

**EXPLORING THE USE OF CASE LEVEL METHODS IN THE
EVALUATION OF TREATMENT FOSTER CARE INTERVENTIONS**

By

JOHN A. P. ANTHONY

**A Practicum
Submitted to the Faculty of Graduate Studies
in partial fulfillment of the Requirements
for the degree of**

MASTER OF SOCIAL WORK

**Faculty of Social Work
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Abstract

This two-stage practicum explored the use of case level methods in the evaluation of interventions in treatment foster homes. The first stage involved the application of case level methods of evaluation to three treatment foster homes over a period of ten weeks. Single system, time series designs were developed in conjunction with treatment foster parents and clinical staff. In the second stage, the methods and processes were evaluated qualitatively using an individual interview format. The central goal was to determine if case level evaluation methods could provide reliable data, that can both describe interventions and measure the effectiveness of treatment on an internally managed and ongoing basis while avoiding negative internal environmental influences to both the process and the outcome of the model. The learning goal for this practicum was the development of skills in evaluation, including design, implementation, and analysis. It was necessary during the implementation phase to reassess the way the design process was approached. This involved streamlining the methods and creating formats for the design of individualized scales.

While the initial research goals were not fully reached, there was evidence to suggest that those goals remain realistic and with practice it may be possible to refine the methods to a point where they remain user friendly and also produce more usable results. Further research entailing a commitment to the methods across a whole program and over an extended period of time is needed to assess the possibility of case level, single system designs for evaluating programs. Feedback from

participants in this project indicated that the evaluation process was relevant to the treatment foster parents and to the lives of their foster children. In conclusion, conducting case level evaluations into treatment methods for a treatment foster care program appears to provide useful data for planning in a way that engages participants in a meaningful fashion.

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Chapter 1

Overview of Practicum

The purpose of this practicum was to explore the use of case level methods in the evaluation of interventions in treatment foster homes. In the past, most evaluation of Treatment Foster Care (TFC) has been implemented at a program level by external evaluators. Case level methods of evaluation are usually internally managed and focus on the assessment of interventions in individual cases.

This practicum was designed in two stages. The first stage involved the application of case level methods of evaluation to three treatment foster homes in New Directions' Regional Specialized Foster Care (RSFC) Program. Single system, time series designs were developed in conjunction with RSFC parents and clinical staff. In the second stage of the practicum, the methods and processes were evaluated qualitatively using an individual interview format. The learning goal for this practicum was the development of skills in evaluation, including design, implementation, and analysis, through the practice and experience of facilitating case level evaluation methodology within a TFC program.

Research Questions

There were four research questions guiding this practicum. The first question was: Have the individual case level designs provided data that can validly and reliably measure the effectiveness of individual treatment interventions? What was required here was knowledge pertaining to the effectiveness of clinical decisions made by the foster parents in consultation with the clinical case manager and treatment methods

employed in the foster home. For this it was necessary to discover whether case level evaluation methods could produce clearer, more definitive results than methods that were already in use, and whether those methods could improve the decision making capacity of the treatment team and could demonstrate the success and failure of strategies in a format that was easily and quickly understood.

The second question was: Would a case level approach be able to fill the need as highlighted by Hudson, Nutter, and Galaway (1994) for descriptive information that qualitatively describes the unique characteristics of the program? This question asked whether the information gathered in the evaluation design phase could be used to build a broader picture of the programs treatment strategies. This addresses a need raised by Meadowcroft, Thomlinson, and Chamberlain (1994) to understand exactly what it is TFC parents and program staff do in relating to the foster children in their care which is different, and therefore, possibly, more effective than other types of care.

The third question was: Would a case level approach, as outlined by Gabor and Charles (1994), enable the RSFC program to collect and analyse data related to treatment outcomes on an internally managed and ongoing basis? Essentially Gabor and Charles had posited that the case level evaluation approach could provide information rich enough to be aggregated to form program level data. This question asks whether or not the case level approaches as identified by Gabor and Charles, (1994) are able, or could be reasonably predicted to eventually be able, to deliver valid and reliable data that can be aggregated to measure effectiveness of the program as a whole. In other words, was the model a workable alternative to large scale, program level evaluations that are most often externally conducted?

The fourth question was: Given that case level designs are, necessarily, internally managed methods of evaluation, what are the various internal environmental influences that impact on both the process and the outcome of the model? In addition, what internal obstacles to outcome evaluation existed and how can they be overcome? This is a political question that attempts to examine the problems that may arise from an approach that has no external controls such as are offered by outside evaluators. It was designed to look at the impacts and influences of various stakeholders on the evaluation process, on outcomes, and on subsequent uses of evaluation data.

Definition of Treatment Foster Care

Treatment Foster Care has been a growing option as a placement for children in care for about 30 years. The terms, foster family based treatment, therapeutic foster care, specialized foster care, specialist foster care and professional parenting are all commonly used in this field and in the literature. The term 'Treatment Foster Care' (TFC) has been selected for use throughout this report in the understanding that the above terms are encompassed by it.

Although every TFC program and every TFC home is different, there are many broadly shared characteristics that distinguish them from residential programs and traditional foster homes. One element of this distinction is that TFC parents are expected to have clinical training which goes beyond basic parenting skills and accept into the nurturing environment of their family homes children with severe and complex problems that cannot be managed in traditional foster care (Wells & D'Angelo, 1994, p. 127). In addition, TFC parents will occasionally receive pre-

service training and should always receive in-service training that exceeds that offered to traditional foster parents. They are considered to be active members of a treatment team that are able to meet the needs of the children placed in their care 24 hours a day. The TFC parent is central to the delivery of treatment services to the child. They play a role both as a support to the child, as he/she receives treatment from outside the TFC home, and as a treatment provider in the home. This presupposes that the caregiver either does not have another occupation, which would conflict with this requirement, or is able to pay for the cost of specialized care for the child while they are at work. Hence, the rates paid to TFC parents reflect the loss of their ability to accept employment or the extra childcare costs.

Another common aspect of TFC is a low level of caregiver to child ratio and a high level of clinical support. This includes respite assistance beyond that provided to traditional foster families in recognition of the additional stress and time invested in meeting the child's treatment needs. When placing children in TFC homes, most TFC programs utilize a matching process, which attempts to achieve the best fit of child to family. The process of placement is usually conducted over time, beginning with introductory visits, and advancing to sleepovers, and weekend stays before a child moves in. Finally, TFC homes generally provide the least restrictive option among the range of residential services for severely emotionally disturbed children and adolescents. (Hawkins, Almeida, Fabry & Reitz 1992, Thomlinson & Krysik 1993).

Rationale for Treatment Foster Care

The rationale for TFC is predicated on a number of clinical premises. The first premise is that the best interventions are those that provide the least intrusive and

the least restrictive environment possible. This acknowledges that in order for children to develop a sense of self and of self-control, the extent to which external restrictions apply should not exceed their ability to be in reasonable control of their own actions.

Secondly, opportunities for normalization must be maximized, including attendance at regular schools, and as much exposure to community programs and events as possible. This involves low adult to child ratios, individualized treatment programs, and considerable investment of time by caregivers to ensure that these experiences are positive and that exposure to troubled youth is minimised while the influence of non-troubled youth is maximized.

The third clinical premise is that the model of care must be the least threatening to the child's natural family. This is in order to support the fourth clinical premise, which rests on an ideological assumption that, in the absence of a hard to determine level of abuse and neglect, the natural family is the most viable environment in which to raise a child. Therefore, opportunities should exist to increase contact with natural families to maximize possibilities for children that are placed in care to return home.

Another rationale for the provision and expansion of TFC is that numerous studies have found it to be a less expensive option for children who would otherwise have been placed in residential care (Gabor & Charles, 1994, p.163).

Treatment Foster Care and Case Level Evaluation

The initial impetus for this practicum came from experience as a TFC parent and support worker for Macdonald Youth Services' (MYS) Alternative Parent Homes

(APH) program between March 1992 and August 1998. This practicum is a culmination of that experience in combination with an interest in evaluation derived from working towards a Master of Social Work degree at the University of Manitoba.

Academically and objectively, it makes good sense to evaluate TFC at the program level using experimental designs, with comparable control groups and a combination of quantitative and qualitative measures (Gabor & Charles, 1994). These methods have proved to be both practical and effective in providing process and outcome related data (Gabor and Charles, 1994; Hudson et al., 1994; Meadowcroft, et al., 1994). However, some of the concepts used to identify success in TFC homes pose some difficulties. They fail to relate directly to the interventions foster parents use and do not seem able to respond to the dilemmas and decisions they face as caregivers. In addition, the premise that success could be based on a measure of the level of restrictiveness accorded to a child's post-placement living environment (Meadowcroft, et al., 1994) appears to not take into account events and issues that occurred in the foster child's life prior to the placement in the TFC home or program being measured. Although these effects can be removed in experimental designs that employ random assignment methods, foster parents may still feel that they are being judged for events that were out of their control. As well, the accepted and recommended practice of comparing TFC homes with residential alternatives (Gabor & Charles, 1994) is a practice that is worth examining critically.

Program level designs play an important role in the evaluation of treatment foster care. However, there remains a need for an evaluation model that can enhance the utilization of evaluation findings to directly influence decision-making at an individual clinical level and be more able to inform parents, children and case

managers of the efficacy of the treatment methods being used. While acknowledging, from personal experience and from years of talking to other parents in both the APH program and the RSFC program, that the most important aspect of a foster home is the acceptance, support and love offered to foster children, there is also a variety of treatment modalities used within TFC (Hudson, et al., 1989; Meadowcroft, Hawkins, Grealish & Weaver, 1990; Snodgrass, 1989). This diversity of method is a strength that requires individualized attention. Therefore, as a foster parent, the utilization of a model that prioritizes the focus on individuals was an attractive concept. It was also felt that a case level approach might be more attractive to staff at RSFC as an on-going evaluation method. This was primarily, because it relates directly to individual treatment outcomes, and offers more immediate feedback for clinical decision-making (Bloom, Fischer & Orme, 1995, p. 21).

Another benefit of case level evaluation is that it ought to be possible to track a child's progress across two or more placements over time. This is an aspect that was not explored in depth in this practicum, because during the period of the evaluation the participants did not move. However, it is possible, and it would have been interesting to discover what obstacles, if any, there would be in that situation.

In addition, my reading of the literature on TFC evaluation found that there was evidence of wide variations in treatment methodologies (Hudson, et al., 1989; Meadowcroft, et al., 1994). However, the nature of those variations was not clearly understood due to a lack of qualitative material that sought to describe in detail the treatment methods used. It was hoped at the outset that the process of goal setting, specification of target problems and selection of interventions that formed the initial stages of the case level evaluations, would provide a vehicle from which would yield

qualitative information that describes treatment methodologies as they relate to specific problems. If this process can be harnessed to produce descriptive data on all or a large percentage of interventions, it will be possible to confidently present the distinct differences in treatment methodology that TFC offers over traditional foster care and residential care alternatives. The ability to describe those differences, and then quantify their effectiveness as interventions in the lives of foster children, would be a useful contribution to the field of service delivery to children in care.

One goal of TFC evaluation has been to establish the effectiveness of the model in comparison to more expensive alternatives. Research conducted by Campbell and Heinrich Research Associates (1993) and by Thomas (1993), showed that Macdonald Youth Services TFC program is a cheaper model than their residential care option. To conduct the research required proof that the two programs were qualitatively comparable. This was difficult to establish as the authors of the study found that the data pertaining to comparisons between children in residential care and those in treatment foster homes were “difficult to interpret” (p. 110). One problem was that separate people, who may have interpreted file information differently, verified the groups for “systematic differences” (p. 110) relating to histories of neglect, abuse, behavioural characteristics, family history, and other relevant factors. Also, although the Department of Family Services classified some of the children in both programs at the same level, the authors felt that there was enough anecdotal evidence from professionals to suggest that the levelling criteria were not consistently applied (p. 110).

Another goal of past studies of foster care has been to identify those characteristics that are most likely to produce successful placements (Cleaver, 1994;

Ward, 1994). While the information derived from such research can aid program planners in the targeting of future foster parents, it does not seek to maximize the potential of foster parents regardless of their characteristics. TFC is a model that provides a variety of care options. Hudson, et al. (1994) found that all the programs they reviewed were comparably different, with different children, different treatment strategies, and different foster parents. The ability to provide different treatment strategies for each child is a key component of the TFC model. Case level evaluation seeks to examine the differences, not for the sake of comparison, but to increase the possibility of success in any given situation. It asks, 'how can the options available to parents, support workers and clinical staff be maximized to increase the life chances of children in TFC?'

Summary

In brief the stated purpose of evaluation at a case level, is to assist TFC parents and those that support them to offer a better level of service to the children in their care. It is to learn what methods are effective for them, not in general, but specifically, for each individual child that comes into a home.

This practicum has therefore, been developed through the personal experience of being a treatment foster parent and through academic study of the literature pertaining to the evaluation of treatment foster care. Specifically, it is an exploration of the feasibility of case level evaluation as a tool for evaluating the effectiveness of treatment interventions in treatment foster homes. To do this involved working for a period of ten weeks respectively with three clinical case managers (CCM's) from the RSFC program and three RSFC families. Each participant was asked to volunteer

their time to share details of the presenting problems and the proposed interventions. They were asked to work in conjunction with their clinical case manager and myself, to design and conduct three distinct case level evaluations. Following this ten-week period, the practicum was evaluated using qualitative methods in order to explore the process as experienced by the participants. Finally, using the information gathered from the experience of implementing the designs and the qualitative data, the findings were analysed to discover implications and draw conclusions.

This practicum report has been organized into six chapters. Following this chapter, that has provided a contextual overview of the practicum, there is a review of the literature pertaining to the evaluation of Treatment Foster Care (TFC). Chapter three provides a detailed explanation of the two-stage methodology employed to carry out the practicum. The first stage is the design and implementation of three case level evaluations in three TFC homes. The second is the qualitative examination of that experience. The results of the first stage of the practicum are presented in chapter four, and the findings of the second stage are presented in Chapter five. Chapter six examines personal growth and learning through the practicum experience and includes a discussion of the implications for future practical application of case level design in the evaluation of TFC.

Chapter 2

Literature Review

Evaluating Treatment Foster Care

Most evaluations of TFC programs to-date have been quantitative in design. Although there is a descriptive body of work based on survey results (Meadowcroft, Thomlinson & Chamberlain, 1994, p. 568), there have been few attempts to use qualitative methods in the collection of data used to objectively evaluate programs. Hudson, Nutter and Galaway (1994), point out that the qualitative differences among programs are absent from the research and call for a greater emphasis on qualitative methods to both describe program elements and collect data pertaining to outcomes in future studies (p. 207). Meadowcroft et al. (1994) found that while the research has been able to identify the types of needs that children in treatment foster care have, it has been less successful in identifying the qualities possessed by TFC parents. The authors suggested that descriptive research into the types of parents that are successfully recruited into existing programs would be beneficial to those attempting to attract parents to new programs (p. 569). Also, while the distinguishing features of TFC in relation to other forms of care, have been well described, the activities of foster parents and other members of the treatment team have not (p. 569). In other words, it is not understood exactly what it is that TFC parents and program staff do in relating to the foster children in their care that is different, and therefore, possibly, more effective than other types of care.

Where qualitative methods have been used the results have been interesting. Cleaver (1994) utilised a strong qualitative component in her 1994 evaluation of the

frequency and effects of foster home breakdown in the United Kingdom (U.K.). In Cleaver's (1994) evaluation, an extensive review of agency records was augmented by an intensive study of ten fostering breakdowns. The qualitative component of her study revealed that the natural parents of children in care were left out of the caring process in situations where breakdowns had occurred. Kufeldt (1995) came to a similar conclusion from a purely quantitative analysis of the attitudes of children in care. In her study, contact with natural parents was found to aid the stability of in-care placements in all but a small minority of cases.

Wells and D'Angelo (1994) took a distinctly qualitative look at "specialized" foster parents to examine the problems of applying a medical model of treatment to a situation where the important variables are relationships between people, and where the impact on both treatment recipient and treatment provider is emotional in nature. Their study highlights the value of qualitative research in the human services and suggests a greater emphasis on qualitative designs.

The report to the provincial government of Nova Scotia, made by the foster care consultation committee project in 1995, utilized strategic management methods to gather information and opinions from which 59 recommendations were made. The methods used were qualitative in that committees of key informants were formed, in which concerns were expressed, beliefs were shared, ideas were discussed and policy recommendations were formulated. The report argues in favour of an approach to foster care services that moves away from a volunteer model towards an accountable, professional model of care that recognises the value of culturally appropriate placements and of maintaining contact with birth family members. Seven years earlier, the Ontario Association of Children's Aid Societies (OACAS, 1988)

conducted a quantitative study of the Ontario foster care system and found that the changing needs of the child welfare population were driving the system towards a professional level of care. While advising that the non-representative samples limited the inferential power of the report's conclusions, OACAS recommended that the foster care system in Ontario be developed in a direction that moves the system away from the volunteer model. As indicated, the two reports used different information gathering methodologies to arrive at similar conclusions.

The use of quantitative methods to measure program effectiveness in TFC has been extensive but the literature suggests it has fallen short of providing inferential evidence to support the kinds of recommendations made by the OACAS.

Meadowcroft et al. (1994), Hudson, Nutter and Galaway (1994), and Gabor and Charles (1994) all wrote articles exploring the research undertaken into the effectiveness of TFC. They concluded that the research undertaken up until 1994 had limited ability to predict outcomes. The purpose of Gabor and Charles' (1994) study was to discuss the various merits of different evaluation designs and propose criteria for future research into TFC. Meadowcroft et al. (1994) and Hudson et al. (1994) were more focussed on the analyses of the results of the research with suggestions for future directions stemming from their findings.

Reddy and Pfeiffer (1997) conducted a review of outcome studies between 1974 and 1996. They found that TFC was effective in improving permanency of placement and psychological adjustment, children's social skills, and behaviour, and in reducing restrictiveness of post discharge placement.

Hudson et al. (1994) and Meadowcroft et al. (1994) found that TFC in its many forms could affect positive change in clients, with improvements at both the

functioning level and on a variety of psychological dimensions. They also found that “most TFC placements were completed as planned” (Hudson, Nutter & Galaway, 1994, p. 208) and follow up studies strongly indicated that TFC was more beneficial to clients than institutional settings (1994). In addition, both articles report that the financial costs of TFC were consistently lower than institutional care for the same population. Meadowcroft et al. (1994) also found that time spent with supervising adults and pro-social peers may contribute significantly to the difference in outcomes found between TFC and congregate care settings. They also concluded that TFC caters to the same type of children as those found in group-care settings. This last finding is important as it serves to legitimize the use of comparisons between TFC and institutional care for evaluation purposes.

Kufeldt (1995) conducted research into the use of inclusive care models. Although her findings could not be generalized beyond the sample, she demonstrated positive outcomes for the foster children in her study. Inclusive care is the practice of including a foster child’s natural family members in decisions and events that concern the foster child while in care. Inclusive care is a common element in TFC and the ability and/or willingness of TFC parents and their clinical staff to work with natural parents is a strong selling point to social workers that have the whole family on their caseload. The argument is that if the child can be reconciled or even reunited with his/her natural family, the outcome for both child and family will inevitably be better than if the sole emphasis is placed on helping the child to readjust to a new and different situation, that is unconnected to his/her own family and community.

Evidence for this position is found in Cleaver and Berridge’s 1987 study of foster home breakdown in England (1987). In observations based on that research,

Cleaver (1994) found that continued links with birth family was an important factor in achieving stability in foster care (1994, p.143). She also found that, to reduce the risk of foster placement breakdown, social workers needed to maintain close contact with the foster home, the foster child and the foster child's birth family. In addition, foster parents who had previous experience, those who were trained and those who received regular professional support experienced fewer breakdowns in placements (p. 142). Each of these characteristics are found in TFC programs.

Cleaver's (1994) study also found that characteristics of foster homes that experience fewer placement breakdowns include foster mothers over the age of forty, foster parents without birth children who were either very young or close to the age of the foster child, and foster homes where other unrelated foster children were present (p. 142). On this last point she notes, "many of the most successful foster homes were not very different from small children's homes" (p.139).

To sum up the findings from the research reviewed so far, TFC has been able to provide a quality of care at least equal to, if not better than, institutional settings for children who would not be considered for placement in the standard foster care system. This has been achieved at a lower cost, and with a long-term prognosis for a stable adult life that is more favourable than the prognosis for children in institutional settings. The reasons for this success, it is argued, are due to better quality time spent with supervising adults and pro-social peers, a capacity for individualized treatment planning, and the practice of inclusivity in regards to biological families.

Gabor and Charles (1994) identify and critique nine recognized research methods. Table 1 provides a synopsis of their opinions. These authors highlight

many shortfalls in much of the research, most of which utilise evaluation designs with poor inferential characteristics. While taking pains to recommend a quantitative

Table 1. Strengths and Limitations of TFC Evaluation Methods.

Evaluation Method	Strengths	Limitations
Program process	Links program goals to actions	No outcome measurement
One group, post test	Measures outcome	Too many confounding variables
Post test with comparison group	Measures outcome	Cannot measure amount of change or attribute change to program
Post test with control group	Measures outcome	Cannot measure amount of change or attribute change to program
One group, pre-test/post test	Measures outcome and change	Not able to attribute change to the program
Pre-test, post-test with comparison group	Strong inferential characteristics	Difficult to form in the field, expensive, time consuming
Pre-test, post-test with control group	Strongest inferential characteristics	Difficult to form in the field, expensive, time consuming
Informal periodic review of client programs	Less disruptive, enables individual focus	Subject to bias and inaccuracy, validity and reliability problems
Systematic monitoring of client progress	Less disruptive, individualized, cheaper, inferential results	None cited, [however these methods yield inferential results slowly.]

(Source: Gabor & Charles, 1994, pp. 166-167).

design that could be effective, they conclude that for many programs the way forward is to adopt an approach that utilises individual case level designs. This was done because it was felt that the quantitative, pre-test, post-test with control group design they recommended was expensive and time consuming, as well as generally too difficult to undertake for the majority of TFC programs.

Gabor and Charles (1994) claim that the post-test with a control group design is unable to measure change or attribute change to the program being measured. As this design is a true experimental design it is difficult to support this assertion. As this design is relatively simple to set up and fairly cost effective it should be considered when designing program level evaluation for TFC. However, there will be problems in creating control groups for this design. There is an ethical issue to the random assignment of children outside of treatment. It would be difficult to justify denying treatment foster care to a child who may need it.

One approach to gathering data that has been used in the evaluation of foster care is case file reviews. This method was used extensively in Cleaver's (1994) U.K. study of foster placement breakdown and by Slaght (1993), who conducted a U.S. study to examine risk factors in foster care. The purpose of Slaght's study was to "better understand the factors contributing to the replacement and length of stay of children in foster care and the relative importance of substance abuse as one of the risk factors." (p. 146). Data for the study was collected through a review of case files on all children entering care in Baltimore, Maryland in August 1988. The files were reviewed again 18 months later.

Slaght (1993) indicates a problem with studies based solely on case file reviews. She explained that poor and incomplete information found in case files suggested that there were other variables at work; "workers feel compelled to focus on problems of greater complexity in order to justify why the child is in care" (p. 152). In addition, Slaght identified that the methodology was problematic. She found that the information on the files was "very sketchy and crucial data ... was absent from many of the records" (p. 148). Case files did not include enough documentation

concerning risk factors, as workers were more focussed on solving immediate problems. As Slaght indicates, this seriously limits the validity of the study, as it is impossible to know whether environmental factors such as poor housing were symptomatic of, or caused by, mental illness or drug abuse.

Consistency of recording was not seen as a concern in Cleaver's (1994) study. However this may not be the case in other programs, which suggests that the validity of case file reviews, as sources of data for evaluative purposes, may be determined by the quality of the reviews.

Evaluation of Alternative Parent Home Program

In 1993, a comprehensive program evaluation was conducted for the MYS Alternative Parent Homes (APH) program by Campbell and Heinrich Research Associates. The evaluation design components included the following: file audits; a time and motion study of clinical staff; interviews of foster parents and children; a survey of respite/support workers; interviews with collateral agency staff; a clinical evaluation of effectiveness; restrictiveness of placement tracking; and an analysis of the cost of care (Campbell & Heinrich Research Associates, 1993). The evaluation, which took a year to complete, found that living environments for children from the APH program were less restricted, both immediately after discharge and when tracked. In addition, it was found that the per diem cost of the APH program was significantly cheaper than MYS's residential alternatives. Costs for most children discharged from MYS were lower than they had been while with MYS.

The evaluation found that the APH program offered benefits with regard to the cost of care while in the program and after discharge. Children were found to benefit

from an increased positive self-concept, acceptable school and work attendance and an increase in the social supports available to them from family members over time. The study found that boys in the program reported a reduction in the size of their friendship networks, while girls' friendships remained stable over time. The evaluators used the Child Behaviour Checklist (CBCL) along with file information to assess the clinical effectiveness with regard to changes in problem behaviour and overall competence. The two methods proved contradictory as data from the CBCL showed that in general no significant change occurred, while the file information indicated substantial improvements in all but one of the eleven areas identified at the point of placement as problematic.

In coming to the conclusion that TFC is a valuable resource, the authors of the report rely heavily on the Restrictiveness of Living Environment Scale (ROLES), and direct comparisons with residential care. There are two problems with this approach. The first is that comparisons between groups of children in residential care and groups in TFC are difficult to make and the second concerns the use of restrictiveness of living scales as an outcome measure.

The differences between groups of children in residential homes and groups of children in TFC homes stem from the different needs of each group prior to placement. The basis for this argument is that both TFC programs and residential programs seek to "match" children to respective homes or institutions in an attempt to get the best possible placement from the outset. Whether entering a TFC home or a residential unit such as a group home, children are selected on the basis of their suitability for that environment, their willingness to be placed, and their likelihood to succeed in a given placement. It should not be assumed that children in group homes

would benefit from a treatment home environment. Nor should it be assumed that children who do well in TFC homes would do as well in a residential setting.

Social workers in Manitoba are bound by provincial law to take into consideration a child's right to live in a family setting. The Second Annual Report of the children's advocate paraphrased the rights and entitlements of children as recorded in the Manitoba Child and Family Services Act.

Section 2(1): Children's best interests shall be paramount in all proceedings of the director, the children's advocate, an agency or a court. In determining their best interests, children shall have the right to have the following taken into consideration: a right to a parent child relationship in a family setting (Manitoba Family Services Act, 1995).

Even if a case can be made for a child to be placed in a non-family setting, such as a group home or a residential treatment center, options for placements that can provide the type of relationships and the kind of environment that the CFS Act speaks to must be explored.

Another issue concerning the comparison of TFC to residential alternatives was raised during a conversation with Brian Ridd (personal communication, October 22, 1998), the co-ordinator of the APH program at the time. The point was made that managers of residential programs at MYS feel that comparing group homes to TFC homes leads to a tendency to negate the work that they do, by creating assumptions that children placed in group homes could do just as well had they been placed in TFC homes for about half the financial cost. The residential program staff believes that there will always be a place for staffed, as opposed to parented, environments particularly for those children who have lost the ability to trust parents and families and need to find a different way to create healthy attachments. They feel that children more suited to residential programs may be placed in TFC homes due to cost

considerations supported by comparative evidence from evaluation studies. Whether this is actually the case is not certain and more research needs to be done in this area if the hypothesis that cost considerations affect placement choices is to be supported empirically.

Given the problems, both experienced and hypothesised, the question is how appropriate is it to draw comparisons between groups of children from residential settings and groups of children from TFC? In addition, what weight can be given to such comparisons and how should the impact upon residential programs be dealt with?

It would be possible with large sample research to statistically correct the anomalies between the populations of residential care and TFC in order to be able to empirically compare the two groups. The question of the feasibility of such research for small non-profit agencies remains an issue.

Comparisons of TFC with residential care are common in the literature (Campbell & Heinrich Research Associates, 1993; Hawkins, Almeida & Samet, 1989; Meadowcroft, 1990; Thomas, 1993; Thomlison, 1992). These comparisons show that whether or not the two groups are comparable, children who have experienced TFC do at least as well if not better than children in residential care in the samples measured. In addition, TFC is considerably cheaper than residential alternatives. For social workers charged with the task of placing children, the logical choice on the continuum of care would be, when suitable, to choose TFC over residential care wherever possible. It still remains vital for TFC agencies to track the progress of their charges after placements have terminated and to keep organised data on the presenting problems of children, before, during, and at the end of placement.

The use of restrictiveness of living scales, as an outcome measure, is a practice that bears further examination. This form of measurement was first developed by Hawkins, Almeida, Fabry and Reitz (1992) who developed the Restrictiveness of Living Environment Scale (ROLES); this was subsequently revised by Thomlinson and Krysik (1993) in the form of the Children's Restrictiveness of Living Environments Instrument (CRLE) (1993) for use in Alberta. Both ROLES and CRLE are based on the concept that children "with special needs should be placed in a treatment environment that minimizes the restrictiveness of the intervention" (Gabor & Charles, 1994, p.163). Thus, the scales score the whole array of possibilities from self maintained residence to secure treatment facility (Campbell & Heinrich Research Associates 1993, Appendix B) and use those scores to assess the degree to which a program influences trends towards enabling individuals to move on to living environments that are less restrictive.

Based on research by Jones (1989), Snodgrass and Bryant (1989) and Stroul (1989), Thomas (1993) asserts that the "extent to which children enter less restrictive settings is considered a fundamental measure of program success" (p. 18). Thomas suggests that there "appears to be an agreement among programs that a 'successful' discharge is one in which the youth leaves the program and is able to go to a less restrictive setting" (p. 17). One problem with this concept is observed by Campbell and Heinrich Research Associates (1993), based on an example within the APH program, is that a child was moved by his placing agency from a potentially "excellent" TFC home for simply financial reasons. In this particular case the move proved to be considerably more expensive than if the child had been left in the home. In this case it is implied that the variable explaining the child's subsequent placements

was not the program but the decision to move him too soon (Campbell & Heinrich Research Associates, 1993, p. 119). Restrictiveness of living scales assume that: (1) placements are successful if they have prepared children for less costly care, and (2) the effect of placements are felt immediately, in that children will move smoothly through a continuum of care that if successful will lessen the restrictiveness of placement at each step. Both assumptions negate other variables that may affect a child's life over time. The program is only one variable in a list which includes maturation effect, peer pressure, change in biological family status, change in social worker, discovery of a talent, therapy outside the home and changes at school. That future environments are considered to be a reasonable measure of success is "based on the assumption" that improvements in "behavioural and psychological functioning" allow children to live in a "less structured setting" (p.17). There may be other reasons why a less restrictive environment has occurred. It is possible that a TFC program can successfully identify issues that require treatment in a more restrictive environment, such as a psychiatric unit. In this way, success is achieved through enabling a child to access the proper services.

To assess these issues, Hudson et al. (1994) and Gabor and Charles, (1994) recommend establishing control groups by randomly selecting children for placement in either TFC homes or "institutional" care. Random selection however, is not possible where the placing agency is legally mandated to place children in the least restrictive, most familial atmosphere possible (Manitoba Family Services, 1995, p. 40). In this sense, scales that measure restrictiveness of living environments are tied to all of the other problems associated with comparisons with children placed in residential care.

If a restrictiveness of living environment analysis can be carried out into the early adult lives of those who have been part of the program, as was achieved by PRYDE, (the therapeutic foster care program of the Presley Ridge Schools, Pittsburgh, Pennsylvania Meadowcroft, 1990), there may be some point to an examination of the data in that it could be argued that over time a clearer picture of the impact of placement options can be seen. On the other hand, time will inevitably produce more variables that could be used to explain change. Sorting out if, and where, childhood experiences of care, outside of the biological family, fit into the larger picture would require very large samples before any firm conclusions could be reached.

ROLES and CRLE are effective in that they can quantitatively describe the nature of the restrictiveness of a child's living environment. However, such scales should not be used in isolation to infer that if a lower level of environment restriction is reached the previous treatment was effective.

Recommendations for Future Evaluation of Treatment Foster Care

While many studies have used quantitative methods to measure program effectiveness in TFC, the literature suggests that the research has been "limited" (Meadowcroft et al. 1994, p. 567), and has "yet to be empirically established" (Gabor & Charles 1994, p. 177). The reasons given are that past research has suffered from small sample sizes, informality, lack of pre-test measures, and lack of control groups (p. 170). According to Gabor and Charles (1994), there are inherent problems associated with the creation of comparison groups or control groups that adequately resemble treatment groups. These problems include, cultural, or ideological

restrictions, ethical considerations, legal mandates and the matching process found in TFC (1994, p. 171). The use of restrictiveness of living scales as measures of outcome effectiveness is justifiable, if used in conjunction with a comparable control group, along with other measures, and in the knowledge that they are not a definitive measure of success. In addition, Wulczyn's (1996) argument that outcomes for foster children have to be researched using cohorts, who share social and economic variables and which are then tracked longitudinally, presents an even greater challenge by making large samples necessary and reducing the choice for selection. Wulczyn presents his argument as a challenge to traditional methods used in the analysis of the foster care experiences of children. With the theory of social dynamics as his framework and with the objective of understanding the process of change, rather than simply the nature of change, he argues in favour of a longitudinal approach that examines the dynamics of change at both the individual and aggregate levels.

The difference between Wulczyn's approach and traditional models is that he advocates the measurement of the probability of transition where none has yet occurred, as opposed to traditional methods that measure the length of time a child spends in foster care. To analyse individual level dynamics, Wulczyn uses event histories as the base from which to conceptualise and measure a child's career in foster care. He explains that a drop or rise in the aggregate number of children in foster care does not mean children spend less or more time in foster homes, nor does it say anything about their individual experiences. "Stability measured at the aggregate level can hide changes in the experience of individuals" (p. 320). Put simply, what Wulczyn is attempting to do is move away from the examination of snapshots of

children in care and towards a model that tracks the experience of children in care through time. His model uses complex statistical procedures, needs large samples and seeks to create a design that can be used to accurately generalize to the larger population. Wulczyn proposes to collect data for his method from event histories that would form the base from which to aggregate data for making larger inferences about the process of change. Applying Wulczyn's methods on a small scale to treatment foster programs would not produce enough data. For example, an agency caring for 100 foster children would be unable to produce a cohort large enough to form a statistically relevant group. Although the information could be amalgamated with that from other agencies to form larger cohorts, to do so would obscure outcomes of individual agency programs. However, the idea that children in care should be tracked over time presents an interesting and workable challenge to care providers.

Meadowcroft et al. (1994) point out that although research has been "limited", TFC has proliferated. Cost of care, cultural appropriateness, and legal mandates are all factors, which have aided the growth of the model. While the research has not been perfect, there has been considerable effort made to assess TFC. Hudson et al. (1994) state, "sufficient studies of TFC programs have now been done so that randomized experiments can compare the relative effectiveness of TFC programs to institutional programs" (p. 208). While the comparison is possible, the appropriateness of the comparison is questionable bearing in mind the differences between the two populations.

Gabor and Charles (1994) have proposed "minimum guidelines" towards "a higher level of evaluation activity" (p. 172). However, the directions proposed by both groups of researchers require conditions that are too rigorous to be realistically

implemented for most organizations. In their conclusion, Gabor and Charles (1994)

say that:

Traditional group methods have been the preferred evaluation approach in this field. However, these methods tend to be disruptive to normal program operations, are difficult and expensive to implement and, even at their best, do not yield information which can help with clinical decision making. Few organizations have the capacity to carry out such evaluations internally; most have to rely on the expertise of outside consultants and specialists. In a day of decreasing resources, reliance on these approaches is likely to result in less, not more, evaluation activity. (p. 177)

In their evaluation of the MYS, APH program, Campbell and Heinrich

Research Associates (1993) suggest that:

It may be useful for APH to define the components of a comprehensive model of care. This should include determining who is engaged in what forms of treatment, describing and evaluating individual approaches, and reviewing foster parents' qualifications and experience in delivering the various treatment modalities. Program staff have indicated that they adopt a systematic approach to their work with clients. The manner in which this approach can be applied within the foster home should be explicated, and integrated with the interventions that parents are currently practising. (p. 31).

There were no suggestions or recommendations as to how this could be achieved and the final recommendations in Chapter 10 of the report only suggest that "treatment modalities" should be "formalized" along with APH "standards" and "file recording requirements" (p.153).

Gabor and Charles (1994) suggest an option. They suggest that for most organizations the most viable alternative to the program level approach is "case level evaluation". Utilising single subject designs, case level evaluation focuses on individuals to track progress and outcomes through the specification of problems and treatment goals; the identification of a dependent variable or "measurable indicator of

change;” and repeated measurement of that variable. The process allows clinical decisions to be made from an empirical basis. Such decisions can be made at any stage of the evaluation process allowing the intervention to be curtailed if results are seen to be unfavourable to the client (Gabor & Charles, 1994, p. 175).

The following is a brief summary of Gabor and Charles’ (1994) example of a case level evaluation approach.

Jim’s problem is low self-esteem. The clinical team discusses strategies and decides on appropriate interventions, which are carefully documented. A standardized instrument will be used to test Jim’s self esteem. The instrument is administered at intervals and the results plotted. The same instrument is then used for a number of children and results are aggregated to form the equivalent of a one-group pre-test/post-test design. From which standard statistical analysis are performed such as t-tests. (Adapted from Gabor & Charles 1994, pp. 175-177)

In this example, Gabor and Charles claim that the ability of the program to positively affect the self-esteem of children in their care is being measured. How this is achieved is documented in the descriptive material that can be summarized to form a sense of what interventions have been used, under what conditions, and which treatments were, or were not successful. However, that the design mentioned above could produce program level data is resting on an assumption that it is possible to produce inferential data from many different inferentially weak sets of data. This is not likely to produce the equivalent of a one-group pre-test/post-test design. This does not mean that it is not worth doing. But it is important to recognize the limitations of the design suggested by Gabor and Charles.

Standardized measures are preferable for aggregation purposes and for the higher degree of reliability that they offer, but validity can be improved by the use of individualised measures that accurately address the specific problems in each case.

Alternative Parent Homes and Evaluation since 1993

The program level evaluation of the APH program, completed for MYS by Campbell and Heinrich Research Associates (1993), was able to offer the agency a comprehensive picture of program process and treatment outcomes. From the results came recommendations, many of which have been acted upon by APH with positive benefits to the program. In this regard, the evaluation was able to meet its goals. Conversely, a goal that was not met was the establishment of a system for an ongoing, internal collection of data on outcome effectiveness. Though the system was presented to the program at the end of the evaluation, clinical data at the level explored by Campbell and Heinrich Research Associates (1993) has not since been collected. Brian Ridd (personal communication October 22, 1998) was the coordinator of APH between 1994 and 2002, prior to which he was a clinical case manager with the program. His explanation for this apparent shortfall seems to bear out Gabor and Charles' (1994) reservations that quantitative, pre-test, post-test designs are expensive and time consuming, as well as generally too difficult to undertake for the majority of TFC programs (personal communication, October 1998).

Firstly, there were problems with the database that Campbell and Heinrich Research Associates used and passed on to the program. One problem was that the people hired by the evaluators to set up and manage the database during the evaluation did not pass the information on to staff in a way that meant anybody could actually operate the database. In addition, the evaluating agency supplied APH with a second database that crashed and the replacement was a simplified version that was not able to manage the same types of data as the original software.

Secondly, the parent body were “unsupportive” of the idea of continuing to evaluate their work with the same clinical measures used in this study.

Thirdly, Ridd felt that parents were liable to be subjective in their opinions of the behaviour of a child in their care, as it reflected on their ability as carers.

Fourthly, Ridd had concerns regarding comparisons with residential care. He felt that residential program coordinators have no desire to see their service as a last resort to be used only if a cheaper, TFC placement cannot be found. He explained that the feeling among residential staff is that residential care offers an alternative for children who, for example, find the close knit family atmosphere too much to handle and prefer to recover from abuse and neglect away from “family atmospheres” that can feel oppressive (personal communication October 22, 1998). In this sense, children in residential care are not necessarily candidates for TFC even though presenting behaviours may appear to be similar. Therefore, comparisons of the two groups can only serve to make residential care look overpriced, and may result in children being pressed into TFC homes who would likely do better in a residential setting. The assumptions contained in these arguments are not self evident and should be further studied, but they are worthy of consideration.

In essence, collecting the data was a lot of work for what was perceived as a dubious return. Within the internal environment the design was politically problematic and lacked the support of program staff and foster parents. The opinion, as expressed by Brian Ridd, upholds Gabor and Charles’ (1994) view that attempts at program level evaluation may lead to less not more evaluation (p.177).

Strengths and Weaknesses of a Case Level Approach

One strength of the case level approach is that it can be conducted on a small scale. A case level evaluation can be started by one caseworker measuring one aspect of one child's treatment. The methodology is cheap to employ for small-scale systems, is time-efficient, and serves to inform clinical decision making on an individual level.

Gabor and Charles (1994) claim that it is possible to aggregate case level data to form program level data. However, many TFC programs, including APH, have fewer than 30 foster families. It remains to be seen whether enough data on the same variables, or a proxy of the same variables, can be generated to aggregate to a program level from such small groups, without compromising the benefits derived from individualized evaluation.

Even so, in most cases the utilisation of single subject designs will be at best descriptive and most frequently exploratory. For the purposes of informing clinical decision making this is not problematic. However, ethical issues make explanatory case level designs difficult to implement (Gabor & Charles, 1998, p. 211) which in turn makes it difficult to link treatment methods with outcome effectiveness. This also means that external validity is limited (1998, p. 212), such that it would be inadvisable to apply lessons learned to other clients without first exploring hypotheses anew in each individual case. Rubin and Babbie (1993) state that limited external validity is "the prime weakness of single subject designs - - - With a sample of one we are dealing with idiosyncratic conditions that cannot be generalized to other clients, practitioners or settings" (p. 327).

Another disadvantage highlighted by Gabor and Charles, (1998) which pertains to TFC, is that single subject designs “work best with specific client target problems, rather than to general methods of problem solving” (p. 214). For example, in the situation of a TFC home, it would be possible to measure the change created in a child’s behaviour by removing or installing certain specific conditions in the home. The general effect of the entire environment cannot be measured using case level designs, because to add or subtract the child’s entire placement would be unethical. It is important to stress that the design presented by Gabor and Charles. (1998) is relatively basic involving only one period of time series measurements, without a period of baseline measurement or a period of intervention removal with which comparison can be made both visually and statistically. Quite complex designs, that measure, for example, alternating, changing, or successive interventions, as well as multiple variables and changing criteria, are also worth considering (Bloom, Fischer, & Orme, 1995, pp. 397-462).

Altshuler and Gleeson’s (1999) article discusses the need for the “well being” of children to be measured as part of any evaluation effort. They stipulate that a longitudinal design must be used to effectively measure changes in child functioning over time (p. 142). They also state that the measures must be valid, easy-to-use, relatively short, and comparable.

In ‘Refining the Evaluation of Treatment Foster Care’, James and Meezan (2002) develop an ecosystemic framework to approach the problem of how to measure interventions where a multitude of variables exist. They suggest that to effectively measure outcomes in the context of TFC it is necessary to do more than measure behavioural problems (p. 240). James and Meezan (2003) point out that very

few studies have addressed other dimensions such as “self-concept, social competence, psychological adjustment, health status and intellectual and academic functioning.” (p. 241). They also argue that the relationships of foster children to their biological families are yet to be evaluated as have their relationship with service providers, schools, peers or community (p. 241).

Summary

The literature review revealed a strong quantitative program level approach to the evaluation of treatment foster care. Where qualitative methods have been used they have either come to the same conclusions as parallel quantitative studies, as in the Nova Scotia report (Ure, 1995), raised new issues that challenge current evaluation models, as in the Wells and D’Angelo study (1994); or they have tended to contradict findings from simultaneously conducted quantitative analysis, as in the evaluation of the APH program (Campbell & Heinrich Research Associates, 1993). In general, there is agreement that TFC has been able to provide cost effective, quality care, with long term prognoses for stable adult lives to children who would otherwise be placed in institutional settings. Explanations for this success include better quality time spent with supervising adults and pro-social peers, individualized treatment planning, and the practice of inclusivity with regard to biological families.

The literature indicates that the research has fallen short of being able to provide inferential evidence relating to outcome effectiveness, citing a limited ability to predict outcomes and poor external validity as problems that need to be overcome. In addition, there is a call for research that describes and identifies effective methodologies of TFC.

Comparisons of TFC with residential options have been common practice and authors have recommended that the practice should continue, as it enables researchers to control for extraneous variables. Outcome effectiveness has been evaluated using standardized tools to measure self-esteem, behaviour, academic performance, social and familial relationships, and levels of restrictiveness found in post-treatment placements.

The use of comparison groups from residential programs is a valuable but imperfect method of forming a comparison. Placement processes and the needs of the children served may render the different groups difficult to compare suggesting caution when adopting the practice. In addition, there are ethical concerns that comparisons of this nature may lend weight to the practice of placing children in cost-effective TFC over more appropriate, although more expensive, residential options. This having been said, comparison with residential care remains the most objective method available of evaluating TFC at the program level.

The use of tools that measure post-placement restrictiveness of living environment as a gauge of success presents a problem in the evaluation of TFC. There is an assumption that program success or failure can be inferred from the results of this type of analysis. ROLES and CRLE measure the restrictiveness of living environments experienced by children. When used with comparable control groups ROLES and CRLE can only be used to determine whether post-placement environments are more or less restrictive for children from TFC than for children from control groups.

That success can be linked to restrictiveness of living in post-placement environments is a concept that is currently in dispute. James and Meezan (2003)

argue that there has been enough research done to doubt the efficacy of such measures. “Thus it cannot be assumed that prevention of more restrictive placements can be equated with improved client outcome.” (p. 240). Whether the concept has been accepted at the consumer level among TFC parents and the children they care for has not been explored. Campbell and Heinrich Research Associates (1993) brought forward a case study of a situation where the concept did not work (p. 119). Although decreased restrictiveness may be an appropriate goal for the majority of TFC children, it does not fit every case, thus it can be frustrating for TFC parents attempting to meet the needs of children for whom success needs to be measured in different ways. Also, reaching the goal may be confounded by variables beyond the control of the TFC home or program. For this reason it is a measure that needs a comparable control group. In addition, the premise that restrictiveness of living in a post-placement environment is related to the impact of treatment should only be viewed as one part of a program level measure of success and used only in conjunction with other clinical measures.

Gabor and Charles (1994) have argued that program level evaluation of TFC imposes conditions that are too rigorous to be realistically implemented for most organizations. Although the APH program was evaluated in 1993 by an outside agency, they have since experienced difficulty in continuing to evaluate their operation at a program level. There were technical problems with computer software, issues taken with one of the measures used, opposition from parents within the program, and concerns that the evaluation was detrimental to their interests of the residential program to which APH was compared.

One alternative route as suggested by Gabor and Charles (1994) is to take a case level approach to the evaluation of TFC. The advantage of this approach is that simple, single subject designs can be used that are cheap and efficient, and serve to inform clinical decision making at an individual level. The disadvantages of this approach are that results are at best descriptive, with limited external validity; there is no realistic possibility of information being aggregated to form program level data; and the general effect of treatment or treatment in general is not measurable.

Evaluation of TFC is clearly a complex issue, in which many designs are possible and none are perfect. Selecting the most appropriate design for TFC requires consideration of the academic literature and the experiences, opinions and attitudes of staff, parents and children in the program. Program level evaluations are important in that they enable program managers to present an overall picture of their programs accomplishments to funders and other stakeholders. They are less able to provide useful information on the effectiveness of clinical approaches. Case level evaluation may be able to provide information that can help to evaluate TFC ecosystemically and to more clearly define the clinical approaches used by TFC programs and provide information that can inform both TFC parents and clinical case managers as to the effectiveness of individual interventions.

In addition, they may be able to address the need as highlighted by James and Meezan (2002) for information that describes outcomes for children beyond placement stability, discharge status, program completion, rates of institutionalization and rates of re-entry to care following discharge (p. 240). Any future TFC evaluations must find ways to enhance the utilization of evaluation findings. It is imperative that program staff and treatment foster parents are able to use the

information generated from an evaluative process to improve the chance of success for the children they care for. Case level evaluation methods may be able to speak to this need through the individualization of the process and the close participation of parents and children. The goal of this practicum is to explore the feasibility of a case level approach to TFC evaluation as either an alternative, or an adjunct, to program level methods.

Chapter 3

Method

The purpose of this chapter is to describe in detail the methods used to carry out each stage of the practicum from the recruitment presentations to participant feedback. It consists of a detailed description of single system design, including analytical procedures and ethical considerations, an explanation of the methods used to qualitatively examine the participants experience and a brief description of the method employed to provide feedback from the participants regarding the role of the facilitator.

There were some difficulties in getting the planned evaluations up and running so the approach was altered. These alterations and the reasons behind them are described in the final section of this chapter.

Case Level Evaluation Method

The case level evaluations carried out for this practicum utilised single system, design methodology in an experiential, inductive approach. This involved an exploration of the issues presented in each of three cases, the definition of target problems, the setting of goals for treatment, the description of intervention strategies, the operationalization of target problems, the collection of data and the analysis of that data. Preparation for this process began with presentations to various groups of participants the details of which appear in the Appendices (Appendices A & B). The main point stressed in those presentations was that, for the purpose of examining case level evaluation as a model in

the context of treatment foster care, it would not be people that are being evaluated but interventions. Also highlighted was the importance of the contextual information that would need to be divulged and the goal of increased objectivity for those in the role of treatment foster care providers. Finally the issue of informed consent was explained.

When meeting with the treatment team, the first item on the agenda was to complete the consent forms. Three consent forms (see Appendix C) were needed, one form for the Clinical Case Manager (CCM), one for the legal guardian and a combined form for the foster parent and their foster children and or biological children should they be involved in the evaluation. The foster parents and the CCMs were presented with an evaluation 'tool bag' which was essentially a folder that contained copies of the consent forms, assessment forms, log books, the written intervention plan and any other material relating to the evaluation process.

Once all consent forms were signed we were free to discuss and record contextual information which included descriptions of the foster family, background of the child, the child's biological family and his/her involvement with them, the child's academic achievements and expectations, the child's interests, behaviour patterns, other presenting problems than the one measured, the child's relationship with members of foster family, friendships and social activities.

Target problems were specified as narrowly as possible and obtainable treatment goals were set. My role in specifying target problems was to facilitate the process through directive questioning rather than by attempting to define the problem myself. Both quantitative and qualitative information was gathered in regard to the target problem

at this stage including history, frequency, severity, type, contributing factors stimulants, and conditions around events. This information was collected to set treatment goals and possibly to be used as data for retroactive baselines and as contextual information for both internal and external validation.

In setting treatment goals, Bloom, et al. (1995) provide a valuable list of “anticipated impediments” (p. 85) that can arise during the goal setting process. This phase of the evaluation design process hoped to avoid those impediments. Those impediments and the standards set to address them at this stage were as follows: first, develop an operational definition and statement of target problems and goals in positive terms with clearly identified performance criteria; second, ensure that the chosen goals are acceptable to all relevant parties and that goals cannot be satisfied in an unsatisfactory way by, for example, completing homework by copying someone else’s (p. 85); third, it is important that the measures used are not being influenced by alternate treatments; fourth, ensure that goals are free of any possible negative consequences; finally, limit the role of the facilitator in discussions around intervention strategies to that of observer.

Also at this time, decisions were made relating to the number and frequency of behaviours to be observed during the course of the case level evaluations. These behaviours were either those arising from the intervention and anticipated as new and positive, or ‘problem’ behaviours identified during assessment. These decisions were dependent on the opportunity for observation and the type of behaviour being observed. All chosen observations were operationally defined by the parents and the CCM during the design phase. It was important to ensure that words such as ‘threatening’, and ‘bossy’

had the same meaning to both parents. The time period chosen for the evaluations was flexible but it was hoped that at least ten weeks of data could be collected. In practice, this goal was, for the most part, reached. Where baseline data was able to be collected retroactively, as in one measure in Case A, data was collected for 13 weeks.

Choosing between individualized rating scales or standardized measurements involved a compromise. While standardized measurements offer reliability, their face validity may be questionable. Individualized rating scales had excellent face validity, as they were custom fit to the client and the target problem. However, the reliability of these instruments was questionable and need to be used in conjunction with standardized scales and other information to check for reliability.

Scales

The standardized scales chosen were *The Behaviour Rating Index for Children* (BRIC) (Appendix E), the *Hare Home Self esteem scale* (HHSE) (Appendix F), the *Self Concept Scale for Children* (SCSC) (Appendix G), the Mood Thermometer (MT) (Appendix H), and the *Index of Sister Relations* (ISR) (Appendix I). All of these scales were reviewed in *Measures for Clinical Practice* (Corcoran & Fischer, 2000).

The BRIC was developed by Stiffman, Orme, Evans, Feldman, and Keeney (1984). It is easy and quick to use, suitable for longitudinal studies, and when completed by adults has good test retest reliability. It also has good internal consistency, with an alpha score of .80 to .86 for adults. The BRIC has good concurrent validity as it

correlated well with the 118-point Child Behaviour Checklist (Corcoran & Fischer, 2000, p. 473).

The MT is a standardized measure developed by Tuckman (1988). It is designed for adolescents and attempts to measure one's awareness of both well and ill being. The internal consistency of the measure was tested using factor analysis "to show the internal association of the four items of poorness of mood" (Corcoran & Fischer, 2000, p. 574). Test-retest reliability showed average correlations of 0.57. The MT correlates well with the Profile of Mood Scale indicating good concurrent validity and it also did well in a test for known groups validity. It was favoured because it would be quick to complete and appeared to have good face validity for use with children. It utilised a graphic image of a thermometer rather than a list of questions and the page had to be turned upside down to read half of the thermometers. Supposedly, this function made it more likely that a child would pay attention to the variously descriptive points of each scale.

The MT asks the participant to mark on a graphic drawing of a thermometer where they feel they are at on a series of five scales that subjectively measure tension confusion anger fatigue and depression. Each of the five mood categories were analysed separately. For a picture of overall mood the categories of tension, confusion, fatigue and depression were added and divided by four. In part, the MT and the BRIC were chosen as both measures were considered to have application across Treatment Foster Care settings. It was hoped that both tools could be used in all three evaluations.

The HHSE was developed by Hare (1985). It is one part of a three-part instrument that is scored by children and examines self-esteem in the realms of home,

school, and peer relationships. The mean from the test samples ranged from 90.4 to 95 with a group mean of 91.1 for all sub-samples based on all three measures. If only one of the three measures is used the mean range is from 30 to 32. No internal consistency data are reported. Test-retest correlations have three-month correlations ranging from .56 to .65 for the three subscales and .74 for the general scale (Corcoran & Fischer, 2000 p. 550). These scores are not particularly high, although the report in Corcoran and Fischer (2000) suggests that it shows “good stability” (p.550).

The SCSC is a relatively straightforward scale developed by Lipsitt and was first published in *Child Development* (1958). It can be scored by children as young as nine years old. The mean score from the test samples for the SCSC was 86.75. Internal consistency has not been tested for this instrument but “two week test-retest correlations range from .73 to .91 indicating good stability” (Corcoran & Fischer, 2000, p. 617). The SCSC correlates well with the Children's Manifest Anxiety Scale providing some evidence of content validity. It “consists of 22 descriptive adjectives tapping children's feelings about themselves, which are responded to on 5-point scales” (p. 617).

The ISR was developed by Hudson (1992). It is a standardized measure designed to be completed by the participant children and examines the degree or magnitude of problems clients have in their relationships with brothers or sisters (Corcoran & Fischer, 2000). In terms of reliability, the ISR has excellent internal consistency with alphas in excess of .90. The validity of the measure is supported by reports of very good content, factorial, and construct validity, with validity coefficients of .60 or larger (Corcoran & Fischer, 2000, p. 379).

The key to designing effective evaluations is to anticipate any problems that may occur with the reliability of the data collected as well as any threats to internal validity. Due to the vested interests of both foster parents and CCMs in seeing their chosen intervention perform well, corroborating evidence was necessary. For each case level evaluation design attempts were made to use multiple measures, combined with information from the foster parent's monthly reports, the CCMs contact sheets and other file information collected as part of regular practice.

Issues of Reliability and Validity

The reliability of the data should be discernible from the data; however, it would be prudent to create good data from the outset by maximizing both the reliability and validity of observations. Following are some rules for maximizing the reliability and validity of data. First, it is important to ensure that the collection procedure is complex enough to be valid but simple enough to be carried out by those actually collecting the data and that the procedure is clearly understood. Second, the data must be monitored and checked. For example, it may be possible to occasionally ask a respite worker or the other foster parent to also observe the target behaviour. Third, using standardized measures with high test-retest reliability and high coefficient-alpha scores that are designed specifically for the client group and situation for which it will be used will increase the reliability of the data. Fourth, it is important to maintain the independence of observed data, so that for example, the act of taking an earlier measurement does not

affect one taken later. Fifth, it is crucial that observations are made and standardized scales are completed under the same circumstances each time.

In practice, to maximize reliability, it was possible to create individualized scales that were concise and easy to complete in very little time. Each individualized scale took less than two minutes to complete. The data was collected on the same day and at the same time of day each week. Also there were at least four scales used in every case and each evaluation utilised at least two standardized measures. Efforts were made to ensure that the procedures were clear to the participants. With hindsight these efforts were not adequate.

The issue of reactivity, which is the effect on the client or on the problem due to the act of measurement, is always uppermost when using repeated measures in time-series designs. This issue relates to the need for multiple measures and triangulation of the design, which will enable data to be corroborated statistically. One way to check for reactivity is to collect data from the child, through the CCM and/or the foster parent, regarding their awareness of the measurement process. Another way is to consider having a period in the evaluation when data is not being collected, after which, a one time, global measure can be taken that can be compared with the time-series data. In each case multiple measures were used and the CCMs were asked to check in with the child participants around their experience of completing the forms.

Protecting the internal validity of the case level evaluation designs is an issue that can, to some degree, be addressed by ensuring that in each case there is enough contextual information to support the data collected from the measures used. Such

information needs to be collected systematically to ensure that it was done and that it was not merely anecdotal. The current practice for CCMs in the RSFC program is to visit their foster families bi-weekly. At these visits the foster parents report on events and discuss their child's progress. This information was included in the documentation and used in the final evaluation. The value of this information is that ideally it will cover the whole spectrum of the child's life, which, when compared to the singularly focussed quantitative measures, may enable the researcher to more accurately attribute change to either the intervention as measured or to events external to the intervention.

Single subject designs do not lend themselves easily to generalization, therefore external validity is not a major issue. With good contextual information it may be possible to apply the lessons from individual case level evaluations to other cases within the same program. However, it would not be advisable to generalize beyond the sample and make clinical decisions for non-evaluated cases based on a single evaluated case.

Single System Design

I intended to keep the designs as simple as possible but considered the following variations: Basic, A-B, A-B-A, A-B-A-B, multiple baseline, and changing criterion. The basic design repeatedly measures the effect of the intervention or the 'B' phase over time. It is possible to augment the basic design with data gathered retrospectively to form a baseline. The A-B design requires a period of measurement where there is no intervention, known as the baseline or 'A' phase. This is followed by the intervention or 'B' phase, which ordinarily lasts longer than the 'A' phase and measures the effect of the

intervention. The 'A' phase acts as a control from which comparisons with the intervention phase can be made. The A-B-A design incorporates a follow up phase, where measurement is continued after the intervention has ended. This enables the practitioner to evaluate the lasting effects of the intervention. In the A-B-A-B design the intervention is removed and measurement is continued for a period equal to the baseline period, after which, the intervention is reinstated. Multiple baseline designs can be used to measure different responses for an individual, the same response for different individuals, or the same response for an individual across different situations (Kazdin, 1998, p. 217). By introducing the intervention at different points along a continually measured baseline, it is possible to demonstrate the effect of an intervention without needing to remove it as in the A-B-A-B design. The changing criterion design uses incremental changes in performance criteria to demonstrate the effectiveness of an intervention. Following a baseline phase, an intervention is introduced for which the criteria for success are changed as goals are reached by the client. If behaviour matches the criteria as it is changed, then success is more likely due to the intervention than to the effect of extraneous variables (1998, p. 220).

The length of the baseline depends on the observed result once measurement has begun. It may be necessary to commence the treatment phase quickly or conversely cancel the intervention. Intervention and follow up periods of measurement are also subject to change and rely on clinical decisions derived from the observed impact of treatment or the withholding of that treatment.

In practice, finding ways to vary the evaluations beyond simple A-B designs proved very difficult. Evaluating practice within the constraints of an academic exercise, such as a practicum, led to design and implementation limitations. For example, it was necessary to fit the evaluations into a specific time frame. This meant that each evaluation period was limited to ten weeks and started when it suited those collecting the data rather than at specific periods when alternative treatments or interventions were planned. The result was that a baseline phase was developed in just one of the evaluations. A baseline was established in part of Case C, but the individualized scale designed to measure the effect of the planned intervention was not used, because the foster parent did not implement the intervention.

Data Collection

The next stage in the evaluations was to collect data, monitor the results and document contextual changes. The data was collected in a variety of ways. Children, foster parents and clinical case managers completed standardized and individualized scales weekly. They were each shown how to fill in the scales and demonstrated that they were confident. The parents and CCMs were asked to show the child participants how to complete the scales they were responsible for. After a ten-week period the evaluations were reviewed with the case managers and foster parents and in each case it was considered appropriate to end the collection of data as planned. Information from the file was collected and reviewed for comparison with other data. All data was then collated and entered into the Singwin program for analysis. From there graphs were

created, statistical analyses were run and the findings were presented to the treatment teams.

Analysis

The detailed analyses of results for each case are presented in Chapter 4. The results were analysed both by visual evaluation of the graph and statistical analysis of the data as clinical decision-making cannot rely solely on either method. Statistical analysis ensures that any distortions in the graphed information will be accounted for, while visual analysis enables the practitioner to evaluate the impact of the intervention in relation to time. Also, it may be that statistically, the data shows that a change has not occurred; yet the graph may indicate that the client's goals were met over the period of measurement. In this case the practitioner may decide to continue the intervention for a longer period and re-evaluate at a later time.

In general, to evaluate visually, straight and level lines were sought to indicate reliability; for example steady change in a singular direction during the intervention phase indicated the presence of a directional trend while a level line indicated that no trend was apparent. Lines that appeared to zigzag with no obvious trend in either direction were analysed statistically. The Singwin program from *Evaluating Practice* (Bloom, Fischer & Orme. 1999) was used to run the statistical calculations. Regression analysis identified the presence of directional trends and also analysed the possibility that the trend was a result of chance alone. The degree of trend is symbolized by the letter *b*. When $b = 1$ this indicates a modest trend. A *b* score of 2 indicates a steep trend while a

score of 0 indicates the absence of a trend. Negative trend scores indicate trends in the opposite direction. The p score gives an indication of the statistical significance of the trend, which is the degree to which the identified trend may have been a result of chance alone. Tests for descriptive statistics were run to define measures of central tendency and standard deviation and chi-square tests were used to determine the statistical significance of the change between baseline and intervention. Singwin defaults to a two-tailed test of significance. However it is appropriate to divide the two-tailed measure of probability given in the Fishers Exact test by two to recreate the test as a one-tailed test where a directional hypothesis is indicated. Alpha levels were set at $p = 0.05$. In practice, using chi-square was not appropriate as the sample sizes were too small. Expected frequencies need to be greater than five in at least three of the four cells of the chi-square results table (Bloom, Fischer & Orme, 1999, p. 596). However for the purpose of practical experience, the chi-square statistic was computed for the two scales of Case A where there was both baseline and intervention data.

In addition each measure was considered for testing for serial dependency using the autocorrelation function in Singwin. This test was done to challenge the assumption of the independence of observations. This can be a particular problem with time series designs due to the repetition of measures over time. Autocorrelation was reported wherever it was indicated statistically. It should be noted however that the absence of statistical evidence of serial dependency does not mean that it does not exist. Data sets may be too small to allow for statistical detection. Autocorrelation was not

reported for data that indicated a trend supported by regression analysis as the methods in Singwin can produce an inaccurate result (Bloom et al. 1999, p, 525).

All information from statistical analysis was combined with clinical judgement that was informed through client consultation.

Ethical Considerations

To meet ethical standards, this practicum required the informed consent of all participants. It was the intent of the practicum to facilitate a case level evaluation method for evaluating interventions in TFC homes. Ultimately, it was the method that was under scrutiny and not the intervention. However, the method did evaluate interventions, the results of which can be used to influence clinical decision-making. Thus, it was important that both elements of the study met ethical requirements.

The intent of the method was to evaluate interventions and not the people implementing them. However, there was a risk that if an intervention was evaluated as unsuccessful, individuals may have interpreted it as a personal failure. This risk was ameliorated through the team approach used throughout the evaluation. Also, it was important that participants recognised that negative evaluations of an intervention are as successful as positive ones, as both results positively influence clinical decision-making. This point was made during the verbal presentations that preceded the evaluation stage of the practicum.

The results of the case level evaluation are the property of the RSFC program and are subject to all confidentiality policies that exist within the agency. All names and

identifying information have been changed in this report. Participants have been informed that the final report may be published and the findings made generally available.

Participants were informed that both an ethics committee and a practicum committee ensured the integrity of the research. The University of Manitoba Ethics Committee approved consent forms appropriate for research involving minors (see Appendix C).

All aspects of informed consent were discussed with the foster parents, the CCMs and the legal guardians. The consent form included the understanding that participation is voluntary for both children and adults, that there would be no cost to those involved, that the participants would be required to volunteer time and effort in the course of the study. In addition the consent form included the issue of confidentiality, the possibility of impact to the agency and the program, and the issue of future presentation or publication of material.

How much time volunteers will be asked to donate was detailed during the recruitment phase and negotiated with the treatment team (including the participating foster parents) and myself. One of the benefits of case level evaluation is that it can be incorporated into practice without adding to the practitioner's workload (Bloom et al. 1995, p. 21). Whether or not this is the case was an important question in the evaluation, so participants were informed that while it was hoped that their workload will not increase it could not be guaranteed.

Another important ethical consideration is that the practicum may have an impact on the organizational structure of the program. The point was not to avoid the possibility of change, but to ensure that those engaged in the process understood that changes in internal power relations, administrative procedures and clinical practice might be an effect of the practicum.

Feedback to the participants for the case level evaluation portion of the practicum occurred on a continual basis throughout the exercise, as the participants, being part of the clinical team, were closely involved with the data and the decisions that stemmed from the findings. With regard to the practicum evaluation that follows the exercise, feedback will be given in a presentation to the RSFC foster parent group meeting when the practicum is complete. Access to the report itself will also be available.

Ethically, single subject evaluation design has many benefits. The process of target specification enables accurate identification of presenting issues and potential for change in the client situation, which objectively assists in the provision of demonstrable help (Bloom et al., 1995, p. 632). The evaluation was designed to ensure that no part of either the evaluation process or the intervention could be harmful. The clients were involved in the process and could withdraw from participation at any point. There was no punishment or consequences for not achieving the goals of the intervention or for not wishing to complete any assigned tasks.

Bloom et al. (1995) advise that the intervention process should not be impacted by the evaluation process (p. 634). This point was adhered to in Case A and C. In Case B the evaluation did in part, enmesh intervention and evaluation in that the CCM used the

Index Format scale as a discussion tool in her weekly meetings with the child. The scale was not designed to judge performance, it was designed to assess change in the relationship between the child and her mother to see whether the treatment plan that had been devised was effective or not. In this respect the process was an open one and did not ethically compromise the study.

Practicum Evaluation

The design for evaluating the practicum used naturalistic inquiry methods to collect qualitative data. Naturalistic inquiry, or ethnographic methodology, is an attempt to study “culture from the point of view of people who inhabit that culture” (Rubin & Babbie, 1993, p. 361). In this case these methods were employed to ensure that the questions asked were understandable and relevant to the interviewees. I interviewed all the adult participants using a combination of closed and open-ended questioning. The decision to go with this design was primarily based on the goals of the practicum, which were focussed on discovery and the exploration of new concepts within a specific milieu. A naturalistic approach to the collection of data allowed for unanticipated affects of the practicum to be documented. In addition, naturalistic inquiry facilitated humanistic methods that personalized the data collection process, an element that was important to this study, as it was desirable that participants felt personally connected to the process. There was also a need for an emphasis on unique and idiosyncratic individual experiences, so as to bring out the differences between different stakeholders.

The decision to not interview the child participants was made to keep the project within reasonable limits. It is understood that this decision does place certain limitations on the results of this practicum, and in the future it may be interesting to include their perspective in the feedback component of any project.

After the evaluation and analysis was complete participants were asked questions that related to their experiences. These questions were not seeking to just fit answers into specified research hypothesis, but attempted to gain a full understanding of each participant's experience from which theory can then be developed. The interviews used a semi-standardized individual format, using some predetermined questions with freedom to digress. In addition, scheduled and unscheduled probes were used. Some undetermined questions to be derived from the interview process were also used. For example some of the participants were asked to elaborate on statements they made.

Feedback on Facilitator's Role

Questions on the feedback questionnaire were completed anonymously and voluntarily by all participants. The purpose of the feedback questionnaire was to help the facilitator determine whether personal goals for the practicum were met. The form comprised of ten questions, with answers to be recorded on a 4 point Likert scale. There was also a space provided on the form for any additional comments.

Adaptations to the Implementation Phase of the Practicum

The initial intent of this practicum was to use the Alternative Parent Home Program (APH) run by MacDonald Youth Services (MYS) as the pool of participants. The APH staff group and the APH Advisory committee (made up of foster parents and management staff) were briefed on the practicum on two occasions (see Appendix A). In addition, a presentation was made to the APH foster parents meeting to explain the purpose of the study in preparation for case managers to ask for suitable volunteers (see Appendix B).

This process netted three groups of participants. The first group consisted of a single foster parent with one foster child and their case manager. The foster parent was interviewed with the case manager and some areas to evaluate were developed. That was as far as the process got because the foster child in the group decided that she was not comfortable with the idea and declined to sign the consent form. All concerned accepted this and we moved on. Two other groups of participants were willing to start and visits to both foster parents were made to discuss the process. This time life outside of the practicum got in the way and a job and location change made working with foster parents in Winnipeg from the MYS program too difficult. A decision was made to change the focus of the practicum to the New Directions RSFC program. This is a similar program to APH and the integrity of the study was not compromised.

However, trying to set up meetings with foster parents and case managers was still very time consuming. TFC parents and their case managers are busy people often

managing crisis situations and the needs of graduate students were, understandably, rarely a high priority. As a result the process was often stalled and a lot of time went by as attempts were made to start individual evaluations.

It was necessary to find a way to implement the evaluation phase more quickly. The process of evaluation design had to begin as soon as the decision to evaluate was made. The goal was to have the whole procedure, from the introduction of participants to the methods of case level evaluation, to the completion of the design of the evaluation last not longer than 3 hours and to have the necessary documents ready at the same time. The necessary steps are outlined in the Case Level Evaluation Set-up Guide (see Appendix D).

The original proposal outlined a six-phase process from the initial meeting with participants to the collection of data. Within this process were three steps that required intensive work with the treatment team, which was comprised of the foster parents and their clinical case manager. These steps were: 1) preliminary assessment; 2) information gathering; and 3) evaluation design. This process had to be revised so that all three steps could be completed in one meeting.

One of the stumbling blocks encountered when attempting to get the APH evaluations off the ground was that my working knowledge of available standardized tests was inadequate. It was necessary to have more immediate access to as many standardized tests as would work in the expected situations. In February 2001, standardized measures and selected scales that were suited to single subject time series designs with the client population were researched. Most of the tests were identified in

the *Handbook of Family Measurement Techniques* by Touliatos, Perlmutter and Strauss, (1990), and in volumes One and Two of *Measures for Clinical Practice* by Fischer and Corcoran, (2000).

The objective of this research was to find standardized scales that were short, were quick to complete, were easy to comprehend and still had good test-retest reliability. There are literally thousands of standardized tests available. One of the best ways to identify them is in the Appendix to chapter 7 of Bloom, Fischer and Orme's book, *Evaluating Practice* (1999). The *Handbook of Family Measurement Techniques* by Touliatos, Perlmutter and Strauss, (1990), and *Measures for Clinical Practice* by Fischer and Corcoran, (2000), provide the most recent descriptions and evaluations of tests relevant to the client group. For the very latest in tests available for sale, Psychological Assessment Resources, Inc (see Catalogue of Professional Testing Resources, 2002) publish a quarterly catalogue of scales, providing brief descriptions and statistical summaries for each measure. It is worth subscribing to, particularly as it is free, but it is a commercial venture and full data on each test are not usually made available. Also, the catalogue does not provide a sample of questions so it is hard to discern face validity before purchasing.

The selection of standardized scales began by first selecting all the scales that were relevant to treatment foster care. Of interest were tests that examined relationships within families, self esteem of children, parenting satisfaction, child satisfaction and child behaviour. Tests that were more geared to performance such as might be used in educational evaluation were avoided. In the search many tests were considered and

rejected. One example was the “Child Sexual Behaviour Inventory” (Friedrich & William, 1992). The main problem with the test was that it was relatively long with thirty-five items, it was designed to be administered every four weeks and was geared towards the examination of past, not current, events. Another example of a rejected test was the “Issues Checklist” developed by Prince (Touliatos, Perlmutter & Strauss, 1990, p. 384). This test was seriously considered but with 44 items was too long. In general tests that were too long or had poor test retest characteristics were rejected. As well, tests with poor face validity or were otherwise irrelevant to the participating client group were omitted.

In addition to the scales already discussed in this chapter, namely the BRIC, the SCSC, the HHSE scale, the ISR, and the MT, the following scales were chosen for the toolbox: 1) Depression Self Rating Scale (Corcoran & Fischer, 2000); 2) The Eyberg Child Behaviour Inventory; 3) The Kansas Parent Satisfaction Scale; 4) The Self Concept Rating Scale; 5) The Walmyr Family Relations Scale; and 6) The Walmyr Peer Relations Scale. Each of these scales is reviewed in *Measures for Clinical Practice* (Corcoran & Fischer, 2000).

All authors and publishers concerned were contacted for permission to use their tests and transfer the forms from the textbooks to the computer and converted them to text formats. They were then available to be printed as needed. The only place that did not grant permission was the Walmyr group. They had a number of measures that appeared to be excellent for evaluation of various interpersonal relationships. One of the drawbacks of the measures was that they did not have a form that used the word ‘foster’

when describing a relationship. It was felt that this would harm the validity of the instrument if used as intended. Permission to purchase some scales and change the wording by reprinting the material with 'foster' inserted was requested and denied.

Another stumbling block was that a format for easily designing individualized measurement tools had not been developed. So during those three weeks two formats were designed. One was a Likert scale and the other was an Index scale. To go with these formats a lexicon of descriptive phrases was developed. This was a list of questions and scale point descriptors to be used as a guide when the measures were designed.

The process of finding participant volunteers from the RSFC program began in the same manner as it had with Macdonald Youth Services APH program. In May 2001, the first group of participants from New Directions RSFC program met to begin the first evaluation (referred to as Case A).

In the initial meeting the purpose of the practicum was explained and the foster parents were provided with a written outline of the design explaining the role of the participants. The theory of case level evaluation was discussed with the clinical case manager involved and she was provided with the same documentation given to the foster parents. In May 2001 we all met to plan the evaluation. This was achieved in one three hour meeting at the foster family's home. Using the 'case level evaluation set up guide' (Appendix D) prepared in February, problems were discussed, and using the templates for the individualized formats, the selection of standardized tests, a lap top computer and a printer all the necessary forms and paperwork necessary for 10 weeks of data collection were produced. Data collection for Case A began on May 10, 2001.

A period of some frustration was experienced as attempts were made to begin evaluations with the other two clinical case managers in the RSFC program. There was some difficulty enlisting the support of a participant, and another moved away from the program just as the process was about to begin. Then in late 2001 one of the clinical case managers left the program. RSFC rehired by early 2002, but the program was now in a state of retraining and not ready to take on the evaluations as proposed. By September of 2002, everything was in place and the final two evaluations began.

These followed the same format as Case A. The treatment foster parents and the case managers were presented with written material describing what they were to expect and then in a meeting the contents of the material was summarized and explained; then questions were raised and answered. The consent forms were presented and start dates were arranged. As in Case A, the respective treatment teams met and over the course of three hours the evaluations were planned and the participants for Cases B and C were ready to begin collecting data.

Summary

Although it was necessary to reassess the way the evaluation design process was approached, the fundamentals of single system design were followed. Although limited, through this method, to just ten standardized scales, the freedom to develop individualized scales, utilizing the guidelines offered in the literature, remained. In that regard consistency with the original intent of the method was maintained throughout the practicum.

Chapter 4

Case Level Evaluation - Design and Analysis

The individual evaluations were designed to reveal various facets of treatment foster care programming, including treatment methods, issues experienced in TFC homes, differences and commonalities. These areas will be discussed in Chapter five. The reporting format of this chapter focuses on outcomes and the evaluation of results.

Each individual case evaluated as part of this practicum was designed to stand-alone. Therefore, the report has been organized to reflect that intent. This chapter was originally to have been just a report on the data for each case but it was more coherent, and congruent with the chosen evaluation method, to report on each case from inception to analysis. To avoid repetition, all descriptions of the standardized measurements have been included in the methods chapter, and are not repeated here.

Each report is broken down into five sections that describe the steps involved in developing the evaluation, these are: 1) presenting issues; 2) target problem and goals; 3) intervention; 4) operationalization of target problems; and 5) data analysis.

The intervention sections include information about changes in intervention that occurred within the evaluation period, descriptions of interventions that were current and expected to be ongoing and information on events that were expected to occur during the evaluation.

In the interests of confidentiality, pseudonyms have been used for all the participants in this report.

Design for Case A

This case consisted of a foster family (the Howels), and an 11-year-old foster child (Rachel). The Clinical Case Manager (CCM) has been given the pseudonym 'Mary Daniels'. The foster family had one other foster child and three of their own children living with them at the time of the evaluation.

Presenting Issues

Rachel had been living with the Howels' since she came into care when she was 8 years old. At the time of the initial interview with the family, Rachel was described as oppositional and antisocial. She would remove herself physically from the rest of the family for hours at a time by taking herself to her room. Her foster mother described her behaviour as "snitty, snotty and bitchy". They reported that she teases other children in a mean and spiteful way. As an example they said that Rachel would do things to set up her younger foster brother to fail such as leaving out special cereal for him to steal. To attempt to intimidate her foster parents Rachel threatens to be bad. She will for example, tell her foster parents that today she is going to be suspended from school. Her purpose is, seemingly, to worry her foster parents. Her foster parents also reported that she is an expert liar. They said she is very good at very believable lies and will use this skill to spread outrageous lies about herself that people are generally very ready to believe. This was a major concern for the family who were in some ways just waiting to become victims of her lies.

Rachel has been extremely resistant to formal therapy and counselling. She was doing relatively well academically. She was passing all subjects at the grade level

appropriate to her age; however she had difficulty establishing lasting friendships with her peers. She has an excellent ability to connect superficially but those connections never got beyond the surface.

She had recently voiced a desire to connect with distant relatives, yet was refusing to speak to her biological father who was attempting to re-establish a relationship with her.

Mary Daniels, her CCM, described her worldview as one that fluctuated from very negative to very positive. For Ms Daniels, Rachel's biggest issue was her inability to connect to and articulate her feelings. She cried at least twice a week but failed to be able to articulate why she was crying. Conversations about her father would almost certainly result in tears. Her foster parents and Ms Daniels said that since they have known her she has never been able to connect her emotional state, such as, being in tears, to concrete reasons or feelings.

Target Problems and Goals

Rachel's issues were complex as were the possible responses. Her foster parents felt that their role should be to work toward drawing Rachel into the daily life of the family and helping her identify what it is that causes her crying episodes. The target problems in this case were as follows; 1) Rachel wants to separate herself from the family physically and emotionally; and 2) Rachel is unable to connect her emotional state to concrete feelings. The goals were to improve Rachel's relationship with the foster family and increase the connection of feelings to real issues.

Intervention

No change in intervention was planned at the time. Interventions into Rachel's behaviour and attitudes followed a holistic approach. She was encouraged to participate in the family and she was rewarded for doing so. In addition, she was given many opportunities to engage and was emotionally supported through times of crisis. The treatment team, comprised of the foster parents and the CCM, were in close contact with the school system and were also engaged in finding individualized counselling as well as working towards healing the rifts within her birth family. The team were hoping that she would agree to begin visits with her biological father in the near future. Two weeks prior to the start of the evaluation, Rachel began attending a 'Kids in Care' group run by the clinical staff of New Directions, RSFC program. She continued to attend the group throughout the period of the evaluation. Her CCM hoped that it would be a positive experience for her as it was the first experience of therapy of any kind that she had been willing to participate in.

Measurement Selection

We chose four measures for this evaluation. The first was the *Behaviour Rating Index For Children* (BRIC) (Corcoran & Fischer 2000). The BRIC was to be completed by the foster parents once a week. One of the intentions of the evaluation process was to find ways for foster parents to observe and record behaviour and attitudes in addition to what they already do which, is to perceive and reflect. The BRIC is a simple instrument designed to meet that goal. From a research point of view the BRIC was used to test the

hypothesis that over the period of the evaluation Rachel's behaviour would improve. The treatment team decided to hypothesize that Rachel's behaviour would improve because of the possible effect of the 'kids in care' group she had only just started to attend.

However, with hindsight and given that her behaviour had been deteriorating over a long period of time this hypothesis may have been too optimistic.

The second measure was the *Mood Thermometer* (MT) (Corcoran & Fischer, 2000). The MT tested the hypothesis that, over the period of time coinciding with the evaluation, Rachel's overall mood would improve and her anger would decrease.

The final two measures were individualized and directly address the target problems. The first ^{part} ~~was a Likert Scale~~. It had one question that it was split into two parts, which were answered as statements. The question was 'This week Rachel became upset around her issues n times.' The second ^{part} ~~part~~ asked about how often she connected feelings to concrete issues. This was completed using response categories between 1 and 9 where 1 = really well, 3 = well, 5 = a little, 7 = barely, and 9 = not at all. As mentioned in the previous chapter the nine-point scale was retained for consistency across the three evaluations completed for this practicum. The foster parents were asked to feel free to use all points of the scale.

One of the goals of the case level evaluation method is to attempt to measure only positive change. This has important ethical ramifications. In this case, because of the nature of the behaviours it was difficult to avoid addressing the negative behaviours, as they were central to the foster parents experience. Therefore to ensure that this individualized instrument had face validity the foster parents were asked to observe both

positive and negative behaviours. The Likert Scale tested the hypothesis that Rachel would increasingly be able to connect her feelings to concrete issues over the period of the evaluation and that should visits with her birth family happen she would be more likely to be able to make those concrete connections.

The second individualized measure and fourth measure overall is an Index format comprised of ten questions that speak directly to the foster parents perceptions that Rachel physically and emotionally removes herself from the foster family. The behaviours that the foster parents were asked to report on were as follows: 1) removal of self – hiding in room; 2) threatening behaviour; 3) setting up others with intent to upset them – pushing buttons; 4) oppositional and or ‘snitty’ and ‘snotty’; 5) oppositional to formal therapy; 6) politeness at the dinner table – accepting what is served; 7) relating to foster father in a normal or positive manner; 8) getting out to play with the other kids without causing problems; 9) acts like an 11 year old (her age, e.g. does not try to parent other kids); and 10) appears happy.

The Index Format was used to test the hypothesis that Rachel’s relationship with her foster family would improve over the period of evaluation. It was speculated that, if Rachel began visits with her birth family during the period of evaluation, her relationship to the foster family might also improve.

Without a specific additional intervention in mind this evaluation hoped to track change in Rachel’s behaviour and to objectively gauge stability of her mood. But with the possibility of upcoming important events at the time, namely the resumption of

contact between the subject and her biological father, it was hypothesized that the evaluation might track the impact of that contact on her behaviour in the foster home, her own perception of her mood and her ability to connect emotional reactions to real feelings. Therefore, except in one case where we were able to establish a retroactive baseline, all the measures had only an intervention phase planned at the time data collection began. However we knew that Rachel has never been able to connect her crying behaviour to any concrete issues so for the individualized Likert scale we can draw in a base line score of 9 for a period of at least a month.

Data Analysis for Case A

a) Behaviour Rating Index for Children

Table 2: Results from Case A: The BRIC

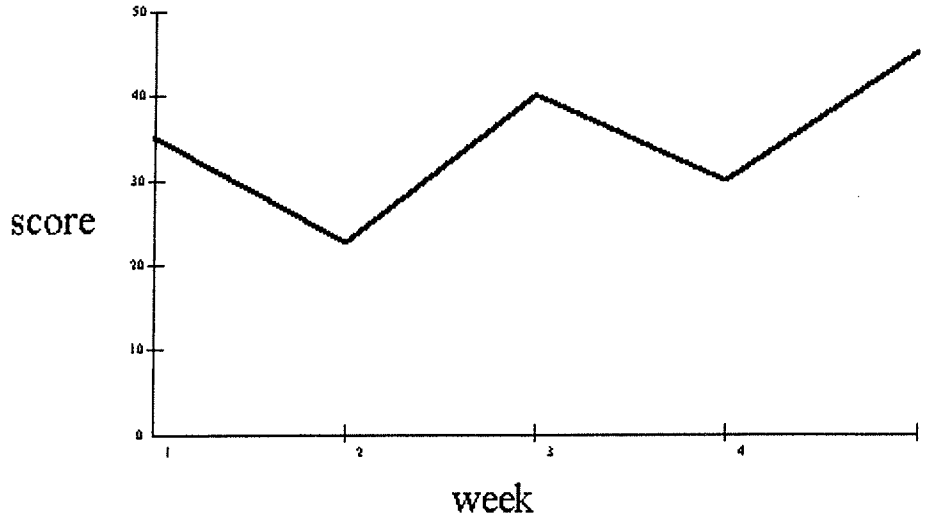
<u>Week</u>	<u>Score</u>
1	35
2	22.5
3	40
4	30
5	45

Note: Range = 0 to 100. High scores indicate more severe behavioural problems. The scale was scored by the foster parents.

The BRIC was fairly straightforward to analyse. Scoring was completed by hand and the data was entered into Singwin (see Table 2 and Figure1). The results show a minimum score of 22.5 with a maximum of 45. The median is 35 and the mean score is 34.5. The clinical range is 30 and above. Visually, the chart indicates a trend towards higher scores suggesting that behaviour was gradually worsening over the five weeks that

the BRIC was used. Regression analysis however can show that $b = 2.75$ and $p = .555$, which indicates that the trend towards higher scores was not significant. As indicated the hypothesis that Rachel's behaviour will improve is clearly not supported by the data. There is however a small indication that the opposite of the hypothesis was occurring and her behaviour was getting worse. This directional change is not significant; this result may have occurred by chance. An administrative glitch caused data to be collected for only the final 5 weeks. This undermines the usefulness of this data.

Figure 1: Results from Case A: The BRIC



b) Individualized Scale Index Format – Relationship with Foster Family

Table 3: Results from Case A: Relationship with Foster Family

<u>Week</u>	<u>Score</u>
1	6
2	16
3	10
4	8
5	16
6	16
7	4
8	13
9	4

Note: Range = 0 to 20. Higher scores indicate fewer problems.

The intervention data for this measure refers to the period at which Rachel began contact with her birth father.

Visually, scores in the baseline phase of between 6 and 16 with no clear trend in either direction indicate that the relationship was, like the chart (Figure: 2), up and down. In the intervention phase, that began as visits with Rachel's birth family commenced, the up and down trend continued but at a lower level. This, therefore, does not support the hypothesis that the relationship would improve over the period of the evaluation; or that the relationship would further improve during the intervention period. There is no statistical evidence of a trend where in the intervention phase regression $b = 0$ and $p = 1.000$. In the baseline phase $b = 1.39$ and $p = .232$. This indicates a trend towards higher scores that is not supported by the p statistic. However the celeration chart (figure 3.1) clearly indicates that while the trend in the intervention phase is flat the trend in the baseline phase is in the direction of the treatment goals, that is an improved relationship with the foster family. The chi square statistic (Table: 4) was computed to test the null hypothesis that the relationship between Rachel and her foster family will not improve. The Fishers exact calculation of probability was divided by two to change the measure

form two-tailed to one-tailed. The score of 0.119 indicates that the null hypothesis cannot be rejected, therefore the data cannot support the significance of a difference between the baseline and the intervention phases. Chi square is not a good indicator as the sample size was too small for chi-square to be an appropriate statistical method to use. In general, results point towards more problems occurring after the intervention than before.

Figure 2: Results from Case A: Relationship with Foster Family

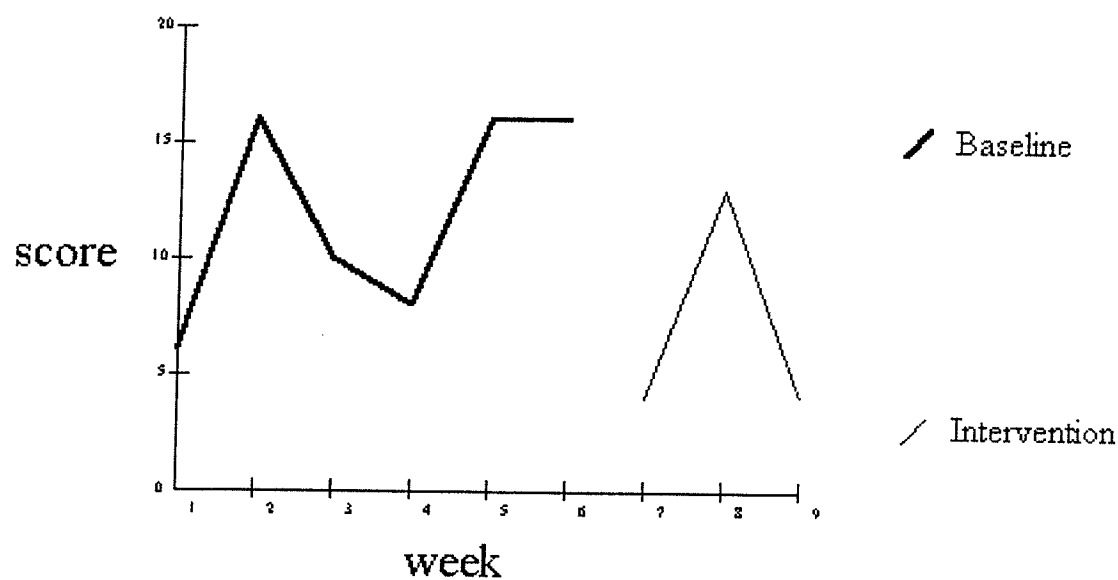
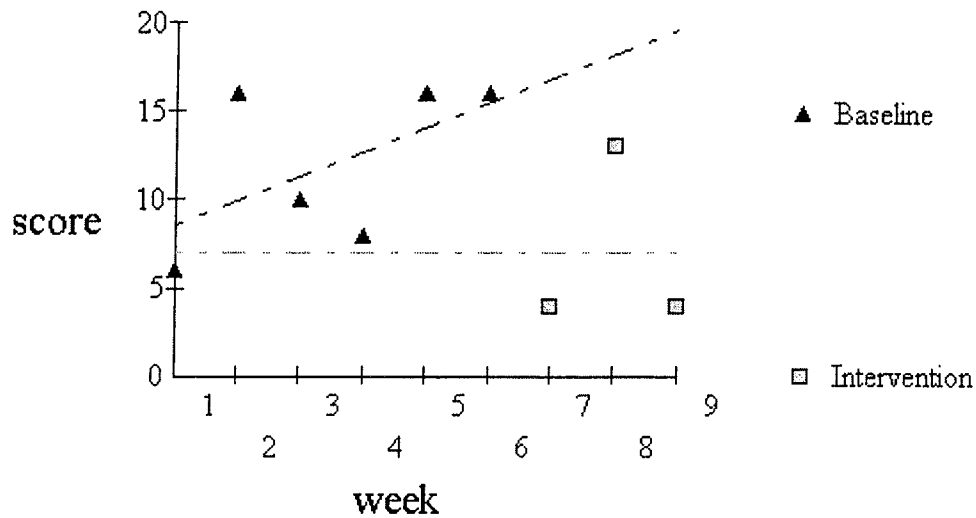


Figure 3: Case A: Celeration Chart Relationship with Foster Family**Table 4: Case A: Chi-Square Relationship with Foster Family**

	(+)	(-)
BASLINE	3	3
	100.00%	50.00%
INTERVENTION	0	3
	0.00%	50.00%
Chi-square = 2.25	DF = 1	P = 0.134
Fishers Exact = .2381	One-tailed Fishers Exact = .119	

c) Mood Thermometer**Table 5:** Results from Case A: MT

Week	<u>Tension</u>	<u>Confusion</u>	<u>Anger</u>	<u>Fatigue</u>	<u>Depression</u>	<u>Overall</u>
1	20	20	10	40	20	22
2	20	20	10	20	20	18
3	10	10	10	20	20	14
4	20	20	10	20	20	18
5	20	10	10	60	10	22
6	10	0	10	10	10	8

Note: Range = 0-100. This instrument measures subjective feeling states at any particular moment. Lower scores indicate better moods.

The Mood Thermometer was straightforward to score. It has 5 components: 1) tension; 2) confusion; 3) anger; 4) fatigue; and 5) depression. Rachel had low scores across the board, which indicates low levels of all mood factors. When combining tension, confusion, fatigue and depression Rachel had a combined score of 18.75 out of 100. The anger factor was an even 10 out of 100 for the whole recording period. Visually (see Figures: 4 – 9) the scores are relatively flat and there is no apparent trend. Regression analysis of overall mood gave a *b* score of -1.93 with a *p* of .254 indicating that the negative trend was not significant. The hypothesis that Rachel's mood would improve over the period of evaluation was not supported by the data. A question arises when examining this data as to the validity of the instrument in this case, because Rachel reported exceptionally good moods throughout the evaluation. However this is in contrast to the information found in the CCM's case notes that indicate that this period was very difficult for Rachel and her mood was frequently poor. There is a possibility

that she wanted to present a positive front through the instrument. That fact that Rachel stopped completing the MT at the point when visits with her birth family began may be significant. Her foster parents reported that at the time visits began she was adamant that everything was perfect, but her behaviour, which was increasingly difficult, suggested otherwise.

Figure 4: Results from Case A: MT Tension

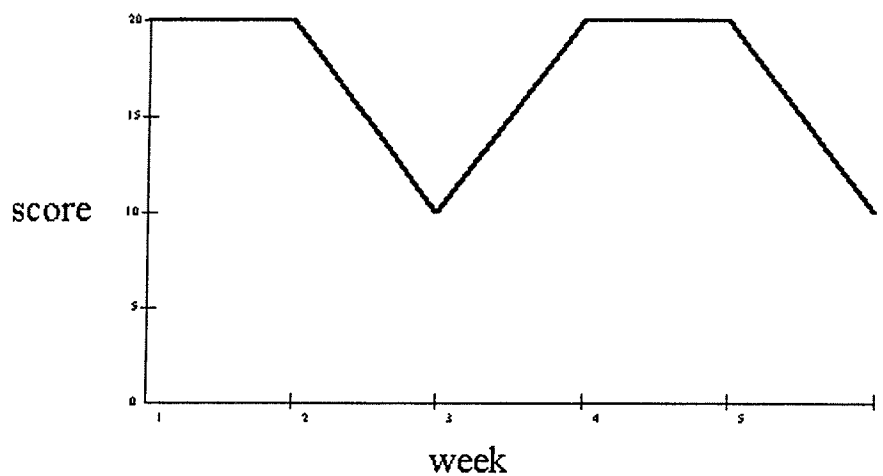


Figure 5: Results from Case A: MT Confusion

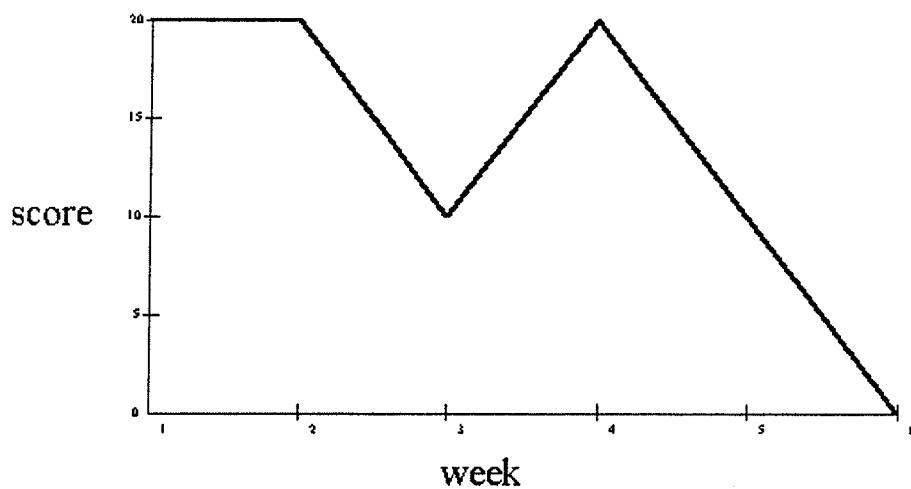


Figure 6: Results from Case A: MT Anger

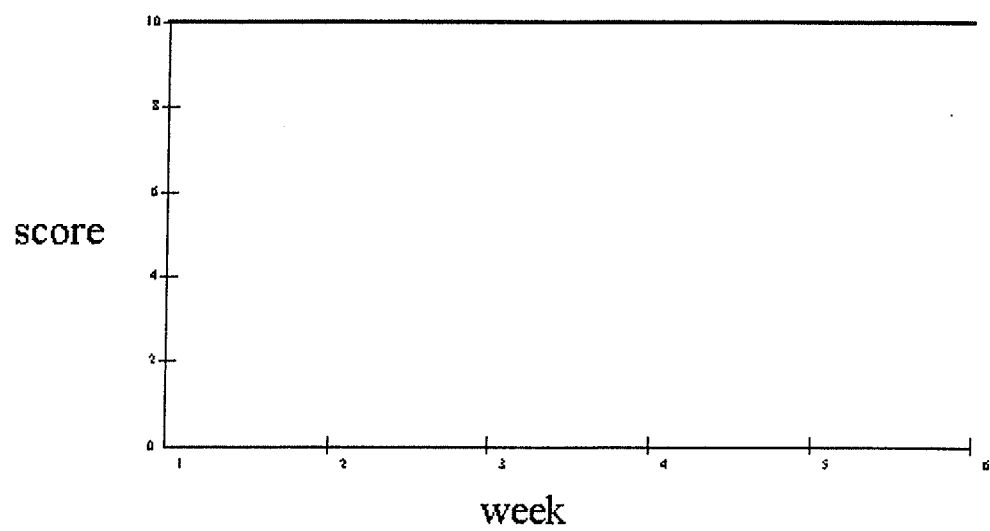


Figure 7: Results from Case A: MT Fatigue

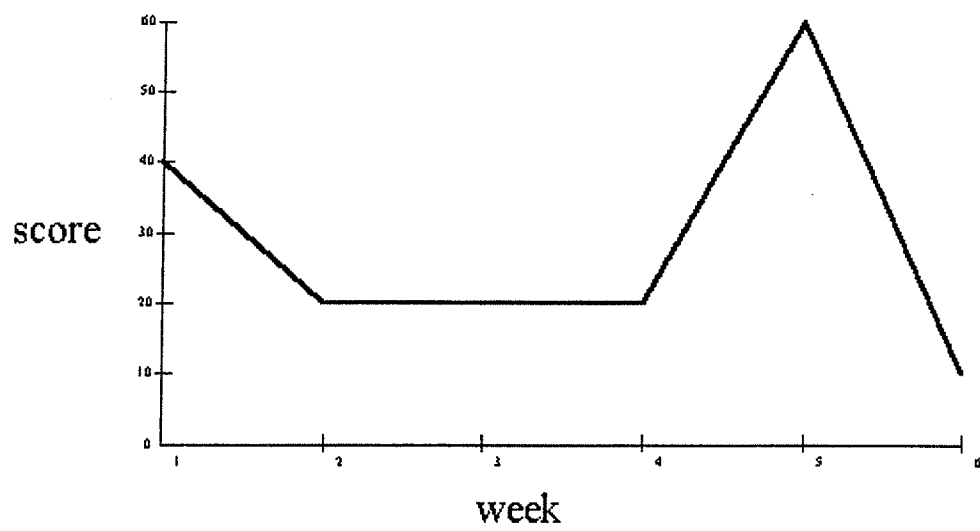


Figure 8: Results from Case A: Depression

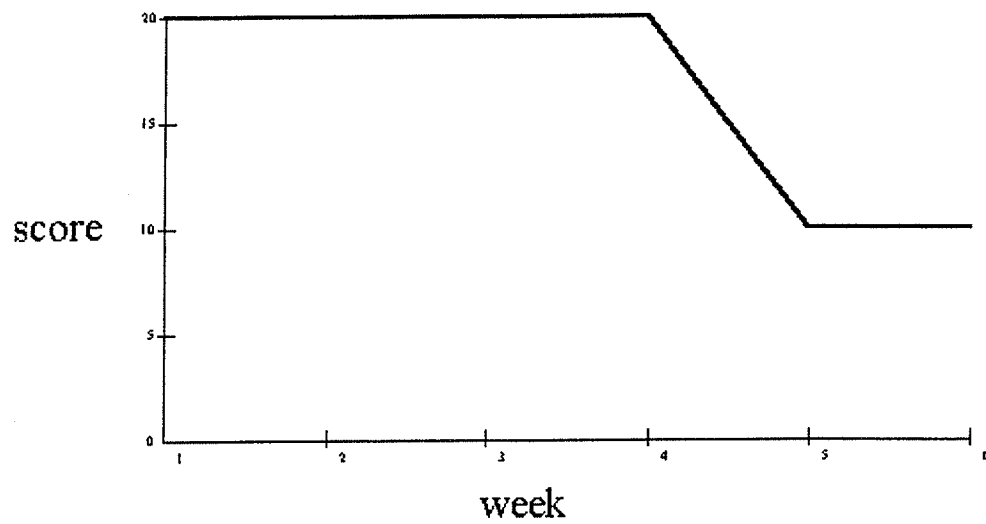
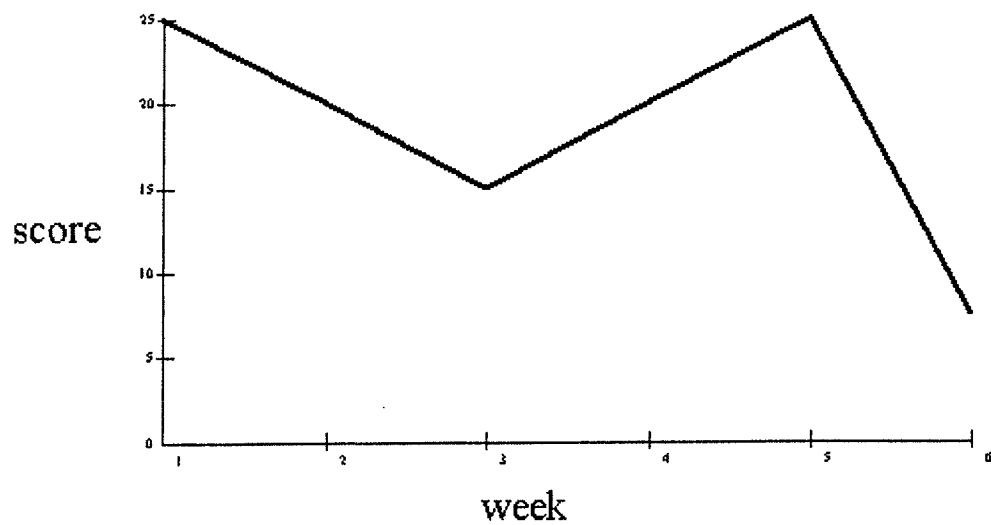


Figure 9: Results from Case A: MT Overall



d) Individualized Scale Likert Format – Emotional Connectivity

Table 6: Results from Case A: Emotional Connectivity

<u>Week</u>	<u>Score</u>
1	1
2	1
3	1
4	1
5	2.5
6	7
7	5
8	1
9	8
<u>10</u>	<u>7</u>
11	6
12	8
13	4

Note: Range = 1 to 9. Higher scores indicate a higher capacity to connect emotional state to concrete feelings.

The foster parents reported each time an emotional outburst was witnessed and rated Rachel's ability to connect her feelings to real issues going on in her life. The scores were then averaged for each week. There was validity in having the number 1 as the most positive point on the scale for the data collection process, but this produced a graph (see Figure: 10) where peaks indicated negative outcomes and troughs indicated positive outcomes. In order to make the graph easier to interpret the scores were inversed. The start of the intervention period was marked at the 10th week. This was the point at which Rachel began visiting with her birth family. Because it was possible to construct results for the three weeks prior to the observed time period results could be entered for 13 weeks. Visual analysis of the data suggests that over the baseline period Rachel was increasingly more able to connect her emotional state to concrete feelings. This trend is supported by the evidence from the measure and by analysis of the

celeration chart (Figure: 11). Regression analysis shows that $b = 0.72$ where $p = .013$ for the baseline phase. Visually, the intervention phase is hard to interpret. Regression analysis shows that $b = -1$ indicating a negative trend towards Rachels emotional connectivity getting worse during the intervention period. In this case $p = .622$ indicating an acceptance of the null hypothesis at least 62% of the time. It is possible that three observation points could not produce enough information to enable a determination of statistical significance. However by observing the trend over the combined baseline and intervention phase the positive trend found in the baseline phase is continued. For the full period the regression analysis indicates that $b = 0.53$ and $p = .007$. The trend to lower scores is modified but because there are more observation points in the data, the trend is statistically significant at $p < .01$. The data therefore, would appear to support the hypothesis that Rachel was more able to connect her emotional state to concrete issues over the evaluation period. However it is not so clear that her ability to do so would improve as visits with birth family members continued. Analysis of the chi-square statistic (Table:7) computed a two one-tailed Fishers exact probability of 0.097. Thus the null hypothesis that there is no difference between the baseline phase and the intervention phase is accepted for alpha levels at or below 0.05. This indicates that there was no statistically significant negative change that occurred from baseline to intervention stage. However this should be regarded carefully as the small sample size, (represented as observation points) particularly in the intervention phase, leaves the use of this particular statistical method open to question.

Figure 10: Results from Case A: Emotional Connectivity

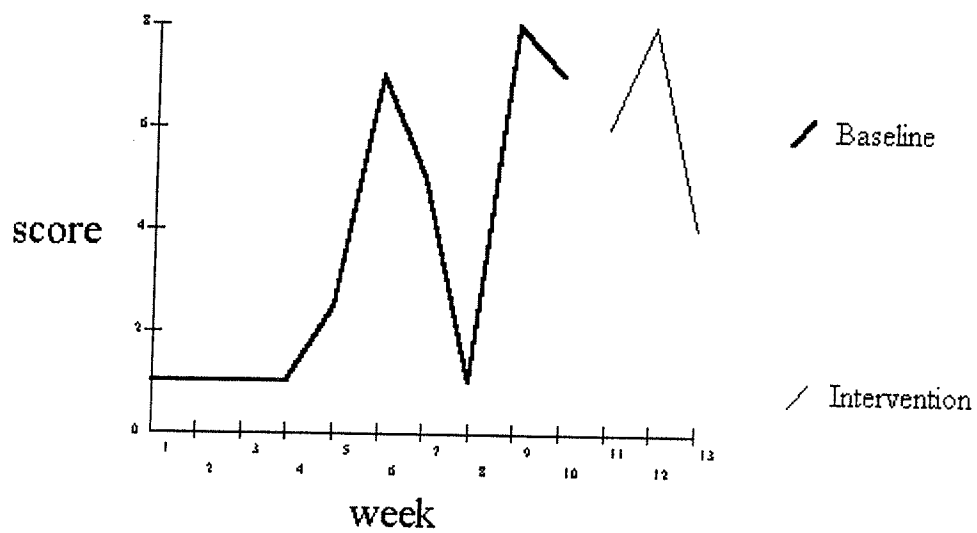


Figure 11: Case A: Celeration Chart Emotional Connectivity

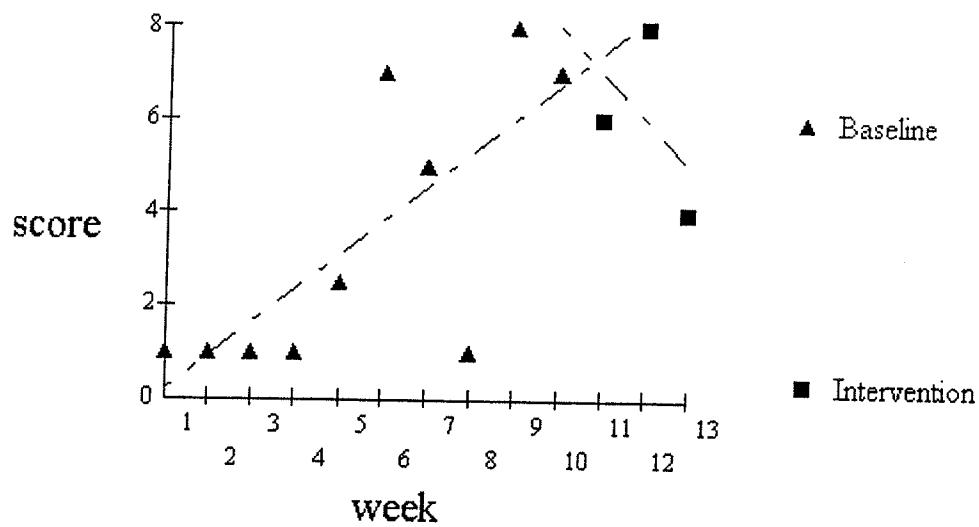


Table 7: Case A: Chi-Square Emotional Connectivity

	(+)	(-)
BASELINE	6	4
	100.00%	57.143%
INTERVENTION	0	3
	0.00%	42.857%
Chi-square = 2.44 Fishers Exact = .1958	DF = 1	P = .118 One-tailed Fishers Exact = 0.097

Case A: Analytical Summary

The data from the standardized instruments proved to be the least useful in this case. The five weeks of data derived from the BRIC was not enough from which to draw any strong conclusions and the MT was made invalid by the foster child's scoring. The data from the individualized measures however did provide some interesting results. The index format scale, that was designed to measure Rachel's relationship with her foster family, reported that the relationship was up and down. This strongly reflected the foster parents experience of life with Rachel and it was consistent with the CCM's observations. The scale to measure Rachel's ability to connect her emotional state to concrete issues

produced interesting data that indicated a strong trend toward improvement in her abilities until she began contact with her father, at which point the trend diminished.

Design for Case B

This case consisted of a foster family (the Peterson's), and a 16-year-old foster child (Nichola). The Clinical Case Manager (CCM) has been given the pseudonym 'Angela'. The foster family had three other foster children living with them at the time of the evaluation.

Presenting Issues

Nichola was in care under a Voluntary Placement Agreement (VPA). This gives her birth mother some rights regarding her care. She can at any time choose to cancel the agreement and have her daughter returned. However the CFS agency has the right, should she do so, to re-apprehend and apply for a temporary order of guardianship. The major presenting issue pertains to Nichola's relationship with her birth mother. Her father had left the family when Nichola was three years old and there are no other siblings.

Nichola has a memory of an inappropriate touch from a man in a nightshirt when she was three years old. She thinks it could have been her father and her mother supports this theory, but it could have also been a boyfriend of Mom's. Nichola has rebelled from her mother's tight obsessive controlling behaviour. It is thought that this may have stemmed from an abusive childhood. In her home community Nichola had started

associating with a street gang and was regularly using drugs and alcohol. She was violent towards her mother and it was this behaviour that had prompted the mother to seek help from Child and Family Services.

Since coming into care and entering the RSFC program, Nichola has been violent twice. Once she attacked her Clinical Case Manager and there was also an incident at school where she got into a fight with another girl. Her current foster parents and her new Case Manager have reported no problems at all and have not witnessed any of the rage that she had previously displayed. Nichola's original RSFC placement broke down as the result of inappropriate actions on the behalf of the foster parents. Nichola's CCM described Nichola as introspective and astute pointing out that she understands that her mother was hurt as a child and believes that her mother's father abused her in childhood. Nichola and her mother had been inconsistently involved in family counselling. Together they had seen two therapists. Nichola was motivated to attend the therapy sessions but her mother often cancelled the appointments. The CCM said that the family therapist pointed out that the mother did not have much of a childhood and is denying Nichola part of hers.

To sum up the presenting issues, Nichola and her mother had an interest in reconciliation but were unable to achieve it. Nichola is left with feelings of anger, which can be expressed as violence towards third parties. She has also been involved in risk taking activities through her street associations. Her self-esteem has also suffered. Her apparent lack of self confidence is seen as part of her reason for being unable to effectively communicate her needs and in turn insists on them being met. Connected to

Nichola's sense of self is her academic performance, which suffered late last year due to turmoil and change in the rest of her life. She is bright and still passed all her subjects but with reduced grades. This did nothing to boost her confidence, so stability is a major goal in her life. In addition, the CCM felt that Nichola sometimes get depressed, although the foster parents say that they rarely see this in her.

Target Problems and Goals

Problems with self-esteem, academic performance, depression and violence are seen in this case as symptoms stemming from the breakdown of the relationship between Nichola and her mother. Given the target problem as the broken relationship, the goals of the treatment plan are to improve trust and communication between mother and daughter. The hypotheses created were: 1) Nichola's relationship with her mother will improve; 2) Nichola will be able to stick to the treatment plan; 3) Nichola's behaviour in the home will remain stable; and 4) Nichola's self esteem will improve.

Intervention

To achieve the treatment goals the family therapist and Nichola's case manager developed an action plan that was agreed to by both Nichola and her mother. Nichola wanted to spend every weekend with her mother. When she is at her mother's home she was to be allowed to go into town to spend time with friends. On returning, she was to relate three innocuous things that happened and she must tell her if she saw and spoke to any of her old friends. In return, Mom was to allow her to date, and display some trust.

In addition, Nichola agreed to learn to control her anger. To help in this regard she met on a weekly basis with Angela who was to discuss her issues with her and together they were to review the treatment goals and methods. The CCM is also in regular contact with the birth mother and the foster parents. Given that this intervention had already begun the evaluation was designed to measure the stability of the intervention over a period of ten weeks.

Measurement Selection

To test the various hypotheses six separate scales were chosen. The *Behaviour Rating Index Scale* (BRIC) was chosen to test the hypothesis that Nichola's behaviour in the foster home would remain stable. The BRIC was to be completed by the foster parents once a week. To test the hypothesis that over the period of the evaluation Nichola would feel better about herself in the light of her relationship with her birth mother, the *Hare Home Self Esteem Scale* (HHSE) was chosen. As the treatment team had no concerns around Nichola's relationships with her peers or with her school, the sections of the scale that dealt in those areas were not included. The treatment team chose to have the CCM support the child in the collection of this data, as she was more involved in supporting Nichola through her relationship with her mother than were her foster parents.

The *Self Concept Scale for Children* (SCSC) was chosen to test the hypothesis that Nichola's general self-concept would improve over the period of the evaluation. Despite some concern that the instrument may appear too simplistic for a person in

Nichola's age group the treatment team were confident that she would not have a problem with it. Nichola completed this instrument with the support of her foster parents.

The treatment team also wanted to monitor Nichola's subjective feeling state during the course of the evaluation. The *Mood Thermometer* (MT) was chosen as it is designed to do exactly that. The hypothesis was that Nichola's mood states would improve over the course of the evaluation. Nichola completed the MT at the foster home with the support of the foster parents.

In order to measure how well the treatment plan was working to improve Nichola's relationship with her mother the team chose to design an individualized scale. The scale asked the question: Can Nichola's level of trust in, and her ability to communicate with, her mother, improve in the areas specified by the treatment plan? (see Appendix L).' The hypothesis was that, Nichola's behaviour towards her mother would improve in line with the objectives developed in the treatment plan. Ten behavioural elements were chosen from the treatment teams experience of the problem. There were five elements that reflected negative behaviours and five elements that reflected positive behaviours. The five negative elements were: 1) verbally abusive towards mother; 2) refusal to tell Mom who where and what information; 3) refusal to do something with Mom; 4) avoidance of going on family visit; and 5) cutting mother out by denying her the right to be attend activities that a parent would normally attend. The five positive elements were: 1) able to problem solve issues outside of Mom's life such as her friends and school; 2) trust Mom with her money/belongings; 3) respond to suggestions and follow through with the plan; 4) embrace strategies to stop assaults; and 5) avoid contact

with inappropriate friends. It would have been possible to put all of the behavioural elements into positive terms; however, the team felt it was more realistic to include negative elements to the measure. Also, using the dual focus enabled the measure to be used in conjunction with the measures used in evaluating the other two cases in this practicum. This instrument, like all individualized instruments lacks reliability data, however, it does have face validity as it responds directly and specifically to the individual problem, being designed to ask questions that relate precisely to the target problem. The scale was scored separately by both the CCM and the foster parents. The CCM's information came from her connection to Nichola and to the birth mother. She had weekly meetings with Nichola wherein they discussed the measure and rated accordingly. The CCM also spoke to Nichola's birth mother by telephone after each visit. The foster parents completed the instrument based on information offered in the informal atmosphere of the foster home.

A crucial element of the evaluation was the treatment plan itself. In order to measure the effectiveness of treatment planning it was necessary to know whether the plan was being consistently followed over the course of the evaluation. The treatment team wanted to be able to adapt the plan to suit the conditions and so a tool was designed that measured how well Nichola was able to follow the plan. The important variable was Nichola's willingness to follow the suggestions made to her by the treatment team. This variable was seen as the key to the success of the plan. In order for Nichola to be able to follow the plan as outlined by the CCM it would have to remain feasible, that is realistic, for Nichola. To measure whether this was being achieved the tool was designed in two

parts. The first was completed by the CCM, and responses were organised as a nine point Likert scale. The CCM was asked to respond to the following statement: Nichola was able to follow through with her side of the treatment plan. The points on the Likert scale were 1 = No not at all, 2 = not really, 3 = much less, 4 = not as well, 5 = same, 6 = better, 7 = much better, 8 = completely, 9 = completely plus independent advance. The last point on the scale was suggested by the CCM as being important as it indicated movement beyond what was expected. 'Independent advance' meant there was an indication that Nichola could not only follow the treatment plan but was also finding and creating ways of improving on it.

The plan was to ask Nichola to respond to two statements: a) I was able to follow through with the treatment plan as directed by my case manager; and b) the treatment plan is realistic and I was able to meet the expectations. Unfortunately an error in the administration of the evaluation occurred which meant that Nichola did not receive her part of the tool. So the only data available is from the CCM. This does not mean that evaluation did not occur along the lines designed; it just meant that it occurred informally without the aid of an objective tool.

Data Analysis for Case B

a) Behaviour Rating Index for Children

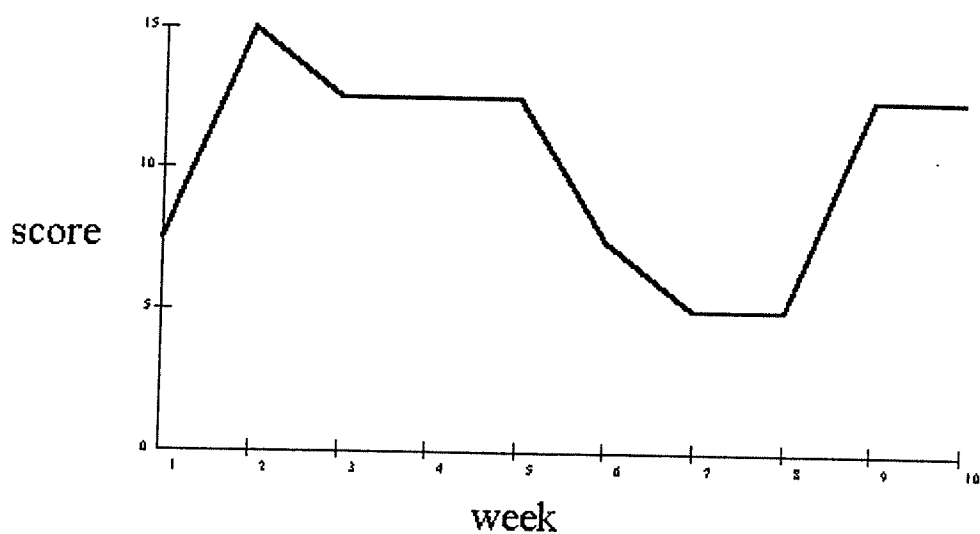
Table 8: Results from Case B: The BRIC

<u>Week</u>	<u>Score</u>
1	7.5
2	15
3	12.5
4	12.5
5	12.5
6	7.5
7	5
8	5
9	12.5
10	12.5

Note: Range = 0-100. High scores indicate more severe behavioural problems. Scored by the foster parents

Visually the data shows that Nichola had virtually no behavioural problems over the reporting period. The chart (Figure: 12) appears to show a deep trough around weeks 6, 7 and 8 but the chart is somewhat deceptive as the y-axis goes only to 15 out of a possible 100 and this distorts the results. Even so there is no positive or negative trend in evidence. Statistically, the mean score was 10.25 and the standard deviation was 3.62. Regression analysis showed that $b = -0.23$ and $p = .598$. This supports the analysis of a stable trend over the ten-week period. Therefore the hypothesis that Nichola's behaviour would remain stable over the ten weeks of data collection is supported by the data. Nichola's behaviour as reported by the foster parents using the BRIC was stable during the course of the evaluation.

Figure 12: Results from Case B: The BRIC



b) Hare Home Self Esteem Scale

Table 9: Results from Case B: The HHSE

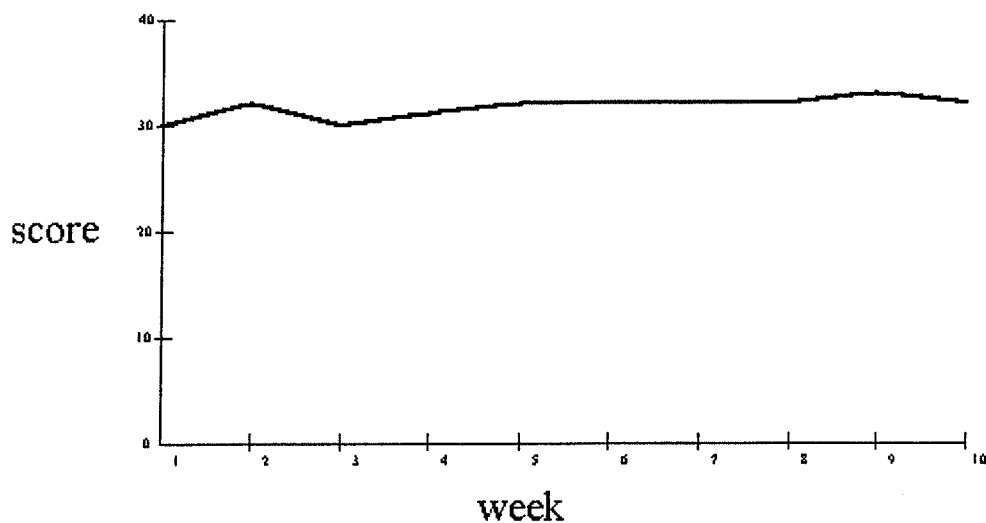
<u>Week</u>	<u>Score</u>
1	30
2	32
3	30
4	31
5	32
6	32
7	32
8	32
9	33
10	32

Note: Range = 10 to 40. Higher scores indicate higher self-esteem. Scored by child with the CCM as part of the weekly post visit debriefing.

Visually, the data indicates that Nichola's self esteem, as it related to her experience of being at her birth mother's home, was both within an average range and

very steady throughout the period of the evaluation (Figure: 13). The trend over the ten weeks of data collection is stable. Statistically, the mean = 31.60 with a standard deviation of 0.96. The hypothesis that Nichola's self esteem in this realm would improve over the evaluation period is not supported by the data. The data shows that Nichola's self esteem was not affected throughout the course of the evaluation and was at an average level as tested for this standardized measure.

Figure 13: Results from Case B: The HHSE



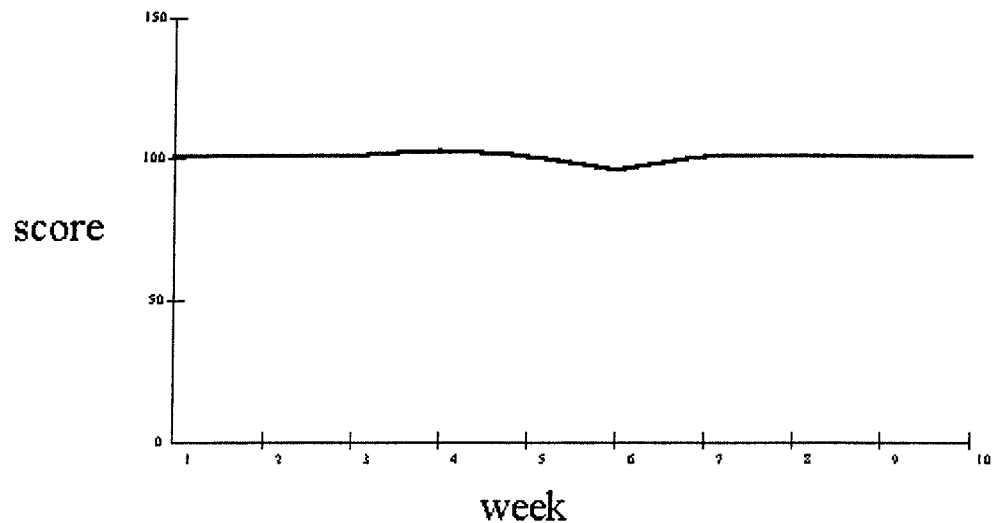
c) Self Concept Scale For Children

Table 10: Results from Case B: The SCSC

<u>Week</u>	<u>Score</u>
1	101
2	101
3	101
4	103
5	101
6	96
7	101
8	101
9	101
10	101

Note: Range = 22 to 110. Higher Scores indicate better self concept.
Scored by child at foster parents home.

The scores in Table 10 indicate that throughout the evaluation period Nichola's self concept was consistently higher than the average recorded for children in the developmental stage of this instrument. The chart (Figure 14) gives a clear visual picture of a stable trend. Statistical analysis does not give any more concise information than can be derived from a visual inspection. The mean over the ten week period = 100.7 with a standard deviation of 1.76. The hypothesis that Nichola's self concept would improve over the course of the evaluation is not supported by the data.

Figure 14: Results from Case B: The SCSCd) Mood Thermometer**Table 11:** Results from Case B: MT

Week	<u>Tension</u>	<u>Confusion</u>	<u>Anger</u>	<u>Fatigue</u>	<u>Depression</u>	<u>Overall</u>
1	20	0	10	40	20	20
2	20	20	20	40	20	25
3	20	20	20	40	20	25
4	20	40	20	40	20	30
5	20	40	20	40	20	30
6	20	40	20	40	20	30
7	20	40	20	40	20	30
8	20	40	20	40	20	30
9	20	40	20	40	20	30
10	20	40	20	40	20	30

Note: Range = 0-100. This instrument measures subjective feeling states at any particular moment. Lower scores indicate better moods. Overall score is an average of the scores for tension, confusion, fatigue and depression.

A visual analysis of all the charts for the MT (Figures: 15 – 20) show that Nichola's mood remained stable throughout the evaluation period. There was a marked increase in the category of confusion for the first three weeks. The scores then level off for the remainder of the study period. When analysing the MT charts visually, it is important to take into account the possible range of scores. The y-axis indicates a range of between 0 to 30 and 0 to 40, where the actual range possible is 0 to 10. As lower scores are more positive, the data supports that Nichola had stable moods during the test period. However there is an issue of autocorrelation with this data set. The straight lines indicated in figures 15, 18, and 19 did not compute on Singwin, while figures 16 and 20 had autocorrelations of 3.831 with alpha levels of .002. Therefore reading too much into this data would be a mistake as it highly possible that the scores as given are not independent.

Figure 15: Results from Case B: MT Tension

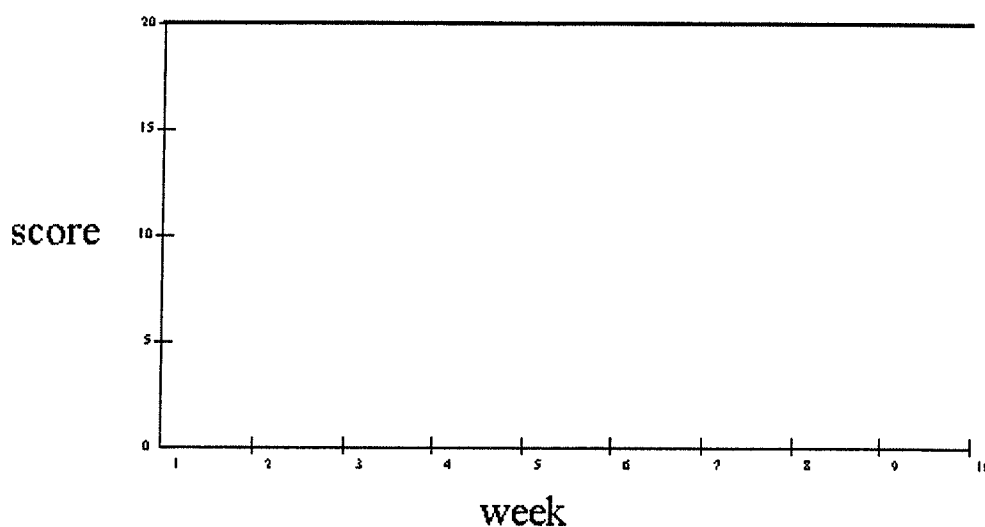


Figure 16: Results from Case B: MT Confusion

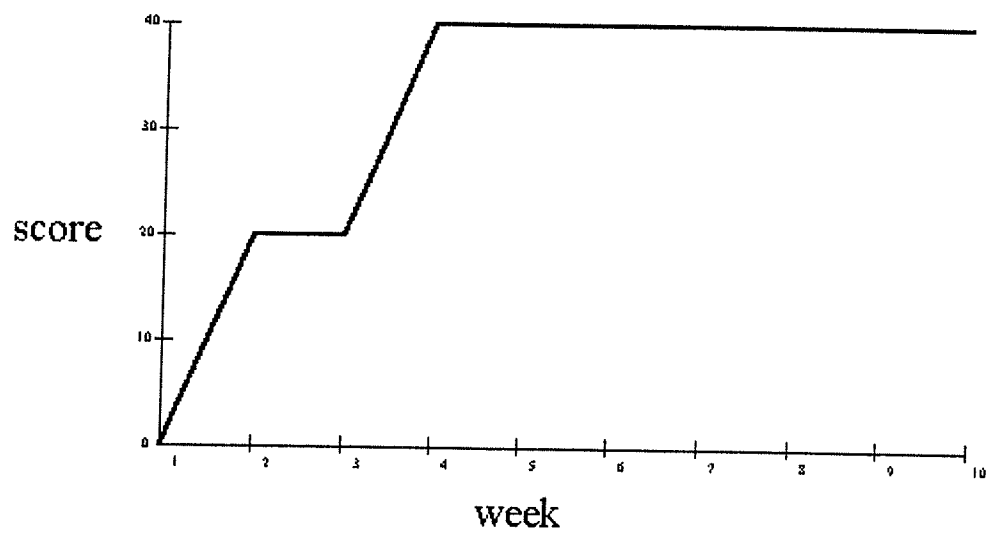


Figure 17: Results from Case B: Anger

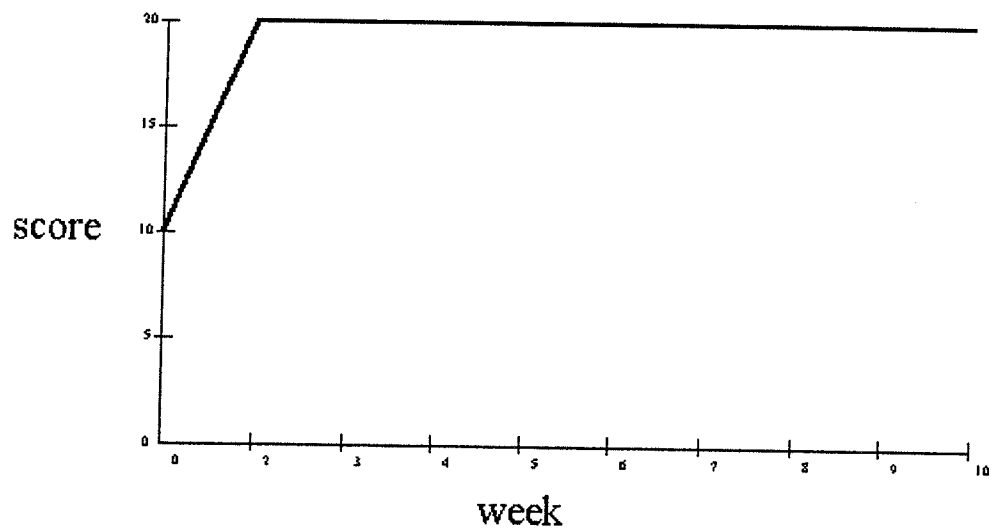


Figure 18: Results from Case B: MT Fatigue

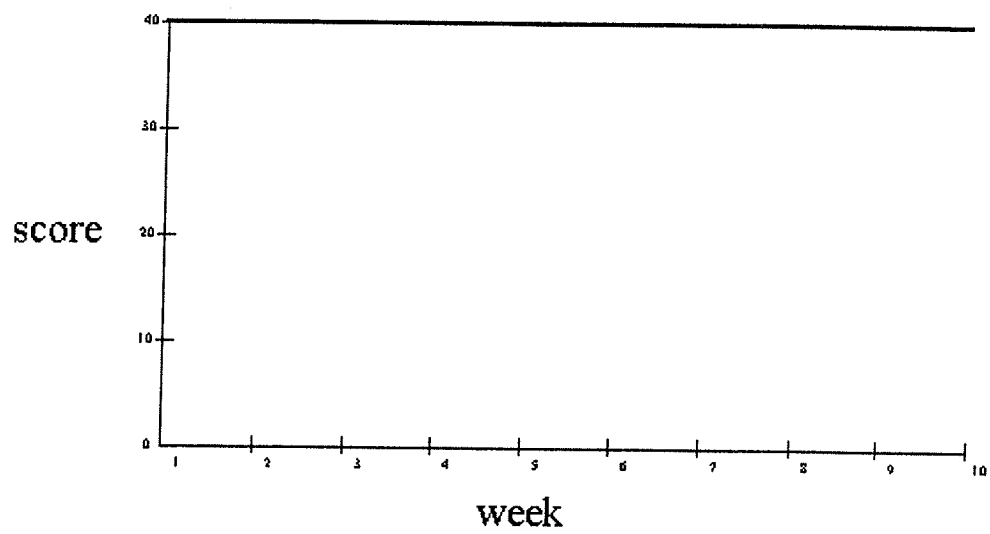


Figure 19: Results from Case B: MT Depression

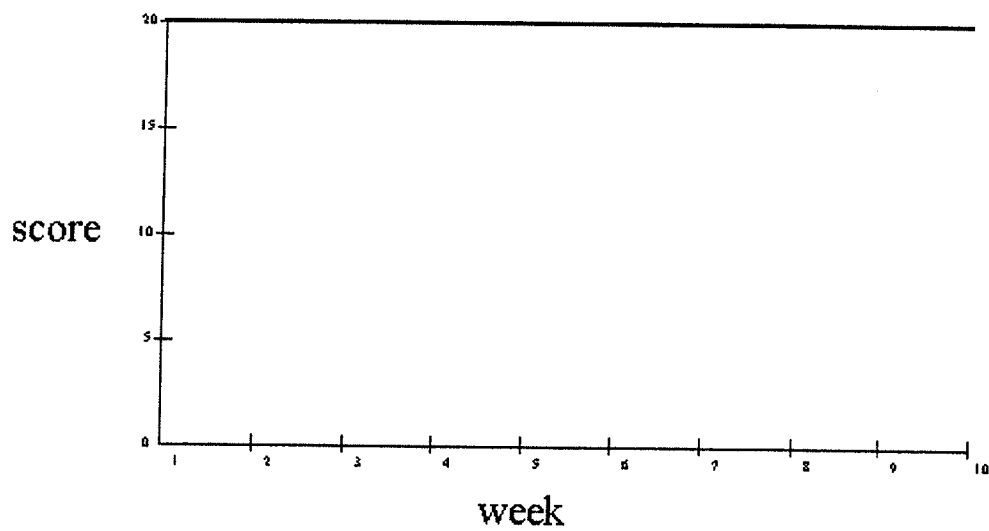
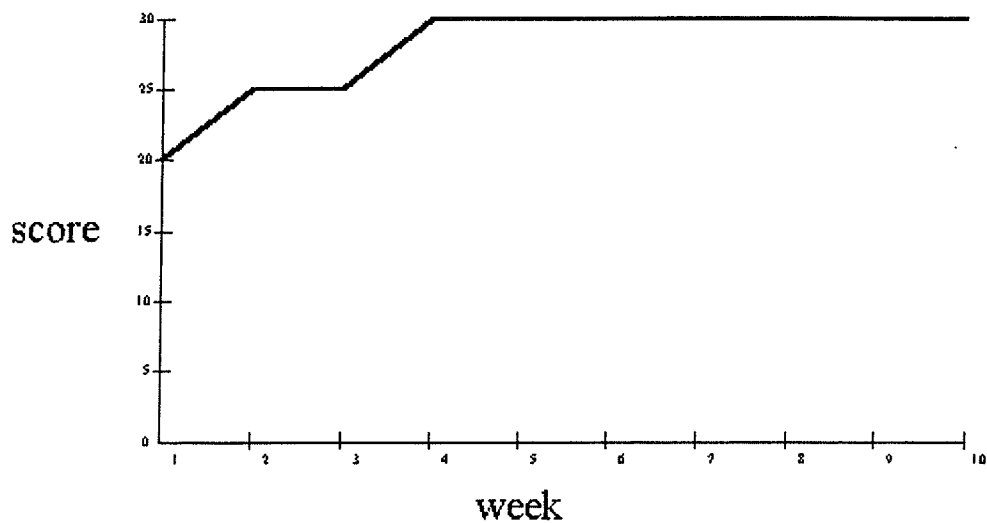


Figure 20: Results from Case B: MT Overall

e) Individualized Scale Index Format – Trust and Communication

Table 12: Results from Case B: Trust and Communication

Week	Score	
	FP	CCM
1	0	10
2	2	11
3	2	6
4	2	4
5	2	6
6	2	4
7	2	4
8	2	4
9	2	4
10	0	2

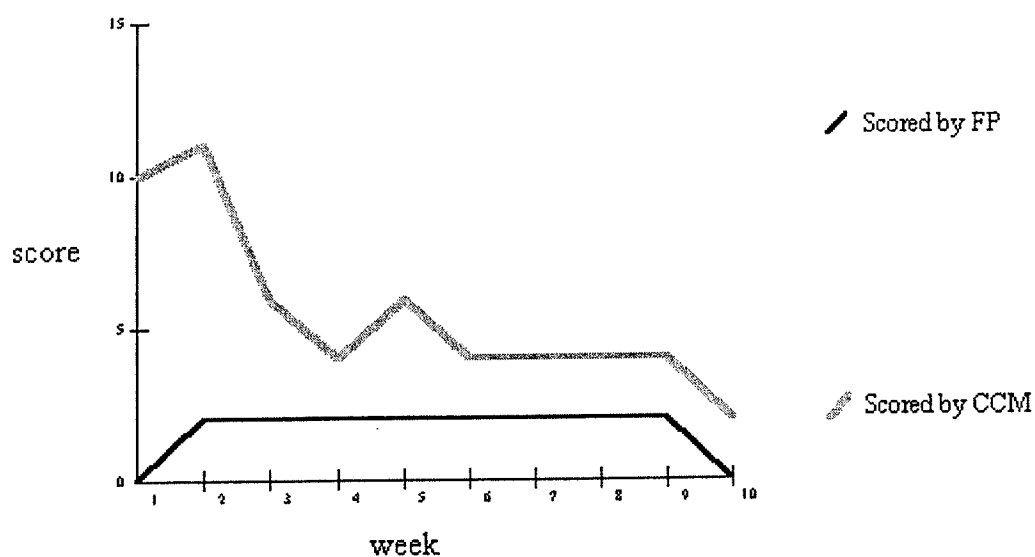
Note: Range = 0 - 20. Lower scores indicate fewer problems.

Visually, the chart (Figure: 21) shows that the foster parents found that there were very few problems in the area of trust and communication between Nichola and her birth

mother over the period evaluated. The CCM found that there was a trend toward fewer problems over the same period. This trend is supported by the statistical analysis of regression that calculates a b score of 0.81 where $p = .001$.

The absence of a trend and the low mean score observed by the foster parents corresponded to the foster parent's expectations. They had expected that Nichola would not choose to verbally share or otherwise offer information pertaining to her visits with them. So in essence it was felt by the treatment team that the scores reported by the foster parents were invalid as they reflected not what happened but what Nichola wanted her foster parents to believe. The CCM felt that the information she collected from Nichola was more reliable as Nichola's mother backed it up. The foster parents also stressed that they had given their scores more from a position of having no evidence rather than from a position of being given information that contradicts data collected by the CCM.

Figure 21: Results from Case B: Trust and Communication



f) Individualized Scale Likert Format – Acceptance and Adherence to Treatment Plan

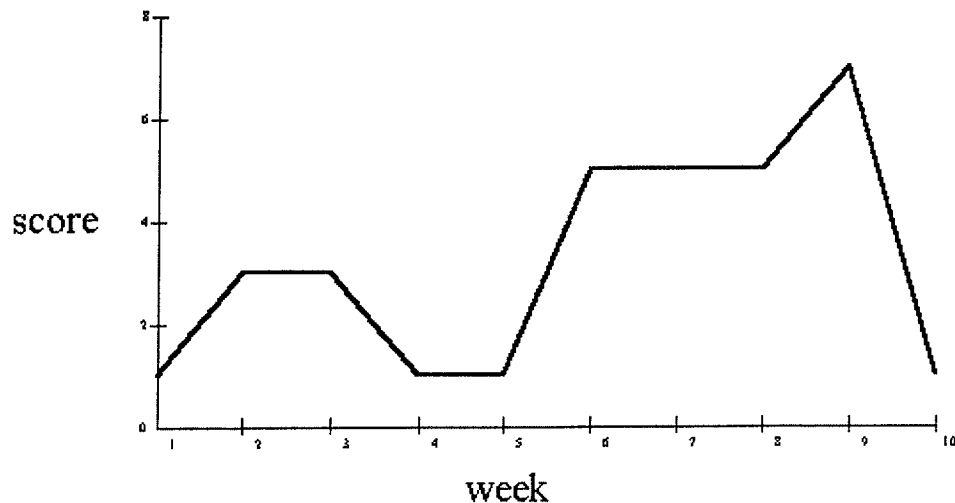
Table 13: Results from Case B: Acceptance and Adherence to Treatment Plan

<u>Week</u>	<u>Score</u>
1	1
2	3
3	3
4	1
5	1
6	5
7	5
8	5
9	7
10	1

Note: Range = 1 to 9. Higher scores indicate a greater acceptance of and adherence to the treatment plan. Scored by CCM

The chart (Figure: 22) includes almost the whole range of possible scores so gives an accurate representation of the data. Visual inspection suggests that Nichola's adherence to the treatment plan was variable. Statistical analysis helps to define the data. The mean score is 3.2 but the variance is higher at 4.84. There is no trend in evidence. Regression analysis shows that $b = .33$ where $p = .188$. While the b shows a slight positive trend this is not statistically significant.

Figure 22: Results from Case B: Acceptance and Adherence to Treatment Plan



Case B: Analytical Summary

All the standardized measures used in this evaluation indicate strongly that Nichola was emotionally and behaviourally stable throughout the 10-week evaluation period. The individualized scale measuring Nichola's adherence to and acceptance of the treatment plan suggest a slight improvement over the ten weeks, while the individualized scale measuring change in her ability to trust and communicate with her birth mother indicated a marked improvement. This was supported by statistical analysis and was also backed up by anecdotal evidence from the birth mother. In addition, the scores produced by the foster parents using the same tool did not contradict the results produced by the CCM.

Design for Case C

This case consisted of a foster family (the Hiams), one 11-year-old foster child (Becky) and one 12-year-old foster child (Lizzy). The Clinical Case Manager (CCM) has been given the pseudonym 'Dave'. The foster family had two of their own children living with them at the time of the evaluation.

Presenting Issues

Lizzy and Becky are siblings. They have lived with the Hiam family for 2 years. Both girls have been diagnosed with Fetal Alcohol Spectrum Disorder and there were various presenting issues. In the case of Lizzy a current issue was her eating habits, her foster parents were concerned with the little amount she ate and had tried many strategies to help and encourage her to eat healthier food. Lizzy frequently complained of stomachache and while medical opinion had been and was continuing to be sought there was still a feeling that Lizzy may have been manipulating them. In Becky's case the foster parents were concerned about inappropriate sexual behaviour. The foster parents wanted to start talking about the issue more, to demystify the topic of sex and sexuality in an attempt to reduce the giggling and giddiness that Becky displayed around the issue of sexuality. Also, sibling rivalry was a big issue. Becky was more outgoing than Lizzy and there was jealousy between the the two of these siblings. Lizzy was adept at emotional manipulation of Becky and there were frequent upsets and arguments. Both girls struggled at school. Their behaviour was good but academics were difficult and they both exhibited low levels of self-esteem.

The foster parents were interested in examining their own perceptions of the girls' behaviour. They felt that sometimes they interact differently with the girls during stressful times. They felt a certain amount of ambiguity about both girls' behaviour, being not certain whether what they were dealing with was perfectly normal or actually quite abnormal.

Target Problems and Goals

In the end the treatment team decided to take a general look at the girl's interaction with and feelings towards each other, to examine their self esteem issues and observe behaviour. The team decided to also try and collect baseline data around Becky's inappropriate sexual behaviour and follow through with an intervention involving the introduction to the home of age appropriate reading material on the subject of sex and sexuality.

Intervention

There was one specific intervention planned; this was to engage Becky in conversation around sex and sexuality by providing age appropriate reading material in the home. Otherwise the treatment team wanted to have an objective look at the sibling rivalry issues. They were interested in the girls' perceptions of the problems in contrast to their own. As well they wanted to know more about both girl's levels of self-esteem and how they compared to the general population. The foster parents were also interested

in objectively observing behaviour. They felt this might address some of the ambiguity they felt about their own response to the behaviour of both girls.

Measurement Selection

To operationalize the problem of sibling rivalry the treatment team used two measures. The first was the *Index of Sister Relations* (ISR), produced by the Walmyr Publishing Co. (see Appendix I). Becky and Lizzy completed the scale on a weekly basis. This was done apart from each other and with the support of the foster parents.

To support this measure the treatment team also designed an individualized index style measure, which was called Index Format Sibling Rivalry (Appendix N).

The foster parents chose five negative behaviours and five positive behaviours to observe and record. Each item on the index was specific to behaviours they were currently experiencing as problems. The five negative behaviours were: 1) fighting over an object, e.g. a pencil; 2) escalating a situation; 3) loud and intrusive arguing; 4) loud behaviour in public places, such as arguing; and 5) blaming behaviour. The five positive behaviours were: 1) workout how to solve a problem among themselves; 2) back down from an argument or a situation that might cause conflict; 3) discuss ideas quietly; 4) behave appropriately in public; and 5) accept responsibility. This scale was designed for the foster parents to score weekly. Therefore there were three measured perspectives on the issue of sibling rivalry. A fourth perspective came from anecdotal observations recorded in case notes completed by the CCM. The hypothesis connected to this target problem was that there would be no significant change in the number or severity of problems the

siblings experienced in their relationship with each other over the evaluation period. The treatment team felt it possible that Lizzy would likely experience more problems than Becky. Scores for the ISR were expected to be around 30. This is on the borderline of the clinical range.

The *Self Concept Scale for Children* (SCSC) was chosen to test the hypothesis that Lizzy and Becky's general self-concept would improve over the period of the evaluation. Lizzy and Becky completed this instrument with the support of their foster parents.

The *Behaviour Rating Index Scale* (BRIC) was chosen to test the hypothesis that Lizzy and Becky's behaviour in the foster home would remain stable throughout the evaluation. The BRIC was to be completed once weekly by the foster parents.

The *Mood Thermometer* (MT) was chosen to monitor Lizzy and Becky's subjective feeling state over the evaluation period. The hypothesis was that Lizzy and Becky's mood states would improve over the course of the evaluation. Lizzy and Becky completed the MT at the foster home with the support of the foster parents.

In addressing the problem of inappropriate sexual attitudes, the treatment team felt it would be possible to measure the change in Becky's attitude toward the subject of sexuality when discussed at home. Two statements were developed. The first was: 'Becky was able to discuss the issues presented without embarrassment.' This statement addressed Becky's comfort with talking about sexual issues with her foster parents. The second statement was: 'Becky can recall what was discussed last week.' This statement was designed to enable the foster parents to track the effectiveness of the material

presented and the interaction that ensued. The hypothesis in this instance was that Becky would be more able to discuss sexual issues without avoidance after the intervention than before it. A nine point Likert scale was used to record responses where 1 = really well, 3 = well, 5 = a little, 7 = barely, and 9 = not at all.

Data Analysis for Case C

a) Index of Sister Relations

Table 14: Results from Case C: The ISR

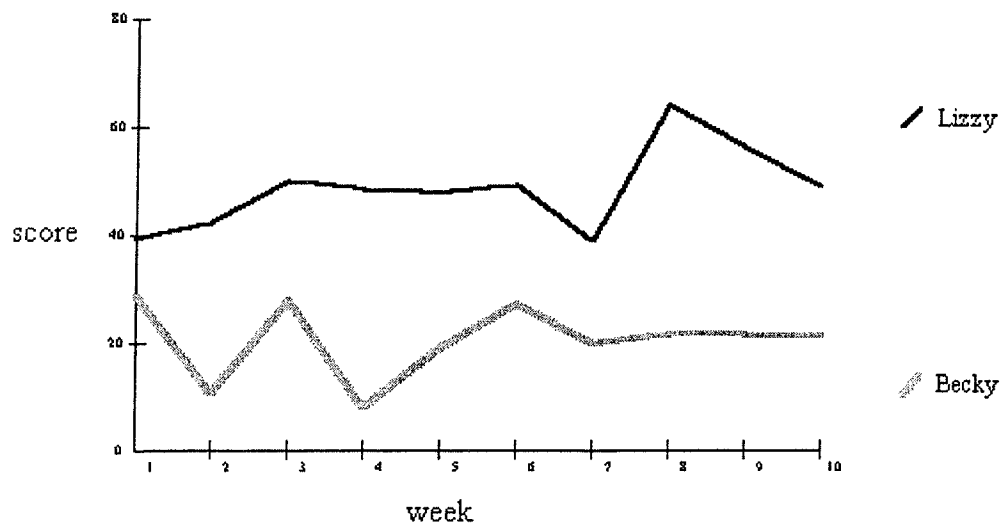
<u>Lizzy ISR</u>		<u>Becky ISR</u>	
<u>Week</u>	<u>Score</u>	<u>Week</u>	<u>Score</u>
1	39.33	1	28.66
2	42	2	10.66
3	50	3	28
4	48.66	4	8
5	48.7	5	19.33
6	49.3	6	27.33
7	38.7	7	20
8	64	8	22
9	56.35	9	21.665
10	48.7	10	21.33

Note: Range = 0-100. Scores under 30 indicate an absence of a clinically significant problem. Scores over 30 indicate the presence of a clinically significant problem and scores over 70 indicate the presence of severe stress with a clear possibility that some type of violence could be considered or used to deal with problems (Hudson, 1992). There was no data for week 9 the score indicated is the median of weeks 8 and 10. Scored by Children.

Visual analysis of the scores in Table 14 and of Figure 23 reveal that Becky's scores are lower than Lizzy's. There is no positive or negative trend in either case so an examination of the mean is relevant. The mean score for Lizzy was 48.47 while the mean score for Becky was 20.7. Lizzy's score is 18.47 points above the cut off point at which a clinically significant problem is indicated. Becky's score is 9.3 points below that point. The hypothesis was that there would be no significant change in the relationship over the

period of the evaluation. This hypothesis was supported, as the scores remained stable for both girls. The data showed that Lizzy had more problems with the relationship than Becky. The treatment team expected this but the size of the difference was a surprise.

Figure 23: Results from Case C: ISR



b) Individualized Scale Index Format - Sibling Rivalry

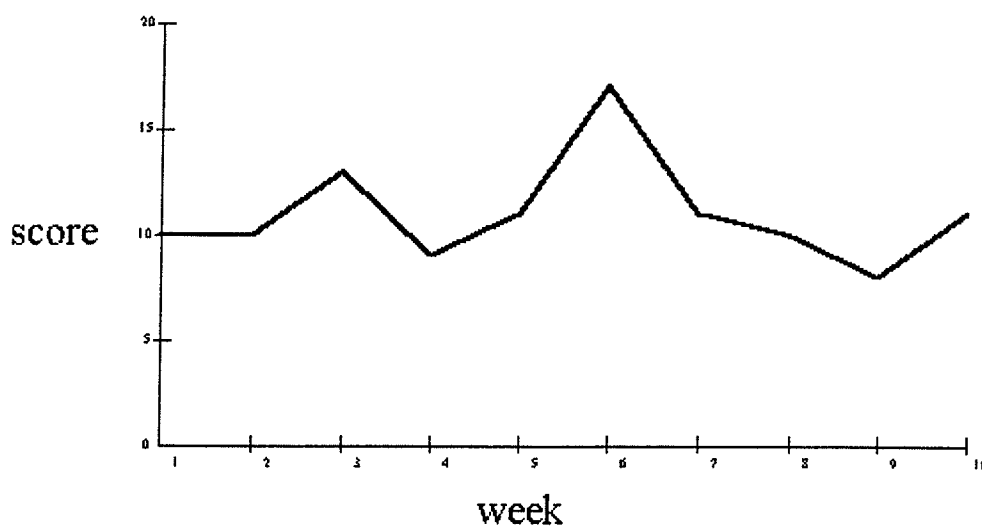
Table 15: Results from Case C: Sibling Rivalry

Week	Score
1	10
2	10
3	13
4	9
5	11
6	17
7	11
8	10
9	8
10	11

Range = 0 to 20. Lower scores indicate fewer problems. Scored by child.

The second tool used to measure sibling rivalry was designed to have a high degree of face validity in that it asked questions that were specific to the parent's experience of the relationship between the two sisters. It could not speak to the question of which child felt more or less negatively affected by the sibling relationship. It can however examine the hypothesis that there would be no significant change in the number or severity of problems the siblings experienced in their relationship with each other over the period of the evaluation. As expected there is no discernible trend in any direction Figure: 24); these scores indicate no significant changes in relationship problems throughout the evaluation period. The mean score over the ten-week period was 11.

Figure 24: Results from Case C: Sibling Rivalry

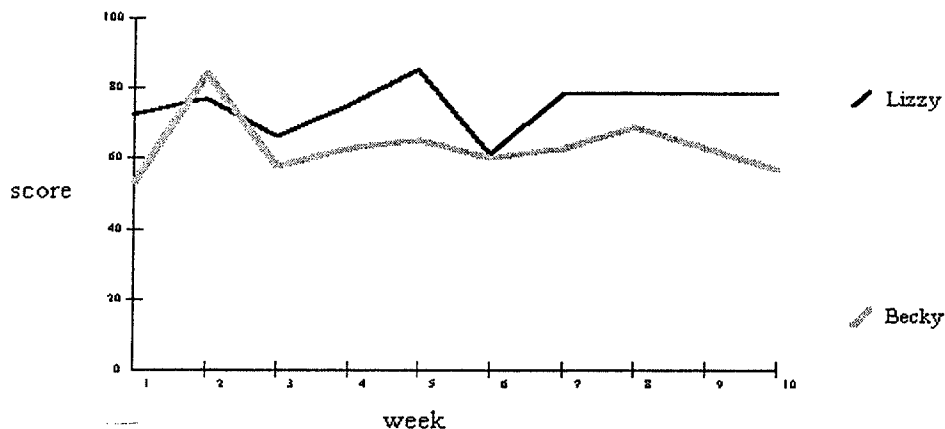


c) Self Concept Scale For Children**Table 16:** Results from Case C: The SCSC

<u>Lizzy SCSC</u>		<u>Becky SCSC</u>	
<u>Week</u>	<u>Score</u>	<u>Week</u>	<u>Score</u>
1	72	1	52
2	77	2	84
3	66	3	58
4	75	4	63
5	85	5	65
6	61	6	60
7	78	7	63
8	78	8	69
9	78	9	63
10	78	10	57

Note: Range = 22 to 110. Higher scores reflect higher self-concept. The mean score in the testing phase of the instrument was 86.75. In the evaluation there was no data for week 9; thus the score indicated is the median of weeks 8 and 10.

Both sets of scores for this measure indicate the absence of a trend in either direction. Therefore the hypothesis that self concept would improve over the evaluation period is not supported. The mean score for Lizzy over the ten-week period was 74.8 and for Becky the average score was 65.5. Both means are below the average of scores recorded during the development of the instrument.

Figure 25: Results from Case C: The SCSC

d) Behaviour Rating Index for Children

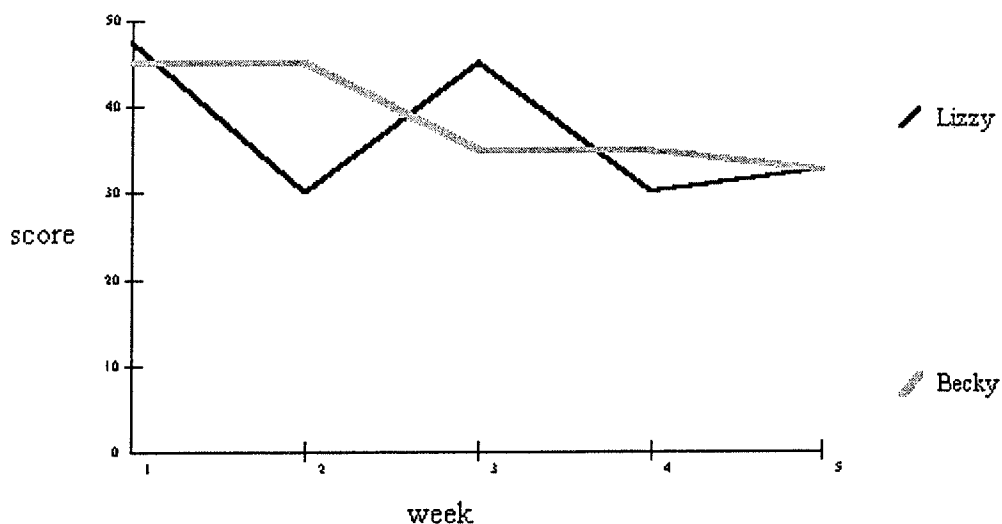
Table 17: Results from Case C: The BRIC

Lizzy week 1-5		Becky week 6-10	
Week	Score	Week	Score
1	47.5	6	45
2	30	7	45
3	45	8	35
4	30	9	35
5	32.5	10	32.5

Note: Range = 0 to 100. High scores indicate more severe behavioural problems. Scored by foster parents

The original intent of the design was for the parents to score the BRIC separately for each girl for ten weeks. An error of administration led to the foster parents scoring Lizzy for the first five weeks and Becky for the second five weeks. This makes it virtually impossible to use the data to answer the hypothesis that their behaviour would remain stable. The scores for the BRIC (Table: 17) were low for each girl but over just five weeks there is not enough data from which to draw any conclusions.

Figure 26: Result from Case C: The BRIC



e) Mood Thermometer**Table 18:** Results from Case C: MT - Lizzy

Week	<u>Tension</u>	<u>Confusion</u>	<u>Anger</u>	<u>Fatigue</u>	<u>Depression</u>	<u>Overall</u>
1	40	30	20	40	40	37.5
2	60	40	60	60	100	65
3	70	10	10	40	100	55
4	40	40	60	70	100	62.5
5	40	30	30	40	30	35
6	40	30	30	30	30	32.5
7	40	10	30	30	50	32.5
8	40	30	40	30	30	32.5
9	40	30	35	30	30	32.5
10	40	30	30	30	30	32.5

Table 19: Results from Case C: MT - Becky

Week	<u>Tension</u>	<u>Confusion</u>	<u>Anger</u>	<u>Fatigue</u>	<u>Depression</u>	<u>Overall</u>
1	70	10	0	60	100	60
2	70	60	0	100	60	72.5
3	40	40	0	80	20	45
4	20	100	0	40	100	65
5	40	40	0	70	100	62.5
6	40	0	0	40	20	25
7	80	70	20	40	20	52.5
8	70	60	0	40	20	47.5
9	70	65	0	40	20	48.75
10	70	70	0	40	20	50

Note: Range = 0 to 100. This instrument measures subjective feeling states at any particular moment. Lower scores indicate better moods. There was no data for week 9; thus the score indicated is the median of weeks 8 and 10.

Visually the Mood Thermometers seem to be presenting some very interesting data (Figures 27 – 32). With the exception of Becky's anger scores there is a lot of

variation in the scoring. This may suggest that the girls responded well to the instrument and that it captured the variation in their mood quite well. One way to check this suggestion is to compare the data to other information such as case notes. When the scores were compared to anecdotal evidence from the written case notes it was not possible to connect mood swings to events. The case notes highlighted the main issues but they did not give a general reflection of how the week had been for each girl. When the foster parents saw the graphs they thought that the peaks and troughs shown were a good reflection of the “moodiness” of the girls. For example, they agreed that Becky exhibited much less anger than Lizzy. They indicated that Lizzy let it all out while Becky bottled her emotions and occasionally flared. That Lizzy’s mood was better than Becky’s overall was also not a surprise as they felt that Lizzy’s superior ability to deal with her feelings generally improved her mood. Regression analysis was run for the overall mood of each girl, as a trend towards improved mood seemed to be visually apparent. For Becky the b score was -1.93 where $p = 0.196$, while Lizzy’s b score was -2.89 where $p = 0.039$. This tells us that the trend seen in Becky’s case, while certainly apparent, may have occurred by chance alone, but the trend noted in Lizzy’s case is statistically significant.

Autocorrelation was calculated to test the MT results for evidence of serial dependency. In Lizzy’s case the test showed that the data was autocorrelated for confusion, anger, depression and in the overall score. In Becky’s case the test suggested that the data was autocorrelated for just tension and fatigue. Given that Lizzy’s overall score appeared to have a statistically significant trend, the test for autocorrelation may not

be appropriate. However, Lizzy's confusion score for example does not display a trend and does appear to be autocorrelated.

The hypothesis that mood would improve over the course of the evaluation period is supported in Lizzy's case but not in Becky's. However this result is mitigated by the possibility that the scores for the MT in Lizzy's case were not independent.

In terms of clinical usefulness the mood thermometers gave the foster parents an interesting glimpse into the lives of their foster children. They were careful not to read too much into them understanding that they were highly subjective tests; however, they were interested to note certain results, such as the scores for depression, that were in the 100 range for 3 weeks in Lizzy's case and for one week in Becky's case. These were surprising scores for the foster parents as they had not thought that the girls were feeling so depressed.

Figure 27: Results from Case C: MT Tension

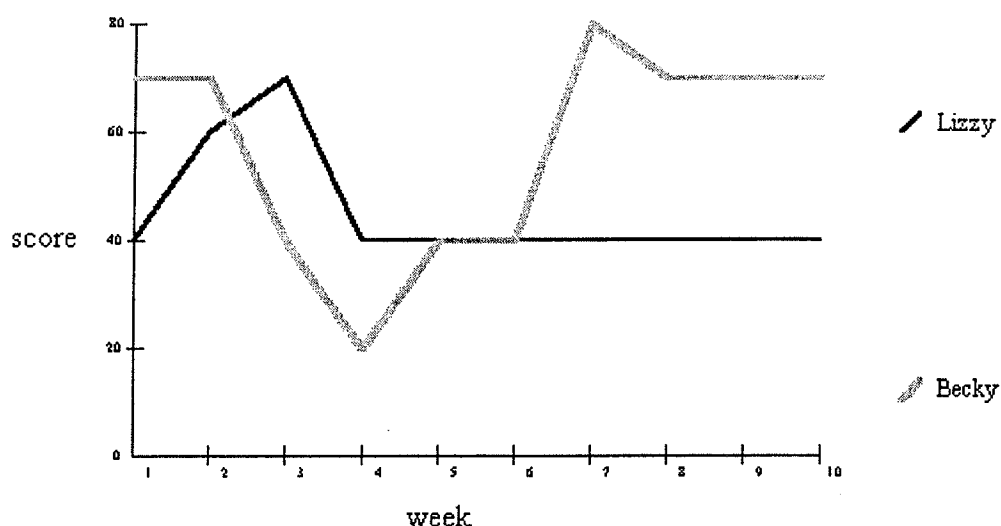


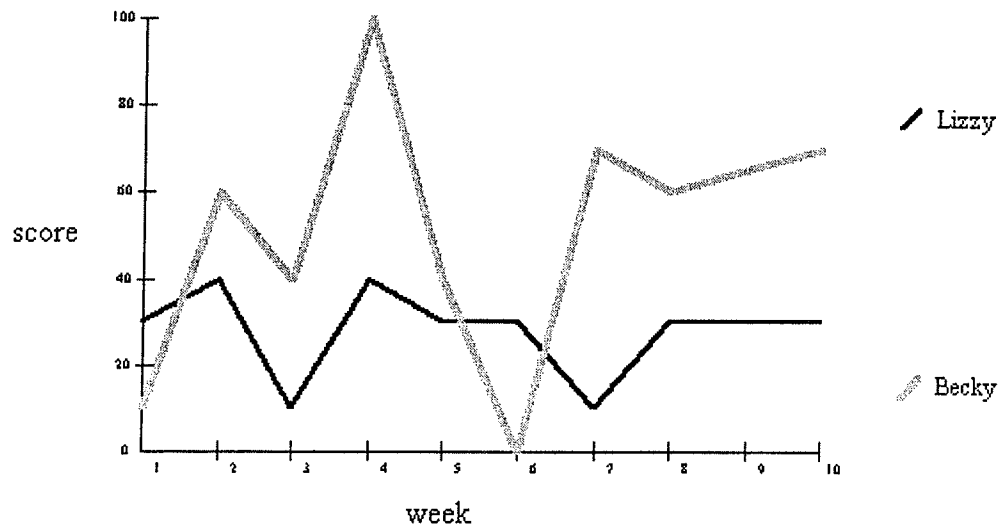
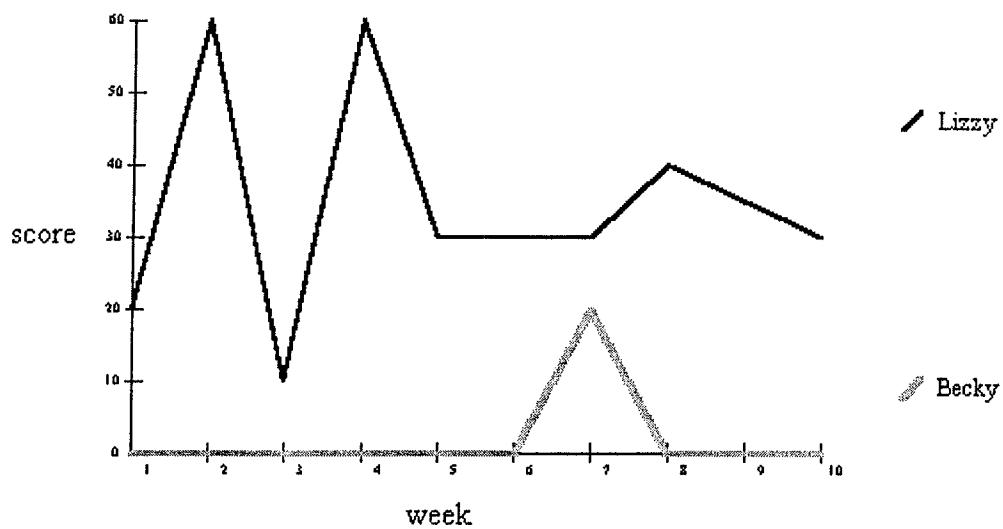
Figure 28: Results from Case C: MT Confusion**Figure 29:** Results from Case C: MT Anger

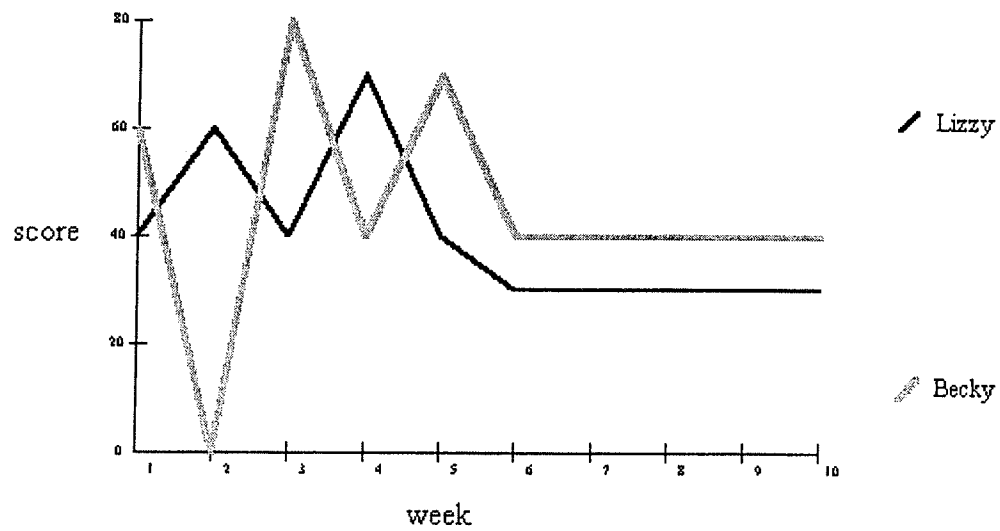
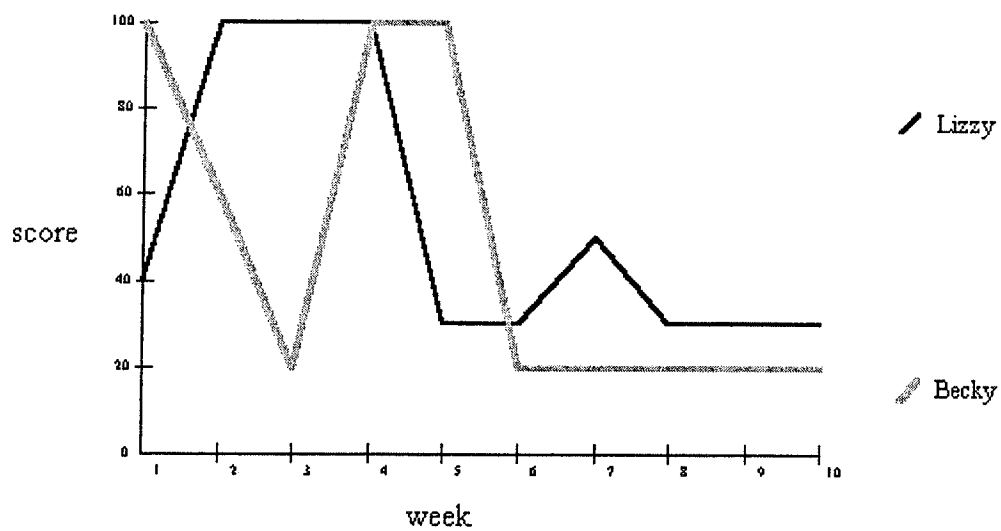
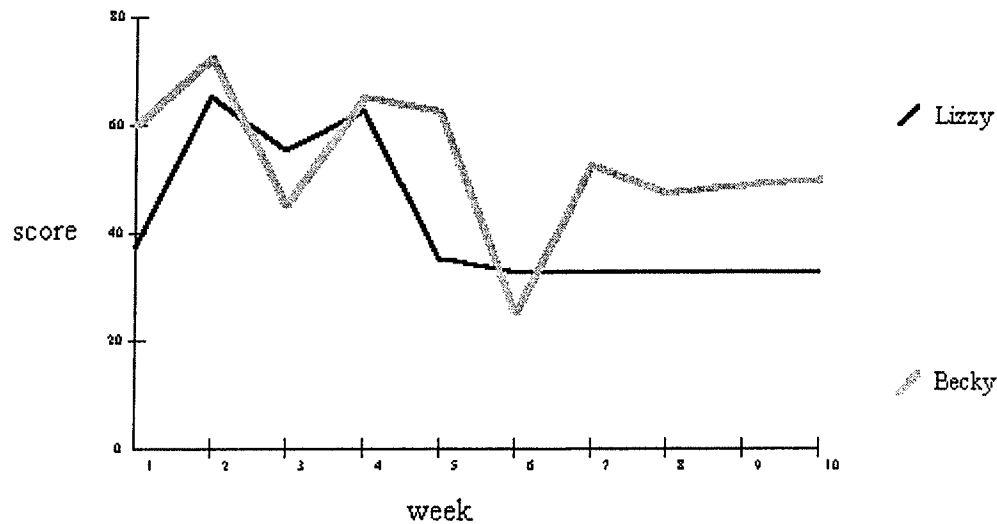
Figure 30: Results from Case C: MT Fatigue**Figure 31:** Results from Case C: MT Depression

Figure 32: Results from Case C: MT Overall



Case C: Analytical Summary

The single individualized scale that was used in Case C indicated that, as expected, the level of rivalry between the siblings did not change. This finding was supported by the standardized scale *Index of Sister Relations* (Corcoran & Fischer, 2000) that the girls completed. The surprise in this instance was that the difference between the sister's scores was so large. The fact that both girls reported lower than average scores on the standardized *Self Concept Scale for Children* was important information, as was the findings of the *Mood Thermometer*, which reflected some unexpected extremes of mood. The information from the BRIC was of little value as it was scored incorrectly.

Summary of Measurement Methods

Of the eighteen measures designed for the participants in all three evaluations, four were not successfully completed due to administrative or other errors; two were completed but were considered upon analysis to have produced invalid data and the remaining twelve produced data that had some analytical merit or purpose. Of the standardized measures, the BRIC was used in all three evaluations but was useful in only one case. In the other two cases the measure was incorrectly completed. The *Mood Thermometer* was also used in all three cases. When used with the two pre-teen participants it provided very interesting information that was then difficult to analyse as much of it tested as being autocorrelated. The MT could not provide any useful data when used by the teenage participants. The frequent straight lines that were produced by the teenagers using the MT instrument could not be tested for autocorrelation using the Singwin program as without variation in observation points the program was unable to make any calculations. Three children completed the *Self Concept Scale for Children* across two evaluations. It provided useful data in each case. The *Hare Home Self Esteem Scale* as utilised in one case and also proved useful. The *Index of Sister Relations* as used in one case, was completed by both sisters and gave excellent information.

It should be noted that as this practicum was an exploration of case level methods in the evaluation of TFC, it is to be expected that the measures used would not be ideal. Not all the standardized measures used were as valid as they could have been under more rigorous research conditions. The standardized measures were chosen in part because they represented instruments that would be easy to use in the field. They were matched

as well as possible to the particular cases. Future practitioners may find that using standardized measures is not feasible because of the inherent difficulty in finding valid instruments that participants will be willing to use.

Overall the Individualized measures provided more interesting data than the standardized measures. Administrative errors occurred in two of the individualized tools; six others were successfully completed. These measures were found to be useful in adding strength to the findings of the standardized tests, reflecting the perceptions of the foster parents, focussing treatment strategies and guiding foster parent observation.

The reason that data from the individualized scales was more interesting was because the participants felt that the information was more relevant to their particular case. In Case A, both individualized measures used provided data that strongly reflected the perceived experience of both the foster parents and the CCM. In Case B, the individualized index format was a primary treatment tool that spoke directly to the participant's individual issues and effectively drove the therapeutic process. It was a powerful tool because the statements the participant was asked to respond to were custom made and so were directly relevant. In Case C, the index format used measured issues of sibling rivalry in a way that a standardized measure could not. It supported the data collected with the ISR by focussing on previously observed problems and established goals and objectives.

Chapter 5

Post-Evaluation Interviews with Participants

The first section of this chapter provides a review of the information gathered during a semi-structured interview format. General questions (see Appendix P) were asked of each participant leaving ample room for clarification, elaboration and digression. There is a brief description of each question followed by a summary of the responses given by the participant groups. There are three distinct respondent groups. The first is the clinical case managers (CCMs); and the second is the treatment foster parents. The individual results from the program coordinator is presented as a third category.

The second section of this chapter is an analysis of the information gathered from the interviews; the strengths and weakness of case level evaluation as experienced by RSFC is the particular focus of this analysis.

Clinical Case Managers

The participants were asked to tell the interviewer about their experience of being involved in the study. The question was intended to relax the CCMs and to give them the chance to respond generally to their experience of being involved in the evaluation. However it was not effective and all the respondents found it too general to be able to respond to as an introductory question.

Workload

The second question the participants were asked was much better as an introduction as it was focussed on a narrow aspect of the evaluation. It asked the participants if they were able to complete the evaluation within the time frame and whether participating added to their workload.

The CCMs for Cases A and C both reported no addition to their workload and no problems completing within the time frame were mentioned. The CCM for Case B did not feel that it added to her workload, but mentioned that having to remember to fill out the forms was stressful. She added that completing the evaluation within the time frame was difficult as she chose to evaluate only when the treatment event occurred. In the event, while there are ten weeks of data represented in the evaluation results, that data was collected over a period of 14 weeks.

Data

The participants were asked about the data collected and the results of the analyses of that data. They were asked whether the results of the evaluation were conclusive, what the data should be used for, and whether there was any purpose beyond purely decision making.

In Case A, the CCM reported that she thought the results were able to confirm their perceptions and there were no surprises. She talked about the MT and how Rachel had presented a happy front. This was not unexpected by the CCM as this was very much the way she saw Rachel operating. Other tests completed by the foster parents showed a different picture, as did anecdotal file information. The CCMs for both Case B and C reported that the scales they had used did not provide data that was

able to conclusively alter or consolidate their opinions about the treatment methods they were using.

With respect to how the data should be used the CCM for Case A said that the data could be used to teach children and foster parents about what was going on for them at the time, to do treatment planning and to teach other CCMs about the problems faced in the program. Beyond clinical decision-making she felt that case level evaluation was another tool in the box to be used as part of treatment. The CCM for Case B also felt that the data could be used in the treatment setting to “move stuck cases.”

In Case C, the CCM thought that the data could be used to tinker with the treatment plan, to aid in the creation of programs by identifying specific needs and to offer to other professionals as evidence of a pattern of behaviour. Beyond the ability to use information for clinical decision making however, he could not see any other purpose.

Process

The participants were asked to comment on both the overall usefulness of the process of the evaluation and whether or not they were able to make confident decisions based on the results.

The CCMs for Cases A and B found that the process was useful. In Case A, the CCM said “the process was useful for [the foster parents] to really just concretely look at certain areas of her behaviour.” She wasn’t sure how useful it was for the participating child as she noted that there is “probably a lot of risk to validity of that instrument” [the MT]. The CCM for Case B answered the first part of the question

with a simple “Yes”, however in the rest of the interview she referred to the process constantly. For her, the process of completing the forms for Nichola was central to the treatment. Doing the evaluation drove the case forward very effectively and gave the CCM a way to engage the child that would not otherwise have been possible. She said: “I think what this tool created was an opportunity for her to develop a level of trust with another adult, which happened to be me, so that she could disclose some pretty serious things.” The CCM for Case B was “frustrated by her [Nichola’s] inability to follow through --- but it always gave us impetus to talk about why she couldn’t which I think evolved into treatment.” She reported that the results “solidified [the team’s] opinion that [Nichola] was struggling with a ton of issues---- made us focus our treatment.” So although she could not use the results to make confident decisions, she was able to “use the tool as a means of moving [Nichola] forward.” The CCM for Case C was much less involved in the evaluation process and not able to provide an answer.

Methods

The participants were asked if they felt the methods used in the evaluation were helpful in their practice and which stages of the process were the most helpful. Each CCM had a different answer to this question. In Case A, the CCM felt that the process of collecting the data, which required foster parents to focus primarily on positive behaviour, was helpful to the team as it was a relief to focus on what was going right for her when so much was going wrong. She also said that it was “a good start in the process of looking at a multi-layered issued kid.” However she also said that it was just a start and not all they wanted.

The CCM in Case B also pointed to the process of collecting the data as being the most useful in her practice. For her the evaluation was a clinical tool in itself that enabled her to considerably advance the treatment goals for the case.

The CCM for Case C felt that anything was helpful. He felt that analysing the data after the evaluation period was the most interesting as they were able to discuss the findings together. However he also said that it “is important for foster parents to be able to say it on their own and sometimes being objective doesn’t give you the whole picture.” By this he meant that objective exercises such as measuring behaviour on a scale cannot replace the practice of openly talking through issues.

The participants were asked whether the method was difficult to apply or not. In Case A and B, the participating CCMs stated that it was “very straightforward” and “not complicated at all”. The CCM for Case C found it to be relatively straightforward, but noted there were a lot of forms over a long time for the foster parents. Interestingly the foster parents in Case C reported that they had no trouble with the amount of work that was required of them in completing the scales.

The CCMs were asked whether they would use the method again and if so what would they do differently. Both CCMs for Cases A and B said they would use it again. The CCM for Case A said “if I can find a methodology that works with a certain behaviour or problem with a kid and learn from that and share that with other people who are experiencing the same difficulty, that’s good information.” She also felt that it was essential to take a look to see “if what we are doing is working otherwise we are just sort of dancing in the dark.”

The CCM for Case B saw huge improvements in the way Nichola and her mother related. Therefore she saw the tool as “really useful.” Case C’s CCM felt that

it would be useful to get an idea of where children were at times of change such as at the introduction of family visits. As for doing things differently, the CCM for Case A thought that it would be hard to find an instrument to measure a child as complex as Rachel. She wasn't sure if it would be possible to create a different design or implement the evaluation in way that would produce more definitive results. Case B's CCM said she would be more consistent in her recording. She also thought that she would challenge herself around involving the birth mother more in the process.

When asked about the benefits of the methods used, the CCM for Case A spoke in general terms of the benefits to treatment planning, learning and evaluation. In Case B, the CCM spoke specifically with reference to her experience of using the method to make a treatment breakthrough in terms of her client's ability to engage therapeutically with her. The CCM for Case C said that the benefit was in getting a regular snapshot to assist in knowing where the children are. He thought that it might also be possible to establish patterns over time.

The only drawback to the method that was discussed was the extra work the evaluation created for the foster parents. However, this was reportedly less of an issue for the foster parents themselves.

Measurement

One set of questions asked was designed to probe further into the measurement stage of the evaluation process. There were common elements to all three cases so it was of interest to discover if there were common experiences. Of interest was which of the tools used in each design were the easiest to use, which were

most useful for decision-making and how cumbersome or difficult it was to collect the data.

There was no common thread in the responses from the participating CCMs. The CCM for Case A reported that Rachel had found the *Mood Thermometer* easy and had enjoyed doing it, at least up until the point that she appeared to start to feel bad. The CCM also reported that the Individualized Index scale that attempted to measure Rachel's connectedness to her foster family was the most useful as it really leant a lot of weight to the way both the CCM and the foster parents were feeling about the case. The CCM for Case B named the Individualized Likert scale as the easiest to use. At other points in the interview she talked at length about how useful the Individualized Index scale was in moving the treatment process forward. The CCM was not involved in the collection of data for Case C so the questions were not relevant. He conceded that collecting the data was indeed easy for him. CCMs for Case A and B also agreed that collecting the data was not cumbersome.

Defining the Program

The CCMs were asked whether the process involved in choosing interventions and designing ways to evaluate them, helped to define more precisely what it is that TFC has to offer children in the program.

The CCM for Case A said "absolutely because I think that you will find you should be able to extrapolate from the data some techniques or program interventions that work or don't. That should be good information for this program -- we probably need to do more case level evaluation." In Case B, the CCM said that the process of evaluation "helps translate theory into practice"; she went on to say that "if we are not

laying it out for foster parents in a collegial way how do they know what it is that we are doing.” She said: “one of the mistakes that we make in clinical treatment is that we are not being clear enough in what the process is.” She also agreed with the theoretical premise brought forward by the interviewer that the process sets down in detail what it is that a program does in terms of treatment. The CCM for Case C was more reserved in his response. He felt that as in any form of study there is always something that can be derived and learned. “There might be some kind of benefit, you might catch something that you might not have at one point.” However, he did think that it could help to define a program so long as there were other considerations taken into account.

Institutional Environment

The CCMs were asked whether they experienced any opposition to the method from within the institutional environment, how supportive the foster parents were of the method, and what impact the method of evaluation had on their relationships with the foster parents.

The CCM for Case A experienced no opposition from anyone in the institutional environment. She reported that the foster parents were very supportive of the method and had done a good job. She also felt that in her relationship with the foster parent group the method had “focussed” them. In Case B, the CCM reported that the only opposition was from the child participant, Nichola, who “was not thrilled with the idea,” and was “disgruntled by the process of filling out forms.” The CCM reported the foster parent as being very supportive as was the birth mother who had been initially interested but had not referred to it again. The CCM for Case B felt that

there had been no change in her relationship with the foster parents which she described as being 9 years in duration, collegial and with an established rhythm. For this CCM the biggest relationship change was between herself and Nichola. She said they went from a non-communicative relationship to a relationship in which the client was able to talk of hopes and dreams, make disclosures and vent frustrations in appropriate ways. "She moved a long way in terms of trusting me with information that she hadn't shared before."

The CCM for Case C did not meet with any opposition to using the method. He also found the foster parents to be supportive and did not report a change in their relationship.

Case Level Evaluation vs. Program Level Evaluation

The CCMs were asked whether they considered case level evaluation to be a useful tool for the agency and whether they would recommend the method over, or in addition to, broader program level evaluation. They were also asked whether they felt case level evaluation had a limited application.

In Case A, the CCM felt that case level evaluation was "critical for clinical case management and both kind of evaluations have their place. But if you don't do case level evaluation you can just keep blindly going forward without focussing." She felt that there were limitations to the method. She felt these included ethical limits and that designs would have to be individualized to fit with the philosophy that there "are no cookie cutter answers." However she said that the method has the ability to "teach us a lot." The CCM for Case B said that she would recommend case level methods to a CCM whenever they felt stuck in a case. She reported that it "pulls

everybody into concert.” By this she meant that the process of evaluation organized the treatment team enabling shared goals to be established and worked towards at the same speed. She could not give a definitive answer to the second part of the question but was willing to entertain the idea that case level evaluation could possibly replace program level evaluation if fully implemented. When asked about the limitations of case level evaluation she said that she found it “hard to imagine using the method across the whole program.”

The CCM for Case C thought that although case level evaluation had a limited application it was a “useful tool,” while it might not be able to be used generally it provided specific guidance that could be used as a starting point or as a way to “tinker” with a program.

Treatment Foster Parents

Workload

The foster parents were asked to describe their role in the evaluation process. They were asked whether or not they were involved in collecting data and how cumbersome that process was.

The foster parents in Case A were given the task of filling out three separate forms. Their foster daughter completed one form. They reported that the data collection process took half an hour per week. They described this as “extra paperwork.” They found that as their daughter was very inconsistent; it was hard to pick points on a scale or select weekly indicators as her behaviour and attitudes varied tremendously. “We had to average it always because she was so far up and down the scale --- she would bounce around so much in there we would be totally confused and

frazzled by the time we finished figuring it out.” They were asked if they would have been prepared to do the evaluating daily to address that issue but they replied “not at all.”

The foster parents in Case B reported that once they sat down to fill out the forms “there wasn’t much to it.” Their foster daughter attempted to avoid the task by feigning tiredness or coming home later than usual. They filled out two forms once a week and their daughter filled out two forms with them and one with her CCM.

In Case C, the foster parents reported that fulfilling their commitment “wasn’t a problem - it didn’t take very much time at all.” They had to help their two foster daughters fill out the forms, as they were much younger than the two other participating foster children.

Personal Impact

The foster parents were asked whether the process of measuring changed things in their home and if so how. The foster parents in Case A did not feel that there was any change at all. They felt that their daughter had not completed her form honestly. They did not believe that she filled out the forms accurately.

In Case B, the foster parents reported that there was a change for them. They said that having the questions to answer on the forms gave them specific things to look for that they would not otherwise have considered. This, in turn, meant that it “was always in the back of your mind, how can I fix it?”

The foster parents in Case C reported that collecting the data had no impact on the way they related to their foster daughters or to any of the routines of the home. However they did find that the process made them “think more about acknowledging

the good things instead of noticing the bad things as much.” They also thought that as a result of completing the sibling relationship scales Becky became more appreciative of her older sister.

The foster parents were also asked about their thoughts and feelings on having their interventions evaluated in this way. There was no opposition to the concept of case level evaluation in from any of the foster parents. The foster parents in Case A said that it might be better in some situations than others. In their case they felt that it had not been very useful. In Case B, the foster parents reported a similar sentiment in that they thought it would not be appropriate in every case, but in their situation it had been a “big help.” The foster parents in Case C simply thought it was “a good idea.”

More specifically, the foster parents were asked whether the process had been helpful and which parts were the most helpful. Then they were asked if they thought the process had helped their children and whether there was any impact on any other children in the home.

In Case A, the foster parents thought that there was too much going on for their foster daughter. Her issues were too complex and her behaviour and attitudes too inconsistent to be able to measure effectively.

The foster parents in Case B thought that the process had helped their foster daughter. They said the other three foster children in their home did not notice it was happening.

In Case C, the foster parents thought that the evaluation was an interesting exercise. They suggested that it would be interesting to do on an annual basis to assess change over a longer period of time. They thought that analysing the data was helpful as it was sometimes “very enlightening.” They felt that the process of

collecting the data had made them more mindful of issues their foster daughters face and had opened up avenues of inquiry they had not previously considered. The Case C foster parent said that there had been no impact on the other children in the home. For example their birth daughter said that she had not felt left out.

With regard to the institutional environment, the foster parents were asked whether they felt any constraints coming from other parts of the program, whether case level evaluation was something that RSFC should pursue either in place of or in conjunction with program level evaluation, and whether they felt as foster parents that the experience had given them a different understanding of what it is they do for the foster children in their home.

All three sets of foster parents reported that they did not feel any constraints at any stage during the process of the evaluation. They all felt that case level evaluation was a good thing for RSFC to be doing but did not feel it could completely replace program level evaluation. The foster parents in Case A thought that they had not gained any insight into their foster daughter through participating in the evaluation. However they added that they could see how it would work better in different cases.

In Case B, the foster parents felt that the evaluation process had given them a set of tools enabling them to ask questions and make observations that they would not otherwise have considered.

The foster parents in Case C felt that the experience had given them a better understanding of what they do as foster parents for their foster children. The foster mother said that it made her realise how much she set the tone in the home. She also commented that the process made her realise all the different facets of a person that are not necessarily revealed in day-to-day living. When the data was analysed it

became evident that they had given values to certain issues that were different than their foster children. They said that it was possible that they were often wrong in their assumptions about what incidents may either negatively or positively affect them or their children.

When asked if they would want to be involved in a case level evaluation process again, all of the foster parents said that they would, although the foster parents in Case A said they would choose a different child on which to focus. The foster parents in Case C thought they might try case level evaluation for themselves just to help maintain their sense of purpose. They felt a more objective approach could help to avoid feeling that nothing is working. It would also enable them to step outside of their daily reality and be like an outside observer visiting after an extended absence.

Program Coordinator

The purpose behind interviewing the Program Coordinator of RSFC was, on one level, to gain an insight into the experience of the program as a whole to the process of case level evaluation. On another level the purpose was to explore the future possibilities for case level methods of evaluation for TFC.

Benefits to the Program

The program coordinator was first asked to describe the role she played in the process of developing interventions and designing evaluative methods. She was then asked what benefits she saw in using case level evaluation now that some parts of the program had experienced it.

In response to the first question, she said that she had assisted in determining the participants for the practicum and had helped to identify some of the issues that might be examined. To the second question she said that she thought that “there was more than one benefit to case level evaluation; first of all it is a really useful way to validate what foster parents are doing and what clinical case managers are doing in terms of clinical interventions... secondly, [in Case B] this was a powerful tool in order to drive the therapeutic process.” The only drawback to the method was that it required someone to “drive the process”. The program coordinator said that the program had been involved in evaluative methods in the past and had used file reviews, and a selection of standardized tests to measure program effectiveness. Although she had produced data for two years, the psychologist responsible for the assessment had not given her any feedback.

When asked about feedback from participants, the program coordinator reported that two of the CCMs were quite excited by the results. She had not had any feedback from the third CCM. In general she felt that “people were excited to see that their work was being validated and that they were on the right track in terms of examining the clinical issues.”

Use of Data

The next group of questions dealt specifically with the data and asked firstly, whether any of the information gathered could be used for evaluative purposes at a program level? A second question asked about the usefulness of the data to the program and a third asked about how the data might otherwise be utilised?

The program coordinator said that the data from these three cases could not be taken and used to evaluate the program as a whole, however she felt that the data was useful to the program in a variety of ways. One of these ways was that it served to demonstrate to foster parents that “you can take tools like this and use them to drive processes that are effective.” Also she thought that the results should be put on the children’s file, that the data should be shared with senior staff at New Directions and discussed as a staff group with a view to putting more case level evaluations into practice. In a separate conversation the program coordinator also stated that given that this is a first attempt at this form of evaluation the data produced is quite impressive. She compared it to previous attempts at data collection in the past that yielded no results at all.

Support for Methods

The program coordinator was asked whether she felt the foster parents and case managers were in support of the methods used, whether there was any opposition felt and what impact there may have been on her relationship with either the foster parent group or the CCMs.

In general she found that the foster parents and case managers were supportive but with reference to some of the errors in completing some scales she thought they were “absent minded.” The only opposition she experienced came from the teenage girls who had difficulty “when they had to do an introspective look at themselves.”

In response to the last question in this set she thought that the methods used served to “create a more sophisticated approach to our program that validates the work that people are doing so that they realise that as a program we are able to use

professional and clinical methods”. The program coordinator also said that “parents look at this and see that all the pieces that are attached to a professional approach come with this kind of work and as a result the foster parents see themselves as growing.”

Case Level Evaluation vs. Program Level Evaluation

The program coordinator was asked whether she considered case level evaluation to be a useful tool for RSFC and whether she would recommend the methods over or in addition to broader program level evaluation. Secondly, she was asked to comment on the limitations to case level evaluation and thirdly she was asked whether she saw any purpose for case level evaluation beyond purely clinical decision making. Finally she was asked whether the information collected could help to define the program.

In response to these questions the program coordinator felt that she would absolutely recommend using case level evaluation over program level evaluations as she felt that the methods used had more power to move clinical practice forward while still producing data that could define what was happening in the program and objectively evaluate treatment methodology. Rather than being limited she thought that the “scope was huge”. She felt that if the process of case level evaluation ever became an expectation the associated problems such as the time consuming nature of the data collection would cease to be obstacles.

Analysis

The post-evaluation interviews were designed to address the four research questions set out at the beginning of this report. The first question was concerned with the effectiveness of the data that was produced; in particular there was a concern about validity and reliability in the measurement of treatment outcomes. The general response of the participants was that the data could not be used as conclusive evidence of either change or stability on its own. However it was interesting that the program coordinator had a more positive view of the data and the possibilities for it. She considered the results to be very valuable as they showed that it was possible to produce good data even on the first attempt of a new method. The majority of the participants found that the results of their evaluation were interesting and informative. They reported that the data offered insight and also validated what they already knew.

The second research question asked whether a case level approach could fill the need for descriptive information that qualitatively described the unique characteristics of the program. It was generally felt that such information could be generated through the methods used. It was CCMs who were specifically asked questions that directly related to this topic. They considered that the methods used did indeed set down in detail what it is that a program is doing in terms of treatment that separates TFC from other forms of care. It was strongly felt by the program staff at RSFC that by helping to translate theory into practice, case level methods enhanced professionalism and collegiality among the treatment teams and within the program as a whole.

The third research question concerned both the sustainability of case level evaluation methods and the inferential ability of the data produced. The foster parents

responded unanimously that the experience of participating in the practicum was a positive one, that it was not overly time consuming and the method was not too difficult or too complicated. They all claimed that they would do it again although they would try to focus on a specific intervention and in one case would select a less complicated subject. Based on this limited sample, there are few objections from the foster parents that might jeopardize the sustainability of a case level approach to TFC evaluation.

The program staff also responded very positively. They were more concerned about the amount of work involved for the foster parents than the foster parents appeared to be, but in one case also felt that the foster parents were at times a little absent minded. The program staff had very different experiences with the methods used as the designs were different and each CCM had a different role to play. For example the CCMs in Case A and Case C had no scales to complete and the CCM in Case B had two plus a central role in helping the child participant in completing two of the scales she was given. Nevertheless all the program staff were extremely supportive of the idea of case level evaluation as a tool to be used by RSFC.

None of the participants felt that the results as presented could be used to evaluate the program as a whole. All the foster parents felt that it should be used in conjunction with broader program level methods, as did two CCMs. The third CCM, who is also the program coordinator, took a different view. She felt that while the data collected in the three evaluations could not be used to discuss or describe the program as a whole, with practice and the introduction of case level evaluation as a program requirement, these methods could “absolutely” be used to evaluate RSFC as a program.

The fourth research question was about obstacles to case level evaluation from within the RSFC and the New Directions agency environment. None of the participants reported any obstacles to the method. Three out of four of the participating children were described as enthusiastic towards the beginning of the ten-week evaluation period. The fourth child was motivated by her desire to improve her familial relationships. All of the children did at some stage complain about filling out the scales. However it was understood that they were under no obligation to use the instruments they were given and in only one instance did a child decide that they wanted to stop participating. The foster parents reported that there was no impact on non-participating children in their home. Having not interviewed the child participants in this project has placed certain limitations to conclusions that may or may not be drawn from the responses given by foster parents and CCM's to this question. For example, it is possible that the children participating deliberately faked all their observations. As well it is possible that the degree to which their foster parents and CCMs report that they had trouble with the data collection aspect of the project was exaggerated.

What the research questions failed to ask, but was addressed in the interviews, was what benefits did partaking in the practicum have for foster parents, foster children and for RSFC as a program? Benefits to working relationships between foster parents and case managers were found as in Case A where the CCM reported that using the methods focussed their work with Rachel. There were also benefits to relationships between a CCM and her child client. In Case B, the child was failing to connect on a therapeutic level with her CCM until they began the process of

evaluation which effectively drove the treatment process and opened up the gates to allow an intervention to occur.

In addition, there were benefits to CCMs in the realm of treatment planning as the process of design helped focus the treatment team and then, as in Case B, drove the process therapeutically. Foster parents reported that both the process of design and the tools provided new ways to perceive and focus on behaviours that were beneficial to both themselves and to the way they worked with their children. There was no incidents where case level methodology was perceived to be obstructing treatment or in any way counter to the best interests of children, foster parents or the program.

Summary

The use of case level methods as experienced through this practicum gave the participants a positive experience of treatment evaluation. While there were clearly shortfalls in the ability of the data to provide conclusive evidence, there is reason to conclude that the data collected was an interesting and useful addition to the program. On the whole, the methods used were relevant to the treatment teams and the process of designing and measuring was found to be beneficial to all concerned. The program coordinator is keen to take the project further and the methods were well received with little opposition from within the agency. This is a strong indication that the RSFC program may choose to use case level evaluation methods in the future.

Chapter 6

Implications and Conclusions

In this chapter answers to the research questions are examined; in addition the lessons learned from the entire practicum experience are discussed.

Conclusions Pertaining to Research Questions

The methods employed were able to produce data that was relevant to the program, had good face validity and provided insight into the lives of the children studied. The data did not reach a high level of reliability and could not be used to generalize to a larger sample. At most it provided a way of addressing issues within the homes and raised questions about treatment modalities.

There was potential for the method to collect data that, consistent with the views expressed by Meadowcroft et al., could help define the characteristics of the program. The program staff were of the opinion that the information collected went a long way towards that goal. However, this goal was not as well met as it might have been. During the design process target problems were identified and ways to measure them were found, but only in Case B was a specific treatment intervention identified and described. This may have been due to the time restrictions imposed by the academic nature of the evaluations. In a normal clinical situation treatment evaluation would be more likely at certain junctures in the life of a child, such as at the beginning of a particular

intervention. This would necessitate a description of the intervention methodology and therefore produce descriptive information relating to interventions.

The participants were confident that the methods used were feasible and that they would work within the program. Two of the CCMs suggested that case level methods were not suited to every case but would be very effective in others. The program coordinator identified her preference that case level evaluation should become a requirement within the RSFC program and suggested that if it did the problems discovered in this first attempt would likely be ironed out in the future. This enthusiasm does not obscure the fact that, even if repeated across the entire program, the instruments used were not likely to be able to produce statistics that could be used to describe the program as a whole. In one case the *Behaviour Rating Index Scale* (Stiffman, Orme, Evans, Feldman, & Keeney, 1984) was an effective tool that helped the foster parents in their perceptions and recording of behaviours. Otherwise, due to error in use, it failed to be properly tested as an instrument. The Mood Thermometer (Tuckman 1984) was also only effective in one case. It was ineffective in the other two cases due to the understandable reticence of the child participants to expose their feelings through use of the scale. The other standardized scales were completed without incident or issue.

Evaluation of Learning

The learning goal for this practicum as stated in Chapter one was the development of skills in evaluation, including design, implementation, and analysis, through the

practice and experience of facilitating case level evaluation methodology within a TFC program. The achievement of these goals was met through the process of intimate involvement with the clinical staff and foster parents at both Macdonald Youth Services Alternative Parent Home program and New Directions Regional Specialized Foster Care program. Through experiencing the process of evaluation alongside the participants, insight and knowledge were attained. The qualitative interviews that were conducted post-evaluation enabled the triangulation of information, which added to the learning experience. Furthermore, the final survey provided reflective feedback on the role of the facilitator.

There were specific lessons learned on the details experienced throughout this practicum. These specifics concern the process of implementation, the process of design, the process of evaluation and the process of analysing both the results and the experience of evaluating treatment methods in TFC homes. An examination of these lessons is possible by trying to identify the processes used that were either effective or ineffective.

It was not effective to try and design each evaluation in more than one meeting with the treatment team. It was effective to condense the process of problem identification, goal setting and operationalization into one long session. It was also effective to have a variety of standardized scales at the design meeting, similarly having a format for the design of individualized scales was helpful. It is expected that with practice the individualized formats would become more varied and more flexible.

Asking participants to complete scales once a week worked well. However to have asked for more may have been counter-productive. It is also questionable whether consistency of scoring would have been maintained over longer periods. There are many scales available that test well for test-retest reliability when used on a monthly basis. Therefore there may be ways of extending evaluation periods by using different tools.

It was not effective to assume that the instructions laid out in the design stage were completely understood. The participants required closer supervision throughout the period of data collection. In other words the design must be supported by measures that ensure implementation, such as weekly follow up phone calls to clarify issues and confirm that activity is going ahead as planned.

In two cases the process of case level evaluation proved to be an effective treatment tool. This was most evident in Case B. Here the process of measuring a child's ability to follow a treatment plan became a vital part of the therapeutic process and was credited by the CCM for driving the process of change for the child and her birth mother. In Case C, the foster parents reported that the process was useful in helping them stand back from the action and be objective, as if looking through the eyes of a person outside of the foster family. In Case A, the process was not regarded as an effective treatment tool. However, it enabled the foster parents and the CCM to enjoy a more professional and collegial approach to their work at a time when they were all experiencing a sense of frustration.

Case level evaluation was also an effective teaching tool. In Case B, the foster parents learned how to examine behaviour objectively while their CCM learned that the tools, she helped to design, could change the nature of her relationship with her client in ways she hadn't previously been able to hope for. The foster parents in Case C learned how to score all the scales they used, as they were involved in that process. They also identified that they learned a lot about their foster children and about how to observe behaviour. In Case A, the learning curve was less steep. They learned nothing new about their foster child but they were pleased to have their perceptions validated by the results.

In addition, the CCMs involved in the study learned a lot about case level evaluation. They learned how to implement the methods, how to define and operationalize target problems, how to design individualized scales and for some, how to collect data. There are other learning goals to be achieved, such as the use of different case level designs and how to analyze the data.

Another valuable lesson learned was that case level evaluation is feasible within the context of a treatment foster care program. There were no major objections from the participants or any other part of the internal environment. The methods were generally considered to be easy to apply and not time consuming. The children involved in using the scales displayed an understandable level of reluctance; however, all but one of the ten child-scored scales were completed.

Comment on Methodology

The case level methods used in this practicum had many flaws. For all the participants and for the facilitator this was a new experience and as in any exploratory undertaking, mistakes were made. As well, the methods employed were not ideal, nor were they implemented perfectly. For example, the cooperation of the adolescents involved in the study was in at least one case suspect. In the future evaluators should explore means to enhance the reliability of observers who are asked to be involved in the scoring of instruments. Also, it would be advisable to have all measures examined by a third party before they are used to ensure that they are as reliable and as valid as possible.

In this practicum there was a limited number of standardized measures available. Future studies should consider expanding the choices to increase the possibility that the instruments chosen are measuring the target problems. That is not to say that all the measure used in this practicum were inappropriate. For example, the Index of Sister Relations used in just one case to examine one specific problem was an excellent choice. Whereas, the BRIC and the MT were used in every case in an attempt to be able to universally aggregate data. It was a compromise that was not effective. The learning from that experience was that standardized measures should be carefully and individually chosen to measure target problems at a case level.

Report on Participant Feedback Questionnaire

After the interviews all nine adult participants were asked to complete a feedback questionnaire as a final task. The following table details the content and results of that survey.

Table 20: Feedback on Role of Facilitator

Statement	Response Categories and number of observations	
	Yes generally	Yes definitely
1. Facilitator well organised in presentation of methods.	1	8
2. Evaluation Process well managed.	3	6
	Yes it was clear	Yes it was very clear
3. Clear and understandable information.	5	4
	Yes I think so	Yes definitely
4. Knowledge of case level evaluation.	0	9
5. Ability to pass on knowledge.	3	6
6. Willingness to recommend facilitator.	0	9

(Feedback questionnaire continued)

	Yes for the most part	Yes completely
7. Expectations of participants were met.	3	6
	A fair amount	A lot
8. Amount learned about case level evaluation.	1	8
	Helpful	Very helpful
9. Helpfulness of facilitator.	4	6

Note: The first two scale points on the original form indicated negative choices. As there was no response in these categories they are not included in this table.

As indicated in Table 17, the participants reported that they felt the practicum was well organized and well managed. Information was clear and understandable and the facilitator had good knowledge of the subject and was effective in passing on information. They also reported that they got what they expected and their experience matched their expectations. As well, the facilitator was helpful to them and they would be happy to recommend the facilitator to others. Finally, all but one reported learning ‘a lot’ about case level evaluation methods from their involvement in the practicum.

The participants were invited to comment further. Only the program coordinator and one CCM chose to do so. The program coordinator added that the practicum process

implemented and facilitated a valuable and perceptive evaluative process. The CCM commented that, for the foster parents in her case, the process had validated and named their daily experience.

Conclusion

In conclusion, conducting case level evaluations into treatment methods for RSFC was a valuable and rewarding experience. While the initial goals were not reached, there was evidence to suggest that those goals remain realistic and with practice it may be possible to refine the methods to a point where they remain user friendly and also produce stronger data. Further research entailing a commitment to the methods across a whole program and over an extended period of time is needed to assess the possibility of case level, single system designs as effective methodology in the pursuit of program level evaluation. Using case level methods and time series measurements for the evaluation of TFC enabled the participating treatment teams to take a close look at their treatment goals and was a good introduction to the methods used in single system designs. The methods used did, in part, meet the demands made in the literature. James and Meezan (2002) called for more measures that address outcomes such as a child's relationships with peers, birth family, and care providers. This was achieved in part in each of the evaluations. Case level evaluation also has the potential to be able to address the need, as outlined by Altshuler and Gleeson (1996), for the longitudinal measurement of "well being" to become central to the evaluation of children in foster care.

One of the major successes of the methods was that the evaluation process did not alienate the participants. The methods used in this practicum enhanced the utilization of evaluation findings within a treatment foster care program that had previously experienced a sense of alienation from evaluation data.

The techniques used were relevant to the lives of the treatment foster parents and to the lives of their foster children. It was possible for them to see the clinical benefits of the method to them as foster parents and to their foster children.

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Appendix A

**Outline of information presented to
APH Clinical Management Team at MYS**

1. An explanation of my own personal interest in case level evaluation as outlined in my rationale, and describing my interest in a method that would explore individual treatment concerns.
2. A description of case level evaluation and single subject designs outlining the strengths and weaknesses and exploring variations within the model.
3. Provide examples of single subject designs including standardized examples.
4. Discuss feasibility issues; such as the number of study units, time limitations, and task assignment.
5. Explain the practicum evaluation process; to include individual interviews of clinical staff, parents and children where appropriate.
6. Answer questions and arrange to meet with the parent group.

Appendix B

Outline of Information Presented to APH Program at MYS

1. I am interested in exploring the feasibility of case level evaluation in a treatment foster care setting
2. I am as interested in the process as in the outcome of each evaluation
3. I am interested in the impact on the organization of this type of evaluation method
4. I want to first evaluate interventions in TFC homes. These are not performance evaluations. I want to use single subject, time series designs to see whether specific interventions as planned by the treatment team meet the goals that the team has set
5. This is not designed to evaluate the effectiveness of the program. It cannot do that. For example, setting specific goals for an intervention is not necessarily part of every day practice. My experience was that we would try different things and just see if anything worked. We never carefully decided upon how much we ever hoped to gain from what we did. I am not necessarily against that approach.
6. This case level idea is not mine. I just want to put it into practice in a real setting and evaluate it.
7. The second part of the practicum is a qualitative evaluation of the methods used
8. This will entail interviewing individually CCM.s foster parent groups and the Program Coordinator.
9. Why am I interested? Because although I have not experienced a program level evaluation as a foster parent, I have found through reading the literature that it was really

difficult to relate the methods used to my own experience, and there was little that came out of those evaluations that was able to inform me as a parent. I had a problem with the ROLES scale and difficulty with comparisons with other programs.

10. I need three study units. That comprises a CCM, and a TFC family

11. I won't play a role in selecting interventions. I only assist in designing the evaluation methods to be used.

12. For the most part, standardized measures will likely be administered by CCM's and behavior will either be observed and scored by parents or self recorded.

13. Ideally, two months will be needed to gather enough data for each case. Also, a two week base line period would be nice, but this may well not be possible. Base lines are preferable, but not always possible or even ethical.

14. The majority of the time will be spent doing the intervention and measuring it. Then possibly a short amount of time doing follow up measurements. Each case will be different so interventions may change as may the design of the study. This depends on what happens. If something is not working then it will be changed. The study can be stopped at any time

15. Participation is completely voluntary, there is no obligation. Your participation is not necessary for me to obtain my degree. I am just here to put into practice some theoretical skills. I have no interest in seeing this method work or fail and if people hate it so much after one week that they all refuse to continue, then that's my result and my

evaluation of the method will discuss the reasons as presented by the participants.

Likewise, participation in the qualitative evaluation of the method is entirely voluntary.

16. Time? Single subject design is supposed to be non-time consuming. It is supposed to fit into your work day. Learning the method is where I come in. I take on a lot of that piece. You will learn as you go just by spending a little time with me discussing the designs, but you are not under any pressure to do so. Choosing the intervention and administering tests is the only part I cannot do for you but the first is already part of your life as a member of your various treatment teams, and the tests are always quickies as long ones lose their reliability in time series designs.

17. I am asking for you to let me in on a small part of your life for a period of two to three months. I do not expect the process to produce extra work. Although this will be a point in the final evaluation. I do expect that you will may be asked by your CCM to do things a little differently for just one intervention in one of your cases.

18. Ideally I would like one parent from each case load. I would like the CCM's to discuss it with the parents over the summer to find out who would be interested. I would like the cases to be various and if possible relatively typical. They do not have to be big tough issues although if they are that is fine too.

Appendix C

TFC Case Level Evaluation Study

Consent Forms

1. Minors
2. TFC Parents and Clinical Case Managers
3. Legal Guardians

Consent Form for Minors

1. This form is for children who may be asked to participate in a research project that John Anthony is doing at Macdonald Youth Services and or New Directions. John is doing the project in order to learn more about how to evaluate foster care. He is also hoping to use his research towards getting a Masters of Social Work degree from the University of Manitoba.
2. Involvement in the project will not have any negative consequences for anybody involved. The project is not designed to evaluate children in foster homes; it is designed to find new ways to evaluate the services that foster children receive while in foster homes.
3. As part of the project, children who participate may be asked to fill out short, weekly or bi-weekly questionnaires that will take no longer than 10 minutes to complete. Doing so is entirely voluntary and will not effect their rights or privileges in any way.
4. Part of the project may involve parents and other caregivers such as respite workers keeping records on some of the positive changes that may be noticeable in the participants in this project. It may also be necessary to ask other people such as teachers for information on any positive changes that they might have seen in school.
5. All information that is collected as part of this project is confidential. That means that John Anthony is not allowed to talk about or write about the information he learns in a way that might disclose the identity of the participants. This is not the same as anonymity, which would mean that John would never know the identity of the participants. In this project John will know the identity of the participants but is not allowed to let anybody else know.
6. It is possible that the report that comes out of this project may be presented to professional audiences or published in academic journals. This information will be presented in a way that conceals the identity of all participants.

7. By signing your name at the bottom of this form you are saying that you understand the meaning of this form and that you agree to participate and understand that you are free to stop participating whenever you choose.

Please ask your foster parents to sign the form as well. This will indicate that they know that you have read, and or, fully understand the meaning of this form.

Name of participating child

Name of foster parent

Signature of participating child

Signature of foster parent

Date

Date

Consent Form for TFC Parents and Clinical Case Managers

I, the undersigned understand that,

1. I am being asked to participate in a practicum on the feasibility of case level methods in the evaluation of treatment foster care interventions. The practicum is being undertaken by John Anthony, a Masters of Social Work Student at the University of Manitoba
2. The integrity of this practicum will be ensured by both an ethics committee and a practicum committee
3. Treatment foster parents, clinical case managers, and the program coordinator will be asked to participate in individual interviews conducted by John Anthony as part of the practicum evaluation process. These interviews will be audio taped and transcribed prior to content analysis. The audiotapes will be destroyed at the conclusion of the practicum. The transcription will have all identifying information removed, will be used for the purposes of analysis only and will not be used for publication.

4. My child may be asked to complete short questionnaires relating to a variety of issues and problems that are to be identified by the APH clinical team or staff of New Directions RSFC program. The instruments used to measure these issues and problems may be administered on a regular basis. Completion of these instruments is voluntary and the child will be informed of the voluntary nature of their participation.
5. Participation in this practicum is voluntary and I am free to withdraw the above named child or myself at any time
6. There will be no financial cost to myself or to the above named child, but I may be required to volunteer time and effort in the course of the study. How much time will be detailed during the recruitment phase and negotiated with the treatment team and John Anthony. It is hoped that my workload will not increase as a result of this practicum. However, as the method may require some change in practice, this cannot be guaranteed.
7. The evaluation method may involve the observation and recording of behaviour of the above named child. The types of behaviour to be observed will be decided by the APH clinical team or staff of New Directions RSFC program and the details of observation will depend on who is to be observing and what is being observed. The intent is for the observation to be non-intrusive; however, it is not possible to ensure that the child will remain completely unaware that their behaviour is being observed.
8. I will be revealing confidential information about the above named child and the treatment methodologies used in the child's foster home to John Anthony, who will not be at liberty to share that information with anybody outside of the APH clinical team or staff of New Directions RSFC program.
9. Information obtained about the children in my care or myself is confidential and will not be shared with others unless I give written consent. There are however limitations to this confidentiality. By law, John Anthony is required to report any concerns that a child may be in need of protection. Information about another person being at risk of harm will also be reported.
10. This practicum may have an impact on the organizational structure of the program. Changes in internal power relations, administrative procedures and clinical practice may be an effect of this practicum.

11. The research may be presented to professional audiences and may be written about in professional journals. This information will be presented in a way that conceals my identity and the identity of my child.
12. I will receive a copy of any material regarding the issue of confidentiality that pertains to myself and to the above named child, for my approval before it appears in the final report.
13. I may ask questions about the practicum, the assessment tools used and any results from the study. I have been advised to contact John Anthony if I have any questions or concerns about the study and its results.

Name of Participant or Legal
Guardian

Name of Researcher

Signature of Participant or Legal
Guardian

Signature of Researcher

Relationship of Participant or Legal Guardian to child

Date

Date

Consent Form for Legal Guardians

I, the undersigned understand that,

1. I am being asked to agree to the participation of _____ (name of child) in a practicum on the feasibility of case level methods in the evaluation of treatment foster care interventions. The practicum is being undertaken by John Anthony, a Masters of Social Work Student at the University of Manitoba
2. The integrity of this practicum will be ensured by both an ethics committee and a practicum committee

3. Treatment foster parents, clinical case managers, and the program coordinator will be asked to participate in individual interviews conducted by John Anthony as part of the practicum evaluation process. These interviews will be audio taped and transcribed prior to content analysis. The audiotapes will be destroyed at the conclusion of the practicum. The transcription will have all identifying information removed, will be used for the purposes of analysis only and will not be used for publication.
4. The above named child may be asked to complete short questionnaires relating to a variety of issues and problems that are to be identified by the APH clinical team or staff of New Directions RSFC program. The instruments used to measure these issues and problems may be administered on a regular basis. Completion of these instruments is voluntary and the child will be informed of the voluntary nature of their participation.
5. Participation in this practicum is voluntary and I am free to withdraw the above named child at any time
6. There will be no financial cost to myself or to the above named child, but foster parents and APH staff or staff of New Directions RSFC program may be required to volunteer time and effort in the course of the study. How much time will be detailed during the recruitment phase and negotiated with the treatment team and John Anthony. It is hoped that workload will not increase as a result of this practicum. However, as the method may require some change in practice, this cannot be guaranteed.
7. The evaluation method may involve the observation and recording of behaviour of the above named child. The types of behaviour to be observed will be decided by the APH clinical team or staff of New Directions RSFC program and the details of observation will depend on who is to be observing and what is being observed. The intent is for the observation to be non-intrusive; however, it is not possible to ensure that the child will remain completely unaware that their behaviour is being observed.
8. Confidential information will be revealed about the above named child and the treatment methodologies used in the child's foster home to John Anthony, who will not be at liberty to share that information with anybody outside of the APH clinical team or staff of New Directions RSFC program.
9. Information obtained about the children and families in the study is confidential and will not be shared with others unless I give written consent. There are however limitations to this confidentiality. By law, John Anthony is required to report any concerns that a child may be in need of protection. Information about another person being at risk of harm will also be reported.

10. This practicum may have an impact on the organizational structure of the program. Changes in internal power relations, administrative procedures and clinical practice may be an effect of this practicum.
11. The research may be presented to professional audiences and may be written about in professional journals. This information will be presented in a way that conceals the identity of the above named child, their foster family and their biological family.
12. I will receive a copy of any material regarding the issue of confidentiality that pertains to myself and to the above named child, for my approval before it appears in the final report.
13. I may ask questions about the practicum, the assessment tools used and any results from the study. I have been advised to contact John Anthony at 774-8999 if I have any questions or concerns about the study and its results.

Name of Participant or Legal
Guardian

Name of Researcher

Signature of Participant or Legal
Guardian

Signature of Researcher

Relationship of Participant or
Legal Guardian to child

Date

Date

Appendix D

Case Level Evaluation Set Up Guide

Meet with Treatment Foster Parents and Case Manager at their home

Explain purpose

- Evaluation of treatment not of parent
- Not a performance review
- Participation is considered to be a positive move towards professional accountability
- In no way can it put parent in a negative light
- Purpose to add some objectivity to the analysis of treatment in the home
- Also to hopefully gain insight to aid clinical decision making
- Cannot evaluate generally
- Can only evaluate specific interventions
- Focusses only on target problems
- No need to change treatment behaviour
- Can measure stability as well as change
- This is an untested pilot project designed to evaluate this particular evaluation model
- Parents do not have to like it
- Present explain and have each parent sign consent forms
- Child must also sign consent forms

Discuss child with parents and case manager

Document case history

- Attention to abuse history, victimization, disorders, syndromes, academics, peers, bio-family involvement, foster care drift history, cultural issues, sexuality issues, involvement with law enforcement, hobbies interests, successes

Locate target problem/s

- Specify as narrowly as possible
- Directive questioning by researcher

Set treatment goals

- Define in positive terms
- Clearly identify performance criteria
- Ensure chosen goals are acceptable to all parties
- Ensure goals cannot be met in unsatisfactory ways
- Ensure measures are not influenced by alternate treatments
- Ensure goals are free of any negative consequences

Select measures

- Pick from standardized measures as close as possible to target problem
 - Pick a scale that the child will complete
 - Pick another relevant scale for the parent to complete such as a behavioural index

Design individualized measures

Using computer, design Likert Scale and Index Format forms

Print all forms

- Standardized forms
- Individualized forms
- Consent forms

Choose start date

- Write date on all forms
- Label forms with participant name

Appendix E

BEHAVIOUR RATING INDEX FOR CHILDREN

Behaviour Rating Index for Children

For each item, please record the number that comes closest to your observations of the child. Record your answer in the space to the left of each item, using the following scale:

1 = Rarely or never

2 = A little of the time

3 = Some of the time

4 = A good part of the time

5 = Most or all of the time

IN GENERAL, HOW OFTEN DOES THIS CHILD:

1. Feel happy or relaxed?
2. Hide his/her thoughts from other people?
3. Say or do really strange things?
4. Not pay attention when he/she should?
5. Quit a job or task without finishing it?
6. Get along well with other people?
7. Hit, push, or hurt someone?
8. Get along poorly with other people?
9. Get *very* upset?
10. Compliment or help someone?
11. Feel sick?
12. Cheat?
13. Lose his/her temper?

Appendix F

HOME SELF-ESTEEM SCALE

HOME SELF-ESTEEM SCALE

In the blank provided, please write the letter of the answer that best describes how you feel about the sentence. These sentences are designed to find out how you generally feel when you are with your family. There are no right or wrong answers.

a = Strongly disagree

b = Disagree

c = Agree

d = Strongly agree

- _____ 1. My parents are proud of the kind of person I am.
- _____ 2. No one pays much attention to me at home.
- _____ 3. My parents feel that I can be depended on.
- _____ 4. I often feel that if they could, my parents would trade me in for another child.
- _____ 5. My parents try to understand me.
- _____ 6. My parents expect too much of me.
- _____ 7. I am an important person to my family.
- _____ 8. I often feel unwanted at home.
- _____ 9. My parents believe that I will be a success in the future.
- _____ 10. I often wish that I had been born into another family.

Appendix G

SELF CONCEPT SCALE FOR CHILDREN

SELF CONCEPT SCALE FOR CHILDREN

Select the phrase that comes closest to the way you are by recording the appropriate number to the left of each statement. Select only one of them. Do the best you can.

1 = Not at all

2 = Not very often

3 = Some of the time

4 = Most of the time

5 = All of the time

- _____ 1. I am friendly.
- _____ 2. I am happy.
- _____ 3. I am kind.
- _____ 4. I am brave.
- _____ 5. I am honest.
- _____ 6. I am likable.
- _____ 7. I am trusted.
- _____ 8. I am good.
- _____ 9. I am proud.
- _____ 10. I am lazy.
- _____ 11. I am loyal.
- _____ 12. I am cooperative.

- _____ 13. I am cheerful.
- _____ 14. I am thoughtful.
- _____ 15. I am popular.
- _____ 16. I am courteous.
- _____ 17. I am jealous.
- _____ 18. I am obedient.
- _____ 19. I am polite.
- _____ 20. I am bashful.
- _____ 21. I am clean.
- _____ 22. I am helpful.

Appendix H

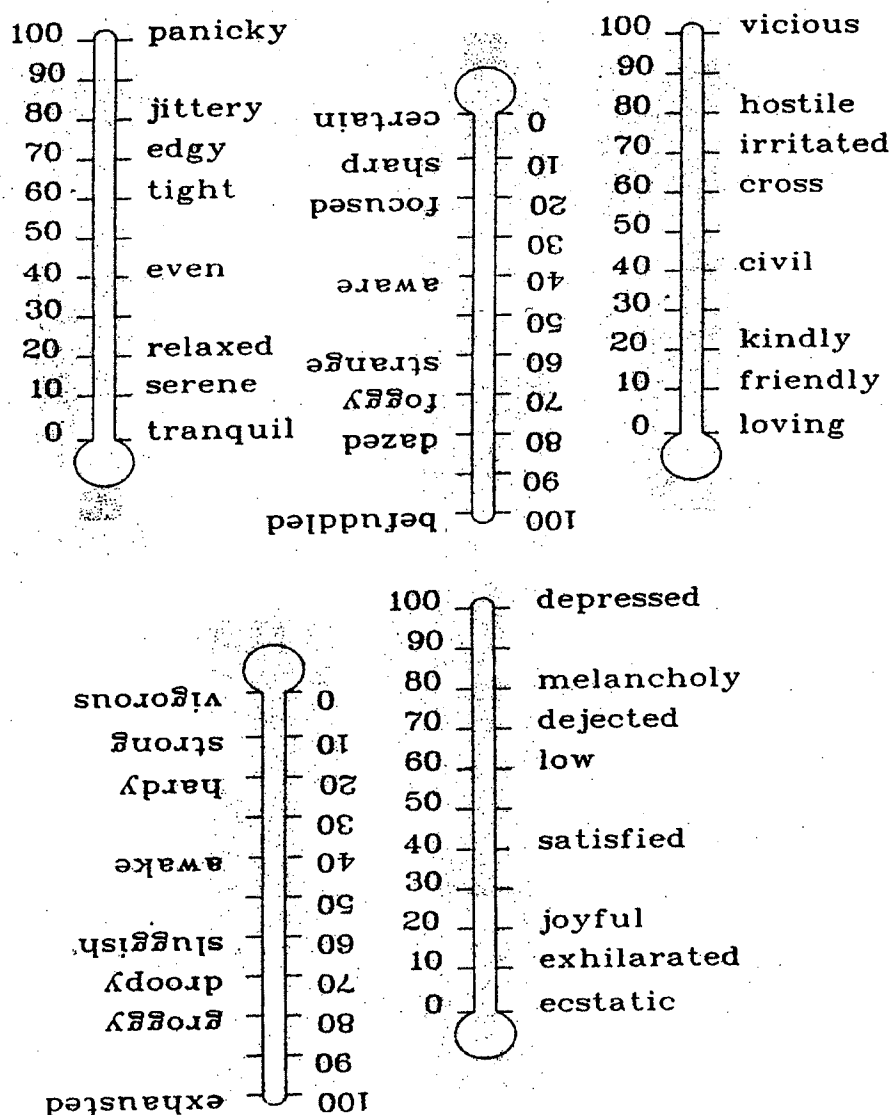
MOOD THERMOMETER (MT)

Instruments for Children

497

MT

HOW I FEEL RIGHT NOW



There are five thermometers to measure your feelings. Mark a line on each one to show how "high" or "low" you feel. Each one measures a different feeling. Don't just mark them all the same. For two of them, you have to turn the paper over. Give your real, honest feeling. Don't just make something up.

Appendix I

INDEX OF SISTER RELATIONS

INDEX OF SISTER RELATIONS

This questionnaire is designed to measure the way you feel about your sister. It is not a test so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

- | | |
|---------------------------|------------------------------|
| 1 = None of the time | 5 = A good part of the time. |
| 2 = Very rarely | 6 = Most of the time. |
| 3 = A little of the time. | 7 = All of the time. |
| 4 = Some of the time | |

1. -I get along very well with my sister. ____
2. -My sister acts like she doesn't care about me. ____
3. -My sister treats me badly. ____
4. -My sister really seems to respect me. ____
5. -I can really trust my sister. ____
6. -My sister seems to dislike me. ____
7. -My sister really understands me. ____
8. -My sister seems to like me very much. ____
9. -My sister and I get along well together. ____
10. -I hate my sister. ____
11. -My sister seems to like having me around. ____
12. -I really like my sister. ____
13. -I really feel that I am disliked by my sister. ____
14. -I wish I had a different sister. ____
15. -My sister is very nice to me. ____
16. -My sister seems to respect me. ____
17. -My sister thinks I am important to her. ____
18. -My sister is a real source of pleasure to me. ____
19. -My sister doesn't seem to even notice me. ____
20. -I wish my sister was dead. ____
21. -My sister regards my ideas and opinions very highly. ____
22. - My sister is a real "jerk". ____
23. -I can't stand to be around my sister. ____
24. -My sister seems to look down on me. ____
25. - I enjoy being with my sister. ____

Appendix J

CASE A: INDIVIDUALIZED SCALE - INDEX FORMAT

Name of child

Rachel

Target problem

Rachel wants to separate herself from the family physically and emotionally

Name of TFC Foster Parents

Howels

Goal

Improve relationship with the foster family

Name of Case Manager

Mary

Date of Commencement

April 26

Current Date

Indicate with a checkmark \checkmark in the boxes on the right whether the behaviours/feelings were observed or felt during the past week.

Problematic Behaviours/Negative Thoughts		1. Yes	2.No
1.	Removal of self – hiding in room		
2.	Threatening behaviour		
3.	Settting up others with intent to upset them – pushing buttons		
4.	Oppositional and or Snitty and Snotty		
5.	Oppositional to formal therapy		

Positive Behaviours/Positive Thoughts		3. Yes	4. No
6.	Politeness at the dinner table accepting what's served		
7.	Relating to David in a normal or positive manner		
8.	Getting out to play with the other kids without causing problems		
9.	Acts like an 11 year old (her age) eg does not try and parent other kids		
10.	Appears happy		

A = Columns 1 + 4

B = Columns 2 + 3

Total = A - B

--

Appendix K

CASE A

INDIVIDUALIZED SCALE - LIKERT SCALE FORMAT

Name of child

Rachel

Target problem

Emotional connectivity

Name of TFC Foster Parents

Howels

Goal

Increased connection of feelings to real issues

Name of Case Manager

Mary

Date of Commencement

April 26

Current Date

Circle the number in the box that corresponds with the scale below

a) This week Rachel became upset around her issues _____ times. She seemed to connect these feelings to concrete issues -----

1

2

3

4

5

6

7

8

9

Total

1 = really well

2 =

3 = well

4 =

5 = a little

6 =

7 = barely

8 =

9 = not at all

Appendix L

CASE B: INDIVIDUALIZED SCALE - INDEX FORMAT

Name of child
Nichola

Target issue/problem
Need to build communication and trust between mother and child

Name of TFC Foster Parents
Peterson

Goal
Improve relationship with birth mother

Name of Case Manager
Angela

Date of Commencement
September 23, 2002

Current Date
September 13, 2002

Indicate with a checkmark \checkmark in the boxes on the right whether the behaviours/feelings were observed or felt during the past week.

Problematic Behaviours/Negative Thoughts		1. Yes	2. No
1.	Verbally abusive toward mother		
2.	Refusing to share information		
3.	Refusing to do an activity with mother		
4.	Avoid being at home to keep away from mother		
5.	Cutting mother out by denying her the right to be attend activities that a parent would normally attend		

Positive Behaviours/Positive Thoughts		3. Yes	4. No
6.	Able to problem solve with mother issues outside of mothers life, such as school friends etc.		
7.	Trust mother with her belongings/money		
8.	Respond to treatment suggestions and follow through		
9.	Embrace strategies to stop physically abusive behaviour		
10.	Avoid contact with inappropriate friends		

A = Columns 1 + 4

B = Columns 2 + 3

Total = A - B

--

Appendix M

CASE B

INDIVIDUALIZED SCALE LIKERT SCALE FORMAT

Name of child
Nichola

Target issue/problem
Acceptance of and adherence to treatment plan

Name of TFC Foster Parents
Peterson

Goal
Conformity to treatment plan

Name of Case Manager

Date of Commencement
September 23, 2002

Current Date
September 13, 2002

Circle the number in the box that corresponds with the scale below

a) treatment plan is realistic and I was able to meet the expectations.								
1	2	3	4	5	6	7	8	9

1 = I strongly agree

2 =

3 = I agree

4 =

5 = I agree partially

6 =

7 = I disagree

8 =

9 = I strongly disagree

Appendix N

CASE C: INDIVIDUALIZED SCALE - INDEX FORMAT

Name of child Target problem
 Lizzy and Becky Sibling rivalry

Name of TFC Foster Parents Goal
 Hiam Improve degree of cooperation between sisters

Name of Case Manager Date of Commencement Current Date
 Dave September 23, 2002 September 17, 2002

Indicate with a checkmark \checkmark in the boxes on the right whether the behaviours/feelings were observed or felt during the past week.

Problematic Behaviours/Negative Thoughts		1. Yes	2.No
1.	Fighting over an object. ie a pencil		
2.	Escalating a situation		
3.	Loud and intrusive arguing		
4.	Loud behaviour in public places, such as arguing		
5.	Blaming behaviour		

Positive Behaviours/Positive Thoughts		3. Yes	4. No
6.	Workout how to solve a problem among themselves		
7.	Back down from an argument or a situation that might cause conflict		
8.	Discuss ideas quietly		
9.	Behave appropriately in public		
10.	Accept responsibility		

A = Columns 1 + 4

B = Columns 2 + 3

Total = A - B

--

Appendix O

CASE C

INDIVIDUALIZED SCALE - LIKERT SCALE FORMAT

Name of child

Becky

Target problem

Immaturity around sexuality. Inability to talk about sexuality

Name of TFC Foster Parents

Hiam

Goal

Able to discuss sexual issues without avoidance

Name of Case Manager

Dave

Date of Commencement

September 23, 2002

Current Date

September 17, 2002

Circle the number in the box that corresponds with the scale below

a)Becky was able to discuss the issues presented without embarrassment

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

b)Becky can recall what was discussed last week

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Total

--

1 = really well

2 =

3 = well

4 =

5 = a little

6 =

7 = barely

8 =

9 = not at all

Appendix P

Interview Guide

ParentsAbout the Evaluation

1. Can you tell me about your experience of being involved in this study?
2. Were you involved in collecting data and what did that entail?
3. Was the data collection process cumbersome, time consuming, or a problem in any way?
4. Did the process of measuring either on standardized tests or on individual scales change things in your home and in what ways (schedules, ways of relating to children, different focus, new perceptions, see different behaviors)?
5. What are your thoughts and feelings on the idea of having interventions evaluated in this way?
6. Has the evaluation process been useful to you as a parent and if so how?
7. Were some parts of the process more helpful than others?
8. Has it helped, or do you see ways that it could help, your foster children?
9. Was there any impact on any other children in your home that were not involved in the process?
10. Would you do it again?

About the Institutional Environment

11. What constraints if any did you experience coming from other parts of the program in implementing both the intervention and the evaluation?
12. Do you consider that case level evaluation is something that APH should pursue - either instead of program level evaluation, as well as, or not at all?
13. Do you feel that the experience has given you a different understanding of what it is as parents that you do for children in your home?

Clinical Case Managers

About the Evaluation

1. Can you describe your impressions of being involved in this practicum?
2. Were you able to complete the evaluation within the time frame and did participating add to your workload?
3. Were the results of the evaluation conclusive?
4. Was the process a useful one over all and were you able to make confident decisions based on the results?
5. Do you feel that the methods used were helpful in your practice and which stages of the process were he most helpful?
6. Did you find it a difficult method or relatively straightforward?
7. Would you use case level evaluation again? If so what would you do differently?
If not why not?
8. What do you see as the benefits of this method?
9. What do you see as the drawbacks?
10. Which of the tools used in the design were easiest to use?
11. Which of the tools were the most useful to decision making?
12. Was collecting the data cumbersome or not a problem?
13. Do you think that the process involved in choosing interventions and designing ways to evaluate them helped to define more precisely what it is that APH has to offer children in the program?

About the Institutional Environment

14. Was there any opposition to using the method from parents, children, or other parties? What form did the opposition take?
15. Do you feel that parents were generally supportive of the method or unsupportive, and in what ways?

16. What impact did using this method have on your relationship with the parent group?
17. Do you consider case level evaluation to be a useful tool for the agency and would you recommend the method over, or in addition to, broader program level evaluation?
18. Do you consider case level evaluation to have a limited application?
19. What do you think the data collected should be used for?
20. Do you see any purpose beyond purely individual clinical decision making?
21. Do you think the information collected can help to define the program?

Program CoordinatorAbout the Evaluation

1. Can you describe the role you played in the process of developing interventions and designing evaluative methods?
2. What benefits do you see in using a case level evaluation now that some parts of the program have experienced it?
3. What kind of response or feedback have you been getting from both case managers and parents?

About the Institutional Environment

4. Do you think that any of the data collected could be used at a program level for evaluative purposes?
5. Of what use to the program is the data collected?
6. How might you envisage the information being utilized by yourself and others in the agency?
7. Do you feel that parents and case managers were generally supportive of the method or unsupportive, and in what ways?
8. Was there any opposition to using the method from parents, children, or other parties? What form did the opposition take?
9. What impact if any did using this method have on your relationship with the parent group and the case managers?
10. Do you consider case level evaluation to be a useful tool for the agency and would you recommend the method over, or in addition to, broader program level evaluation?
11. Do you consider case level evaluation to have a limited application?
12. Do you see any purpose beyond purely individual clinical decision making?
13. Do you think the information collected can help to define the program?