-makers but also a clear mandate to be involved in the process of program development on an ongoing basis.

The approach we use in conducting evaluations borrows heavily from many evaluators such as Patton (1978), Rutman (1980), and Wholey (1977). Essentially, our model of evaluation consists of three stages or phases: program logic assessment, process evaluation, and outcome evaluation. In practice, these are not distinct phases. However, we have found that it is necessary to work through the first two phases prior to attempting outcome evaluation.

PROGRAM LOGIC ASSESSMENT PHASE

The program logic assessment phase is just what its name implies: an assessment of the logic of a program. In other words, does the program make sense? Is there (a) a clearly articulated program logic model, (b) a well-known and shared program model, and (c) agreed-upon indicators of the expected effects of the program's activities?

The logic model depicts program activities, goals, and objectives and the causal assumptions that link the activities to the objectives. It also has to withstand basic questioning, such as: Who are the clients? Why are they here? What are the intake/discharge criteria? What is the program trying to do with clients? How do they do it? When a new program is being planned, the evaluator can provide valuable input to management about whether the model has been well thought out and has potential for being implemented as intended. In an already operational program, this kind of analysis can help determine if planned changes in one part of the program will "fit" with the rest of a program or with the rest of the service system in which the program is operating.

PROCESS EVALUATION PHASE

After defining the program model, we use it to determine if the program is being implemented as intended. This task includes:

1. an assessment of program effort or inputs, such as staffing, material resources, and staff-client ratios;
2. an assessment of processes, both internally and regarding the program's operations in the larger service system; and
3. an assessment of the extent to which the treatment strategy has been implemented, such as the type, quantity, and quality of treatment provided and the conditions under which it was provided.

Among the many benefits of this phase is that it tends to involve a very dynamic and interactive process between the manager and the evaluator. The evaluator is learning about the program and about the manager's information needs. The manager is also learning about the program while becoming a partner in designing the evaluation itself. Ideally, the manager is involved in all the evaluation decisions involving data collection, measurement and design issues. In addition, evaluation activities are where possible "built in" to program processes so that the program will be self-evaluating. When the data have been collected, the manager is involved in data analysis and interpretation. This leads to a better understanding of the conclusions and an increased tendency to implement the recommendations.

OUTCOME EVALUATION

If the program has been implemented as intended, we move on to the third phase, outcome evaluation. Whereas the main goal of the process evaluation phase is program improvement, outcome evaluation is intended to:

1. prove or verify a causal connection between program activities and program results;
2. identify program impacts, both expected and unexpected;
3. determine program efficiency; and
4. determine program effectiveness.

When an evaluator has worked through the first two phases of evaluation, outcome evaluation is more likely to focus on questions that are answerable given the particular program and available comparison groups.

The examples that follow illustrate the internal evaluator's role as management consultant in each of the three phases of evaluation presented above.

EVALUATION OF PROGRAM LOGIC

This first example focuses on the development of a cross-campus program description by the senior management group at Thistletown's Syl Apps campus. This campus houses our three secure programs: detention, custody, and treatment. The task of developing a cross-campus program description was a timely one because the management structure had recently undergone significant changes, with a new management group directing the operations of all three programs. However, we were not starting completely from scratch. One of the three programs, the secure detention program, had already begun to develop their program description. In addition, the draft set of accreditation standards developed by the Ontario Association of Children's Mental Health Centres was useful in identifying content areas that needed to be addressed.

An ad hoc committee, consisting of the director, three program managers, clinicians, and program resource staff with cross-program responsibilities (e.g., chaplain, principal) worked with the program evaluation consultant to draft a mission statement and philosophy of service. The next task involved identifying cross-program objectives. This was done using a modified version of the Delphi technique (Udinsky, Osterlind, & Lynch, 1981, pp. 33–40). Each member of the ad hoc committee was instructed to anonymously write a set of objectives (up to a maximum of six) on three-by-five index cards, one objective per card. The objectives identified had to meet all of the following criteria: (a) be consistent with the Syl Apps campus mission statement; (b) be broad enough to apply to all three programs; (c) be realistic, attainable and measurable; and (d) refer to a general outcome rather than program activities.

These objectives were then reduced to a subset of superordinate objectives by the program evaluator and were given to the ad hoc committee for review. The subset required only minor revisions. Use of the Delphi technique allowed the ad hoc committee to reach a consensus about program objectives in an efficient and productive way. Subgroups of the ad hoc committee were then given lead responsibility for the remaining tasks (articulation of roles, activities, etc.), with the evaluator acting as a facilitator and objective reviewer.

Even though the activities of the evaluator during development of the program logic model were not the traditional functions of program evaluators in most organizations, they were consistent with the role of the evaluator as a management consultant. In addition, the process by which the document was produced facilitated organizational integration and formed the foundation for direction of program operations.

PROCESS/IMPLEMENTATION EVALUATION

This example illustrates the second phase of the evaluation model, in which process or implementation issues are the main focus. One of the programs at the centre, TRE-ADD, is a well-established program for autistic and developmentally disordered clients. Services include assessment, consultation, outpatient, day treatment, residential, and parent relief components. Prior to the establishment of the Information and Evaluation Department at Thistletown, the program had already begun a practice of periodic self-evaluation of its services. With the acquisition of evaluation support, the program's senior management decided to expand this process to include routine feedback about the program's functioning in terms of their predetermined program goals. It was also decided to obtain feedback from a number of different sources and in a number of different ways, given the type of client, the lengthy duration of service, and the variety of services provided. Consequently, the evaluator was asked to design a number of satisfaction measures for program-monitoring purposes that would augment evaluation processes already in use by the program.

One of these measures, the Parent Satisfaction Questionnaire, is administered annually to parents of clients. It surveys their perceptions of services provided and of changes in their child's behavior. At the time of the analyses discussed here, many clients had been receiving service for more than 10 years, so data on changes in parents' perceptions over time were also available. Responses to a recent survey indicated continuing satisfaction with the services received. However, the feedback also identified some concern about the social integration of children in the school setting. Although the program had located all of the classrooms in community schools, some parents still felt that their children were ghettoized within one area of the school, thus increasing stigmatization and decreasing possibilities for normalization. Based on this feedback, senior management decided to move these classrooms to higher traffic areas in the schools as opportunities arose. This modification of the program would not have happened without a formal mechanism for obtaining clients' perceptions of the service. Another area of concern for some parents was the difficulty they had in obtaining access to the parent relief service offered, that is, it was not available when they needed it. This led to an examination of the booking patterns to see how many requests for service had indeed been turned down, and this in turn led to revisions in how parent relief was provided.

Over time, the evaluation of this program has identified a number of similar issues that have led to improvements in the program's operation.

Without the ongoing input of an evaluator with a "management-support" perspective, these kinds of changes would have been much less likely to happen.

OUTCOME EVALUATION

Timely access by decision-makers to reliable and valid data about program activities is crucial for effective internal evaluation (Love, 1983; Newman, Heverly, Rosen, Kopta, & Bedell, 1983). Clearly, then, one of the first tasks of the internal evaluator is to help managers determine what data they need and what data they can get.

Interface is a tertiary-level program for families and their emotionally disturbed children. An evaluator has worked with the program from its inception in 1982. Consequently, the first two phases of evaluation had been addressed well enough for the program to move on to preliminary outcome evaluation. Collection of pre-post change scores on clinically relevant instruments had been initiated. However, in order to relate these data to program inputs and treatment strategies, existing data collection processes needed to be redesigned and automated. For example, one of the admission criteria is that clients have received treatment from other social service providers prior to coming to Interface. Also, referrals are expected to come from other service providers rather than from clients themselves. This information was being documented for each case, and a detailed referral report was completed each month. However, there was no central information bank available to answer these and other process or outcome questions.

Intake information was automated to provide a clinical and demographic profile of clients at admission. The client registry gives information about the duration and types of service a client receives. It also tracks the movement of clients across various treatment interventions. The time-task form allows the program to quantify the various program inputs. This is crucial because Interface has many service components, including home support, school day-treatment program, a developmental assessment clinic, outpatient family therapy, a mediation/assessment service for the court, specialized foster care, and intensive family therapy with three-day inpatient admissions for whole families. Finally, the pre-post clinical outcome scores are being automated and integrated with the other three databases.

Throughout the development of these databases, the program management, the evaluation consultant, and the information systems consultant have worked collaboratively. This team work helps ensure that the databases will be user-friendly, that the data definitions and database are consistent with the program logic model, that all of the data can be integrated for analysis purposes, and that the data can support relevant outcome questions.

The evaluation model and activities we have described are a support to management because they are based on an understanding of management functions. The first phase, for example, is identical to the first phase of strategic planning, that is, understanding the business of the organization in order to assess whether resources and energies are being directed toward these ends. The second phase of evaluation is particularly useful for day-to-day operations because it focuses on improving a program so that "things are done well." The last phase is essential for accountability both within an agency and externally, given its emphasis on effectiveness, or "doing the right things."

This model can be applied to any size of agency and to all types of social services. The key factors, in our experience, are that evaluation must be organizationally linked to senior management but must function independently of the unit of analysis in order to maintain objectivity. In addition, all evaluation activities must be timely, or their usefulness to management is nil. Indeed, without these key ingredients the evaluation function reduces itself to a frill and will be eliminated in times of fiscal restraint. Ironically, it is during times of fiscal restraint however, that management has the greatest need for this type of support, especially as management is "a continuous process of assessing and reassessing opportunities and operations, of controlling and correcting, and of moving in new directions as conditions allow or dictate" (Clifford & Sherman, 1983).

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