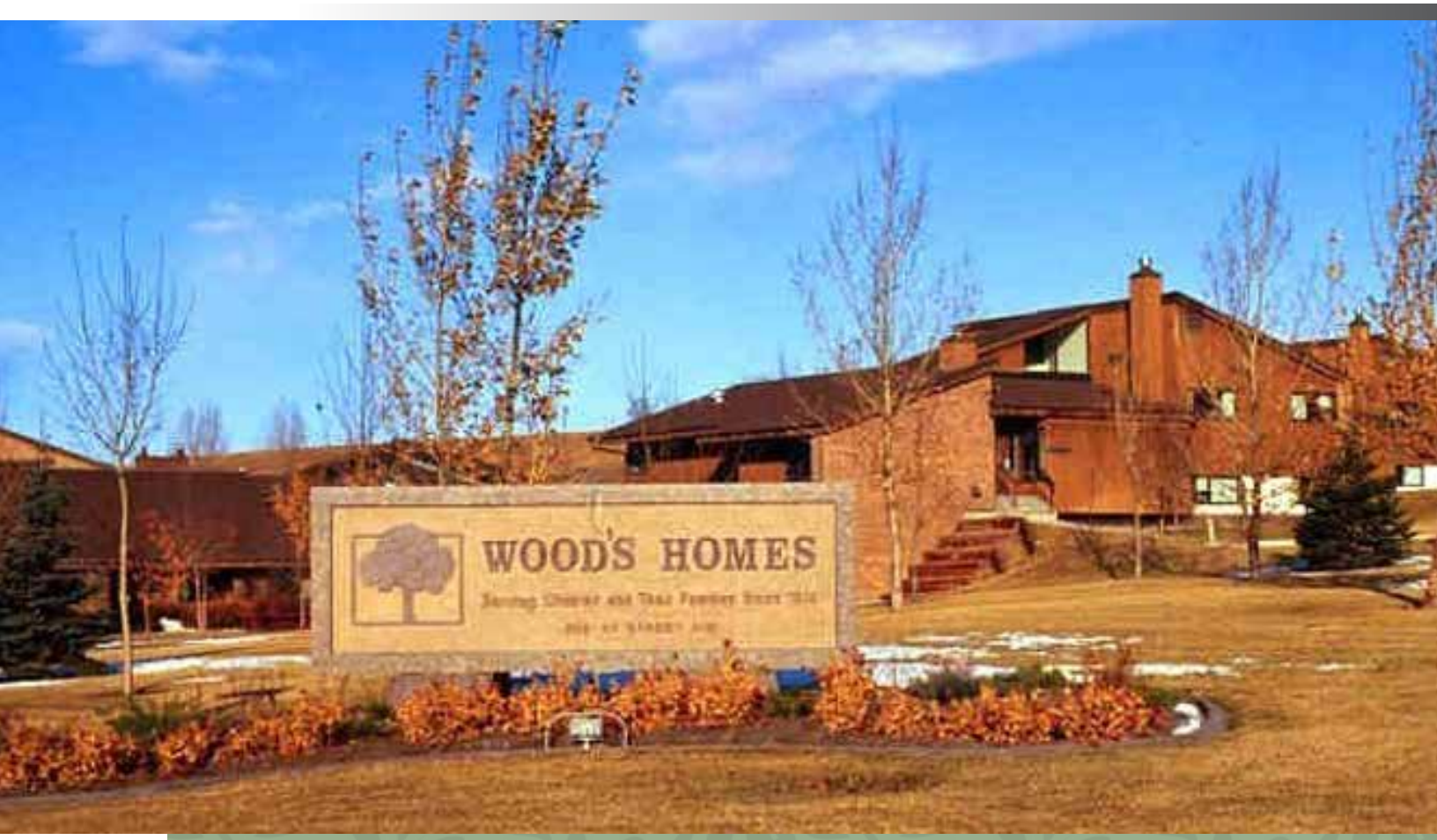
WOOD'S HOMES JOURNAL

Evidence to Practice

VOLUME 2, ISSUE 1 | WINTER 2018



Wood's Homes
Working For Children's Mental Health
Since 1914

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WOOD'S HOMES
WORKING FOR CHILDREN'S MENTAL HEALTH
SINCE 1914

Wood's Homes Journal – Evidence to Practice is published by Wood's Homes and is designed to showcase leading applied research and practice knowledge of mental health services for children, youth and families in Canada. Articles are the responsibility of the authors.

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Introduction to Wood's Homes Journal – Evidence to Practice, Volume 2 Issue 1

BRUCE MACLAURIN

It has been well documented by the Mental Health Commission of Canada that by adolescence, an estimated 1.2 million children and youth are affected by mental health concerns in Canada. Less than 20% of those young people receive treatment deemed to be appropriate and timely however, contributing to the gap between the first identification of a child's mental health concerns with the desired engagement in services. Child and adolescent services across Canada are challenged to address the growing demand for intervention, while at the same time further developing the foundation of evidence supporting these interventions.

Volume 2, Issue 1 of the *Wood's Homes Journal – Evidence to Practice* continues the work first outlined by Matheson (2014), about one organization's journey to embed evidence within practice. This issue begins with an article by Jane Matheson which highlights the creation of the Wood's Homes Research Chair in Children's Mental Health, from a dream to reality over a 15-year period. Dr. Angelique Jenney was hired as the Research Chair in April, 2017 and we invite you to look for her work in subsequent issues of this journal.

Cindy Jing Fang, Janet Stewart and co-authors prepared an important article on the development of a framework for outcome measurement for single session, walk-in therapy at the Eastside Family Centre. The paper highlights the collaborative process established by the Eastside clinical team and Wood's Research Department.

Brittany Corolis led the preparation of an article exploring the complexities of client engagement within the spectrum of child and adolescent treatment. This review highlighted the roles that staff, clients, and organizations play in creating strong and enduring relationships with children, youth and their family systems. This serves as a foundation for a current study exploring engagement from the perspective of staff members of Wood's Homes.

Bruce MacLaurin, Bjorn Johansson and team provide an overview of a study which examined the experience of children and youth who have been involved with street life, successfully exit the street, but are subsequently re-involved with the street. This study was supported by the Alberta Homelessness Research Consortium and funded by the Government of Alberta.

Luc Wittig led the work on an article reviewing key steps and stages of organizational transition to an evidence-informed approach to practice. Wittig highlights the characteristics of staff and organizations that support this transition, and the perceived barriers that may challenge the process.

The Wood's Homes Outcomes Measurement (WHOM) is documented in an article drawing from an earlier iteration published in Canada's Children. The article summarizes the shift from the early foundations of the National Outcome Matrix (NOM) to the current version of WHOM.

The final article continues the tradition of practice lessons learned over time. Story #56a, written by Sue McIntyre, is reproduced with the permission of Clem Martini, Editor of "One Hundred Stories for One Hundred Years" published in 2013. The article describes the very poignant story of "Miss Adventure", and the impact this young person had on Wood's Homes over time.

This issue of the *Wood's Homes Journal – Evidence to Practice* is an opportunity to share our knowledge with others who are committed to improving mental health services for children and youth. We invite suggestions and discussions on the material in this issue and look forward to learning from your experiences.

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Matheson, J. (2014) The research department at Wood's Homes: The little engine that could, *Wood's Homes Journal - Evidence to Practice*, Vol 1(1), 2-4

The Dreaming and the Dawning of the Wood's Homes Research Chair in Children's Mental Health – Circa 2000-2015

JANE MATHESON

When you dream up a crazy idea with another person, the story has two versions, two realities, two meanings and this dream is no different....

FIRST VERSION - GAYLA ROGERS

"I was just starting my second term as Dean (around 2005) and a new expectation was added to the duties of Dean – we were now required to raise funds for scholarships and Research Chairs. I needed a strategy and a game plan and I needed to set goals and targets. But how were we to compete with medicine, engineering and the business school; and how

> *"Dreams, if they're any good, are always a little bit crazy"*
>
> RAY CHARLES

could we engage donors of social programs and social agencies to invest in social work research and students. We needed to connect the dots between effective programs and practices and the type of research that would demonstrate their outcomes and worth. It sounds like an easy case to make – but it really wasn't/ isn't.

Those used to donating to the university understand the value of research and the time it takes to cure cancer or build better bridges; those who choose to donate to social causes and social programs just want to see the shelter up and running or vulnerable children being served. Bridging the gap required some out of the box thinking.

Unbeknownst to me at the time, Jane was also dreaming and scheming how she could parlay the development of a research department into a credible, evidence-producing enterprise that could demonstrate not only social return on investment but also track and document the difference that programs and services Wood's Homes were providing to vulnerable children, youth and families.

One day, almost in passing, I said to Jane "wouldn't it be amazing if we could somehow create a University research chair but have it 'housed' at Wood's Homes so that the research was rooted in practice, that research questions came from practice, solved the actual problems practitioners were grappling with and essentially produced evidence of program effectiveness in real-time?" I expected her to look at me like I was dreaming in technicolour but it turns out she had

been thinking along those same lines. All we had to do now was to turn the concept of a University research chair on its head . . . and, oh yes, find a funder." (From memory…Gayla Rogers, Dean, Faculty of Social Work, University of Calgary)

SECOND VERSION - JANE MATHESON

"I can't remember what year it was. I know Gayla was the Dean at the Faculty of Social Work and we were talking about working together. We had already worked together very successfully on a SSHRC grant – about partnership, in fact. I was just finished my PhD work and had my fledgling Research Department at Wood's Homes up and running – such as it was. I was on a research bandwagon, I recall and so anything about 'research' caught my eye. I would look in university newspapers and see Canada Research Chairs advertised and wonder why they were always for pure science and never for social science. I knew nothing about Research Chairs - what they do and how they got funded - but it seemed like something good that we could do together; something that would benefit both organizations equally. That was what I liked about it most. So, I asked Gayla – how about we do this? She knew more about the obstacles that would stand in our way and so I am sure she was inwardly gasping. But it's funny, I only remember her eyes lighting up with the possibility." (From memory…Jane Matheson, CEO, Wood's Homes)

However, this particular dream also has one outcome, one vision and one success story! It took more than 10 years but our dream did become a reality. This is a story about how that happened.

BACKGROUND

About 15 years ago, Wood's Homes wanted to find ways to answer the very good question posed by a board member who found himself stymied with queries from legislators or potential supporters and donors about proving clients get better when they come to a Wood's Homes service. The questions he posed to us – in various forms – were: "What is success?" or "What does success look like?" or "How do you know you are successful?" Finding the answer to these questions for 25-30 programs required gathering data, counting events, determining categories and themes, and eventually creating a small Research Department in the late 1990s with one person. Today it has four staff.

This department operates with a bottom-up philosophy. In other words, the importance of front-line staff is paramount. Collecting data, understanding why the data is important to collect carefully as well as the meaning behind it and then receiving reports on results cannot be underestimated when one wants to develop research capacity. We learned early on that it is not enough just to want, need or be required to measure something. One cannot find anything of substance in isolation from the people and the work they are doing.

This front-line focus began with those early days. Managers, supervisors and directors came together at management meetings with legal size charts full of check marks. These sheets were records of items we collectively decided were important to collect – numbers of violent episodes with children, numbers of suicidal attempts or self-harming behaviours, numbers of times children ran away, numbers of relief staff used in one week, complaints and compliments – just to name a few examples. We did not think about these topics very carefully, we just did it. We only knew that these topics were important issues for us, that anecdotal stories were not facts and that we needed facts to determine if something was a problem or we needed to decide on an intervention or strategy. That was the basic reason for this early-days work.

This time-consuming process, while arduous and sometimes aggravating, taught senior leaders about the simplest of data collection processes in a manageable way. It also led to comparative work between similar programs (Why are we using more relief staff than you are? Why do we think you have less violence in your program than in mine?) As a result, similarities and differences in program mandates were more evident. Over time, the original topics noted for collection were changed, dropped or honed to become more specific (counting runs of different time lengths or violence of serious and less serious types). Many of these categories created some 15 years ago, still stand today.

This simple activity then determined the next – we hired a Research Lead. For about five years one person collected and crunched data, hired a research assistant here and there and basically managed our sheets of paper and ideas single-handedly. Yes, it was unsophisticated and catch-all but we did start a database, determined a system of collecting information,

researched and landed on outcome measurement tools – all of which has stood the test of time. Looking back, we call that time and the development of that department – "the little engine that could."

The final phase was the inevitable and slow growth of the Research Department into the four people who work there today. They are capable and keen learners as well as competent practitioners. They are able to collate information, help programs understand the data, create documents we need for reporting to funders or determining issues and help us analyze results. We depend upon them all. However, there is so much more that we want to do, and so the idea of the Research Chair was born.

> *… the moment that one commits oneself, then providence moves too.*
>
> GOETHE

The Wood's Homes Research Chair in Children's Mental Health is rooted in a few basic premises. The first is that its "research" must be easily and readily accessible, user-friendly and understandable to dad and mom, helper and counsellor and in some cases, even children and youth. The second is that it is embedded in practice first and enhanced by measurement, experiment and hypothesis. The third is the desire to strengthen and further develop into the future our long-standing relationship with the University of Calgary, Faculty of Social Work by putting the best of both of our worlds together to enhance services for children, youth and families.

These premises are very different than traditional, more academic and medically based Research Chairs devoted to child and adolescent mental health. Those definitely have their place but so does a Chair that is rooted in community and whose clients need practical help right away. It was not an easy sell.

At first, even our staunchest supporters were wary. The Board of Directors of the Wood's Homes Foundation was frankly puzzled – "Why would I want to have them raise $3M only to give it to the University," was their first (and fair) response. They and a whole list of others then played devil's advocates and mined our case for every reason that this idea would not work. While it was challenging to face the detractors, this process of requesting criticism worked in our favour. We rewrote the case, discussed our theoretical plan ad infinitum to make sure it still had teeth and learned how to stand our ground with the most important points of our initiative while acquiescing to some other ideas. In the end, the result was unfettered support and enthusiasm and a true community collaboration. Our appreciation for all of those advisors to this day is immeasurable.

We now stand on the cusp of the future. As Goethe wrote, *"…. the moment that one commits oneself, then providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issue from the decision."*

After many years of talking, convincing and keeping our eyes on the prize, we have the support of a Founding Chair Partner – Canadian Oil Sands with $500,000 and other major and very generous donors – The United Way, the Estate of Barry Mickelson, a past board member and family, two anonymous donors and some in-house donors and supporters. As well, the University stepped up to the plate with their own complementary and matching contribution. It should be noted that the University also took a leap of faith into the unknown by adapting their regular Chair managing processes to the needs of this one – joint leadership, community-based, shared financing.

At the time of this writing, the Research Chair had been launched and searching for the right person to take on this role had begun. At that time, we dreamed of finding an academic with experience "in the field" with children, adolescents and families who would embrace our joint accountabilities and welcome community involvement. We will find the right person and the innovative work of partnerships and learning will begin soon. *

And as you can see, we now know that dreams do come true!

** Editorial Note: The search for the Research Chair was indeed successful. Angelique Jenney, Ph.D. was hired as the Wood's Homes Research Chair in Children's Mental Health in April, 2017. Look for Dr. Jenney's contributions in subsequent issues of the* Wood's Homes Journal – Evidence to Practice.

From Practice to Research – Examining Outcomes of Single Session Walk-In Therapy

CINDY JING FANG, JANET STEWART, DEAN SOENEN,
BJORN JOHANSSON & BRUCE MACLAURIN

INTRODUCTION OF EASTSIDE FAMILY CENTRE

The Eastside Family Centre (EFC) walk-in single session therapy service was developed more than 25 years ago in response to the need for immediately accessible and affordable mental health services. The centre was founded at a time when funding and related resources for people with mental health issues were declining while the need for locally-based mental health services was increasing (McElheran, Stewart, Soenen, Newman and MacLaurin, 2014). The centre is located in an ethnically diverse, high-density, lower socio-economic area of Calgary, Alberta. Clients from this area as well as across the city and beyond, are welcome to come to the centre and request a therapy session when they are ready to do so (McElheran et al, 2014). The EFC works in collaboration with community services such as schools, social service agencies, hospitals, mental health services and the justice system. The development of the centre and the clinical approach are well documented in the research and practice literature over the past two decades (Slive, MacLaurin, Oakander & Amundson, 1995; Miller & Slive, 2004; Slive, McElheran & Lawson, 2008; Clements, McElheran, Hackney & Park, 2011; McElheran, et al., 2014).

OVERVIEW OF THE EASTSIDE FAMILY CENTRE APPROACH

The EFC therapists, who include social workers, psychologists, clinical nurses, consulting psychiatrists, marriage and family therapists, masters level clinical students and family physicians, conducted and consulted on 3,104 walk-in sessions during 2014 (Wood's Homes Research Department, 2015). Walk-in therapy at Eastside is designed for individuals, couples and families to leave the session with a sense of emotional relief and positive outcome (Slive & Bobele, 2012). Therapists and clients collaborate during the therapy session to discover how best to relieve distress, think about problems in a new way and/or develop a new strategy to deal with a problem.

Walk-in sessions are organized around the Milan 5-part session model (Boscolo, Cecchin, Hoffman, & Penn, 1987). This model includes a pre-session which is a review of a set of forms the client has completed, the 40-minute session, an intersession or the consultation of a therapist with the team of the EFC therapists, providing the team's intervention to the client and finally, a debrief with all therapists involved in the session. Please refer to McElheran, et al., (2014) for further detail on the clinical approach used at Eastside Family Centre.

DEVELOPING AN OUTCOMES FRAMEWORK AT EASTSIDE FAMILY CENTRE

EFC has been the focus of a number of evaluative and research initiatives over the past 25 years. Findings suggest that the centre has been very successful in providing accessible and cost effective mental health services, and users report a high level of satisfaction with the services that they received at EFC (Hoffart & Hoffart, 1994; Harper-Jaques, McElheran, Slive, & Leahey, 2008; Miller, 1996, 2008; Miller & Slive, 2004; Whitford, 1994). These isolated and independent research studies have contributed greatly to the growing body of evidence supporting the use of walk-in, single session therapy as a primary form of intervention for individuals and families at risk.

Over the past 20 years, many service sectors have called for an ongoing and systematic collection of data that would inform outcome measurement and support comparisons of program functioning over time. Specifically, there is an interest in knowing what interventions are most effective for which type of clients, for what type of presenting concerns, and over what time period (Trocmé, MacLaurin, Fallon, Shlonsky, et al., 2009). This led to the next step of research and evaluation developed at Eastside Family Centre.

During the summer of 2012, the management and staff of the EFC met with Wood's Research Department to examine the changing needs of the clients using single session walk-in counselling. There was speculation that a higher percentage of clients were presenting with acute mental health concerns, specifically depression and anxiety. Early discussions proposed conducting a time-limited research study to examine this practice question, however consensus was reached on developing a comprehensive data collection framework that would support tracking client data and outcomes on an ongoing basis. Collecting data on clients each year would generate an ongoing database that could address practice and research questions each year as well as monitor changes in client profile and presenting concerns for clinical populations over time. A study team was established during the Fall of 2012 with a mandate of developing and pilot-testing an outcomes framework. Data collection primarily used information that was currently collected for all clients, in addition to two new clinical scales measuring acuity of depression and anxiety. Reports on the pilot test data were scheduled throughout 2013 and the outcome framework was modified to incorporate all revisions based upon the pilot test period. The data collection process that was initiated in November, 2012 continues on an ongoing basis.

DESCRIPTION OF DATA COLLECTED FOR MEASURING OUTCOMES

Data Collected Before the Session

The Client Demographic Form gathers information about the client such as how they found out about the service, primary language spoken in their home, and location of residence. The Client Confidential Questionnaire collects information related to what prompted the client to seek counselling on that day. These questions include determining the single most important concern that the client wishes to share; identifying who is most affected emotionally by this concern; and what the client would like from the day's session. Clients also rate their distress level on a scale ranging from no distress to extreme distress (Duncan, Miller, & Sparks, 2004). The forms, questionnaire and distress scales have been used to collect information on all new or repeat clients for the past two decades. Two new scales were added to the data collection process prior to the EFC walk-in 2012. This included the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7).

Data Collected Following the Session

Following the completion of each session, clients complete a feedback form adapted from the Outcome Rating Scale (Duncan, Miller, & Sparks, 2004). As well, clients provide a measure of their post-session distress, feedback on the goodness-of-fit of the session for them, as well as their therapeutic alliance with the therapist and team for the session (McElheran et al., 2014). The therapist responsible for leading the session provides feedback on additional variables including type and level of risk in the session, client resources, form of intervention, and use of psychiatric consultation.

PRELIMINARY FINDINGS

Demographics and Presenting Concerns

The sample for the first two years of data collection (November 2012 to October 2014) includes 2,641 unique clients and 3,560 sessions. Primary adults are lone adults in an individual session or the adult completing intake forms for couple or family sessions. Of these adults, 59.7% were female and 40.3% were male. About 41.7% of the primary adults were between the age of 25 to 39, followed by 40 to 59 (35.6%), 18 to 24 (15.1%), and 60 and over (5.4%). About two thirds of the clients reside in the Northeast and Southeast quadrants of Calgary, the area that EFC was initially designed to serve.

With regard to the session configuration, 71.6% of the sessions were individual sessions, 17.9% of the sessions were family sessions and 10.5% of the sessions were couple sessions. Over 58% of clients heard about EFC from other professionals, while 15.6% found out about EFC from family and friends, 12.5% from physicians, and 9.7% from mental health agencies. Among all the sessions, about 57% of clients visited EFC for the first time. EFC clients frequently had a counselling history as 70.4% of clients were previously involved and 16.8% were currently involved in counselling. About 10% of clients had present involvement with child welfare while 7.7% of clients had past involvement with child welfare.

Top presenting concerns identified by clients and therapists include mental health concerns, couple/relationship issues, family relationship issues and parent/child relationship issues. According to therapists, 71% of clients had presenting concerns ranked as medium severity, while 12.9% of clients had high severity.

Assessment and Measurement Instruments

During the session intake, clients were asked to report on their level of distress by crossing a 10cm line ranging from no distress to extreme distress. Following the session, clients are asked again to rate their level of distress to determine if there was a change in distress. Among all the clients, 86.7% of them had a decrease in distress after the intervention, 6.2% of clients had no change in distress, and 7.1% of clients had some increase in distress after the intervention. The mean distress scores for all clients were 7.0/10.0 at pre-test, and 4.1/10.0 at post-test, reflecting an average decrease of 2.9/10.0. Distress change differed by sex as the mean distress scores for male clients were 6.77 at pre, and 4.03 at post, with a decrease of 2.72 in distress change, while the mean distress scores for female clients were 7.18 at pre, and 4.2 at post, with a decrease of 2.97 in distress change. T-test is a measurement designed to assess the statistical significance of the difference between two sample means. Independent samples T-test indicated significant difference between the mean distress change for males and females ($p<.001$).

Level of satisfaction is seen as a critical element in determining success for individuals accessing clinical services. The satisfaction rating scale ranges from 0-10 (0-Strongly Disagree 10-Strongly Agree). With regard to clients' level of satisfaction, 'how heard, understood, and respected client felt' was rated at 8.98, followed by 'whether worked on and talked about what client wanted' at 8.90, 'how fitting therapist's approach was' at 8.84, and 'overall satisfaction with session' at 8.54.

Patient Health Questionnaire (PHQ-9) is used as a screening and diagnostic tool for mental health disorders specific to depression. The results PHQ-9 indicated that over half of the clients had Moderate (Scale of 15 to 19) or Severe (Scale of 20 to 27) severity in PHQ. Independent samples T-test indicated significant difference between the mean PHQ severity for male clients (13.99) compared to female clients (14.63) ($p<.050$).

General Anxiety Disorder (GAD-7) is a standardized rating scale to measure severity of various signs of generalized anxiety disorder. The results of GAD-7 indicated that nearly half of the clients were rated as Severe (Scale of 15 to 21) for the GAD. Independent samples T-test indicated significant difference between the mean GAD severity for male clients (12.67) compared to female clients (13.41) ($p<.010$).

Feedback from the intake and assessment measurements indicate that clients are coming to Eastside Family Centre with relatively high levels of severity for depression and anxiety. The immediate outcomes following the session indicate that the majority of clients had a decrease in distress following intervention, and most clients were highly satisfied with all aspects of the walk-in single session service provided by EFC.

Factors Associated with Distress Change and Satisfaction

The study team was interested in examining factors that were associated with select outcome variables. Outcome variables included in the EFC Outcome Measurement Framework include client distress change and satisfaction with the service of EFC. Chi-square is used to examine the differences with a number of categorical variables, and it indicates how well an observed breakdown of people over the various categories fit the breakdown that was expected. The results showed that a number of factors were associated with distress change and satisfaction.

Preliminary analyses noted a range of factors associated with a change in level of distress. These variables include: if the client noted someone who is most emotionally affected by the presenting concern; the client's pre-session level of distress; if the client had previously tried things to address the presenting concerns; if the client indicated that help was needed; if the client identified things that would indicate the session was headed in the right direction; the level of PHQ severity; the level of GAD severity; the level of risk acuity; and levels of client satisfaction with different aspects of the services ($p<.001$). Other associated factors included if the client had indicated a source of strength or if the client had previous counselling ($p<.010$), as well as the primary language spoken in the home, how the client found out about EFC, gender of primary adult, configuration of the session or client ranking of severity of concerns ($p<.050$).

Chi-square analyses indicated that client's overall satisfaction with the session was associated with a number of related factors. These variables include: the client's post-session level of distress; distress improvement; the client's satisfaction with team ap-

proach; the client's satisfaction with being heard, understood and respected; the client's satisfaction with having worked on and talked about what they wanted; and the client's satisfaction with the therapist's approach ($p<.001$). Other variables associated with overall satisfaction include; the configuration of the session; the client's pre-session level of distress; the level of risk acuity; and if the client presented with identified mental health concerns ($p<.010$).

Indicators Predicting Outcomes

Logistic regression is used to identify factors that predict categorical outcome variables; versus, for example improvement versus no improvement. Based on the Chi-square analyses, only those variables that have a significant relationship are used in the logistic regression models. Preliminary analyses indicate that factors predictive of improvement in level of distress included: if the client noted someone who is most emotionally affected by the presenting concern; if the client indicated a source of strength; if the client had previous counselling involvement; and if the client noted something that would indicate the session was headed in the right direction. Similarly, variables predictive of improved client satisfaction include: the configuration of the session; the level of client risk; and if the client presented with an identified mental health concerns. The findings of regression analyses are preliminary and the growing database will support more rigorous analyses leading to highly predictive models.

CONCLUSION

The development and implementation of the EFC Outcome Measurement Framework clearly supports and informs the work that is being done with walk-in single-session counselling at Eastside Family Centre. Analyses of the initial two-year database confirms that EFC is serving an acute population with relatively high severity in anxiety and depression. Preliminary findings indicate that clients have a significant decrease in their level of distress following their session and are highly satisfied with the style and process of intervention. Ongoing analyses will further our understanding of factors that are highly predictive of positive outcomes.

Documenting positive change over the course of a single session walk-in session is a critical step in intervention research. Equally important however is understanding the impact of the sessions on clients over extended time periods. The Study Team has been meeting to develop and implement a follow-up study of clients who access Eastside Family Centre. Specifically this work will include a randomly selected sample of clients who agreed to be contacted one month post-session for a telephone interview related to longer-term outcomes of their walk-in session. These findings will further inform best practice and contribute to the development of single session walk-in services.

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Understanding the Process of Client Engagement

BRITTANY COROLIS & BRUCE MACLAURIN

There is general agreement that client engagement is an essential element for successful treatment, however there is less consensus on how this construct can be defined for different populations and for different forms of treatment. Previous research has defined client engagement as the number of days a client attends treatment or by treatment retention (Pullman, Ague, Johnson, Lane & Beaver, 2013). Defining client engagement in this way may not be the best indicator as compliance to treatment is often due to family, school, court, or medical obligations (Jetton, & Rund, 2013; Pullman et al., 2013, and Watt & Dadds, 2007). In recent years the definition of client engagement and the factors that contribute to client engagement in mental health treatment has expanded and has become more comprehensive and ecologically based (Pullman et al., 2013). This review of the literature will look at child, youth and adult engagement in a variety of residential and community based mental health treatment centres. Using a broad range of clients as well as a variety of treatment services provides a more global view of the factors that contribute to meaningful client engagement.

The most frequently used definitions of engagement focus on client attitudes about treatment and client behaviours while in treatment (Joe, Simpson, & Broome 1999; Staudt, 2007; Staudt, Lodato, & Hickman, 2012), as well as the importance of the relationships formed, and the interactions that occur

between treatment staff and client (Cunningham, Duffee, Huang, Steinke, & Naccarato, 2009; Dakof & Tejeda, 2001; Gragg & Wilson, 2011 & Pullmann et al., 2013). Staudt et al. describe engagement as having a behavioural component (completing treatment activities), and an attitudinal component (the client is emotionally committed to treatment and believes in treatment). Pullman et al. (2013) elaborate on this definition and describe engagement as having five domains; conduct, attitudes, relationships, empowerment, and social context. Having reviewed the definitions of engagement, it is evident that both client and staff factors influence a client's engagement, as well attitude and behaviour factors. Other elements that should be considered suggest that: 1) engagement starts from the very first moment the client comes into contact with the treatment centre (Risser & Schewe, 2013 and Simpson & Joe, 2004), 2) engagement is as an ongoing process that changes throughout the clients treatment (Dakof & Tejeda, 2001; Gragg & Wilson, 2011), and 3) engagement requires collaborative involvement (Cunningham et al., 2009; Dakof & Tejeda, 2001 and Staudt et al., 2012).

For this review, client engagement is defined as a multidimensional ongoing process which begins at the start of treatment. At the core of this process are the relationships that develop between client and staff, client behaviours and attitudes (before and during treatment), and the characteristics of individual staff and the treatment program. Based upon this working definition, it is important to consider that there are a number of factors that can contribute to, or challenge client engagement. These factors include client factors, staff factors, and organizational or program factors.

FACTORS CONTRIBUTING TO CLIENT ENGAGEMENT

Client Factors Contributing to Engagement

The experiences a youth has before entering treatment can influence their willingness to engage with staff as well as with the initial treatment process. Lau and Weisz (2003) found that children who experienced maltreatment in the past were more likely to terminate treatment early, or would have a slower time engaging (Koverola, Murtaugh, Connors, Reeves, & Papas, 2007). A client's cultural background is another important consideration. Risser and Schewe (2013) found that American Caucasian children successfully completed treatment at a higher rate compared to children who were minorities in the U.S. Having staff who are culturally sensitive to each client's unique cultural background can be crucial to the success of treatment. Hopelessness and stigmas are other barriers which are often experienced by clients attending treatment for a mental health concern, or other family or behavioural issues (Staudt et al., 2012). Often feelings of hopelessness can halt the client's progression through treatment, making it very difficult to become motivated to create change.

A client's attitude toward treatment and beliefs about treatment can greatly impact their engagement. Clients who are not committed to treatment and do not understand or believe in the benefits of treatment, are challenged to fully engage in treatment (Staudt et al., 2012). Simpson and colleagues explain motivation is a crucial part of the treatment process for youth who are in substance use treatment (Simpson, Joe, Rowan-Szal, & Greener, 1997). Clients who are motivated, committed, and educated about the treatment process are more likely to become engaged in treatment. It is important to remember however, that youth who are initially engaged at the start of treatment may be challenged by external factors related to the treatment staff and organizational factors of the treatment program.

Staff Factors Contributing to Client Engagement

Broome, Flynn, Knight, and Simpsons (2007) found a number of staff factors that contribute to successful client engagement. These factors include; the amount of confidence the staff have about their skills, having a positive work environment, and staff being involved in professional community practices (Broome et al., 2007). These factors were supported by Moos and Moos (1998) who found that staff who work in a positive environment tend to provide a positive environment for their client groups.

Workplace stress and subsequent staff burnout are other staff factors that can contribute to client engagement in treatment. Landrum, Knight and Flynn (2012) found that organizational stress, for example large caseloads, are associated with greater staff stress and contribute to staff burnout. Landrum and colleagues concluded that staff stress and burnout are associated with lower client participation in treatment. Due to large workloads, treatment staff may feel like they don't have enough time with their cli-

ents to complete assessments and paperwork, as well as being compassionate and genuine. Staudt et al. (2012) describe the time limits staff have with clients as "stripping the human connection." When staff feel they have to rush through sessions, and caseloads are so large staff cannot remember details about past sessions, the human connection is lost and the client may become less engaged. Staudt et al. (2012) also emphasize the importance of staff being passionate about their work. Staff working in residential treatment facilities often have to work long hours or work overtime in order to provide the best care and treatment for the clients. Clients are very aware of which staff enjoy being at work and who have a passion for the work. These are often the staff that clients create meaningful relationships with and become engaged with (Staudt et al., 2012).

Lastly, the relationship or rapport that is created between a client and staff can contribute to the level of engagement the client experiences. This is commonly referred to as the "therapeutic alliance" (Horvath & Greenberg, 1994). Trust, likeability, comfort, attractiveness and credibility are factors that can contribute to the bond that forms between the client and staff (Martin, Graske, & Davis, 2000).

Organization Factors Contributing to Client Engagement

The third factor that contributes to, or influences client engagement is the organization of the treatment centre or program. Many organizations find that a client's treatment needs are unique and therefore treatment plans and programming must be individualized (Timko, Semple, & Moos, 2003). Broome et al. (2007) explain that although there are good clinical reasons for diversity in programming, it is important for organizations to be aware that this diversity could lead to a disjointed and less engaging treatment environment. Another factor that can contribute to the engagement level of a youth is the size of the treatment program they are attending. Programs larger in size that have a low staff to client ratio can have poorer treatment outcomes, due to reduced social interactions (McCaughrin & Price, 1992). One factor that can ensure that the appropriate staff to client ratio is present in treatment centres is the accreditation process. Organizations that meet or exceed accreditation standards tend to have better client outcomes (McCaughrin & Price, 1992). Based on the positive association found between engagement and outcomes, it is likely that accredited organizations will have stronger client engagement (Broome et al. 2007).

It is evident there is a vast array of client, staff and organizational factors that can influence and contribute to a client's engagement. Each unique client will have different treatment needs, and will enter treatment with diverse experiences. The personal, staff and organizational factors that contribute to each client's engagement will also be different and unique.

LEARNING ABOUT ENGAGING WITH CHILDREN AND YOUTH

Research and practice wisdom confirm that engagement with children and youth is a crucial element to a successful treatment process. There is benefit to further understanding how staff establish meaningful professional relationships with children and youth, and exploring what new staff can learn in order to facilitate their work when employed. A study currently being conducted at Wood's Homes is learning from staff who are identified by clients, peers or their supervisors as being exemplary at engaging with children and youth. In-depth interviews are being conducted with staff to learn about what makes them good at connecting with children and youth, how they learned these skills, and how this can be taught to others. This evidence will inform practice at Wood's Homes and serve as a foundation for ongoing research on client engagement with children and youth, families, and in different treatment settings.

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Recurrence of Street-Involvement: Exploring the Experiences of Calgary Youth

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INTRODUCTION

The literature generally defines street-involved youth as those young people 25 years of age or younger who are homeless or under-housed; have been forced to leave their families of origin; who have run away from their homes without the consent of their parent or guardian; or who left foster or group care placements (Hammer, Finkelhor, & Sedlak, 2002; Kufeldt & Nimmo, 1987b). Canadian street youth are frequently characterized as having unsuccessful experiences with the helping professions including child welfare (Worthington & MacLaurin, 2008; Min Park, Metraux, & Culhane, 2005; Robert, Pauze, & Fournier, 2005; Viner & Taylor, 2005); the criminal justice system (Baron, 2006; Gaetz, 2004; Hagan & McCarthy, 1997); children's mental health (Worthington & MacLaurin, 2008); and education (Thompson, O'Brannon III, and Maccio (2004). Street-involved youth are exposed to a wide range of risks including: drug use (Clatts, Goldsamt, Yi, & Gwadz, 2005; Hagan & McCarthy, 1997; Robert, Pauze, & Fournier, 2005); physical and mental health (Dachner & Tarasuk, 2002; Boivin, Roy, Haley, & Galbaud du Fort, 2005); sexual health risks (Public Health Agency of Canada, 2006), pregnancy (Haley, Roy, Leclerc, Boudreau, & Boivin, 2004; Weber, Boivin, Blais, Haley, & Roy, 2002); and survival or obligatory sex (Haley, Roy, Leclerc, Boudreau, & Boivin, 2004; Public Health Agency of Canada, 2006). Street involved youth are seen to be a population at risk requiring intervention to reduce risks while living on the street but also to assist them to successfully transition from the streets to more stable housing accommodations.

Youth who appear to have ended their street-involvement continue to pose challenges to the professional service community as more than 50% of street-involved youth reported a previous episode of street-involvement in a recent survey of 344 street youth in Calgary (Worthington & MacLaurin, 2008). Youth with repeated episodes of street involvement were identified as a population with increased risk (Worthington & MacLaurin, 2008). Further information is needed to understand the risk and protective factors associated with youth who become re-involved with the street following a period of stable housing.

This paper reports on findings from a study designed to examine youth with multiple episodes of street involvement in Calgary, Alberta. The study received funding from the Alberta Homelessness Research Consortium (AHRC)[1] Informed by previous research by Auerswald & Eyre, (2002) and Worthington & MacLaurin (2008), this community-based research partnership was designed to identify the risk and protective factors associated with recurrence of street involvement, and service approaches that are effective in maintaining housing and stability.

OVERVIEW OF THE RESEARCH LITERATURE

Street-involved youth are living on the streets of most Canadian cities. Despite an increase in the recognition of this social issue, the plight of street-involved youth is seen to worsen in Canada. Street-involved youth are generally defined as individuals who are 25 years of age or younger who are either runaway, homeless, or underhoused (i.e., living in temporary or unreliable housing). These youth may be described as the most street entrenched; however, recent evidence indicates that there are additional youth becoming involved in street life who are less recognized or understood, who have significant and specific risks, and who would benefit from prevention and support services. Recent definitions of street-involved youth have expanded on the runaway and homeless definition to include youth who are not living on the street but who experiment and engage in street-involved activities and identify with street culture and street peer groupings (Worthington, MacLaurin et al., 2008).

1 This research was supported by the Alberta Homelessness Research Consortium (AHRC) which is managed by the Alberta Secretariat for Action on Homelessness (ASAH) and funded by the Government of Alberta (GOA). The opinions of the authors found herein do not necessarily reflect those of the AHRC, the ASAH, or the GOA, and should in no way be construed as being either official or unofficial policy of the GOA or its agencies

Youth Street-involvement Compared to Adult Homelessness

Youth living on the street present as a unique service population in comparison to the adult homeless population. Homelessness for adults is described first and foremost as a housing and poverty issue, which establishes the context in which individual risk factors can trigger a homeless episode (Tutty et al. 2010). Four specific structural issues contribute to adult homelessness: (1) an increasing number of people are being priced out of the affordable housing market; (2) employment opportunities for those individuals with secondary education are dwindling; (3) institutional supports have been reduced for those people with severe mental health and addiction concerns; and (4) people are excluded from affordable housing due to racial, ethnic, and/or class discrimination (Burt 2001). Street-involved youth have experienced many of the same individual risk factors associated with the adult homeless population, including high rates of childhood maltreatment, child-welfare involvement, mental health concerns, incomplete education, and drug use; however, the factors that trigger their street involvement are different (Goering et al. 2002; Tutty et al. 2010; Worthington et al. 2008). Understanding the factors that contribute to the street youth trajectory is critical to understanding how best to serve this population at risk.

Risks Associated with Street Involvement

Street-involved youth experience a decrease in rights, opportunities, and social supports (Grover 2002; Worthington, MacLaurin, Huffey, Dittmann et al. 2008), which may exacerbate the risks associated with living on the streets. Street-involved youth are also at higher risk of developing mental-health problems, some of which can lead to suicide (Boivin, Roy, Hayel, and Galbaud du Fort 2005; Clatts, Goldsamt, Yi, and Gwadz, 2005); becoming involved in survival or obligatory sex (Haley, Roy, Leclerc et al. 2004b); developing physical health concerns including contracting sexually transmitted diseases (Public Health Agency of Canada 2006a); getting involved in criminal and delinquent activity (Baron 2006); using and abusing drugs (Roy, Haley, Leclerc et al. 2002); and simply not meeting their basic physical needs for food, clothing, and shelter (Dachner and Tarasuk 2002).

PERSPECTIVES ON STREET INVOLVED YOUTH

The lens or perspective with which we view street youth in Canada has a great impact on the way we respond to the needs of this population. The lens has shifted constantly over the past half century. Prior to the 1960s, youth on the street were seen as delinquents who were there as a result of their own individual pathology and deviant nature (Appathurai, 1987). This position shifted during the 1960s as the counter-culture movement saw an increased number of middle-class teens living on city streets. Factors related to the family and school were primary areas of concern in the literature on street youth in the 1970s, while maltreatment of children became a paramount concern for research and service delivery during the 1980s (McCormack, Janus, & Burgess, 1986). With the end of the 20th Century and the beginning of the 21st Century, structural factors now play an increasing role in understanding street youth. The increase in HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), chronic poverty, inadequate housing, unemployment or under-employment, deinstitutionalization, and the challenged and overworked systems of child welfare are all critical factors that impact street-involved youth in Canada (Kufeldt & Burrows, 1994; van der Ploeg & Scholte, 1997).

CLASSIFICATIONS OR TYPOLOGIES OF STREET INVOLVED YOUTH

A number of typologies have been developed in Canada and the United States over the past 30 years to help researchers and practitioners better understand the unique characteristics of youth who are involved in the street (Adlaf & Zdanowicz, 1999; Kufeldt & Nimmo, 1987; Kufeldt & Perry, 1989; Miller, Miller, Hoffman, & Duggan, 1980; Zilde & Cherry, 1992). Typologies generally include, but are not limited to, youth who experiment with street life by occasional running or truancy, children who run from home to escape maltreatment and harm, and those young people who have spent years living on the streets and are firmly entrenched in the street lifestyle or in the sex trade.

A recent ethnographic study based in San Francisco developed a life-cycle model that has proven to be useful in understanding the duration and range of street involvement that youth experience (Auerswald

& Eyre, 2002). This model proposes a series of stages that youth encounter on the street and includes an initial engagement in street life, a stage where youth become more comfortable with street life, and finally, periods of crisis during which some youth may transition off the street. A cyclical pattern is noted, however, in that many youth who exit the street may become re-involved. The model describes key influences at each stage, including street mentors who provide youth with basic street survival skills and assist in understanding the culture of street life (see Figure 1).

The Auerswald and Eyre (2002) life-cycle model assists practitioners and researchers in understanding the Canadian street-youth population and the specific risks that are associated with recurrence of homelessness. These classification systems consider pathways to the street, the frequency and duration of street involvement, the level of individual choice for being on the street, and options for leaving the street. While these classifications provide an understanding of the range of street-involved youth, further work is required to test these typologies in order to understand which children and youth are most at risk for repeated street involvement.

RESEARCH METHODOLOGY

The number of street-involved youth in Calgary increased over the past decade and current estimates suggest youth, between 14-25 years of age, make up a significant proportion of the total homeless population in this city (City of Calgary 2006; City of Calgary 2008; Calgary Homeless Foundation 2011). Street-involved youth frequently experience multiple episodes of street involvement as more than half of youth surveyed in Calgary had previously lived on the streets in other North American cities (Worthington, MacLaurin et al. 2008). Auerswald and Eyre's life-cycle model is useful in understanding the duration and range of street involvement that youth experience (Auerswald and Eyre 2002). This model identifies a cyclical pattern to youth street-involvement, highlighting how youth who exit the street may become re-involved over time. A primary goal for many street-youth service organizations is supporting youth to move to stable housing and it is critical to understand how best to help youth who have extricated themselves resist a return to the street. This study will examine the experience of youth who have become re-involved in street life and specifically examine:

1. risk and protective factors associated with recurrence of street involvement, and

2. service approaches that are effective in maintaining housing and stability.

Research Design

This study used community-based research principles to address this research that is guided by the needs of the service community. The research team involved academic and agency-based research members skilled in the design and implementation of qualitative research as well as street-outreach workers and managers with the substantive and practical knowledge about this population.

Sample

A purposive sample of 15 youth who were currently street involved and had a previous history of having lived on the streets were recruited from Exit Community Outreach Services in Calgary.

Interviews

Qualitative interviews were conducted as this methodology has proven to be appropriate with this population. Qualitative interviews enable the researcher to gather information about specific areas that require a deeper understanding, and probe and clarify areas that are difficult to capture on a survey instrument. Qualitative interviews are an appropriate data collection method when working with street-involved youth as they allow youth to tell their stories and guide the process without being confined by a set of fixed responses.

Semi-Structured Interview Guide

A semi-structured interview guide was developed by the Research Team and training was provided on the topics of in-depth interviews as well as the sample population. An initial set of questions was prepared by the Research Team during the project's initial phase. These questions were based upon literature findings and questions from previous street-involved youth studies that were meaningful for service providers. Two meetings occurred with the street outreach teams employed at Exit Outreach to discuss the project and the interview guide. This provided an opportunity to review and adapt questions to serve current practice perspectives.

Training

One Study Interviewer was used to conduct the qualitative interviews. A training review was provided on all components of the study. The Study Interviewer was a doctoral student at the Faculty of Social Work, University of Calgary, and had extensive experience working with street-involved youth as well as conducting qualitative interviews. The Study Interviewer had worked with the Study Team on two previous studies on youth homelessness and had participated in all previous training protocols. A review of the training protocols was completed to ensure the Interviewer was current with the process for the study.

Data Collection

Data was collected with in-depth interviews with a total of 15 youth recruited from Exit Community Outreach of Wood's Homes. Posters advertising the study were posted at Exit, and Community Outreach Workers assisted in providing background to the study as well as highlighting youth who had experienced repeated episodes of street-involvement. The Study Interviewer spent extended periods of time at Exit over a three-week period and approached street-involved youth and asked if they would be willing to participate in an interview about recurrence of homelessness. Snowball sampling was also used to supplement the purposive sampling: street-involved youth who completed interviews were asked to refer peers who might also be interested in participating in an interview. Interviews occurred at a private interview area in the agency where confidentiality was ensured and where agency safety protocols could be utilized. Participants received a $20.00 gift certificate for refreshments at Tim Hortons at the conclusion of the interview.

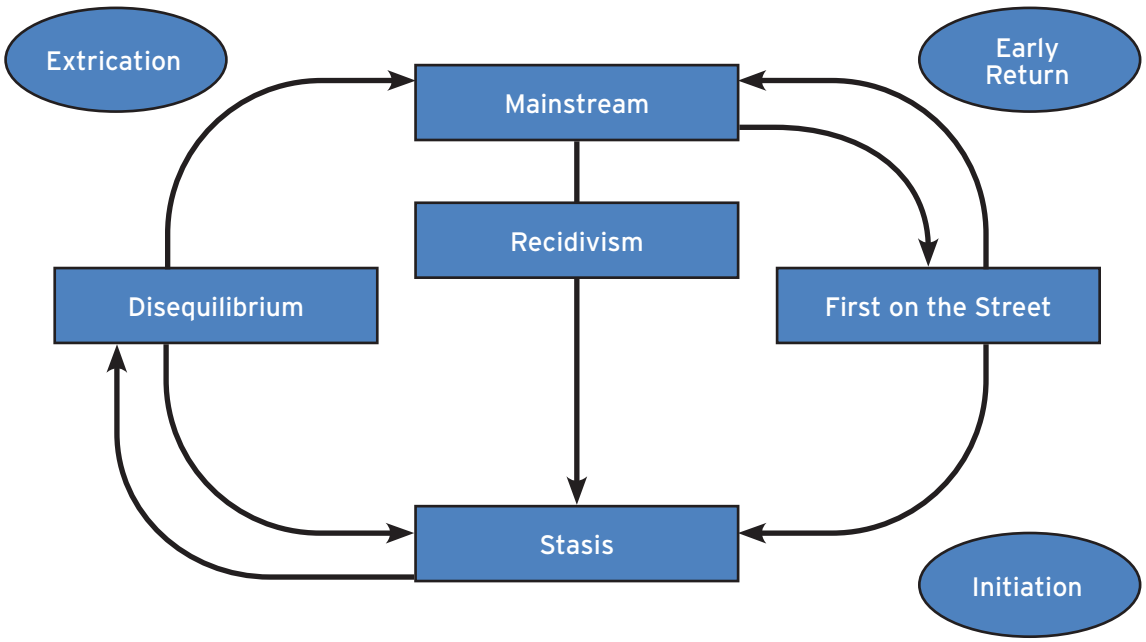
Transcription

All in-depth interviews were recorded on audiotape and then transcribed verbatim. Transcripts were forwarded to an experienced transcriptionist, and were reviewed for accuracy and completeness. During transcription, specific name and place references were replaced with pseudonyms or deleted. No identifying information was recorded on transcripts.

Data Analysis

Analysis of the qualitative data was conducted using ATLAS ti software by Scientific Software Development. Transcripts were imported into ATLAS ti for analysis. Preliminary thematic coding was completed on the qualitative data.

Figure 1: The Life Cycle Model of Youth Homelessness
(Auerswald & Eyre, 2002)



PRELIMINARY STUDY FINDINGS

Characteristics of Participants

In-depth interviews were conducted with 15 street-involved youth to gain insight into their experiences with repeated episodes of homelessness. Interview participants included those from primarily White or Aboriginal ethno-cultural backgrounds and ranged in age from mid-teens to mid-20s. A total of 10 males and 5 females were interviewed.

All young people who were interviewed confirmed that they had at least one previous episode of street involvement, and discussed patterns of movement on and off the streets in previous years. In these interviews, youth tended to focus on the time periods when they were most street-involved.

Family Life

Family structure and home life were identified by several youth as factors that prompted them to become first involved in the street as well as later episodes. The majority of the youth interviewed indicated that they had come from lone-parent families who had experienced divorce or separation, as well as blended families. First experiences of street-involvement included being asked to leave home due to their behaviour, being out of control, or in response to romantic relationships. One youth indicated that her first episode of homelessness occurred when she was 17 years of age, specifically: "Oh I was spending too much time at my boyfriend's house than I was at home so my mom decided to kick me out. ...she did the same thing and I told her no, I'm not going home... yeah, I'd had enough."

Violence within the family was a common theme for participants. Forms of violence included physical, sexual or emotional abuse, or living in homes with intimate partner violence. One female youth reported feeling like she could not trust men for an extended period of her life and these experiences had an impact upon how she interacted with others. A young person identified that some street-involved youth felt that the street was a better or safer option than home as he was in greater control of the chaos.

Alcohol and substance abuse were noted frequently for parental figures for youth who were interviewed. Early entry to drug use was not challenged by some parents as noted by one interviewee: "Well it was just me and my dad so, but he was always working and you know he drinks every day too and smokes pot, so I kinda grew up around that. So I started off with the pot and then stopped but then I would just drink and I'd get rowdy and he didn't like that much, so."

Families experienced complex and multi-layered concerns. Given the priority of family in the lives of street-involved youth however, it is critical that services support re-engagement with family members during the transition process from street-life.

Child Welfare Involvement

Most street-involved youth reported that they had been involved with child welfare services at various stages of their lives. Child welfare was frequently initiated to respond to family conflict and maltreatment initially however youth explained that their ongoing involvement was often because of their problem behaviour.

Child welfare involvement was frequently a response to extreme violence and abuse in the family that extended over years. One youth reported that child welfare first became involved with her family as a result of child physical abuse resulting in critical harm to a newborn: "Ah yeah, cause my stepdad beat up my sister when she was six months old... yeah, I was six. They put him in jail for like, I don't know, a month? He wasn't supposed to be staying with us when he got out but he was."

The majority of youth interviewed described child welfare experiences that reflected repeated involvement over time. Several identified that there was a lack of relationship with the investigating worker and they did not feel that they could work with these individuals. Interventions at home or in care were not viewed as being effective and youth felt they had little input or control over their lives while in care. Frequent turnover for child welfare staff reduced the chances of having the same worker for extended periods of time. One youth suggested that the child welfare experience would have been improved if workers would only call youth back on the same day so they could get a response. A general feeling among interview participants was that child welfare was not a high quality service for children and youth. Living in foster care or group care was seen as a supportive environment for

some youth. One young person said that after he was finished with addictions counselling, he would like to apply for a foster placement again as he appreciated the time spent in this home. When asked what was special about this home, the youth suggested it was as simple as "treat others the way that you want to be treated." Another youth found that a group care facility resembled a family environment and indicated: "But I liked it cause it felt kind of like a family, you know… like we'd go out and do normal things together and we'd sit and have dinner together and stuff. And make dinner like normal… all of us kids were there for a reason but we all got along pretty well. So it wasn't that bad."

Drug Use

Substance use was common among street-involved youth, and interview participants indicated that street drugs were available to everyone on the streets. While this was seen as a good thing for many youth, others, who identified that they were struggling with addictions, found that the street and shelter system challenged them to remain abstinent. Further, many youth who were interviewed knew where to get drugs and could identify which parts of Calgary or other Canadian cities catered to specific types of drug. One youth said "It was hard at first. I mean it's still hard cause like I have a hard time being in shelters cause I've an addiction, right and everybody there has like mentally something wrong or you know, an addiction. So I find it really hard and I find it hard to like get stable and stuff when I'm in a shelter and you know I'm dealing with an addiction as well."

The stories of several youth reflected an increasing and escalating trajectory of drug use over time. One youth reported that he experienced a wide range of drugs including alcohol, marijuana, prescription pills, and injection drug use. One youth reported that she had started injecting drugs as her boyfriend did it regularly.

Drug use is frequently reported to be an activity done by couples who are on the street or have moved to stable housing. There are challenges in serving youth in need when their partner or boyfriend/girlfriend is also involved in a drug lifestyle. One youth reported: "Both of us use, he uses a lot more than me, I think he's the one that needs rehab more than I do… but I'm making these steps for myself."

Another priority service is the connection of young people who are beginning the transition away from the street to available and appropriate addictions and counselling services.

Involvement in Relationships

The majority of respondents interviewed reported being involved in relationships while living on the street. Most of these relationships were with partners who were also homeless. Youth reported benefits and drawbacks to having a relationship with other homeless youth as they had lots of things in common, however this frequently led to trouble. One youth reported: "Depends on the situation because me and my ex, it just got really bad when we were homeless like we would just drink and do drugs and you know get in trouble. Like it was our intention to do things good but it was, we were just drinking so we could never do anything but now me and my boyfriend now, it's like we're actually trying."

Many youth reported that their street relationships resulted in pregnancies and the majority of children had been apprehended by child welfare or were living with family members in formal arrangements. One youth reported the anguish of not being able to see her child: "She won't let me… and my oldest is turning three this month. It's hard being away from them cause I'm used to seeing them and it's killing my boyfriend more than it is killing me."

Supports Away From the Streets

Youth on the street provide valuable social support to each other. This in itself may be a stumbling block however for transitioning away from street life. Being accepted by specific groups on the street was perceived to be a replacement for family and friends. Maintaining these meaningful connections and supports during a transition to stable housing poses other challenges. One youth was very clear in his response about the lure of street friends and family groups. He said: "Don't associate with other people. Like don't become friends with that scene because it just sucks you in. It's so much harder to get out if you know everybody. Like I go to the *XXXX* Program and like you know, I know almost everybody there and it's just really bad. It makes it harder because then they think that they're your friends and they just want to hang out with you during the day and you can't go and screw off and do your own thing, you know?

And you get sucked in. Obviously you get a few things done productively when you're by yourself, right?"

Youth identified benefits and drawbacks to cutting ties with their street friends. One person, speaking of his first rental apartment, identified that he had several friends from the street move in to help him with the many responsibilities of the apartment. This living arrangement was short-lived as he was asked to leave after one month. One youth stated: "Yah, well I told them if you're going to crash here, you guys better be cleaning up because I'll be supporting you, the roof, the food and the help... Yah, I wasn't ready and I still don't think I'm ready." At the same time, severing relationships with supports and friends from the street can create isolation for young people who have moved into a new housing arrangement. Not everyone is able to identify additional supports for themselves while living away from the streets. One youth responded to the question of: "Who would you invite over to your home first when you get stable housing" by saying perhaps her father who she had not seen for a long period. Her father did not know that she had been homeless for extended periods. She struggled in identifying other friends away from the streets that could come for a meal.

Transitions to School or Employment

Youth who have moved to stable housing are challenged to make a transition to employment or a return to school. One key challenge is moving to legal employment rather than earning money through illegal means, as well as the shift to a lower hourly wage for employment in the service industry. Youth identified that they sometimes felt stigmatized as a result of their homeless episodes. A female youth reported: "I usually work at like coffee shops cause I like talking with people and stuff... but I find it a lot harder to find a job right now because my phone got stolen a couple weeks ago and my boyfriend dropped his phone so now we both don't have phones and I put XXX Program's number on my resume, and you know, it just looks bad... and then like it's embarrassing cause I try and play it off like I'm not homeless. Cause I don't like to tell them. I hold it back cause people treat you differently. And I don't know, like I know I don't look homeless, so I don't even pull it off but if you know, they find out then it's like cause that's what happened with a job like last week she called here and found out I was homeless so yah she freaked out cause I said that this was my house phone."

Completing high school is a goal for many street-involved youth as this is seen as a way to get off the streets and improve their lives. Most of the youth interviewed had participated in some form of educational program while street involved. Youth described the benefits of educational programs that had flexible scheduling and structure, that supported working at their own speed. Regular attendance poses problems for many youth however. One youth reported that: "No I want to go back. I want to go back and just finish my GED. I don't have that. Yah, just cause I can do something with that. Cause I do want to go to school but yah... I mean I don't want to be homeless and be going to school and have nothing cause that would just be too hard. I can't sit there and study at a shelter with 300, 400 other people."

Services to Support Housing Stability

Younger youth who are transitioning off the street are seen to require significant levels of support to maintain the process. As well, the type of support should meet their current needs and stage in life. One youth reported that: "Um, I think, the younger people are sort of – you know a lot of us want to have our own place, right? I did end up getting my own place for a little bit, well, it wasn't really mine. What happened was they put me in a house with a little old lady... I wasn't there enough, that is why I lost the place, cause I was very uncomfortable, I mean. I think that happens to a lot of people to. A lot of the good young people anyways. And I understand that there is a lot of them who just end up partying and screwing up right, but I wasn't a partier, not really anyways."

Youth identified other ways to support themselves when getting off the streets and staying off the streets. Counselling services are not seen to work for everyone and alternative forms of supportive counse. ling are valued, and specifically natural supports. A youth reported: "What used to be now a days, you know I've realized this in the past... is that you know when I was well, I can say three, four years ago, I just wanted to party and everybody said you need counselling, you need counselling. But you know if the other person doesn't want to talk about his problem with an adult because he hears it every day. He really wants to talk to somebody like not another youth but like another younger generation that they could have like an older brother to look up to. Like a role model like that. Someone young that they can talk to, joke around with, and take them out for coffee, a movie."

CONCLUSIONS

This article highlights results from a community-based research study that incorporated information from 15 in-depth interviews with youth on factors associated with recurrence of street involvement as well as services that impact upon housing stability. These results provide a snapshot of the lives of street youth within the Calgary community, and point to areas where further work can be done to support the process of leaving the streets and achieving success with stable housing. The street youth involved in the study openly shared their experiences and stories, and the hope is that these data will contribute to a better understanding of the complexity of their lives, their strengths and challenges, and ways in which services could serve them better. Street-involved youth are a diverse, marginalized population facing multiple challenges and insufficient and fragmented support from institutions and services. Ongoing community discussion, research and planning are required to better meet the needs of street-involved youth in Calgary. This research forms a strong foundation on which to base a larger mixed-method study on this population.

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A Shift to an Evidence-Informed Approach to Practice

LUC WITTIG & BRUCE MACLAURIN

INTRODUCTION

There has been growing movement in recent years towards an evidence-based orientation to practice in human service organizations across North America (Aarons, 2004). Evidence-based practices, or EBP, are those specific clinical approaches that have been methodically developed and tested through research and clinical consensus and are primarily driven by the results of the research (Willenbring et al., 2004). These practices are traditionally considered to be superior to those without a strong research foundation. Using a therapy based in evidence and research supports confidence in the value and benefit of clinical services. On the other hand, when clinical approaches do not have a strong evidence base, questions are raised about what factors inform decisions or the direction of practice, and whether optimum outcomes can be achieved. Most organizations do not embrace a pure evidence-based approach as this would require blind clinical trials using treatment and control groups. Rather, an emphasis is placed upon evidence-informed practices, or EIP. These clinical approaches are those that are strongly influenced by evidence and the results of the research that has been done with similar client groups.

Wood's Homes has embraced an evidence-informed orientation to practice over the past two decades as demonstrated by the specific clinical models for each programs along with the outcome measures and indicators used to measure meaningful clinical change. Evidence informed practice is prioritized at Wood's Homes as demonstrated by the use of evidence and outcomes to inform decisions on program development, program reorientation, as well as program closure (Matheson, 2014). Evidence-informed practice was not always standardized at Wood's Homes, nor did this transformation occur quickly. Matheson (2014) highlighted that this change was a continuous process that occurred over time. It began with recording, monitoring and documenting events and critical incidents that raised clinical questions, and highlighted actual versus preferred outcomes. Continued success with addressing these practice topics led to the development of a research department that serves as the foundation of the current research department.

There is benefit in understanding the factors that impact upon an organization's interest in and ability to embrace an evidence-informed orientation to practice. A review of the literature was conducted to determine current knowledge. Following the initial introduction of EBP to the social service sector in the 1980s, there has been an increasing knowledge base demonstrating the relative merits of evidence-informed practice (Cooper et al., 2008), however relatively few studies have investigated the attitudes about EIP held by those conducting practice. The literature review used a keyword directed search, focusing on evidence-based practice, attitudes, barriers, social services, social work, and psychology among others. Articles identified and used were strictly those relating to the human social service sector. Those relating to evidence-based practices in medicine, pharmaceuticals, education and other similar non-social service fields were excluded. A total of 22 relevant articles were identified through this method. Results and evidence presented in each piece of literature were analyzed and compared to each other to create accurate themes. A complete summary of each article was created in the form of a literature review table (Wittig, 2015). The review highlighted that attitudes towards evidence-informed practice are complex and multi-faceted. Key themes were identified and aggregated into domains reflective of staff characteristics, agency characteristics, and perceived barriers.

STAFF CHARACTERISTICS

A handful of studies examined had been completed on the topic of personal characteristics in association with EIP attitudes, and these particular publications highlighted key trends. For example, multiple studies reported that the longer an individual holds the same position, the less value they assign to EIP.

Although the exact reason for the trend is unknown, it has been suggested that those that have maintained the same position for long periods of time are more established in their ways of doing things, and are less receptive to the idea of change and adaptation which are necessities for the implementation of EIP (Cooper et al., 2008; Stahmer & Aarons, 2009). Unexpectedly it was also discovered that age on its own has no association with attitudes towards EIP (Nakamura et al., 2011). Numerous sources also suggested an implication of education with attitudes towards EIP (Aarons, 2004; Aarons, 2006; Aarons & Sawitzky, 2006). It was found that the more highly educated an individual is the more likely this person is going to have positive attitudes towards EIP (Aarons, 2004; Aarons, 2006; Aarons & Sawitzky, 2006). Furthermore, one study proposed that interns were a group most open to EIP which may be related to their higher levels of education but lower levels of experience (Aarons, 2004). The association between gender and EIP has been examined but is not clearly understood. A lone study suggested that men are more likely to support evidence-informed treatments then women, and men are more likely to seek out and use published sources to influence treatment choices (Aarons & Sawitzky, 2006), whereas a second study found that EIP are of more interest to females then males (Aarons, 2006). Ethnicity was found to play an insignificant role in influencing practitioner attitudes towards EIP (Stahmer & Aarons, 2009). This literature review also revealed that an individual's position has an influence on their views of EIP (Stahmer & Aarons, 2009). Once again this association is not well understood, but one study found that managers and supervisors show less appeal towards EIP while still understanding their importance (Aarons, 2004). More research is required to clarify this trend completely. Finally, it was reported that individuals who have previously used an EIP with positive results are more open to using an evidence-informed practice in the future compared to those who have not (Aarons & Palinkas, 2007).

AGENCY CHARACTERISTICS

This literature review identified that corporate work environment plays an important role in influencing service providers' attitudes towards EIP. Clinicians are more likely to have positive views towards EIP if they have organizational support, and if they are working closely with supervisors that are current with modern EIP techniques (Aarons & Palinkas, 2007). Agencies with less stressful and more engaging working environments have been found to have staff with more positive beliefs toward EIP (Aarons, et al., 2012). Along with this trend, low levels of corporate bureaucracy have also been shown to increase worker receptivity to EIP within these work environments (Aarons, 2004). A relationship between agencies with strong transformational leaders and positive views of EIP was reported (Aarons, 2006). This leadership style strives to promote innovation, intellectual curiosity, and learning, while motivating followers to go above and beyond expectations. Furthermore followers of this kind of leadership style are frequently evaluated qualitatively on their work as opposed to quantitatively (Aarons & Sommerfeld, 2012). Aarons (2006) also reported that organizations that reflected more transactional leadership styles were associated with staff groups that were less open to EIP. Characteristics of transactional leadership style noted in this article included situations that promoted specific goals, and where staff were evaluated on unchanging predetermined criteria (Aarons, 2006). Furthermore it was found that supportive, innovative, and constructive working environments promote positive EIP views, whereas poor organizational climates (reflective of depersonalization, emotional exhaustion and role conflict) are found to create a corporate environment that promotes negative views towards EIP (Aarons & Sawitzky, 2006). Other work reported that agencies which promoted clinician competency and the expectation that clinicians put the needs of the client first had higher rates of approval towards and use of EIP by the staff working in these work settings (Aarons, 2009).

PERCEIVED BARRIERS

A final theme identified in the review of the literature was the perceived barriers of EIP. Several studies found that many service providers felt EIP was too rigid and unyielding in structure, and left little room for their own personal experiences, expertise, and judgment (Bellamy, Bledsoe, & Traube, 2006; Willenbring et al., 2004). Specifically, up to 45% of service providers felt that their own experiences are more valid and applicable than random controlled studies (Willenbring et al., 2004). It was also discovered that numerous studies cited lack of knowledge and training as a major obstacle to the widespread use of EIP (Nelson, Steele, & Mize, 2006; Willenbring et al., 2004), along with lack of administrative support

(Barratt, 2003). Time restraints associated with EIP was also a heavily cited barrier by service providers (Barratt, 2003; Bellamy, Bledsoe, & Traube, 2006). As most service providers are inadequately trained in EIP, numerous comprehensive and time consuming trainings were required (Bellamy, Bledsoe, & Traube, 2006). Even after staff were properly trained, it was reported that they needed to learn how to apply EBP into daily work which initially resulted in less efficient use of work hours (Nelson, Steele, & Mize, 2006). Additionally, many service providers reported that EIP was intrinsically more time consuming given the need to stay current with applicable research literature (Bellamy, Bledsoe, & Traube, 2006). Moreover, the inability or unwillingness to contribute to the current research body was cited as a reason that many service providers chose to forgo EIP (Bellamy, Bledsoe, & Traube, 2006). Only one-third felt their contribution to research could benefit service delivery, and even less had interest in completing clinical research (Rous & Clark, 2011). Another identified theme was concern for the lack of standardized monitoring systems, and the absence of a strict treatment evaluation guideline (Barratt, 2003). Specifically people reported concern with the various definitions of EIP and recommended higher rates of EIP implementation would occur if there was a governing body overseeing categorizations of EIP and EBP (Barratt, 2003). Related to this was the need for further knowledge and understanding about EIP (Aarons, 2004), and one study found that up to half of service providers did clearly understand what EIP was (Willenbring et al., 2004). Some have suggested that there is non-consensus as to what should be classified as evidence in EIP (Rubin & Parrish, 2007).

CONCLUSION

It is well known that individuals will work in a way that reflects what they believe (Aarons & Palinkas, 2007). Clearly this poses a challenge when contemplating or initiating a transition to an evidence-informed orientation to practice, as beliefs are complex, well-ingrained, and multi-faceted. As well, no clear pathway or direction has been identified, as the research literature on attitudes to EIP is foundational and identifies many areas for future research to clarify competing findings. The research does however, suggest factors to be considered when planning a transition to EIP. The literature indicated: 1) young age or lack of experience may be an asset when planning to implement or promote an evidence-informed orientation; 2) leadership style is a critical factor when deciding who should be promoted to positions of authority during a period of change; 3) evidence informed practice is dynamic and ever changing requiring practitioners to keep current with research to inform and adapt clinical approaches; and 4) keeping current requires an investment in time and effort.

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Wood's Homes Outcomes Measurement (WHOM)

BRUCE MACLAURIN, DANIELA NAVIA, JANE MATHESON & BJORN JOHANSSON

INTRODUCTION

There is agreement that all children and youth deserve timely access to effective resources to promote optimal mental health and well being in Canadian jurisdictions (Office of the Provincial Advocate for Children and Youth For Ontario, 2011; Government of Alberta 2008). The question of how well children and families are served by systems of care however has historically been overshadowed by the urgency to help children at risk (Trocmé, MacLaurin, & Fallon, 2000). Over the past two decades, there has been growing agreement on the value of measuring outcomes for children and

youth experiencing mental health issues (Barwich, Boydell, Cunningham and Ferguson, 2004: Epstein, Kutash & Duchnowski, 2005). There are growing examples of social service organizations taking up this challenge in a meaningful manner in Canada. This paper reports on the development of an outcome measurement framework at Wood's Homes, a non-profit organization offering a broad spectrum of child and family mental health services in Calgary.

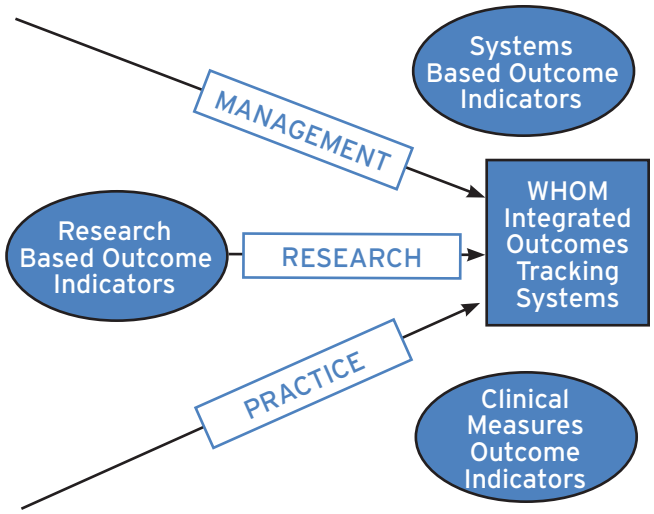
WOOD'S HOMES

Wood's Homes is a large non-profit children's mental health centre based in Calgary, Alberta. Founded in 1914, the organization now has a staff group of more than 450 who are involved in the delivery of 40+ programs and services for at-risk children, youth and their families. The spectrum of services includes campus based, special education, community-based and clinical and crisis counselling. Wood's Homes Research Department is active in conducting research and evaluation as well as academic collaborations on funded projects. The organization has consistently been recognized by Accreditation Canada for its quality service and attention to outcome measurement. Wood's Homes has tracked outcomes for children and youth involved with their spectrum of mental health services for more than two decades (Matheson, 2014; Kontrimas, 2014). This inquiry has been driven by specific practice questions and resulted in a significant body of evidence and capacity for evaluative research.

DEVELOPMENT OF WOOD'S HOMES OUTCOME MEASUREMENT (WHOM)

In 2011, the Wood's Research Department initiated the Wood's Homes Outcome Measurement (WHOM) framework, building upon the foundational model of the National Child Welfare Outcomes Indicator Matrix (NOM), a framework for tracking outcomes for children, youth and families involved in child welfare (Trocmé, MacLaurin, & Fallon, 2000; Trocmé et al., 2009). The NOM framework used four outcome domains; child safety, child well-being, permanence and family and community support. A total of 10 outcome indicators were chosen based on information that could be documented using available systems- based client data. During the initial development of NOM, the need for an incremental outcomes development strategy was identified specifically to address the differing uses of outcome measurement for managers and clinicians. The three elements of this strategy adapted for WHOM included 1) systems-based outcome indicators; 2) clinical outcome-based approach using measures for clinical practice; and 3) research-based outcomes. These three elements were proposed to provide an integrated outcomes tracking system (see Figure 1).

Figure 1 - An Incremental Multi-Level Outcomes Approach *(Adapted from Trocmé, MacLaurin & Fallon, 2000)*



WHOM OUTCOME DOMAINS AND INDICATORS

Wood's Homes tracks outcomes on the range of campus based, special education, community-based and clinical services using the established outcome domains related to child safety, child well-being, permanence and family and community support. Select outcome indicators were developed for each domain that can be tracked by all programs and services. As well, additional outcome indicators were developed or adapted to specific program areas based on the context of their interventions with families. All indicators are designed to report on the percentage or rate of children and youth experiencing the specific indicator within the reporting year to allow consistent comparison with the program from year to year. The Wood's Homes data information system is used as the primary source of data for the majority of indicators.

For example, within the safety domain there is a wide range of outcome indicators designed to measure the risks and strengths associated with the safety of the child or youth. Safety indicators include violent

events, running away, disclosures and allegations of abuse or neglect, bullying, injury or accidents, criminal justice involvement or substance use within the program. All safety indicators report on the total number of events as well as the percentage of clients involved in the specific event. For the child well-being domain, outcome indicators include improvement in behavioural functioning, improvement in school behaviour as well as attendance, graduation, and finding employment. The permanence domain reports on indicators including the rate of clients who return or remain in the home, clients who transition to less intrusive levels of placement, unplanned discharges and follow-up after discharge. The family and community support domain includes indicators related to the rate of clients who have contact involving the program and their families (including visits between the program and the families, and telephone contact), improvement in family capacity, community referrals, involvement in cultural placements and programming, and client, family and caseworker satisfaction results.

As illustrated in Figure 1, there is value in an outcomes-based case planning approach using measures for clinical practice in addition to tracking systems-based outcome indicators. A range of clinical measurements are utilized to report on progress at an individual level in addition to being reported at an aggregate program, service group or agency level. Clinical measurement tools include Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), Ages and Stages Questionnaire (ASQ), Strengths and Difficulties Questionnaire (SDQ), Family Assessment Form (FAF), Family Adaptability and Cohesion Evaluation Scale (FACES) and Parenting Relationship Questionnaire (PRQ). The CAFAS is a widely-used assessment scale designed to measure the degree of functional impairment among children and youth ages 6 to 17 with emotional, behavioural or substance use symptoms and disorders (Hodges, 1989). PECFAS, an adapted form of the CAFAS specifically for children younger than 7 is also used to determine rate of improvement in behavioural functioning (Hodges, 1994). The ASQ, a parent completed age-specific questionnaire designed to assess the development of children from 4 to 60 months of age (Squire, Potter and Bricker, 1999). For older clients, the SDQ, a brief questionnaire developed by Goodman (1997) is used to capture parental, child or teacher perceptions of negative and positive behavioural attributes of the child and the impact of interventions on their perceptions (1997). The FAF is used as a measure of family functioning and an outcome measure. The FAF is multi-dimensional practice based instrument used to identify strengths and problem areas in family functioning, and to influence service planning based on family outcomes (McCroskey and Meezan, 1997). As an alternative to the FAF, the FACES II is a self report assessment of family functioning and cohesion utilized by programs with less intensive family involvement (Olson, Portner & Bell, 1982). Lastly, the PRQ is also used as an assessment of family and parenting relationships to showcase potential areas of focus for clinical work and as an outcome measure (Kamphaus and Frick, 2005). All of these measures are investigated, then implemented and tested for applicability with all programs. The CAFAS tool for example has stood the test of time and is able to be used to measure change for children and youth, and is easily trained to and understood by front-line staff. This latter aspect is a critical element of the outcomes work being conducted at Wood's Homes.

CONCLUSIONS

The Wood's Homes Outcome Measurement is a step towards developing valid and reliable outcome measures for children and youth served in a spectrum of services for children and youth. This framework will establish a foundation on which to base decisions for children and youth experiencing mental health concerns as well as provide evidence regarding which interventions are most useful for which populations, for what presenting concerns, and for what duration.

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Practice Lessons: Story #56A

SUE MCINTYRE

Laura was a high-spirited young woman who came to Wood's. I was the intake co-ordinator at that time and the senior therapist. Her parents called and were very concerned about her. She was the kind of kid everyone enjoyed, but at the same time could make you crazy. She attracted kids around her. When she was at the Parkdale Campus she would stir things up, and then when she was at Bowness Campus, she would stir things up there. Though she was a ward of the court, her family was very involved and very concerned about her.

I became her therapist. She was always teetering on the edge of things, but there was never any clarity about what was up with her. One minute she was doing really well in school, and then suddenly she would be getting everyone going at the cottage and encouraging kids to lock the doors on staff. Her behaviour

became more and more worrisome. We wondered if perhaps there was some kind of disorder and had her assessed – but nothing. She started to drift further and further away from Wood's and began spending time downtown. At first she was just on the fringe of things, and then she was in the sex trade. But, she would always come back to Wood's.

There were always people who were trying to find out what the thing was about her that made her push the envelope. And it was especially difficult, because everyone really liked this kid. Even the youth court judges liked her. People became more and more concerned.

I thought, we have to try something really different with her. So we created this character, Miss Adventure. The idea of Miss Adventure was that it was a tool for talking about what would come over Laura. And it was a way of talking about that behaviour separately – it meant that Miss Adventure was the bad one, not Laura.

Laura always had an edge. There was a time when she ate nails for instance. Another time, I remember going to a huge conference downtown and seeing her on the floor of the building, exhausted and sleeping – it was the building where her mom worked. Then Laura would come back and say, "I'm not going to do this anymore." So we would take her Miss Adventure's clothes out and bury them.

She would often come to my office with a knapsack on her back. I would have to look in it. Sometimes there was a cat; sometimes there was a dog. There were rabbits sometimes. Harold, who was in charge of maintenance, built a pen for the rabbits because Laura would always come back for the rabbits.

This was a difficult time for the staff. Laura knew that she was at risk. She knew that.

And then Miss Adventure disappeared for a long time. She was at CYOC (Calgary Young Offender Centre) for a while, but she would still communicate with people at Wood's, phone them, connect with them. She was released from CYOC to a group home, and there was some trouble. While she was at this particular group home, she was supposed to be there at eleven, and she wasn't one evening, so they locked her out. She headed downtown and was murdered that night.

Everyone was devastated. The funeral was a big event. Many, many people were there, including many of the people she knew from the street. The hardest lunch I ever had was with her mother after that. She asked me if Laura knew this could happen. And I said yes.

The events leading to her death broke a lot of barriers. They forced people to look at street kids in the sex trade differently. The events were instrumental in the development of EXIT, because if EXIT had been there, we could have got her safe. For a long time her mother sat on the advisory committee.

A marker devoted to Miss Adventure was placed out in the woods west of the Bowness Campus. As far as I know, it is still there today. *

** Editorial note: the marker is still there – located on the west side of Wood's Homes Bowness Campus. A photograph of Miss Adventure's marker is shown above. This story was previously published as Story #56a in One Hundred Stories for One Hundred Years, released in 2013. The story was reprinted with permission and the support of Clem Martini, the Editor of this book. The book citation follows:*

REFERENCE

Martini, C., (2013) One hundred stories for one hundred years: A history of Wood's Homes as told by the people who lived and worked there. Edmonton: Brush Education Ltd.

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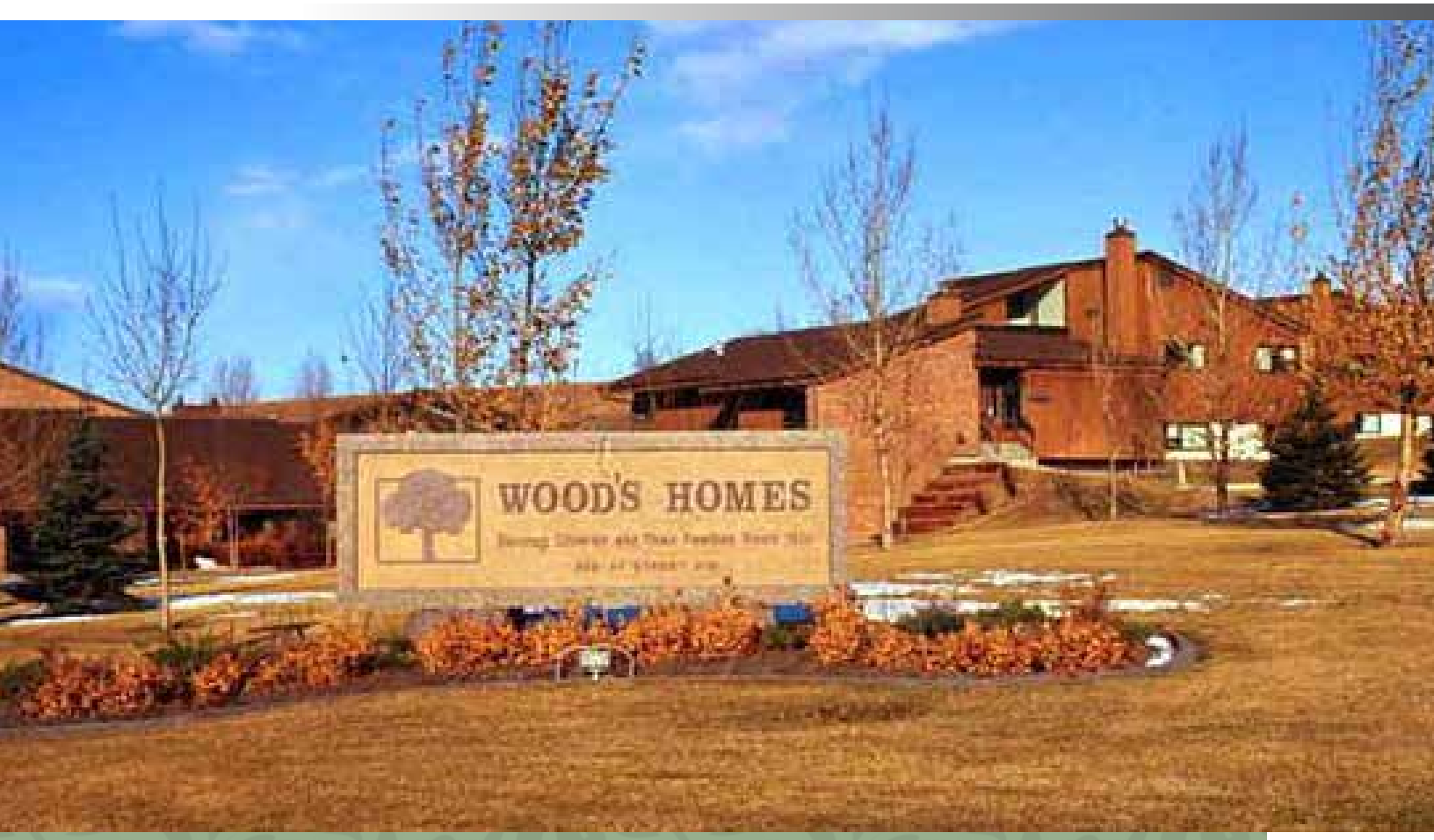

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