

**PROGRAM AND CLINICAL EVALUATION:
IN SEARCH OF INTEGRATION**

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**BY
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**A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of**

MASTER OF SOCIAL WORK

**Faculty of Social Work
University of Manitoba
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ABSTRACT

The current literature does not adequately address the integration of clinical evaluation methodology with the design and planning for program evaluation. Although there appears to be little evidence in support of an integrated approach, it may not be presumed that the two are incompatible and unworthy of further investigation.

This report describes a practicum which incorporated an integrated approach to the evaluation of a treatment program for male adolescent sexual offenders. The practicum was designed to address the gap in the current evaluation literature regarding the feasibility and utility of integrating clinical and program evaluation strategies through three methods: 1) a review of the literature regarding the historical development of program and clinical evaluation theory; 2) interviews with a selected number of key informants; and 3) the application of an evaluation design which integrated clinical and program evaluation strategies.

The findings of this study indicate that an integrated approach may be feasible and that the process has potential benefits for the users of the evaluation. Some of these benefits may involve the development and selection of tools which may be used for ongoing program monitoring, as well as the apparent adaptability of the process to changes in program operation. In regard to the utility of the approach in meeting the information needs of direct service workers, program administrators and funders, there is little evidence upon which to draw conclusions. It is apparent that the integration of clinical and program evaluation strategies requires a strong commitment to the process at all levels of organizational functioning in order to obtain optimal benefits from the

findings. This may involve a closer examination of the ways in which information is managed within an organization and the provision of means for promoting use. The practicum findings point to the conclusion that further study is required to determine the nature of integrating clinical and program evaluation strategies in the evaluation of human service organizations.

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To Gord for being consistent and for bringing balance to my life.

To my family - Mom, Wendy, Grandma & Grampa - for always believing I can do anything and for never failing to tell me that you feel that way...

Lana

"We are all faced with a series of great opportunities disguised as impossible situations."

Anonymous

1.0 INTRODUCTION

In the past, clinical evaluation and program evaluation have been treated as separate and distinct approaches to the evaluation of human service organizations. The development of each has been marked by involvement on the part of different disciplines; program evaluation originated in the public administration sector as a response to demands for accountability on the part of providers of fiscal resources; clinical evaluation emerged in the field of behavioural psychology and purported to address the failure of program evaluation to adequately address practitioner and practice issues. Through the development and evolution of each approach, the separation of program and clinical evaluation activities has persisted.

Current literature does not adequately address the integration of clinical evaluation methodology with the design and planning for program evaluation, and it appears that most research in this area is based on implicit assumptions about such a connection. Several theorists have indirectly acknowledged the need for agency managers to understand how the evaluation of clinical practice may enhance treatment outcomes and agency decision making, planning and accountability efforts (Richey, Blythe & Berlin, 1987; Doueck & Bondanza, 1990; Gabor & Grinnell, 1994). However, most authors do not even consider the possibility of linking the knowledge generated through the evaluation of clinical practice with information regarding the program as a whole.

Although there appears to be little evidence in support of the integration of clinical and program evaluation activities and the resultant knowledge, it may not be presumed that the two are incompatible and that integration is unworthy of further investigation. Perhaps

a combined approach would augment the process and the findings of evaluation research by offering insight into practice issues and linking them to overall program assessment. Likewise, combining program evaluation and clinical evaluation activities may be of use to those with the authority to make decisions regarding particular programs, as a combined approach may lead to more clearly specified and measured intervention activities and corresponding outcomes.

This report describes a practicum which incorporated an integrated approach to the evaluation of a treatment program for male adolescent sex offenders. The practicum was completed between December 1994 and April 1995 within the context of Campbell & Heinrich Research Associates, a private research and consulting firm which has had extensive experience in the field of clinical and program evaluation. The practicum was designed to address the gap in the current evaluation literature regarding the utility of a combined model of clinical and program evaluation designs for evaluating human service organizations. The following learning objectives formed the foundation of the practicum:

- 1) To gain a solid understanding of the theoretical foundations of evaluation research and the integration of clinical evaluation with program evaluation through an extensive review of relevant literature.
- 2) To determine the feasibility and utility of integrating clinical evaluation with program evaluation in the evaluation of human service organizations.
- 3) To determine factors that may be considered useful and beneficial from the perspective of the users of the evaluation findings.

The proposed design of the practicum included four specific components: (1) a literature review for the purpose of developing an understanding of the theoretical foundations of evaluation research and identification of potential issues that may concern the integration of clinical evaluation with program evaluation; (2) an application of a type of integrated design which combined clinical and program evaluation strategies within the context of a program for male adolescent sex offenders; 3) interviews with a selected number of key informants who were able to comment on the utility of each of clinical and program evaluation separately and in combination; (4) a summary of the findings and directions for further research.

The practicum report is outlined in detail in the next six sections. After these introductory comments, the second section contains a review of the literature concerning the history of clinical and program evaluation, as well as recent attempts to address an integrated approach. The description of the application of an integrated approach is summarized in the third section. The fourth section offers an overview of the findings of the key informant interviews and is followed by a summary of the conclusions. The final section delineates the student's evaluation activities in regard to findings and the achievement of learning objectives.

SECTION 2: LITERATURE REVIEW

The integration of program and clinical evaluation has not been fully addressed in the body of literature regarding the evaluation of human service organizations. Although it appears that each may serve a complementary function in the improvement of programs and the amelioration of social problems, the utility of a strategy which integrates these approaches cannot be clearly discerned from the writings of early theorists. This may be due to differences in the focus of study, variations in methodology and contrasts in the historical development of each approach. This section of the report describes the development of program and clinical evaluation from an historical perspective, with a particular emphasis on examining the context in which each was developed.

Before reviewing the literature regarding the historical development of program and clinical evaluation, it is important to clarify the factors that distinguish each approach. These factors appear to be related to the unit of research analysis and the research methodology associated with the evaluation. According to Rutman (1984), "program evaluation entails the use of scientific methods to measure the implementation and outcomes of programs for decision making purposes," (p. 10). The focus of program evaluation research is on programs and their ability to influence specific target population groups. Program evaluation activities are usually related to assessing the achievement of program goals and objectives. Methodology associated with program evaluation may include experimental and quasi-experimental research designs, and the use of control groups or examining changes in client groups over time.

Clinical evaluation involves activities that are undertaken for the purpose of assessing clinical outcomes for individual clients. These are usually based on an assessment of client problems as identified by clinicians or workers involved in direct practice (Fischer, 1978). The research designs which are used for clinical evaluation may be experimental or quasi-experimental, although there is an increasing trend toward the use of single-subject designs. Indicators of client change may be assessed through behavioural checklists, standardized measures, or rating scales completed by client or therapist.

The differing historical developments of each evaluation strategy and the different disciplines in which each has originated also appears to be related to the absence of literature regarding an integrated approach. While program evaluation emerged from the scientific management theory in the mid 1930's, clinical evaluation commenced with the introduction of psychotherapeutic interventions in the field of psychology around the same time. The following section provides an overview of the literature regarding the historical development of program and clinical evaluation approaches. In addition literature regarding the potential utility of an integrated approach will be summarized.

2.1 HISTORY OF PROGRAM EVALUATION

Given the move toward systematic evaluation of programs during the recent past, it is surprising to note that evaluation efforts have been the result of years of practical and theoretical development. Although planned social evaluation has been noted as early as 2200 B.C., with military personnel selection in China, program evaluation as it is practised today is less than a century old (Guba & Lincoln, 1981). Since its initiation in the 1930's, program

evaluation has evolved through a number of forms which has resulted from a developmental process of construction and reconstruction of theory. This process has been influenced by shifts in the acceptance of knowledge regarding the nature of social problems and changes in what is considered appropriate methodology and epistemology.

Program evaluation began to emerge as a distinct part of social research during the nineteenth century. During that time period, the Industrial Revolution brought about radical social and economic change which transformed the social conscience and the structures of social agencies (Maduas, Scriven & Sufflebeam, 1983). Governments in Britain and the United States began moving toward the reform of educational and social programs. Social research became the tool for the rational planning of such reform as the use of survey research and statistical analysis gained credibility as valid means for assessing the magnitude of various social problems (Cronbach et. al., 1980).

In Great Britain, early evaluations directed toward reforming education, hospitals, orphanages, and public health agencies were impressionistic and informal in nature. Often government appointed commissions were given the responsibility for conducting investigations into areas of public concern. These Royal Commissions were used in Great Britain and in Canada to evaluate social problems and social policy. Although these have continued to serve as a means for exploring social conditions, their use for the evaluation of individual social programs has been limited. At the turn of the century, this appeared to be the extent of government involvement in program evaluation endeavors.

The practice history of program evaluation appears to have progressed most rapidly in the context of the educational system (Guba & Lincoln, 1981; Rossi & Freeman, 1993).

In the late 1800's, Joseph Rice began systematic evaluation efforts by devising and using achievement tests to support his contention that time was being inefficiently used in American schools. This initiated the use of individual assessment strategies to evaluate entire programs. A short while later, Alfred Binet was commissioned by the government of France to develop a means for screening mentally handicapped children within the public school system (Guba & Lincoln, 1989). Binet designed an instrument that measured an individual child's ability to cope with simple life situations. This instrument was revised by American researchers and was instituted as a permanent component of the American school system (Guba & Lincoln, 1989). The rapid advance and acceptance of mental tests was furthered by the need to screen personnel for induction into the armed services in World War I.

It is important to note that these early efforts directed toward program evaluation were focused on the measurement of individual difference. There was little evidence that evaluation could be linked to the assessment of school programs and curricula. The process of assessment was simply viewed as providing information about the individual. The utility of the test results in regard to providing information about programs was not considered.

Early evaluation methods were closely linked to the scientific paradigm of inquiry. The methods of science were increasingly being advanced as the only way in which to obtain knowledge about the physical and natural sciences (Maduas, et al., 1983). The legitimation of the scientific community was eagerly sought by researchers who wanted to study the social world. The use of the scientific method was further advanced by the positivist epistemology that characterized the turn of the century.

The influence of the scientific paradigm and positivism upon program evaluation strategies extended into the 1930's. During this time period, scientific management became a powerful force in industrial circles and was soon adopted by educational administration (Maduas, et al., 1983). Schools were seen to be similar to factories, with students being considered as raw materials which were to be processed by the educational system (Lincoln & Guba, 1989). Ralph Tyler emerged as leader in the educational field and in the general practice of evaluation (Maduas, et al. 1983).

Tyler was commissioned by the Bureau of Educational Research at Ohio University to determine the differential effects of various types of highschool curriculum. The 'Eight Year Study', launched in 1933, involved the development of tests that measured whether or not students learned what their teachers had intended them to learn (Tyler, 1983). Tyler conceptualized educational curriculum as broadly planned activities that were associated with intended behavioral outcomes among students (Maduas, et al., 1983). Thus, according to Tyler, evaluation involved a comparison of intended outcomes with actual outcomes. This appears to mark the emergence of a link between the evaluation of programs and the achievement of service objectives. There is agreement among more recent theorists that program evaluation was born out of Tyler's early work in the American educational system (Maduas, et al., 1983; Lincoln & Guba; 1981; 1989; Cronbach et al., 1980).

Tyler's understanding of the link between program objectives and outcomes set the stage for evaluation activities to assume a dynamic role in the continuous improvement of human service programs. Between the mid 1940's and 1960, evaluation practice and theory did not undergo significant change. Maduas et al., (1983) label this period as the "Age of

Innocence" but believe that the "Age of Ignorance" provides a more appropriate description because of public negligence in regard to social problems. As America rebounded from World War II there was evidence of poverty, racial prejudice, exhorbent consumption and widespread waste of natural resources. These problems grew as there was very little recognition by mainstream society and government institutions of their existence. Instead, a general optimism about the future and the improved economic climate prevailed.

2.1.1 Theoretical Development of Program Evaluation

Program evaluation emerged as a distinct discipline during the early 1960's in the United States (Shadish, Cook & Leviton, 1991; Brawley & Martinez-Brawley, 1988). Increased tax revenue resulting from a strengthened economy led to the emergence and expansion of government social service programs. In the United States, large scale social programs were launched in education, income maintenance, housing, health and criminal justice. These programs were initiated under the U.S. government's concern with fostering "The Great Society" (Cook & Shaddish, 1986). Government was concerned with eliminating poverty and bolstering the standard of living for all Americans. As resources were plentiful, there were few calls for government agencies to demonstrate the efficiency and effectiveness of any developmental efforts (Maduas, et al., 1983). Although evaluation endeavours persisted, there was little evidence that these findings were used to judge or improve programs.

During this decade, there was optimism on the part of government and academia that large social programs could ameliorate social needs and that social science theory would point

to clear targets for change (Cook & Shaddish, 1986). It was not until near the end of the 1960's, that the large scale expansion of social programs left government questioning the increased expenditures associated with the programs. Believing that social science theory could adequately provide a means for description and evaluation, government began to request evidence of the results achieved by the programs. These early studies on the large scale American programs were experimental and tended to equate research with evaluation (Hudson & Mayne, 1992). Notwithstanding the blurry distinction between research and evaluation, specialists in the technique and methodology of evaluation research emerged and increased grant support facilitated the initiation of large evaluation studies (Rossi & Freeman, 1993).

In Canada, the move toward evaluation was influenced by the work in the United States but did not involve the large scale experimentation (Hudson & Mayne, 1992). Instead, the use of program evaluation can be attributed to federal government initiatives that required government departments to conduct periodic evaluations. In the 1960's evaluation was carried out by planning and evaluation units operating in several government departments. Calls for better government accountability led to the development of the Office of the Comptroller in 1978. This government office was established as a focal point for financial management which was to include performance reporting to Parliament and the implementation of evaluation policy (McQueen, 1993). In contrast to the experimental nature of the American social program evaluations, evaluation in Canada was less directed toward proving that social interventions worked and focused more on fostering accountability within government (Hudson & Mayne, 1993).

As the practice of evaluation grew significantly in the 1960's in the United States and in Canada, so did evaluation theory and written resources regarding practice. Before this time period, evaluation was associated with the specific discipline in which it was practised and those involved in completing evaluations were forced to rely on limited methodological writings or personal experience. The development of the practice of evaluation until the 1960's could be related to social, economic and political trends. Although these contextual factors have played a key role in the advancement of evaluation theory since that time, the landmark works of Suchman, Campbell and Scriven have facilitated the link between early evaluation practice and theory. The initial work of these authors gave evaluators a specialized body of theory from which to develop practice.

Many authors have attempted to summarize and describe the evolution of evaluation theory since the 1960's (Alkin, 1972; Cronbach et al., 1980; Lincoln & Guba, 1989; Maduas et al., 1983; Scriven, 1993; Shadish et al., 1991). Most of these authors do not provide a comparative framework from which to examine key differences among the predominant theorists and to assess shifts in evaluation theory over time. The exception to this may be found in the work of Shadish et al. (1991). Shadish, Cook and Leviton (1991) propose and use a framework for evaluation theory analysis that is based on five components which they advocate are indicative of a good theory of evaluation. These components include; 1) a theory of social programming or the concern with the nature of social programs and their role in social problem solving; 2) a theory of knowledge construction or the fundamental concerns with epistemology; 3) the role that values play in judging the worth of a program; 4) direction for the use of evaluation findings in social policy and programming; and 5) issues the

evaluator faces in regard to methodology, resource constraints and staff limitations. According to these theorists, every comprehensive evaluation theory could be improved by explicitly justifying each of these components.

As the tasks associated with this historical overview are not to critique theory but to describe its development, this framework will not be used in its entirety. Instead, four attributes of the major evaluation theories will be examined in relation to the chronological evolution of the field. These attributes include; 1) theory of knowledge construction; 2) the purpose for which evaluations are conducted; 3) preferred methods and approaches; and 4) criteria for determining how value or worth is assigned to the program. For the purposes of clarification, a brief description these characteristics follows.

The first attribute involves the author's theory of knowledge construction and the philosophical assumptions regarding what may be considered acceptable knowledge. Most of the early evaluation theorists were influenced by logical positivism which assumed that the social work exists as a system of distinct, observable variables, independent of the knower (Maquire, 1987). This was characterized by ontological realism or the belief in more than one reality irrespective of the knower. Early realists held that one true reality could be determined through scientific inquiry. Critical realism, which was influential around the same time evaluation theory was developing, provided less confidence that reality could be discovered through investigation but rested in the belief in a substantial reality. More recent evaluation theorists could be considered ontological relativists as they believe that there are multiple socially constructed realities available to the knower. The theory of knowledge construction

is important to program evaluation theory as it pertains to the determination of the nature of reality and the justifications for knowledge claims (Shadish et. al., 1991).

The second attribute which will be examined in reviewing the development of evaluation theory relates to the purposes for which program evaluations are conducted and the utility of the findings. Evaluation findings may be used for monitoring programs or assessing the effectiveness in attaining desired outcomes. In addition, evaluation findings contribute to the body of theory regarding a specific social problem or describe the theoretical constructs underlying a specific social intervention. These two uses of program evaluation are termed instrumental and enlightenment by Shadish, Leviton and Cook (1991). A theorist's perspective on the purposes for which evaluations are conducted is a key element of describing a particular theory.

The third attribute which assists in describing the development of evaluation theory is the methods and approaches to evaluation advocated by each theorist. This may include the preferred design and data collection techniques. In addition the unique contributions of theorists in regard to their approach to implementation will be examined.

The final attribute relates to the role of the evaluator in assigning worth or merit to a program. The theorists' positions in regard to the criteria against which programs should be evaluated will be described within the review. As evaluators are often called upon to judge programs, the importance of a theory of value in regard to evaluation is a critical element.

It is important to note that a description of evaluation theory according to the attributes outlined above will not offer a comprehensive description, rather it forms an attempt at highlighting the aspects of theory development that may be considered relevant to

the study of integrating clinical evaluation and program evaluation. Some theorists did not explicitly state their position regarding each of these components, which resulted in forming assumptions based on other components and the writings of their critics.

The remaining overview of the development of program evaluation will be presented as encompassing three distinct historical periods of program evaluation theory development. The first period, consists of the 1960's and involves the works of such authors as Suchman, Campbell and Scriven. The next period of significant development in evaluation theory was the 1970's at which time theorists such as Weiss, Wholey, Stake and Patton contributed to evaluation knowledge. The overview will conclude with a discussion of program evaluation theory from the late 1970's to the present. The writings of Cronbach, Rossi, Lincoln and Guba and Maquire will be reviewed as part of the examination of these recent developments in program evaluation theory.

2.1.2 Early Evaluation Theories: Canon or Catalyst?

Three theorists emerged in the 1960's as pioneers in the field of program evaluation. The writings of Suchman, Campbell and Scriven served as catalysts in the early discussions regarding evaluation theory. All three authors were involved in academia, and were highly regarded as knowledgeable social researchers (Hyde, 1984; Shadish et. al., 1991). Their application of social research strategies for program evaluation purposes stimulated discussion and framed program evaluation as a distinct form of social research.

Consistent with the optimistic social climate of the 1960's, Suchman, Campbell and Scriven believed that there existed immediately implementable solutions to social problems.

Their writings demonstrate confidence with regard to social programs and the ability of such programs to ameliorate social problems (Campbell, 1969; Suchman, 1967; Scriven, 1972). As a result of the influence of the post-positivist approach to knowledge construction of previous decades, all three authors advocated for rigorous epistemological and methodological standards for evaluation (Hyde, 1984; Shadish et. al., 1991). Particular emphasis was placed on the attainment of valid causal knowledge regarding the effects of social programs.

Suchman's (1967) book titled Evaluative Research was hailed as the starting point for a unique body of literature regarding program evaluation and for the generic study of evaluation practice (Hyde, 1984). Like many theorists of his time, Suchman was influenced by logical positivism. Although his written works do not explicitly state his theory of knowledge construction, his search for objective knowledge through scientific rigor leads to the conclusion that he believed that an objective reality may be known by an observer of the social world (Suchman, 1967). This suggests that he may be considered an ontological realist.

In a similar manner as other theorists of his time, Suchman believed that program evaluation strategies had the potential to contribute greatly to the process of rational planning;

"The current desire to judge the worthwhileness of such programs is but one aspect of modern society's belief that many of its social problems can be met most effectively through planned action based upon existing knowledge, including the design of even better solutions in step with advancing knowledge. The commitment of the modern world to planned social change is overwhelmingly apparent on the national and international scene," (Suchman, 1967 p.2).

According to Suchman, the purpose of program evaluation was to obtain knowledge that would assist in understanding and solving social problems. In later years, he clarified his stance in regard to the utility of evaluation activities: "evaluation study should be a problem-solving enterprise with a clear-cut relationship to some decision-making function," (Suchman, 1972, p. 55). According to Suchman, the primary use of evaluation findings was to contribute to existing knowledge about the amelioration of specific social problems; however, he believed that the findings could also have utility with regard to program monitoring and the assessment of effectiveness.

Suchman indicated that evaluation should involve the use of the scientific method to test program goals and objectives. These goals and objectives should reflect outcomes that are recognized by the general society as desirable or holding positive value. Suchman advocated for the use of methodological rigor in evaluating the program's influence on specified indicators of goal attainment. He believed that the scientific method provided the appropriate means for studying programs. Suchman contended that the scientific method was not bound to particular subject matter and that the laws of inference which applied to other forms of research could easily be applied to evaluation research. In addition, he advocated for a systems approach which allowed information from the process of evaluation to be incorporated into system management (Hyde, 1984).

Suchman's theory of value was not well developed. This may have been due to the introductory nature of his book and the absence of direction regarding the role of values in determining the worth or merit of programs. Although Suchman did advocate for the use of goals and objectives as criteria for assigning merit or worth to social programs, he did not

clearly identify whose values or goals should be considered. Suchman alluded to the use of some combination of the evaluator's values and those of the program managers.

Shortly before the publication of Evaluative Research, Donald Campbell wrote several works regarding scientific methodology and the social sciences. Campbell and Stanley's (1963) Experimental and Quasi-Experimental Designs for Research, and its key concepts of internal and external validity, has been rated as more influential than any other evaluation writing (Shadish et al., 1991). Although Campbell's work was directed toward social science researchers in general, program evaluators were interested in the methodology as it appeared to give technical direction to evaluation research as an area of applied social research. Of interest, Campbell himself never completed an evaluation and saw himself primarily as a catalyst to the early discussions of evaluation theory.

Campbell was concerned with describing and explaining how humans learn about the real world and how that process may be improved (Campbell, 1984). Campbell's early work was heavily influenced by logical positivism which dominated the philosophy of science during the 1960's (Campbell, 1981). Campbell was an ontological realist in that he believed that reality could exist independent of the knower, though it may never be known perfectly by observers. As this served as a bias in the experimental situation and was considered a constant threat to validity, Campbell went to great lengths to develop controls to safeguard its interference in the experimental process (Campbell & Stanley, 1963). This was consistent with his great concern for the description of causal process related to program objectives and outcomes. In later years Campbell was definitive in his rejection of logical positivism but

believed that the rejection among social scientists had led to decreased concern for methodological rigor (Campbell, 1984).

Campbell was optimistic about the instrumental use of evaluation research findings in improving social policy and programs. He did not believe that all research findings would be used by decision makers. Instead he asserted that only findings derived from sound methodology would yield information that program administrators would naturally use (Campbell, 1973). According to Campbell, the evaluator need not be concerned with utility as this deters from the credibility of the factlike findings. Thus, the purpose of evaluation efforts becomes simply the search for truth and the description of possible causal links between service activities and outcomes.

Campbell's belief in rigorous experimental outcome evaluation methodology was well developed in his writings (Campbell, 1963; 1972; 1984). His 1963 book on experimental designs he outlined innovative ways in which to introduce experimentation into the real life environments of programs. These designs were considered quasi-experimental as they allowed for some understanding of causal relationships in situations where randomization was not possible for practical or other reasons. Although Campbell did advocate the use of these designs, he believed that social scientists should strive to use true experimental designs whenever possible in order to complete "hard-headed evaluation of effects," (Campbell, 1969). For evaluation researchers in particular, Campbell believed that randomization was a means for easily dealing with ethical issues related to the selection of treatment recipients and was the best way to establish the causal effectiveness of programs (Shaddish et al, 1991).

Campbell's concern with causality and improving research validity was reflected in his

development of concepts related to the threats to internal validity (Campbell & Stanley, 1963).

Cross validation was another method clearly advocated by Campbell. He indicated that "too many social scientists expect single experiments to settle issues once and for all," (Campbell, 1969, p. 427). According to Campbell (1973), not only does cross validation allow for the researcher to establish a better understanding of causal processes, but it has the potential to improve the field of evaluation research. Campbell advocated for freedom for all the participants in the research process to have access to the findings. In addition, he encouraged the sharing of information between evaluators in order to enhance methods through constructive analysis by evaluators.

Campbell supported the use of quantitative and qualitative research methods (Campbell, 1969). This may be considered unusual given his concern for methodological rigor and the scientific method. However, Campbell justified his acceptance of qualitative methods by acknowledging that qualitative information often provides the basis for quantifying social indicators (Campbell, 1973).

As a result of his support for scientific rigor and the influence of logical positivism, Campbell believed that there may be a distinction between facts and values. He did however, recognize that evaluations could not be value-free and that values should be considered in the evaluation process (Shaddish et al., 1991). The source of the values or direction regarding prioritization of which values should form the basis for the criteria of merit is not clear from Campbell's writing.

Michael Scriven was a more forceful advocate in acknowledging that evaluation assigns merit or worth to social programs. Scriven's work in the field of educational evaluation also appeared in the mid 1960's and in many ways was similar to the work of his contemporaries. Like Campbell and Suchman, Scriven was an ontological realist who acknowledged that humans have limited ability to perceive reality. Scriven advocated for the use of scientific rigor and was concerned with validity and bias control. However, he believed that bias was inherent in the utilization of managerial goals rather than in the selection of research design as argued by Campbell (Scriven, 1972).

Scriven was the first major theorist to describe different purposes for program evaluation research (Shaddish et al, 1992). His use of the terms formative and summative allowed for the distinction between evaluation findings that could be used for program improvement and findings which could be used to examine program outcome (Scriven, 1972). Scriven was optimistic about the utilization of evaluation findings as he believed that the transfer of knowledge may be similar to the transfer of products in the free market economy (Scriven, 1983). Building on this premise, he developed what he called a "Consumerist Ideology" related to use. Scriven believed that consumers of evaluation findings will use information to determine which product to buy or which policy to enact or maintain. According to Scriven, the evaluator does not need to focus on a particular research study or be concerned with utilization, as the transfer and use of information is simply a matter of supply and demand.

Scriven's use of the consumerist ideology was consistent with his emphasis on the role of values. He believed that managerial values as embodied in program goals should not serve

as the only means to assessing the merit or worth of programs. Scriven strongly opposed the managerial goal driven evaluations approach:

"Relevant though that is to the concerns of the manager, it is of no interest at all to the consumer. The road to hell is paved with good intentions...the distinction between intended effects and side effects is of no possible concern to the consumer who is benefitted or damaged by them alike," (Scriven, 1983, p. 233).

Scriven believed that the evaluation of programs in relation to managerial goals was greatly influenced by positivist ideology because treating a program as equivalent to its success in achieving its goals was a way for evaluators to avoid making value judgements. Instead Scriven advocated for a goal free evaluation which would investigate all possible effects of the program; "One of the evaluator's most useful contributions may be to reconceptualize the effects, rather than to regurgitate the manager's conception of them" (Scriven, 1972 p. 320). According to Scriven, merit or worth would be assigned ultimately by the evaluator who is to be objective and unbiased in discovering the facts related to merit (Scriven, 1972).

Scriven's goal free evaluation appeared to stimulate dialogue regarding the role of values in determining the merit or worth of programs. He believed that disciplined and scientific investigation of value claims could be accomplished by assessing how much the object or program being evaluated met important needs (Shaddish, et al, 1991). According to Scriven, evaluators must refuse to be co-opted by managers who design program objectives and take a stand on issues of value. Unfortunately, Scriven like other theorists of his time failed to consider the important role management has in determining how, or if the evaluation findings will be used. This apparent weakness in early evaluation theory led to the development of utilization focused theories in the 1970's.

2.1.3 1970 to 1980: Evaluation Theory and Use

Evaluation theorists in the early 1970's were less optimistic about the role of evaluation research in the process of rational planning. The recognition that findings were not always utilized by those with the power to make program decisions resulted in the development of several theories of use. The works of Weiss, Patton, Stake and Wholey offered a reexamination of early evaluation theory and methodology and sought to determine ways in which to promote optimal utility of the findings.

Carol Weiss was one of the first authors to contribute to the body of evaluation theory related to utility. Her early writings emphasized experimental methodology as a way to assess program goal achievement. She stated that the purpose of evaluation research is to "measure the effects of a program against the goals it set out to accomplish as a means of contributing to subsequent decision making about the program and improving future programming," (Weiss, 1972b p. 4). This view was similar to the views of earlier theorists regarding the purpose of evaluation and the underlying assumptions about the construction of knowledge. Like Suchman, Campbell and Scriven, Weiss was an ontological realist who believed in an objective reality and that humans are capable of knowing more than one reality (Shadish, et al., 1991). Her practical interpretation of this theory, specifically in regard to prioritizing the reality of the evaluation stakeholders, separates her theory from these early theorists.

Weiss (1972c) indicated that the primary purpose of evaluation should be to enlighten decision makers regarding the nature of social problems rather than to improve individual social programs. This belief was related to her pessimism regarding the frequency with which evaluation findings were used by those with the authority to stimulate change. She blamed

the lack of demonstrated use of early evaluations on situational constraints associated with the organization as well as the approaches taken by the evaluators. Among the constraints which she identified as frequently limiting the use of evaluation results was the political nature of evaluation research (Weiss, 1972b). Weiss believed that because evaluations are designed to yield conclusions about the worth of programs and the allocation of resources, they are highly politicized activities (Weiss, 1972a). She criticized early evaluation theorists for being too optimistic about the ability of rational planning efforts to ameliorate social problems, while ignoring the political and social context of the evaluation. Weiss believed that evaluators must be aware of the overt and covert purposes for evaluation; "People decide to have a program evaluated for many different reasons, from the eminently rational to the patently political," (Weiss, 1972b p. 11).

In order to increase utilization by decision makers who act in the political arena, Weiss (1972b) argued that evaluators must be aware of the perspectives of all stakeholders or all the potential users of the evaluation findings. In addition, she proposed three elements of an evaluation that could improve the utility of the findings:

1. the explication of the theoretical premises underlying the program and direction of the evaluation to analysis of these premises,
2. specification of the "process model" of the program - the presumed sequence of linkages that lead from program input to outcome, and the tracking of processes through which results are supposed to be obtained,
3. analysis of effectiveness of components of the program, or alternative approaches, rather than an all-or nothing assessment of the total program, (Weiss, 1972a).

These elements require the evaluator to have a detailed understanding of all facets of the program including the independent and dependent variables associated with individual client intervention and those associated with the overall program.

Although Weiss believed in the scientific method as a means for assessing the accomplishment of program goals and for describing causal processes, she did not advocate for the use of a particular methodology (Weiss, 1972b). Instead, she placed utility as the paramount consideration in the selection of evaluation design and method.

Weiss (1972b) claimed that evaluation involves judging the merit or worth of a program against program goals and objectives. This appears to indicate that Weiss believed that the evaluator should be considered responsible for describing merit rather than prescribing what ought to be considered worthwhile in terms of program outcome. According to Weiss, the description of value or merit should reflect stakeholder's values in order to direct the evaluation and to ensure full utilization of the findings.

Weiss (1972a) maintained a critical stance regarding the ability of early evaluation research to assist in the rational planning process. This was due, in part, to the emerging realization that evaluation findings did not demonstrate that large scale social programs were adequately addressing social need. She did believe that rational planning may play an important role in the future of social policy but that it must be closely linked to improved means for the transfer of useful knowledge about social problems (Weiss, 1987). Weiss's work was influential in directing evaluators to consider issues related to utilization (Shadish et. al., 1993).

Among theorists who contributed to the burgeoning body of knowledge regarding evaluation and utilization, Joseph Wholey appeared to hold views most similar to Carol Weiss. As with Weiss's theory, Wholey (1984) believed that evaluations should take into account the information needs of all stakeholders in order to promote use. Wholey's personal

experience in U.S. federal evaluation departments influenced him to focus on program managers as the primary users of evaluation findings. As a result, Wholey (1983) saw program evaluation as a means to encourage "good government" through the provision of useful information regarding program effectiveness and efficiency. His theory was directed toward improving the accountability efforts of program managers working in government agencies.

As Wholey's work appeared several years after that of Weiss, his theory of knowledge construction was less influenced by logical positivism. Although he did not specifically articulate his stance in regard to knowledge construction, he did indicate that scientific rigor and objectivity may not always be the best approaches to obtaining truth in the process of evaluation. Wholey argued that the approach should be based on the utility of the resultant information. This does not provide a clear understanding of his theory of knowledge construction but rather, points to the pragmatic nature of his evaluation theory.

Wholey was not prescriptive regarding evaluation methodology but did believe that the experimental model was not the only valid approach to evaluation research (Shaddish et al., 1992). As utility was of primary importance, he advocated for the selection and implementation of a methodology that would facilitate use for program managers. Although he did not identify particular research designs or data collection methods that would yield the most useful information, he was responsible for developing two evaluation models; the evaluability assessment approach and rapid-feedback evaluation (Wholey, 1983; 1984).

Wholey's (1983) unique contribution to evaluation methodology involved the use of the evaluability assessment as a means for promoting useful evaluations. The evaluability

assessment, according to Wholey, may provide information about the context of the program and the likelihood that program objectives can be met. An evaluability assessment could be conducted by evaluators as a pre-evaluation activity or as a means for program monitoring. Wholey believed that conducting an evaluability assessment carries the potential to give evaluators the opportunity to assist program managers in implementing mechanisms that would enhance the utility of an evaluation before the evaluation commenced.

Wholey (1984) also developed the rapid-feedback evaluation method. This method involved a quick, preliminary assessment of program performance as part of the process of developing the evaluation design and indicators of program performance. In completing a rapid-feedback evaluation, an evaluator could use existing data or estimates of program effectiveness according to knowledgeable individuals. According to Wholey (1983), this approach is based on the sequential purchase of information which takes into account the cost and utility of implementing more extensive data collection procedures at sequential stages in the evaluation process. Wholey argued that this approach has the potential to give program managers immediate feedback on program performance which may be a means for encouraging use.

In a similar manner as Weiss, Wholey advocated for the use of program goals and objectives as the primary criteria for determining the merit of a program. This descriptive approach to valuing relies on program managers to ascertain worth. Of interest, Wholey's experience in government evaluation and planning agencies appears to have influenced his understanding of values related to efficiency, and ultimately, resource expenditure. Wholey

identified improved efficiency as a purpose for evaluation efforts but did not directly address the associated underlying values.

Wholey's contribution to utilization theories of evaluation was primarily in his development of practical methodological approaches. As his view of the purpose of evaluation involved providing instrumental knowledge about specific programs for program management, he advocated for an approach that would link evaluation to other management functions. It is this contention that led to the development of the evaluability assessment and rapid-feedback evaluation methods. As these methods were more closely related to program processes than program objectives and outcomes, Wholey appeared to be one of the first evaluation theorists to move away from sole reliance on the experimental paradigm as the only means for evaluating social programs.

Another noteworthy theorist who addressed issues of utilization was Robert Stake. Stake (1972) deviated from earlier theorists such as Suchman, Campbell and Scriven in his pronounced departure from the scientific method as the only means for obtaining knowledge about the social world. He also differed from other utilization theorists as he held a naturalist epistemology which was supported by his apparent belief in the creation of truth and reality by individual perceivers (Guba & Lincoln, 1981). Stake (1972) based this theoretical stance on what he called tacit knowledge or knowledge that is gained from everyday life experience with objects and events. According to Stake, tacit knowledge could be used for naturalistic generalization which is "arrived at by recognizing the similarities of objects and issues in and out of context and by sensing the natural covariations of happenings," (Stake, 1983a, p. 282). In this manner, Stake advocated that superior evaluations would result from the collection of

tacit knowledge for the purpose of developing expectations about situations and contexts rather than the use of objective measures aimed at scientific induction and the development of laws.

Stake indicated that the primary purpose of evaluation should be to provide understanding about social problems and the ways in which they may be ameliorated. He advocated for the use of case studies which involve the collection of tacit or experiential knowledge regarding an institution, a program, a responsibility or a population (Stake, 1983a). Stake believed that evaluation users would closely identify with the experiential knowledge obtained through a case study and this would serve to enlighten local stakeholders (Shadish et al., 1991). Stake (1972) did not ignore the ability of evaluation findings to contribute to the decision making process but thought this a secondary purpose of evaluation research.

In keeping with his rejection of the experimental paradigm and his use of the case study method, Stake (1972) developed what he called the responsive approach to evaluation. He contrasted this approach to preordinate evaluation in which goals and objectives are emphasized and tested. Stake described responsive evaluation as "based on what people do naturally to evaluate things: they observe and react," (Stake, 1983b, p.292). According to Stake (1972), an evaluation may be considered responsive if it orients more directly to program activities than to program intents, if it responds to audience requirements for information, and if the different value perspectives of the people at hand are referred to in reporting the success and failure of the program. Stake believed that the methodology best able to meet the criteria associated with responsive evaluation was the case study. This

involves gathering information which is of value to the audience. This may include planned observations, interviews and the preparation of narrative reports.

Stake's departure from evaluation approaches which are dependent on program goals is similar to Scriven's goal-free evaluation. Of interest, Stake used Scriven's ideas about the bias inherent in measuring the achievement of program goals and the role of the evaluator in determining the worth of a program, to develop his approach (Stake, 1983a). Like Scriven, Stake encouraged the evaluator to become involved in both describing and judging programs.

"Both description and judgement are essential - in fact, they are the two basic acts of evaluation. Any individual may attempt to refrain from judging or from collecting the judgements of others. Any individual evaluator may seek only to bring to light the worth of the program. But their evaluations are incomplete. To be fully understood, the program must be fully described and fully judged," (Stake, 1972, P.34).

Stake (1975) admitted that he diverged from Scriven in his understanding of whose values should be included in the judgement process. While Scriven looked for universal values among relevant stakeholders, Stake acknowledged the potential diversity of values. This appears to somewhat weaken his stance in regard to the role of the evaluator as a judge of program merit.

Before summarizing the main utilization theories which emerged in the mid 1970's, it is important to note the contribution of Michael Patton. Patton's utilization-focused evaluation approach appeared to incorporate elements from each of the theories described above. Like Weiss, Patton was not optimistic about the use of evaluation research to direct the rational planning process: "Evaluation findings will seldom have the enormous kind of influence envisioned by social scientists who wanted to rationalize the decision making

process," (Patton, 1978, p. 35) Instead, he believed that a utilization-focused evaluation would increase the likelihood that the evaluation findings would be substantial, meaningful and relevant for the users.

Patton appears to have taken Weiss's conclusions regarding the importance of stakeholder input and moved it toward a more practical model. In his book Utilization-focused Evaluation (1978) Patton walks the evaluator through an example of an evaluation from the initial contact with stakeholders to data analysis. At each stage Patton offers suggestions for improving the utility of the findings from the perspectives of program managers and other stakeholders. His concern for the utilization needs of program managers places his theory and approach close to that of Wholey.

Patton was not prescriptive regarding the selection of methods for the evaluation. He encouraged creativity and flexibility in regard to methods and placed utility as the paramount consideration (Patton, 1981; 1982). Like Stake, he believed that the evaluator must be willing to use alternative paradigms that do not rely on quantitative data and program objectives as sole means for determining the worth of programs (Patton, 1978). Patton's greatest contribution was likely his pragmatic approach to encouraging the use of evaluation findings.

The concern for methodological rigor that characterized earlier evaluation theory was replaced with an emphasis on utilization. Theorists endeavoured to identify potential users of evaluation findings and means for ensuring optimal use. These theorists expanded the use of evaluation findings to incorporate both enlightenment with regard to social problems and to assist in improving programs at the local or administrative level. Emphasis was placed on

meeting the information needs of a range of stakeholders and as a result, different methodologies and approaches appeared in the evaluation literature.

2.1.4 1980 to the Present: Building on the Past

From 1980 to the present time, several evaluation theorists have attempted to advance evaluation theory based on knowledge gained from earlier theorists regarding the nature of evaluation and social programs (Shadish et al., 1991). Theorists such as Rossi and Cronbach have attempted to address concerns about obtaining valid knowledge and for the ability to make inferences about the effects of social programs. Rossi and Cronbach have also sought to confront issues of use, although in a less direct way than Weiss, Wholey, Stake and Patton. Other authors have abandoned the theoretical foundations of the past in search of different research paradigms. For theorists like Lincoln and Guba, and feminist researchers such as Maquire, learning from the past has resulted in the rejection of traditional evaluation approaches and the examination of alternative paradigms of inquiry.

It is difficult to summarize the state of evaluation theory as it has developed over the past 15 years. It appears that theorists have become less prescriptive about the ways in which to do evaluation and are encouraging evaluators to be flexible and open to a range of approaches and methodologies (Cronbach, 1982; Prosavac & Carey, 1980; Rossi & Freeman, 1993). For the purpose of providing an overview of recent developments in evaluation theory the works of Rossi, Cronbach, Lincoln and Guba, and Maquire will be examined. As Rossi and Cronbach offer similar approaches, they will be discussed together except where their perspectives diverge.

Peter Rossi and Lee Cronbach have been contributing to the literature regarding program evaluation since the mid 1960's. Over the past 30 years both of their theoretical approaches to evaluation have shifted from emphasis on the scientific aspects of evaluation to a more pragmatic view which acknowledges the scientific methodology but is responsive to the evaluation context. (Cronbach, et al., 1980; Rossi, 1972; Rossi & Freeman, 1993). For Cronbach, change appears to have been more difficult because of his early work with theories of measurement and his development of statistical methods for testing instrument reliability (Shadish, et al., 1991).

Neither Rossi or Cronbach devoted much of their writings to explaining their theory of knowledge construction and it is difficult to make assumptions given their acceptance of diverse evaluation approaches. Although the influence of logical positivism and early concern with scientific rigor suggests that Rossi and Cronbach may be considered ontological realists, their later writings are based on a contingency model to the selection of method and approach. This offers less conclusive information about their theory of knowledge construction (Cronbach, 1982; Rossi & Freeman, 1993). Cronbach appears to be marginally less elusive in his belief about how the social knowledge can be obtained and alludes to holding multiple theories (Shadish et al., 1991).

According to Rossi and Cronbach, the purpose of evaluations may be threefold; 1) to monitor program implementation; 2) to assess program impact and efficiency; 3) to analyze the conceptualization and design of interventions (Cronbach et al., 1980; Rossi & Freeman, 1993). This third purpose, which examines the theoretical assumptions regarding intervention techniques was not fully developed by other theorists and can be considered unique to recent

evaluation theory. Although this appears similar to Weiss's concern with enlightenment or increasing stakeholder understanding of social problems, she did not address the potential theoretical and conceptual contributions of evaluation findings to existing bodies of social knowledge. By emphasizing the monitoring, impact assessment and theoretical development functions of evaluation Rossi and Cronbach seem to take into consideration the knowledge needs of a range of stakeholders including local program management, and legislative and funding bodies.

Both Rossi and Cronbach advocated for the use of multiple evaluation methods. They believed that evaluation designs and methods should be chosen according to the purposes for which the evaluation is being conducted and the context of the program. Rossi encouraged evaluators to tailor the design and method choice to the information needs of stakeholders and to the practical realities of the program: "The individuality of each evaluation makes it difficult to offer many principles about the conduct of evaluations," (Rossi & Freeman, 1993, p. 404). Rossi suggested that evaluators use experimental and quasi-experimental designs for assessing program impact. Although he accepted the use of qualitative data, Rossi indicated that quantitative data is often seen to be the most efficient in terms of evaluator time and resources.

In a similar manner, Cronbach advocated for a flexible approach to evaluation. He criticized early theorists as he believed that they exclusively "advocated a summative, hypothesis-testing style," (Cronbach et al., 1980, p. 215). Cronbach believed that "under many circumstances, the emphasis on assessment of outcomes of a supposedly fixed program runs counter to the aims of understanding the problem," (Cronbach et al. 1980, p. 216).

However, Cronbach did develop a detailed method for determining the many alternatives available to the evaluator in any one situation. These methods included models for addressing internal validity, internal and external inference, and statistical means for testing the generalizability of the findings (Cronbach, 1982).

Rossi and Cronbach appeared to hold a descriptive theory of determining the merit of social programs. Rossi indicated that "to evaluate is to make judgements; to conduct an evaluation is to provide findings that can be used to substantiate judgements," (Rossi & Freeman, 1993, p.407). This appears to give the evaluator responsibility for simply providing information on program effectiveness in attaining intended program outcomes, rather than prescribing what ought to be considered worthwhile. Cronbach held a similar view on the role of the evaluator: "It is not the evaluators's task to determine on his own whether a program is worthwhile or what action should be taken. The evaluator cannot judge for others, any more than a counsellor can decide what career a student should prepare for," (Cronbach, 1982, p. 8).

The criteria against which programs should be judged according to Cronbach and Rossi should be derived from multiple sources. These may include an examination of intended and unintended program effects, factors that appear to have relevance to the decision making process with regard to the program and estimations of the extent to which the material needs of clients are met (Shadish, et al., 1991). Thus, it appears that the use of program goals and objectives as exclusive criteria of merit was not viewed as relevant according to Cronbach and Rossi.

The written works of Cronbach and Rossi reflected a change in evaluation theory that is flexible and more accommodating to the specific information needs of programs and stakeholders. This shift away from the rigid approaches to evaluation and the influence of positivism which was advocated by earlier theorists, appears to have allowed for the emergence of alternative paradigms of inquiry. Two of these alternative paradigms, the naturalistic and the feminist, will be discussed in regard to the work of Lincoln and Guba, and Maquire.

Although Lincoln and Guba (1989) have advocated for the use of alternative research paradigms in evaluation for the past 15 years, their latest writings indicate that they believe that evaluation theory is on the threshold of fundamental change. They believe that there have been significant advances in the methodology and approaches to evaluation since the early theorists began writing about evaluation. However, Lincoln and Guba (1989) feel that there are three flaws in previous theories; 1) a tendency toward managerialism and difficulties associated with the evaluator's relationship to the manager; 2) the failure to accommodate value pluralism by the lack of attention paid to the influence of multiple value systems; and 3) over commitment to the scientific paradigm of inquiry and the positivist school of knowledge construction. Lincoln and Guba advocated for the move toward the 'Fourth generation of evaluation' which is based on an alternative research paradigm.

Guba and Lincoln's (1981) early writings were greatly influenced by Robert Stake and his responsive approach to evaluation. In constructing their own approach to evaluation, they incorporated aspects of Stake's (1972) criteria for responsive evaluation. They differed from

Stake in their theory of knowledge construction and ways in which that theory influenced their understanding of evaluation practice.

Guba and Lincoln's theory of knowledge construction was well delineated in their writings. They rejected the utility of the scientific paradigm on the ground that it "reflects a discredited epistemology of science - positivism. It is apparent that sophisticated scientists can not longer accept positivism...yet practitioners continue to act as if positivism were valid," (Guba & Lincoln, 1983, p.312). Instead, Guba and Lincoln advocated for the use of a naturalistic paradigm. According to these authors, the naturalistic paradigm; 1) incorporates the multiple realities of those involved in the evaluation; 2) is not dependent on the objectivity of the inquirer; 3) acknowledges the role of values in the research process; and 4) is not overly concerned with generalization and constructing laws, (Guba & Lincoln, 1989). Guba and Lincoln believed that the naturalistic paradigm offers rich information on the context of the inquiry and may be sensitive to the process of research. They link the use of the naturalistic paradigm to grounded theory research as data is not sought to confirm a theory, but develops as a result of the data. The influence of Stake's concepts of responsive and preordinate evaluation approaches is evident in Guba and Lincoln's writings, however, their unqualified rejection of positivism and the scientific method set them apart from Stake.

The purpose of evaluation according to Guba and Lincoln is not clear from their written works. They identified stakeholders as they key users of findings and define this group as all the individuals who have an interest in the evaluation process and outcomes (Guba and Lincoln, 1989). It appears that they did not see managers and decision makers as

exclusive users of the findings, as they rejected evaluation processes that depend on a great deal of managerial involvement without consulting workers.

Guba and Lincoln (1989) advocated for methods which can be utilized in the natural setting. This is in keeping with their belief in multiple realities which are dependent on the time and context of the observation. These authors strongly suggested the use of instruments that are readily at hand to humans or those which take into account human experience. Qualitative methods are considered the best and most easily implementable as they rely on the direct employment of human sensation. Guba and Lincoln did not negate the potential utility of quantitative evaluation but rather believe that qualitative methods are more relevant to human experience and reality.

As noted earlier, Lincoln and Guba emphasized the importance of acknowledging the role of values in the process of evaluation. As evaluation involves assessing the merit or worth of a program against some value standard, the authors believed that it was important to take into account the multiple realities and value positions of the stakeholders (Lincoln & Guba, 1989). This is not unlike the view of Cronbach and Rossi as it points away from program goals as criteria of merit and relies on a range of standards.

Guba and Lincoln's (1989) Fourth Generation Evaluation offered a means by which an alternative paradigm of inquiry could be utilized for program evaluation. The authors hailed this as an innovative way to look at evaluative research that would move researchers beyond the scientific paradigm toward a new and enlightened approach to human inquiry. Unfortunately, beyond the clear articulation of the naturalistic paradigm, no other elements of the theory were new or inventive. In fact, even the presentation of an alternative paradigm

could not be considered innovative as feminist evaluators had been searching for new paradigms for a decade before the publication of Guba and Lincoln's book. Patricia Maquire's work as a feminist evaluation theorist will be summarized briefly next.

Patricia Maquire (1984) is a feminist theorist who challenged the dominant scientific paradigm of inquiry. Her evaluation of a battered women's support group involved a participatory approach to evaluation research. Group participants served as the researchers and thus, they owned the research questions, the process and the findings.

Maquire, as a feminist researcher, rejected the dominant androcentric paradigm for not addressing the power imbalance associated with the production of knowledge. She believed that power is derived from knowledge and that the dominant paradigm often restricts those with the least power from accessing knowledge that would improve their life circumstances. The alternative paradigm that she proposes, ensures that the knowledge remains with the participants as they have responsibility for almost all aspects of the research process. According to Maquire, the purpose of evaluation should be to empower individuals, groups and communities.

Maquire is not prescriptive regarding methodology and evaluation criteria. In a similar manner as other feminist researchers, she appears to favour qualitative methods as they correspond to the value placed on experiential knowledge. The criteria for determining a program's merit or worth is dependent on the group or community involved in the study. The extent to which the evaluation demonstrates achievement of these standards is also determined by the participants.

Maquire, as a representative of feminist evaluators, challenged the existing evaluation theories for their failure to address the political nature of evaluation. Although this may have been mentioned by earlier theorists, the lack of power associated with the oppression of groups such as women and ethnic minorities was not recognized. Feminist evaluation theory brought attention to the role of knowledge as power in relation to evaluation research.

2.1.5 Summary

Program evaluation activities were initiated during the 1960's as a result of growing interest in the effectiveness of social programs on the part of government and other interested groups. In the United States, the post-war "Great Society" programs resulted in the emergence of large scale social programs. These programs were introduced as federal government initiatives and evaluation efforts were structured into the development and delivery of the services across the United States. This led to the rapid emergence of evaluation theory and expertise from the 1960's forward.

In Canada, the use of program evaluation can be attributed to federal government initiatives that required government departments to conduct periodic evaluations. Calls for better government accountability led to the development of the Office of the Comptroller in 1978. This government office was established as a focal point for financial management which was to include performance reporting to the Canadian parliament and the implementation of evaluation policy. In contrast to the experimental nature of the American social program evaluations, evaluation in Canada was less directed toward proving that social interventions worked and focused more on fostering accountability within government.

Evaluation theory since the 1960's may be conceptualized as moving through three phases of development. The first decade saw theorists emphasizing the role of scientific rigor. In the 1970's, program evaluation theory shifted to address issues of use. Theorists of this time period criticized early evaluators for being too naive in their understanding of how evaluation findings would influence programs. This focus on utility is still evident in more recent program evaluation literature; however, an equal emphasis is placed on scientific rigor. Program evaluation theory which has been developed since the beginning of the 1980's appears to indicate that evaluators have adopted a more flexible approach to program evaluation.

Although program evaluation theory is relatively new, it has experienced change as a result of the early debates regarding methodology, utility and the role of values. This has resulted in a better understanding of the purposes for which evaluations are conducted and more awareness regarding the needs of programs. It is likely that the less prescriptive approaches of recent theorists are more able to meet the needs of all the users of the evaluation findings and can be easily adapted for a range of contingencies. Generally, this appears to be an improvement in the way in which evaluations are conceptualized.

The flexible approaches advocated in recent evaluation theory literature appear to hold great potential for the use of alternative methods and approaches to the accomplishment of program evaluation research. Consideration for the needs of a range of stakeholders may compel evaluators to be more aware of all aspects of the program. This could allow for the use of clinical or case level evaluation strategies integrated with program evaluation methods as a means of increasing awareness of stakeholder need and providing information to meet

those needs. A review of the historical development of clinical evaluation may offer some understanding in this regard.

2.2 HISTORY OF CLINICAL EVALUATION

"Probably there is no other area of human endeavour which so badly needs a thoroughgoing application of the scientific method as does psychology, for probably in no other area are there so many misconceptions, so many half-truths, and so many abortive attempts to understand behaviour," (Underwood, 1957, p.1).

The history of clinical evaluation is embedded in the field of experimental psychology and has origins dating to the early nineteenth century (Boring, 1950). The scientific study of human behaviour was initially developed by individuals who were trained in the biological and physical sciences. Many of the early theorists borrowed from the scientific inquiry methods of physics which was considered the ideal form of modern science during the nineteenth century. It was not until 1950 that applied psychology emerged as a distinct area of psychological research and clinical intervention became the focus of experimentation and systematic assessment.

Prior to 1920 causal relationships were investigated in psychology using two distinct analytical approaches (Robinson & Foster, 1979). These two approaches were identified as experimental psychology and individual psychology. Those involved in experimental psychology sought to identify relationships between variables through direct physical manipulation of specific experimental conditions. Others who were working in the area of individual psychology attempted to identify relationships between specific characteristics

through the statistical manipulation of variables. The first fifty years of experimental and individual psychological investigation primarily involved attempts to describe and understand human mental processes.

The beginning of experimental psychology is said to be linked to the work of Fechner and other German scholars of the 1850's (Barlow & Hersen, 1984). Fechner was a physicist who concentrated on human sensation and developed means for assessing sensation through several psychophysical methods (Boring, 1950). Fechner's methods involved the repeated measurement of an individual's responses to different intensities of a stimuli. Using these methods, he was able to determine sensory thresholds of various sense modalities. Fechner was concerned with variability within the subject and worked with only several subjects at one time.

The establishment of the first psychological laboratory by Wilhelm Wundt in 1879 was considered to mark the inception of psychology as a unique discipline (Robinson & Foster, 1979). Wundt was a student of Fechner and like his teacher was interested in human sensation and perception. Because he believed that these were private experiences that could not be directly observed by another individual, he used a research method call introspection. Introspection was a highly specific procedure in which trained subjects learned to describe their experiences in an objective manner. Wundt attempted to study trained individuals with the clear assumption that after some replication, the findings would generalize to the entire population.

The early work of Fechner and Wundt in regard to the scientific study of human perception influenced others who were concerned with describing and explaining human

psychological processes. Hermann Ebbinghaus drew on Fechner's method to study what he called 'higher mental processes' or memory and learning (Boring, 1950). Basic to Ebbinghaus's experiments was the development of the nonsense syllable, which was an instrument designed to assess learning and memory (Barlow & Hersen, 1984). The nonsense syllable made use of various combinations of three-letter words to test learning retention under different conditions of practice and different chronological intervals (Robinson & Foster, 1979). What was significant about the work of Ebbinghaus was the emphasis on repeated measures of performance in one individual over time. This appears to have formed the basis for later research approaches which involved the individual serving as their own control in the process of experimentation.

The development of psychological experimentation which was initiated by the early German psychologists moved to North America at the turn of the century (Boring, 1950). The American contribution to the development of this new scientific psychology was to alter the purpose of investigation from describing mental processes to understanding the utilization of mental processes in the fulfilment of human need (Robinson & Foster, 1979). Influenced by Darwin's theory of evolution and the desire to assess personal capacity to successfully adjust to the environment, a functional school of psychology was developed. Functional theorists such as William James and John Dewey added to Wundt's investigative technique of introspection to include objective observation. The impetus toward functionalism seemed to play a significant role in developing the applied dimension of psychological experimentation.

As noted earlier, individual psychology evolved as a separate yet related, area of psychology before the 1920's. Galton's 1869 study of the tendency of genius to run along family lines advanced the use of correlational rather than experimental methods to identify relationships between psychological and biological traits (Robinson & Foster, 1979). Statistical methods were seen to address the recognized limitations of experimental methods for social science research, which primarily involved the lack of control necessary for determining causality. The statistical methods of individual psychology made use of large numbers of subjects in order to increase the validity of the relationships under examination. These studies were often labelled as naturalistic as they did not involve the direct manipulation of an independent variable but rather sought relationships among naturally occurring phenomenon.

Early psychological experimentation for the purpose of examining the human cognition and behaviour laid the foundation for the use of experimental psychology to determine the effectiveness of clinical intervention. At the turn of the century, the use of psychotherapy and psychoanalysis to assist individuals with psychological difficulties was gaining acceptance among researchers and clinicians. This led to the emergence of applied psychological research which sought to evaluate the effectiveness of the interventions.

Psychological research before the twentieth century was considered a pure or basic form of research. The purpose for which psychological research was completed involved enlightenment or for theory generation. As the science of psychology developed and became more sophisticated, so did treatment services for individuals experiencing behavioral and emotional problems (Barlow & Hersen, 1984). Occasionally, therapists would document the

type of intervention and the status of the client in order to communicate the findings to colleagues. It was not until around the 1950's that psychological research was noted as a means for determining the effectiveness of these interventions.

Early documentation of therapeutic effectiveness moved psychological research toward an applied science. This change involved an alteration in the purposes for which research was conducted, rather than a significant change in the research methods used. The primary change encompassed the move from the experimental setting of the laboratory to the more complex situation of the natural environment in which clinical work was being accomplished (Arzin, 1977). Applied psychological research became a vehicle for assessing the application of intervention strategies aimed at improving some aspect of the human condition (Baer, et al., 1968). While non-applied or basic research focused on the development of theory, applied psychological research had the goal of producing findings that would have the potential to modify the social world. Given the emphasis on psychology as a science, it is not surprising that logical positivism was highly influential in both the applied and basic research areas.

The recent past has seen a shift among theorists regarding the distinction between basic and applied research (Lazarus & Davison, 1971). The relationship between clinical research and research conducted in the laboratory is seen to be mutually influential rather than as opposing elements of a continuum as generally treated in the literature. Clinical research appears to be both influenced by trends in experimental psychology, as well as responsible for these changes. As a result, the distinction between basic and applied research is less important in recent literature.

The following section provides a brief overview of the history of applied psychological research and the evaluation of clinical intervention. The theoretical and practice context of psychoanalysis and behaviourism in which evaluation activities emerged will be briefly reviewed. In addition the early debates regarding the effectiveness of psychotherapy and the resultant move toward clinical evaluation activities will be summarized. Finally, the most common approaches to research and evaluation will be discussed in regard to their historical development and utility for the evaluation purposes.

2.2.1 The Development of Psychotherapy and Behaviorism

Applied psychological research was born out of a psychoanalytic framework developed by Freud and Breuer during the 1930's. This framework involved the conceptualization of basic psychological processes, developmental stages, symptom formation and other processes considered as contributing to personality and behaviour (Kazdin, 1982). In its early stages, psychoanalysis was primarily directed toward the alleviation of symptoms in patients whose difficulties emulated those of the neurologically impaired (Urban & Ford, 1971). As the focus of psychoanalysis was the individual, studying one or a few subjects was recognized as the best research method and as the most effective means for understanding the human psyche.

An example of such research was related by Breuer, through the commonly known case of Anna O.. Anna O. was treated for hysterical symptoms through psychoanalysis. In a series of treatment sessions, each symptom expressed by Anna O. was addressed through hypnosis and discussion. After each symptom was traced back to the determined cause, the

symptom disappeared. This appeared to be similar to the multiple baseline experimental design that may be found among the compliment of single subject research designs of the more recent past.

Freud and Breuer's contribution to applied psychological research was significant. Although these early clinicians were not aware of contemporary scientific principles, they began to form a link between the intervention of psychoanalysis and an examination of its effectiveness. Unfortunately, the use of what appeared to be anecdotal descriptions of individual cases by Freud and Breuer, and other psychoanalysts led to the documentation of many successful endeavors that may not have been valid interpretations of client change (Barlow & Hersen, 1984). After the work of Freud and Breuer, the domain of psychotherapy has experienced elaborate change which has seen wider and more heterogeneous behaviours becoming the target for intervention (Urban & Ford, 1971). Tactics akin to those introduced as psychotherapy were soon utilized to produce beneficial changes across an array of problems. For example, psychological interventions were applied to the rehabilitation of offenders, the socially constrained and to those experiencing general difficulties in daily functioning (Robinson & Foster, 1979). Soon psychotherapy was seen to be beneficial to those who were able to function reasonably well, as well as those who believed that functioning could be improved through intervention. This has led to a shift in defining targets of change and the behavioral patterns that should be fostered. The change in the focus of psychotherapy to include a wide range of behaviours and psychosocial characteristics appeared to have launched the acceptance of behavioral psychology as a legitimate and relevant school of psychological thought.

Behavioral psychology has roots in the work of Pavlov at the turn of the century (Kazdin, 1982). Pavlov's experiments with laboratory animals involved studying their learning behaviours through the use of respondent conditioning. A unique feature of Pavlov's work was the clear specification of the independent variables or the conditions of training. Pavlov's concern for the explanation of behaviour was the antecedent to the development of behavioural psychology.

In the mid 1950's Pavlov's work was furthered by Skinner. Skinner, like earlier behaviourists, also experimented with laboratory animals utilizing only one or a few subjects. He was concerned with operant conditioning or the alteration of subject behaviour through the use of reinforcement. During Skinner's experiments, animals such as rats or pigeons were enticed to perform a desired behaviour through consistent reinforcements of food (Skinner, 1956). His ability to predict the behaviour of the animals increased and he noticed the potential utility of applying his work to intervening with humans;

"So far as I can see, I began simply by looking for lawful processes in the behaviour of the intact organism. Pavlov had shown the way, but I could not then, as I cannot now, move without a jolt from salivary reflexes to the important business of everyday life," (Skinner, 1956, p. 223).

Skinner was the first to link behavioral theory with the prediction of behaviour. He believed that this was an important contribution to psychology as he felt that psychologists should be concerned with the future behaviours of their clients; "Behaviour which has already occurred and may never be repeated is of limited interest," (Skinner, 1953, p.69). Instead, he felt that psychologists should be concerned with predicting behaviour or at least specifying some of the features of a client's behaviour under certain circumstances. According to

Skinner, behavioral psychology could assist therapists in making more accurate predictions about future behaviour. Skinner saw this as the most important contribution of behaviourists to psychological intervention (Skinner, 1953).

The history of clinical research can be linked to specific theoretical approaches to the practice of psychology. Although the distinctions between psychological approaches were an important aspect of the development of applied psychology, current researchers and theorists are more willing to accept an eclectic approach to clinical practice rather than solely relying on psychoanalytic or behavioral approaches (Brehm & Smith, 1986). However, the influence of these two approaches on the development of applied research and clinical evaluation was great and continues to be observed in evaluation research endeavors.

Soon after psychotherapy became an applied science and was acknowledged as a means to meeting the difficulties of individuals, clinicians began to search for ways to evaluate practice. As mentioned earlier, the first attempts at evaluation primarily involved the case study method. With the advancement of scientific methods and more complex evaluation designs, clinicians began searching for data that would support the effectiveness of clinical intervention. The following section provides a summary of the literature regarding the controversial issue of the effectiveness of psychotherapy.

2.2.2 The Effectiveness Debate

"No responsible writer has ever reviewed the evidence of outcome studies and concluded that counselling and psychotherapy...have an average benefit beyond that seen in comparable control groups," (Truax & Carkhuff, 1965, p. 13).

This statement represented a growing view among theorists and clinicians that questioned the utility of psychotherapy in treating psychological disorders. In 1952, Hans Eysenck published a paper which reviewed selected studies reported in the psychological literature. This paper marked the beginning of a controversy that did not subside but supported the development and use of more advanced methods and designs for clinical evaluation. Since Eysenck's work other authors, such as Bergin and his colleagues, have reviewed the psychotherapy outcome literature and have reported mixed findings with regard to effectiveness.

Eysenck's work is well known for illustrating the ambiguous nature of the findings of early psychotherapy efforts (Bergin, 1971). His work involved a review of nineteen studies reported in the literature between 1927 and 1951. Over seven thousand cases were involved in these studies and the interventions included the more traditional psychoanalytic approaches of the time, as well as eclectic types of treatment (Eysenck, 1952). Eysenck reported the results under four categories: 1) Cured or much improved; 2) Improved; 3) Slightly improved; 4) Not improved. His findings indicated that about two-thirds of all neurotic individuals who entered psychotherapy improved substantially within two years, and that an equal number who never entered therapy improved within the same time period. As psychologists viewed this as a direct attack on the relevancy of their work, several researchers and clinicians began to take on more comprehensive reviews of the psychological literature regarding therapeutic effectiveness.

In an effort to understand Eysenck's findings, Allan Bergin reviewed his work in 1971. Although Bergin disputed Eysenck's methods and results on many points, he supported

Eysenck's findings with regard to the ambiguity of therapeutic outcomes as reported in the literature (Bergin, 1971). Bergin viewed the systematic evaluation of psychological outcome studies, and Eysenck's work in particular, as playing a key role in the development of psychotherapy research. Bergin states:

"I would like to point out that Eysenck's critiques have had a positive and extremely facilitative effect upon psychotherapy research. He has been a prime stimulant, if not irritant, pressing the field toward rigorous examination of its assumptions and procedures," (Bergin, 1971, p. 228).

Inspired by Eysenck's work and desiring a fuller understanding of the effects of psychotherapy, Bergin conducted his own review of a sample of studies conducted between 1952 and 1969. He chose studies which he believed were representative of the empirical status of psychological research at the time and he attempted to categorize outcomes as either positive or negative. His findings indicated that while the methodological sophistication and precision of the studies had improved markedly since Eysenck's review, the evidence continued to yield the general conclusion that on the average psychotherapy had modestly positive effects (Bergin, 1971). It is important to note that Bergin went so far as arguing that some cases were worse off after therapy than they were before receiving the intervention (Smith, et al., 1980).

It appears that these findings disappointed Bergin, who was widely respected in the field of psychotherapy and behavioral change. Although he believed that psychotherapy was of benefit to most individuals who experienced difficulties, the absence of clear positive outcomes led to further analysis of research and evaluation methods (Bergin, 1966). It became apparent that the uncontrolled case study which was characteristic of the studies

incorporated into Eysenck's review were no longer as prevalent during the time of Bergin's review (Lambert et. al., 1986).

Bergin concluded that more sophisticated research designs were being used to evaluate the effectiveness of clinical practice. These new methodologies which replaced the case study method were seen by researchers and clinicians to better address the interference of variables external to the study (Barlow & Hersen, 1984). Bergin advocated for improvements to existing research designs and the development of valid criterion measures against which to measure the effects of psychotherapy. He further recommended that clinicians who undertake research should be concerned with the selection of outcome criteria as there exist the multiple factors which may influence change (Bergin, 1971). The work of Bergin was recognized as one of the most thorough reviews regarding the effectiveness of psychotherapy and was considered as critical in moving the search for the demonstration of effectiveness toward a more systematic assessment of clinical strategies (Lambert, 1982).

In later years Bergin worked with several colleagues in the completion of similar reviews of the psychological literature. Lambert and Bergin conducted several reviews which built on Bergin's work. The first involved adding studies published through 1977 to Bergin's 1969 review. The findings were more optimistic than those of past reviews as it appeared that psychotherapy was beneficial for about two thirds or more of the research subjects (Bergin & Lambert, 1978). Although the authors considered this to be a more favourable conclusion, Lambert admitted that the findings with regard to spontaneous remission or improvement without therapeutic intervention "may vary from 0% to 90% at follow-up," (Lambert, 1982, p. 2).

Recent reviews completed by Bergin and his colleagues demonstrated a positive evaluation of the role of psychotherapy in assisting individuals with psychological and behavioral difficulties. According to these authors; "There is now little doubt that psychological treatments are, overall and in general, beneficial, although it remains equally true that not everyone benefits to a satisfactory degree," (Lambert, et al., 1986, p. 158). The move toward a more favourable assessment of the effects of psychotherapy was viewed as due to the appearance of better research designs which incorporated controlled trials and random assignment to control or experimental groups. Bergin and his associates concluded that recent developments in the empirical study of psychotherapy had yielded statistically significant effects as well as information that was clinically meaningful.

The debate started by Eysenck, and continued by several other theorists, appeared to have compelled clinicians to demonstrate the effectiveness of their interventions. This in turn, led to the development and use of evaluation designs and strategies which were suited to the particular clinical setting. Experimental designs used for evaluating clinical effectiveness will be discussed next.

2.2.3 Experimental Designs in Psychotherapy Research

This section outlines the specific ways in which researchers and clinicians have studied the effectiveness of psychotherapy. Kiesler (1971) distinguished between several types of designs which replaced the case study methods utilized before the 1950's. According to Kiesler, the studies could be conceptualized as correlational-naturalistic studies, generalist-manipulative studies and experimental-naturalistic designs. Since Kiesler's summary of

research designs in 1971, single subject designs have gained popularity among clinicians and researchers, and have grown to replace the experimental-naturalistic designs. For the purpose of this review four types of research approaches will be reviewed: 1) the case study approach; 2) correlational-naturalistic studies; 3) experimental-manipulative studies; and 4) single subject designs.

It is important to note that these four approaches developed in a somewhat chronological order. Case studies were used in early clinical research but as researchers noted limitations in that approach, other strategies were developed. This did not preclude the use of earlier approaches for evaluative purposes; rather, each of the following continue to be used alone, and in combination, for the description and evaluation of clinical intervention strategies.

Case Study Approach

The case study or the intensive study of the individual has played a central role in clinical practice. Individual cases or series of cases have exerted great influence on subsequent research and therapeutic intervention. One such example involved the work of Freud and his use of the case study method to document the process of psychoanalysis and its perceived effects. Freud's work laid the foundation for the extensive use of the case study approach for clinical evaluation purposes.

The case study has been defined in many different ways. Generally, the case study refers to the intensive investigation of the individual client (Kazdin, 1981). Traditionally this has been recognized as encompassing detailed descriptions of individual client outcomes

which often rely on anecdotal accounts of the therapist in order to make inferences about the role of therapy in the process of change. Aside from the focus on the individual, the case study has come to refer to a methodological approach which does not specify or control for factors which could contribute to change in the individual or group of individuals (Campbell & Stanely, 1963). As the purpose of experimentation is to rule out factors other than the independent variable as responsible for change, the contribution of the case study method to evaluation strategies has been limited.

Despite the apparent weaknesses of the case study, several unique characteristics make them worthy of consideration. Lazarus and Davison (1971) outlined six attributes which they believed gave this approach some credibility: 1) A case study may cast doubt on a general theory; 2) A case study may have heuristic value and lead to further research in a particular area; 3) The case study method allows for the examination of rare phenomena; 4) A case study may provide the opportunity to test new principles in different ways; 5) The case study approach can assist in providing contextual information about the application of theory; and 6) The case study method may, under certain circumstances, provide enough experimenter control to furnish information that is considered scientifically acceptable. The utility of case study approach appears to be related to the circumstances under which the research is conducted and the specific characteristics of the process of investigation.

Kazdin (1981) suggested that the case study method has the potential to allow researchers and clinicians to make inferences about the effects of treatment in the clinical setting. He believed that there are several dimensions for evaluating the utility of the information obtained through the case study method. The inclusion of systematic data

collection mechanisms and the use of continuous or repeated assessments are noted as the most important elements contributing to the process of inference. According to Kazdin, relying on anecdotal information which has not been used to establish past patterns of client behaviour does not lead to any conclusions about the role of therapy in client change. The information obtained through the case study method may also be evaluated by reviewing the type and magnitude of the effect and the number and heterogeneity of subjects. If a case study demonstrates that client change occurred to a large degree shortly after therapy was initiated and if this was demonstrated with clients who vary in demographic or other characteristics, the influence of therapy upon client change may be examined further.

Although the case study as traditionally defined did not allow for the clinician to make valid inferences about the role of therapy in the process of change, it was considered to be of some value to researchers and clinicians. The case study approach did not rely on extensive statistical procedures which often yielded group norms and probabilities and did not provide information about a given individual in the group. Instead, this approach permitted the relating of therapeutic effect to specific contingent patient characteristics and allowed for the use of qualitative data regarding the context of the intervention (Lazarus & Davison, 1971).

Notwithstanding the apparent utility of some of the information derived from the case study approach, it is still considered the least methodologically sound of the clinical evaluation strategies. Its major weakness lies in the insufficient control of extraneous variables, which results in the inability to make inferences about the relationship of therapy to client change.

Correlational-Naturalistic Studies

Correlational studies involved studying change in the natural environment, outside of the controlled laboratory setting. As mentioned earlier, these designs were originally used by Galton in the eighteenth century to examine the extent to which intelligence was related to hereditary factors. Around the 1940's with the emergence of Roger's model of client centred therapy, correlational studies became the dominant design for clinical evaluation as they were considered less intrusive to the therapeutic process (Kiesler, 1971). Although these designs are deemed less useful for evaluating the effectiveness of clinical intervention today, they are still used in circumstances where alternative designs are not feasible.

Correlational-naturalistic research designs were used to measure events that occurred naturally during psychotherapy. The investigators who used these designs, did not control the therapist or client factors of interest and were cautious that the process of measurement or other research activities did not alter the natural flow of therapy (Kiesler, 1971). Since using this type of design involved complex statistical procedures for analysis, large groups of subjects were studied. The essential elements of correlational research are;

"its identification of variables in terms of measurements of already existing subject characteristics, rather than in terms of manipulative operations performed by the investigator, and its use of a single, standard test situation for all subjects, rather than a different set of treatments for each research group," (Schontz, 1965, p. 132).

An example of a correlational-naturalistic study may involve examining the personality characteristics of psychiatrists whose psychotherapy with schizophrenic patients was highly successful. The findings may lead to a conclusion about a relationship between the two variables as they exist in the natural clinical setting.

Correlational research was seen to be useful as it allowed many behavioral variables to be studied simultaneously and their interrelationships assessed with relative lack of interference with natural processes (Kiesler, 1971). During the early stages of applied psychology this was viewed as a more comprehensive strategy than the case studies method as case studies involved the manipulation of only one or a few variables. The examination of multiple variables in combination with each other was recognized as indicative of the complexity of real-life. Correlational studies allowed the researcher or clinician to address the multi-dimensional nature of human behaviour (Shontz, 1965).

The disadvantages to utilizing correlational research designs were related to causation and the inability of the findings to ascertain which of the factors produced the intended effects (Robinson & Foster, 1979). As the purpose of evaluating clinical work was to establish the effectiveness of psychotherapy, establishing causality or measuring the effect of the independent variable upon the dependent variable was of paramount importance. This proves difficult in most correlational studies as the dependent and independent variables are interchangeable (Bergin & Strupp, 1970). For example, if it is found that there is a relationship between specific personality characteristics of psychiatrists and successful outcomes for schizophrenic patients, it would be helpful to infer that the characteristics were responsible for the positive outcomes. Unfortunately it is not possible to attain certainty in this regard, as patients who may be for some reason more inclined to improve may influence the personality characteristics that psychiatrists demonstrate during the therapy session. The interpretive ambiguity of correlational studies does not allow for the isolation of critical variables or the factors responsible for change (Kiesler, 1971). Accordingly, the most serious

error in using these designs "arises from investigators' tendencies to assign it powers of proof that it does not possess and thus to draw unwarranted conclusions or inferences from the data it provides," (Schontz, 1965, p. 158).

Since causality is difficult or impossible to establish through correlational designs, their utility for applied research regarding clinical effectiveness is limited. It has been suggested that "While there is limited promise in the naturalistic study of the therapeutic process, there does seem to be a significant source of hypotheses and methods in the observation of spontaneous change processes which occur in the natural course of life events," (Bergin & Strupp, 1970). This indicates that naturalistic designs may be relevant for initial investigation into the effectiveness of therapy or as a stimulus to further research.

Experimental-Manipulative Designs

Experimental-manipulative studies were used in psychology in the 1950's by behavioral psychologists who moved psychotherapy into the laboratory and opened up controlled experimentation in behaviour modification (Kiesler, 1971). The general strategy of these designs involved the manipulation of one or more independent variables while attempting to control for other relevant variables by holding them constant or using random assignment of individuals to experimental groups. The aim was to determine the differential effects of the manipulated treatment or treatments and to establish causality between the dependent and independent variables. In practical terms, this meant describing the types of interventions that produced desired changes in specific patients or patient groups. These

designs were predominantly based on between group comparison approaches to psychological research.

Experimental-manipulative designs appear to be influenced by the work of Fisher during the 1930's and later by Campbell and Stanely in the 1960's. Fisher's contribution involved the development of statistical procedures that would allow inferences to be made with regard to the relationship between the independent and dependent variables (Campbell & Stanely, 1963). Fisher was an agronomist who attempted to find ways to generalize findings from one group or plot of land to the larger group or plot from which the sample was taken. Fisher worked out the properties of statistical tests which made it possible to estimate the relevance of data obtained from one small group with certain characteristics to the universe of individuals (Barlow & Herson, 1984). This marked the beginning of random assignment to experimental groups and reinforced the use of comparison group approaches to basic research.

Although Fisher's work was completed in the 1930's, it was not until the 1950's that applied psychology began to make use of experimental-manipulative designs. Underwood's (1957) authoritative book on the topic of psychological research directed clinicians and academics to ground their work in the scientific method. He encouraged researchers to search for general laws in human behaviour and to explain causal relationships between treatment and outcome. In accomplishing this task, Underwood (1957) strongly advocated for the group comparison approach to psychological experimentation which he believed were the most appropriate for determining causality and were the only ones suited to the statistical procedures developed by Fisher.

Underwood indicated that researchers and clinicians should be concerned with clearly defining and describing "the gross components of the research situation, namely, stimuli, organisms and responses," (Underwood, 1957, p.17). This was to facilitate the understanding of the effects of manipulating one of these components. Underwood built on the factorial designs of Fisher which addressed the existence of multiple variables. This was seen to be an improvement from naturalistic studies which were not as helpful in isolating variables to determine their relationship in the process of change.

Generalist manipulative experimental studies continued to be the dominant form of clinical research throughout the 1970's and into the mid 1980's. Chassen's (1979) revised book on research design in clinical psychology and psychiatry received much attention for his proposal of the extensive model of research design. This model followed from Underwood's work in that the use of comparison groups formed the core design alternatives. The essential features of Chassen's extensive designs involved estimating the relative efficacy of therapy by testing hypotheses across patients. Chassen (1979), like Underwood, was concerned with the use of numerical summaries of data gathered from groups of therapy patients. These numerical summaries involved proportional representations of the number of clients who improved, or arithmetic averages taken from rating scales. The extensive model pertained to research with groups of individuals.

It is important to note that Chassen mentions an alternative research model which he terms the intensive model. This model is in contrast to the extensive model in that hypotheses are tested within individuals rather than across individuals. Mathematical summaries are less relevant to the intensive model as the data from each patient is analyzed separately. Chassen's

recognition of an alternative approach to clinical research was noted as significant by theorists who were examining the value of single subject designs for clinical evaluation (Kazdin, 1986). Perhaps this was due to the growing realization that group comparison approaches and manipulative approaches demonstrated weaknesses in inferring causality and in practical clinical application.

Although manipulative experimental designs permitted better description of causal relationships than was possible in earlier naturalistic studies, interpretive errors remained as a threat to clearly understanding the relationship between the dependent and independent variables. The basic interpretive problem appeared to lie with the matter of control and ensuring that all factors which may be relevant to the dependent variable were held constant or monitored during the clinical trials (Kiesler, 1971). This was important given the emphasis on statistical interpretation and the lack of a means for addressing the problem of internal validity through statistical manipulation. In addition, since controlled treatment comparisons were not made within subjects, there was no way to interpret or account for change in an individual participant (Leitenberg, 1973).

Underwood (1957) offered several suggestions for researchers and clinicians to resolve the problem of confounding variables. One such method was the replication of the study. Another was to build one or more potentially relevant variables into the experimental design as additional independent variables. By incorporating additional dimensions, researchers could evaluate whether the factor had significant effects on the dependent variable and the extent to which an interaction between variables influences the process of change (Kiesler, 1971). Although these suggestions assist researchers and clinicians in understanding

the role of confounding variables, this remains as a problem in psychological research because of the applied nature of the science which is carried out in complex natural settings.

The means for addressing the problems of confounding variables appeared to add to the practical difficulties that were experienced by researchers and clinicians attempting to evaluate therapeutic interventions. Traditional experimental-manipulative studies made use of complex statistical procedures and required large groups of individuals to participate in the research and control groups. This was practically difficult for clinicians who wanted to evaluate the effectiveness of their practice with individual clients (Gingerich, 1990). In addition, as numerical summaries of group results were often based on averages the magnitude of change in individual clients was obscured. This may have been considered useful to those desiring information about larger programs, but were not practical for clinicians. These difficulties moved clinicians and researchers toward the search for alternative evaluation and research designs, such as single subject research designs.

Single Subject Research Designs

The single case as unit of analysis emerged as a promising approach to applied research in the early 1970's. Researchers and clinicians began to recognize the limited influence of research upon the practice of clinicians (Bergin & Strupp, 1972). Investigations of groups were seen to distort the primary phenomenon of interest through the use of group averages and case studies were recognized as not providing enough control in the experimental process (Barlow, 1980). Researchers began to look for ways in which to experiment at the case level as means of examining therapeutic effectiveness.

The development of single case research as currently practised can be traced to the work of Skinner and the experimental analysis of behaviour outlined previously (Ruckdeschel & Farris, 1981). Skinner searched for lawful behavioral processes through studying one or a view subjects and tabulating performance frequencies. He used the research subject as its own control in observing lawful behavioral processes related to an independent variable (Kazdin, 1982). The analysis of the individual as a means for assessing cause and effect relationships among therapeutic variables moved from the laboratory to the applied clinical setting.

Although much of the experimental work related to single subject designs in clinical settings involved operant conditioning as a particular behavioral approach, the use of the designs extended beyond the behavioral school of psychology (Ruckdeschel & Farris, 1981). Authors such as Kazdin (1982), Barlow and Herson (1984), Robinson and Foster (1979) have advanced the use of single subject designs within the broad field of psychology. These authors have developed the designs and advocated for their use as a means of bridging the gap between clinical psychological practice and research.

Single subject designs, as described by their proponents in psychology, are based on the quasi-experimental designs outlined by Campbell & Stanley in the mid 1960's (Ruckdeschel & Farris, 1981). The general approach to single subject designs involves the selection of a target behaviour for which change is desirable, and the repeated measurement of the behaviour over time (Robinson & Foster, 1979). This allows for the establishment of a baseline for the frequency of behaviour performance before an independent variable is introduced. Barlow and Herson (1984) suggest that in order to make conclusions about the

influence of therapy in later phases of the design, the baseline phase should continue until a stable behavioral pattern is achieved.

After a stable baseline measure of the behaviour is accomplished, the intervention is introduced to the subject and the behaviour is measured again. Some of the single subject design variations involve reversal or multiple baseline strategies (Robinson & Foster, 1979). Designs which are based on these strategies involve withdrawing the treatment or intervention under study and examining the extent to which the treatment or intervention influenced the target behaviour (Kazdin, 1982). Multiple baselines are achieved through the sequential withdrawal and introduction of the intervention or combination of interventions over time (Barlow & Herson, 1984). The analysis of research findings is primarily accomplished through visual inspection, although statistical procedures have been applied to findings from single case designs (Kazdin, 1982).

The unforeseen popularity of single subject designs as an approach to clinical evaluation appeared to be predominantly related to their practical utility in the clinical setting (Siegal & Young, 1987). The clinical setting often involved only one or a few clients and was not recognized as conducive to the use of group designs which require large numbers of relatively homogeneous subjects and typically involve the use of highly complex inferential statistics for analysis. Single subject designs were seen as inherently more flexible than other designs as they addressed the clinician's need to adjust the intervention during the course of therapy.

It is important to pay particular attention to the emergence of single subject designs in the field of clinical social work. Before the 1970's, social work professionals assumed that

their interventions were effective, even when little evidence existed to support that assumption (Blythe and Briar, 1985; Campbell, 1990; O'Hare, 1991). The use of single case research designs turned clinical social work toward the assessment of practice and is worthy of further discussion.

The issue of practise effectiveness came to the attention of researchers and practitioners in 1978 after Fischer published article that provided an overview of research literature regarding casework effectiveness. Similar to the work of Eysenck and Bergin, Fischer choose to review clinical social work research literature. He chose to review studies which he felt met minimum methodological criteria including the use control groups, random selection and measurable outcomes (Fischer, 1978). Only 11 studies met this criteria and nine of these indicated a lack of positive change.

Fischer's work set off a debate among social work professionals who believed in the validity of their interventive efforts but who had not considered empirical assessment of their work (O'Hare, 1991). Fischer's work served as a statement regarding the status of research in social work and the apparent lack of attention on the part of practitioners to establish evidence of practice effectiveness. Although Fischer appeared to advocate group designs in his early work, his later publications favoured single subject research designs and strengthened the link between single case research and social work practice (Bloom & Fischer, 1982). His books offered similar strategies to those outlined by psychologists such as Kazdin, Barlow and Herson and Robertson and Foster. The differences appeared to be related to the decreased emphasis on behavioral targets of change and the move toward subjective phenomena, such as attitudes and feelings as targets of change.

Around the same time that Fischer pointed to the need for an increase in the research activities of social work practitioners, Hudson advocated for social workers to engage in measuring client change. In 1978, he put forth two axioms of practice:

"The first states: If you cannot measure the client's problem, it does not exist. The second, a corollary of the first, states: If you cannot measure the client's problem, you cannot treat it. Since these axioms are stated as universal propositions, they may be refuted by citing only one concrete exception. Everyone is invited to find and cite such exceptions," (Hudson, 1978, p. 65).

According to Hudson, the relationship between evaluation and practice was seen to be essential. Hudson encouraged the use of single subject designs and standardized tools by developing short self-reporting scales. He compiled a package of self report instruments related to attitudes and self-perceptions which were designed to be utilized by practitioners in the clinical setting (Hudson, 1982).

The emphasis on the relationship between measurement and practice was also explored by Jayaratne and Levy (1979), and Briar and associates (1980;1985;1987). Jayaratne and Levy proposed the use of empirical clinical practice which essentially involved clinicians in using the scientific method and research process in their daily clinical practice. Single subject designs were recognized one such means for accommodating the integration of research and practice (Jayartne & Levy, 1979).

In a similar manner, Briar and his associates advocated for empirically based models of practice. Contrary to theoretically based models which have been the dominant means for approaching social work practice, these theorists suggested that research should play a significant role in the choices available to a practitioner in a given situation (Blythe & Briar, 1985). Single case designs were seen to best facilitate the use of such models as they allow

for the empirical validation of the effectiveness of theoretical approaches (Ivanoff, Blythe & Briar, 1987). In addition, Briar believed that single case evaluation may be easily adapted by practitioner-researchers who are constrained by the realities of the clinical setting (Briar, 1980).

Single subject research designs were revolutionary in their influence on clinical evaluation and the development of social work research literature. Although they continue to dominate the literature regarding clinical evaluation, critics have pointed out several limitations related to their use. First, there appears to be some limitations relating to the conflicting objectives associated with research and practice. In some instances, the experimental control required for research conflicts with clinical practice and the interests of the client (Gingerich, 1990). Albeit this also concerns other approaches to research, the role of the clinician as both practitioner and researcher carries the potential for compromises in methodological rigor or clinical intervention.

Another limitation involves the applicability of single subject designs to a range of approaches to clinical practice. Single case evaluation has been criticized for not being compatible to non-behavioral or psychodynamic approaches to practice (Applegate, 1992). Several researchers have attempted to address this issue by stating goals in measurable terms and forming intermediate goals as targets for intervention (Nelsen, 1981; Ivanoff, Blythe & Briar, 1987). Other theorists are not convinced that research techniques developed for use with a particular approach to practice, such as behaviorism, are universally applicable to all therapeutic frameworks (Gingerich, 1990).

These limitations have appeared to have little influence in changing research on clinical practice over the past decade. Single subject designs continue to be highly regarded as useful for both psychologists and social workers doing research in applied settings (Kazdin, 1982; Robinson, Bronson & Blythe, 1988). They have been used as a means of helping practitioners evaluate client progress, make treatment decisions and establish a degree of accountability. It is the use of single case evaluation designs as mechanisms for accountability that has resulted in their use for the evaluation of social service programs. Although their use in this regard has been limited, single case research designs may be considered responsible for providing the practical tools for social workers and administrators to examine the effectiveness of programs.

2.2.4 Summary

Clinical evaluation strategies originated in the field of applied experimental psychology. Early psychoanalytic and behavioural theorists advanced the use of assessment methods to determine the effectiveness of therapeutic intervention. Clinical evaluation in social work may be considered a more recent development resulting from improved methodologies and efforts directed toward maintaining accountability.

The evaluation of clinical intervention has changed emphasis since the initial studies in applied psychology. Evaluation research has shifted from a focus on the individual, such as with the case study approach, to studying groups of individuals. In recent years, group approaches to clinical evaluation have been replaced with research designs which focus once again on the individual. The emergence of these single subject designs has provided a

practical means for clinical practitioners to make inferences regarding the effects of the intervention.

Scientific rigor and empirical validation have assumed increasing roles in the assessment of client change. Current evaluation strategies appear to take into account the practical difficulties associated with implementing group research approaches which are considered more methodologically sound. This has resulted in the use of research approaches that are adaptable to small groups or which utilize several different approaches. The emphasis on considering both validity and practical implementation has served as an improvement to clinical evaluation methods.

The improved technology and methodology appears to have increased evaluative efforts of clinicians. Although practitioners may experience difficulty in assuming the roles of both practitioner and researcher, there is expanded potential for evaluation to occur at the case level. This in turn, may be beneficial to those who are concerned with issues of accountability and it is plausible that information obtained through case level evaluation may be highly useful for decision makers and others interested in the effectiveness of therapeutic intervention.

2.3 INTEGRATION AND UTILITY: A SYNTHESIS OF THE LITERATURE

The development of program and clinical evaluation approaches have clearly been influenced by different theoretical orientations and different social contexts. As a result, each has been applied to distinct, yet interrelated, domains of the social world. While program evaluation has occurred within the context of social programs which aim to ameliorate the

needs of groups or sub-populations, clinical evaluation has been concerned with addressing the needs of individuals who experience psychosocial difficulties.

The differences in the origins of clinical evaluation and program evaluation have resulted in different applications of each. Program evaluation in human service organizations began as a means for fostering accountability and to affirm that resources were being applied to social problems in the most effective manner possible (Hudson & Mayne, 1992). Conversely, clinical evaluation began as applied research with the goal of developing theory and determining interventions that had the potential to be generalized to other clinical settings (Barlow & Hersen, 1984). More recently, efforts directed toward maintaining accountability have served to increase clinical evaluation activities.

Just as these differences have contributed to the virtual separation of clinical evaluation from program evaluation activities, they have also resulted in differences in perceptions of the results each may yield. The research questions associated with the evaluation of programs are often directed toward service activities and the demonstration of the efficacy of programs in terms of client outcome (Doueck & Bondanza, 1990). The research questions associated with clinical evaluation are also aimed at producing knowledge regarding client outcomes, but generally involve clearly specifying the interventions undertaken (Kuechler, Velasquez & White, 1988).

Although the historical development of program and clinical evaluation has led to the separate use of each strategy, there exist some similarities in the contextual factors which have influenced the development of both approaches. Early program and clinical evaluation efforts appeared to emerge from an emphasis on the examination of the individual. The

intelligence testing of Galton and Binet utilized information obtained through individual assessment for evaluation of groups and programs. In a similar manner, the 1960's brought about an increased emphasis on methodology and scientific rigor in the both clinical and program evaluation strategies. This appeared to result from the influence of positivism, and the need to legitimize both social interventions and evaluation as a unique aspect of social research.

The utilization of evaluation findings emerged in the 1970's as an issue of importance for program and clinical evaluators. Both evaluation strategies experienced a shift in methodology and approach that placed utility as the paramount consideration. The past decade has seen changes in evaluation methodologies employed and the purposes for which program evaluations are conducted. Current trends have shifted from an emphasis on controlled research, to focus on approaches that are flexible and best able to meet the information needs of all those involved in the evaluation (Kuechler, Velesquez & White, 1988). This has resulted in the development and acceptance of different methods for evaluating programs which are more suited to the purposes of the evaluation being undertaken and the objectives of the program. In the same manner, clinical evaluation strategies have shifted focus over the past few decades, to address the needs of practitioners for useful information that can be obtained through practical means. This balance between the provision of information that is valid and useful is also valuable for meeting the accountability needs of decision makers and administrators. It appears that the trend toward service accountability has influenced the field of both clinical and program evaluation as the

literature indicates that evaluators are being forced to be more adaptable to the changing information needs of evaluation consumers.

Current evaluation literature reveals little in the way of examples which demonstrate the integration of clinical evaluation and program evaluation activities. It may be assumed that this is the result of the previously mentioned differences in origins and theoretical foundations of each or of simplistic notions of adding the two. Although these differences have, in the past, served as obstacles to the full integration of clinical evaluation procedures with program evaluation purposes, there exist similarities in factors related to the historical context in which each has developed. It is conceivable that the different purposes for which each are traditionally used may be reconciled and that an integrated approach may better serve those who are working toward understanding and improving human service organizations.

The nature of the link between clinical and program evaluation approaches is not clear from the literature. Beyond the shared goal of implementing practical evaluation strategies and providing useful information, little else leads to the consideration of an integrated approach. As mentioned earlier, perhaps an examination of the purposes for which evaluations are conducted may offer some understanding of the potential link between clinical and program evaluation. Cheliminsky (1978) outlines three purposes for evaluating interventions and programs which serve to give direction to the process of evaluation and to determine the results intended. These purposes include the generation of knowledge regarding social problems and corresponding interventions, the collection of information to be used for program or service management, and the production of information on the performance of the service for purposes of accountability to funders and others. Each of

these will be explored in relation to the potential for the integration of what may be traditionally considered clinical and program evaluation components.

2.3.1 Evaluation As a Means of Increasing Knowledge

Evaluation research is often utilized as a means of increasing the fundamental knowledge of some particular problem and the intervention associated with addressing the problem (Mayne & Hudson, 1992). In keeping with that purpose, it can be assumed that some evaluation efforts are aimed at producing knowledge which may be generalized to a variety of situations. While clinical evaluation may provide important and useful information regarding the intervention utilized, program evaluation strategies may reveal the administrative and political context of overall service delivery. This, in turn, leads to a full description of the intervention and its context.

Historically, both program and clinical evaluation strategies have been employed as means for increasing knowledge about social problems and social interventions. As noted in earlier, clinical evaluation was developed out of the study of psychology and the growth of psychological theory. In a similar manner, program evaluation was influenced by the desire to produce knowledge about social problems and their amelioration through large scale social programs.

It appears that program and clinical evaluation have been used as a means for producing knowledge about the social world. Although evaluation research is often intended to lead to direct action to change a specific program, sometimes evaluation is used to increase the fundamental understanding of social problems and ways in which to address the problems.

In more specific terms, the purposes of evaluation efforts are often directed toward producing knowledge that can be generalized to other settings, places and time periods (Hudson & Mayne, 1992). This is especially evident in the evaluation of demonstration projects which historically have sought to contribute to existing knowledge about a particular social problem. Case level evaluation and program evaluation methods are able to generate knowledge regarding particular aspects of social service activities and outcomes.

Case level evaluation methods provide very specific information about the intervention and the results produced in clinical settings. Although researchers have acknowledged the lack of relevance of clinical research in guiding clinical practice, much of the problem can be attributed to the use of traditional research designs that do not examine the context of the individual and the intervention. Information resulting from the use of single subject designs appears to address both researcher's and decision-maker's concerns regarding the context of the research and ability of the knowledge to be generalized to other organizations or service settings and program evaluation designs. Program evaluation methodologies contribute to the generation of knowledge by offering a means to understanding the specific conditions under which the intervention is employed and by providing information on overall service delivery and context.

2.3.2 Evaluation as a Means of Improving Program Delivery

Evaluation research has long been considered an aid to the management and improvement of service delivery. Clinical evaluation strategies have been suggested by several authors (Doueck & Bondanza, 1990; McCroskey & Nelson, 1989; Thomlinson,

Sieppert & Grinnell, 1992) as a means for giving agency administrators and decision makers information on program activities and effectiveness. Doueck and Bondanza (1990) make a specific argument for the utility of single-case designs in producing valuable information for program supervisors and administrators. These authors believe that demonstrations of program effectiveness through single-subject research may be used by program managers to enhance the decision making process and to generate information regarding the structures of existing programs. Likewise, Thomlison et al. (1992) suggest that single-system research designs reinforce program evaluation and program planning at the program level and they may be used to enhance practice at all client system levels.

Clinical evaluation techniques may also generate important information regarding intervention strategies. Agency administrators may find it useful to know, in precise terms, the intervention strategies that are being used to accomplish program goals and objectives. Single subject research, as a specific clinical evaluation design, requires that practitioners clearly define and operationalize treatment approaches and interventions before assessing change (Nelson, 1981; Proctor, 1990). O'Hare (1991) suggests that clinical assessment efforts may be directed toward understanding what intervention methods are comparably beneficial to clients at less cost in time, money and clinical effort. Although this relates directly to issues of accountability, it also speaks to program management functions and to the need for decision makers to have information regarding the types of intervention that have yielded acceptable outcomes in an efficient manner.

Finally, with regard to program management, a clinical evaluation component integrated with a program evaluation component may provide useful information on client

outcomes (Thomlison, Sieppart & Grinnell, 1992). While program evaluation generally does not concern client improvement at individual case level, clinical evaluation generally takes into account specific client outcomes and client satisfaction with service. Combined approach to the selection and implementation of evaluation strategies may yield empirical evidence regarding program effectiveness. This type of information has the potential to be of great benefit to line workers by giving them feedback on the services they provide. This information is also important to decision makers and administrators as it may provide the foundation for rational planning in human service organizations.

2.3.3 Evaluation as a Means of Providing Accountability

In an era of diminishing resources, it has become increasingly important for human service organizations to demonstrate the efficacy of their intervention strategies. This has influenced recent developments in both program and clinical evaluation strategies. The evaluation of programs has been deemed to be an important means for justifying expenditures for those who fund programs and those who are recipients of service. Subjective indicators of practitioner competence and figures reflecting client usage are no longer considered adequate justification for the existence of a program or intervention (Mayne & Hudson, 1992). Instead, there is a growing demand for more objective evidence regarding the outcomes associated with specific service activities. The integration of clinical evaluation with program evaluation may satisfy stakeholder demands for valid data in the determination of client outcomes and overall program effectiveness.

Clinical evaluation methodology over the last several years has been most closely linked to the use of single subject designs. These research designs are increasingly being recognized as the most useful method for evaluating specific interventions in clinical settings. Single case designs are considered as more methodologically sound than the uncontrolled case study. Additionally, the designs utilize data gathered from clinical settings and thus may be generalized to other real contexts. As well, it has been argued that single-subject designs enable researchers to utilize standardized objective measures and sophisticated procedures lacking in other approaches to studying client change (Thomlison, Sieppert & Grinnell, 1992).

This is of particular interest to those who require more empirical evidence of program efficacy.

2.4 SUMMARY

The conclusions derived from a review of the literature and the consideration of the integration of clinical and program evaluation strategies may be summarized as follows:

- Program and clinical evaluation approaches developed out of different theoretical origins. As a result, each has been applied to distinct, yet interrelated, domains of the social world. Program evaluation has occurred within the context of social programs which aim to ameliorate the needs of groups or sub-populations, whereas clinical evaluation has been concerned with addressing the needs of individuals who experience psychosocial difficulties.

- Although there are differences in the methods and technology of program and clinical evaluation, both have experienced similar trends with regard to the increasing consideration for validity, utility and practical application of methods. This appears to have resulted in more adaptable evaluation approaches which aim to meet the needs of all those involved in the evaluation.

- The link between program and clinical evaluation strategies has not been clarified in the current literature. It has been suggested that consideration of the purposes for which evaluations are conducted may offer a means for conceptualizing the potential relationship. The purposes for which evaluations are conducted and the rationale for an integrated approach as a means of better achieving the identified purposes may be summarized as follows;
 - A) A clinical evaluation component integrated with the design of an overall program evaluation compels practitioners to specify and operationalize service activities. The resulting information is useful to program planners and administrators who are concerned with long and short-term program management.

- B) Clinical evaluation provides information on individual client outcomes while the evaluation of programs generally examines global aspects of client change. Detailed information on client outcome is increasingly being demanded by funders and others who desire accountability from human service organizations.
- C) The use of clinical evaluation strategies produce knowledge regarding a particular intervention's ability to effectively deal with specific social problems. Incorporating a clinical evaluation component within the design of a program evaluation will not only give the individual practitioner information on personal performance, but may advance the use of an innovative intervention strategy.

3.0 APPLICATION OF AN INTEGRATED APPROACH

The practicum was completed within the context of Campbell & Heinrich Research Associates (CHRA) between December 1994 and April 1995. The student was involved in the early phases of the evaluation and participated in the initial meetings with staff and administrative representatives. Responsibilities associated with the practicum included the development and implementation of data collection instruments, data collection and analysis.

CHRA is a private research and consulting firm that has had extensive experience evaluating social service and health related programs. CHRA adopts a collaborative approach to evaluation which endeavours to meet the information needs of those involved in the evaluation and the users of the findings. In accordance with practical and methodological considerations, CHRA may incorporate a clinical evaluation design component into the program evaluation design. In the past, CHRA has used such an integrated approach to evaluating social service organizations.

In November 1993, CHRA was contracted by MacDonald Youth Services (MYS) to complete an evaluation of the Edgewood Program for male adolescent sexual offenders. The original evaluation plan outlined an 18 month evaluation which would end in April 1995. Due to a change in the duration of treatment, the evaluation was extended to 24 months ending in December 1995. The next section describes the evaluation including a description of the Edgewood program, the evaluation design and data collection methods. An outline of practicum activities will follow the description of the evaluation.

3.1 Practicum Context: The Edgewood Program Evaluation

3.1.1 The Edgewood Program

The Edgewood Program of Macdonald Youth Services is a structured residential treatment program for male adolescent sex offenders. The Program incorporates a variety of psychotherapeutic, cognitive and behavioural elements in the treatment process. The Edgewood Program is delivered in an open community based setting and provides residential services to six high risk youth, after care services to program graduates, and support and short-term family therapy to offenders' families. The program is funded by the Manitoba Department of Family Services. In recognition of the multiple needs of this population, resources additional to those generally provided to a residential care unit have been allocated to the Edgewood Program. Program documents indicate that the overall goal of treatment for every offender admitted to Edgewood is total abstinence from sexual offending behaviour.

Clients access the Edgewood Program through referral from mandated child welfare agencies. In order to be eligible for admission to the Program, clients must be between the ages of 13 and 17 years and be considered to require a highly structured placement. In addition, clients must have committed a hands-on sexual offense and accept some responsibility for the offending behaviours. Because treatment at Edgewood requires the integration of knowledge with personal experience, clients must be developmentally and intellectually capable of participating in group living and treatment. Clients must also have educational or employment alternatives available as the Edgewood Program does not provide day programs.

The Edgewood Program is staffed by one clinical case manager, one treatment worker supervisor, six treatment workers and a pool of relief workers. In addition, a liaison worker is available half time to provide after care services to discharged clients. The treatment workers are trained child care workers and the clinical case manager is a social worker. Edgewood staff are selected on the basis of past experience and training in the area of adolescent sex offender treatment.

The integrated model of treatment offered at the Edgewood Program includes assessment, individualized treatment schedules, sex offender specific peer group therapy, individual therapy and after care services. Family therapy is also provided through the Edgewood Program. Edgewood's approach to offender treatment can generally be considered cognitive behavioural as treatment focuses on teaching the offenders new perceptual and cognitive thinking patterns. In addition, elements of the relapse prevention model are incorporated into treatment for the purpose of developing control plans with clients. The relapse prevention model is based on the premise that re-offending can be avoided by understanding the behavioural, cognitive, social and environmental components associated with the offending behaviours. It is implied in this model that individuals can control their behaviour through understanding the thought patterns and external influences which relate to their offending behaviours.

The assessment begins at referral and focuses on the client's amenability to treatment, risk level, functioning level and prognosis for success. In some cases, assessment consists of two interviews with the client, the referring worker and family members. Legal and other documents regarding the client's history are then reviewed. The assessment information is

compiled and used to shape the individual treatment plan of the offender. Unfortunately the comprehensive nature of the assessment process is sometimes compromised by the lack of information that is provided on the offenders by referring or collateral agencies. In addition, the pre-admission assessment process has been accelerated on a few occasions for different reasons. In these instances, the initial assessment has been completed while the adolescent is in the program.

In order to ensure that the client is progressing through treatment, a levelling system has been implemented as part of the individual treatment schedules of Edgewood clients. Each of the six levels or stages of treatment at Edgewood is accompanied by corresponding indicators of successful performance in group and individual therapy. After the offender consistently demonstrates the behaviours associated with a particular level or stage of treatment, he is moved on to the next level and the corresponding behavioural expectations are increased. The time required for the completion of each level varies in length from two to eight weeks depending on the individual offender. Originally, the program was to involve clients for a period of 8-10 months in residential treatment and a minimum of six months in the after care program. After a year of operation, staff have realized that this may not be a realistic expectation for all clients, as some adolescents require from four to six months to build trusting relationships with staff and other participants before they begin demonstrating the desired behaviours. This has impeded progression through the stages of treatment, and staff believe some clients may require almost 18 months to complete the program.

Sex offender specific peer group therapy forms the core of services provided by the Edgewood Program. The groups are open to new participants at any time in order to

facilitate the different treatment requirements of individual clients. Clients enter the group as soon as they move into the Edgewood house. Group meetings occur twice weekly and average between 1-2 hours in duration. One of the group sessions is dedicated to the provision of psycho-educational material including teaching and task oriented activities derived from the Psycho-educational Curriculum for Adolescent Sex Offenders developed by Joseph Richardson, Peter Loss and Jonathan Ross (1988). This material is used to teach factual information and concepts related to cognitive thinking patterns, offending behaviours and the offender's own victimization. The other weekly group session is designated as a process group in which participants are encouraged to integrate information learned during the psycho-educational group with personal experience. Within the process group participants are invited to share past experiences with respect to offending and victimization. Participants are also confronted in regard to cognitive distortions and rationalizations, and are challenged to understand the impact of the offense upon the victim.

Therapeutic work accomplished through group therapy is augmented by an individual therapy component. Edgewood Program participants are required to attend two weekly individual treatment sessions with an assigned treatment worker. Sessions range in length from 1-2 hours and may encompass a variety of issues. Often the individual therapy time is spent in preparation for group, either through a review of material covered in previous sessions or by preparing the adolescent to share personal issues. Individual therapy may also include work related to the client's family of origin or the resolution of issues that arise from group living.

The above mentioned elements of the Edgewood Program are set in the context of a residential setting. This is seen by the program to enhance the process of treatment as the different components of the program relate to each other and support one another. Having the clients reside at the place of treatment also results in the opportunity to provide intensive, highly structured services to clients who may be at a great risk of re-offending. As well, information with regard to individual client progress may be monitored by members of the treatment team and incorporated into the daily activities of the client.

Since the beginning of the Edgewood Program, staff have noted the importance of building better relationships between clients and their families. In response to the adolescents' treatment issues and to the requests from families for support and information, the program has taken on an increased role in the provision of services to families. These services include short-term or crisis oriented family sessions that are facilitated by the clinical case manager or the treatment worker supervisor.

One of the unique aspects of sex offender specific treatment at the Edgewood Program is the after care service component. Near the completion of residential treatment, each client engages with a liaison worker who assists them in the process of discharge from the Edgewood Program. The liaison worker acts as a resource to the offender and the family or caregivers after the client moves out of the Edgewood residence. As continued attendance in group is required of the offender, the liaison worker monitors attendance and assists the offender in making healthy life choices. Clients remain in the after care component of the Edgewood Program for a minimum of six months. Recently, Edgewood has initiated a therapeutic group specifically for after care clients.

With respect to the after care component, it is important to note that the staff responsible for providing the after care services is also employed by the Edgewood Program as a treatment worker. This provides an excellent opportunity for continuity of treatment, and allows the after care component to be clearly linked to the Program through the liaison worker's participation as a member of the treatment team.

3.1.2 The Evaluation Design

As mentioned earlier, CHRA was contacted by MYS in November 1993 to discuss involvement in the evaluation of the Edgewood Program. The evaluation was initiated by MYS and was to fulfil several purposes: 1) to describe the unique characteristics of the Edgewood Program; 2) to document the effectiveness of the Edgewood Program in reducing recidivism with regard to sexual and non-sexual offenses; 3) to assess the effectiveness of the program in improving the psychosocial functioning of program participants and 4) to document the cost of care in relation to alternative forms of treatment. In addition to the involvement of the program staff and administrators, an evaluation advisory committee comprised of representatives from other sex offender treatment services in Manitoba was developed to guide the evaluation process.

The proposed research design of the Edgewood Program evaluation included five specific components; (1) a documents review and interviews with program staff and other service providers for the purpose of developing a detailed description of the program; (2) a file review which provided information on the client population; (3) an AB single case design with follow-up which monitored the Edgewood youths' offending behaviour prior to, during

and after treatment; (4) a one group pre-test posttest design which involved the collection of psycho-social and behavioural information from the adolescents and Edgewood Program staff; and (5) a between group comparison design which focused on offending behaviour and cost of care that would compare adolescents in the Program with a matched group of youths from Community and Youth Corrections. The design components are described in detail below.

Documents Review and Staff Interviews

A review of program literature and interviews with staff were conducted for the purpose of developing a detailed description of the Edgewood Program. Based on the literature, staff interviews and information obtained from other Manitoba sex offender treatment programs, the unique characteristics of the Edgewood Program were examined.

File Review

One aspect of the evaluation was the development of a description of the sex offenders who were involved in the Edgewood Program. A file review provided basic descriptive information on the adolescents and summarized data contained on intake forms and in case notes. Demographic information and data pertaining to identified problems was summarized as part of the file review.

AB Single Case Design

Referring agencies were asked to provide detailed histories on the adolescents admitted to the Edgewood Program. The information that was collected included an offense history and a description of the adolescent's behaviour prior to placement. This pre-admission information on offending behaviour served as a baseline for the evaluation and was compared

to information collected during and after admission to the program. This design element was considered the most closely related to what may be traditionally considered clinical evaluation.

One Group Pre-test Posttest Design

A number of standardized psychosocial inventories were completed by program participants as part of the initial assessment and admission process. These instruments were selected in consultation with program staff and in accordance with identified program goals and objectives. The assessment package included the Piers-Harris Children's Self Concept Scale, the State-Trait Anger Expression Inventory, the Beck Depression Inventory and the Loss and Ross Risk Assessment Scale. The results of these inventories were used as pre-test scores. Posttest scores were derived from re-administration of the instruments midway through treatment and prior to discharge from the program. A detailed description of the measures and their psychometric properties was provided in an interim report.

In addition, several rating scales were developed specifically for the Edgewood Program to assess aspects of behaviour and cognition that were deemed as important indicators of change by staff. One of these scales was developed by staff to examine the extent to which the adolescents engage in responsible behaviours. Changes in the demonstration of pre-assaultive behaviours was assessed through a staff completed rating scale developed by the evaluators. Victim empathy, which has been identified as an important component of offender treatment, was evaluated based on qualitative methods which asked staff and program participants to describe the offense or offenses which precipitated entrance into treatment, as well as to describe the offender's understanding of the impact of the offence

upon the victim. A complete description of the assessment package is contained within the interim evaluation report found in Appendix A.

Between Group Comparison Design

A between group comparison design was utilized to evaluate the effectiveness of the Edgewood Program in reducing sexual and non-sexual offending behaviours. A group of 26 adolescent sex offenders from Community and Youth Corrections whose probation orders were terminated in 1992 served as the comparison group. The original evaluation design called for a matched comparison group based on selected criteria deemed of relevance to treatment outcomes. As the total number of sex offenders whose order was terminated in 1992 was relatively small (n=25), all the offenders were included in the comparison group. Sexual and non-sexual offending behaviour and the cost of care for each Edgewood Program participant and each Community Youth and Corrections Participant were monitored. As the evaluation will not be completed until December 1995, this design component is still in progress.

3.2 Practicum Activities

The practicum activities encompassed a wide range of tasks associated with the Edgewood Program evaluation. The completion of almost all the design elements were related to an approach which integrated clinical and program evaluation strategies. However, particular emphasis was placed on completing tasks which demonstrated the integration of clinical and program evaluation. These were seen to include components of the evaluation which informed direct service workers with regard to client characteristics and client change.

Likewise, practicum activities also included components which provided administrators with information pertaining to the program as a whole, through the use of methods associated with clinical and program evaluation approaches.

The practicum activities may be conceptualized as being related to three components of the Edgewood Program evaluation. The first, involved the preparatory work conducted with staff and administrators which aimed to solicit important information about the program while providing knowledge with regard to the evaluation process. The second component related to the process of the evaluation and incorporated activities which were related to implementing an approach which integrated clinical and program evaluation. Dissemination of the evaluation findings and the mechanisms for providing feedback to staff and administrators comprised the third component of practicum activities. These three components provide a framework from which to describe and discuss the activities completed as part of the practicum.

3.2.1 Evaluation Knowledge and Preparation

Practicum activities began with the process of defining and clarifying goals and objectives with direct service workers and representatives of administration. This was an important element in implementing an integrated approach as it allowed the student evaluator to contribute to the process of determining service priorities and the examination of individual treatment goals in the context of the program and sponsoring agency. Clarifying goals and objectives provided the evaluator and the staff with a shared understanding of the relationship

between service objectives, service activities and outcomes. In addition, this information laid the foundation for identifying indicators of client improvement over the course of treatment.

A clinical measures package was developed to assess client change over time in regard to psychosocial behaviours and characteristics which were deemed by staff to be indicators of success in treatment. The clinical measures were selected on the basis of their suitability to the assessment of the identified goals and objectives, as well as on the type of information each instrument could yield. Emphasis was placed on achieving a balance between the program's needs for information on client outcome, and individual workers' needs for feedback on clinical performance in client progress. It was anticipated that taking into account direct service workers' information needs, as well as the practical issues related to measures administration, would result in the use of the instruments as therapeutic process tools.

The initial process of clarifying goals and objectives may be considered unique to the use of an approach which integrates clinical and program evaluation. Reconciling the clinical goals and objectives of individual workers with the goals and objectives of the program as a whole was necessary for the integration of clinical and program evaluation strategies as it allowed for the links between individual outcomes and program outcomes to be understood. This process appeared to be useful to direct service workers in that data collection instruments were implemented to ensure consistency across workers and to keep workers focused on the identified goals and objectives. For administrators, the process of determining priorities among goals and objectives was seen to be important to understanding the treatment process and for program planning. The work associated with clarifying service objectives and

informing on the process of the evaluation appeared to provide all those involved in the evaluation with an understanding of the evaluation process and with expectations regarding the findings.

3.2.2 The Evaluation Process

Activities related to the process of the evaluation primarily involved data collection and periodic monitoring of staff information needs. Putting into place mechanisms to ensure completion of the clinical measures was a significant component of the process of the evaluation. Other components of the evaluation which could be more traditionally associated with a program evaluation approach were also completed as practicum activities associated with the evaluation process.

Protocol for ensuring consistent data collection was developed by the student evaluator in the early stages of the evaluation. The student evaluator provided staff with information about each measure and trained staff regarding the administration of the measures to clients. In addition, the clinical case manager was given instructions for scoring and interpretation of the measures. After several months, it became apparent that staff were not being provided with timely feedback regarding by the clinical case manager. In order to promote the assessment instruments as relevant to the work of the direct service workers, several staff were trained to score and interpret the measures. Once again, it was anticipated that staff would be more likely to use the instruments as clinical evaluation tools if they received timely feedback and if the measures were deemed relevant to the treatment process.

In order to augment data collected as part of the clinical measures package, the student evaluator reviewed Edgewood Program client files. Data on demographic characteristics and family background were collected. In addition, information related to problem areas and sexual offending behaviours were included in the file review. This practicum activity, although traditionally associated with program evaluation strategies, demonstrated an integrated approach as the information obtained through the clinical evaluation component was combined with the information from the file review. This provided a more comprehensive description of client characteristics and client change over time.

The student evaluator engaged in other activities which may traditionally be related to a program evaluation approach. Protocol for obtaining information about the comparison group was prepared to be used in latter phases of the evaluation. In addition, a program description was developed based on information obtained from staff and project documents. The program description provided a comprehensive outline of the process of service delivery and the ways in which the goals identified in earlier stages were to be achieved. The relationship between the program goals, the service activities and the desired outcomes were reviewed. This appeared to be an important element in the integrated approach as it resulted in the completion of a detailed description of treatment which may be useful for direct service workers, administrators and other interested individuals.

It is important to note that the process of the evaluation was influenced by changes in the delivery of service by the Edgewood Program. The most significant was likely the extended duration of treatment for clients. As mentioned earlier, program documents originally indicated that clients would remain in treatment for six to eight months. After one

year of service delivery, staff became aware of the multiple needs of their clients which required long-term treatment and the duration of treatment was extended to 18 months. This had serious implications for the evaluation as it appeared that only a small number of boys would finish treatment during the evaluation period. The evaluation was altered to assume more of a case study approach.

Due to the small numbers of clients from which to examine outcome data, the practicum activities included the construction of clinical profiles for all boys who had been discharged from the Edgewood Program between December 1993 and March 1995 (n=5). The profiles included information obtained from the file audit, completed clinical measures and interviews with direct service workers. Constructing the clinical profiles afforded the student evaluator another opportunity to demonstrate an integrated approach. Both clinical and program evaluation strategies were used to construct the profiles and the resulting information was directed toward the information needs of direct service workers and administrators.

The unique aspects of the process of an evaluation which integrates clinical and program evaluation approaches appear to lie in the way in which the evaluator depends on direct service workers to participate in data collection. As information that is clinical in nature can best be secured through workers at the line level, they hold an important role in the evaluation. Because of this, the process seems to require mechanisms that reward direct service workers through meeting their needs for practical information about client progress. Unfortunately, in the case of the Edgewood Program evaluation the process for giving workers ongoing feedback was in place, but was not utilized extensively.

3.2.3 Dissemination of the Findings

Practicum activities related to the dissemination of the evaluation findings primarily involved the presentation of oral and written reports. The oral reports focused on preliminary findings with regard to client outcome. The clinical the profiles were presented to staff in order to provide feedback on clinical outcome and to solicit additional information about individual clients. The student evaluator also presented the clinical profiles to representatives of administration and the evaluation advisory committee.

The verbal presentation of the clinical profiles to direct service workers and representatives of administration was an important link between findings derived from what may be traditionally considered program and clinical evaluation methods. As there were only a few boys who had completed treatment mid-way through the evaluation, the profiles offered data regarding outcome in a case study format. This provided information that had the potential to be used by both direct service workers and administrators. This was evident through the preparation of a more formal written interim report.

The practicum encompassed many of the activities related to preparing an interim report which presented preliminary evaluation findings. The tasks most closely associated with disseminating the findings from an integrated approach involved the process of synthesizing the findings obtained from both of the clinical and program evaluation strategies incorporated into the evaluation design of the Edgewood Program. Although most of the activities which were associated with collecting and analysing the data for interim report may be considered part of the practicum, the analytic work related to producing information of value to direct service workers, administrators and other decision makers was the focus of

the practicum activities. This was demonstrated through the completion of an interim report which was written by the practicum student. The interim evaluation report of the Edgewood Program may be found in Appendix A.

3.3 SUMMARY AND DISCUSSION

One of the primary learning objectives of the practicum involved investigating the feasibility and utility of integrating clinical evaluation with program evaluation strategies in the evaluation of human service organizations. This was to be accomplished through the application of an integrated approach. The evaluation of the Edgewood Program of Macdonald Youth Services provided the context for the exploration of an approach which integrated clinical and program evaluation strategies.

In general, it appears that the integrated design of the Edgewood Program evaluation holds the potential to provide useful information for all those involved in the evaluation. However, the full utility of integrating clinical and program evaluation strategies is difficult to determine at this time as staff and administrators have not reviewed the interim report and have not yet examined the recommendations outlined in the report. It appears that the information provided addresses the needs of the evaluation users as identified in earlier phases of the evaluation.

The feasibility of using an approach which integrates clinical and program evaluation strategies in the evaluation of human service organizations is difficult to determine from the Edgewood Program evaluation. The small number of clients from which to collect outcome data served as an obstacle to the analysis of changes in client characteristics over time.

Although programs with smaller numbers of clients may provide a more conducive setting for an integrated approach because of the time involved in scoring and interpreting clinical measures, the statistical analysis of data obtained from small groups proves difficult. However, it is important to note that the integrated design of the Edgewood Program evaluation appeared to be more flexible than other approaches. It appears that design components easily adapted to a case study approach when changes in the duration of treatment resulted in fewer admissions and fewer subjects from which to assess change over time. For the Edgewood Program evaluation an integrated approach appeared to be well suited to the process of the evaluation.

It may also be noted that the feasibility of employing an evaluation approach which integrates clinical and program evaluation strategies is highly dependent on the involvement of program staff. An integrated approach requires a great deal of involvement from direct service workers in the collection of data regarding clinical change. The clinical youth care workers responsible for providing treatment at the Edgewood Program expressed interest in using the clinical measures and were compliant in regard to data collection. These characteristics of the Edgewood Program staff contributed to the suitability of the integrated approach for this particular evaluation. In other settings where staff may not be as willing to contribute to the evaluation, the feasibility of integrating clinical and program evaluation strategies may not be as evident.

The integration of clinical and program evaluation appears to hold some promise as a means for evaluating human service organizations. In the case of the Edgewood Program, an integrated approach was not particularly successful as staff and administrators hesitated

in making full use of the information that was provided by the evaluation. This may have been related to information transfer within the agency which resulted in the final report being poorly circulated to interested individuals. This may have been a function of the type of information in that it was not recognized as useful to the agency, or it may have been associated with practical difficulties such as the timing of the completion of the report. At the time of writing this practicum report, the student evaluator was unable to determine the exact reasons why the report was not read or acknowledged by the Edgewood Program administrators and staff but instead could only consider that feedback was not given to the evaluation team regarding the findings.

4.0 KEY INFORMANT INTERVIEWS

In order to better understand the potential utility of integrating clinical and program evaluation, interviews with key informants were conducted. The purpose of the key informant interviews was to obtain information on several themes related to the integration of clinical evaluation with program evaluation. Factors associated with the process of evaluation were considered, as well as issues related to the synthesis of goals and objectives of clinical and program evaluation. The product of evaluation efforts was also examined and was framed in the context of the utility of evaluation findings. In a similar manner, the information needs of the program or service, as identified by the key informants was considered in regard to each model's ability to adequately meet those needs.

Nine key informants were included in the sample. Key informants were selected by the student in consultation with the practicum advisor. Selection was based on general criteria related to knowledge and recent experience in regard to evaluation research. Interview participants included three direct service workers, three program administrators and three evaluators. Two representatives of the practicum placement were included in the group of key informants. Interview participants possessed a range of experience with regard to evaluation research. The direct service workers who were interviewed had only been involved in one program evaluation, and only one of these had experience with clinical evaluation. Key informants who held administrative positions had more experience with program evaluation but no experience with clinical evaluation. Of the evaluators who participated in the key informant interviews, all considered themselves to be evaluators of programs.

The findings from the key informant interviews may be organized into three sections. The first section outlines the information needs of those involved in evaluations. This includes the needs of interview participants in relation to their respective roles within an organization and the view of the evaluator in regard to their experience with stakeholder groups. The second section addresses the preferred evaluation methods and processes identified by the key informants. The final section summarizes interview participants' opinion of the potential utility of an approach which integrates clinical and program evaluation.

4.1 Information Needs

The information needs of interview participants varied somewhat according to their respective roles. The direct service workers indicated that they desired evaluative information on the effectiveness of their intervention as well as on what elements of the intervention were related to the desired outcomes. These respondents felt that this type of information could provide them with clinical direction if the feedback was offered in a timely manner. In addition to information on the outcomes associated with treatment, the direct service workers who participated in the interviews also wanted evaluation efforts to describe the process of treatment in a way that was relevant to improving worker performance.

Administrators who participated in the key informant interviews indicated that they wanted information similar to that desired by line workers but were more concerned with using the information for the purpose of program monitoring. These respondents indicated that they wanted valid data on client outcomes that would allow them to alter programs when necessary. Program administrators who participated in the key informant interviews also

noted that they wanted to have access to descriptive data about client problems and the characteristics associated with successful outcomes. The ability of programs to produce such information for funders was recognized as a way to justify the costs of programs and as a means to securing continued funding. Although information related to the unit cost of program operation was mentioned by one administrator, data on resource allocation as related to program effects was not deemed as meaningful as comprehensive service descriptions and client demographic information.

Evaluators who participated in the interviews were able to describe the information needs of all evaluation stakeholders including direct service workers, administrators, funders and other decision makers. According to the evaluators, funders are increasingly demanding information on program effectiveness and client outcomes. Evaluators believed that this may be problematic because administrators and direct service providers of programs are often afraid of committing to an evaluation that examines outcomes. It was suggested that this is due to the difficulty related to having the administrators and direct service workers articulate their approach to service provision and the associated goals and objectives. This appears to contradict the views of the administrators and direct service workers who participated in the key informant interviews, as they presented with a keen interest in clarifying their approach to intervention and service goals.

Evaluators indicated that funders and decision makers have recently begun to place a high priority on assessing the longitudinal impact of programs. Although it was recognized that such studies are costly and present with methodological problems, the benefits of

information regarding the lasting effects of programs was noted as the most useful for all those involved in the evaluation process.

4.2 Evaluation Methods and Processes

Key informants were asked to describe the type of evaluation methods that they preferred. Although a variety of techniques were mentioned, all respondents favoured evaluation methods which could be easily incorporated into the existing process of service delivery. This was recognized as a way to improve staff compliance and to better facilitate the collection of relevant information. In addition, these methods were viewed as a way to promote ongoing evaluation after the more formal evaluation had concluded.

Administrators and direct service workers felt that evaluation methods should challenge staff to develop clinical and evaluation skills. The process of the evaluation was noted by administrators and line workers as a valuable way to teach staff new skills and to induce program change when necessary. Evaluators who participated in the key informant interviews were less concerned with staff skill development and instead emphasized the use of more rigorous methods which produced valid findings.

In regard to the types of methods preferred by key informants, both qualitative and quantitative methods were deemed useful. Although administrators and direct service workers believed that qualitative data provided important information about the context of the program and client change, there was recognition that funders often require more quantitative data. The evaluators who participated in the interviews noted that quantitative

data is often considered to be more valid by funders and decision makers, who require empirical evidence of program outcomes.

4.3 An Integrated Approach

In relation to the information needs and preferred evaluation methods of evaluation users, key informants were asked to comment on the potential benefits of integrating clinical and program evaluation strategies. Direct service workers and administrators remarked that a clinical evaluation component integrated with program evaluation strategies could provide practical feedback that would allow them to monitor and modify intervention techniques. For direct service workers, an integrated evaluation approach was seen to be beneficial in that the consistency of direct service workers in setting client goals and objectives that are in keeping with overall program or agency goals could be assessed.

The integration of clinical and program evaluation approaches was generally considered beneficial as it appeared to have potential as a means for increasing workers' abilities to evaluate their own practice. This benefit appeared to be related to the evaluation tools that are often left behind by evaluators for the use of programs in ongoing evaluative efforts. Staff use of evaluation tools, such as clinical measures, were noted as a way to build additional skills among both administrators and direct service workers. Administrators felt that using clinical evaluation strategies could give individual workers a greater sense of control over the evaluation process and may reduce anxiety with regard to the evaluation.

Evaluators also believed that there could be potential benefits to an approach which integrated clinical and program evaluation strategies. These benefits included increased

motivation on the part of workers in contributing to the evaluation process. Evaluators felt that workers would be more likely to comply with data collection methods if they received direct feedback regarding the effectiveness of their intervention. This was noted as a means for informing social work practice as a whole and as a means of improving services to clients within the particular program under review. Although evaluators mentioned several benefits to an integrated approach, they were less optimistic than service providers and administrators regarding the potential utility of such an approach.

All of the key informants who participated in the interviews indicated that the greatest weakness associated with integrating clinical and program evaluation strategies was the time intensive nature of such an approach. The process of consulting with staff regarding clinical and program goal and objective clarification was noted by evaluators, administrators and direct service workers as a cumbersome endeavour. Evaluators noted that achieving a common understanding of goals and objectives among staff of human service organizations often proved difficult in that anticipated outcomes were not usually stated in measurable terms. It was suggested that this process could be complicated by an integrated approach which would require a great deal of consistency between goals formed at the client level and overall program goals formed at the agency or program level.

Direct service workers and administrators were concerned with requirements for data collection and the time necessary to complete lengthy assessments. Although these individuals indicated that they wanted more practical information and timely feedback on client outcomes, they felt that a balance should be maintained between the requirements of the evaluation and their need for information. Direct service workers and administrators

appeared to be willing to invest time and other resources in an approach which integrated clinical and program evaluation strategies, providing that the data collection mechanisms were not overly cumbersome or contrary to the logical flow of service.

Overall, an approach to evaluation which integrates clinical and program evaluation strategies was seen to have potential utility for all those involved in the evaluation process. Although most of the respondents did not have experience with an integrated approach, almost all indicated that there appear to be benefits to such an approach. According to interview participants, the benefits primarily rest in the type of information that could be potentially produced by the integration of clinical and program evaluation strategies. The resultant information was seen as holding great utility for direct service workers, administrators and funders. In addition, the process of employing an integrated approach was useful in that it may compel staff and administrators to clarify goals and objectives in measurable terms and it could facilitate the introduction of means for ongoing program monitoring.

4.4 Summary

Direct service workers, program administrators and evaluators who participated in the key informant interviews agreed that an approach to evaluation which integrated clinical and program evaluation strategies had the potential to benefit users of evaluation findings. Although many of the interview participants did not have experience with such an approach, all respondents felt that integration of the two approaches could meet the information needs of all those involved in the evaluation. For the direct service workers, the integration of

clinical and program evaluation strategies was noted as a potential means for informing practice and assessing the effectiveness of particular therapeutic approaches. Administrators felt that combining case level evaluation and program evaluation may provide them with the information about the psychosocial characteristics of their clients and may assist in clearly defining components of service delivery. Funders would likewise receive the information they require through outcome data on individual clients and groups of clients.

The process of an evaluation which integrated program and clinical evaluation strategies was noted by all key informants as holding many potential benefits in addition to the findings. Several respondents noted that the potential to learn new assessment skills and to become familiar with evaluation instruments would be valuable. It was suggested that the benefits of the process, such as the tools left behind by evaluators and ability to articulate goals and objectives, often are not reported by evaluators. Key informants noted that the process associated with the integration of clinical and program evaluation strategies carries great potential in relation to increased knowledge of evaluation strategies.

5.0 PRACTICUM EVALUATION AND CONCLUSIONS

This report describes a practicum which examined the integration of clinical and program evaluation strategies for the evaluation of human service organizations. The following learning objectives formed the foundation of the practicum:

- 1) To gain a solid understanding of the theoretical foundations of evaluation and the integration of clinical and program evaluation through an extensive review of the relevant literature.
- 2) To determine the feasibility and utility of integrating clinical evaluation with program evaluation in the evaluation of human service organizations.
- 3) To determine factors that may be considered useful and beneficial from the perspective of the users of the evaluation findings.

The learning objectives were formulated to be met through four specific components of the practicum: (1) a review of the literature; (2) interviews with key informants; (3) application of an integrated approach; and (4) a summary of the findings. This section provides an evaluation of the practicum experience and offers a summary of the findings with regard to earlier practicum components.

5.1 Evaluation of the Learning Experience and Student Performance

The practicum outlined in this report occurred over a period of approximately 18 months from December 1993 to June 1995. The activities associated with the application of an evaluation which integrated clinical and program evaluation strategies were carried out as part of a formal evaluation initiated by the Edgewood Program of Macdonald Youth Services.

During the course of the evaluation, changes to the program which resulted in a longer duration of treatment, led to minor adjustments in the evaluation design. The primary change involved lengthening the involvement of the evaluation team and providing the organization with an additional report on the findings. This resulted in an increased length of time required for completion of the practicum. As the process of gathering data, completing the analysis and disseminating the findings was not completed according the original evaluation work plan, but occurred over a much longer period of time, plans to solicit feedback from staff were not completed. In addition, a report outlining the preliminary findings was not circulated to all staff by administrators before the completion of the practicum. Unfortunately, these delays to the process of the evaluation influenced both the conclusions of the practicum and my understanding of how the learning goals and objectives were accomplished.

An evaluation of my involvement as a graduate student completing a practicum can be considered as encompassing two dimensions. The first, is related to my performance and the demonstrated ability to perform the tasks associated with the practicum. The second, involves the degree to which the learning goals were achieved through the practicum experience. As the practicum is an exercise in skill and knowledge development, each of this are important to the evaluation of the practicum experience.

Overall I believe that my performance as a student evaluator with Campbell & Heinrich Research Associates was adequate. In relation to the evaluation activities, I was available to staff when they required assistance with specific evaluation components which was demonstrated through contacts which were initiated by staff. I set aside additional time to ensure that staff were comfortable with the assessment and data collection instruments and

when it appeared that direct service workers were not receiving timely feedback, I provided them with training on scoring and interpretation. It was unfortunate that this did not result in the use of the instruments for program monitoring or as therapeutic process tools.

In regard to providing the program with information on the evaluation findings, this seemed to be a strength of my involvement. I initiated opportunities to provide oral summaries of preliminary findings with direct service workers and administrators. I also completed a comprehensive written report of the evaluation findings, which was to be disseminated to staff and interested professions working with adolescent sexual offenders in Manitoba. I made every attempt to ensure that the information was provided to the program and was conducive to use by direct service workers and administrators.

In addition to the activities associated with completing the components outlined in the research design, I believe that my performance was strengthened by my participation in activities which involved examining the context of service provision through more experiential means. Staff invited me to be a participant observer in selected elements of treatment in order to increase my knowledge of the program and to better describe program participants. This allowed for the opportunity to talk with participants about the treatment process and to inform them of the evaluation. Informal feedback from direct service workers regarding this area of my involvement in the evaluation was generally positive and was recognized as a good means for understanding service delivery issues. These activities fostered a greater level of comfort with the evaluation process among staff and might have been more beneficial if they had occurred early in the evaluation.

A broad range of skills were developed through the completion of this practicum. The process of assisting the Edgewood Program to define clinical goals and objectives and reconciling those goals with those of the overall program may be recognized as an important task in skill development. In addition, determining appropriate indicators of client change and gathering instruments to assess the indicators involved the practice of new skills related to the selection of standardized and non-standardized clinical measures. The final skill developed through the practicum was associated with the writing of the interim report and ensuring that the information gathered from what may be traditionally considered program and clinical evaluation strategies was integrated into a meaningful representation of the program and its effects.

A personal evaluation of the degree to which I achieved my second and third learning goals can best be described as couched in uncertainty. As the evaluation was extended and the practicum components which depended on the receipt of feedback from staff were delayed, it became increasingly difficult to draw conclusions from the practicum. Although the absence of solid conclusions regarding the integration of clinical and program evaluation activities may be a function of the little attention paid to the topic in the literature, there are still many issues related to its feasibility and utility unresolved.

It is difficult for me to determine if my learning goals were met because of my inability to fully comment on the strengths and weaknesses of integrated approach. However, I learned a great deal from the evaluation process and from the practicum activities. The review of the literature offered a good foundation from which to integrate practice and theory for the purpose of the Edgewood Program evaluation and for the purpose of my own

development as a practising evaluator. The comprehensive nature of the literature review met and exceeded my expectations of what I would learn about the historical development of evaluation theory.

Overall, I consider the practicum experience to be positive. Although the activities did not proceed according to the original plan because of changes to the program and other contingencies, I was provided with an opportunity to examine the obstacles faced by those who evaluate human service organizations. In addition, I was allowed to consider how these obstacles may influence the conclusions that can be drawn regarding an integrated approach.

5.2 Practicum Findings and Conclusions

As mentioned earlier, the practicum findings have been limited by changes to the evaluation process which resulted in having little feedback from Edgewood Program staff regarding the preliminary evaluation findings. A better understanding of the integrated approach adopted for the Edgewood Program evaluation may have been achieved if the evaluation had been carried out as scheduled, and if final conclusions about the program would have been offered within the time allocation of the practicum. Although this did not occur, it is important to note that the following conclusions related to integration can be considered within the context of the continuation of the evaluation.

Before summarizing the conclusions, it is important to review the operational definition of an integrated approach which was adopted for the purpose of this practicum. Activities associated with employed an evaluation design which incorporated what may be traditionally considered program and clinical evaluation strategies were conceptualized as

including three components; 1) activities related to preparing staff and program management for this approach through a process of clarifying goals and objectives; 2) tasks associated with the completion of the evaluation design such as collecting and analysing data; and 3) activities related to disseminating the findings to interested individuals and groups. These three components directed the findings and conclusions which resulted from the application of an integrated approach.

The practicum conclusions have been influenced by the primary learning objectives and may be organized into the following five sections. The first relates to the differences and similarities in the historical development of program and clinical evaluation which have influenced the separate treatment of each in the body of evaluation literature. The second, summarizes the feasibility of an integrated approach through the examination of the process of integration including the selection of methods and the ways in which the design components may be completed while employing such an approach. The utility of an integrated approach to evaluation will be discussed in the third section as it relates to the purposes for which evaluations are conducted and meets the identified information needs of those involved in the evaluation. An evaluation of the practicum findings, including a discussion of the limitations, will conclude this section.

5.2.1 Historical Influences to the Development of Clinical and Program Evaluation

A review of the literature regarding the historical development of program and clinical evaluation reveals that each arose from different contexts. While program evaluation theory originated in the public administration field and in the search for accountability in the

government organizations, clinical evaluation developed in the field of experimental psychology through the search for knowledge related to human behaviour and cognition. Although the contextual differences appeared to play a role in the absence of a link between the two approaches, similar trends in methodology and the type of information provided may be noted. Early program evaluation literature reveals an emphasis on scientific rigour and establishing causal relationships between programs and outcome indicators. In a similar manner, clinical evaluation as practised within the field of applied experimental psychology was concerned with advancing the scientific method as a means for studying human cognition and behaviour.

In the 1970's, changes in both clinical and program evaluation resulted in an increased emphasis on issues related to utilization of evaluation findings. For program evaluation, this was evidenced in the work of authors such as Patton, Wholey and Weiss who sought to encourage evaluation approaches which would yield information that was useful to stakeholders. In clinical evaluation, the emphasis on use was related to the work of Bergin and others who sought to use clinical evaluation findings as evidence of effectiveness of therapeutic interventions thus increasing the utilization by clinicians and other interested individuals.

More recent literature regarding the development of clinical and program evaluation strategies indicates a move toward flexible approaches which vary according to the context and information needs of those involved. Program evaluators have adopted a range of methods and have become concerned with factors related to the utility and validity of the findings. Clinical evaluation approaches have likewise moved toward methods which are

more practical and which yield useful and valid information about client outcomes. The current status of both clinical and program evaluation approaches appears similar in that less prescriptive means for conducting evaluations are being advanced and there is an increased awareness regarding the type of information needed by stakeholders. It appears that the integration of clinical and program evaluation is possible given the corresponding changes each approach has undergone over the past two decades.

5.2.2 The Feasibility of an Integrated Approach

Current literature does not adequately address the feasibility of an approach which integrates clinical and program evaluation strategies. Likewise, the processes and methods associated with such an approach has not been extensively discussed in the evaluation literature. As mentioned earlier, the historical development of clinical and program evaluation has been separate but reveals similar trends related to evaluation processes and methods. Both approaches have experienced a shift toward the utilization of methods which are flexible and easily adapted to the existing flow of service within the agency being evaluated. This emphasis on flexibility has resulted in the use of a wide range of methods in the program evaluation field. In the clinical evaluation literature, the increased use of single case designs can also be seen to be related to the need for flexibility and for methods which are conducive to use within an applied setting. Based on the literature, it may be suggested that an approach which integrates clinical and program evaluation is feasible as it may be more accommodating to the desire for such flexibility with regard to the evaluation design and process.

Key informants who were interviewed as part of the practicum were in agreement with the literature in that they indicated a preference for evaluation methods which correspond with the existing service delivery structure of the program, while meeting the information needs of program staff. This was defined as encompassing methods and processes which were sensitive to the time constraints of staff and the need to set priorities among evaluation tasks, as well as the suitability of the evaluation tools to the intervention being evaluated. In addition, methods and processes which increased staff skill levels were seen by key informants to be highly valuable. When asked if the preferred evaluation methods and processes could be accommodated through an integrated approach, key informants indicated that it appeared that integrating clinical and program evaluation could facilitate a better process for completing the evaluation than other approaches because it seemed to be more readily adaptable to the existing structure of service delivery. As many of the key informants did not have experience in this area, there appeared to be some question as to the use of an integrated approach as the exclusive means to incorporating the preferred methods and processes.

The processes and methods associated with an integrated approach and the concerns outlined by key informants were further explored through the completion of the Edgewood Program evaluation. The process of clarifying goals and objectives was crucial to this type of integrated evaluation because of the need to determine indicators of change at both the individual client and program levels. Although this was considered a time consuming process, it was noted by the key informants from the Edgewood Program as a way to examine the service structure and to ensure that the evaluation was in keeping with that structure. As the Edgewood Program was still in developmental stages, clarifying client and program goals and

objectives also served to promote consistency among direct service workers with regard to intervention and assessment. The exercise of clarifying goals and objectives with the Edgewood Program staff appeared to be useful beyond the need for such information for the purposes of the evaluation. The strength of this process appeared to be related to staff having a concise understanding of anticipated program effects which could be used by direct service workers and administrators.

In addition to the process of clarifying goals and objectives, determining indicators of client change and putting into place mechanisms for assessing the indicators appeared to be another important feature of the integrated evaluation design which required special attention by the evaluator and staff. After the indicators of change were identified and a clinical measures package was developed staff were assigned responsibility for ensuring the measures were completed. This could be considered a unique aspect of an integrated approach as the collection of outcome data required a commitment to the process at all levels of the organization including support from administration and compliance with regard to the clinical measures on the part of direct service workers. In the case of the Edgewood Program evaluation, there were few difficulties related to the collection of data regarding outcomes by direct service workers. However, the assessment process did not appear to be considered intrinsically valuable as it was not fully supported by the Clinical Case Manager who was responsible for providing feedback to the direct service workers on client change. Although key informants from the Edgewood Program indicated that the assessment tools were appropriate to the goals and objectives of the program and that they had the potential to be used as monitoring and process instruments, the use of the information from the measures was

limited to the formal evaluation. This did not allow for the identified potential benefits of an integrated approach to be achieved as feedback regarding client outcomes was not provided in a timely manner. This in turn, did not allow for individual evaluation of staff assessment skills or for a means to informing practice on an ongoing basis.

It is important to note that the type of integrated approach adopted for the Edgewood Program evaluation appeared to offer some flexibility with regard to data collection and analysis. Since the Edgewood Program experienced changes associated with the duration of treatment, the evaluation had to be adapted to accommodate the longer treatment duration of individual participants. The evaluation was modified to incorporate a case study approach which was easily accomplished within the existing plan for data collection. The ability to adapt the evaluation to changes in the program may be seen as a strength of an integrated approach and lends support for the feasibility of the process.

Conclusions regarding the feasibility of an integrated approach as it relates to the preferred processes and methods of program staff are difficult to determine from the Edgewood Program evaluation. Although key informants pointed to the potential for an approach which integrated clinical and program evaluation to be a better process for staff and administrators, the Edgewood Program evaluation did not indicate that this was particularly helpful. The activities related to goal and objective clarification appeared to be considered favourable but the use of clinical measures as process tools and as means for monitoring practice was not as successful. Overall, an approach which integrates clinical and program evaluation may be a viable means to evaluating a program such as the Edgewood Program;

however, a great deal of commitment at both direct service and administrative levels is required to achieve the greatest benefits from the process of an integrated design.

5.2.3 Utility of an Integrated Approach

According to the literature, evaluation activities may serve three general purposes; 1) to increase knowledge about a social problem and a corresponding intervention; 2) to monitor programs over time; and 3) to assess program outcomes or effects. These purposes coincided with the identified information needs of key informants who contributed to this study and the aims of the Edgewood Program evaluation.

Key informants who participated in the interviews desired different types of information which depended on their individual roles and responsibilities. Direct service workers indicated that they desired evaluative information on the effectiveness of their intervention, while administrators wanted information that would allow them to monitor programs. Evaluators noted that often funders and other stakeholders were interested in information that would assist in determining the transferability of the technique to other contexts.

The purposes of evaluation efforts and the types of information desired by those involved was somewhat clarified through the review of the literature and the interviews with key informants. However, the link between the information needs of all stakeholders and the ability of an approach which integrated clinical and program evaluation activities to meet those needs was less obvious. Key informants who participated in the interviews indicated that although they did not have extensive experience with an integrated approach, they felt

that it had some merit in that it held the potential to meet the information needs of all those involved in the evaluation. This was seen to be related to common sense assumptions about the importance of clarifying goals and objectives and the activities which are engaged in to meet the identified goals and objectives. The perceived ability of an integrated approach to meet the information needs of those involved in the evaluation was viewed as positive in the abstract but the lack of experience with such an approach limited the findings in this regard.

The application of an approach which integrated clinical and program evaluation strategies provided some understanding of the ways in which such an approach could fulfill the purposes of undertaking an evaluation of a human service organization. The evaluation of the Edgewood Program of Macdonald Youth Services which incorporated a clinical evaluation component within the overall evaluation of the program, aimed to provide information for a range of individuals and groups. The benefits of an integrated approach appeared to give administrators, funders and direct service workers information about client outcomes in a way that is linked to the therapeutic process and which offered a richer context to the understanding of individual clients. For administrators and funders in particular, knowledge of individual client problems and improvement, may have provided more direct information about the effects of specific program management strategies and cost-related issues. Although there was little evidence that the information was used for these purposes in the case of the Edgewood Program, administrators and funders were very interested in the verbal report of individual client change.

It may be noted that before preliminary evaluation findings were provided to the program, representatives of the Edgewood Program felt that an integrated approach would

address the information needs of all of interested individuals. However, once the preliminary findings were provided to the program, they were not shared extensively with direct service workers. This may lead to the assumption that the information was not as relevant as first anticipated and that the integrated approach may not have fulfilled the purposes for undertaking the evaluation of the Edgewood Program or the information may have been more useful to administrators and funders than to direct service workers. This must be interpreted cautiously as there may be other factors which influenced the lack of attention received by the interim evaluation findings.

Overall it is difficult to determine if an approach which integrates clinical and program evaluation better fulfills the purposes for which evaluations are undertaken than other evaluation approaches. It appears that integrating the two strategies carries the potential to meet the information needs of those who may use evaluation findings but the application of the approach during the evaluation of the Edgewood Program did not lead to significant interest in the preliminary findings on the part of program staff. Once again, it is not possible to draw further conclusions regarding the utility of an integrated approach because of the many factors which may have influenced the dissemination of the findings among staff.

5.2.4 Evaluation of the Findings and Conclusions

The practicum findings and conclusions appeared to contribute in a general way to existing knowledge regarding evaluation research. The literature review offered solid evidence of the lack of attention paid to an evaluation approach which integrates clinical and program evaluation strategies and the different historical contexts which have resulted in a

virtual separation of the two approaches. In addition, the findings encourage further study in this area and point to the need for diverse practice examples in order to determining the full utility of this approach.

Although the findings and conclusions appeared to hold the potential to benefit evaluators and increase knowledge related to evaluation theory, they were limited by several factors. First, the extended time period of the evaluation and the poor dissemination of the findings within the program resulted in very little feedback upon which to base conclusions. Although selected staff were able to comment on the application of an integrated approach, their assessment of the resultant information was not available. Given the slower than anticipated pace of the program and the evaluation, it became apparent near the end of the practicum that time would not permit the student evaluator to solicit feedback from staff. Unfortunately, all staff were not presented with the preliminary findings within a reasonable time period and therefore they were not able to comment on the utility of the evaluation approach. This severely limits the findings and leads to the conclusion that perhaps the integrated approach was not as relevant as anticipated.

The second limitation involved the process of the evaluation and the implementation of the clinical measures package. As staff were consulted regarding the inclusion of specific clinical measures in the package, it was assumed that the tools would be used for purposes beyond the formal evaluation. This did not occur even after the student invested considerable time to train staff in the completion and interpretation of the measures. The lack of attention paid to the clinical measures as therapeutic process tools limits the findings in regard to the benefits of the process associated with an integrated approach to evaluation. Although the

evaluation design focused on outcomes and did not incorporate interim or process objectives, staff articulated a commitment to using the measures for skill development and client monitoring. This did not occur which serves as a limitation to the findings and leads to concerns about the value of this process given that it was not utilized by staff beyond data collection for the formal evaluation.

The lack of examples within the literature of approaches which integrate clinical and program evaluation strategies have influenced the exploratory nature of this study and the tentative nature of the conclusions. In addition, only one type of an integrated approach was examined during this practicum which did not allow for conclusions to be drawn regarding other means of integrating the two strategies. Overall, the findings and conclusions provide a limited contribution to existing knowledge regarding evaluation theory and practice.

5.3 Summary of Implications for an Integrated Approach

A review of the literature related to the historical development of evaluation theory indicates that there has been a recent trend within both clinical and program evaluation areas to adopt evaluation approaches and methods which are flexible and best able to meet the varying information needs of all stakeholder groups. An approach to evaluation which integrates data obtained at the case level with information about the program as a whole may be one means of accommodating the search for methods which are practice based and which provide information to be used by a range of interested groups such as direct service workers, program administrators and funders.

Based on the practicum findings outlined earlier, it appears that an approach to evaluation which integrates clinical and program evaluation is feasible but the implementation of such an approach requires a strong commitment to the process at all levels of program functioning. In the case of the Edgewood Program evaluation, the process of goal and objective setting was considered a valuable exercise which resulted in a great deal of involvement from direct service workers and administrators; however, the use of data collection instruments for program monitoring and increasing worker skills was less obvious and was not used by staff beyond the formal evaluation. Although the Edgewood Program evaluation design focused on outcomes rather than processes, it appears that an integrated approach is likely to be most beneficial to direct service workers and administrators if the evaluation methods and the resulting data are considered valuable for informing practice and ongoing program monitoring.

Notwithstanding the apparent limited value of the process, the integrated approach adopted for the purposes of the Edgewood Program evaluation sufficiently accommodated changes in the program resulting from a longer duration of treatment. Because clients were remaining in treatment longer, the evaluation was extended and was altered to involve a case study approach. This points to the flexibility of the process of integrating clinical and program evaluation strategies as related to the Edgewood Program evaluation design and data collection methods and may be seen as a strength of the processes and methods utilized.

The integration of clinical and program evaluation strategies appears to be a logical means for providing information to meet the various needs of direct service workers, program administrators and funders. Although an integrated approach was considered by key

informants to offer a reasonable route to ensuring that specific information needs are met by the evaluation, it was difficult to draw conclusions based on the application of the approach within the Edgewood Program evaluation. Administrators and representatives of funders did express interest in obtaining information on outcomes for individual clients, which appeared to offer them a rich description of the context of service delivery. However, the preliminary evaluation findings were not promptly circulated to staff by program administrators, which brings into question the utility of the integrated approach for all potential evaluation users.

Speculation regarding the factors which may have influenced the lack of attention paid to the preliminary evaluation report may lead to an examination of the ways in which information is managed within the organization and the potential need for education related to using the findings from this approach. Perhaps those involved in the evaluation require the means to incorporating evaluation findings into daily program management and service delivery. Another factor related to program management and the poor dissemination of the findings may have involved political issues related to the documentation of sensitive information. Regardless of the particular reason that the findings were not reviewed by the program, the role of the program administrators in facilitating the use of the information is key and may deserve further consideration in adopting an integrated approach.

The exploratory nature of this practicum and the findings lead to the conclusion that further study is required to determine the nature of integrating clinical and program evaluation strategies. As the current evaluation literature does not adequately address a rational or method for employing an integrated approach and the case study of the Edgewood Program evaluation demonstrated only one means of integration, further application of this approach

is essential to increasing knowledge regarding its utility and determining the conditions under which it may be considered most useful.

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APPENDIX A

**THE EDGEWOOD PROGRAM
OF
MACDONALD YOUTH SERVICES**

INTERIM REPORT

MAY 1995

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SECTION 1: INTRODUCTION AND METHODOLOGY

The Edgewood Program of Macdonald Youth Services is a Level IV residential treatment program for male adolescent sexual offenders. The program was initiated as a result of Macdonald Youth Services' past experience in providing residential services to sexually aggressive individuals within their existing residential care program. This led to an increased awareness of the need for specialized services for sexual offenders in which trained and skilled staff could provide intensive treatment without creating risks for non-offending clients. The Edgewood group home was chosen as the site for the sexual offender specific residential treatment program and officially began service delivery in April 1993.

In the fall of 1993, Macdonald Youth service contracted with Campbell and Heinrich Research Associates (CHRA) to complete an evaluation of the Edgewood Program. The evaluation was initially designed to extend over a 19 month period ending in May 1995. This was altered after the first year of the evaluation as the program had experienced changes related to the duration of treatment. Although program documents originally indicated that clients would remain in treatment for 6-8 months, after the first year of service it became apparent to staff that program participants presented with multiple problems which required long term intervention. As program participants remained in the Edgewood Program for an average of 18 months, it was deemed advantageous to extend the evaluation to December 1995. This was intended to allow the evaluation team to examine behavioral and psychosocial characteristics of 8 program graduates. The evaluation design is summarized in Table 1 as follows.

TABLE 1

Research Methods and Purpose

EVALUATION COMPONENT	PURPOSE
Documents review	Describe the sexual offender specific services offered by the Edgewood Program.
Interviews with collateral service providers	Describe existing services for adolescent sexual offenders in Manitoba.
File review	Describe program participants in terms of demographic characteristics, offending behaviours and other psychosocial characteristics.
AB single case design with follow-up	Monitor offending behaviour of program participants upon discharge from the Edgewood Program.
One group pre-test posttest design	Examine change in selected psychosocial and behavioral variables over time.
Between group comparison design	Compare post-treatment offending rates and cost of care of Edgewood Program clients with a group of youth who received treatment services from Community and Youth Corrections.

This interim report is the second of three reports which will be prepared by CHRA for Macdonald Youth Services. The first report provided a description of the Edgewood Program and program participants based on information obtained from project documents, interviews with staff and a review of client files. In addition, existing services for adolescent sexual offenders in Manitoba were explored through interviews with collateral service providers. Ongoing data collection and monitoring have been the focus of evaluation activities since the first report. In addition, a preliminary investigation into the offending behaviours and post-treatment cost of care for the comparison group of participants from

Community and Youth Corrections has been conducted. The findings pertaining to the comparison group will be summarized in the final evaluation report.

From June 1995 to the completion of the evaluation in December, the evaluation team will complete the remaining components of the research design. This will include data collection activities such as periodic monitoring of Edgewood client files and clinical measures. In addition, data regarding post-treatment cost of care and offending behaviours will be assessed for Edgewood Program graduates and the comparison group from Community and Youth Corrections. Information regarding cost of care will be examined through follow-up contact with individual probation officers and information regarding offending behaviours will be accessed through Youth Court records. It is anticipated that eight Edgewood Program participants will have been discharged from the program by December 1995 which may allow for statistical analysis of change in selected psychosocial characteristics. A final evaluation report will be submitted to Macdonald Youth Services in December 1995.

This Interim Report is organized into six sections. After these introductory remarks, services for adolescent sexual offenders in Manitoba will be examined. The third section provides a description of the Edgewood Program in terms of its relationship to McDonald Youth Services, the specific treatment model employed and resource allocation. A profile of Edgewood clients and preliminary data regarding client outcome follows in sections four and five. The remainder of the report outlines conclusions and recommendations.

SECTION 2: SERVICES FOR ADOLESCENT SEXUAL OFFENDERS

In Manitoba, responsibility for the provision of services to adolescent sexual offenders has been assumed by Manitoba Justice and Manitoba Family Services. Although neither Department appears to possess a clear mandate regarding such services, both are involved in their delivery. Manitoba Justice provides service through Community and Youth Corrections, which assumes responsibility for community-based and institutional programming for adolescent sexual offenders. Manitoba Family Services is involved in treatment through the provision of resources to programs such as the Edgewood Program, and to various initiatives delivered by the mandated Aboriginal and non-Aboriginal child and family services agencies. In addition, voluntary organizations and private counselling agencies provide services to adolescent sexual offenders.

In order to gain a better understanding of the services available to adolescent sexual offenders and to determine the role of the Edgewood Program in the context of available services, personal interviews were conducted with representatives of collateral service agencies and government departments. Eleven individuals representing eight organizations were selected in consultation with the Edgewood Program for inclusion in the interview process. The service providers represented Community and Youth Corrections, West Region Child and Family Services, the Forensic Behavioral Management Clinic, Community Holistic Circle Healing and private counselling practices. The initial interviews with these service providers were completed in May 1994 and followed a standardized protocol. One year later, in May 1995, the original participants were contacted again to obtain information on program changes. Five additional participants were consulted including three representatives of service

agencies and two representatives of government departments. Data derived from the interviews was used to describe existing services for male adolescent sexual offenders, and as the basis for an analysis of issues related to the provision of services.

2.1 Description of Existing Services

Treatment services for adolescent sexual offenders in the province are provided by Manitoba Justice, by voluntary organizations that receive some or all of their funding from Manitoba Family Services, by other voluntary agencies and by private therapists. Manitoba Justice is involved in the planning and delivery of services through its Community and Youth Corrections division. These services are delivered through probation units and institutional settings such as the Manitoba Youth Centre and Aggasiz Centre for Youth. Manitoba Family Services supports offender programs in a limited way through the distribution of resources to voluntary organizations, including mandated and non-mandated Aboriginal and non-Aboriginal agencies. The mandated Aboriginal agencies that provide, or are developing, sexual offender treatment services include West Region Child and Family Services and Southwest Child and Family Services, the latter of which is involved in a unique community based initiative operating at Hollow Water First Nations. As the largest mandated agency, Winnipeg Child & Family Services delivers limited services to sexual offenders. The collaborative initiative being delivered by Community and Youth Corrections and Winnipeg Child and Family Services that was described in the preceding section of the report is the only offender program offered by this agency at the present time.

The non-mandated, non-Aboriginal voluntary organizations that provide services to the offender population are Macdonald Youth Services and Children's Home of Winnipeg. The Children's Home initiative is a recent one, and is being implemented on a very limited basis by that agency.

In addition to the involvement of the above organizations, the Forensic Behavioral Management Clinic of Native Clan provides specialized assessment and treatment services to sexual offenders. The majority of the Clinic's clients are adult sexual offenders, who are mandated to treatment by Correctional Services of Canada. Due, in part, to the demand for sexual offender treatment services and the shortage of resources in this area, private therapists are also involved in the provision of sexual offender treatment. Private therapists offer their services on a fee-for-service basis and may contract with other organizations regarding the assessment and treatment of specific offenders.

CHRA examined the treatment services available in Manitoba for adolescent sexual offenders to determine how their approaches were similar or dissimilar to the Edgewood approach. It was anticipated that this information would add to our understanding of how the Edgewood Program fits into the complement of treatment services available for adolescent sexual offenders. In addition, it was expected that a comprehensive description of existing services would allow for a discussion of the jurisdictional, policy and treatment issues related to the provision of services to this population. A brief description of the services that are available for adolescent sexual offenders in Manitoba is provided below.

2.1.1 Manitoba Justice

Manitoba Justice provides services to adolescent sexual offenders through its Community and Youth Corrections division. Community based services are delivered by probation officers, and institution based services are delivered at the Manitoba Youth Centre and Agassiz Centre for Youth. The Community and Youth Corrections division has traditionally employed a cognitive behavioral approach to treatment that rests on the assumption that sexual offending behaviour is a learned behaviour which can be controlled and replaced with non-threatening patterns of interaction. A primary goal of the cognitive behavioral approach is to assist adolescents to learn new perceptual and cognitive thinking patterns that will enable them to control their offending behaviour. Community and Youth Corrections has recently conducted a review of its approach to sexual offender treatment, and has made a conscious decision to adopt a relapse prevention model focused on the determinants of recidivism as outlined in the work of Pithers, Marlatt and others (Pithers et. al., 1983; Pithers et. al., 1988). The relapse prevention model is based on the premise that re-offending can be avoided by understanding the behavioral, cognitive, social and environmental components associated with relapse. After an understanding of these components is achieved, relapses can be prevented if offenders learn appropriate coping responses to high risk situations. High risk situations are defined as those which increase the risk of a potential relapse and challenge the individual's sense of personal control. It is implied in this model that individuals can learn to control their behaviour if they make a decision to do so.

Community and Youth Corrections staff have been trained on this model and have been provided with written resources outlining sexual offender intervention plans. Although the original relapse prevention model appears to advocate for the use of group therapy as a vehicle for communicating new cognitive and behavioral patterns, probation workers in rural areas are encouraged to adapt the approach for use with individual clients. The impact of the relapse prevention model of treatment on the actual delivery of treatment services within Community and Youth Corrections has not been evaluated since it was adopted almost one year ago. In the future it will be important to review the adoption of the relapse prevention model within Community and Youth Corrections to assess the merit of this approach.

Community-Based Services

Community based services that are currently offered through Community and Youth Corrections probation units primarily consist of peer group therapy sessions. There is some variation of treatment in rural areas, where individuals may have to travel a considerable distance to access services, or where the number of offenders in a particular area does not warrant group intervention. In these areas, services are generally provided by an individual probation officer who is responsible for supervising and monitoring the offender.

Community and Youth Corrections initiates three to four therapeutic peer groups of 8-10 boys each in Winnipeg every year. Most of the groups are closed to new participants once formed, and therefore intake of new group members occurs only at selected times through the year. The groups are two hours in duration and occur once per week. In addition to the therapeutic groups a psycho-educational group has been offered by Community and Youth Corrections. In the psycho-educational group, the facilitators take

on a teaching role and disseminate information on sexuality and the cognitive patterns associated with offending behaviours. For offenders who require extended treatment, this particular group is considered a means of preparing youth for participation in a therapeutic group. The length of expected client attendance at each group provided by Community and Youth Corrections in Winnipeg varies from three months for the psycho-educational group to two years for the closed therapeutic groups.

Community and Youth Corrections in cooperation with Winnipeg Child and Family Services have co-sponsored an additional treatment group for adolescent sexual offenders. The group is facilitated by a Child Abuse Coordinator from Winnipeg Child and Family Services, Central Area, and a probation officer from Community and Youth Corrections. The group has been in operation for approximately four years and is open to new participants at any time. Recently, a 10 week psychoeducational group has been added to the joint services offered by these two agencies. The initiation of this cooperative service has been based primarily on worker interest rather than a directive from Community and Youth Corrections or Winnipeg Child and Family Services, and services are only available in one area of Winnipeg.

Treatment for sexual offenders from rural areas are offered by Community and Youth Corrections in western Manitoba. Services have been initiated in the Westman Region as the result of the development of a community Sex Offender Treatment Advisory Group (SOTAG). SOTAG, is comprised of representatives from mental health, education, mandated child welfare services and Community and Youth Corrections. The group was formed by workers at the line level out of a recognized need to share community resources and train

workers to provide specialized sexual offender treatment services to individuals who may be involved with multiple social service systems. SOTAG meets weekly to provide a forum for linking participants with other service providers and to discuss policy and program development.

As a result of the SOTAG initiative and the desire by probation workers to provide sexual offender specific services two therapeutic groups for male adolescent sexual offenders have been offered in Brandon. The groups consist of approximately 8 boys each and are semi-open which allows for intake at selected times throughout the year. The groups meet weekly and the duration of treatment is approximately two years, depending on the length of the probation order. As with other programs of Manitoba Justice, a relapse prevention approach is utilized. Volunteers from the community are involved as facilitators of the groups.

Institutional Services

Institutional services for adolescent sexual offenders are provided at the Manitoba Youth Centre and Agassiz Centre for Youth. The Manitoba Youth Centre offers therapeutic groups for adolescent sexual offenders committed to closed custody. Until recently the groups were open to new participants at any time in order to facilitate the different committal dates of offenders. Since the adoption of the relapse prevention approach and the recognized need to introduce material in a sequential manner, the groups are only open to new participants during the first three months of each session. Approximately 20-30 juveniles participate in the sexual offender specific group at the Manitoba Youth Centre every year. The therapeutic group is the only sexual offender specific treatment offered at the Manitoba

Youth Centre and participants are integrated with the rest of the institutional population for all other programs.

Institutional based sexual offender treatment is also offered at the Agassiz Centre for Youth located in Portage la Prairie. The Agassiz Centre for Youth is a youth facility that assumes responsibility for sentenced offenders from rural and northern areas of Manitoba. The Agassiz Centre offers a number of different programs for residents, including a sexual offender specific residential treatment program. Group therapy forms the core of the sexual offender programming at the Aggasiz Centre and is offered on a daily basis. One or two therapeutic groups of 10-12 boys each are offered to offenders living in a sexual offender specific residence. The groups are open to new members at any time in order to facilitate the inclusion of offenders with different lengths of committals. The group work is supported by the residential component which has instituted a levelling system related to the successful completion of designated stages of treatment.

The approach to sexual offender treatment that has been utilized at the Aggasiz Centre is consistent with the Positive Peer Culture and Thinking Errors program adopted by this facility. The Positive Peer Culture approach is built on the premise that the offenders can and should be involved in helping themselves and each other. The Thinking Errors program focuses on helping the residents identify faulty thinking patterns and behaviours. For sexual offenders at Agassiz, these programs are augmented by the use of the cognitive behavioral approach of the relapse prevention model.

One of the most unique features of the sexual offender specific treatment provided at the Agassiz Centre for Youth is the incorporation of traditional Aboriginal healing with

contemporary theories of sexual offender treatment. As the institution serves rural and remote areas of Manitoba, most of the offenders committed to the Agassiz Centre are of Aboriginal descent. Staff working with the youth at Agassiz have recognized the need for programming that is relevant to the offender's world view and have initiated work to formally develop a culturally appropriate service model that incorporates some of the elements of the relapse prevention model. On several occasions, staff have attended a healing circle in an offender's community in order to facilitate the link between the sexual offender's treatment at Agassiz and the Aboriginal traditions of an offender and his community.

Currently, Manitoba Justice, through Community and Youth Corrections, provides treatment services to the largest proportion of adolescent sexual offenders in Manitoba. The most recent change to service provision involves the introduction of the relapse prevention model by the department. This appears to have resulted in the use of a consistent approach among existing service providers, but the full utility of the model for probation officers working with individual clients has not been explored. A representative of Community and Youth Corrections anticipates that the model will be used as a guide for workers in rural areas where it is difficult for geographic or other reasons to provide sexual offender specific services. It will be important to monitor the impact of this change on service delivery as it relates to the treatment of adolescent sexual offenders.

2.1.2 Voluntary Organizations

The following voluntary organizations are involved in the delivery of services to adolescent sexual offenders.

Winnipeg Child & Family Services

Sexual offender treatment services are offered sporadically by the various area offices of Winnipeg Child & Family Services. As was mentioned earlier, group treatment for adolescent offenders is currently being provided through a joint initiative of Winnipeg Child and Family Services, Central Area, and Community and Youth Corrections. While this initiative reflects Community and Youth Corrections' intent to provide services for this population, it does not reflect a plan of Winnipeg Child & Family Services to assume shared responsibility in this area. Rather it reflects the commitment of an individual staff person to be involved in the provision of treatment services for sexual offenders, many of whom are on her regional area's caseload.

West Region Child and Family Services

West Region Child and Family Services, a mandated First Nations child and family services agency, is currently involved in the process of designing a residential treatment program for adolescent sexual offenders in rural Manitoba. The agency is planning to offer treatment services through a four bed group home located in the town of Dauphin. It is anticipated that priority will be given to permanent wards of the agency in order to ensure that clients will remain in the program for longer than 18 months. As agency staff have noted that many of the boys who are eligible for admission to the program possess learning disabilities which make school attendance and participation difficult, a vocational program will be

incorporated into treatment. Para-professional treatment workers will deliver both sexual offender specific therapy and vocational instruction.

The initiative of West Region Child and Family Services is still in developmental stages and the first admissions to the program will likely occur in the Fall of 1995. Although there is recognition that the residential treatment service will interact with other services, the nature of the links have not yet been defined, nor has the approach to service provision been formalized. It will be important to monitor the development of this program, especially in regard to the approach adopted, as the recognized developmental difficulties experienced by clients appears to call for some modification of the cognitive behavioral approaches, which currently have widespread acceptance among service providers.

Community Holistic Circle Healing

Treatment services for sexual offenders are provided by the Community Holistic Circle Healing (CHCH) project of the Hollow Water First Nations Indian Band in Hollow Water, Manitoba. The project was initiated by community members who recognized that services provided by Manitoba Justice were not culturally appropriate and did not meet the needs of offenders in the Hollow Water community. The project currently receives demonstration funding from the federal department of Justice and additional resources are provided through staff allocations from agencies such as Southeast Child and Family Services, the Northern Alcohol and Drug Abuse Program, the local school and local health care providers.

The approach to service provision at CHCH is unique in that the needs of the victim, the offender and the community are considered in planning for the healing of all those affected

by the sexual offense. CHCH treatment services begin at disclosure of the offense and involve two separate teams of service providers. One team is victim-focused, and provides support regarding the disclosure and notifies the authorities regarding the incident. Another team is assigned to the offender, for the purpose of assessing the treatment needs of the offender and determining if the offender is prepared to take responsibility for the offense. Each team works with the victim and the offender concurrently in preparation for sentencing by the court. As CHCH requires that the offender plead guilty to the offense before they can engage in services, the court process is limited to sentencing and does not require the victim to testify.

The process of determining the nature of the sentence involves all community members, who select the appropriate treatment alternatives for the offender. A provincial judge, a crown attorney and a defense attorney attend the sentencing circle at Hollow Water. The sentencing circle provides the victim, the offender, family members and other community members with the opportunity to openly discuss the offense and reaffirm the innocence of the victim. The judge is presented with suggestions regarding the sentence by any community member who wishes to contribute his/her recommendations. In addition, the treatment team assigned to the offender presents a potential treatment plan for the offender.

The sentence which is imposed generally requires the offender to attend and participate in treatment services at CHCH, as well as the completion of some community work. Due to a recognition of the entrenched nature of offending behaviour, CHCH desires sentences that are five years in duration. Services available to offenders in fulfilment of the sentence involve group and individual therapy. The treatment progress of the offender is monitored by the community at scheduled open meetings.

Services to adolescents at CHCH have generally been the same as those provided to adults. CHCH has recognized a need to alter some of the group work to accommodate the developmental needs of adolescents. This has resulted in a longer duration of group involvement for adolescent participants.

Macdonald Youth Services

In addition to the Edgewood Program of Macdonald Youth Services which is the focus of this report, this organization also offers a residential service for male adolescent sexual offenders and group therapy services. The residential service consists of a four bed, level V group home which is designated as sexual offender specific. Although many of the boys admitted to this facility have demonstrated sexual offending behaviours, they possess other problems and require a highly structured placement. Boys living in the group home may be involved in some type of sexual offender therapy, but it is considered only one element of treatment. Residents are often required to attend an Abuse-Reactive therapeutic group sponsored by Macdonald Youth Services. This group is an open group offered to Macdonald Youth Services clients and clients referred from Child and Family Services. The group addresses issues related to sexual victimization and the propensity to react to victimization by demonstrating sexual offending behaviours.

Children's Home of Winnipeg

Sexual offender specific services have been offered in a limited way by Children's Home of Winnipeg. Recently, Children's Home of Winnipeg designated two placements in one foster home as sexual offender specific. The goal of providing this option is to reduce the risk to non-offending clients and to offer more structure to offenders through the use of

trained caregivers. Sexual offender specific therapy is not provided by the agency, but the offenders attend other treatment services available through Children's Home. Staff of this agency have indicated that waiting lists for sexual offender treatment precipitated the need to find alternative placements for this population, and that no further sexual offender specific services are being planned.

Forensic Behavioral Management Clinic

The Forensic Behavioral Management Clinic is a program of Native Clan, Inc., and provides assessment and treatment services for Manitoba sexual offenders. The majority of their clients are male adult sexual offenders who are referred from Correctional Services of Canada. This federal department serves as the primary source of funding for the Clinic.

Adolescent sexual offenders are occasionally referred to the Clinic from mandated child and family services agencies, Community and Youth Corrections and the courts. Individuals may also access service through a self-referral process or with assistance from family members. The Forensic Behavioral Management Clinic provides treatment for up to four adolescent sexual offenders each year.

Services provided to adolescent offenders by the Forensic Behaviour Management Clinic differ from the services offered to adult offenders in form, although not in content. For example, assessment may include a thorough examination of the client's arousal patterns through phallometric testing, but it is completed in a way that is sensitive to the adolescent's developmental stage. Treatment for juvenile offenders is delivered through less structured individual therapy sessions occurring once per week instead of long term group therapy, as

is generally the case with adult offenders. Occasionally, counselling may incorporate laboratory session in which the arousal patterns of the offender are addressed.

The Forensic Behavioral Management Clinic utilizes a cognitive behavioral approach to treatment that includes some aspects of the relapse prevention model. Upon disclosure of the offense and referral to the Clinic, treatment generally consists of the following elements; 1) assessment including an examination of the offense cycle and deviant fantasies, psychological testing, phallometric testing and interviews with the offender and family members; 2) identification and elimination of cognitive distortions such as denial and rationalization; 3) an examination of the offending behaviour including a look at the specific details of the offense; 4) the identification of risk factors or emotional, cognitive and behavioral factors that signal pre-offense happenings; and 5) identification of coping strategies such as anger and fantasy management. An examination of the offender's own victimization and work aimed at assisting the offender to develop victim empathy are also key elements in the treatment offered at the Forensic Behavioral Management Clinic.

2.1.3 Private Counselling Services

Service are provided to adolescent sexual offenders in Winnipeg through several private counselling practices. Two therapists from private counselling agencies were interviewed for the purpose of describing the services they provide. These individuals indicated that they generally receive referrals from mandated child and family services agencies, the courts or offenders' families. The services they provide include assessment for treatment and individual therapy. With regard to assessment for treatment, private

practitioners are frequently called upon to complete assessments which may serve as evidence in court proceedings.

Several different approaches to the treatment of sexual offenders are utilized by private therapists in Winnipeg. Respondents indicated that the dominant approach adopted by private therapists is cognitive behavioral, but therapists also employ other approaches depending upon the needs and developmental stage of the client. Therapists indicated that their clients often require basic information on sexual offending and sexuality, and therefore a psychoeducational component may be included in the treatment. Therapists noted that the educational components of treatment must be balanced with therapy that addresses the offending behaviours, as a means of reducing clients' immediate and long term risks of re-offending.

The two practices included in the interview process were considered by representatives of other organizations and agencies to be the primary providers of individual adolescent sexual offender counselling in Winnipeg. Private practitioners indicated that their organizations together serve up to 30 adolescents every year.

2.2 Issues Affecting the Provision of Service

An overview of the perceived strengths and weaknesses of existing services for adolescent sexual offenders was obtained through the collateral service provider interviews and interviews with representatives of Community and Youth Corrections and the Manitoba Family Services. Collateral service providers were asked to comment on the ability of the existing system to meet the needs of adolescent sexual offenders in Manitoba, and to outline

the difficulties they face in providing service to this population. This was augmented by information obtained from Manitoba Family Services and Manitoba Justice representatives who were involved in the policy and planning functions within their respective departments. Their responses were analyzed in order to identify the key policy, service and treatment issues regarding the delivery of services to this population. This sub-section identifies jurisdictional issues, service coordination issues, gaps in services to offenders from rural areas, issues related to after-care services, and challenges relating to the treatment model employed by most service delivery agents.

2.2.1 Jurisdiction

Currently, services to adolescent offenders fall under the jurisdiction of Manitoba Justice and Manitoba Family Services. As Manitoba Justice oversees law enforcement and the administration of justice through the courts, youth who have committed an offense are the responsibility of the Department through its Community and Youth Corrections Division. Manitoba Family Services' involvement is related to its role in the provision of protective services to children under the age of 18 years, as required under the Manitoba Child and Family Services Act. Thus, an offender who is under the age of 18 years may be the responsibility of one or both systems.

With regard to adolescent sexual offenders, Manitoba Justice is guided by the Young Offenders Act. Under the Young Offenders Act, provisions are made for the rehabilitation of offenders who are between 12 and 18 years of age. As was mentioned earlier, this has resulted in the provision of a number of programs for adolescent sexual offenders by Community and Youth Corrections in Manitoba. Although Community and Youth

Corrections have assumed responsibility for delivering treatment services to this population, their specific mandate, and the standards governing their activities are unclear. Community and Youth Corrections see their involvement in service provision as filling a service gap that is not being addressed by other systems. With an absence of standards in this regard, Community and Youth Corrections have recently adopted protocols for intervening with adolescent sexual offenders which defines their role in service provision to this population.

Manitoba Family Services lacks the mandate to provide treatment services to adolescent sexual offenders, as a discrete population. The Child and Family Services Act gives child and family services agencies the mandate to provide services to children in need of protection. The mandate of protection places the focus of intervention primarily on the victims of abuse and does not address the treatment needs of young sexual offenders. However, adolescent sexual offenders may come into the care of child protection agencies. In their role as guardian of the child, individual agencies have recognized that adolescent sexual offenders require specialized treatment services.

Simply put, the legislated responsibility for the provision of services to adolescent sexual offenders is poorly defined. This serves as a weakness, both at the individual case level and as it pertains to program planning and policy development. Service providers involved in delivering direct services to clients indicated that defining the role of each system in supporting treatment often proves difficult. Similarly, at the policy and program development level, there is uncertainty regarding the responsibility for further service development and evaluation.

Despite these jurisdictional issues, Manitoba Justice and Manitoba Family Services have been involved in service delivery and service planning pertaining to adolescent sexual offenders. There is support within both departments for an approach to service provision which would allow for shared responsibility and would result in the involvement of Community and Youth Corrections, Family Services, voluntary organizations and other provincial departments such as Mental Health. However, unless the jurisdictional issues are resolved, funding for services will continue to be ad hoc and dependent on political will. Further, gaps in service delivery will remain an issue until the Acts governing the involvement of the two key Departments are expanded or revised with respect to the treatment of this high risk population.

2.2.2 Service Coordination

Given the jurisdictional issues, the absence of a coordinated approach to service provision in Manitoba comes as no surprise, and this was identified as a weakness by collateral service providers. Although it was affirmed that available services are of good quality and have the potential to meet the needs of many offenders, a wider range of needs could be met through a coordinated approach.

Representatives of the two government departments indicated that steps are being taken to enhance service coordination in rural Manitoba. The approach taken by the Westman Region of Community and Youth Corrections through the development of the Sex Offender Treatment Advisory Group is one such example. In a similar manner, the CHCH of Hollow Water was initiated as a community response to both the needs of the victim and the offender through the involvement of community members and professionals.

The involvement of multiple agencies in case management and treatment planning has the potential to address some of the gaps that exist in our current delivery system. In addition, service coordination may be a means of limiting the geographical barriers to service participation experienced by offenders from rural and remote communities.

2.2.3 Services to Rural and Northern Offenders

It is clear from a review of existing services that few treatment opportunities are available to juvenile sexual offenders from rural Manitoba. In some instances, boys in rural and remote communities may not receive any treatment services and may have limited contact with professionals while on probation. The services that are available are unlikely to be located in the offender's community, which may precipitate the need for a placement outside the community and away from his support system. This is especially relevant for boys from northern reserve communities in Manitoba.

Representatives of Community and Youth Corrections and Manitoba Family Services recognize that geographical barriers impede the provision of services in some communities. Group therapy becomes impossible when sexual offenders do not reside in reasonable proximity to one another and/or when trained staff are concentrated in urban locations. Individual therapy that is available to offenders is often the responsibility of probation officers, who do not reside in the community and have limited contact with the offender. The dearth of services available to offenders from rural areas was recognized by service providers and representatives of government departments as a weakness of the Manitoba service system. It has been suggested that community based approaches to intervention which would allow for treatment to be delivered by members of the community, as well as the recent

adoption of a protocol for intervening with adolescent sexual offenders on the part of Community and Youth Corrections, may assist in improving the services available to offenders from rural or remote communities.

2.2.4 After Care Services

With the exception of those services provided through the Edgewood Program, follow-up or after care services for adolescent sexual offenders in Manitoba do not exist. Although service providers indicated that follow-up is key to the treatment process and to the prevention of re-offending behaviours, there were no resources directed at this activity.

A limited form of follow-up services are provided through Manitoba Justice for offenders who are in custody, and are nearing the end of their committal. Short term re-integration services are available to all offenders who have been committed to custody in Winnipeg as a means of monitoring their release into the community. However, even this limited service is not yet available for boys from rural areas.

For offenders placed on probation, service ends when workers no longer possess the mandate to provide service or as the probation order expires. Given the long term commitment required for meeting the treatment needs of sexual offenders, and the potential for many boys from rural areas to return to their home communities without ongoing support or treatment, the lack of after care services presents as a weakness in the service system. Again jurisdictional issues are at least partly responsible for the gap in this area. The questions that are asked at the service delivery level often pertain to whose responsibility it is to fund such services, given the shortage of available treatment resources.

2.2.5 Treatment Model

One final issue pertaining to the provision of services to adolescent sexual offenders in Manitoba is the nature of the treatment model that has been adopted by most sexual offender treatment programs. The relapse prevention model of sexual offender treatment that was formally adopted by Community and Youth Corrections approximately one year ago, has become the most commonly employed approach to sexual offender treatment in Manitoba. Aspects of this approach could be found in most of the programs under review, and it was evident that relapse prevention was perceived as an effective approach. Although the relapse prevention approach has gained wide recognition in this regard, there have been no attempts to evaluate the utility of the model in different service settings in Manitoba, or with populations that may not be amenable to a cognitive based approach. One example would be youth who suffer from fetal alcohol effect (FAE) or fetal alcohol syndrome (FAS), or those who are learning impaired or developmentally delayed.

The utility of cognitive behavioral approaches to the treatment of developmentally delayed or impaired individuals has been investigated by the Interagency Fetal Alcohol Program that was recently initiated by Mount Carmel Clinic. The program director indicates that individuals exposed to alcohol during pregnancy have difficulty with cognitive or behavioral approaches to treatment as they are often unable to easily link cause to effect in regard to behaviour. In addition, they may experience problems in abstract thinking, which may be a requirement of cognitive behavioral therapies. Although these individuals may appear highly verbal and thus appear to be high functioning, they may have difficulty interpreting communication nuances and may be confused about issues related to sexuality.

This presents as a problem when employing a cognitive behavioral approach to sexual offender treatment. Notwithstanding the difficulties in diagnosing adolescents with FAE, FAS, or learning difficulties, the problems inherent in implementing one approach with all adolescents warrant consideration. It may be important to assess the appropriateness of cognitive behavioral models of treatment on a case by case basis, to ensure that the limited treatment spaces are well utilized. Further, the relapse prevention approach to the treatment of adolescent sexual offenders should be closely monitored to assess its overall effectiveness, as well as its appropriateness in treating individual adolescents.

2.3 Summary

Manitoba Justice plays a major role in delivering sexual offender treatment services in the province, although these services are concentrated in urban centres. Manitoba Family Services has the potential to play a role in this area with respect to the development of policies for the treatment of adolescent sexual offenders who may be clients of mandated child and family services agencies. Currently, this department provides funds to voluntary agencies to deliver services for this population. Winnipeg Child & Family Services, which is closely aligned with Manitoba Family Services, provides few treatment services for adolescent sexual offenders, and these are provided on an ad hoc basis. Manitoba Family Services assumes a role in the delivery of sexual offender specific services through its allocation of funds or staff to Winnipeg Child and Family Services, First Nations child and family services agencies and to other organizations. Relatively few services are delivered outside of Winnipeg, and very few can be considered residential treatment services. The development of a four bed

residential treatment program by West Region Child and Family services will increase the total number of Manitoba residential treatment spaces to 10. The remaining 6 spaces are provided through the Edgewood Program of Macdonald Youth Services.

Service delivery to adolescent sexual offenders is affected by jurisdictional issues which do not clearly delineate the roles and responsibilities of different government departments. These issues impair service coordination, and limit the comprehensive nature of the services that are provided.

Services to adolescent sexual offenders appear to have developed in response to the recognized merits of relapse prevention and other cognitive behavioral approaches. However, the demonstrated effectiveness of these models for the treatment of adolescent sexual offender should be examined, as should the appropriateness of their application to special populations, such as offenders who suffer from FAE, FAS or learning impairments.

SECTION 3: DESCRIPTION OF THE PROGRAM

The Edgewood Program of Macdonald Youth Services is a level IV residential treatment program for male adolescent sexual offenders. The Program incorporates a variety of psychotherapeutic, cognitive and behavioral elements in the treatment process. The Edgewood Program is funded by the Department of Family Services and is delivered in an open community based setting. Services provided include residential services to six high risk youth, after care services to program graduates, and support and short-term therapy to offenders' families. Program documents indicate that the overall goal of treatment for every offender admitted to Edgewood is total abstinence from sexual offending behaviour.

Clients access the Edgewood Program through referral from mandated child welfare agencies. In order to be eligible for admission to the Program, clients must be between the ages of 13 and 17 years and approved for Level IV residential care. In addition, clients must have committed a hands-on sexual offense and accept some responsibility for the offending behaviours. Because treatment at Edgewood requires the integration of knowledge with personal experience, clients must be developmentally and intellectually capable of participating in group living and treatment. Clients must also be able to participate in educational or employment alternatives available as the Edgewood Program does not provide day programs.

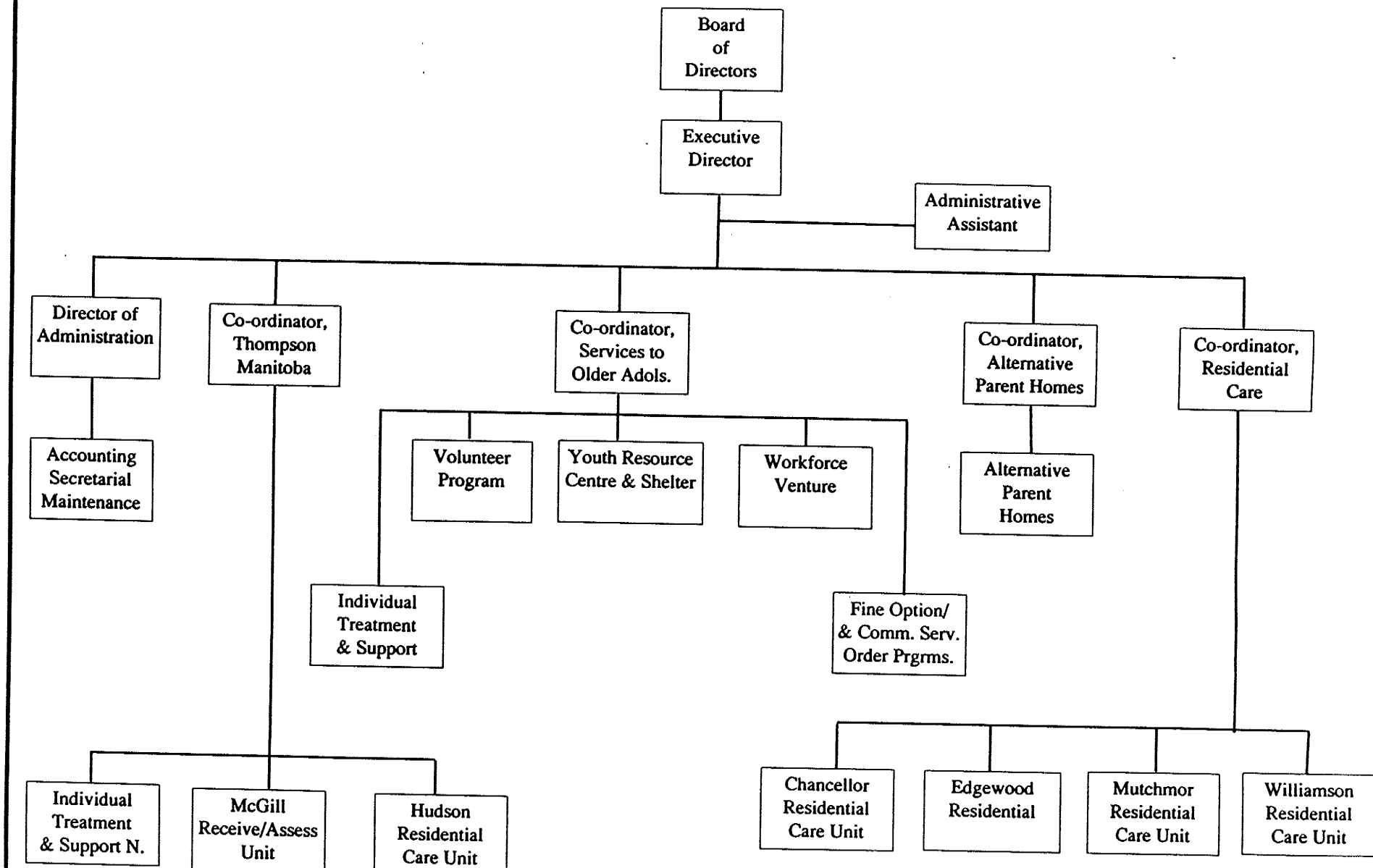
3.1 Organizational Structure and Staffing

The Edgewood Program is a project of Macdonald Youth Services residential care services, and as such, is accountable to the Macdonald Youth Services Board of Directors through the Coordinator of Residential Care and the Executive Director. Edgewood's relationship to Macdonald Youth Services and position among the compliment of services available through that agency is displayed in Figure 1.

FIGURE 1

MACDONALD YOUTH SERVICES

ORGANIZATIONAL STRUCTURE: PROGRAMS AND SERVICES

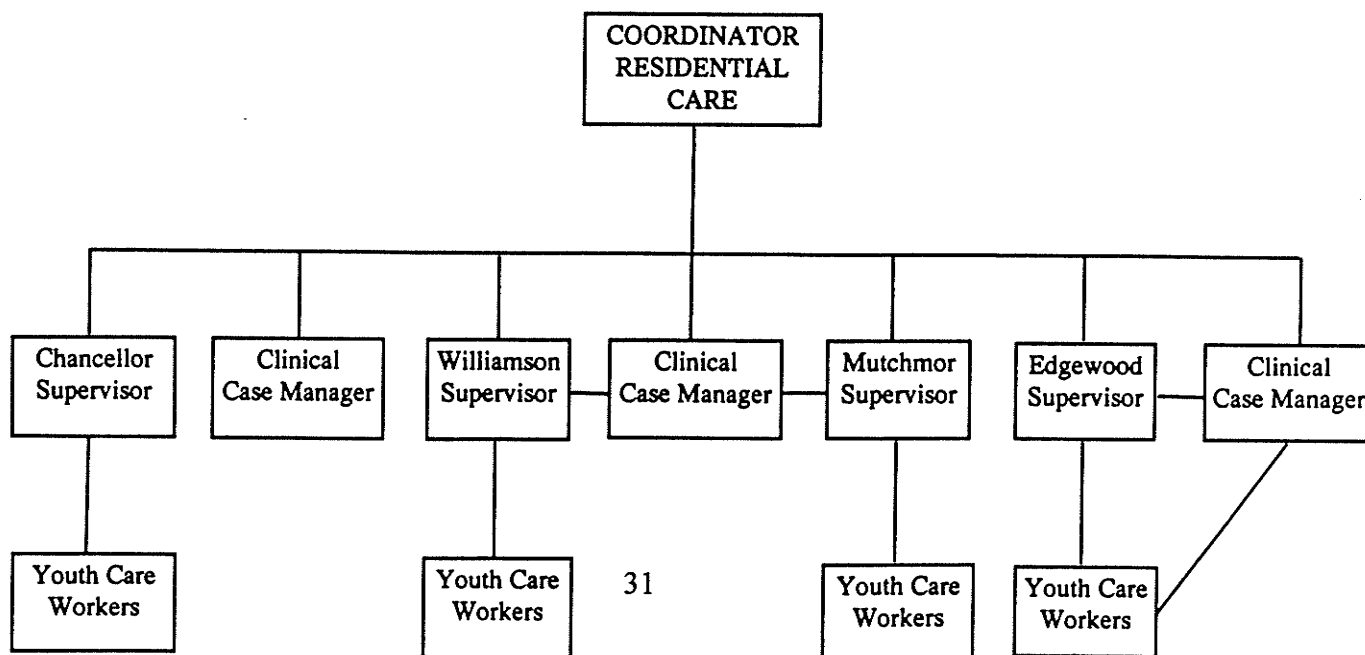


The Edgewood Program is staffed by a Treatment Worker Supervisor and seven Youth Care Workers. A Clinical Case Manager is also available to provide individual therapy and case consultation for approximately three days per week. The treatment worker supervisor and the clinical case manager work as a team and are responsible to the Coordinator of Residential Services. After care services to discharged clients are provided by one of the Edgewood Youth care workers who devotes approximately half time to liaison activities. The functional reporting relationships of Edgewood staff to Macdonald Youth Services are summarized in Figure 2.

FIGURE 2

MACDONALD YOUTH SERVICES

**RESIDENTIAL CARE SERVICES:
AUTHORITY RELATIONSHIPS**



3.2 The Treatment Model

The integrated model of treatment offered at the Edgewood Program includes assessment, individualized treatment schedules, sexual offender specific peer group therapy, individual therapy and after care services. Services to the offenders' families are also provided through the Edgewood Program. Edgewood's approach to offender treatment can generally be considered cognitive behavioral as treatment focuses on teaching the offenders new perceptual and cognitive thinking patterns. Elements of the relapse prevention model are also incorporated into treatment for the purpose of developing control plans with clients.

The assessment begins at referral and focuses on the client's amenability to treatment, risk level, functioning level and prognosis for success. In some cases, assessment consists of interviews with the client, the referring worker and family members. Legal and other documents regarding the client's history are then reviewed, and the assessment information is compiled and used to formulate the individual treatment plan of the offender. Unfortunately, the comprehensive nature of the assessment process is sometimes compromised by the lack of information that is provided by referring or collateral agencies.

In order to ensure that the client is progressing through treatment, a levelling system has been implemented as part of the individual treatment schedules of Edgewood clients. Each of the six levels or stages of treatment at Edgewood is accompanied by corresponding indicators of successful performance in group and individual therapy. After the offender consistently demonstrates the behaviours associated with a particular level or stage of treatment, he is moved on to the next level and the corresponding behavioral expectations are increased. Although the Program has targets within which it is suggested the offender

complete each level, the time required to successfully accomplish each stages varies from two to eight weeks depending on the individual offender. Originally, the program was to involve clients for a period of 8-10 months in residential treatment and approximately six months in the after care program. After a year of operation, staff realized that this may not be a realistic expectation for all clients, as some participants require from four to six months to build trusting relationships with staff and other participants before they begin demonstrating the desired behaviours. This has impeded progression through the stages of treatment, and staff have indicated that clients require an average of 18 months to complete the program.

Sexual offender specific peer group therapy forms the core of services provided by the Edgewood Program. The group is open to new participants at any time in order to accommodate the different treatment schedules of individual clients. Clients enter the group as soon as they are admitted to the program and move into the residence. Group meetings occur twice weekly and average between one and two hours in duration. The original intention of program staff was to integrate psycho-educational and process content into each group session. However, the integration of these two components into each session proved difficult because of the different intellectual and comprehension levels of individual participants. At the present time, one weekly group session is dedicated to the provision of psychoeducational material including teaching and task oriented activities derived from the Psychoeducational Curriculum for Adolescent Sex Offenders developed by Joseph Richardson, Peter Loss and Jonathan Ross. This material is used to teach factual information and concepts related to cognitive thinking patterns, offending behaviours and the offender's

own victimization. In addition, information regarding healthy relationships and sexuality are addressed in the psychoeducational group.

The second weekly group session is designated as a process group in which participants are encouraged to integrate information learned during the psychoeducational group with personal experience. Participants are invited to share past experiences with respect to offending and victimization. Within the process group participants are also confronted with regard to cognitive distortions and rationalizations, and are challenged to understand the impact of the offense upon the victim.

Attendance at an additional group related to household management is also required by participants. The weekly house meeting is designed to allow participants to discuss and resolve issues related to group living. Although the content of this group is not sexual offender specific, it has been used as a forum for the resolution of personal conflicts that arise in the context of a residential treatment service.

Therapeutic work accomplished through group therapy is augmented by an individual therapy component. Edgewood Program participants are required to attend two weekly individual treatment sessions with an assigned treatment worker or the clinical case manager. Sessions range in length from one to two hours and may encompass a variety of issues. Often the individual therapy time is spent in preparation for group, either through a review of material covered in previous sessions or by preparing the adolescent to share personal issues with the group. Individual therapy may also include work related to the client's family of origin.

The above mentioned elements of the Edgewood Program are set in the context of a residential setting. This is seen by staff as enhancing the process of treatment as the different components of the program relate to each other and support one another. Having the clients reside at the place of treatment also results in the opportunity to provide intensive, highly structured services to clients who may be at great risk of re-offending. As well, information with regard to individual client progress may be monitored by members of the treatment team and incorporated into the daily activities of the client.

Monitoring the individual treatment progress of program participants is augmented by strong communication between Edgewood Program staff and the clients' day program workers. Edgewood residents have been able to access educational services through the W.O.L.F. program offered at a local high school. Because many of the boys who enter treatment at Edgewood have demonstrated past behavioral difficulties at school, most program participants require the more individualized curriculum and smaller class size provided by this program. Depending on the needs and abilities of individual participants, each boy may spend the morning in school and the afternoon at a work experience program offered by Macdonald Youth Services. The Workforce Venture Program offers participants the opportunity to gain practical employment experience, as well as to complete additional educational credits. Edgewood staff maintain regular communication with these programs in order to monitor participants progress and daily behaviour.

Since the beginning of the Edgewood Program, staff have noted the importance of building better relationships between clients and their families. According to program documents, Edgewood originally intended to provide a therapy group to parents and other

family members. This did not occur as there existed geographical barriers to extensive family involvement with clients from rural communities and families who were available and willing to participate were not suited to a group setting. Instead, Edgewood has responded to the adolescents' treatment issues and to requests from individual families for support and information by taking on an increased role in the provision of short-term family therapy and mediation. The Clinical Case Manager, the Treatment Worker Supervisor and the Liaison Worker have each taken an active role in assisting program participants and their families resolve issues that arise as the proceeds through treatment in the Edgewood Program.

One of the unique aspects of sexual offender specific treatment at the Edgewood Program is the after care service component. Near the completion of the residential treatment component, each client engages with a liaison worker who assists them in the process of discharge from the Edgewood Program. The liaison worker acts as a resource to the offender and the family or caregivers after the client moves out of the Edgewood residence. Monitoring group attendance and assisting the offender in making healthy life choices are also responsibilities associated with the liaison role.

Program graduates from earlier phases of the Edgewood Program were required to return to Edgewood for group sessions as part of the after care services. As the program began discharging clients, a group specifically for program graduates has been initiated by the Clinical Case Manager and the Treatment Worker Supervisor. Currently, any clients who complete the residential component of treatment are assisted by the liaison worker in the transition to the after care group. Clients remain in the after care component of the

Edgewood Program for at least six months. Several clients have been involved in the after care services as voluntary clients for almost one year.

The after care services have undergone several changes since the Program was initiated. Perhaps the most significant has been the recent development of a residential component in cooperation with the Individual Treatment and Support Program (ITS), the supported independent living program of Macdonald Youth Services. After the first several clients who completed treatment at the Edgewood Program were discharged from the residence, it became apparent to staff that clients experienced difficulty moving from the structured setting of the group home to independent living. In response to these difficulties, Edgewood staff and staff from the ITS Program recently located and leased a house near the Edgewood residence. It is anticipated that this will give program graduates the opportunity to remain connected to the residence while the liaison worker assists in the transition to independent living. In addition, it is expected that a support worker from the ITS program will assume an increasing role in the client's life as the aftercare component comes to a close. Because only one client has been discharged since this arrangement has been initiated, a further description will be included in the final evaluation report.

3.3 Funding Arrangements and Program Budget

The Edgewood Program is funded by Manitoba Family Services as an approved residential care facility. The financial resources allocated to the Program are considered more intensive as the residence is approved for six beds rather than the typical eight beds. The

implications of having fewer clients reside in the home is seen to offer benefits in terms of treatment, but results in additional per diem costs associated with operating expenses.

The total daily cost of care for Edgewood Program participants may be calculated by summing the administrative costs and operating expenses of the program and dividing by the total number of days of care provided in a given year. This results in a daily rate for individual clients. The administrative costs were based on revenue received by Macdonald Youth Services from Manitoba Family Services in the form of administrative grants. The total per diem for administrative expenses related to the Edgewood Program was found to be \$64.93. The yearly operating expenses of the program was calculated by summing the cost of staff salaries and benefits, maintenance of the residential facility and additional clinical consulting services, and dividing by the total number of days of care provided in the year under consideration. Budget documents indicate that this totalled \$385,327.66 for the 1994/95 fiscal year or a per diem rate of \$175.23. This results in a total per diem of \$240.16 for the Edgewood Program.

Several additional costs must be considered as they relate to the total cost of maintaining a boy in the Edgewood Program. The first involves the cost of the day program in which four Edgewood Clients participate. The cost for the Workforce Venture program of Macdonald Youth Services for these four clients may be estimated at \$ 20.55 for each client per day. This is a conservative estimate as this figure only includes staff salaries and does not include the administrative costs associated with the program. In addition, the costs to the guardian agency of supervising a boy placed at the Edgewood Program and the costs of supervision by Community and Youth Corrections are expenses related to the placement.

The daily cost of Child and Family Services supervision may be estimated at \$4.83.¹ A comparable estimate of the cost of supervision to Community and Youth Corrections is unavailable.

The total cost of maintaining a boy in the Edgewood Program for one day ranges from \$245.01 for boys not participating in the Workforce Venture program, to \$265.56 for boys attending Workforce Venture for one half day. The higher per diem is likely a conservative estimate as at least one boy in the program is provided with an additional 20 hours of support per week which was not included in the calculations. Using the estimate of 18 months as the average duration of residential treatment and the per diem which includes the cost of the Workforce Venture Program, the total cost for one boy to complete treatment is approximately \$145,394.10.

It is important to note that the total cost of maintaining each boy in the program is not passed on to the agency. Generally, the agency is responsible for the per diem associated with the operating expenses or approximately \$240.16 for the Edgewood Program. The remaining costs are incurred by the Department of Family Services directly, and by Macdonald Youth Services.

¹. The estimate of Child and Family Services supervision costs were based on figures received from Child and Family Services of Central Manitoba for the 1991/1992 years. Costs were calculated using estimated ratio of worker time spent on supervising children placed outside the care of the agency as a proportion of the agency's operating budget and the total number of days care provided by the agency. CHRA is currently in the process of securing the necessary data to calculate supervision costs for the most recent fiscal year.

3.4 Summary

The preceding section has described the Edgewood Program for male adolescent sexual offenders. With regard to the program, the following summary points can be made;

- The Edgewood Program is a project of Macdonald Youth Services, and as such, is responsible to the Board of Directors through the Coordinator of Residential Care and the Executive Director. The project is funded by the Department of Family Services through the distribution of administrative grants and fees paid by the clients' guardian agencies.
- The Program is staffed by a Clinical Case Manager, a Treatment Worker Supervisor and seven Youth Care Workers. Staff utilize what may be considered a cognitive behavioral approach as treatment focuses on teaching the offenders new perceptual and cognitive thinking patterns. Treatment is delivered through peer group therapy and individual therapy.
- The duration of treatment has changed since initial program implementation. Rather than the anticipated 6-8 month term of treatment as outlined in the original program documents, clients currently remain in the residential treatment program for an average of 18 months.
- Treatment is enriched by regular communication between the Edgewood staff and other programs in which program participants are involved.
- After-care services form a unique element of services provided by the Edgewood Program. A liaison worker is available to discharged clients for the purpose of monitoring group attendance and supporting the offender in making healthy life choices. An after group consisting of program graduates has recently been initiated by the Edgewood Program.
- The total cost of maintaining a boy in the Edgewood Program ranges from \$ 245.01 to \$ 265.65 per day. If the average duration of treatment is 18 months, the total cost for one boy to complete treatment may be estimated as high as \$145,394.10.

SECTION 4: EDGEWOOD PROGRAM CLIENT PROFILE

In order to obtain a preliminary description of the clients served by the Edgewood Program a file audit was completed on 12 client files maintained by the Clinical Case Manager. These files represent all of the admissions to the Edgewood Program since its inception in May 1993. File contents are derived from several sources including records forwarded by the placing agency, intake forms and assessment notes completed by Edgewood staff at the point of admission, and notes documenting any personal information the client may offer during his placement at Edgewood. The files contain information on family history, completed psychological assessments, legal documentation, school or day program related data, incident reports and process notes. Unfortunately, several of the files maintained by the clinical case manager did not contain enough information to describe client characteristics accurately and additional data had to be obtained through interviews with youth care workers. The results are reported in the following four sections: demographic information; family composition and involvement; identified problem areas, and history of offending behaviour.

4.1 Demographic Information

The files indicate that clients ranged in age from 14 years to 17 years at the time of placement at the Edgewood Program. Two clients were 14, six were 15, three were 16 years at admission and one was 17 years old. Information on client age may found in Table 2.

TABLE 2

CLIENT AGE AT ADMISSION TO THE EDGEWOOD PROGRAM

AGE IN YEARS	FREQUENCY
14	2
15	6
16	3
17	1
TOTAL	12

Seven of the twelve participants were of Aboriginal decent. Of the Aboriginal clients, five were considered Treaty Indian and one was considered Non-Treaty Indian. The remaining client of Aboriginal decent was Metis.

Half or six of the twelve participants did not have significant contact with mandated child welfare services prior to notification of offending behaviours and placement at Edgewood. For the remaining half of the clients whose families had more extensive involvement with mandated child welfare agencies, the length of contact varied. Three clients were involved with Child and Family Services from shortly after birth, and the other three were involved with Child and Family Services for more than five years prior to placement at Edgewood.

The current status of Edgewood clients with respect to child welfare services was varied. Five of the boys were placed in care as a result of voluntary placement agreements and five were placed under a permanent order of guardianship. One client was under apprehension by Child and Family Services and one boy was placed at Edgewood as a result

of a temporary order of guardianship. All clients were considered to require a Level IV or V placement upon admission to the Edgewood Program.

Most of the program participants were placed at Edgewood by rural child welfare agencies. Of the twelve boys admitted to the Edgewood Program, only four were placed by agencies mandated to provide service in Winnipeg. Two of these clients were placed by the rural offices of an agency with jurisdiction over an area which includes both rural and urban settings. Of interest, this results in the admission of only two clients from the Winnipeg area.

4.2 Family Composition and Involvement

Edgewood clients come from families with diverse compositions. Four of the boys' families could be considered blended as the client lived with one birth parent, a step-parent and a combination of step and birth siblings. Three clients had families composed of a single parent and three clients were adopted. The remaining two boys could be considered to have families consisting of members of their extended families. Information on family composition is summarized in Table 3.

TABLE 3

FAMILY COMPOSITION OF EDGEWOOD CLIENTS

FAMILY COMPOSITION	FREQUENCY
Blended	4
Single birth parent	3
Extended birth family	2
Adoptive extended family	2
Adoptive nuclear	1
TOTAL	12

Information on family involvement was also obtained through the file review. Six clients were regarded as having regular contact with their mothers and five boys were regarded as having regular contact with their fathers. Five clients had no contact with their fathers and of these five, three did not have contact with either parent.

All of the Edgewood clients had siblings, with four of the boys having four or more siblings. Consistent with earlier findings in regard to family composition, the relationships of the clients to those considered siblings were varied. Five of the twelve clients had families that included birth siblings exclusively and the remaining boys had some combination of adoptive siblings, step siblings and foster siblings. Of interest, half of the boys were the oldest among their siblings.

4.3 Identified Problem Areas

Edgewood Program files indicate that most clients enter treatment with histories of being the victims of multiple forms of abuse. Ten of the twelve boys were known to be victims of emotional abuse and nine boys had experienced physical abuse. Nine clients could be identified as suffering from neglect while residing with their families and eight clients were abandoned on one or more occasions. Eleven or almost all of twelve clients were victims of sexual abuse. Table 4 depicts the findings in regard to Edgewood residents' past history of abuse. It may be noted that several client files did not yield enough information to draw conclusions regarding the boys' background and presenting problems. In these instances the research team resorted to reviewing the file audit instrument with individual youth care workers.

TABLE 4
EDGEWOOD CLIENT HISTORY OF ABUSE

	FREQUENCY (N=12)
Sexual Abuse	11
Emotional Abuse	10
Physical Abuse	9
Multiple Forms of Abuse	9
Neglect	9
Abandonment	8

The file audit also provided information pertaining to other problems in Edgewood clients' families of origin. All of the clients who have been admitted to the Edgewood Program have experienced problematic family relationships. Eleven of the twelve boys came from families with a history of alcoholism and an equal number had a history of intergenerational abuse. Ten clients were faced with issues of loss, rejection and abandonment with regard to family relationships. Table 5 provides information regarding the family problems of Edgewood clients.

TABLE 5
FAMILY PROBLEMS OF EDGEWOOD RESIDENTS

PROBLEM AREA	FREQUENCY (N=12)
Problematic Family Relationships	12
Family History of Alcoholism	11
Family History of Intergenerational Abuse	11
Loss, Rejection and Abandonment Issues	10

The file audit indicates that clients had a number of presenting problems, in addition to the offending behaviours which precipitated placement at in the Edgewood Program. Of the twelve clients admitted into the Edgewood Program, almost all (eleven) had behavioral problems, exhibited violent and aggressive tendencies and were considered as having low self esteem. Seven clients were considered academically or intellectually delayed and five

admitted to having suicidal thoughts. Four boys experienced chronic health complications.

Table 6 summarizes the identified problems of Edgewood clients.

TABLE 6
IDENTIFIED PROBLEMS OF EDGEWOOD CLIENTS

PROBLEM AREA	FREQUENCY (N=12)
Behaviour Problems	11
Violent and Aggressive Tendencies	11
Low Self-Esteem	11
Academic or Intellectual Delays	7
Suicidal Thoughts	5
Chronic Health Complications	4

As mentioned previously, almost all (eleven) of the Edgewood Program participants experienced prior sexual victimization. The age at which victimization first commenced ranged from two to five years of age for five clients, and from six to eleven years for another five clients. Information was unavailable for the remaining boy.

Seven of the eleven boys were known to be sexually victimized by more than one offender. More than half (six) were offended against by both a male and a female. Four boys were victimized by only male offenders and one boy was victimized by only by female offenders. The offender in nine of the cases included a family member and in eight of the cases the offender was an adult or older child.

The nature of the victimization experienced by each boy varied. For eight of the eleven boys who had been sexually victimized, the offense occurred over time and was not considered an isolated incident. Among the characteristics of the sexual assaults experienced by program participants, fondling of both the victim and the offender were the most common activities. Information on the additional features of Edgewood clients' sexual victimization experiences is depicted in Table 7.

TABLE 7
FEATURES OF SEXUAL ASSAULTS EXPERIENCED BY
EDGEWOOD CLIENTS

FEATURES OF ASSAULTS	FREQUENCY (N=11)
Fondling of victim	8
Fondling of offender	7
Manual stimulation of victim's genitals	7
Exhibitionism	6
Forced to observe sexual offense	5
Oral stimulation of victim	5
Oral stimulation of offender	4
Manual stimulation of offender's genitals	4
Kissing	4
Exposed to pornography	4
Observed while undressed	3
Attempted penile anal penetration	3
Penile anal penetration	3
Vaginal penetration	3
Digital anal penetration of offender	1
Digital anal penetration of victim	1
Penetration with foreign objects	1

4.4 History of Offending Behaviour

The history of the offending behaviours of Edgewood clients was derived from the file review and was supplemented by information obtained from individual youth care workers.

The Program initially intended to secure official victim and offender statements from the

police or placing agency at the time of each admission. Unfortunately, these documents have been difficult to obtain and therefore staff have been left to rely on a summary of the mandated child welfare agencies' understanding of the offense(s) as found in Edgewood Program intake forms. The following summary of Edgewood Program participants' offending behaviours primarily pertains to those offenses which precipitated admission to the Program.

Ten of the twelve boys admitted to the Edgewood Program had been formally charged with one or more sexual offenses. Of these ten boys, half were charged with more than one sexual offense. Although the file review yielded little information regarding the nature of non-sexual offenses committed by clients, it could be determined that seven of the twelve boys had previously been charged with other offenses.

It is important to note that two boys who were admitted to the Edgewood Program were not formally charged with sexual offenses prior to entering treatment. According to the Clinical Case Manager, the offending behaviour began when the boys were younger than 12 years of age which is considered outside the jurisdiction of the Young Offenders Act. Since entering treatment at the Edgewood Program, formal charges have been initiated for one boy. Limited information about his offending behaviours were obtained from his file. Information regarding the offending behaviours of the boy who has not been formally charged with a sexual offense was not available from his file.

The age at which the offending behavior was first identified as a problem varied for the Edgewood clients. The age at first offense ranged from 6 years to 14 years for nine of the boys. Information regarding the age at which the remaining three boys first demonstrated

sexual offending behaviours was unavailable. Table 8 summarizes the boys' ages at first offense.

TABLE 8
AGE AT FIRST SEXUAL OFFENSE

AGE	FREQUENCY (N=12)
12 to 14 years	5
9 to 11 years	2
8 to 6 years	2
Missing	3
TOTAL	12

For most of the clients (ten), the offending behaviour occurred over a period of time and was not considered an isolated incident. Of the ten clients for whom information on the number of victims was available, five had offended against between one and three individuals. Three clients had between four and six victims, and two clients had seven or more victims.

Eight of the eleven Edgewood clients for whom information was available had offended against a younger or same aged child and two clients had offended against both an adult and a same aged child. One client had offended against an adult and a younger child. Five of the boys had offended against females only and one had offended against a male. Five boys had offended against both a female and a male.

The relationship to the victim could be described as familial, including both immediate and extended family members, for four of the eleven Edgewood Program participants for

which data was available. Two boys had offended against non family members and five had offended against both a family member and an individual external to the boy's family.

The nature of the offending behaviours demonstrated by each boy varied. Almost all of the Edgewood clients had fondled their victims and had forced their victims to watch them masturbate. Information on the features of Edgewood clients' offending behaviours is depicted in Table 9.

TABLE 9

**FEATURES OF SEXUAL ASSAULTS PERPETRATED BY
EDGEWOOD PROGRAM PARTICIPANTS**

FEATURES OF ASSAULTS	FREQUENCY (N=11)
Fondling of victim	10
Exhibitionism	9
Manual stimulation of victim	8
Kissing	7
Attempted vaginal penetration	6
Vaginal penetration	6
Observed victim while undressed	5
Fondling of offender's genitals	5
Manual stimulation of offender by victim	5
Forced to observe sexual offense	4
Oral stimulation of victim by offender	4
Oral stimulation of offender by victim	4
Digital anal penetration of offender	4
Penile anal penetration of victim	4
Exposed victim to pornography	4
Attempted anal penile penetration of victim	2
Bestiality	2
Penetration with foreign objects	1

4.5 Summary and Overview of Issues Pertaining to Client Data

This section of the report has focused on describing the characteristics of Edgewood Program Clients. Specifically, clients have been described in terms of demographic characteristics, family composition and involvement, identified problems and offending behaviours. The Edgewood Program client profile may be summarized by the following:

- Demographic information obtained in client files indicates that program participants range in age from 14 years to 17 years at admission. Most of the boys were Aboriginal and half had extensive involvement with mandated child welfare agencies prior to placement at Edgewood. Only two of the twelve boys admitted to Edgewood were from the Winnipeg area.
- Clients admitted to the Edgewood Program have many problems to address in addition to the sexual offending behaviours that precipitated admission. Most of the adolescents were identified as having behaviour problems, low self-esteem and violent and aggressive tendencies. Over half were considered intellectually delayed.
- Most of the boys who have participated in the Edgewood Program have been the victims of multiple forms of abuse and almost all had been sexually victimized. A large proportion of clients came from families with a history of intergenerational abuse and alcoholism.
- Ten of the twelve Edgewood Program clients had been formally charged with one or more sexual offense at admission to the program. Of the remaining two boys, one was charged shortly after admission and the other had no charges pending.

It may be noted that two issues pertaining to the file audit that were raised in the first report completed by CHRA, appear to still present as concerns. The first pertains to the missing, partial and/or inaccurate nature of the information contained in the client files. The second pertains to the high proportion of clients who possess some degree of intellectual disability. A third issue related to client residency was evident in the most recent file review.

Staff have identified problems with the incomplete nature of the information provided by placing agencies. When this occurs, Edgewood Program staff must piece together the

client's history from conversations with the Child and Family Services workers, intake and initial assessment notes, discussions with Community and Youth Corrections and discussions with the clients themselves. Although staff can provide information regarding the clients when asked, this information is not always recorded in client files. This is especially relevant to the files maintained by the clinical case manager.

Since the last report in May 1994, the evaluation team has attempted to assist with file organization and management. Recommendations regarding client files were passed on to the clinical case manager in order to resolve the difficulties related to the missing information. File management has not significantly improved, which carries the potential to compromise the evaluation findings given the small number of clients who will complete the program before the evaluation comes to a close.

The first file audit raised a potential discrepancy between the type of boys who were targeted for admission to the Edgewood Program and the boys that were admitted. Although this may have been influenced by the intake process which resulted in the admission of boys who were already residing in the Edgewood house rather than the selection of candidates, the large proportion of boys with intellectual or cognitive delays has remained.

The final issue pertains to the residency of clients from the Edgewood Program. Most of the boys admitted to the Edgewood Program resided in rural Manitoba before placement and have family members living in their community of origin. During the after-care component of service delivery, clients must live within a reasonable distance of Winnipeg in order to participate in services. In some instances, clients will have resided away from their community and members of their family for over two years.

SECTION 5: PRELIMINARY DATA ON CLIENT OUTCOME

A primary purpose of the Edgewood Program has been to improve client functioning with regard to selected behaviours and psychosocial characteristics. This section of the report addresses the extent to which the program has been successful in its efforts, based on the assessment of outcome indicators derived from discussions with staff and a review of program documents. These findings represent a preliminary overview of program effectiveness and pertain to the first two years of service delivery.

It is important to note that changes in the duration of treatment have greatly influenced the evaluation of the Edgewood Program. The original evaluation design called for the examination of treatment outcomes for 10-12 program graduates in May 1995. However, as the duration of treatment has increased from 6-8 months to approximately 18 months, fewer boys have completed treatment. This has resulted in a total of six program graduates from which to assess program effectiveness at the present time. Unfortunately some of the pretest measures were not available for one client and therefore only five boys are included in most of the analysis.

Four standardized assessment tools were used to measure clinical change in Edgewood clients over time; the State-Trait Anger Expression Inventory (STAXI); the Piers-Harris Children's Self Concept Scale; the Risk Assessment Inventory; and the Beck Depression Inventory. These instruments were chosen in consultation with staff and were considered to assess the indicators of successful accomplishment of program goals and objectives. A brief description of the scales and the constructs which they assess will precede

the information on Edgewood client outcomes. A more comprehensive description of the clinical measures may be found in Appendix A.

The standardized instruments were supplemented by two additional measures which were constructed specifically for the Edgewood Program evaluation. The Responsibility Rating Scale was developed by staff in the early phases of program development and was designed to assist with individual assessment of the expected behaviours associated with the levels or stages of treatment. The second instrument developed by CHRA for use by the Edgewood Program was the Sex Offender Rating Scale. This purpose of this scale was to assess pre-assaultive behaviours and the offender's cognitive interpretation of the behaviours. The Responsibility Rating Scale and the Sex Offender Rating Scale were completed by staff on at least a monthly basis.

The preliminary analysis of outcome data will be accomplished through the examination of client change over time according to client scores on each of the clinical measures. As the sample size is small, it is possible to adopt a case study approach which incorporates information regarding the psychosocial history of the client, his offending behaviours and his scores on the clinical measures. This will be presented in the form of clinical profiles of individual cases. A summary of the findings will form the conclusion of this section.

5.1 Clinical Measures

As mentioned earlier, four standardized assessment tools and two therapist rated scales were used to examine the effectiveness of the Edgewood Program. In addition, a

school/work inventory designed to assess attendance and behaviour was implemented by the evaluation team in early phases of the evaluation. Unfortunately, the form was not consistently completed by the youth care workers and therefore the analysis of school and work attendance relied on limited information available in files or supplied by school records. As the information on school attendance was not available for all six program graduates, it was excluded from the analysis.

State-Trait Anger Expression Inventory

The State-Trait Anger Expression Inventory (STAXI) was used to evaluate Edgewood Program client change in regard to the experience and expression of anger. The STAXI is a standardized instrument which conceptualizes the experience of anger as having two components: state and trait anger. State anger is defined as, "an emotional state marked by subjective feelings that vary in intensity from mild annoyance to intense fury and rage," (Spielberger, 1991, p. 1). The experience of state anger varies according to situational opportunities and perceptions. Conversely, trait anger is defined as, "the disposition to perceive a wide range of situations as annoying or frustrating, and the tendency to respond to such situations with more frequent elevations in state anger," (Speilberger, 1991, p. 1). Trait anger is seen to consist of two characteristics which make up subscales of the overall construct:

- T-Ang/T:** Angry Temperament - measures general propensity to experience and express anger without specific provocation.
- T-Ang/R:** Angry Reaction - measures individual differences in the disposition to express anger when criticized of treated unfairly by others.

The expression of anger, as conceptualized by the STAXI, has three major components. These are represented by the following subscales of the STAXI:

- AX/In:** Anger In - measures the frequency with which angry feelings are held in or suppressed.
- AX/Out:** Anger Out - assesses how often an individual expresses anger toward other people or objects in the environment.
- AX/Con:** Anger Control - measures the frequency with which an individual attempts to control the expression of anger.
- AX/EX:** Anger Expression - a research scale based on the responses to the 24 items of AX/In, AX/Out and AX/Con. It provides an general index of the frequency that anger is expressed regardless of what manner.

The STAXI consists of 44 items, which form the six scales and two subscales. Normative data has been collected from adult men and women, college students, adolescents and special interest groups such as prison inmates, military recruits and surgical patients, to aid interpretation. The norms are presented as percentiles which allow a comparison of individual respondents with others who are similar in age and gender. Scale scores falling between the 25th and 75th percentile may considered within the normal range. Scores above the 75th percentile may indicate that a client is more prone to experience, outwardly express or suppress anger than individuals with lower scores.

Edgewood Program staff identified the experience and expression of anger among program participants as presenting obstacles to client functioning. Intense angry feelings and the inappropriate expression of anger were seen to be related to the sexual offending behaviours and to the sexual victimization experiences of program participants. In addition, anger was regarded as contributing to the behavioral problems demonstrated by clients.

In order to assess change in the experience and expression of anger over time, the STAXI was administered to program participants early in the treatment process and again at discharge. As the State anger subscale measures the experience of anger at the time of scale administration, it was not considered useful in assessing change over time and was not included in the analysis. Change in the Trait anger scale and the T-Ang/R subscale was desired for boys who scored below the 25th or above the 75th percentile. The rationale for including low scores as targets for change rests on the belief that Edgewood Clients should experience some anger, given their psychosocial history and offending behaviours. As the T-Ang/T scale is skewed in a direction that prevents these scales from discriminating among respondents with low scores, changes in scores below the 25th percentile were not desired.

Change in the anger expression subscales was desired for those boys who scored below the 25th percentile or above the 75th percentile on each of the subscales. It was assumed that scores below, or near the 25th percentile were indicative of problems related to the expression of anger. Low scores on the Ax/In, Ax/Out subscales may represent less frequent suppression of angry feelings and less frequent outward expression of anger, respectively. Although the less frequent outward expression of anger is likely considered positive for a population of sexual offenders, too little expression may be problematic in relation to the energy required for suppressing or controlling angry feelings. Likewise, scores above the 75th percentile on the Ax/Con subscale may indicate that the respondent is investing a great deal of energy controlling anger, which may not be sustained over time.

The following table summarizes the percentile scores for pre-post administration of the STAXI to five program graduates. The table also highlights the specific subscales in which change was desired, and the outcome pertaining to the desired change.

TABLE 10

PRE/POST STAXI SCORES FOR EDGEWOOD PROGRAM GRADUATES

	R1	R2	R3	R4	R5
Trait Pre	60	33	84**	54	19*
Trait Post	26	4	19	91	14
T-Ang/T Pre	51	51	97**	68	23
T-Ang/T Post	23	23	38	95	23
T-Ang/R Pre	84**	24*	12*	35	24**
T-Ang/R Post	35	12	6	84	35
Ax/In Pre	43	35	69	43	18**
Ax/In Post	43	18	57	18	50
Ax/Out Pre	93**	54	99**	83*	43
Ax/Out Post	54	22	63	91	78
Ax/Con Pre	68	68	81*	48	30*
Ax/Con Post	19	96	88	30	19
Number of areas in which change was desired	2	1	5	1	4
Number of areas in which change was accomplished	2	0	3	0	2

* denotes area in which change was desired only

** denotes area in which change was desired and accomplished

As the table indicates, all of the program graduates scored outside the normal range on at least one subscale of the six subscales at the beginning of treatment. One boy scored below the 25th percentile or above the 75th percentile on five of the six subscales.

Improvement in relation to the assessment of the experience and expression of anger was noted for three of the five program graduates. These three individuals scored within the normal range of the 25th to 75th percentile on at least one of the subscales for which change

was desired. For the boy whose STAXI scores fell outside the normal range in five subscales, improvements in the experience and expression of anger can be noted for three areas. In addition, high scores associated with the outward expression of anger improved for two out of the three boys for whom it was a problem at intake.

It is important to note that two of the five boys were discharged from the Edgewood Program before the completion of treatment. Respondent number four turned 18 years of age and was faced with a great deal of uncertainty about a future placement at the time he completed the clinical measures. This likely influenced his response to the STAXI. In a similar manner, Edgewood staff attempted to obtain an extension of care for respondent number one before he turned 18 years but were unsuccessful. The completion of the measures occurred shortly before the boy and staff were aware of the impending discharge, and therefore the influence of this factor is limited.

Piers-Harris Children's Self Concept Scale

The Piers-Harris Children's Self-Concept Scale is a brief, self report measure which was utilized to assess self-concept in Edgewood Program clients. This 80-item scale, subtitled "The Way I Feel About Myself," provides a global self-concept rating as well as six cluster scales to aid in the detailed interpretation of the scale (Piers, 1984). The cluster scales may be summarized as follows;

Behaviour:

Assesses feelings about typical behaviours and responsibility for actions.

Intellectual and School Status:

Measures feelings about performance associated with intellectual and academic tasks.

Physical Appearance and Attributes:

Assesses perceptions regarding physical appearance and specific physical attributes.

Anxiety:

Assesses feeling of contentment with current life status, as well as indicators of dysphoric mood.

Popularity:

Assesses feelings regarding relationships with peers.

Happiness and Satisfaction:

Measures life satisfaction and desire to be different or to be involved in different life circumstances.

Normative data provides the means for interpreting a particular client's scores in relation to an extensive sample of children who completed the Piers-Harris Children's Self-Concept Scale. Total scores which are ranked below the 40th percentile are considered below average. For individual cluster scales, scores above the 50th percentile for each scale are indicative of above average self-concept. Scores within the 16th to 50th percentile are considered average and scores below the 16th percentile are below average. Total scores and cluster scores above the 70th percentile must be interpreted cautiously as they tend not to be representative of the way the individual views himself.

Self-concept has been identified as a problem among Edgewood Program clients. The Piers-Harris Children's Self-Concept Scale was administered at intake and at discharge to five program participants, with the purpose of assessing changes in self-concept over time. Change was desired for each cluster scale in which a respondent scored at or below the 20th percentile, in order to include those individuals who could be considered as having average to low self concept. Total scores below the 40th percentile were also identified as targets for

change. Table 11 summarizes the Piers-Harris Children's Self-concept Scale scores of five Edgewood Program graduates.

TABLE 11

PRE/POST SELF-CONCEPT SCORES FOR
EDGEWOOD PROGRAM GRADUATES

	R1	R2	R3	R4	R5
Behaviour:					
Pre	23	14**	66	23	82
Post	50	63	94	18	82
Intellectual & School Status:					
Pre	20**	50	69	20**	98
Post	57	69	69	31	69
Physical Appearance:					
Pre	45	58	58	16*	72
Post	91	72	93	16	93
Anxiety:					
Pre	98	18**	69	47	57
Post	47	57	82	47	82
Popularity:					
Pre	98	18**	88	8**	88
Post	69	69	88	20	56
Happiness & Satisfaction:					
Pre	72	4**	72	56	72
Post	56	72	91	9	91
Total Score:					
Pre	72	31**	90	28*	88
Post	48	52	86	28	94
Number of areas in which change was desired	1	5	0	4	0
Number of areas in which change was accomplished	1	5	NA	2	NA

* denotes area in which change was desired only

** denotes area in which change was desired and accomplished

As the table indicates, four boys scored quite high at both administrations of the scale, resulting in few areas in which change was desired. Although this appears to indicate that the boys experienced little difficulty related to self-concept, scores above the 70th percentile must be interpreted cautiously as they are likely inflated. This is especially evident for a cluster scale such as popularity, where three of the five boys scored at the 88th percentile and above at pretest. This is likely not a realistic representation of their self-concept in this area as the boys had recently moved into the Edgewood house and engaged in new day programs. Scores which were very high across all or most cluster scales must be interpreted with extreme caution.

Of the four boys for which change was desired in at least one component of self-concept, all experienced positive change in one or more areas. For respondent number two, who appeared to experience difficulty related to five components of self-concept at pretest, post-test scores indicated improvement in all five areas. It is difficult to determine any patterns in the self-concept scores of Edgewood clients at intake, but it appears that almost all of the boys feel good about their physical appearance at discharge.

It is important to once again point out the scores for respondent number four. His score related to happiness and satisfaction with life circumstance at post-test was much lower than at pretest. This is not surprising given his impending discharge and the uncertainty related to his future, and calls for the interpretation of his scores in the context in which the assessments were completed.

Beck Depression Inventory

The Beck Depression Inventory (BDI) is a brief 21-item instrument designed to assess the severity of depression in adolescents and adults. The BDI was administered to Edgewood Program clients at admission and again at discharge. A total score derived from the pre-post administration of the BDI to program graduates provides an estimate of the overall severity of depression.

Total scores may be interpreted in relation to clinical cut-off scores determined by the scale authors (Beck & Steer, 1987). Scores below nine are considered within the normal range or asymptomatic. Scores of 10 to 18 indicate mild-moderate depression and scores of 19 to 29 indicated moderate-severe depression. Scores above 30 are indicative of extremely severe depression. The following table summarizes the BDI scores for six Edgewood Program graduates.

TABLE 12

PRE/POST BDI SCORES FOR EDGEWOOD PROGRAM GRADUATES

	R1	R2	R3	R4	R5	R6
Pretest	27	18	11	20	6	29
Post-test	8	17	2	17	4	16
Change desired:	Yes	Yes	Yes	Yes	No	Yes
Desired change accomplished:	Yes	No	Yes	No	NA	Yes

According to BDI scores obtained at admission to the Edgewood Program, five of the six program graduates presented with problems related to depression. Of these five clients,

the BDI scores of two boys did not improve significantly. Two boys whose scores at intake indicated moderate-severe depression and mild-moderate depression, improved at discharge to be found within the normal range or asymptomatic. One client whose BDI score was indicative of severe depressed at intake, appeared to improve to experience mild depression. Overall, there appears to be some improvement in the experience of depression among Edgewood Program graduates.

Risk Determination Check List

The Risk Determination Checklist is a vehicle for obtaining the therapist's perspective on the offender's risk of reoffending (Ross & Loss, 1988). The scale requires that the worker consider the seriousness of the offending behaviour, the client's general amenability to treatment, and their potential long-term response to treatment. In determining the Edgewood clients overall risk of reoffending, staff completed the 21 item Checklist at intake and again at discharge for six program graduates.

The scale is constructed in a way that requires the therapist/worker to select a risk category which ranges from low to high risk. Weighted scores are assigned to each of the categories and the weighted scores are averaged to obtain a mean determination of risk for the client's total score. Average scores below two place the offender at low risk of reoffending, while scores between two and four indicate medium risk of reoffending. Scores above four suggest that the offender is at high risk of committing another sexual offense. Table 13 depicts the pre-post Risk Determination Check List scores for six Edgewood Program graduates.

Pretest data was not available for respondent number 1.

TABLE 13
PRE-POST RISK DETERMINATION CHECK LIST SCORES
EDGEWOOD PROGRAM GRADUATES

	R1	R2	R3	R4	R5	R6
Pretest	na	1.8 Low	2.4 Med	2.3 Med	3.3 Med	0.1 Low
Post-test	4.1 High	2.3 Med	2.6 Med	2.7 Med	1.7 Low	2.4 Med
Change in risk rating:	Na	Yes	No	No	Yes	Yes

Change in post-test scores occurred for three of the five program graduates for which Risk Determination Check List scores were available. The changes involved an increased risk rating for two of the boys. This increase may be due to new disclosures of offenses during the course and treatment and greater therapist awareness regarding the offending behaviours of clients. In addition, it is important to note that the Risk Determination Check List is not designed for the purpose of comparing different offenders' overall risks of reoffending, but rather assesses each offender's individual risk of reoffending. This results in less conclusive data regarding group outcomes related to re-offending risk.

Information pertaining to the re-offending behaviours of Edgewood Program graduates was secured from program staff. It appears that none of the boys who completed treatment at the Edgewood Program have been charged with sexual offenses. In regard to

non-sexual offenses, one boy has charges pending for failure to attend scheduled appointments with his probation officer.

5.2 Clinical Profiles of Edgewood Clients

Clinical profiles were constructed for eight Edgewood Program participants for the purpose of examining clinical outcomes in the context of the clients' psychosocial history and offending behaviours. These eight clients include the first six boys who were discharged from the Edgewood Program. The profiles incorporate information obtained through the file audit, discussions with staff members and the completion of the standardized clinical measures. This information was supplemented by data obtained from the completion of the Responsibility Rating Scale and the Sex Offender Rating Scale which were developed specifically for the Edgewood Program. A visual profile of individual client scores on the STAXI and the Piers-Harris Children's Self-concept Scale may be found in Appendix B.

CASE STUDY #1: GARY¹

Background and Family Composition

Gary is a 17 year old Aboriginal boy who was placed at Edgewood in April of 1993. He was admitted to Edgewood at age 16 after being charged with sexually assaulting a child while residing in a foster placement. Gary's family has been involved in the child welfare system since Gary was apprehended at 18 months of age.

Gary was adopted by a non-Aboriginal family after being in care from 18 months to age 4. His family moved out of the province shortly after his adoption. Gary's parents noted behavioral problems immediately after Gary came to live with them. They were more aware of his self-destructive behaviours and became fearful of Gary's

¹. All names and identifying information have been changed to maintain client confidentiality.

violent outbursts when he approached adolescence. The violence behaviours increased in severity and his adopted parents decided to relinquish custody of Gary to a local child protection service. Gary was taken into care and requested to return to Manitoba in order to initiate contact with members of his biological family.

Problem Areas

Gary has been involved in numerous social services since his adoption. He was diagnosed as Attention Deficit-Hyperactivity Disorder and demonstrated violent and aggressive tendencies, which resulted in poor attendance and participation in educational programs. On several occasions the behavioral problems and violent outbursts became so severe that his adopted family feared for their safety while he was at home.

Little information is available in regard to Gary's biological family. His parents had substance abuse problems and he was subject to abuse and neglect while he was living with them. Around the time of his return to Manitoba and his attempts to reunite with his family, both of his parents passed away. Gary continues to deal with issues of loss and rejection, and struggles with his identity as an Aboriginal Canadian.

Victimization

Gary was approximately 5 years old when he was first sexually victimized. He was victimized on two occasions by two different offenders who were older children. The behaviours included fondling, manual and oral stimulation and vaginal penetration of a female offender.

Offending

Although files indicate that Gary made numerous sexual overtures while he was attending primary school, sexual offending behaviours were not identified as a serious problem until he was 14 years old. At that time Gary was placed in a foster home and was responsible for sexually assaulting the 7 year old daughter of the foster parents. The assaults took place over a period of 12-14 months and included fondling and digital vaginal penetration. Gary was charged with one sexual offense and was sentenced to two years of supervision under Community and Youth Corrections.

CLINICAL MEASURES PROFILE:

Gary completed the four clinical measures at intake to the Edgewood Program and around the time of his discharge. As Gary's discharge date was uncertain due to efforts to obtain an extension of his care past age 18, the measures were administered several weeks before he was aware of his impending move. Staff indicate that Gary

had not completed treatment at the Edgewood Program when he was released into an independent living program.

STAXI

Gary's STAXI scores indicate that he experienced some anger at intake. He did not present as overly impulsive or quick-tempered but he appeared highly sensitive to criticism or negative evaluation by others. He expressed his anger externally toward people or objects in the environment. This was consistent with the behaviour problems that he demonstrated in the form of verbal and physical outbursts. However, at first administration of the STAXI Gary did expend a normal amount of energy controlling the expression of anger.

Near the end of treatment, Gary's STAXI scores indicate that he was experiencing and expressing less anger. He appears less sensitive to negative appraisal from others and less frequently expresses his anger toward the external environment. He appears to expend less energy controlling his anger which may be related to the less frequent experience of anger. This is likely not a positive change as Gary moves away from the structured environment of Edgewood to an independent living situation. However, it appears that Gary may have experienced fewer difficulties related to the experience and expression of anger at discharge than at admission to the Edgewood Program.

Piers-Harris Children's Self-Concept Scale

Gary's total score at admission to the Edgewood Program indicated that he was above average in how he viewed himself. His scores in relation to the cluster scales of popularity and anxiety were likely inflated give his recent move to Edgewood and the circumstances around the death of his parents. Gary would be expected to score much lower on these two subscales, as well as on the happiness and satisfaction scales, as he was new to the Edgewood residence and was dealing with issues of loss. Although relative to normative data it does not appear that he is experiencing difficulties in self-concept related to any of the life areas, he sees himself as relatively weak in the areas of behaviour and intellectual and school status. The admission of some behavioral difficulties appears to influence the way that he sees himself relating to other people and is consistent with his elevated Ax/Out scores on the STAXI and with his history of behavioral problems.

At post-test Gary's total self-concept score was average in comparison to normative data. He viewed himself as above average in physical appearance and popularity. Gary's scores on all the other cluster scales were within the normal range. His scores on the behaviour and intellectual and school status cluster scales indicated that he felt better about himself in these two areas at discharge.

Beck Depression Inventory

Gary's scores on the Beck Depression Inventory were 27 and 8 for pretest and post-test respectively. At admission to the Edgewood Program Gary appears to have been moderately to severely depressed. This is likely a fair representation of his feelings given the loss he had experienced in regard to his family of origin. At discharge from the Edgewood Program Gary's scores on the Beck Depression Inventory indicated an improvement as his score was within the normal range.

Risk Assessment Check List

A pretest Risk Assessment Check List score was not available for Gary. Gary's overall post-test score was 4.1 which places him at high risk of reoffending. It is difficult to interpret change over time without data from the time of admission.

Responsibility Rating Scale & Sex Offender Rating Scale

Gary's monthly scores on the Responsibility Rating Scale reflect a trend toward decreased performance of responsible behaviours. Although data is not available from the time of Gary's admission to the Edgewood Program, scores from 10 months prior to discharge are available. In December 1993 Gary was considered by staff to be adequately performing the desired responsible behaviours and received a rating of 105. From that time until his discharge in October 1994 his score consistently dropped to result in a score of 50 at discharge. This may be related to staff assessments of his treatment progress which indicate that Gary had not completed treatment at Edgewood by the time he turned 18 years and was transitioned into an independent living situation.

Gary's monthly scores on the Sex Offender Rating Scale indicate some improvement in behaviours, beliefs and attitudes regarding the sexual offense. In January 1994 staff gave Gary a total rating of 16 out of a possible 35 on the Sex Offender Rating Scale. According to the staff rating in November 1994, Gary showed no change in behaviour, beliefs and attitudes over time.

CASE SUMMARY:

It appears that Gary improved in some areas of psychosocial functioning but did not fare as well in others. Overall, he was less prone to experience anger and less frequently expressed that anger toward objects in the environment at discharge. However, he spent less energy controlling the expression of his anger at discharge which is not a positive attribute for a sexual offender. Gary's view of himself in relation to his behaviour and his school performance improved from admission to

discharge from the Edgewood Program. His overall view of himself was average as compared to normative data.

The most notable improvement in Gary's clinical measure performance relates to the assessment of depression. This must be interpreted cautiously as the administration of the pre-test coincided with difficulties related to his relationship with his family of origin and may have been situational rather than indicative of his general feelings.

Gary's risk of reoffending did not appear to improve from admission to discharge. Staff rating of risk was high at discharge and this was supported by only minimal improvement in behaviours, beliefs and attitudes toward the offense. Gary was however, able to accurately describe the offense and to suggest what some of the possible effects of the offense might be on the victim. Staff noted that Gary accepted responsibility for the offense at discharge and was able to demonstrate some victim empathy.

According to Edgewood staff, Gary had encountered problems after being discharged from the program. He attended school for several months after leaving Edgewood but has not continued. The liaison worker has had minimal success in engaging Gary in the after care service component.

CASE STUDY #2: ROY

Background and Family Composition

Roy came to Edgewood at age 14 from a reserve community in rural Manitoba. His family has been extensively involved with the child welfare system since approximately 1976. Roy had been charged with a total of seven offenses, six of which were related to theft and mischief. He was charged with one sexual offense.

Roy lived with his biological mother and father from birth until he was 2 years of age. Around that time, his parents were unable to adequately care for him and his older brother because of problems related to alcohol abuse. The children were placed with Roy's maternal grandparents but were returned home on several occasions. Roy's sporadic stays with his parents would not last long, as Roy was physically abused by his father. Roy has four younger siblings who also did not reside with their mother. His father moved to another community and Roy had limited contact with him. Roy's grandparents have remained very involved in his life.

Problem Areas

Roy's problems appear to stem from family difficulties. Roy was physically abused and neglected while living with his parents, and still deals with issues of loss and rejection from the many attempts at reunification with his family. Files indicate that he has behaviour problems and has demonstrated violent and aggressive tendencies.

Victimization

Roy was victimized by three different offenders beginning when he was nine years of age. These offenders were male and female non-family members who were approximately the same age as Roy or a little older. The victimizations involved a range of forced sexual behaviours including exhibitionism, fondling, oral sex and vaginal penetration of one of the female offenders.

Offending

Roy's offending behaviours began at approximately 12 years of age when he sexually offended against a younger female cousin. The assaults took place over a period of one year and involved fondling, digital vaginal penetration and penile vaginal penetration. Since coming to Edgewood, Roy has disclosed approximately seven other incidents of offending behaviour which occurred with younger members of his immediate and extended family.

CLINICAL MEASURES PROFILE:

Roy completed the clinical measures at admission and one month prior to discharge. He participated in the Edgewood Program for approximately 20 months and was discharged at age 17.

STAXI

Roy's STAXI scores were within normal range for five of the six scales of interest. He appeared to experience a normal amount of anger when provoked or presented with a frustrating situation. The frequency with which he expressed his anger inwardly or outwardly and the energy he expended in controlling his anger were also within the normal range when compared to others of similar age and gender.

At discharge from the Edgewood Program, Roy's STAXI scores were lower for all scales with the exception of anger control. His high score (96th percentile) on the anger control subscale and very low scores on all other scales appears to suggest that Roy is working very hard to suppress or deny his anger. This is likely not a positive

change as his ability to sustain a great deal of control over anger expression may be questionable.

Piers-Harris Children's Self Concept Scale

Roy's overall self-concept scores compared with normative data indicate that he was average in how he viewed himself at both administrations. At pre-test, Roy recognized that he had some behaviour problems but he was satisfied with the status of his life. At discharge this appeared to improve as all of Roy's scores on the cluster scales were above the 50th percentile, indicating above average self-concept in each area.

Beck Depression Inventory

Roy's level of depression has remained relatively stable since entering Edgewood. His pre-test score on the BDI was 18 and his post-test score was 17, indicating mild-moderate depression at both administrations.

Risk Determination Checklist

Roy's rating at intake was 1.8 or low overall risk. The rating near the end of treatment is higher at 2.3 indicating medium overall risk. This increase is likely due to the disclosures made by Roy regarding additional offending behaviours which added to staff's concerns in this area.

Responsibility Rating Scale & Sex Offender Rating Scale

Staff rating of Roy's ability to perform the responsible behaviours expected of Edgewood residents as summarized by the Responsibility Rating Scale, fluctuated greatly between December 1993 and December 1994. During that year, Roy went through periods of what appears to be increasing demonstration of responsible behaviour and other periods in which he was not complying with treatment as expected. It is difficult to make assumptions about his progress in this regard as there appears to be only a marginal trend toward improvement.

Roy's monthly Sex Offender Rating Scale scores appear to suggest some improvement in Roy's beliefs, behaviours and attitudes toward the offense. Staff rated Roy as better able to understand the offense and the thought patterns which precipitate his offending behaviour. Roy's score early in treatment was 19 out of a possible 35. This improved to 30 out of a possible 35 at discharge from the Edgewood Program.

CASE SUMMARY:

It appears that during his stay at Edgewood Roy improved in some areas of psychosocial functioning. He appeared to be less angry at discharge and viewed himself as above average in all elements which were outlined by the Piers-Harris Children's Self-Concept Scale as important to self-concept. Roy's scores on the BDI indicated that he did not fare as well in terms of his depressed state.

Staff rated Roy as presenting an increased risk of reoffending at discharge. This is contradicted by Roy's Sex Offender Rating Scale scores which indicate Roy's increasing ability to monitor his beliefs and sexual offending behaviours. In addition, staff indicate that at discharge from the Edgewood Program Roy demonstrated a solid understanding of his offending behaviours as he could accurately describe the offenses and suggest potential effects upon the victim. According to staff, Roy assumed responsibility for the offense and was beginning to empathize with the victim.

Since discharge from the Edgewood Program in January 1995, Roy has experienced some difficulties. He remained in contact with liaison worker and was engaged in after-care services for a brief time. Roy's recent whereabouts cannot be determined and he is no longer attending school. As he is still required to meet with his probation officer but also not attended these meetings, charges for breach of his probation order will be laid once he is located.

CASE STUDY # 3: ANDY

Background and Family Composition

Andy was admitted to Edgewood in December of 1992, when he was 15 years old. He had previously been in custody for eight months at Aggassiz Centre for Youth as result of being charged with two counts of sexual assault. Upon release from Aggassiz, it was determined that Andy was still at great risk of re-offending and required a structured placement that could provide sexual offender specific treatment.

Andy is Aboriginal and has lived with his family in northern Manitoba. His family moved on several occasions, residing in a reserve community and in an urban centre. Andy's family consisted of his biological mother and father and three younger sisters. He continues to have regular contact with his family members.

Andy's family has not experienced extensive involvement with mandated child welfare services in the past. Child and Family Services became involved with Andy's family around the time of his placement at Edgewood. He was placed under the guardianship of the agency through a voluntary placement agreement.

Problem Areas

Andy's family has a history of alcoholism and intergenerational abuse. Andy was physically abused and neglected by his mother, and continues to deal with issues of loss and rejection. Before entering treatment at Edgewood, Andy demonstrated violent and aggressive tendencies and had admitted to considering suicide on several occasions.

Victimization

Andy was victimized by two family members beginning when he was 10 years old. One offender was male and the other female; both offenders were older children. Victimization involved exhibitionism and forced observance of sexual activity, as well as manual stimulation and attempted penile anal penetration.

Offending

Andy offended against his two year old niece and a young female cousin. The assaults were brought to the attention of family members when the two year old child was brought into the hospital requiring surgery for rectal damage. This offense occurred when Andy was 14 years old but file information indicates that his offending behaviour began at age 12. Since coming to Edgewood, Andy has disclosed several other incidents and staff estimate that he has had up to nine different victims.

CLINICAL MEASURES PROFILE:

Andy completed the clinical measures at admission to the Edgewood program, as well as shortly after discharge. He participated in sexual offender specific treatment at Edgewood for approximately 18 months. Upon discharge Edgewood staff made arrangements for Andy to enter an independent living program of Macdonald Youth Services in order to provide additional support to Andy while he was engaged in after care services.

STAXI

Andy's STAXI scores at admission to the Edgewood Program indicated that he frequently experienced anger and that he would most often express his anger toward people or objects in the environment. Although he appeared quick-tempered and prone to experience anger with little provocation, he was unlikely to experience anger when treated unfairly or criticized. Andy's scores on the anger expression scales indicate that he frequently expressed his anger externally in the form of verbal or

physical outbursts. However, he also seemed to expend a great deal of energy controlling the expression of his anger.

At discharge, Andy's scores on the STAXI indicate some improvement. He appeared to experience anger less often and was within the normal range for the inward and outward expression of anger. His score on the T-Ang/R scale indicate that he was less likely to experience anger when treated unfairly at discharge than he was at intake. Given Andy's history of victimization this is an area which an increase in the experience of anger would be desired. Andy invested a great deal of energy into controlling the expression of anger at discharge as his score on the Ax/Con was at the 88th percentile. Although this may present as a difficulty in his efforts to sustain control over his anger, the relative infrequency in which he experienced anger may result in few problems in this area.

Piers-Harris Children's Self-Concept Scale

At intake Andy generally appeared to feel good about himself in all areas associated with the six cluster scales. His overall score places him very much above average in his self-concept. This may have been how Andy viewed himself or it may have been the result of his wanting to be perceived positively by staff. Social desirability was likely influential in his selection of responses, as his scores mid-way through treatment were with the normal range.

Andy's self-concept scores at discharge indicate that he is again very much above average. His total score places him above the 99th percentile in how he views himself. His scores on the behaviour and physical appearance cluster scales indicate that he sees himself as especially strong in these areas. As most of his scores on the cluster scales are above the 70th percentile, consideration of the Piers-Harris Self-concept profile as an accurate representation of Andy's self-concept is questionable.

Beck Depression Inventory

Andy's pre score on the BDI was 22 indicating mild-moderate depression. At discharge from the Edgewood Program Andy's score on the BDI was 2 indicating the absence of feelings related to depression. Andy appears to be much less depressed at discharge than when he entered treatment at Edgewood. This is a noticeable and important improvement given file information which documents his previous suicidal tendencies.

Risk Determination Checklist

The staff's assessment of overall reoffending risk for Andy has decreased, from 4.5 at admission to 2.6 at discharge. This indicates a change in risks related to reoffending

behaviours from high risk to medium risk. The decrease in the risk rating appeared to be due to staff evaluation of Andy's general amenability to treatment and long-term response to treatment.

Responsibility Rating Scale and Sex Offender Rating Scale

Staff rating of Andy's ability to perform responsible behaviours associated with treatment at Edgewood reflect a general trend toward increasing responsibility. Although during the 16 months for which data was available, staff rated Andy as experiencing periods of difficulty in demonstrating the desired behaviours, scores for the seven months prior to his discharge indicated generally consistent demonstration of responsible behaviours.

In a similar manner, Andy's monthly Sex Offender Rating Scale scores appear to suggest some improvement in his beliefs, behaviours and attitudes toward the offense. Staff rated Andy as better able to understand the offense and the thought patterns which precipitate his offending behaviour. Roy's score early in treatment was 18 out of a possible 35. This improved to 30 out of a possible 35 at discharge from the Edgewood Program.

CASE SUMMARY:

It appears that Andy experienced positive change during his involvement with the Edgewood Program. His STAXI scores indicate that he experienced anger less frequently at discharge and was able to express his anger appropriately. He continued to expend a great deal of energy controlling the expression of his anger, which may be difficult to sustain if he begins to experience anger more frequently.

It is difficult to assess change in his feelings about himself, as his self-concept score at discharge was extremely high compared with normative data and may not have been an accurate representation of his feelings. However, it is important to note change in pre-post BDI scores as Andy improved from indications of moderate depression to within the normal range. It is possible to assume that Andy felt somewhat better about himself and his life circumstances at the completion of treatment.

Staff rated Andy as being at less risk of reoffending at discharge than at admission to the Edgewood Program. According to staff, Andy was able to accurately describe the circumstances of the offense which precipitated admission to Edgewood both at admission and at discharge. His understanding of the behaviours and consequences of the offense improved during his involvement in treatment at Edgewood and at discharge he was able to identify pre-assaultive thoughts and behaviours, as well as

demonstrate an increased understanding of the victim's experience. Staff indicate that Andy no longer blamed his family for the offence, but assumed full responsibility.

Since leaving Edgewood Andy appears to be fairing quite well. He is being monitored by an independent living worker from Macdonald Youth Services and the liaison worker from the Edgewood Program. As he is residing close to the Edgewood house, he frequently returns for group sessions or social activities. His attendance at school has remained consistent and he has been successful in completing required courses in the regular high school program.

CASE STUDY # 4: TIM

Background and Family Composition

Tim was admitted into the Edgewood Program at age 16 years after being charged with two sexual offenses. He is Aboriginal and has resided in a reserve community in rural Manitoba for most of his life. Among the many problems Tim faced, chronic health concerns were likely the greatest. When he was a young child, he was involved in an accident which resulted in a severe head injury. This had left Tim with brain damage that was demonstrated through aggressive and destructive behaviours and other medical complications.

Tim was adopted by his aunt when he was several months old because his mother had a substance abuse problem and could not adequately care for him. At 14 years of age he was reunited with his mother but she encountered problems related to his violent outbursts. He was placed in care of Child and Family Services under a voluntary placement agreement in 1991. Shortly afterward the agency received a permanent order of guardianship for Tim. Tim has 6 siblings, some of which are biological siblings and some of which are adopted siblings. All of his siblings have lived in his aunt's home.

Problems Areas

Some of Tim's problems can be linked to early childhood experiences in his family of origin. He was subject to abuse and neglect perpetrated by his mother who abused alcohol and solvents. Tim demonstrated severe behaviour problems, as well as violent and aggressive tendencies. The head injury he experienced as a young child has also left him with intellectual delays and chronic medical problems.

Victimization

Tim was two years old when he was first sexually victimized. He was victimized by three different male, non-family members. Each of these victimization experiences occurred over a period of time. One of these instances occurred while he was residing in a group home outside of the province, where he was sexually assaulted by another resident. The victimizations involved a range of behaviours including exhibitionism, fondling and oral stimulation of the offender's genitals.

Offending

Tim's offending behaviours consisted of a series of one-time assaults. Although these appear to have begun as early as age six years, Tim was not considered at serious risk of sexual offending until charges were laid when he was 15 years old. His offending behaviours included exhibitionism, fondling, attempted anal penetration and bestiality. His victims were both family and non-family members.

CLINICAL MEASURES PROFILE:

Tim was admitted to the Edgewood group home before sexual offender specific treatment was initiated at the residence. As he was already residing in the home and had a history of sexual offending behaviour, it was determined that he remain at Edgewood to participate in treatment. Tim received treatment for approximately 7 months and was discharged on his 18th birthday. As the guardianship agency was unwilling to pay for after care services, the liaison worker has had limited contact with Tim after his discharge.

Tim completed the clinical measures early stages of treatment and again at discharge. Because he left the program at the same time the evaluation was initiated, the Responsibility Rating Scale and the Sex Offender Rating Scale were not completed for him.

STAXI

According to Tim's STAXI scores at intake into the Edgewood Program, Tim appeared to experience a normal amount of anger. When he did experience anger, he would express it externally through verbal or physical outbursts. He expended a normal amount of energy controlling the expression of his anger.

Tim's STAXI scores at the end of treatment indicate that he was extremely angry. High scores on all three anger experience scales indicated that he was impulsive and felt angry often. When he would feel angry, he continued to express his anger

outwardly and used less energy controlling the expression of his anger. This may be considered a dangerous profile for an offender who had few or no external controls or supports upon leaving Edgewood. Although there appears to be little improvement in the experience and expression of anger for Tim at discharge, the anger profile must be interpreted in the context of Tim's discharge from the program.

Piers-Harris Children's Self-concept Scale

Tim's scores on the Piers-Harris Children's Self-concept Scale indicate that his self-concept was stable over time. His total score was 44 on both administrations, which places him below average in how he saw himself. His scores on individual cluster scales were average at both administrations with the exception of the happiness and satisfaction subscale. At intake he viewed his life circumstances as quite positive and scored above normal in this area. At discharge, Tim was not pleased with his circumstance and scored around the 7th percentile. Once again, Tim's posttest assessments appear to reflect his feelings about leaving the Edgewood Program.

Beck Depression Inventory

Tim's BDI score at admission to the Edgewood Program was 20, indicating mild-moderate depression. His BDI score at discharge was only marginally better at 17 and does not indicate improvement in his feelings of depression.

Risk Determination Checklist

Staff rated Tim as at medium risk (2.3) of reoffending at intake. This increased somewhat to 3.7 at discharge but was still considered a medium rating. The slight increase in the risk rating appears to be related to the agency's unwillingness to fund after care services for Tim and the belief that he left Edgewood without completing treatment.

CASE SUMMARY:

Overall, Tim did not experience positive change in any of the behavioral or psychosocial areas assessed by the clinical measures. He experienced more anger at discharge and was more likely to express his anger toward people or objects in the environment. His scores indicated that he viewed himself as below average at both administrations when compared with normative data. He was extremely unhappy and somewhat depressed at discharge.

Although Tim did not complete treatment at Edgewood, staff indicate that he did leave the program with a better understanding of his offending behaviours. He could not describe the offending behaviours at intake but could accurately describe each

offense at discharge. At intake he blamed the victims for the assaults, while at discharge he assumed responsibility for almost all of the incidents. Staff indicate that his level of victim empathy increased marginally during his stay at Edgewood.

Since leaving the Edgewood Program staff have had limited contact with Tim. He moved back to his home community after being discharged from Edgewood. Staff believe that he may have resumed sexual offender treatment in his home community but the nature of the treatment is unknown.

CASE STUDY #5: RICK

Background and Family Composition

Rick was placed at Edgewood in May, 1993 at age 15 years. He came into care after being charged with two counts of invitation to sexual touching against his five year old sister. Rick remained in the Edgewood Program for approximately 18 months, at which time he went to live with a family member.

Before residing at Edgewood, Rick lived with his mother, his younger brother and his younger sister in rural Manitoba. Rick's father lived in nearby community and had regular contact with Rick and his siblings. Rick's family has a history of alcoholism and intergenerational abuse.

Problem Areas

Rick had a history of behaviour problems and demonstrated violent and aggressive tendencies. He appeared to have had difficulties with his parents' separation and had experienced feelings of loss and rejection in regard to his father's move away from the family. Rick did relatively well in school prior to coming to Edgewood and continued to attend a regular high school program through his stay in the Edgewood Program.

Victimization

Rick was sexually victimized by a male adult family member at approximately age 11.

Rick was forced to watch the offender masturbate and was presented with pornographic videos.

Offending Behaviour

Rick offended against his five year old sister and seven year old brother. His offending behaviours began with touching his victims and progressed to forced manual and oral stimulation of his genitals by his victims, and attempted vaginal

penetration of his sister. The offending behaviours occurred over approximately one year.

CLINICAL MEASURES PROFILE:

Rick completed the four clinical measures at admission to the Edgewood Program and at discharge. The time between the first administration and the last was approximately 18 months. Rick was discharged from the program as he had completed the residential component of treatment.

STAXI

At pre-test Rick's scores on the STAXI indicated that he did not experience anger very often. This was demonstrated by low scores on all three T-ang scales and especially on the T-angR which refers to the experience of anger when treated unfairly. Rick's scores on the anger expression scales place him within the normal range for the outward expression of anger and the energy expended in controlling anger. His low score on the Ax/In scale appears to indicate that in circumstance in which he does feel angry, he is less likely to express his anger internally.

Rick's STAXI scores at discharge indicate that he continues to experience very little anger. Although he is unlikely to experience anger without provocation, he is more likely to get angry when treated unfairly. At discharge, Rick scored higher on both the internal and external expression of anger, indicating the more frequent expression of anger. His score on the Ax/Out scale and his low score on the Ax/Con scale demonstrates a change toward less control and more outward expression. This is likely not a positive change for an offender who has left an environment with external controls such as the Edgewood Program.

Piers-Harris Children's Self-concept Scale

Overall, Rick's scores on the Piers-Harris Children's Self-concept Scale at both administrations placed him very much above average in regard to how he viewed himself. At intake, he appeared to feel relatively strong in the area of intellectual and school status as compared with the other five self-concept cluster scales. At discharge from Edgewood this was somewhat lower, but he viewed his physical appearance as a relative strength. Although his post-test score on the popularity cluster scale indicated that he saw this as a relative weakness compared with other components of self-concept, he still scored within the normal range in this area. Rick's view of his popularity among peers as a relative weakness is likely related to his impending move away from Edgewood.

Beck Depression Inventory

Rick's scores on pre-post completions of the BDI were 6 and 4 respectively. Scores below 9 are considered within the normal range or asymptomatic and therefore depression was not a concern for Rick during his stay at Edgewood.

Risk Determination Checklist

Staff rated Rick at medium (3.3) risk of reoffending at intake into the Edgewood Program. At discharge this rating had decreased to low (1.7) risk of reoffending.

Responsibility Rating Scale & Sex Offender Rating Scale

Monthly staff ratings of the degree to which Rick was able to perform the desired responsible behaviours were available from December 1993 to July 1994. These ratings do not indicate a strong trend but range from 170 during Rick's best month, to 72 shortly before discharge. It is difficult to describe any behavioral changes based on the Responsibility Rating Scale scores.

In a similar manner, staff ratings of Rick's behaviour and understanding of his offending patterns varied from December 1993 to his discharge from the Edgewood Program. His ratings ranged between 22 and 30 out of a possible 35.

CASE SUMMARY:

Change in Rick's psychosocial functioning and behaviour from admission to the Edgewood Program to discharge is difficult to assess based on his scores on the clinical measures. At admission to the program, most of his scores on the STAXI were within the normal range or lower, indicating that he did not experience or express anger frequently. In addition, his scores on all six cluster scales of the Piers-Harris Children's Self-Concept Scale placed him above average when compared with normative data and his BDI scores indicate the absence of depression. These scores did not change significantly at discharge from Edgewood.

The high scores at both administrations leads to suspicion regarding the role of social desirability in Rick's selection of item responses. This may have been especially relevant to his overall self-concept score which appeared to indicate that only 5% of children in the normative sample feel better about themselves than Rick. Staff have confirmed that Rick placed a high priority on pleasing staff and may have completed the scales in a way that he felt reflected positively on their opinion of him.

Although determining change in Rick's psychosocial functioning is problematic because of his higher than normal performance on the clinical measures, staff believe that Rick left the Edgewood Program with a better understanding of his offending behaviours. Staff indicated that Rick assumed responsibility for the offenses and was able to accurately describe the facts of the offense at admission to the Edgewood Program. However, they believed that he was unable to determine the specific ways in which he manipulated the circumstances of the offense that made it more likely to occur. At discharge staff rated Rick's ability to demonstrate empathy for the victim as higher than at admission. Rick himself was able to articulate some of the consequences of the assaults which were specific to his victims.

CASE STUDY # 6: GLEN

Background and Family Composition

Glen is an Aboriginal youth who resided in a remote reserve community in northern Manitoba. Although there were many problems in his family of origin, contact with Child and Family Services was initiated only several years ago in 1991. Child and Family Services involvement was a result of Glen being charged with three counts of assault and one count of sexually assaulting his younger sister. Glen was admitted to Madonald Youth Services residential programming at age 15 and entered the sexual offender specific treatment at Edgewood at age 17.

Before being taken into care by a mandated child welfare agency under a temporary order of guardianship, Glen lived in a blended family with his mother, step father and four siblings. One of these siblings was biological, the remaining three were step-siblings. Glen was the oldest child in the family home. After coming Edgewood Glen had regular contact with his mother, and sporadic contact with his biological father.

Problem Areas

Glen's family has a history of physical, emotional and sexual abuse and neglect. Much of this has been the result of alcohol abuse by his mother. Glen demonstrated behaviour problems and had violent and aggressive tendencies. Before coming to Edgewood he had difficulties in school and was considered intellectually and academically delayed.

Victimization

Glen was victimized by an adult, male, family member beginning when he was four years old. The victimization occurred over a lengthy period of time, during which Glen was forced to manually and orally stimulate the offender's genitals. The offending behaviours progressed to include penile anal penetration of Glen by the offender.

Offending Behaviour

Glen sexually offended against his sister and four other extended family members. All of the victims were younger children. It is believed that the offending behaviour against his sister began when Glen was 14 years old and ended at age 15 when it was discovered by his mother. Offending behaviours for all his victims consisted of fondling the victim. This progressed during his offenses against his sister to also include vaginal penetration.

CLINICAL MEASURES PROFILE:

Glen entered treatment at Edgewood in May 1993 and was discharged on his 18th birthday approximately nine months later. Staff believe that he had not completed treatment at Edgewood but would have opportunities to continue working on his offending behaviours through the after-care component of services.

As Glen resided in the Edgewood house before the sexual offender specific programming was initiated, he did not complete all of the clinical measures that were determined useful for the evaluation. Pretest scores for the STAXI and the Piers-Harris Children's Self-concept Scale, as well as monthly ratings for the Responsibility Rating Scale and the Sex Rating Scale were not available for Glen.

STAXI

Glen's STAXI scores at discharge indicate that he often experienced a great deal of anger. He appeared to be easily frustrated and was sensitive to criticism from others. He would experience a great deal of anger when he felt that he was treated unfairly. His scores on the STAXI also indicated that he expressed his anger frequently by internalizing his feelings or by externalizing it toward other people or objects in his environment. Although it does appear that he made efforts toward controlling his anger at discharge, the amount of anger he experienced and the frequency with which he expressed this anger, suggests a poor prognosis in terms of re-offending risk.

Piers-Harris Children's Self-concept Scale

Glen's total self-concept score at discharge from Edgewood placed him above the 99th percentile when compared with normative data. Likewise five of six of the individual cluster scales were above the 90th percentile. The exception was the popularity scale in which Glen scored around the 70th percentile. It is difficult to interpret his results as it appears that they are inflated. Glen's profile is consistent with what the scale authors' term "Fake Positive" as he responded to almost all of the items in a positive direction. Likely this is not an accurate reflection of how Glen saw himself at discharge, given his STAXI scores which indicated the frequent experience of anger.

Beck Depression Inventory

Glen's BDI score at beginning of treatment was 29 indicating severe depression. At discharge this score was somewhat lower at 16 representing change to mild depression. Although there appears to be some improvement from intake to discharge, the score is still above the normal range. The presence of depression may be related to the anger that Glen experienced at discharge as assessed by the STAXI.

Risk Determination Checklist

Staff rated Glen at low risk (.04) of re-offending at intake. This rating increased at discharge to 2.4 or medium risk of re-offending. The increased risk rating was likely due to staffs' increased awareness of offending behaviours as a result of additional disclosures of offenses during treatment.

CASE SUMMARY:

Change in Glen's psychosocial functioning and behaviour cannot be determined from the clinical measures as pre-test measures were not available for two of the four scales. This prohibits any discussion regarding improvement in the selected psychosocial areas.

Staff indicate that Glen had not completed treatment when discharged from the Edgewood Program on his 18th birthday. They noted little improvement regarding his understanding of the offending behaviours. Glen was unable to describe the behaviours which he used to make the assault more likely to occur and staff indicated that Glen placed the responsibility for the assaults on his own victimization. In addition he did not demonstrate an increased understanding of the victim's experience from intake to discharge from the Edgewood Program.

Glen has remained in contact with the Edgewood Program since his discharge over one year ago. He resides in Winnipeg and regularly engages in recreational activities organized for Edgewood residents, in addition to voluntarily attending the Edgewood after-care group. He attends school consistently and is expected to graduate from high school in June 1995. Although Glen was discharged from the Edgewood Program as a result of his age and not his completion of treatment, staff indicated that he has fared quite well.

5.3 Summary

The Edgewood Program has experienced changes in the planned duration of treatment since the program was initially designed. The extended treatment schedules of program participants has resulted in only six program graduates. This has serious implications for the evaluation and for the utility of the clinical measures for evaluative purposes. It is difficult to draw solid conclusions about program effectiveness based on data obtain from only six clients. In addition, tests of statistical significance are impossible to complete. Therefore, the following summary of the findings pertaining to program effectiveness must be interpreted with caution;

- The Edgewood Program appears to have had some success in assisting clients to function better. Program graduates as a group improved in the experience and expression of anger as measured by the STAXI. Of the five boys for whom this was a problem at intake, three appeared to have improved in at least one area related to anger or anger expression. In a similar manner, all three of the boys for whom self-concept was a problem at intake improved in at least one area at discharge.
- Edgewood Program graduates appear less depressed at discharge. Depression was recognized as a problem for five of the six boys at intake. Three of these five boys experienced improvement with regard to depression.
- Findings in regard to change in the risk of re-offending of program graduates are difficult to interpret. According to staff ratings on the brief Sex Offender Rating Scale, most of the clients presented with fewer risks at discharge than at intake. This contradicts findings from the Risk Assessment Inventory (RAI), which is the more comprehensive of the two instruments. Findings from the RAI indicated an increased risk for all but one of the five clients for whom data was available. Results from the

RAI appeared to be influenced by new information on the boys' histories, which was not available at intake.

- None of the Edgewood Program graduates have been charged with a sexual offenses since discharge from the program. Charges for a non-sexual offense are pending for one boy who has breached the terms of his probation order.
- With regard to clinical outcomes, there appeared to be only minor differences between the boys who were discharged because they reached the age of majority and those boys who were discharged as a result of completing treatment. In addition, of the three boys discharged on their 18th birthdays, one has remained in school and is stable in his placement. In the same way, of the three boys who were discharged at the completion of treatment, only one has remained in school and is stable in his placement. This seems to suggest that the length of treatment may not be related to improved client psychosocial functioning and behaviour.
- Although the conditions of the discharge appear to have an influence on some of the boys' scores on the clinical measures, this was not the case for all clients. Of the three boys who were discharged at the age of 18, all were faced with a great deal of uncertainty. Of these three clients, two were rated poorly in terms of clinical outcomes and school attendance. Conversely, of the three boys who experienced a lengthy, planned transition away from Edgewood, all appeared to experience some improvement with regard to the measures but one has re-offended by breaching his probation order. Only one has remained in school and is stable in his post-discharge placement. Of interest, this client was transitioned into the ITS program and resides in close proximity to the Edgewood house.
- Although the small number of program graduates has resulted in few outcome measures from which to make assumptions regarding program effectiveness, the instruments have may have utility for staff as individual measures of progress. The value of the measures in terms of monitoring client progress has not been fully realized by the Edgewood staff as scoring of the measures is not accomplished in a timely manner.

SECTION 6: CONCLUSIONS AND RECOMMENDATIONS

The Edgewood Program of Macdonald Youth Services is a level IV residential treatment program for male adolescent sexual offenders. It is the only program of its kind in Manitoba, although a similar program is currently being developed by West Region Child and Family Services.

The Edgewood Program is funded by Manitoba Family Services and is delivered in an open, community based setting. Services provided include residential services to six high risk youth, after care services to program graduates, and support and short-term therapy to offenders' families. Core therapy components are consistent with those offered by other sexual offender treatment programs throughout the province. Program documents indicate that the overall goal of treatment for every offender admitted to Edgewood is total abstinence from sexual offending behaviour.

The Edgewood Program is staffed by a Clinical Case Manager, a Supervisor Treatment Worker and seven Youth Care Workers. Staff utilize what may be considered a cognitive behavioral approach as treatment focuses on teaching the offenders new perceptual and cognitive thinking patterns. Treatment is delivered through peer group therapy and individual therapy. The work accomplished through therapy is enriched by regular communication between Edgewood staff and external service providers.

After-care services form a unique element of services provided by the Edgewood Program. A liaison worker is available to discharged clients for the purpose of monitoring group attendance and supporting the offender in making healthy life choices. An after group consisting of program graduates has recently been initiated by the Edgewood Program.

Changes to the program since it was developed two years ago have resulted in a longer duration of treatment for clients. Program documents indicate that the original intention of the program was to discharge clients after six to eight months of treatment. Because staff have recognized that program participants present with many problems in addition to the sexual offending behaviours, treatment has been extended to approximately 18 months.

The Edgewood Program is resource intensive as only six boys reside in the treatment facility. The estimated per diem for all aspects of treatment ranges from \$245.01 to \$265.65. If the average length of treatment is 18 months, the total cost for one boy to complete treatment may be estimated as high as \$145,394.10.

During the first two years of service provision, the Edgewood Program has admitted 12 clients to the program. The demographic characteristics, identified problem areas and known offending behaviours may be summarized as follows:

- Program participants range in age from 14 years to 17 years at admission. Most of the boys were Aboriginal and half had extensive involvement with mandated child welfare agencies prior to placement at Edgewood. Only two of the twelve boys admitted to Edgewood were from the Winnipeg area.
- Clients admitted to the Edgewood Program have many problems to address in addition to the sexual offending behaviours that precipitated admission. Most of the adolescents were identified as having behaviour problems, low self-esteem and violent and aggressive tendencies. Over half were considered intellectually delayed.
- Most of the boys who have participated in the Edgewood Program have been the victims of multiple forms of abuse and almost all had been sexually victimized. A large proportion of clients came from families with a history of intergenerational abuse and alcoholism.

- Ten of the twelve Edgewood Program clients had been formally charged with one or more sexual offense at admission to the program. Of the remaining two boys, one was charged shortly after admission and the other had no charges pending.

It may be noted that two issues pertaining to the file audit that were raised in the first report completed by CHRA appear to still present as concerns. The first pertains to the missing, partial and/or inaccurate nature of the information contained in the client files. The second pertains to the high proportion of clients who possess some degree of intellectual disability. A third issue related to client's place of residence became evident as a result of the most recent file review. These issues are outlined below:

- Since the last report in May 1994, the evaluation team has attempted to assist with file organization and management. Recommendations regarding client files were passed on to the clinical case manager in order to resolve the difficulties related to the missing information. File management has not significantly improved as important information on client history and offending behaviours is still absent from some of the files. This carries the potential to compromise the evaluation findings, given the small number of clients who will complete the program before the evaluation comes to a close.
- The first file audit raised a potential discrepancy between the type of boys who were targeted for admission to the Edgewood Program and the boys that were admitted. Although this may have been influenced by the intake process which resulted in the admission of boys who were already residing in the Edgewood house rather than the selection of candidates, the large proportion of boys with intellectual or cognitive delays has remained.
- The final issue pertains to the residency of clients from the Edgewood Program. Most of the boys admitted to the Edgewood Program resided in rural Manitoba before placement and have family members living in their community of origin. During the after-care component of service delivery, clients must live within a reasonable distance of Winnipeg in order to participate in services. Further, in order to involve family members in treatment, their ability to travel to Winnipeg is required. In some instances, clients will have resided away from their community and members of their family for over two years. The long term impact of this separation must be considered.

This report outlined findings in regard to the effectiveness of the Edgewood Program in improving client functioning and behaviour. Four standardized assessment instruments and two additional instruments were administered by staff to program participants at admission to the Edgewood Program and at discharge. Due to the extended treatment schedules of program participants, findings related to only six clients were obtained. It is difficult to draw solid conclusions about program effectiveness based on this small number of clients. Therefore, the following summary of the findings pertaining to program effectiveness must be interpreted with caution.

- The Edgewood Program appears to have had some success in assisting clients to function more effectively. Program graduates as a group improved in the experience and expression of anger as measured by the STAXI. In a similar manner, all three of the boys for whom self-concept was a problem at intake, improved in at least one area at discharge.
- Edgewood Program graduates appear less depressed at discharge. Improvement in the area of depression could be noted for three of the five boys for whom it was a problem at intake.
- None of the Edgewood Program graduates have been charged with a sexual offenses since discharge from the program. Charges for a non-sexual offense are pending for one boy who has breached the terms of his probation order.
- Findings in regard to change in the risk of re-offending of program graduates are difficult to interpret. According to staff ratings on the Sex Offender Rating Scale, most of the clients presented with fewer risks at discharge than at intake. This contradicts findings derived from the Risk Assessment Inventory which indicated an increased risk for all but one of the five clients for whom data was available.

- With regard to the clinical measures, there appeared to be only minor differences between the boys who were discharged because they reached the age of majority and those boys who were discharged as a result of completing treatment. In addition, of the three boys discharged on their 18th birthdays, one has remained in school and is stable in his placement. In the same way, of the three boys who were discharged at the completion of treatment, only one has remained in school and is stable in his placement. This seems to suggest that the length of treatment is not related to improved client psychosocial functioning and behaviour.
- Although the conditions of discharge from the Edgewood Program appear to have an influence on some of the boys' scores on the clinical measures, this was not the case for all clients. Of the three boys who were discharged at the age of 18, all were faced with a great deal of uncertainty. Of these three clients, two did not fair as well in relation to the clinical measures and the continuation of school. Conversely, of the three boys who experienced a lengthy, planned transition away from Edgewood, all appeared to experience some improvement as indicated by the measures, but one has re-offended by breaching his probation order. Only one has remained in school and is stable in his post-discharge placement. Of interest, this client was transitioned into the ITS program and resides in close proximity to the Edgewood house.

The findings presented in this Interim Report point to the following recommendations:

1. **The Edgewood Program should review its approach to the treatment of male adolescent sexual offenders to determine if it is appropriate for use with all program participants.** The client profile indicated that a large proportion of clients possess academic or intellectual delays. In addition, almost all program participants come from families with a history of alcohol abuse. Although the link between the cognitive difficulties experience by the clients and exposure to alcohol before birth cannot be confirmed through file information, the high proportion of clients with intellectual delays and the length of time required to complete treatment leads to questions about the appropriateness of the cognitive behavioral model. This model should be examined by the Edgewood Program in order to determine its appropriateness for use with all program participants.
2. **The Edgewood Program should review the length of time required to complete treatment.** Changes to the program have resulted in a longer duration of treatment. Although some clients may appear to need longer periods of time to integrate the knowledge obtained through treatment, the estimated \$145,394.10 required to keep a boy in the program for the average stay of 18 months must be considered. Perhaps the recent link with the independent living program of Macdonald Youth Services and the creation of residential component of the after-care program, will provide opportunities to discharge clients earlier to the after-care program.

3. **The Edgewood Program should focus its attention on the needs of rural and Northern children who constitute a large percentage of its client base. This may include re-structuring the program to allow for follow-up in the client's home community, and a re-definition of the involvement of family members in the treatment process** Most of the boys in the Program resided outside of Winnipeg prior to placement in the residential unit. Even if the boys remain in Winnipeg to receive after care services, their transition to a rural or remote community may prove difficult.

4. **The Edgewood Program should review and update the client files to ensure that the information contained in them is recent and complete.** The files maintained by the clinical case manager were incomplete during the first file audit and have not improved although the evaluation team had assisted in file organization and management. Poor file management has the potential to compromise the evaluation findings given the small number of clients who will complete the program before the evaluation comes to a close.

The above recommendations must be examined in the context of the special issues that were raised in Section 2 of this report. Jurisdictional issues continue to impact upon organizations such as Macdonald Youth Services that try to offer specialized services to offenders, and limit its ability to plan and deliver services in a comprehensive, coordinated fashion. However, these issues do not limit an organizations's ability to evaluate its services over time, and continue to strive towards service excellence.

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