Durham Family Court Clinic
Community Support Team – Program Evaluation

Final Report

Submitted to:
Provincial Centre of Excellence for Child and Youth Mental Health

Program Evaluation Grant # EPG-1339

November 30, 2011

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Executive Summary

Durham Family Court Clinic: Community Support Team
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A program evaluation designed to assess the efficacy of the Durham Family Court Clinic Community Support Team, a mobile community based counselling service that assists in the rehabilitation and reintegration of youth involved with the justice system. This project will inform service planning and delivery and build capacity for future and ongoing evaluation.

The Purpose

- To examine the level of alignment and engagement between the Community Support Team and program participants.
- To evaluate the efficacy of the Community Support Team in improving youth functioning.
- To build the internal capacity of Durham Family Court Clinic to evaluate programs and services.

The Program

Durham Family Court Clinic (DFCC) is a charitable organization dedicated to fostering a healthy and safe community by enhancing and supporting the well being of children, youth and families who have involvement with the legal system. The goal of DFCC is to provide a spectrum of counselling, assessment and mediation services to meet the individualized needs of clients served within the Durham Region. In specific, DFCC's Community Support Team (CST) is a mobile community based counselling service that assists in the rehabilitation and reintegration of young persons who have become involved in the youth justice system between the ages of 12 and 17. Through collaboration with community service providers, such as probation services, mental health supports and educational services, the CST program provides clinical counselling and support services that focus on youth and family functioning, as well as relevant environmental and mental health factors.

The Plan

An evaluation framework and program logic model will be created in order to examine therapeutic alliance and evaluate program efficacy. Counsellors will collect data using the Youth Level of Service Inventory/ Case Management Inventory (YLS/CMI), the Working Alliance Inventory Short-Form (WAI-S) and the School Engagement Checklist. Data from a small sample of program participants will be entered into a database for analysis. Pilot-tests will be conducted and a final report will be prepared based on the findings. Results of the evaluation will also be shared with relevant stakeholders and community partners.

The Product

Project Activities Summary:

1. Support was acquired for the program evaluation at multiple levels within the organization through regular communication regarding the process at CST team, staff and management meetings.

2. Throughout this initiative CST counsellors were directly involved in developing the logic model, evaluation framework and surveys. All were in agreement and acknowledged the importance of evaluation in ensuring effective service delivery.
3. Surveys developed included a School Engagement Checklist, Client Satisfaction Survey and Referral Source Satisfaction Survey.
4. A literature review was conducted by an undergraduate and graduate student.

In building capacity for future program evaluation:

1. An Internal Ethics Review Committee was created. Members were not related to the program being evaluated, and resource material was provided to prepare them for their role.
2. The agency established a partnership with the University of Ontario Institute of Technology, for this and future evaluation initiatives.
3. The existing DFCC Access Database was enhanced and now compatible with software used by both universities and the Ministry of Children and Youth Services when conducting research evaluations.
4. Assessment instruments currently being used by CST for assessment and treatment planning are also used to evaluate program outcomes.
5. The knowledge and experience gained during this grant will be applied to future planning evaluation endeavours within DFCC.

Knowledge Exchange Activities:

Information regarding the CST Program Evaluation was shared with multiple community service providers through committee and agency meetings. Regular meetings occurred with primary stakeholders to share information, receive feedback and participate in developing evaluation framework and tools.

Amount awarded: **$ 18,725.00**
Final report submitted: **November 30, 2011**
Region: **Central East Region**

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Introduction

Durham Family Court Clinic (DFCC) was founded in August of 1980 with a mandate to provide assessments and service brokerage for youth in conflict with the law. DFCC is dedicated to fostering a healthy and safe community by enhancing and supporting the well being of children, youth and families who have involvement with the legal system. Specifically, the goal of the organization is to provide a spectrum of counselling, assessment and mediation services to meet the individualized needs of clients served within the Durham Region.

In 1988, DFCC expanded their services to include the Community Support Team (CST). The CST is a mobile community based counselling service comprised of seven (7) counsellors that assists in the rehabilitation and reintegration of young persons who have become involved in the youth criminal justice system between the ages of 12 and 17. Through collaboration with community service providers, such as probation services, mental health supports and educational institutions, the CST counsellors provide clinical counselling and support services that focus on youth and family functioning, as well as relevant environmental and mental health factors. The philosophy of the CST is one of optimism, with the belief that youth and their families are capable of positive change when given access to appropriate and adequate resources. Currently, the CST serves an average of 75 clients a year.

Youth who have been convicted of an offence and have a court ordered condition to attend counselling are referred to the CST by Durham Probation Services. At the onset of involvement, the counsellor engages in direct contact with the client, the client's family, and the referral source in order to complete a comprehensive assessment of the young person, including a psychosocial history. The Youth Level of Service/Case Management Inventory (YLS/CMI) is administered, along with other psychometric instruments such as Massachusetts Youth Screening Instrument-2 (MAYSI-2), the Pride in Delinquency Scale (PID), the Criminal Sentiment Scale Modified (CSS-M), the Measures of Criminal Attitudes and Associates-Revised (MCCAA-R) and the School Engagement Checklist. These instruments identify

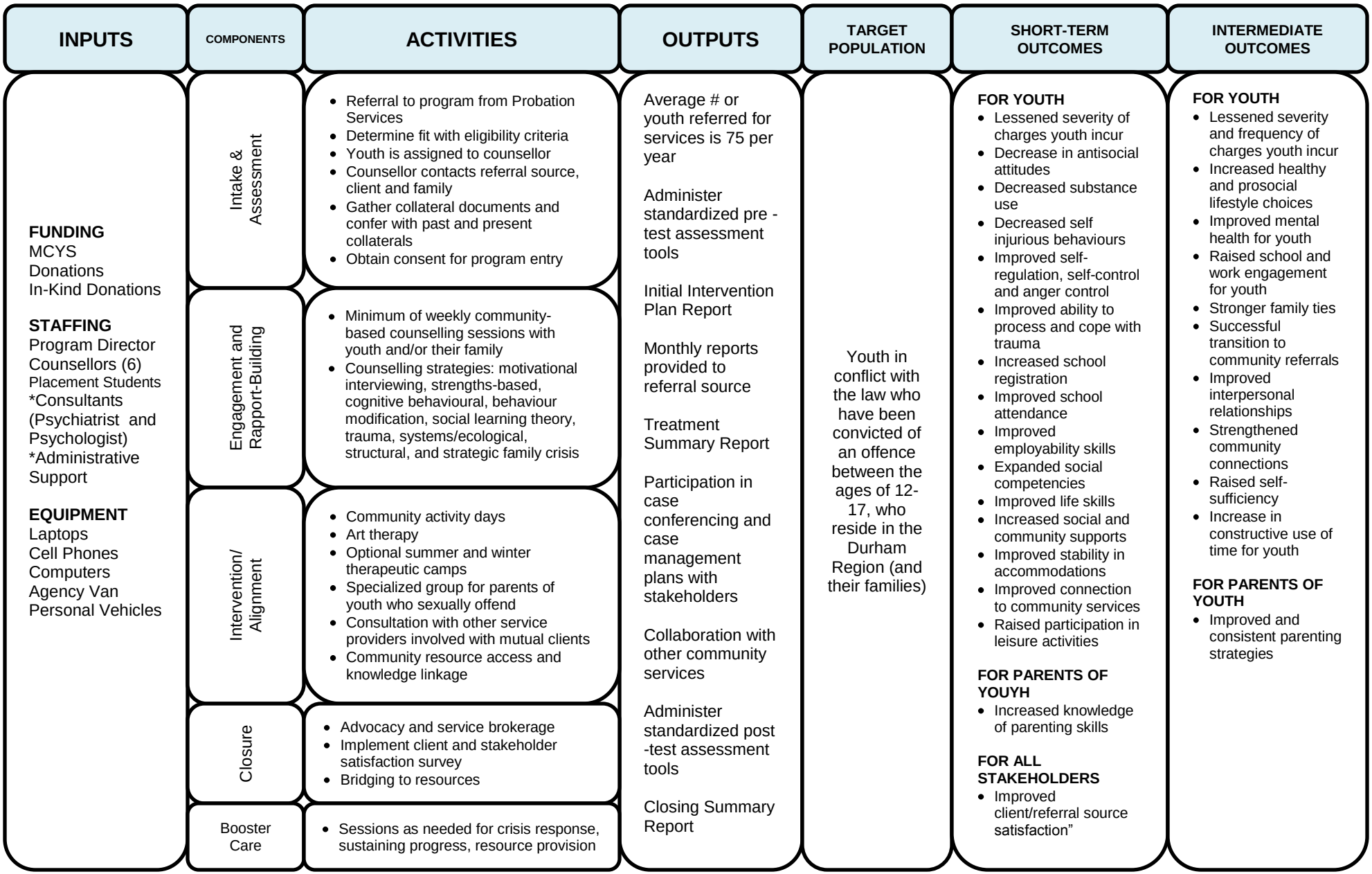
potential mental health issues, procriminal sentiments, and criminal associates and activities. From this comprehensive assessment, a service plan is developed.

Once a service plan has been developed, CST counsellors employ evidence-based approaches to achieve desired outcomes. Motivational interviewing, social learning and cognitive behavioural strategies, family counselling, and various other evidence-supported approaches are employed. At minimum sessions are held with youth weekly. Desired outcomes of the service include reduced risk of recidivism, improved family functioning, increased educational engagement, constructive use of leisure time, decreased substance use, improved interpersonal relations, increased association with prosocial peers, acquired problem solving skills, and more (see Figure 1).

The purpose of this program evaluation is to evaluate the efficacy of the CST in improving youth functioning. In particular, youth satisfaction with CST services, educational engagement, and changes in criminogenic risk factors among CST youth will be examined. Further, this evaluation will examine the level of alignment and engagement between CST counsellors and program participants. Specifically, the following process evaluation questions will be examined: What is the level of alignment and engagement between CST counsellors and youth? Do youth perceive their CST counsellor as helpful and supportive? How satisfied are youth with CST services? How satisfied is the referral source with the CST services delivered to their clients? In addition, the following outcome evaluation questions will be assessed: Is there a positive change in educational engagement among youth involved with CST? To what extent do the risk and needs on the YLS/CMI change during a youth's involvement with CST? To what extent does the YLS /CMI risk level of a youth change during CST involvement? While the youth is involved with CST services, is there a reduction in criminal behaviour?

Information from the pilot testing will be used to evaluate the efficacy of assessment instruments, such as the YLS/CMI and WAI-S, and will also inform service provision for justice involved youth who present with mental health issues.

Figure 1 – Program Logic Model for Community Support Team (CST) Program



LONG-TERM GOAL: Reducing recidivism and enhancing health integration into the community among youth in conflict with the law.

Literature Review

The Youth Level of Service/Case Management Inventory (YLS/CMI) is a tool designed to evaluate and predict an adolescent offender's likelihood of engaging in delinquent behaviour and to assist with the offender's treatment planning and case management (Rennie & Dolan, 2009). The YLS/CMI allows the youth worker to identify the adolescent's needs, strengths, and barriers in order to select and address the most appropriate treatment goals. The YLS/CMI is a 42-item inventory. Youth are assessed on eight factors commonly associated with criminal behaviour, each of which contains between three and seven sub factors. More specifically, the eight categories of criminogenic need and risk include prior and current offenses or dispositions, family circumstances, education and employment concerns, peer relations, substance abuse, leisure and recreational needs, personality or behavioural problems, and antisocial or procriminal attitudes and orientations (Hoge & Andrews, 2006). Aspects of mental health functioning are assessed within the substance abuse and personality or behaviour categories. The YLS/CMI has four risk estimate categories, based on total assessment scores, ranging from low to very high risk. Youth with a lower score on the assessment are said to present with fewer risk factors, while youth with a higher score on the assessment present with a larger number of criminogenic needs.

Not surprisingly, addressing an offender's criminogenic need and risk factors may result in a reduction of the youth's YLS/CMI score and may also be associated with a decrease in the likelihood of subsequent criminal or antisocial behaviours. Two strategies that may be employed to reduce the likelihood of recidivism and address a youth offender's overall risk are increased therapeutic alliance and improved school engagement. Previous research has suggested that enhancing an adolescent offender's therapeutic relationships and encouraging meaningful academic involvement may result in improved treatment outcomes and a lessening of antisocial behaviour (Karver, Handelsman, Fields, & Bickman, 2005; Katsiyanis, Ryan, Zhang, & Spann,

2008). As such, the remainder of this review will examine the ability of educational engagement and therapeutic alliance to improve outcomes for youth involved with the law.

Therapeutic Alliance

Therapeutic alliance, or working alliance, refers to the relational connection and collaborative partnership between the client and the therapist (Karver et al., 2005). As Hawley and Garland (2008) have proposed, mutual collaboration and agreement on treatment goals between the client and therapist can positively impact the outcome of a therapeutic intervention. Similarly, a study conducted by Thompson, Bender, Lantry and Flynn (2007) revealed that a strong therapeutic alliance significantly predicted positive treatment outcome. Specifically, the authors found that a positive working alliance between the therapist, the youth client and their family members encouraged treatment engagement, positive relationship building, and successful treatment outcome (Thompson et al., 2007). As noted by Karver et al. (2005), successful treatment outcome is correlated with a reduction in further participation in antisocial behaviour. As a result, therapeutic alliance may be an important factor for improving treatment outcomes for adolescent offenders and reducing recidivism.

Various tools have been developed to assess the client-therapist relationship. However, the most commonly employed tool is the Working Alliance Inventory (WAI) (Hatcher & Gillaspy, 2006). The WAI is a self-report measure composed of 36 items rated on a 7-point scale, with 12 items in each of the three subscales: collaboration on tasks, agreement on goals, and therapeutic bond (Busseri & Tyler, 2003). The WAI consists of both a therapist form, completed by the therapist, and a client form, completed by the client. More recently, an abbreviated, short-form of the WAI (WAI-S) has been developed. The WAI-S consists of 12 items with 4 items on each subscale. Both subscale and total scale scores based on the WAI and WAI-S have proven to be highly similar in terms of predictive ability and have demonstrated high levels of internal consistency (Busseri & Tyler, 2003). Nonetheless, the WAI-S is often preferred to the full-scale version because of its ease of use and efficiency.

Overall, therapeutic alliance, as measured using the WAI-S, may be an important factor for improving treatment outcomes among youth. Research has suggested that working alliance is significantly associated with a decrease in mental health symptoms, improved family relationships, increased self esteem, higher levels of perceived social support, and satisfaction with therapy (Hawley & Garland, 2008). Thus, a positive and collaborative client-therapist relationship undoubtedly acts as a protective factor against antisocial behaviours among youth and may result in a reduction of criminogenic needs and risks associated with the YLS/CMI scale.

Educational Engagement

As previously mentioned, addressing educational engagement may be an important step in improving outcomes for youth involved with the law. In fact, the YLS/CMI considers poor educational experiences to be a risk factor for future criminal conduct. Many youth who are, or have been, engaged in antisocial activities have experienced academic failure or educational alienation (Christle & Yell, 2008). Disruptive classroom behaviour, low academic achievement, truancy, and problems with peers and teachers are all considered potential risk factors for problem behaviour (Hoge & Andrews, 2006). As such, encouraging positive involvement in the academic setting may result in the reduced likelihood of a youth engaging in antisocial behaviour.

Previous research has examined the relationship between academic engagement and antisocial behaviour and recidivism (Christle & Yell, 2008; Katsiyanis, Ryan, Zhang, & Spann, 2008). A study by Katsiyanis and colleagues (2008) reported that there is a relationship between poor academic achievement and problem behaviours. As the authors suggested, poor academic performance can have a negative effect on adolescents' behaviours and may also be highly correlated with subsequent recidivism. In addition, Christle and Yell (2008) found semi-literacy to be common among youth at risk, suggesting that academic failure may be a strong

predictor of delinquency. Thus, youth who do not experience academic success may be more likely to engage in antisocial behaviour and may also be at increased risk for recidivism.

In contrast, youth who are academically engaged are less likely to be involved in delinquent behaviour (Christle and Yell, 2008). Not surprisingly, youth who experience academic success demonstrate higher self-motivation and self-esteem (Waugh, 2002). Additionally, a constructive school environment may help to combat antisocial behaviours and attitudes and may lead to a reduction in recidivism (Christle & Yell, 2008). Consequently, educational engagement may be an important protective factor against delinquent behaviour.

In summary, the extant literature suggests that therapeutic alliance and educational engagement may be important protective factors for combating antisocial behaviour among youth. While therapeutic alliance is primarily concerned with promoting a positive relationship between a client and their therapist, this alliance has been shown to have a direct impact on successful treatment outcomes and may have important client benefits such as improved mental health and higher levels of perceived social support (Hawley & Garland, 2008). Further, improving school engagement has been associated with a decrease in the occurrence of delinquent behaviours, as well as a reduction in recidivism rates. Undoubtedly, previous research has suggested that both therapeutic alliance and school engagement are integral to lowering a youth's criminogenic risk.

Methodology

In order to ensure that all relevant stakeholders were included in the creation of the evaluation framework, DFCC developed a Planning Evaluation Project Team. The Planning Evaluation Project Team included the DFCC Executive Director, the CST Program Director, and a CST counsellor. A consultant from the Centre of Excellence for Child and Youth Mental Health was integral to providing support and feedback to the Project Team at the onset of the project and throughout the grant term. The project team worked directly with CST counsellors to brainstorm several questions designed to evaluate how interventions and activities impacted program participants. Questions that were of primary interest, and could feasibly be assessed during the brief evaluation phase, were selected for analysis (see Table 1 and Table 2).

Data Collection

The population for the evaluation included all youth clients in the CST program. Only clients who provided informed consent were included in the sample. Youth, and their parent or guardian, were provided with a detailed consent form outlining the details of the project and requesting their participation, when appropriate. (see Appendices). Clients were informed of their right to refuse participation without risk or change to service. In total, 30 program participants provided consent.

Four main sources of data were employed: youth report, parent and guardian report, referral source report, and data collected at intake into the CST program. The CST counsellor assigned to the participant was responsible for collecting all relevant data. The data was entered into a Microsoft Access Database by administrative support staff, student placement, and the Program Director. The database employed for this project was pre-existing but did require updating. New and revised instruments were added and programmed to generate relevant reports on data.

Following collection and entry, the data was exported from the electronic record-keeping database system into a Microsoft Excel file and made available to a graduate student

researcher for analysis. Data was coded and inputted into the Statistical Package for the Social Sciences (SPSS) software. In order to ensure the confidentiality and anonymity of program participants, personal identifiers, such as the name and birth date of the client, were removed prior to granting access to the student researcher and program participants were identified using an arbitrary case number.

Measures

Youth Level of Service/Case Management Inventory (YLS/CMI). The YLS/CMI is a 42-item inventory used to measure an adolescent's risk and need in order to address appropriate treatment goals. Youth are assessed on eight categories of criminogenic need and risk including prior and current offenses or dispositions, family circumstances, education and employment concerns, peer relations, substance abuse, leisure and recreational needs, personality or behavioural problems, and antisocial or procriminal attitudes and orientations (Hoge & Andrews, 2006). The YLS/CMI is required to be completed at onset of involvement with CST and re-administered at six-month intervals. Using repeated measurement allows for client progress to be captured. Thus, YLS/CMI data was collected during, and prior to, the pilot evaluation period.

Working Alliance Inventory Short Form (WAI –S). The WAI-S is an instrument designed to assess the client's participatory relationship with a treatment provider (Busseri & Tyler, 2003). For this study, the WAI-S was used to measure therapeutic alliance and engagement between the CST staff and youth. The instrument is composed of 12 items rated on 7-point scales, with 4 items in each of the three subscales: collaboration on tasks, agreement on goal, and therapeutic bond. For the purpose of the pilot program evaluation, the WAI-S was administered monthly over a three-month period. Both a client version and a therapist version of the WAI-S were used. Additionally, a caregiver version and a therapist for caregiver version of the WAI-S were completed if parents and guardians were involved in counselling services. All Working Alliance Inventories completed by youth, and/or parents and guardians, were done

independently of the counsellor, placed in a sealed envelope and provided to the Program Director.

School Engagement Checklist. The School Engagement Checklist is a tool developed by DFCC in order to measure educational engagement. The 5-item checklist consists of three items measuring registration, one item measuring attendance, and one item measuring the number of credits achieved (see Appendices). The School Engagement Checklist is completed at the onset of involvement with the CST team and is re-administered in the months of December and June and again at the end of service.

Client Satisfaction Survey. The CSS is used to measure client satisfaction with CST services. The instrument is composed of 31 items (see Appendices). Twelve items are used to assess the clients experience with their counsellor. These items are measured using a five-point Likert Scale ranging from “never” to “always.” An additional 16 items are used to examine the client’s self-reported progress while involved with the CST. These items are measured using a five-point Likert scale ranging from “none” to “great.” Lastly, the client is asked to rate their overall satisfaction with their counselling experience. Three items are used to measure overall satisfaction. The final survey item is an open-ended question asking participants to provide additional comments and feedback.

The CSS is completed by the youth at the end of service. Participants are asked to complete the survey independently of the counsellor, place it in a sealed envelope, and return it to the Program Director.

Referral Source Satisfaction Survey. The RSSS is 10-item instrument used to measure the referral source’s level of satisfaction with CST services (see Appendices). Nine items are measured using a five-point Likert scale ranging from “completely dissatisfied” to “completely satisfied.” The final item is an open-ended question asking the referral source to provide additional comments or feedback.

A copy of the RSSS is mailed to the referral source with the participants closing report. The referral source is asked to complete the survey and return it the Program Director.

Analysis

The analyses for this evaluation were conducted using SPSS 19.0. Descriptive statistics were conducted to describe the characteristics of the participants in the sample and the level of alignment and engagement between CST staff and youth. Client WAI-S scores were directly compared to counsellor WAI-S scores in order to examine the level of congruence. Specifically, independent sample *t*-tests were conducted to assess for significant differences between the client's self-reported therapeutic alliance and the counsellors self-reported therapeutic alliance. Changes in WAI-S scores over time were also noted. Similarly, in order to examine the extent to which the YLS/CMI risk and need level of a youth change during CST involvement, independent sample *t*-tests were conducted. Initial YLS/CMI subscale scores were compared to interim scores in order to determine if there was a significant mean difference between the two scores.

Limitations

As previously mentioned, only a small number of program participants consented to participating in the study. Additionally, due to the brevity of the evaluation period, we were not able to collect pre-, interim- and post-test outcomes for many of the instruments. For example, the YLS/CMI is administered at six-month intervals and consequently, may not have been captured during the three-month evaluation period. In addition, when rating the initial YLS/CMI the counsellor relies on information reported by the client and obtained from the Probation Officer. As service progresses, clients may become more honest with the information they share with their counsellors and counsellors are able to use direct observations of clients and their families to inform the subsequent tests. The possibility of more accurate information at interval tests could show increased risks when in fact the same risk factors were present and just not reported earlier.

Client's missing meetings and counsellors vacation schedules during the evaluation period, contributed to the difficulty of implementing the WAI at the intended intervals. Missed meetings are an anticipated occurrence among the CST client population due to multiple factors.

Further, the current study did not use a treatment control group. As such, there is no way to confirm that differences between pre-, interim-, and post-test outcomes are the result of CST interventions.

Nevertheless, it is important to note that this planning evaluation was intended to build internal capacity to conduct program evaluation. The project was intended to help implement a process that will allow for ongoing program monitoring and monitoring of outcomes without disruption to service. Thus, due to the nature of the evaluation, these limitations are not unexpected.

Table 1 – Process Evaluation Matrix

Evaluation Question	Activity and Target Population	Indicator	Source of Data	Data Collection Instrument	Method of Data Collection
What is the level of alignment and engagement between CST staff and youth?	Weekly counselling with youth in conflict with the law who have been convicted of an offence who are between the ages of 12-17 who live in the Durham Region	Counselling attendance, frequency of contact with counsellor, and participation level	CST clients and client files and reports	Client Satisfaction Survey, Worker Alliance Inventory (WAI), and attendance records	Counsellors and data entry analyst collect data Data is collected when the file is closing
Do youth perceive their CST counsellor as helpful and supportive?	Weekly counselling with youth in conflict with the law who have been convicted of an offence who are between the ages of 12-17 who live in the Durham Region	Scores on the Client Satisfaction Survey and responses from a qualitative questionnaire on satisfaction	CST clients	Client Satisfaction Survey and Qualitative Questionnaire	Program Director, counsellors and data entry analyst collect the data Data is collected at six-month intervals and when the file is closing
How satisfied are youth with CST services?	Weekly counselling with youth in conflict with the law who have been convicted of an offence who are between the ages of 12-17 who live in the Durham Region	Scores on the Client Satisfaction Survey	CST clients	Client Satisfaction Survey	Program Director, counsellors and data entry analyst collect the data Data is collected when the file is closing
How satisfied is the referral source with the CST services delivered to their clients?	Weekly counselling with youth in conflict with the law who have been convicted of an offence who are between the ages of 12-17 who live in the Durham Region	Scores on the Referral Source Satisfaction Survey	Probation Officers (referral source)	Referral Source Satisfaction Survey (RSSS)	Program Director, counsellors and data entry analyst collect the data Instrument is mailed to referral source at program exit

Table 2 – Outcome Evaluation Matrix

Evaluation Question	Outcome	Indicator	Source of Data	Data Collection Instrument	Method of Data Collection
Is there a positive change in educational engagement among youth involved with CST?	Increased school registration, improved school attendance, and increased school and work engagement	School registration, attendance, and credit achievement	CST client and scores on School Engagement Checklist	School Engagement Checklist	The counsellor collects the data. The data is collected at service initiation and at six-month intervals.
To what extent does the YLS/CMI risk level of a youth change during CST involvement?	Lessened severity and frequency of charges youth incur	Reductions on YLS/CMI subscale ratings and risk level rating	CST counsellors, client files, and other individuals involved with the youth (parents, educators, etc.)	YLS/CMI	The counsellor collects the data. Data is collected at service initiation, six-month intervals, and at program exit.
To what extent do the risk and needs on the YLS/CMI change during a youth's involvement with CST?	Decreased substance use, aggression and antisocial attitudes. Improved mental health, self-regulation, anger control, parent-child relationships and school attendance. Increased participation in leisure activities, and knowledge of parenting skills	Reduction on risk/need YLS/CMI subscale ratings, reduction on YLS/CMI final score, and reduction on YLS/CMI risk level rating.	CST counsellors, client files, and other individuals involved with the youth (parents, educators, etc.)	YLS/CMI	The counsellor collects the data. Data is collected at service initiation, six-month intervals, and at program exit.
While the youth is involved with CST services, is there a reduction in criminal behaviour?	Lessened severity and frequency of charges incurred by youth Decrease in antisocial attitudes	Number of charges among clients, changes to severity of charges (according to the Criminal Code of Canada), and reduction of scores on tools measuring criminal attitudes	Probation Officer, client files, Criminal Code of Canada, and CTS clients	Client disclosures of new charges, Probation Officer, Pride in Delinquency (PID) scale, and Criminal Sentiment Scale – Modified (CSS-M)	The counsellor collects criminal involvement data continually. Scale data is collected at service initiation and program exit.

Results

As previously mentioned, 30 youth provided informed consent to participate in the pilot evaluation. All participants were between the ages of 12 and 20. Of the participants in the sample, the vast majority (97%) were male. Additionally, all of the youth included in the sample were residing in the community. None of the participants were in custody at the time of data collection.

Process Evaluation Results

Q. 1. What is the level of alignment and engagement between CST staff and youth?

The average participant score on the WAI-S at initial assessment was 64.5. Descriptive statistics revealed that, on average, clients scored therapeutic alliance with their CST counsellor six points higher at interim assessment. Specifically, the average participant score on the WAI-S at interim assessment was 70.5 (see Figure 2). However, while a substantial increase in WAI-S scores was noted, the results of the independent sample *t*-test revealed that this difference is not statistically significant ($t = -1.821$, $p = .081$). Nevertheless, a substantial increase in therapeutic alliance may reflect a significant improvement in treatment, and in turn, a significant improvement in functioning. Such tests were beyond the scope of this pilot evaluation.

Figure 2 – Average Client-Rated WAI-S Total Score based on Time of the Assessment

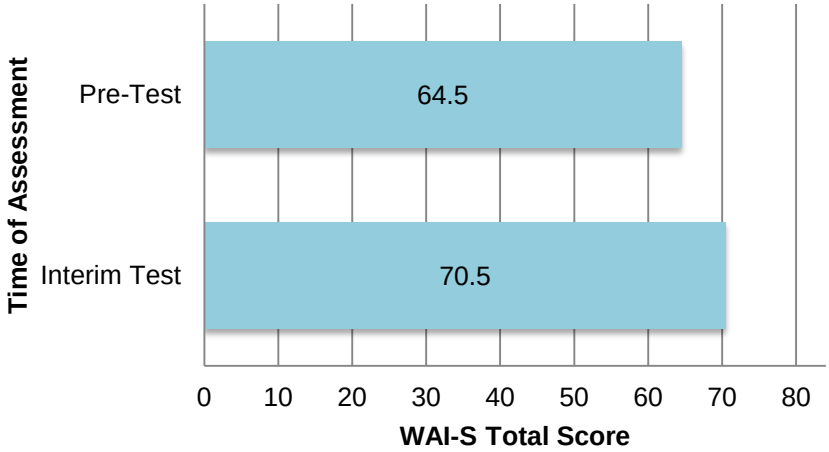
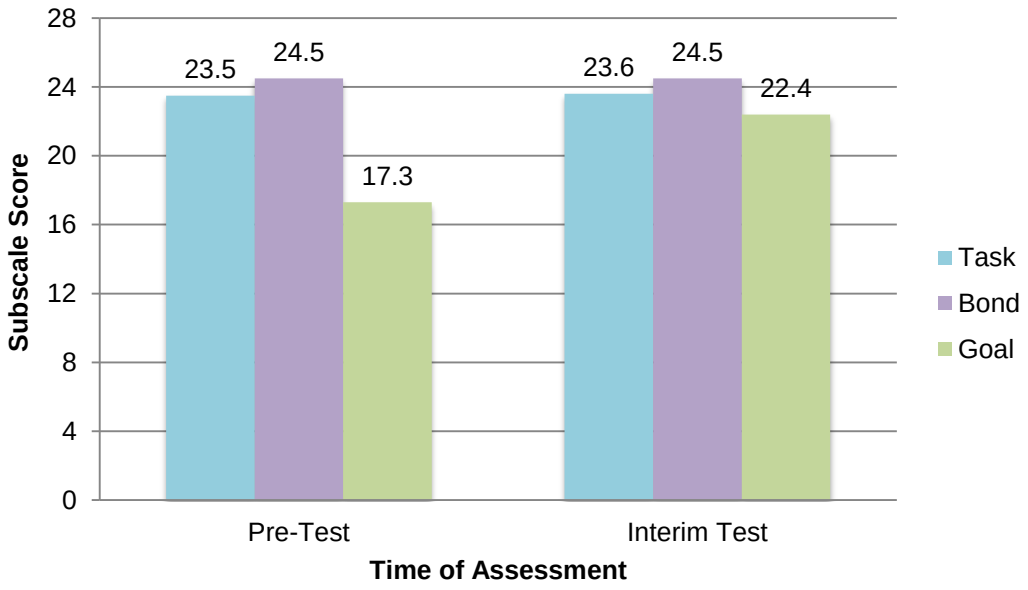


Figure 3 displays the average client-rated WAI-S subscale scores at initial and interim assessment. As the figure suggests, scores on the task and bond subscales remained relatively stable over time. However, there was a notable increase in the goal subscale scores from the initial assessment to interim assessment. Specifically, the average client-rated score on the WAI-S goal subscale increased by 5.1 points, from 17.3 to 22.4, over time. The results of the independent sample *t*-test suggest that this difference is statistically significant (t = -3.751 p = .001). Thus, there is a statistically significant difference between the average client-rated WAI-S goal subscale score at initial assessment and the average client-rated WAI-S goal subscale score at interim assessment. As involvement with their counsellor progressed, participants reported a significant improvement in therapeutic alliance surrounding their treatment goals.

Figure 3 – Average Client-Rated WAI-S Subscale Scores based on the Time of the Assessment



Additional independent sample *t*-tests were conducted to assess for significant differences between client-rated WAI scores and counsellor-rated scores. Client WAI-S scores were directly compared to counsellor WAI-S scores in order to examine the level of congruence. Scores from both the initial assessment and the interim assessment were compared. At initial

assessment, client WAI-S scores averaged 66.1, while therapist-rated WAI-S scores averaged slightly higher at 66.6. At the interim assessment, client-rated WAI-S scores averaged slightly higher than therapist-rated scores (71.0 and 68.8, respectively). The results of the analysis suggested that there were no significant mean differences between client-rated WAI-S scores and therapist-rated WAI-S scores at the initial assessment (t = .171, p = .865) or the interim assessment (t = .676, p = .507). These results suggest that there is congruency between youth and CST counsellors on levels of alignment and engagement.

Unfortunately, due to a lack of client satisfaction and referral source satisfaction survey responses, we were unable to explore the remaining three process evaluation questions in this pilot evaluation. It should be noted that these surveys are completed by the client and referral source at the end of involvement with CST and only a small number of clients ended service during the pilot test period. Future and ongoing evaluation efforts will attempt to address this limitation.

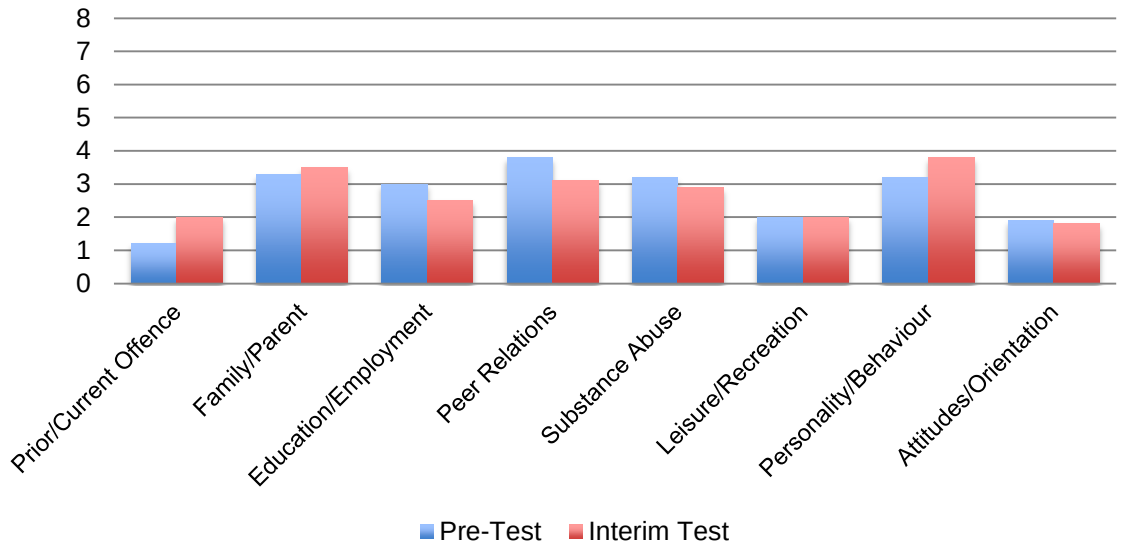
Outcome Evaluation Results

Q. 2. To what extent do the risk and needs on the YLS/CMI change during a youth's involvement with CST?

Eight independent sample *t*-tests were conducted in order to examine the extent to which risk and need level scores on the eight YLS/CMI subscales changed during a youth's involvement in the CST. Figure 4 displays the average youth YLS/CMI subscale scores at initial and interim assessment. Scores remained relatively stable over time. In contrast to what was expected, minor increases were noted on three of the subscales. Specifically, risk scores for the prior and current offenses/dispositions subscale (Subscale 1), family circumstances and parenting subscale (Subscale 2), and personality and behaviour subscale (Subscale 7) increased from the initial assessment to the interim assessment. However, the results of the independent sample *t*-tests revealed that these increases were not statistically significant (t = -.957, p = .353 [Subscale 1], t = -.305, p = .764 [Subscale 2], t = -.718, p = .483 [Subscale 7]). A

decrease in risk score was noted for education and employment (Subscale 3), peer relations (Subscale 4), substance abuse (Subscale 5), and attitudes and orientations (Subscale 8). However, while some improvements were noted, these improvements were not statistically significant (t = .580, p = .570 [Subscale 3], t = 1.750, p = .99 [Subscale 4], t = .697, p = .496 [Subscale 5], t = .199, p = .845 [Subscale 8]). Lastly, there was no change in the average leisure and recreation (Subscale 6) risk level scores.

Figure 4 – Average YLS/CMI Subscale Scores based on the Time of the Assessment

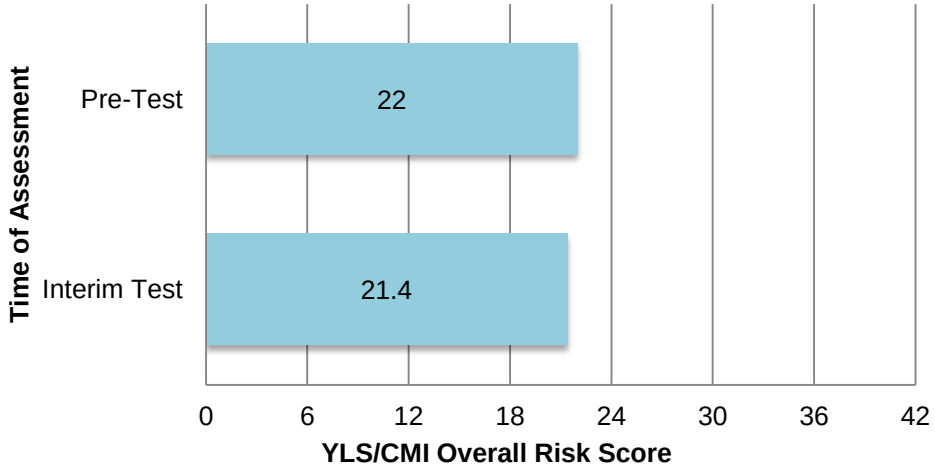


Q. 3. To what extent does the YLS/CMI risk level of a youth change during CST involvement?

Lastly, a final independent sample t-test was conducted to examine the extent to which the YLS/CMI overall risk level of a youth changed during CST involvement. The initial YLS/CMI overall risk score was compared to the interim score in order to determine if there was a significant mean difference between the two. The average participant YLS/CMI risk level score at initial assessment was 22 or moderate. At the interim assessment, the average youth YLS/CMI risk level score on was slightly lower at 21.4 (see Figure 5). While a slight decrease in

the overall risk level rating was noted, the results of the independent sample *t*-test revealed that this difference is not statistically significant (t = -.212, p = .835).

Figure 5 – Average Client-Rated WAI-S Total Score based on Time of the Assessment



A lack of available data prevented us from examining the remaining two outcome evaluation questions. Unfortunately, a number of instruments had not been in use long enough to generate adequate sample sizes. However, despite the fact that data for the pilot evaluation was limited, these instruments are undoubtedly significant tools for future and ongoing evaluation efforts.

Conclusion and Recommendations

Discussion of Findings

Overall, preliminary findings from the pilot evaluation suggest that there is a positive improvement in therapeutic alliance between CST counsellors and youth as engagement progresses. A substantial increase in WAI-S scores was noted from initial assessment to interim assessment. Specifically, there was a statistically significant improvement in the average client-rated WAI-S goal subscale score at interim assessment when compared to the initial assessment. As involvement with their counsellor progressed, participants reported a significant improvement in therapeutic alliance surrounding their treatment goals.

As Hawley and Garland (2008) have proposed, mutual collaboration and agreement on treatment goals between the client and therapist can positively impact the outcome of a therapeutic intervention. An examination of the relationship between WAI-S scores and treatment outcome was beyond the scope of this evaluation. Nevertheless, such relationships should be examined in the future. Specifically, future evaluation studies should examine whether a strong therapeutic relationship acts as a protective factor against antisocial behaviours and is associated with a reduction of criminogenic needs and risks associated with the YLS/CMI scale.

Additionally, pilot results displayed a minor improvement in YLS/CMI scores. A reduction in risk levels was noted on four of the YLS/CMI subscales. However, while improvements were noted, these improvements were not statistically significant. Additionally, there was only a slight reduction in participants overall YLS/CMI risk levels.

Unfortunately, this evaluation was unable to explore five of the original evaluation questions. As previously mentioned, a lack of response on client satisfaction and referral source satisfaction surveys prevented us from examining how satisfied participants and stakeholders

are with CST services. Additionally, due to a lack of data, we were unable to examine changes in educational engagement among youth participants.

Overall, the number of participants who had completed pre, interim and post-tests was relatively small. Future and ongoing evaluation efforts will attempt to address the limitations of this evaluation. Instruments will continue to be implemented on an ongoing basis in order to generate a large enough sample size to conduct a more thorough evaluation.

Recommendations and Next Steps

The literature is clear in indicating that the therapeutic alliance can have a positive impact on treatment (Hawley & Garland, 2008; Lantry & Flynn, 2007). The CST recognizes the importance of strong counsellor – client relationships and activities to foster this are included in the CST service delivery model. The CST client population has diverse needs and thus building alliance and engagement is integral to the treatment process. The Working Alliance Inventory Short Form appears to have been a reliable and realistic way of obtaining information regarding therapeutic alliance from both counsellors and clients. Feedback from CST counsellors indicated that the brief survey was realistic to implement, clients were willing to complete it and it encourages the counsellor to review goals, tasks and bonds at regular intervals.

The other tools that were used for the planning evaluation process during the pilot test period include the Youth Level of Service/ Case Management Inventory, School Engagement Checklist, the Client Satisfaction Survey and the Referral Source Satisfaction Survey. During the test period CST counsellors developed familiarity with implementing the tools and feedback in respect to implementation was provided during team meetings.

Preparing a program for evaluation is a big task. The importance of involving primary stakeholders early in the process became apparent as their input was integral to the development of the program logic model and the evaluation framework. Having their participation allowed for better engagement and understanding in the planning process and

commitment to program evaluation. Having access to a consultant at the Centre for Excellence (the Centre) proved to be very helpful in directing the process. While the phone support was helpful the Project Team found the site visits from the consultants to be invaluable.

From this experience DFCC has begun to build internal capacity in the area of program evaluation and has been the plan all along, plans to use the experience gained during this grant to prepare other DFCC programs for evaluation. Of value was the Centre's support in providing valuable resources to support the establishment of an Internal Review Committee and use of various. (See Appendices)

Based on these insights, the following have been developed as recommendations.

1. It is recommended that the WAI-S continue to be administered as this project has shown it is a realistic instrument to use with the CST clients. Given the success, expanding the use of the WAI-S to other DFCC community based programs will be strongly considered.
2. It is recommended that the Community Support Team continue to implement the tools as used during the planning evaluation process to build the data base for an anticipated program evaluation.
3. It is recommended that in preparing future DFCC programs for evaluation, the assigned Project Team draw on internal capacities developed through this grant to assist in the process.
4. It is recommended to utilize the available supports from the Centre including accessing a consultant for direct site visits.

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Appendices