Sometimes the most interesting findings a research project can yield do not lie within the outcomes that it produces, but in the investigation process itself. Although launched with the single purpose of conducting an evaluation for Wediko Children’s Services of its short-term residential program, this research project bore products that would be of interest to a larger population of program evaluators/field-based researchers. This is an evaluation effort told in three parts. In the first part, an outcomes study of a subpopulation of Wediko’s program participants (children who attended the program and reapplied one year later) is described. Additional levels of analyses were conducted in an effort to explicate process issues that arose during the proposal, data collection, and statistical analysis phases of the study. These analyses, explained in the second part, yielded the identification of barriers that arose during this study’s undertaking and recommendations to the agency under evaluation on how to begin to implement strategies to improve its quality assurance practices. In the third part, the author’s responses to the project and a collection of valuable lessons learned on the subject of program evaluation/field-based research are described; one being that you should never underestimate the value of simply asking questions!
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INTRODUCTION

Although people have always been driven to assess and evaluate their actions, the process of such evaluative efforts often goes unexamined. Sometimes the most fascinating aspects of a research project can be found within the process itself, not within the outcomes that it produces. This study grew out of the researcher’s interest in conducting an evaluation of Wediko Children’s Services’ Summer Program, a short-term residential program for children and adolescents with a variety of emotional and behavioral disturbances. The results and experience of this effort will be described in three sections.

Section one includes a review of the literature on program evaluation, a description of Wediko’s summer program, and an outcomes study, including statistical analyses conducted to determine if and how the children and adolescents presented differently to their parents and caregivers one year post-treatment. Section two and three are comprised of additional levels of analyses that were conducted in an effort to explicate process issues that arose during the proposal, data collection, and statistical analysis phases of the study.

In the second section of the paper, the author describes the process of the evaluation study. This includes the identification of barriers that arose during this study’s undertaking and recommendations to the agency under evaluation on how to begin to implement strategies to improve its quality assurance practices.

The third section of the paper consists of a “narrative” evaluation. In this section are the author’s responses to this project and the presentation of lessons that are more immediately applicable to program evaluators/field-based researchers.

Program Evaluation and Residential Treatment

Only through the analysis of their impact can residential programs develop and refine the effective elements of their treatment (Verhagen, 1995). Beyond that of establishing treatment effects, program evaluation findings can serve a number of important functions. They can be used to attract funding, support accreditation and licensing needs, act as reinforcement for stakeholders and treatment staff, and aid in program promotion (Nansel et al., 1998). Evaluation findings can aid in policy development, provide accountability, and assist in program-related decision-making
(Kettner & Daley, 1988). Furthermore, as managed care models continue to expand into the mental health arena, they will likely limit their service providers to those agencies that are able to demonstrate treatment effectiveness (Nansel et al., 1998). Agencies unable to do so can suffer financial repercussions and fail to survive in a health system dominated by managed care (Hicks, 1989).

Despite the advantages of performing evaluations, many residential programs fail to conduct outcome research. Larzelere et al. (2001) speculated that residential treatment centers have minimal interest in providing evidence of program effectiveness because they traditionally receive secure funding and have no external need for demonstrating accountability. Bourque, Bradshaw and LeBlanc (1995) offered another explanation for the widespread failure of agencies to evaluate their programs. They argued that many residential centers feel threatened by program evaluation and fear what they might uncover.

Whatever the reason, numerous programs across the country neglect to conduct program evaluations. Nansel et al. (1998) found that only 65% of residential centers for youth with behavioral disorders \((n = 93)\) were conducting any form of outcome investigation. Thirty-four percent of those agencies reported that conducting program evaluations was externally mandated. That means that only 21 of the 93 programs that were sampled conducted evaluations without external pressure.

Program directors often identify a shortage of resources as the primary obstacle preventing their agencies from conducting evaluations (Pfeiffer, 1989). An experienced staff, sufficient time, and adequate research facilities and equipment are often in short supply. Pfeiffer, Burd, and Wright (1992) found that 89% of clinicians who worked at residential treatment centers \((n = 273)\) indicated that there was insufficient time to conduct any kind of research endeavor. Seventy-seven percent cited a lack of funding as a chief reason for failing to incorporate research efforts into their job responsibilities.

Pfeiffer et al. (1992) also found that only 11% of psychologists, psychiatrists and social workers working in residential treatment centers reported that research of any kind was a required part of their job, and 82% reported a lack of internal funding for research at those sites. Forty-eight percent of the sample, however, indicated that as students they
anticipated integrating some type of research into their careers after completing their graduate studies.

Individuals who work in the residential field must do so despite a scarcity of training, time and resources. Direct care workers typically lack proficiency in program evaluation methodology. Even if residential staff members were competent in evaluation procedures, their clinical responsibilities often leave them overworked and underpaid. The resources and equipment (i.e., computers and statistical analysis software packages) upon which researchers commonly rely in their evaluation endeavors often are limited or nonexistent in residential settings.

The obstacles that program directors and clinicians claim are preventing them from conducting program evaluations are compelling. However, even if the commonly cited barriers ceased to exist—if staff had undergone the required training, if time were abundant, and if the resources were available—it remains unlikely that many of the residential programs that are not already conducting forms of evaluation would initiate the endeavor.

Many residential agencies greatly underestimate the value of program evaluation. All of the reasons that programs indicate for why they fail to conduct evaluations are symptoms of this indifference. If the programs that presently fail to conduct evaluations truly appreciated the practice, they would prioritize it by building the objective into their funding models, or by exploring partnerships with universities (Pfeiffer, Burd, & Wright, 1992). With such partnerships, graduate students make perfect candidates for the job of evaluation consultation. Students can obtain the necessary experience and data for Master’s or dissertation level projects, and the agencies receive valuable information about which active treatment ingredients are working and which require further development—all despite a program’s limited resources.

Effectiveness of Residential Treatment

Historically, the majority of empirical studies on child mental-health services have focused on outpatient therapy, with relatively less attention paid to residential treatment (Curry, 1995). Prior research reviews of traditional residential treatment centers, however, indicate that only a few studies provide evidence for their success (Bates, English, & Koudou-Giles, 1997; Pfeiffer & Strzelecki, 1990). Research by
Larzelere et al. (2001) suggests that traditional residential treatment centers may be adequate in treating severely disturbed children and preparing them to return to less restrictive settings. However, evidence within the literature is inconsistent.

Research on outcome trajectories in traditional residential treatment suggests that the effectiveness of programs may be restricted to the reduction of risk behaviors and depression and the enhanced management of psychosis (Lyons et al., 2001). Findings from this same study suggest that residential treatment centers unintentionally may promote maladaptive behaviors like anxiety and hyperactivity.

Asarnow, Aoki and Elson (1996) recommended a “career” view of services for children with serious emotional and behavioral problems. They found that after being discharged from residential treatment centers, 32% of children re-entered out-of-home placements by the end of the first year, 53% by the end of the second year, and 59% by the end of the third year. Additionally, 82% of the sample population required special education services, and 57% required outpatient mental health services following discharge. This means that a single, intensive intervention—like a summer treatment program—is rarely sufficient in meeting the needs of children who require residential care of any kind. Is does not, however, suggest that single, intensive interventions are always inadequate.

Evidence exists to suggest that single, intensive interventions can be effective with both out-patient and in-patient approaches to services. Multisystemic therapy (MST), for example, which relies on a “home-based model of service,” is limited in duration and routinely lasts for only four to six months (Sheidow, Henggeler, & Schoenwald, 2003, p. 310). Henggeler, Melton, and Smith (1992) demonstrated that MST has the potential to serve as an effective alternative to incarceration for a sample ($N = 84$) of juvenile offenders by reducing recidivism by 43% and out-of-home placement by 64% at the 59-week follow-up.

Research on outpatient therapy historically has taken precedence over research on traditional forms of residential treatment, and research on traditional forms of residential treatment has taken precedence over research on intensive summer treatment programs. Comprehensive evaluations of intensive summer treatment programs and recreational programs are almost nonexistent in the research literature (Marx, 1988;
Michalski, Mishna, Worthington, & Cummings, 2003). The few published evaluations that do exist, however, are promising.

Pelham et al. (2000) reported that children who attended intensive summer treatment programs in conjunction with proper medication were significantly better at rule following, good sportsmanship, peer negative nominations, and summer program teacher post-treatment ratings of inattention/over-activity than children who only received behavior modification treatment. However, almost all children in both conditions were rated as improved and all parents perceived treatment as beneficial.

Michalski et al. (2003) found that children and adolescents who attended a summer camp for youth with a variety of psychosocial problems reported less social isolation, experienced modest improvements in self-esteem, and expressed high levels of satisfaction with their experience. Although measures for social skills did not significantly differ from those of pre-treatment at the six to eight month follow-up, parents reported improvements in child cooperation, responsibility, and self-control.

Although existing studies on the effects of intensive, summer-treatment programs are promising, deficits within the research literature exist. Historically, evaluations of summer treatment facilities have relied on self-reports of program staff, graduates, and parents/primary caregivers (Bidgood & Pancer, 2001). Few evaluations have measured the long-term effects of intensive, summer-program treatment. As a result, there is a shortage of—and a significant need for—long term, multi-dimensional evidence to support summer residential treatment for youth.

Reasons for this Study

The motivation for this study developed as a result of the program’s adherence to a fixed-time admission/termination model, the agency’s use of comprehensive assessment during the application process, and the researcher’s interest in the program’s treatment model.

Every child and adolescent who participates in Wediko’s summer program is involved in a fixed-time admission/termination experience, which allows the composition of each group to remain constant—significantly reducing confounds that occur with a changing staff or peer group (Parad, 1983). Furthermore, staff members work all shifts. As a result, maximum consistency of clinical interventions is achieved (Parad, 1983).
Because data on children who participated in the program was obtainable through the analysis of information completed by parents during the application process, further reliance on parental involvement was unnecessary. Because a reliance on parental involvement for research purposes is often met with a variety of obstacles, including illiteracy, transportation limitations, apathetic attitudes about the program undergoing the evaluation, and a lack of understanding of how contributing to evaluation-related research can benefit the program (Ogles & Owens, 2004), avoiding ongoing dependence was a goal.

Many of the programs that do manage to engage in some form of evaluation often fail to collect any preadmission information. As a result, these agencies are unable to establish baseline measures of individual strengths or problem behavior (Pfeiffer, 1989). Furthermore, many programs fail to conduct long-term follow-up. It is imperative to do so because behavioral changes at the time of discharge cannot be used to accurately predict post-treatment functioning (Levine, Toro, & Perkins, 1993; Curry, 1995).

Fortunately, Wediko collects a considerable amount of data on each child during the application process. The preadmission questionnaire is completed by parents, teachers, and therapists and includes items on demographics, history of problem behaviors, history of services, family stressors, child strengths, risk factors, behavioral descriptions, and current goals. This extensive—and highly valuable—collection of information is used to maximize the clinical impact of every child’s stay at Wediko (i.e., in the assignment of child to living group, and in the development of treatment goals and strategies that are unique to each child).

The application process begins with an extensive assessment of each child. The agency’s first objective is to establish whether or not the characteristics of the applicant are consistent with Wediko’s therapeutic/educational methodology (Botman & Leichtman, 2001). Specifically, Wediko reviews the educational, mental health, and medical records within the application materials to learn about each child’s developmental, educational, and social history (Botman & Leichtman, 2001). Descriptions about each child’s current functioning are embedded within the application materials in the form of a questionnaire. This questionnaire contains items created by the agency that are completed by the child's family, school and, if applicable,
therapist (Botman & Leichtman, 2001). Clinical staff from the agency conducts structured interviews with each applicant and his or her family to learn about the context in which the child lives. This information, combined with the data pulled from the questionnaire, is used to develop a case conceptualization, determine acceptance or denial, and if accepted, used to create a treatment plan (Botman & Leichtman, 2001).

An initial objective of this study was to utilize existing forms of data collection in an effort to assist Wediko in their future evaluation efforts. Specifically, the researcher believed that by modifying existing programmatic functions rather than relying on completely novel strategies for collecting data, the agency would be more likely to continue engaging in evaluation practices in the future. For this reason, the study took advantage of the extensive assessment tools that Wediko currently employs for clinical purposes and utilized them as a means by which to collect data on program participants.

Such an approach is practical and provides insight into how parents and caregivers perceive the children who attend the program. These individuals can accurately determine what is characteristic and what is unusual behavior for their child. Additionally, because a child’s emotional and behavioral problems are often at their worst during unstructured times, parents and caregivers are privy to behaviors with which other observers (e.g., teachers) may have less experience (Ogles & Owens, 2004).

THE WEDIKO TREATMENT MODEL

Overview

At Wediko, therapeutic treatment does not take place behind the closed door of a clinic or in the isolation of a hospital ward. The program strives to adhere to an alternative treatment approach—one that is both comprehensive and coherent. Based in the tradition of the therapeutic milieu, the program’s model works to exploit every possible moment for therapeutic purposes.

Bettelheim and Sylvestor (1948) first used the term, “therapeutic milieu,” to describe residential treatment programs that endorse a single theoretical framework to which the entire staff subscribes in conceptualizing a child’s pathology and formulating a treatment strategy (Noshpitz, 1992). Milieu therapy supports the view that the events that occur between psychotherapy sessions—sitting down to eat dinner, playing a game with one’s peers, getting ready to go to sleep—can and should be used by childcare
workers to teach adaptive behaviors and promote the practice of those behaviors. Every
daily event within the life of a child is an opportunity for adults to engage that child in

Created in the tradition of this model, Wediko’s summer program was formed to
foster successful experiences in the lives of at-risk boys and improve existing
distortions in affect and cognition (Wediko Children’s Services, 2005). The program
maintains a staff-to-child ratio of 2:1, along with the ability to design and implement
individual treatment and educational plans. Current services within the program include
a school; therapeutic groups for at-risk girls; and specialized groups for children with
Asperger’s Syndrome, children with Attention-Deficit Disorder, and children of
problematic adoptions (Wediko Children’s Services, 2005)

The goal of Wediko’s summer program is similar to those of most summer
treatment programs: provide multi-modal, highly structured therapeutic programming
for children struggling with difficulties that include attention deficits, impulse control
problems, negativity, academic underachievement, low self-esteem and poor social
skills. Social feedback (e.g., smiles and praise) and incentive systems (e.g., candy, toys,
and recreational activities) are intended to direct behavior into increasingly adaptive
functioning (Wediko Children’s Services, 2005).

Unlike individual psychotherapy or specialized school programming—treatment
approaches that are unable to control for behavioral interventions around the clock—
children who attend Wediko live on site. As a result, consistency of services and
intervention strategies is enhanced and the necessary adherence to repetition during the
promotion of adaptive behaviors can be accomplished systematically.

Wediko’s Theory of Why the Program Works

Wediko has described why the agency believes the program works on its website
(http://wediko.org). Leichtman (2005) described the program’s reliance on a
comprehensive therapeutic milieu to guide treatment. Wediko clinicians and direct care
workers strive to foster an extremely structured environment that is protecting,
psychologically safe, and nurturing. Wediko exploits the child’s perspective that the
program is camp and relies on the allure of its multitude of recreational activities to
motivate the child to fully engage in the therapeutic aspects of the program. Specifically,
the activities at Wediko are offered with the intention of stimulating every child to either revitalize latent interests or develop new ones.

The program relies on guiding and nurturing relationships with the staff members to simultaneously provide supervision and special interpersonal bonds that provide a secure base that fosters healthy exploration, age-appropriate fun, and the development of problem solving skills (Leichtman, 2005). Wediko contends that it is these secure relationships that encourage children to express their needs verbally rather than act out physically, develop their conversation skills, and support appropriate risk-taking behavior (Leichtman, 2005).

Wediko describes the children that attend their summer program as being deprived of success in at least one or more of the following domains of functioning: family, school, and community (Leichtman, 2005). For this reason Wediko strives to provide incentives to encourage pro-social behavior, thereby making success the norm for children who often experience it as the exception (Leichtman, 2005). Wediko seeks to accomplish this by providing positive feedback when the child demonstrates any effort. It is believed that together, effort and partial success begin to construct a heartiness that encourages resiliency (Leichtman, 2005).

Wediko maintains the central belief that a child's growth will be limited or reversed by a lack of psychological safety (Leichtman, 2005). Consequently, the concept of safety is discussed with both children and staff at the program’s start. Wediko’s staff rely on a hierarchy of behavioral interventions (see Appendix A) when a child defies the program’s safety guidelines (Leichtman, 2005). This encourages the children to be responsible for their behavior and provides a systematic provision of feedback that supports increased self-observation and control (Leichtman, 2005).

Wediko believes that its program is different from similar programs because it relies on the assumption that a child’s symptoms prevent the development of competencies and should not be the primary focus of treatment (Leichtman, 2005). Instead, the goal is to foster a variety of adaptive competences. This requires that the problematic behaviors be contained through cognitive-behavioral interventions in order to access a child’s strengths. These strengths, in turn, are developed for higher-order coping. Wediko endorses the idea that positive gains are made when a child’s personal
identity ceases to focus on problems and is ordered around effort, ability to learn, mastery, and interpersonal connection (Leichtman, 2005).

Wediko believes that such an approach routinely results in children whose emotions are incorporated into their cognition and choice-making behavior, whose expectations of being successful have increased, and who have developed the willingness to take risks and try new activities as well as problem-solve interpersonal conflicts (Leichtman, 2005). The program also contends that a summer at Wediko will result in children who experience increases in verbal skills, increases in self-monitoring skills, increased connection to others, and a greater willingness to receive feedback about their behavior (Leichtman, 2005).

Specifically, the program asserts that a small number of children complete the program without exhibiting significant gains in functioning that are “documented” and “observed by their families and teachers alike” (Leichtman, 2005, http://wediko.org). Wediko contends that significant gains are commonly displayed in the following areas of functioning:

More accurate and sustained listening; increased capacity for self-regulation noted by gains in impulse control/emotional control and more sustained task activity; increased capacity for accurate self-observation; enhanced ability for effective choice-making and planning; more understanding of the impact of one's functioning on others; more capacity to accurately think through sequences of events; increased ability to identify one's own emotional signals; increased problem-solving efficacy accompanied by advances in incorporation, compromise and negotiation; advances in sharing and being able to constructively participate in groups; increased range of interests; increased capacity to pursue goals; and enhanced capacity to accept external incentives and be motivated to pursue personally defined goals. (Leichtman, 2005, http://wediko.org)

Wediko attributes the gains that are made in functioning among children who attend the summer program to the thousands of corrective repetitions that occur across a variety of environmental contexts (Leichtman, 2005). The agency estimates that over the course of
one summer at Wediko, each child receives approximately 600 hours of therapeutic input from staff, activity specialists and educators, and that this feedback, in sync with “emerging levels of increasingly successful conduct, establishes new neural connections” that remain once the child returns home if the necessary supports by family and school are in place (Leichtman, 2005, http://wediko.org).

Program Staff

The direct care staff is largely comprised of college students who are interested in entering the fields of psychology, social work, and education after they graduate. Each clinical team also includes a supervisor and an assistant supervisor. Individuals who have worked in the summer program for a number of years fill both of these positions. The supervisors are either graduate students in related fields or licensed therapists. One of the two on-site clinical psychologists provides individual and group supervision for the clinical team supervisors. Each clinical team of staff meets twice a week for group supervision to discuss treatment strategies for the children that they serve and address staff dynamics that might be impacting their ability to deliver treatment.

All members of the staff participate in a weeklong orientation that is facilitated by the clinical supervisors and program coordinators to prepare the general staff to work with children with severe emotional disturbances. This orientation includes presentations and small-group discussions on typical treatment population demographics, brain chemistry, psychopharmacology, methods of intervention, physical restraint techniques, and group dynamics.

Program Schedule

The program adheres to a consistent daily schedule that is determined by the overall developmental level of each group (see Appendix B). Wediko relies on a four-stage model to conceptualize developmental level of child groups: “Mastery” is comprised of the youngest children (approximately 7 to 10 years of age), “Charter” is comprised of older children (approximately 10 to 13 years of age), “Focus” is comprised of younger adolescents (approximately 14-15 years of age), and “Crossroads” is comprised of older adolescents (approximately 16-17). It is believed that adhering to the daily schedule provides greater consistency and predictability, two structures necessary for quality treatment provision.
The clinical staff wakes each cabin group 30 minutes before breakfast and helps them perform any necessary morning routines (e.g., brushing teeth, showering, and getting dressed). All meals are conducted in a similar fashion. Staff and cabin members sit around one large table and pass food and serve themselves. Every morning each child group member receives a different “job” for the day, one of which may be waiter. The waiters set the table before meals, go to the kitchen to replenish food items as needed during meals, and oversee the cleanup effort afterwards.

Every group spends 30 minutes cleaning their cabins. The children, who were not assigned “waiter” responsibilities for that day, find that they have cabin-related duties (e.g., sweeping and mopping) and perform them at that time as well as clean their individual bunk areas.

Each group attends three group activities a day (e.g., mountain-biking, archery, and theatre). Activities are one hour in length, rotated every three days, and determined by program coordinators. At some point in the day, group members participate in two additional recreational activities that they have chosen as individuals. During all activities, children can earn coupons by participating and adhering to the behavioral expectations of the activity staff (which are reviewed prior to beginning any activity). These coupons can be redeemed every few days for a variety of age-appropriate toys and prizes.

Each cabin has group therapy every day. Group therapy lasts for approximately one hour and varies greatly in content depending on developmental level of the group. Group therapy topics include interpersonal dynamics occurring within the group and treatment goals for the summer. The daily group therapy meeting’s goals are to improve conversational skills, identify and address issues of concern, and practice give-and-take problem-solving (Leichtman, 2005). Wediko’s belief is that daily group therapy meetings provide each child with an opportunity to give and receive personal feedback to one another, and enhance higher levels of social reasoning, build interpersonal proficiency, and develop greater self-control (Leichtman, 2005).

Every child at Wediko, attends the onsite school five days a week. Students are assigned to classes according to age and ability. Every class has both a math and English component and lasts for one hour and 45 minutes. Classes are designed to maintain
academic involvement over the summer months, limit the decomposition of achievement, and build on the student’s knowledge base while concentrating on developing classroom behavior that maximizes learning (Leichtman, 2005).

Every group attends a daily swimming activity and an evening recreational activity. After dinner, those students who have earned above a minimal number of positive behavior points and below a maximum number of negative behavior points are permitted to visit the on-site arcade. Points are determined for each child three times a day using a rating scale that incorporates both self-reflection and the observation of a staff member (see Appendix C and D). These points are also used to structure incentive systems for the children via individual contracts that are written by the group’s supervisor (see Appendix E).

On Sundays, the schedule is altered dramatically. All groups still attend general swim and group therapy, but Think City and individual and group activities are replaced with “Special Sunday” activities. It is believed that this deviation from the typical schedule provides the children with opportunities to apply their treatment progress in novel situations, and at times, with members of different cabin groups. Every Sunday, the entire setting congregates for “Sunday Sing,” a group sing-along.

Special Sunday activities vary from week to week. The first Sunday is “Frog, Newt, and Toad Day.” The cabin groups search for reptiles and amphibians, have them judged on quantity and quality, and release them. On “Track and Field Day,” cabin groups are split up into different groups and compete in field events, relay races, and obstacle courses. The third Sunday of the summer is “Visitor’s Day.” This is the only day of the summer when families are invited to visit their child outside of a family therapy meeting context. On the fourth Sunday of the summer, cabin groups again are divided and assigned to different groups for “Water Carnival,” which is comprised of relays, canoe races, and water balloon tosses. On the fifth Sunday of the summer, cabin groups perform a rehearsed skit in front of the entire Wediko community. Performances include dances, songs, and poetry. On the final Sunday of the summer, each cabin group is responsible for an activity booth (e.g., dunking booth, face painting activity, or watermelon seed spitting contest) at the “Crafts Carnival.”
RESEARCH QUESTIONS AND HYPOTHESES

Initially, information about the outcomes for children who had attended Wediko’s summer program was going to be used to provide the agency with data about treatment effects at one-year follow-up. Due to the restriction of data obtained and due to the fact that pre-admission data was not collected on any of the children who did not reapply one year after treatment, thereby rendering comparison between those individuals who reapplied and those who did not impossible, the anticipated analyses could not be run. As a result, it became the researcher’s task to alter the line of questioning from which this project was spawned. The researcher’s initial question was the following: “Does the program work?” The question was reframed to the following: “How are children who reapply after attending Wediko’s summer program similar/different one year later, as determined by their parents or caregivers?”

Children who attend Wediko’s summer program are enrolled for exhibiting externalizing behavior problems, internalizing behavior problems, or both. However, analyses to determine how parents and caregivers perceive their child’s behavior have not been conducted previously. The literature suggests externalizing behavior problems (e.g., impulsiveness, aggression, and attention-demanding behaviors) are more prevalent among boys, while internalizing behavior problems (e.g., depression and anxiety) are more prevalent among girls (Keily, Lofthouse, Bates, Dodge, & Pettit., 2003; Rozario, Kapur, Rao, & Dalal, 1994). For this reason, it was hypothesized that boys have a higher rate of externalizing behaviors than girls at both pre- and post-treatment and that girls have higher rates of internalizing behaviors than boys at both pre- and post-treatment.

It was also hypothesized that parents rate their children’s behavior as significantly less problematic on both the internalizing and externalizing scales post-treatment. Although reapplication to the program suggests a continued need for services, the act of reapplying suggests that parents were satisfied, to some degree, with treatment.

METHOD

Participants

Parents and caregivers of 46 children (17 females, mean age = 12.4 years; 29 males, mean age = 11.8 years) who were enrolled in Wediko Children’s Services’ summer program during the 1999-2003 period participated in the study. Of the sample,
three children attended the program in 1999 and reapplied in 2000; four attended the program in 2000 and reapplied in 2001; twelve attended the program in 2001 and reapplied in 2002; and 21 attended the program in 2002 and reapplied in 2003. Data on exactly how many children attended the program one year and reapplied the next was unavailable for all years. Because Wediko does not maintain records of this information, the files had to be reviewed closely from year to year to search for the subset of the population who attended once and reapplied the following year. Information on whether or not the children reapplied more than once was not collected. Of the sample, all but two were accepted into the program at reapplication, both of whom attended in 2001 and reapplied in 2002. Reasons for rejection are unknown.

Materials

Each participant completed the Wediko Child Application-Parent Form every year that the child applied to the summer program. The Wediko Child Application-Parent Form consists of questions and rating scales that are used to assess child and family demographics, school information, history of problem behaviors, history of services (e.g., hospitalizations, specialized school settings, and counseling), family stressors, child strengths, risk factors, behavioral observations, and treatment goals (see Appendix F). Initially, this collection of information was used—in conjunction with a series of interviews, and forms completed by both a child’s teacher and therapist—to determine goodness of fit between child and program. If the child were accepted, information from the application form was used to maximize the clinical impact of the child’s stay (i.e., in the assignment of child to living group, and in the development of treatment goals and strategies).

Procedure

In late March of 2003, the researcher contacted the executive director of Wediko Children’s Services to propose the idea of conducting an evaluation of the agency’s summer program. The researcher sent a letter and brief concept paper outlining two potential evaluation strategies to the director (see Appendices G and H). He also constructed and included a logic model of the summer program to convey explicitly his conceptualization of the program’s goals and treatment ingredients (see Appendix I).
The first of the two evaluation strategies outlined in the concept paper proposed that the researcher create an abbreviated version of the Wediko Child Application-Parent Form that included only items designed to assess any recent changes in demographics, along with the application scales that measure individual strengths and risk factors as well as the behavioral description and send this form to parents and caregivers 12 months post-treatment. If parents of children who attended Wediko in the summer of 2002 completed the abridged questionnaire during the summer of 2003, pre-treatment and one-year follow-up information could be obtained.

The second evaluation strategy outlined in the concept paper relied solely on archival data from the application forms of children who applied to the program more than once. It was proposed that by comparing information from the Wediko Child Application-Parent Form from one year to the next, valuable data could be collected without any further involvement of parents. The director contacted the researcher to inform him that the agency would allow an evaluation of Wediko’s summer program using the second of the two strategies outlined in the concept paper.

Information about child behavior was collected from the archival files of children who attended Wediko and reapplied one year later during the 1999-2003 period. Only data about children whose parents or caregivers signed a research consent form were collected (See Appendix J). This information, taken from the Wediko Child Application-Parent Form, was collected with the intention of comparing parental responses from one year to the next in order to determine program effectiveness.

Development of Measures

The measures that were used to assess parental/caregiver perception of change in the child population one year after treatment were derived from the existing Wediko Child Application-Parent Form. The Wediko Child Application-Parent Form allows parents and caregivers to rate their child’s performance within a number of different domains (e.g., interpersonal functioning, cognitive ability, and problem behaviors). The application form’s scales are categorized into three different sections: “Strengths,” “Risk factors,” and “Behavioral Observations.”

Because Wediko altered aspects of its parent application form during the 1999-2003 period, special considerations had to be made before the data could be analyzed.
Both the “Strengths” and “Risk Factors” sections of the parent application form were originally dichotomous in nature (i.e., parents and caregivers were instructed to “Put a check in the box if the item applies to your child”) and later converted into a four-point scale (i.e., parents and caregivers were instructed to “Indicate how well each of the following statements describes your child’s behavior: 0 = Not all descriptive, 1 = Slightly descriptive, 2 = Fairly descriptive, and 3 = Highly descriptive”). For this reason, scaled scores had to be recoded as dichotomous if earlier data were to be salvaged. Specifically, all ratings that were 0 or 1 were recoded as 0. All ratings that were 2 or 3 were recoded as 1.

Initially, data from the “Strengths” and “Risk Factors” sections of the application were going to be analyzed in order to determine if and how parents and caregivers rated their children one year after participating in Wediko’s summer program in an effort to provide the agency with information on its treatment effects. However, the restrictions of the data rendered them useless, and for that reason, they were excluded from further analyses.

The “Behavioral Observation” section of the form did not undergo dramatic changes during the 1999-2003 period. It continuously utilized the four-point scale. It did, however, along with the “Strengths” and “Risk Factors” sections, possess different items during different years. Only items that remained constant throughout the period under investigation were analyzed.

Data considered to be ambiguous (i.e., items in which one of the four options was not clearly indicated) was excluded from all analyses. Only three instances of ambiguous data occurred. In one instance the “Behavioral Observations” item, “cries, whines” was marked in an ambiguous way; in two instances the “Behavioral Observations” item “teases, provokes others” was marked in an ambiguous way.

Due to the broad range of types of behaviors within the “Behavioral Observation” section of the application, other considerations had to be made. Achenbach’s (2000) Child Behavior Checklist (CBCL), a standardized instrument used to assess behavioral and emotional problems and competencies within children and adolescents ages 4-18 years, was used to guide the creation of variables from the Wediko Application-Parent Form questionnaire items within this section. A number of items on the Wediko
Application – Parent Form resembled items on the CBCL and were categorized into three new variables in step with the CBCL’s organization (see Appendices K-P). Only items within the Behavioral Observation section of the Wediko Application – Parent Form were used because only this portion of the document has consistently existed in categorical form. The three newly created variables were “Externalizing Problems,” “Internalizing Problems,” and “Attention Problems.”

Reliability for the three newly constructed variables was measured to establish whether or not an item within a given subsection elicited similar responses to the other items within that subsection, thereby providing some evidence that the subsection was measuring the same underlying construct (i.e., externalizing problems, internalizing problems, and attention problems). A Cronbach’s alpha was used to measure reliability. The value of a Cronbach’s alpha coefficient ranges from 0 to 1. The closer the coefficient is to 1, the more reliable the collection of items is in eliciting similar responses. Nunnaly (1978) has designated a value of 0.7 to be an acceptable reliability coefficient.

The seven items within the “Externalizing Problems” section exhibited acceptable reliability (Alpha = .85, see Table 1). The items within this section were: 1) threatens, bullies; 2) is destructive, breaks things; 3) hits, pushes, fights; 4) yells, screams; 5) swears, curses; 6) teases or provokes others; and 7) throws temper tantrums.

The seven original items within the “Internalizing Problems” section exhibited acceptable reliability (Alpha = .75). However, because reliability could be increased by removing “is a withdrawn child,” (Alpha = .76, see Table 2), the item was eliminated. The six remaining items within this section were: 1) cries, whines; 2) says s/he can’t trust other people; 3) withdraws or avoids contact with others; 4) seems anxious, nervous; 5) is slow-moving; and 6) seems sad, unhappy.

The four items within the “Attention Problems” section failed to exhibit acceptable reliability (Alpha = .59, see Table 3). As a result, the variable was not used in further analyses. The items within this section were: 1) restless, fidgety, moves around constantly; 2) seems lost in his/her own thoughts; 3) acts impulsively, acts without thinking; 4) seems anxious, nervous.

The newly created variables that were extracted from the Wediko Application – Parent Form were used to assess if and how parents and caregivers rated their children.
differently one year after attending the summer program on the basis of both externalizing and internalizing problems.

Analyses

Initially, differences in how each respondent rated each child on the newly created variables across consecutive application periods were to be analyzed in order to determine treatment effects for all children who attend Wediko’s summer program within one distinct arena of functioning (i.e., home). Within-subjects analysis of 12-month change was to be used to determine effects of programming for these children on the reduction of externalizing problems, internalizing problems, and attention problems. Means of pre-treatment and post-treatment scores for each scale were going to be analyzed in order to determine effects using paired samples t-tests (2-tailed).

Further investigation would determine whether or not a number of aspects of a particular child’s life modulated treatment effects. These factors included sex of the student, age of the student, and living conditions (i.e., whether or not the student resided with a biological parent, and whether or not the student resided with married caregivers), and the presence or absence of outside agency involvement (excluding that of Wediko).

Due to the limitations of data (i.e., only data on children who reapplied one year after attending Wediko’s summer program was collected), the projected study could not be undertaken as planned. For this reason, it became the researcher’s task to alter the line of questioning from which this project was spawned (i.e., from “Does the program work?” to “How are the children who reapply one year after attending Wediko’s summer program similar/different one year later?”).

Because data were collected over a period of years, preliminary analyses were conducted to test the assumption that the subsets of the sample were fundamentally similar from one year to the next. Insufficient data on the 1999-2000 and 2000-2001 samples existed, and, as a result, could not be included in a chi-square ($\chi^2$) analysis to test that assumption. The researcher did, however, conduct a $\chi^2$ analysis for the 2001-2002 and 2002-2003 cohorts in order to determine if they, the largest two of the four subsets, were fundamentally different in some way. Specifically, populations were examined by sex, by whether or not their primary caretakers were married or unmarried (unmarried =
separated, divorced, or single), and by whether or not the child resided with at least one biological parent.

The $\chi^2$ of independence analysis is employed to investigate the relationship between two discrete variables. In a $\chi^2$ analysis, the null hypothesis produces expected frequencies and tests them against the observed frequencies. If the expected and observed frequencies are similar to one another, the null hypothesis is preserved and the value of the $\chi^2$ is small. If the two frequencies are significantly different, the null hypothesis is rejected and the value of the $\chi^2$ is large (Tabachnick & Fidell, 2001).

Data on rates of externalizing problems were analyzed using the general linear model mixed analysis of variance statistic, a combination of within-subjects (repeated measures) and between-subjects designs. Gender was the between-subjects factor and pre- and post-ratings of externalizing behavior were within-subjects factors. The dependent variable was overall externalizing behavior.

Data on rates of internalizing problems were also analyzed using the general linear model mixed analysis of variance statistic. Gender was the between-subjects factor and pre- and post-ratings of internalizing behavior were within-subjects factors. The dependent variable was overall internalizing behavior.

Paired samples t-tests were used to determine changes in how parents endorsed both externalizing and internalizing items on the application one-year post-treatment.

RESULTS

The two subsets of the sample were not found to be significantly different in terms of either sex differences [$\chi^2 (N = 39, 3) = .96, p. > .5$] or whether or not the children resided with at least one biological parent [$\chi^2 (N = 38, 3) = .00, p. > .5$].

The two subsets of the sample were found to be significantly different with regards to whether or not they resided with married caregivers [$\chi^2 (N = 36, 3) = 3.86, p = .05$]. Specifically, twice as many children were living with married caregivers than unmarried caregivers in the 2001-2002 sample, and twice as many children were living with unmarried caregivers than married caregivers in the 2001-2002 sample.

Although no significant differences existed between the 2001-2002 and 2002-2003 subsets of the sample in terms of sex and whether or not the children resided with a biological parent, they did differ significantly in terms of whether they lived with married
or unmarried parents or caregivers. This suggests that the different subsets of the sample are not indistinguishable, and all subsequent analyses should be interpreted with caution.

Comparisons of externalizing and internalizing problems for girls and boys were made using a mixed analysis of variance. Significant differences were not found among girls and boys on either the externalizing ($F(1, 43) = 2.95, p = .09$) or internalizing problems ($F(1, 43) = 2.05, p = .16$) (See Tables 4 and 5 for group means).

T-tests were performed on pre- and post-ratings of externalizing and internalizing variables in order to determine whether or not parents rated their children differently one-year post-treatment. Significant differences between pre-treatment and post-treatment were not found for either externalizing behaviors ($t(44) = .67, p = .51$) or internalizing behaviors ($t(44) = -1.05, p = .30$) (see Tables 6 and 7 for group means).

DISCUSSION

This section includes the following: a discussion of the research hypotheses, limitations of the study, the identification of barriers that existed during the study’s undertaking and related recommendations to the agency under evaluation on how to begin to implement strategies to improve its quality assurance practices, and an explication of valuable lessons learned on the subject of program evaluation/field-based research.

Discussion of Research Hypotheses

It was hypothesized that boys would have a higher rate of externalizing problems than girls at both pre- and post-treatment and that girls would have higher rates of internalizing problems than boys at both pre- and post-treatment. The results suggest that parents of both boys and girls who reapply to Wediko’s summer program rate their children similarly with regard to externalizing and internalizing problems. This is not consistent with current literature that suggests that externalizing behavior problems are more prevalent among boys, while internalizing behavior problems are more prevalent among girls (Keily et al., 2003; Rozario et al., 1994).

Although gender differences commonly exist for externalizing and internalizing symptom presentation, it is possible that residential treatment facilities serve girls with less gender-typical problem behaviors. Further analyses suggest that parents rated their children as having significantly more externalizing symptoms than internalizing
symptoms at both initial application ($t(44) = 4.98, p < .01$) and reapplication ($t(45) = 2.99, p = .01$) (see Tables 8 and 9). It is possible that the event or events that precipitate a parent’s decision to enroll their child in residential treatment may be more typically externalizing in nature (e.g., acting out in school as opposed to being disengaged while there).

It was hypothesized that the children who attended Wediko’s summer program would undergo significant positive change as a result of treatment. Specifically, it was predicted that, at one-year follow-up, children who attended the program would exhibit a decrease in externalizing and internalizing problems as determined by their parents or caregivers. The parental ratings of children did not differ significantly at one-year follow-up for either externalizing or internalizing problems.

Numerous possible explanations exist for this finding. If behavior had significantly improved, reapplication might have been deemed unnecessary by parents. However, reapplying in itself suggests that parents must have been satisfied with treatment enough to want to enroll their child a second time. Because it was never determined why children reapplied to Wediko’s summer program, understanding this contradiction is difficult. Perhaps reapplication was motivated by the parents’ need for respite, the parents’ desire to provide their child with experiences that could not be offered at home (e.g., canoeing), or because the child reported having a positive experience the previous summer.

It is possible that behavior, in fact, did change in those areas in which none was detected for a myriad of reasons: parents may have been less sensitive to change in their child’s behavior than anticipated; parents may not have identified and altered their own behavior, some which may have contributed to their child’s problem behavior; significant change may have occurred but failed to be sustaining; and noticeable improvement in a child’s behavior may have occurred in one domain (i.e., school) but failed to do so in another (i.e., home).

The children in this study worked throughout the summer to alter their self-perceptions (i.e., from problem-focused to skill-based). Many of their families, however, failed to simultaneously actively engage in family therapy, a component of the program. Family therapists encouraged participating parents to challenge how they perceived their
child and worked with them to identify and alter their own behavior, some of which may have contributed to their child’s problem behavior. Until recently, only those children from the city of Boston (78.26% of the sample) were given the opportunity to attend weekly family therapy. The number of families that took advantage of that opportunity is unknown. In 2004, however, Wediko made weekly family therapy available to all families. Families in the Boston area needed to travel only to Wediko’s office in Boston. Families in New Hampshire could travel to the setting and meet with their child’s clinical supervisor. Families who either did not have reliable transportation or lived far away were given the opportunity to have weekly family therapy sessions over the phone and extended family therapy sessions (3-4 hours) the day before visitor’s day—which occurs half-way through the summer and is the only day on which families are invited to visit with their child—and the day before treatment ended. Furthermore, parents were told that a child’s acceptance into the program was contingent upon the family’s commitment to meeting weekly for family therapy (in any of its forms). The recent promotion of this treatment component presumably will increase the effects of each child’s stay at Wediko.

Another possibility is that significant change occurred but failed to be sustaining. When applying the second time, parents often indicated that they noticed a change in behavior but that it deteriorated after a number of months. Parents described this phenomenon in a section of the application that is specifically allotted for comments of parents whose children had attended the program a previous summer.

It is possible that noticeable improvement in a child’s behavior occurred in one domain (i.e., school) but failed to occur in another (i.e., home). Although teachers’ ratings were not computed for the purposes of this study, they may account for effects undetected by parents. Parents’ and teachers’ ratings may differ for a multitude of reasons. The different raters likely rely on different child base-rates during their assessments. Teachers typically have more exposure to children and thus, have a greater measure of comparison (Ogles & Owens, 2004).

Finally, it should be recognized that a lack of statistical significance does not necessarily demonstrate a lack of clinical significance. All of the participants in this particular study reapplied to Wediko’s summer program at least once. This suggests that the parents and caregivers involved in this evaluation were satisfied with the program to
some degree. The reasons for their satisfaction (e.g., observable change in their child’s behavior or appreciation for the 6-week respite period that occurred when their child was at Wediko), however, cannot be determined.

**Limitations of the Study**

Conducting research using archival data has a number of advantages (e.g., minimal reliance on participants, capacity to analyze data across multiple years at one time). Unfortunately, however, the use of archival data in this particular study resulted in a number of limitations.

The method of evaluation used in this study only offered insight about the small subpopulation of children that reapplied to Wediko during the 1999-2003 period. This sample of children may somehow be different from those that attend the program only once and fail to reapply the following summer (Parad, 1983). Valuable information on those children who did not apply to the program a second time—whether due to a reduced need for services or the utilization of alternative services—was unavailable for analysis.

A control population was not used as a standard of comparison in the evaluation. As a result, the treatment condition could not be compared with a similar population who did not participate in summer residential treatment. It was assumed—perhaps erroneously—that no change would occur within the population of children that enrolled in Wediko’s summer program without treatment.

The employment of a single global measure in determining programmatic success has significant disadvantages. Relying on only one instrument (e.g., the parent application) may limit the evaluation’s sensitivity to small changes or improvements in specific target arenas (Ogles & Owens, 2004) and may not directly address the goals of Wediko’s summer program.

Similarly, reliance on one type of reporter (i.e., parents and caregivers) provided information about behavioral change in only one domain of functioning (i.e., home). Ogles and Owens (2004) identify a number of advantages to using teachers as evaluators of children’s behavior during an evaluation. Teachers see large numbers of children and develop an understanding of age-typical behavior; they observe children in relation to their peers and in relation to adults; they are able to provide feedback about multiple
domains of interest (e.g., academics and social interactions); and they observe children during structured and unstructured times, and during solitary and group-related activities. Failure to incorporate the perspectives of teachers prevented school functioning from being assessed, and therefore, provided a limited assessment of behavior and reduced the ecological value of the evaluation.

Only data describing problematic behavior was analyzed in this study. Data on child strengths or demonstration of non-problem focused behaviors was not included in analyses. For this reason, no assumptions about the development of assets can be made from the findings.

The assessment focused solely on outcomes and did not investigate processes related to treatment. Examination of the program’s theoretical orientation and reasons for the implementation of its treatment ingredients was not conducted. Similarly, the degree of fidelity to which the program adheres to its theoretical model was not established.

Finally, it was never determined why children reapplied to Wediko’s summer program. Perhaps reapplication was motivated by the parents’ need for respite, the parents’ desire to provide their child with camp-like experiences (e.g., canoeing), or the child’s positive experience with previous summer. It was assumed, perhaps erroneously, that the children reapplied due to a continued need for services.

Given these limitations, many of which were products of an over-reliance on archival data, Wediko should consider including alternative methods of data collection in their future evaluation endeavors.

Identification of Barriers that Existed during Data Collection and Recommendations to Wediko Children’s Services for Improving Quality Assurance Practices

Currently, Wediko does not endorse an outcomes orientation in their provision of services, nor does it conduct frequent formal evaluations of its summer program. Developing its quality assurance practices would result in numerous benefits and will increase its chances of survival in a health system that, as current trends suggest, will one day be dominated by managed care (Hicks, 1989).

The following recommendations emerged from the researcher’s experiences during the proposal, data collection, and analyses phases of this project. Although the
following recommendations will require considerable time and effort to implement, doing so will undoubtedly result in several advantages that exceed simple remuneration for the necessary resources. The benefits of evaluation will profit both the program staff, and the children and families that they serve.

*Determine Reasons for Reappllication to the Summer Program*

Whether children reapply due to a continued need for services or satisfaction with the previous summer’s experience is typically unknown. For this reason, it is recommended that Wediko assess for this information during the reapplication process. If the reasons for a child’s reapplication are unknown or assumed, intervention may be misdirected.

*Maintain Electronic Records of Who Attended the Summer Program and Who Reapplied*

When the researcher arrived at Wediko’s central office and requested that a list of those children who attended the program and reapplied the following summer be produced to guide data collection efforts, the office staff informed him that was not possible because the information is not entered into a database. Additionally, they informed the researcher that because the office staff leaves Boston for Wediko’s New Hampshire setting days before the program’s start date, and because adjustments in program enrollment continue up until the first day of treatment, complete lists of the children who actually attended the program could not be generated either.

It is recommended that Wediko keep electronic records on who attended the program, and who reapplied. This information will be critical in any future efforts to determine program effectiveness.

*Determine How Application Information Is Used in Treatment Provision*

Currently, Wediko collects a considerable amount of data on each child during the application process. The preadmission questionnaire is completed by parents, teachers, and therapists. It contains items on demographics, history of problem behaviors, history of services, family stressors, child strengths, risk factors, behavioral descriptions, and current goals. Along with child interviews, this information is used to maximize the clinical impact of every child’s stay at Wediko (i.e., in the assignment of child to living group, and in the development of treatment goals and strategies that are unique to each child).
It is recommended that Wediko begin assessing how precisely this information is used by clinical team supervisors and staff once the program has begun. Doing so will aid them in the construction of an application that will not only serve their needs during the application process, but in the treatment of the children once they enroll in the program.

Measure Treatment Effects at Multiple Intervals

Treatment effects should be measured at frequent intervals to determine both short-term and long-term benefits. Routine follow-up measures should be sent to parents (e.g., at two months, six months, and one year) to track treatment effects. Acceptance to the program should be contingent upon agreement to such follow-up in order to maximize compliance. Doing so will exhibit Wediko’s commitment to continued quality assurance.

Solicit Child and Staff Participation in Evaluation Efforts during Treatment

Children should be asked to rate their own experiences during the summer. A reliance on multiple raters will ensure a more ecological evaluation. Similarly, staff members should rate the children early into treatment and again late in the summer to assess within-program gains.

Incorporate Teachers’ Observations in Evaluation Procedures

Teachers’ observations should be incorporated into evaluation procedures. Teachers see large numbers of children and develop a concept of age-typical behavior; they observe children both with their peers and with adults; they observe each child across multiple activities (e.g., academics and social interactions); and they observe children during both structured and unstructured times, and during solitary and group-related activities (Ogles & Owens, 2004).

Integrate Evaluation Responsibilities into a Particular Staff Member’s Job Description

It is recommended that Wediko consider incorporating program evaluation responsibilities into a particular staff member’s job description. Doing so will ensure that assessments are conducted routinely. The use of Scantron or web-based applications may be employed to guarantee that the data are collected easily, are clean, and are entered automatically into some form of evaluation analysis program, thereby reducing staff responsibility.
Link Wediko’s Mission Statement to Agency Goals and Objectives and Allow Agency Goals and Objectives to Guide Evaluation Efforts

It is important to note that information that is collected for the purposes of evaluation may be quite different than the information that is currently collected on the application form (i.e., information used for clinical purposes). Data collected for evaluation purposes should be directly related to goals and objectives derived from the program’s mission:

Our mission is to provide a protective, nurturing and stimulating learning environment which pulls for higher levels of functioning. Our intensive therapeutic program is committed to an integrated skill building approach which expands the adaptive capability of children and their families.

The agency should develop an operationalized definition of “higher levels of functioning,” link it with program goals and objectives, incorporate fundamental aspects of those goals and objectives into their evaluation scales, and determine whether parents observe significant increases in those arenas at various intervals post-treatment. Similarly, “adaptive capability” should be clearly defined, its critical components identified, and the processes involved in the program’s attempts to “expand” those components explicated. Then, measures developed to assess whether those components changed post-treatment can be developed. Lastly, change in “adaptive capability” of both children and their families should be linked to goals and objectives before being assessed.

Integrate Assessment Tools into the Wediko Child Application-Parent Form

A less comprehensive approach would include altering some aspects of the application form. Currently the Wediko Child Application-Parent Form contains a section exclusively for parents whose children have attended the program before. This section, labeled, “For parents of children returning to the Wediko Summer Program: Do you have any comments and/or suggestions?” routinely was utilized by parents to indicate whether their child exhibited noticeable changes in behavior. Because Wediko is interested in continued evaluation and because parents of children who have attended the program are interested in reporting their level of satisfaction with treatment, the agency should consider expanding this section of the application form. Specifically, Wediko should
consider incorporating a scale that assesses whether or not parents witnessed improvement; and if improvement was observed, in what areas it took place, to what degree, and for how long. Integrating this assessment tool into the application form will motivate the parents of children who are reapplying to complete it.

Lessons Learned about Program Evaluation/Field-Based Research:
A Graduate Student’s Perspective

Background

I do not claim to be an impartial researcher with regard to this study. My decision to undertake this particular project was a result of my own experience working for the agency under consideration. It was at Wediko that I realized that I wanted to devote my life to working with children at risk for developmental failure. For this reason, I not only saw myself as a stakeholder invested in the program’s success, but I felt compelled to make a contribution to the agency that so heavily impacted my professional development. At the time of the study, Wediko did not conduct any form of routine program evaluation. I understood the value of assessing program effectiveness, and as a result, desired to collaborate with them in taking on this responsibility.

When I proposed the project to Wediko’s executive director, he was reluctant to grant permission due to the project’s complexity and encouraged me to think about alternatives. Nonetheless, I presented him with two potential evaluation strategies and I developed a logic model of the summer program to communicate my conceptualization of the program’s goals and treatment ingredients. He contacted me to inform me that he had accepted my proposal and agreed to allow me to evaluate Wediko’s summer program using one of the two strategies outlined in the concept paper.

When I arrived at Wediko’s central office, I learned first-hand about some of the problems that occur when collecting archival data. Lists of children who had attended the program could not be generated to guide data collection efforts, and the files from which the data were collected were often incomplete or missing. My experiences during both the proposal and data collection phases of the project led me to believe that my efforts would only minimally impact the agency and how it operated.
My Responses to the Project

The concept of program evaluation rests on the assumption that programs will utilize the findings to reform treatment components in an effort to improve the services that they provide. Unfortunately, the impact of many evaluations is minimal.

Initially, I was not overly concerned by this fact. I never anticipated that conducting an evaluation of Wediko’s summer program would facilitate any type of dramatic change. In all honesty, I was thankful that Wediko had accepted my proposal for the simple reason that I was going to be able to collect data for my Master’s project at a place where I enjoyed living and working.

I deliberately conducted the project in such a way as to limit the impact that data collection would have on the clinical operations of the program—I collected archival data during a time when treatment was not occurring. However, at the project’s completion, I feared that in an effort to minimize my impact on the clinical operations during data collection I had minimized my impact on clinical operations indefinitely.

I recognized that I neglected to develop a significant partnership with Wediko in this particular endeavor, and in retrospection, that was a grave error. Securing a strong partnership with the agency under evaluation is vital. Failure to do so threatens the utility of the entire project and puts the efforts of the evaluator at risk for being futile.

During the proposal phase of this study, I saw myself as a Wediko “insider.” I thought that I would be able to provide a sufficient degree of internal accountability, rendering a “partnership” unnecessary to some degree. After all, I had a long-standing relationship with Wediko and had worked in its summer program for a number of years. Over time, however, I came to believe that I was not an insider. I assumed that I possessed little influence over the administration or development of the program. I was sure that their interest and partnership were essential if this project were to have a significant impact on the program. Unfortunately, I never bothered to obtain it.

About the same time that I decided that I was not really an insider, I began to believe that I was not really an “outsider” either. I assumed that I failed to provide significant external accountability just as I failed to provide significant internal accountability. Routinely, when a true outsider arrives to evaluate a program, people take notice and even change their behavior. The very idea of the evaluation encourages people
to think about ways that they can improve things and often, improvements are made. Chelimsky (1997) states that “the mere presence of the function and the likelihood of a persuasive evaluation can prevent or stop a host of undesirable government practices” (p. 16), and in some cases can influence the agency to initiate a host of desirable ones. Upon the completion of the project, I was confident that I was unable to provide the external accountability to accomplish that.

My greatest error, I believe, was failing to demystify evaluation for the agency. During my visits to the Wediko office to collect data, I spoke with numerous people about what I was doing. Everyone was somewhat curious. I explained that my interest in learning more about how the program works was benevolent in nature—that I just wanted to repay the agency for having such an impact on my own personal and professional development. Many people, however, even those with whom I had worked for years, were suspicious, often challenged my motivations, and subtly insisted that my goal was to expose the program’s shortcomings.

I could have easily offered to give a presentation on the value of evaluation and assessed for interest prior to beginning my research. What I know about the wonderful people working in Wediko’s central office, they would have been open and interested in greater collaboration.

Since completing this project, I learned that a good evaluation will result, not only in valuable information about the program’s outcomes, but will help the program learn to evaluate itself; thereby, rendering the evaluator useless. I assumed that my connection with Wediko, although necessary for me to gain access to the program in order to evaluate it, limited the degree to which I could pass the responsibility off to someone else within the agency. I was hoping to render myself useless but feared that I maintained some degree of responsibility for promoting the implementation of an outcomes-orientation.

I returned to Wediko in June of 2005 to work once more in the summer program. I was delighted to learn that many of my fears were unsubstantiated. The agency was in the process of making considerable programmatic changes. Through observation and conversation, I learned about some of the recent developments.

Wediko created two full-time “program development” positions to secure grant funding and begin reviewing and developing programmatic activities (e.g., program
promotion). The one member of the program development staff with whom I spoke acknowledged the need to demonstrate effectiveness in their efforts to promote the summer program.

Wediko had maintained relationships with two researchers (both of whom were formally direct care providers in the summer program during their undergraduate careers) for many years. Their research efforts have recently expanded to include the collection of data on behavioral change at multiple intervals during the program. They have also begun to use the Wediko Child Application-Parent Form to collect data on each child pre-admission. Data that were collected during the summer of 2005 were analyzed twice during the summer and presented to each clinical team to increase awareness of child group dynamics and to identify changes that occurred in each child’s behavior throughout the program.

I asked one of the researchers about her plans to continue and expand the research efforts currently under way. She informed me that she and her colleague were in the process of applying for grant money to continue the assessment research. She speculated that in a few years the agency would be collecting data on program participants post-treatment in an effort to evaluate long-term parental/caregiver assessment of behavioral change and overall program effectiveness.

I discussed many of these recent developments with Wediko’s executive director. He described the agency’s evolution and its history of development. He stated that in its past, the summer program would survive long periods of stagnation—periods in which little programmatic change occurred—followed by a brief period of significant change—times in which the program reevaluated how and why it did what it did rather than deferring to tradition. He recognized that Wediko’s summer program was on the threshold of one of those periods of significant change. Furthermore, he expressed an interest in changing the culture of the agency to one in which development and evaluation are central values. He cited this study as being critical to the recent developments and the agency’s interest in being more thoughtful about its programmatic structures.

Initially, I did not believe that this study would have a significant impact on how the summer program operated. I was thrilled to discover that Chelimsky (1997) was correct in her assessment that the mere presence of someone asking questions can be
influential to a program’s development. The director thanked me, not for the answers to this study’s particular research questions, but for reminding him that asking questions is a good thing.

Suggestions for Beginner Program Evaluators/Field-Based Researchers

Getting Started

1) Learn about past research/evaluation endeavors that have been undertaken or supported by the agency with which you wish to work. Developing a clear sense of an agency’s research/evaluation history will provide you with valuable information about its stance on research efforts similar to your own.

2) Take time to learn about the culture of the agency with which you wish to work and their theory of how change occurs within the program. Understanding the unwritten rules and expectations of the agency with which you wish to work will help you navigate both social relationships within the agency and its system of organization. As a result, you will be prepared to provide information to the agency that is deemed valuable by its members.

3) Do not expect everyone to be as excited as you are—or even appreciative of your efforts. Many people who work in direct service seem to undervalue research efforts. It is often the case, however, that direct care providers do not yet recognize its worth or understand its relevance to someone working on the “front lines” of treatment provision.

4) Maintain simplicity while designing your project. Inevitably, your task will become more complicated than anticipated. For this reason, do what you can to preserve simplicity in its design.

5) Explain yourself and the project thoughtfully and thoroughly. Formulate a clear plan and explicate the theoretical foundation for your interest in the research project as well as the hypothesized results. Doing so will increase the likelihood of the project’s acceptance.

6) Develop a partnership with the agency under evaluation/study. Do so by assessing what they would like to learn or by demystifying what you plan on doing (e.g., via a presentation).
7) Offer choices about how you plan to proceed. Presenting the agency with options about how to implement a research/evaluation project will increase collaboration and appeal to the program members as “co-researchers” or “co-evaluators.”

8) Make your needs known to the agency before beginning. Review your research/evaluation plan with all individuals on whom you will rely and inform them, in advance, of what resources/supports you will require of them (e.g., a tour, lists of names, files, and access to a copier).

9) Develop a contract with the agency with which you are working. Once your plan has been accepted by the agency under consideration, develop and agree upon an anticipated timeline and identify all products. Review and discuss the contract with the program stakeholders before beginning. If the data does not exist, does not exist in the form described to you, or the necessary resources were unavailable, you will be under less pressure to proceed with the project as originally planned.

Data Collection

1) If you are engaging in archival research, develop a clear sense of what condition data are in before you arrive. Archival data sets exist in degrees of completion. You may find that records are missing, nonexistent, or only partially complete. Make an effort to learn about the data set before you take on large research/evaluation projects so that you can anticipate how to proceed if the information on which you plan to rely is limited.

2) Take detailed notes along the way. What occurs during the proposal phase, data collection, and analysis can be more interesting than the findings that the process ultimately yields. The story that accompanies your research/evaluation efforts may prove to be the most interesting find. Because it is impossible to recreate all that happens along the way, be sure to explicate your process in detail as it occurs.

3) Allocate plenty of time to accomplish data collection. Data condition often takes longer than expected. Provide yourself with ample time to complete this phase of your evaluation/research.

Throughout the Evaluation/Research Process

1) Be persistent. Securing permission and collaboration takes time and diligence. Do not anticipate that the agency with which you are interested in working will accept
your proposal without concern or discussion. Be patient and be prepared to make substantial modifications to your original strategy.

2) Do not underestimate the value of simply asking questions! Recognize that the mere presence of someone asking questions can be influential to a program’s development.

CONCLUSION

During the summer, most mental health providers cutback or postpone services for families who have children with Attention-Deficit/Hyperactivity Disorder [and other emotional and behavioral problems], and school-based programs often adjourn until the fall (Pelham & Hoza, 1996). For this reason, it could be argued that the goal of summer treatment programs is not to cure children with short-term, intensive therapeutic services, but rather prevent the decomposition of gains made during the academic year while working to improve academic, social and mental-health functioning with aggressiveness unique to milieu-based interventions. However, the research that exists to demonstrate the effectiveness of summer residential programs (Pelham et al., 2000; Michalski et al., 2003) and other forms of time-limited treatment strategies (e.g., MST) (Henggler et al., 1992; Huey, Henggler, Brondino, & Pickrel, 2000) in decreasing the severe problem behavior of children suggests otherwise.

Given the evidence that indicates short-term inventions can be highly effective at eliciting change, summer residential programs are in a unique position to dramatically affect the lives of the children and families that they serve. However, only by continually evaluating their impact can they determine if and how they are realizing that potential.

All forms of psychotherapeutic intervention should be evaluated; however, residential agencies maintain a greater responsibility in assessing their programs. Because residential programming is so costly and because programs remove the children they serve from their homes and families, they possess a heightened ethical obligation in assuring that their treatments are effective (Parad, 1983). Failure on the part of a residential treatment program to conduct routine evaluations of its services is not simply irresponsible, it is unethical.

Limitations of the data that were collected for the purposes of this study prevented the researcher from providing Wediko Children’s Services with an evaluation of their
summer program. Information was collected, however, on children and adolescents who attended the program and reapplied one year later. Analyses suggested that parents of boys and girls who attended the program rated their children similarly with regard to externalizing and internalizing problems. Significant reductions in problem behavior were not reported at one year post-treatment.

Additional levels of analyses yielded observation and recommendations for both the agency under consideration and program evaluators/field-based researchers. Derived from process issues that arose during the proposal, data collection, and statistical analysis phases of the study, these recommendations may serve Wediko Children’s Services in their efforts to improve quality assurance practices and fledging researchers in their efforts to assist residential programs evaluate their treatment programs.
References


Hicks, G.G. (1989). Group care survival: Learning from the experience of the hospital


### Table 1

**Reliability Analysis – Scale (Alpha) for Externalizing Problems**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
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</thead>
<tbody>
<tr>
<td>Threatens, bullies</td>
<td>1.35</td>
<td>1.09</td>
<td>9.81</td>
<td>20.73</td>
<td>.69</td>
<td>.8229</td>
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<tr>
<td>Hits, pushes, fights</td>
<td>1.33</td>
<td>1.04</td>
<td>9.84</td>
<td>20.66</td>
<td>.74</td>
<td>.8158</td>
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<tr>
<td>Yells, screams</td>
<td>1.86</td>
<td>0.97</td>
<td>9.30</td>
<td>21.60</td>
<td>.69</td>
<td>.8698</td>
</tr>
<tr>
<td>Swears, curses</td>
<td>1.58</td>
<td>1.01</td>
<td>9.58</td>
<td>24.30</td>
<td>.34</td>
<td>.8698</td>
</tr>
<tr>
<td>Teases or provokes others</td>
<td>1.72</td>
<td>1.10</td>
<td>9.44</td>
<td>21.49</td>
<td>.59</td>
<td>.8375</td>
</tr>
<tr>
<td>Throws temper tantrums</td>
<td>1.79</td>
<td>0.99</td>
<td>9.37</td>
<td>21.24</td>
<td>.71</td>
<td>.8204</td>
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Reliability Coefficients:  
N of Cases = 43  
Alpha = .8539
Table 2

Reliability Analysis – Scale (Alpha) for Internalizing Problems

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cries, whines</td>
<td>1.30</td>
<td>1.08</td>
<td>5.16</td>
<td>12.23</td>
<td>.45</td>
<td>.45</td>
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<tr>
<td>Says s/he can’t trust others</td>
<td>0.91</td>
<td>1.06</td>
<td>5.56</td>
<td>11.44</td>
<td>.59</td>
<td>.59</td>
</tr>
<tr>
<td>Withdraws or avoids contact with others</td>
<td>0.86</td>
<td>1.01</td>
<td>5.60</td>
<td>12.91</td>
<td>.40</td>
<td>.40</td>
</tr>
<tr>
<td>Seems anxious, nervous</td>
<td>1.40</td>
<td>1.07</td>
<td>5.07</td>
<td>12.02</td>
<td>.49</td>
<td>.49</td>
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<tr>
<td>Is slow-moving</td>
<td>0.60</td>
<td>0.90</td>
<td>5.86</td>
<td>13.69</td>
<td>.35</td>
<td>.35</td>
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<tr>
<td>Seems sad, unhappy</td>
<td>1.40</td>
<td>0.93</td>
<td>5.07</td>
<td>11.16</td>
<td>.77</td>
<td>.77</td>
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Reliability Coefficients: N of Cases = 43

Alpha = .7607
Table 3

Reliability Analysis – Scale (Alpha) for Attention Problems

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<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless, fidgety, moves around constantly</td>
<td>2.00</td>
<td>1.09</td>
<td>3.20</td>
<td>2.25</td>
<td>.46</td>
<td>.2742</td>
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<tr>
<td>Seems lost in his/her own thoughts</td>
<td>0.93</td>
<td>0.96</td>
<td>4.27</td>
<td>3.25</td>
<td>.22</td>
<td>.6443</td>
</tr>
<tr>
<td>Acts impulsively, Acts without thinking</td>
<td>2.27</td>
<td>1.01</td>
<td>2.93</td>
<td>2.56</td>
<td>.42</td>
<td>.6443</td>
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Reliability Coefficients:  
N of Cases = 45  
Alpha = .5497
Table 4
Group Means for Externalizing Problems

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<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Grand Mean</th>
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<tr>
<td>Boys</td>
<td>1.64</td>
<td>1.46</td>
<td>1.55</td>
</tr>
<tr>
<td>Girls</td>
<td>1.53</td>
<td>1.66</td>
<td>1.60</td>
</tr>
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</table>

Table 5
Group Means for Internalizing Problems

<table>
<thead>
<tr>
<th></th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Grand Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>1.01</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Girls</td>
<td>1.23</td>
<td>1.50</td>
<td>1.37</td>
</tr>
</tbody>
</table>
Table 6  
**Group Means for Externalizing Problems**

<table>
<thead>
<tr>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.60</td>
<td>1.54</td>
<td>.06</td>
</tr>
</tbody>
</table>

Table 7  
**Group Means for Internalizing Problems**

<table>
<thead>
<tr>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.09</td>
<td>1.19</td>
<td>-.10</td>
</tr>
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</table>
Table 8  
Group Means for Externalizing and Internalizing Problems at Pre-Treatment

<table>
<thead>
<tr>
<th>Externalizing</th>
<th>Internalizing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.60</td>
<td>1.09</td>
</tr>
</tbody>
</table>

Table 9  
Group Means for Externalizing and Internalizing Problems at Post-Treatment

<table>
<thead>
<tr>
<th>Externalizing</th>
<th>Internalizing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.53</td>
<td>1.20</td>
</tr>
</tbody>
</table>
Appendix A
Wediko Children’s Services Hierarchy of Behavioral Interventions
## Appendix B

### Wediko Children’s Services Daily Schedule

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00</td>
<td>Wake-Up</td>
<td>Wake-Up</td>
<td>Wake-Up</td>
<td>Wake-Up</td>
<td>Wake-Up</td>
<td>Wake-Up</td>
<td>Pre-Vocational</td>
<td>Wake-Up</td>
</tr>
<tr>
<td>7:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Training (7:30-9:45)</td>
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</tr>
<tr>
<td>7:30</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Wake-Up</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Bedroom Routines</td>
</tr>
<tr>
<td>7:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(7:30-9:45)</td>
<td>Bedroom Routines</td>
</tr>
<tr>
<td>8:00</td>
<td>Think City</td>
<td>Think City</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
</tr>
<tr>
<td>8:15</td>
<td>M-F</td>
<td>M-F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>8:00-9:45</td>
<td>8:00-9:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Activity 1</td>
<td>Activity 1</td>
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<td>Activity 1</td>
<td>Activity 1</td>
<td>Activity 1</td>
<td>Activity 1</td>
<td>Activity 1</td>
</tr>
<tr>
<td>9:15</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group (9:10-10:00)</td>
<td>Group/Aideship (9:10-10:00)</td>
</tr>
<tr>
<td>9:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:45</td>
<td>Playground</td>
<td>Activity 1</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 1</td>
<td>Literacy</td>
</tr>
<tr>
<td>10:00</td>
<td>Activity 1</td>
<td>Activity 1</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 1</td>
<td>Literacy</td>
</tr>
<tr>
<td>10:15</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
<td>Group (10:10-11:00)</td>
</tr>
<tr>
<td>10:30</td>
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<td>10:45</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>Cabin Clean-Up</td>
<td>Cabin Clean-Up</td>
<td>Group Therapy</td>
<td>Group Therapy</td>
<td>Group Therapy</td>
<td>Group Therapy</td>
<td>Group Therapy</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>11:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>Lunch</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:45</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td>Group</td>
<td>Group</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:15</td>
<td>Therapy</td>
<td>Therapy</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
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</tr>
<tr>
<td>12:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinics</td>
</tr>
<tr>
<td>13:00</td>
<td>Activity 2</td>
<td>Activity 2</td>
<td>Activity 3</td>
<td>Activity 3</td>
<td>Activity 3</td>
<td>Activity 2</td>
<td>Activity 1</td>
<td>Activity 1</td>
</tr>
<tr>
<td>13:15</td>
<td>Group (1:00-1:50)</td>
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48
Appendix C
Wediko Children’s Services Daily Behavior Checklist

> WEDIKO BEHAVIOR CHECKLIST <
© Harry W. Parad / Wediko Children’s Services

Name: ___________________________ Group: ___________________________ Date: ___________________________

Personal Goal(s): ____________________________________________________________

<table>
<thead>
<tr>
<th>CREDITS</th>
<th>self</th>
<th>staff</th>
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<tr>
<td>Participation: Joined in, made a good effort in the group, stayed with the group.</td>
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<td>Listened to staff and others.</td>
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<td>Communication: Used words to express feelings and thoughts.</td>
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<td>Positive Appearance: Kept body and space clean.</td>
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Overall Credit + Feedback Total: __________

DETOURS

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<tr>
<th>VERBAL AGGRESSION</th>
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<th>total</th>
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<tr>
<td>Physical Aggression: Hit, pushed, threatened or postured.</td>
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<td>Withdrawal: Held back, isolated self from others, spaced out, walked off.</td>
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<td>Disorganized speech: Off-track behavior.</td>
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Detour Total: __________

Rating Scale: 0 = Not at all 1 = Below expectation 2 = At expectation 3 = Above expectation

Acceptance of Feedback:

yes = 1  no = 0  
(Add to overall Credit total)
Appendix D
Wediko Children’s Services Checklist Rating Form

> WEDIKO BEHAVIOR CHECKLIST >

Scoring Rules * Focus and Crossroads
(Revised 7/4/96)

For Credit Behaviors

A. If student rates himself/herself the same or lower than staff, add the two scores.
B. If student rates himself/herself higher than staff, the staff score is the final rating.
C. The one exception is if student and staff both rate a credit behavior as zero (0).
   To reward students for accurate and honest ratings, the student receives a one (1).

Sample grid:

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<th>If staff</th>
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For Detour Behaviors

If student rates himself/herself the same as staff, then add the two scores.
If student rates himself/herself higher than staff, then double the staff score — plus one (1).
If student rates himself/herself lower than staff, then double the staff score — plus two (2).

Sample grid:

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Appendix E
Sample of a Wediko Children’s Services Individual Contract

Magellan versus Barbed Wire
The Choice is up to NAME

Wediko is pleased to welcome NAME as an important member of the Orion cabin group for the summer of 2004. The Orion staff is looking forward to helping NAME identify and work on the issues presented in this individual contract. For NAME to be successful he must be honest about the problems with which he needs help, and he must be willing to make new choices and try new behaviors.

In his Wediko interview, NAME was able to review his past year at NAME School in detail. He accepted responsibility for hard times and he was able to give himself credit for his classroom accomplishments. Specifically, NAME was able to identify several times this past year when he handled his adolescent impulses and dealt with events from his past in ways that were upsetting to his mother and others who care about him. Anyone who knows NAME understands that he is an intelligent and caring person. At times, however, his behavior makes it difficult for other people to be around him. NAME’s family is worried that unless he makes big changes, he will continue to push people away.

At school this year, NAME tried to get by by paying attention in class only 40-50% of the time. Because NAME is so bright, he was able to do that in elementary school and still manage to do well and earn good grades. Now, however, NAME must pay attention in class closer to 90% of the time. This is because the work in middle school is incremental. That means that what is taught on one day is the foundation for what is taught the next day, the next week, the next month, and so forth until the end of the semester.

At Wediko, staff found that a number of things helped NAME work with adults more effectively. The staff at NAME School should modify these suggestions to fit the school resources while concomitantly meeting NAME’s needs. The staff of NAME School can do their part to help NAME manage his behavior by doing the following:

1) When NAME is frustrated or overwhelmed he has a hard time using words. Adults should be patient and encourage him to talk about his thoughts and feelings. Likewise, adults should not talk to
NAME when he is frustrated unless he is ready to listen — specifically, when he is willing to listen without interrupting, and while seated and still.

2) Teachers who have trouble with NAME tend to take his sometimes-difficult behavior personally and get drawn into power struggles. Adults should understand that working with NAME rather giving him orders is the best way to get him to comply with expectations.

3) NAME gets stuck on semantics. As a result, the staff at NAME School should do their best to use very deliberate language when they give instructions in the classroom. For example, because NAME takes instructions very literally, adults at NAME School should do their best to explain things clearly and specifically.

4) The staff at NAME School should use either a daily behavior checklist or a contract similar to this one. By doing so, both mom and school will know when his behavior or academic work begins to slip before it gets out of control (i.e., to the point where NAME feels hopeless about getting things back on track).

5) NAME School should utilize a consultant (e.g., a school psychologist, guidance counselor, or social worker) to structure the daily behavior checklists or contract that they employ with NAME.

6) NAME should have check-ins with the same staff member (e.g., NAME, NAME, or NAME) every morning so that everyone can get a sense of how NAME is feeling when he gets to school. He should also meet with this person several times a day to review his behavior (by using the standardized checklist). The frequency of these meetings should be increased as needed. Flexibility is key!

7) NAME School should maintain weekly contact with mom so that everyone is on the same page about NAME’s successes and struggles.

8) NAME School should host monthly meetings with mom, NAME’s teachers, and his “go-to” person (i.e., NAME, NAME, or NAME) to discuss his progress.

9) Emergency meetings for conspicuous successes (e.g., NAME turned in all of his homework over the last two weeks) and conspicuous difficulties should be held to keep everyone informed of NAME’s academic and behavioral performance.

10) NAME School should do their best to avoid relying on suspensions to manage NAME’s behavior.

11) Adults at NAME School should recognize that NAME routinely has a difficult time at the end of the year due to his early history of losses. Thus, NAME attempts to disengage from the people with whom he has formed relationships upon realizing that the conclusion of the term is approaching.

NAME’s mother is also making a commitment to change things at home. Specifically, NAME’s mom is going to work on managing her frustration when he is having a difficult time and learning about different ways to foster success for NAME at school and at home. Although NAME’s mom has worked very hard in family therapy over the course of the summer, she must make a commitment to continue meeting with clinicians throughout the school year. By doing so, she can continue to explore different ways to help NAME manage his behavior while receiving support for her efforts. Additionally, it was very helpful for NAME to work on social skills in dyad meetings with one other student. Wediko recommends that NAME’s mother do her best to continue providing him with these opportunities.

At Wediko this summer, NAME has done a wonderful job following the rules and routines and being respectful with both staff and other students about 95% of the time. NAME has done a fantastic job at participating during group therapy! He spends most of the time with the group working hard to make and keep friends. At times he has also taken on the role of a positive leader, choosing to help and encourage other students who are struggling.
Sadly, the other 5% of the time, NAME seems to stop thinking about all his promises to his mother and himself; and he just gives in to his impulses. He has provoked other members of his cabin group, engaged in highly sexualized behaviors, used offensive words or phrases, told offensive jokes, thrown huge tantrums when staff asks him to use words to talk about his thoughts and feelings, and said hurtful things to his staff and cabin mates. He has also had a hard time with maintaining proper hygiene, keeping his personal space clean, and completing chores at a satisfactory level.

NAME, regardless of how caring and intelligent you are, you are 13-years-old and you getting older and stronger every day. When you say hurtful things, shut down, or throw tantrums, you frighten people. Your mom and Wediko are worried that these behaviors will continue to push people away.

NAME, the Orion staff believes in you and your ability to make safe and positive choices and think for yourself; instead of being influenced by the sometimes-negative behavior of your peers. At times, NAME, you communicate your thoughts and feelings, you choose to work with people, you earn incentives and you make times with the Orion group a lot of fun. You also have the ability to use your hands and your mind in constructive ways to keep busy and take on challenging tasks. When you choose these behaviors, the metaphor that comes to mind is that of the famous explorer, Magellan.

Magellan was intelligent and courageous. He worked very hard to make what was once a very small world much, much bigger. In fact, he was the first man to circumnavigate the globe. Not only did he accomplish great feats, he communicated what he had found with the rest of the world. Magellan, like you, was inquisitive, interesting, and exciting to be around.

The Orion staff thinks that you can choose Magellan behaviors more often. Key Magellan behaviors include:

1. **Talking and sharing**: Using safe words to identify what you are thinking and feeling with your family, your teachers, other children, and the Wediko staff; and using words to tell adults how they can help you. It is important to practice communicating the whole message to other people so they can understand your needs.

2. **Listening to the whole message**: Being attentive and allowing both peers and adults to finish what they are telling you without interrupting them so that you can receive the whole message, and repeating what they said to you in your own words.

3. **Compromising with peers and adults**: Choosing to meet people half way rather than making demands to have it your own way.

At other times, you remind staff of Barbed Wire. Barbed Wire has two purposes. First, it keeps things locked inside so they cannot get out. Second, it hurts people who attempt to get in. At times, NAME, you can be like Barbed Wire. You lock up everything deep inside—your thoughts, your emotions, and your life history — so that no one can know. When people make an effort to talk with you about these things, you behave in ways that can be hurtful. Some Barbed Wire behaviors include:
(1) **Automatic tune-out**: Grunting at and interrupting both peers and adults when they are trying to communicate with you.

(2) **Cocooning**: Becoming hyper-focused on something other than the person who is speaking to you in order to prevent yourself from listening to their whole message.

(3) **Topsy-turvy behavior**: Stomping and flaying around when you become frustrated with adults who are talking to you, screaming out repeated songs and phrases until you are out of control.

NAME, your progress with Magellan and Barbed Wire behaviors will be reviewed each day at group checklist times, using the same exact rating system. You will have a special chart to help you keep track of your points. Staff will remind you of your choices with key words like “Magellan” and “Barbed Wire.” It is important to try to accept this feedback and not yell or argue when adults recognize these phrases.

In this individual contract, you will have to earn above a minimum number of Magellan points and stay below a maximum number of Barbed Wire points to earn contract rewards. You with your Contract Manager, NAME, will discuss the first point totals. Since no one is perfect, you will be able to earn rewards even if you make some mistakes. The choice is up to you, NAME.

NAME, we all hope that the key concepts stick in your head and your heart. Make the best of this opportunity. This contract will be reviewed for possible changes after three days and after one week. We the undersigned have read and understood the terms and conditions of this contract. NAME, we believe that you can choose Magellan behaviors more often — Good Luck!

________________________________      ___________      ___________
Student                  Contract Manager         Date

________________________________
Supervisor

________________________________      ___________      ___________
Orion Staff                  Orion Staff

________________________________
Orion Staff

________________________________
Orion Staff
## Contract Scoring Sheet

### NAME

Date: ______

### Magellan Behaviors

**Talking and Sharing**: Using words to identify what you are thinking and feeling and communicating the *whole* message to other people so they can understand your needs.

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<tr>
<th>Self</th>
<th>Staff</th>
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**Listening to the whole message**: Being attentive and allowing both peers and adults to finish what they are telling you without interrupting them so that you can receive the *whole* message, and repeating what they said to you in your own words.

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**Compromising with Peers and Adults**: Choosing to meet people half way rather than making demands to have it your own way.

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### Barbed Wire Behaviors

**Automatic Tune-Out**: Grunting at and interrupting both peers and adults when they are trying to communicate with you.

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<th>Self</th>
<th>Staff</th>
<th>Total</th>
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**Cocooning**: Becoming hyper-focused on something other than the person who is speaking to you in order to prevent yourself from listening to their whole message.

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<th>Staff</th>
<th>Total</th>
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**Topsy-Turvy Behavior**: Stomping and flaying around when you become frustrated with adults.

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<th>Self</th>
<th>Staff</th>
<th>Total</th>
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Appendix F
Wediko Child Application-Parent Form

Child Application - Parent Form
© Wediko Children's Services

New Hampshire Summer Program
72-74 East Dedham Street
Boston, MA 02118
Phone: (617) 292-9200
Fax: (617) 292-9275
wediko@wediko.org

CHILD INFORMATION:

Child's name: ____________________________ Sex: □ Male □ Female

Age: _______ Date of birth (Month, Day, Year): _______ - _______ - _______ Height: _______ Weight: _______

Child's current street address: ___________________________________________________________

City: ____________________________ State: ____________________________ Zip: ____________________________

Please list any previous years at Wediko: Summer(s) ____________________________ Winter(s) ____________________________

PARENT / CARETAKER INFORMATION:

First parent or caretaker's full name that child lives with: ____________________________

Age: _______ Occupation: ____________________________ Home phone: _______ - _______ - _______ - _______ - _______

Mobile phone: _______ - _______ - _______ - _______ - _______ Work phone: _______ - _______ - _______ - _______ - _______

Second parent or caretaker's full name that child lives with: ____________________________

Age: _______ Occupation: ____________________________ Home phone: _______ - _______ - _______ - _______ - _______

Mobile phone: _______ - _______ - _______ - _______ - _______ Work phone: _______ - _______ - _______ - _______ - _______

Are parent(s)/caretaker(s): □ Married □ Separated □ Divorced □ Other (describe): ____________________________

If applicable, please describe visiting arrangements ____________________________

Who does the child live with? □ Biological parents □ Adoptive parents □ Foster parents □ Other (describe): ____________________________

LEGAL GUARDIANSHIP INFORMATION:

Child's legal guardian name(s) (if different from above): ____________________________

Address: ________________________________________________________________

Home phone: _______ - _______ - _______ - _______ - _______ Work phone: _______ - _______ - _______ - _______ - _______

Page 1
STATE OR PRIVATE AGENCY INFORMATION:

Please note if any state or private agency is involved in the child’s life.

Worker: ___________________________ Agency: ___________________________

Address: ___________________________ City: __________ State: ______ Zip: ______

Since (referral date): _______________ Phone: ___________ ______ ______ ______

SCHOOL INFORMATION:

Child’s current school name: ___________________________

Phone: ___________ ______ ______ ______

Contact person: ___________________________ Role: ___________________________

Address: ___________________________ City: __________ State: ______ Zip: ______

Will there be changes in the child’s living situation or school setting after the summer program?

☐ Yes  ☐ No  ☐ Maybe  (If yes or maybe, please describe the changes being considered): ___________________________

MEMBERS OF CURRENT HOUSEHOLD:

Please check all of the people who currently live with the child:

☐ Biological mother  ☐ Adoptive mother  ☐ Foster mother  ☐ Other ___________________________

☐ Biological father  ☐ Adoptive father  ☐ Foster father  ☐ Other ___________________________

☐ Biological brother(s) Name(s) ___________ Age(s) ___________

☐ Biological sister(s) Name(s) ___________ Age(s) ___________

☐ Stepmother Name ___________ Age ___________

☐ Stepfather Name ___________ Age ___________

☐ Stepbrother(s) Name(s) ___________ Age(s) ___________

☐ Stepsister(s) Name(s) ___________ Age(s) ___________

☐ Foster brother(s) Name(s) ___________ Age(s) ___________

☐ Foster sister(s) Name(s) ___________ Age(s) ___________

☐ Other relative(s) Name(s) ___________ Age(s) ___________
FAMILY MEMBERS / SIGNIFICANT OTHERS LIVING ELSEWHERE:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Whereabouts</th>
<th>Frequency of visitation</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

HISTORY:

At what age did the child first indicate to you that s/he might be a special needs child? What were the special needs that were identified?

1. Age: _______  Problem: ____________________________

2. Age: _______  Problem: ____________________________

3. Age: _______  Problem: ____________________________

Please describe any times the child has been hospitalized:

1. Age: _______  How long: _______  Reason: ____________________________

2. Age: _______  How long: _______  Reason: ____________________________

3. Age: _______  How long: _______  Reason: ____________________________

Please summarize all previous specialized school settings and/or living situations.

1. School/Living situation: ____________________________  Dates: ____________________________
   Reason: ____________________________

2. School/Living situation: ____________________________  Dates: ____________________________
   Reason: ____________________________

3. School/Living situation: ____________________________  Dates: ____________________________
   Reason: ____________________________

Page 3
FAMILY INFORMATION:

Please describe times of the day or list activities which are most pleasant and enjoyable for your family. Be sure that the child applying to Wedko is present at these family times.

1. 

2. 

3. 

Please describe times of the day (or activities) that are most upsetting and stressful for your family.

1. 

2. 

3. 

Please describe your family’s biggest or most serious problems.

1. 

2. 

3. 

FAMILY STRESSORS:

Below you will find a list of events that can potentially be stressful for both parents and children. If they apply, please check those events that have occurred in your family, and list the date.

1. Marital stress:
   - Separation Date: 
   - Remarriage Date: 
   - Divorce Date: 
   - Other Date: 

2. Hospitalization or serious illness:
   - Parent/Caretaker For what: Date: 
   - Sibling For what: Date: 
   - Other family member For what: Date: 

3. Death:
   - Family member Who: Date: 
   - Close friend Who: Date: 
   - Other Who: Date: 

59
FAMILY STRESSORS (CONTINUED):

4. Family move(s):
   From: ______________________ To: ______________________ Date: __________
   From: ______________________ To: ______________________ Date: __________

5. Work-related problems:
   Who: ______________________ Describe: ______________________ Date: ______
   Who: ______________________ Describe: ______________________ Date: ______

6. Financial problems:
   Describe: ___________________________ Date: ______

7. Key family member separation from the family: (i.e., sibling, parent, etc.)
   Name: ______________________ Reason: ______________________ Date: ______
   ___________________________ Date: ______
   Name: ______________________ Reason: ______________________ Date: ______
   ___________________________ Date: ______

8. Problems with alcohol and/or other drugs:
   Describe: ___________________________ Date: ______

9. Additional family crises or difficulties:
   Describe: ___________________________ Date: ______
   Describe: ___________________________ Date: ______

COUNSELING / THERAPY:

Often, people in the family (besides the child applying to Wediko) have sought some type of professional counseling or therapy. If this applies, please describe below:

1. Entire family  ☐ Yes  ☐ No  When/Duration: ______________________
   Primary issues: ___________________________________________________

2. Couple  ☐ Yes  ☐ No  When/Duration: ______________________
   Primary issues: ___________________________________________________
COUNSELING / THERAPY (CONTINUED):

3. Mother/Caretaker   □ Yes   □ No   When/Duration: __________________________
   Primary issues: ____________________________________________________________

4. Father/Caretaker   □ Yes   □ No   When/Duration: __________________________
   Primary issues: ____________________________________________________________

5. Other family members   □ Yes   □ No
   Name(s): __________________________ When/Duration: __________________________
   Primary issues: ____________________________________________________________
   Name(s): __________________________ When/Duration: __________________________
   Primary issues: ____________________________________________________________

CURRENT ADJUSTMENT:

From your point of view, what are the child’s best qualities?
1. ________________________________________________________________

2. ________________________________________________________________

3. ________________________________________________________________

From your point of view, what are the child’s most serious problems?
1. ________________________________________________________________

2. ________________________________________________________________

3. ________________________________________________________________
**CHILD'S STRENGTHS:**

At Wediko, knowing the areas in which children excel is essential to providing effective treatment and education. Identifying your child's strengths helps Wediko place him/her in the most appropriate group. Please rate the degree to which the child displays each of the following strengths.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all descriptive</td>
</tr>
<tr>
<td>1</td>
<td>Slightly descriptive</td>
</tr>
<tr>
<td>2</td>
<td>Fairly descriptive</td>
</tr>
<tr>
<td>3</td>
<td>Highly descriptive</td>
</tr>
</tbody>
</table>

0 1 2 3 Easygoing temperament
0 1 2 3 Sense of humor
0 1 2 3 Fine motor skills
0 1 2 3 Reads social cues accurately
0 1 2 3 Average or above average IQ
0 1 2 3 Capacity for connectedness
0 1 2 3 Stable mood
0 1 2 3 Hopeful future orientation
0 1 2 3 Special talents: ______________________

**RISK FACTORS / BEHAVIORAL ISSUES:**

At Wediko, we are particularly concerned about certain problematic behaviors. Information about these behaviors is essential for group placement decisions and individual treatment planning. Below you will find a list of some of these problem behaviors. Please rate the degree to which the child displays each of the following behaviors. Using this scale, write in one number for each item.

<table>
<thead>
<tr>
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<td>Highly descriptive</td>
</tr>
</tbody>
</table>

_____ Aggressive outbursts    _____ Fire setting    _____ School suspensions
_____ Alcohol/drug abuse      _____ Gang involvement _____ Self-injurious behavior or threats
_____ Attachment difficulties _____ Harms animals    _____ Sexualized behavior
_____ Retreats into fantasy  _____ Stimulus seeking _____ Early sexual activity
_____ Bedwetting              _____ Defies authority    _____ Soiling (encopresis)
_____ Stealing                _____ Suicidal ideation  _____ Obsessive/compulsive behavior
_____ Court involvement       _____ Sleeping disorders _____ Verbal attacks (racial and sexual insults)
_____ Daytime wetting          _____ Poor hygiene      _____ Rapid shifts in mood
_____ Eating disorders         _____ Runs away        _____ Tics
_____ Weapon incidents/use    _____ Poor reality testing
### BEHAVIORAL DESCRIPTIVE

Please indicate how well each of the following statements describes your child's BEHAVIOR AT HOME. Circle a number using the following scale:

0 = Not at all descriptive  
1 = Slightly descriptive  
2 = Fairly descriptive  
3 = Highly descriptive

- **0 1 2 3** Is a withdrawn child.
- **0 1 2 3** Acts weird, odd.
- **0 1 2 3** Is destructive; breaks things.
- **0 1 2 3** Is able to wait for things.
- **0 1 2 3** Seems lost in own thoughts.
- **0 1 2 3** Swears, curses.
- **0 1 2 3** Threatens, bullies.
- **0 1 2 3** Rocks back and forth.
- **0 1 2 3** Seeks anxious, nervous.
- **0 1 2 3** Follows adults' instructions.
- **0 1 2 3** Rigid or stuck thinking, perseverates.
- **0 1 2 3** Remains calm when stressed.
- **0 1 2 3** Is quiet, untalkative.
- **0 1 2 3** Teases or provokes others.
- **0 1 2 3** Ability to tolerate frustration.
- **0 1 2 3** Tests limits; tries to get away with things.
- **0 1 2 3** Says s/he can't do things.
- **0 1 2 3** Deficits in social skills.
- **0 1 2 3** Says s/he cannot trust other people.
- **0 1 2 3** Won't take credit for own success.
- **0 1 2 3** Is well-coordinated, athletic.
- **0 1 2 3** Is intelligent, bright.
- **0 1 2 3** Cries, whines.
- **0 1 2 3** Often depressed.
- **0 1 2 3** Expresses self well with words.
- **0 1 2 3** Repetitive hand movements.
- **0 1 2 3** Hits, pushes, fights.
- **0 1 2 3** Yells, screams.
- **0 1 2 3** Is slow-moving.
- **0 1 2 3** Has a good attention span.
- **0 1 2 3** Is a friendly, sociable child.
- **0 1 2 3** Blames others for things s/he does wrong.
- **0 1 2 3** Gets irritable or angry easily.
- **0 1 2 3** Seems sad, unhappy.
- **0 1 2 3** Says things that don't make sense.
- **0 1 2 3** Restless, fidgety, moves around constantly.
- **0 1 2 3** Throws temper tantrums.
- **0 1 2 3** Withdraws or avoids contact with others.
- **0 1 2 3** Cooperates with others.
- **0 1 2 3** Distracts easily.
- **0 1 2 3** Atypical thoughts and ideas.
- **0 1 2 3** Gives in to others, submits.
- **0 1 2 3** Is an aggressive child.
- **0 1 2 3** Acts impulsively; acts without thinking.
Appendix G
Letter Requesting Permission to Evaluate Wediko’s Summer Program

Dear Harry:

I am writing to you in order to follow up on the conversations we have had in the past about conducting my Master’s project research at Wediko this summer.

Currently, I am learning about program evaluation through my work at Miami University’s Center for School-Based Mental Health Programs. I would like to apply this knowledge to Wediko and implement a method by which the agency can evaluate its program.

When we first discussed the idea of evaluating the program as my Master’s project, you explained to me how involved and demanding the endeavor could be. Remember, I read your dissertation—I’m a believer! After reading through the child application materials that Allison and Bonnie [office staff] sent me and brainstorming with my advisor, however, I developed a plan that I hope will both serve my needs and those of Wediko. When conceptualizing these ideas I was careful to ensure that my research interests will not conflict with the clinical responsibilities that I will be assuming this summer. I briefly outlined my ideas in the attached concept paper. I have two goals for the following proposal: (1) Obtain the required experience in program evaluation for my Master’s project, and (2) Make a significant contribution to Wediko’s summer program.

I would like to speak with you about my ideas. Please call me after you have had an opportunity to read over the enclosed concept paper. I look forward to discussing it with you. Thank you for your consideration.

Sincerely,

Chris Reiger

Enclosure: Concept Paper and Logic Model
Appendix H
Concept Paper

The Evaluation of Wediko’s Summer Program: A Concept Paper
Christopher J. Reiger
Miami University
April 7, 2003

Overview

Only through the analysis of their impact can residential programs develop and refine the effective elements of their treatment (Verhagen, 1995). Beyond that of establishing treatment effects, program evaluations can serve a number of important functions. They can be used to attract funding bodies, support accreditation and licensing needs, act as reinforcement for stakeholders and treatment staff, and aid in program promotion (Nansel et al., 1998).

Despite the advantages of doing so, many residential programs are unable to conduct outcome research. Nansel et al. (1998) found that only 65% of residential centers for youth with behavioral disorders (n = 93) were conducting any form of outcome investigation.

For anyone who has worked in residential, the reasons for this are obvious. A shortage of resources is the primary obstacle preventing agencies from evaluating their programs (Pfeiffer, 1989). Necessary resources like an experienced staff, sufficient time, and adequate research facilities and equipment are often in short supply. Eighty-nine percent of clinicians who worked at residential treatment centers (n = 273) indicated that there was insufficient time to conduct evaluation research. Seventy-seven percent cited a lack of funding as a chief reason for failing to assess programmatic success (Pfeiffer, Burd, and Wright, 1992).

Many of the programs that do manage to engage in some form of evaluation often fail to collect any preadmission information. As a result, these agencies are unable to establish baseline measures of individual strengths or problem behavior (Pfeiffer, 1989). Furthermore, many programs fail to conduct long-term follow-up. It is imperative to do so because behavioral changes at the time of discharge cannot be used to accurately predict post-treatment adaptability (Curry, 1995).

Unlike many programs, Wediko collects a considerable amount of data on each child during the application process. The preadmission questionnaire includes items on demographics, history of problem behaviors, history of services, family stressors, child strengths, risk factors, behavioral descriptions, and current goals. This extensive—and highly valuable—collection of information is used to maximize the clinical impact of every child’s stay at Wediko (i.e., in the assignment of child to living group, and in the development of the treatment goals and strategies that are unique to each child).

Proposed Study

If an abbreviated version of the Wediko Child Application-Parent Form—one that included only items designed to assess any recent changes in demographics, along with the scales that measure individual strengths and risk factors, and the behavioral description—were sent to parents 12 months post-treatment, Wediko would have ample data to evaluate its effects. If parents of children who attended Wediko in the summer of
2002 completed the abridged questionnaire during the summer of 2003, the program would have access to pre-treatment and one-year follow-up information. For an additional 10 minutes per parent, the summer program would be able to assess its efficacy.

Wediko lends itself to evaluation research for a number of distinctive reasons. Because the summer program adheres to a fixed-time admission/termination model, 12-month follow-up surveys for every child can be sent to all parents simultaneously. This model enjoys another advantage for evaluation research: the composition of each group remains constant—significantly reducing confounds that may occur with a changing staff or peer group (Parad, 1983). Furthermore, because staff members work all shifts, maximum consistency of clinical interventions is achieved (Parad, 1983).

Because Wediko’s summer program is a planned short-term treatment setting for all of its residents, it requires a demanding but short-term commitment from its researchers (Parad, 1983). During my commitment to Wediko, I will assume full responsibility for the partnership’s evaluation project. These duties will include, but are not limited to the following:

• Refining the measurement instrument
• Sending out the questionnaires
• Receiving the completed questionnaires
• Coding the raw data
• Analyzing the data
• Keeping the administration informed of my progress

I understand that the responsibilities of the clinical staff are far too demanding to expect that they contribute to the evaluation. Furthermore, I realize that almost all data collection will occur before the program begins and after it ends.

As outlined above, a lack of resources (i.e., time, facilities, and money) is commonly cited as the chief roadblock preventing agencies from evaluating their programs. As a graduate student, I have the time, I have access to adequate research facilities necessary for data analysis, and because this research also serves as my Master’s project, I will work for free. Respectful of confidentiality, I realize that I likely will have to return to the setting in the fall to code data for analysis.

Alternative Plan of Evaluation

If the requirements of the above study (i.e., contacting the parents of children who attended the program last summer) are incongruent with Wediko’s privacy standards, an alternative form of evaluation can be implemented by harvesting data from the archival files of children who attended Wediko more than once. By comparing information from the Wediko Child Application-Parent Form from one year to the next, valuable data can be collected without any further involvement of parents. This method, however, will only offer insight about the small subpopulation of children that return to Wediko year after year. This sample of children may somehow be different from those children that attend the program only once (Parad, 1983). Valuable information on those children who did not apply to the program a second time—whether due to a reduced need for services or the utilization of alternative services—will be unavailable.

Conclusion
I endorse Harry Parad’s (1983) view that clinical research should be integrated into Wediko’s clinical goal as a vital and constant objective. Program evaluation is the responsibility of all residential agencies that wish to establish which active treatment ingredients are working and which require further development. It is my desire to partner with Wediko in taking on this responsibility.

References


Appendix I
Wediko Children’s Services’ Summer Program Logic Model

**Mission Statement**
- To provide a protective, nurturing and stimulating learning environment which pulls for higher levels of functioning. The program is committed to an integrated skill building approach that expands the adaptive capability of children and their families.

**Guiding Philosophies behind Mission Statement**
- Match of child with living group
- Comprehensive therapeutic milieu that is protective, facilitating, limit-setting, safe and nurturing
- Opportunities for nurturing, guiding, and containing relationships
- Participation in activities structured to control failure, facilitate success, and provide incentive

**Inputs**
- 24 hour 2:1 child to adult ratio (a substantial number of adults hold advanced degrees or are currently enrolled in graduate level programs in psychology, special education, social work or medicine)
  - Week-long training for staff
- Recreational equipment (e.g., sports equipment, canoes, kayaks, mountain-bikes, musical instruments, theatre props, archery equipment, art supplies, fishing rods and tackle, rowboats)
- 450-acre campus (including a school, gymnasium, athletic fields, lake, dining hall, cabins, and low-stimulation environment)

**Activities**
- Group therapy
- School
- Recreational activities
- Medication trials
- Feedback/incentive systems

**Outputs**
- 7 hours/week of group therapy
- 9 hours/week of school
- 7 hours/day of recreational activities
- Medication trials as needed
- Individual behavior contract/incentive system

**Initial (In-Program) Outcomes**
- Normalized attitudes about therapy
- Reduced school anxiety
- Recreational skill development
- Desire to modify behavior

**Intermediate (In-Program) Outcomes**
- Active participation in therapy
- Active participation at school
- Increased capacity for accurate self-observation
- Decreased number of age-inappropriate behaviors

**Long-Term (Post-Program) Outcomes**
- Revised personal identity (from problem-focused to skill-based)
- Increased self-esteem
- Increased overall age-appropriate functioning

**Mission Statement**
- To provide a protective, nurturing and stimulating learning environment which pulls for higher levels of functioning. The program is committed to an integrated skill building approach that expands the adaptive capability of children and their families.

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**Long-Term (Post-Program) Outcomes**
- Revised personal identity (from problem-focused to skill-based)
- Increased self-esteem
- Increased overall age-appropriate functioning
Appendix J  
Consent to Participate in Research Form

Research Consent Form - Parent

At Wediko Children’s Services, we conduct research to improve our understanding of application material of the children and the ways counselors can help them. We collect information about children at Wediko using checklists, interviews, and questionnaires. Part of the data will be analyzed immediately during the summer to help staff learn about the children and how to work with them. Other parts will later be studied to understand how the children interact with one another and with adults, how problems develop, and how we can best help.

All of the material will be confidential. The last names of the children will not be provided to any person who might use the data. Only research personnel approved by Wediko will have access to the data. All such personnel will first sign agreements stating that they will not discuss anything about the children with anyone except Wediko staff or research personnel. No other identifying information, such as addresses, names of relatives or friends, therapists or teachers, will ever be released. In case of research publication, the data will be reported in ways that make it impossible to identify any individual child.

If you have any questions about projects, please contact Dr. Harry W. Parad, Executive Director, Wediko Children’s Services. Please call: (617) 292-9200.

Parent Consent Agreement

I have read the above description of the research project. I believe that I have been fully informed about the project. I also certify that the Participant is under eighteen and that I am the parent (guardian) of the participants. I authorize Wediko, Dr. Parad, and personnel approved by Wediko and Dr. Parad to conduct research as described above. Under these conditions, I agree that Wediko and the researchers are the sole owners of all the material collected so long as they abide by the conditions of this agreement.

Name of child ____________________________________________________________
Signature of Parent/ Legal Guardian __________________________________date _____________________

Wediko Supervisor ________________________________________________________

Child Consent Agreement

I have read the above description of the research project. I believe that I have been fully informed about the project. I authorize Wediko, Dr. Parad, and personnel approved by Wediko and Dr. Parad to conduct research as described above. Under these conditions, I agree that Wediko and the researchers are the sole owners of all the material collected so long as they abide by the conditions of this agreement.

Signature of child _______________________________________________________________

Please return this form to Wediko Children’s Services at the Boston address below.
### Appendix K
Comparison of Child Behavior Checklist (CBCL) Items on the Internalizing Problems Index with Wediko Application-Parent Form Items

<table>
<thead>
<tr>
<th>CBCL Item</th>
<th>Wediko Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cries a lot</td>
<td>Cries, whines</td>
</tr>
<tr>
<td>Feels others are out to get him/her</td>
<td>Says s/he can’t trust other people</td>
</tr>
<tr>
<td>Suspicious</td>
<td></td>
</tr>
<tr>
<td>Would rather be alone than with others</td>
<td>Withdraws or avoids contact with others</td>
</tr>
<tr>
<td>Nervous, high-strung, or tense”</td>
<td>Seems anxious, nervous</td>
</tr>
<tr>
<td>Too fearful or anxious</td>
<td></td>
</tr>
<tr>
<td>Overtired</td>
<td>Is slow moving</td>
</tr>
<tr>
<td>Underactive, slow moving, or lacks energy</td>
<td></td>
</tr>
<tr>
<td>Unhappy, sad, or depressed</td>
<td>Seems sad, unhappy</td>
</tr>
<tr>
<td>Withdrawn, doesn’t get involved with others</td>
<td>Is as withdrawn child</td>
</tr>
</tbody>
</table>
Appendix L
Number and item on the Child Behavior Checklist that constitutes the Internalizing Problems Index that did not have adequate correlates on the Wediko Application – Parent Form

12. Complains of loneliness
31. Fears he/she might think or do something bad
32. Feels he/she has to be perfect
33. Feels or complains that no one loves him/her
35. Feels worthless or inferior
51. Feels dizzy
56. Physical problems without known medical cause
   a. Aches or pains (not stomach or headaches)
   b. Headaches
   c. Nausea, feels sick
   d. Problems with eyes (not if corrected by glasses)
   e. Rashes or other skin problems
   f. Stomachaches or cramps
   g. Vomiting, throwing up
   h. Other
52. Feels too guilty
65. Refuses to talk
69. Secretive, keeps things to self
71. Self-conscious or easily embarrassed
75. Shy or timid
80. Stares blankly
88. Sulks a lot
112. Worries
Appendix M
Comparison of Child Behavior Checklist (CBCL) Items on the Externalizing Problems Index with Wediko Application-Parent Form Items

<table>
<thead>
<tr>
<th>CBCL Item</th>
<th>Wediko Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cruelty, bullying, or meanness to others</td>
<td>Threatens; bullies</td>
</tr>
<tr>
<td>Threatens people</td>
<td></td>
</tr>
<tr>
<td>Destroys his/her own things</td>
<td>Destructive; breaks things</td>
</tr>
<tr>
<td>Destroys things belonging to his/her family or others</td>
<td></td>
</tr>
<tr>
<td>Gets in many fights</td>
<td>Hits, pushes, fights</td>
</tr>
<tr>
<td>Physically attacks people</td>
<td>Yells, screams</td>
</tr>
<tr>
<td>Screams a lot</td>
<td></td>
</tr>
<tr>
<td>Swearing or obscene language</td>
<td>Swears, curses</td>
</tr>
<tr>
<td>Teases a lot</td>
<td>Teases or provokes others</td>
</tr>
<tr>
<td>Temper tantrums or hot temper</td>
<td>Throws temper tantrums</td>
</tr>
</tbody>
</table>
Appendix N
Number and item on the Child Behavior Checklist that constitutes the Externalizing Problems Index that did not have adequate correlates on the Wediko Application – Parent Form

3. Argues a lot
7. Bragging, boasting
19. Demands a lot of attention
22. Disobedient at home
23. Disobedient at school
26. Doesn’t seem to feel guilty after misbehaving
27. Easily Jealous
39. Hangs around with others who get in trouble
43. Lying or cheating
63. Prefers being with older kids
67. Runs away from home
72. Sets fires
74. Showing off or clowning
81. Steals at home
82. Steals outside the home
86. Stubborn, sullen, or irritable
87. Mood change
93. Talks too much
96. Thinks about sex too much
101. Truancy skips school
104. Unusually loud
105. Uses alcohol or drugs for nonmedical purposes
106. Vandalism
Appendix O
Comparison of Child Behavior Checklist (CBCL) Items on the Attention Problems Sub-Index with Wediko Application-Parent Form Items

<table>
<thead>
<tr>
<th>CBCL Item</th>
<th>Wediko Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t sit still, restless, or hyperactive</td>
<td>Restless, fidgety, moves around constantly</td>
</tr>
<tr>
<td>Daydreams or gets lost in his/her thoughts</td>
<td>Seems lost in own thoughts</td>
</tr>
<tr>
<td>Impulsive or acts without thinking</td>
<td>Acts impulsively; acts without thinking</td>
</tr>
<tr>
<td>Nervous, high-strung, or tense</td>
<td>Seems anxious, nervous</td>
</tr>
</tbody>
</table>
Appendix P

Number and item on the Child Behavior Checklist that constitutes the Externalizing Problems Index that did not have adequate correlates on the Wediko Application – Parent Form

1. Acts too young for his/her age
8. Can’t concentrate, can’t pay attention for long
13. Confused or seems to be in a fog
46. Nervous moments or twitching
61. Poor school work
62. Poorly coordinated or clumsy
80. Stares blankly