The perceived value and utility of outcome measures amongst administrators and direct service practitioners in family service agencies in Ontario.

Robin E. Perry

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The Perceived Value and Utility of Outcome Measures
Amongst Administrators and Direct Service
Practitioners in Family Service Agenciest in Ontario

by

Robin E. Perry

A Thesis
presented to the University of Windsor
in partial fulfillment of the
thesis requirement for the degree of
Master of Social Work
in
The School of Social Work

Windsor, Ontario, 1991
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Abstract

This quantitative-descriptive study reports data from a survey of administrators and direct service practitioners in family service agencies throughout Ontario. It explores the actual utility and perceived value of standardized measures or instruments (more specifically outcome measures) into agency protocols and direct service with client systems. The study samples were composed of one administrator and one practitioner employed in each family service agency affiliated with the Ontario Association of Family Service Agencies.

Although generalizability of findings are limited due to a modest response rate, identified trends and results can provide impetus for future research endeavour.

Both sub-populations were predominantly social work educated and trained with a diversity of experience relative to their respective roles. Findings suggest that standardized evaluation does not appear to have been utilized in any convincing fashion by administrators or practitioners within family service agencies.

Although the majority of agencies have established evaluative service goals, the standardized measurement of goal attainment is less pronounced. Limited funds and resources were most often cited by administrators as factors inhibiting the integration of research into practice. When such instruments are utilized, both sub-populations reported the use of multiple measures, soliciting evaluations from multiple sources within the family, typically utilizing client self-reports. However, instrument type and
variables of concern for determining treatment success vary between sub-populations, where administrators most often reported the use of client satisfaction inventories and practitioners reported use of a more veritable range of instruments. Practitioners also reported a likelihood to employ measures not endorsed by their administrators or agency protocol.

No significant associations between a broad host of variables relative to the structure of the agency and practice characteristics could be found with measurement use. However, findings suggest a possible incompatibility with respect to perceived purpose and value for measurement use between sub-populations of administrators and practitioners.

Implications of the study are directed toward future research, social work education and the social work profession in general.
Acknowledgements

There are a number of people whom I wish to acknowledge for their contribution to the research project. First, I would like to thank my advisor, Dr. Michael J. Holosko, for his patience, guidance and expertise, all of which were significant factors in making the completion of this research study a truly rewarding learning experience. I would also like to thank my two readers, Dr. Donna Hardina, School of Social Work, and Dr. Barry Taub, Department of Psychology.

Appreciation is extended to the Ontario Association of Family Service Agencies for their assistance and co-operation throughout this study, and all member administrators and practitioners that participated in this study.

Finally, I would like to thank all my friends and family, particularly my father, Mr. Ernest Perry, for their devoted support and encouragement.
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INTRODUCTION

Outcome measures, as part of a broader attempt to integrate research methodologies into clinical practice, have maintained a historical relevance in the development of both research and practice trends in the fields of psychology and social work. The use of research techniques in practice is related to the validation of interventions, and the necessity of substantiating the effectiveness of the clinicians efforts in facilitating desired change within the client system. As such, the use of standardized measures has generally become an acceptable means by which the effectiveness of practice interventions can be evaluated.

Eysenck (1952) was an early researcher who used outcome measures to demonstrate the limited success of psychotherapy in addressing client problems. His study served as the primary impetus in the development of a plethora of subsequent studies, over the past forty years examining the value of psychotherapy and qualitative factors likely to influence particular outcomes (Zilbergeld, 1983; Smith et.al., 1980; Bergin, 1971). Since Eysenck's study, the majority of psychotherapy outcome research has been germane to the field of psychology. Clinical social work practice, (despite encouragement in the literature for the development of an empirical knowledge base) responded with less enthusiasm, borrowing knowledge generated from research endeavors in
psychology. Only recently has social work engaged in a self
critical analysis that equals that observed within the field
of psychology.

As insights and knowledge into psychotherapy became more
pronounced over time, the complexities associated with
understanding how to appropriately measure change, and
determining variables related to successful outcome, became
more apparent to researchers. Generally, as therapy
orientations became more client-centred and the demand for
research evaluations more prominent, the criteria for
measuring change became more behaviourally specific. This
trend occurred despite theoretical and epistemological support
in the literature for more "holistic" evaluations that would
acknowledge the multitude and interrelationship of potential
factors which can impact on treatment.

As family therapy gained greater popularity and
recognition as a treatment modality, it attempted to establish
its credibility through effectiveness studies. Specifically,
family therapy posed a unique set of problems for outcome
research which had traditionally addressed issues related to
individual psychotherapy where greater control and
measurability was evident. Although its general effectiveness
may have been substantiated, there appears to be a significant
void in the literature with respect to the identification of
specific relationships that impact on successful family
treatment. More importantly, there is minimal information
regarding the evaluative techniques used by those providing family therapy and the extent to which outcome measures play a part in such evaluations.

In fact, of the research that exists, there is no evidence which suggests research findings are incorporated into practice trends or evaluations (Barlow, 1981a; Luborsky et al., 1971). The incompatibility of research designs to direct practice situations, of researcher and practitioner roles and aims, as well as specific methodological and epistemological concerns may have contributed to this reality. Despite these limitations, the necessity and value of integrating research into direct practice remains apparent (Grinell Jr., 1989). To encourage such an integration, research designs that provided clinically significant information while acknowledging the statistical necessity for evaluating the efficacy of direct practice and service plans has received endorsement in the literature (Knikern, 1985; Jacobson, 1985). Despite these attempts, the literature has been less convincing in demonstrating if clinicians and administrators endorse those values that are likely to contribute to a greater utilization of outcome measures in direct practice.
Statement of Purpose

The use of outcome measures in making statements of treatment effectiveness has been supported on ethical, theoretical and fiscal grounds. The literature has historically valued the development and utility of such measures for research, practice, and accountability purposes. The value of using outcome studies has been clearly substantiated in the literature for both clinical and administrative purposes. Indeed, such measures can provide empirical justification of a treatment modality thus ensuring ethical practice trends (Patti, 1987; Eysenck, 1984). In addition, their use may contribute to general knowledge meant to guide professional practices (Laungani, 1984).

As well, routine use of outcome measure can have a number of practical administrative benefits that promote cost-effective service delivery, and the prediction of treatment outcomes thus permitting an efficacy of time, energy and money aimed at providing tailored services specific to presented clients needs (Carter, 1983). Additionally, their use can help facilitate administrative decisions regarding the allocation of resources amongst competing programs, the supervision of clinicians, the improvement of practice and administrative procedures, the evaluation of new methods and services, where findings can influence public policy and provide quantifiable evidence of service success to the community and respective
funding bodies (Child Welfare League of America, 1984; Carter, 1983; Christopher, 1976).

Despite the overwhelming use and endorsement of outcome measures in the literature, the extent to which they are employed in direct practice and the value ascribed to such measures is less certain. This has particular significance in family practice situations where limited research regarding those variables likely to impact on particular outcomes has been conducted. This study will examine the value and utility of outcome measure use within family service agencies from both a clinician as well as an administrator’s points of view.

The primary emphasis is to determine if relationships exist between measurement use and socio-demographic information regarding administrators and clinicians, agency characteristics, practice characteristics of clinicians, and administrators and clinicians perspectives on the value of measurement use. Implications are directed toward shaping future efforts aimed at incorporating research designs into practice, as well as directing future studies that attempt to examine variable relationships likely to impact family therapy outcomes.

The Concepts

*Family Service Agencies* are those accredited organizations that provide professional counselling/therapy services for individuals, couples, and families. For this study, they
represent members of the Ontario Association of Family Service Agencies (OAFSA) which is a constituent organization of 48 member agencies across the province. Membership includes organizations of varying sizes, from varied geographic areas, serving a wide diversity of communities. Clinicians are qualified professionals who hold a post secondary degree or diploma, and are employed by a family service agency for the purpose of providing professional therapy/counselling.

Therapy is defined as the provision of professional counselling/treatment to families, couples, and individuals requiring assistance in personal adjustment, family, social, and other interpersonal relationships. This definition is consistent with that accepted by the Ontario Association of Family Service Agencies and The United Way. It addresses all difficulties and perceived problems that a client system may experience for which therapy is considered an appropriate treatment/intervention.

Administrators/Upper Level Managers are those individuals who are responsible for a combination of service delivery, financial, and/or personnel management within a family service agency. They use administrative skills to direct and control an organization's functioning. Depending on the size of the organization these functions may be the responsibility of one person, namely the executive director, or be delegated to other persons (Dobrowolsky, 1986) For the purpose of this study, administrators must be familiar with service plan, the
budget, the demographics of their respective agencies. Standardized measure(s) refer to any tests, scales, rating forms, questionnaires, interview schedules that are completed by or administered to staff, clients or third parties which have been tested for their reliability and validity (Magura, 1980).

Outcome measures are standardized measures applied at discharge or immediately following the termination of service with a client (within one month).

Follow-up studies involve the collection of data using standardized measures from clients at least one month after discharge or termination.
REVIEW OF THE LITERATURE

The importance of outcome studies cannot be understated with respect to the development of psychotherapy in North America. More specifically, such studies have been significant in providing legitimacy for various treatment modalities, and shaping professional knowledge in both psychology and social work pertaining to treatment effectiveness and service accountability.

In order to enhance an understanding of outcome studies in direct practice, this chapter presents a review of theoretical and empirical research in the literature organized according to: 1) the historical significance of outcome studies; 2) emerging trends in outcome research; and 3) outcome studies and direct practice.

The Historical Significance of Outcome Studies

Generally, psychotherapy structures itself around the objective of changing a person or promoting a person's growth (Sanford, 1962). It is the measurement of that change at termination of treatment which constitutes an outcome study (Sanford, 1962; Strupp and Bergin, 1969; Newman, 1983). The clinical and research significance of measuring outcomes is understood by its general incorporation into the overall treatment paradigm (Raimy, 1952; May, 1965; Cohen, 1979; Gurman et al., 1986). Treatment paradigms are structured around the basic premise that in order to meet the general
objective of psychotherapy, an individual or client-system state must be known (and/or assessed) before and after the treatment intervention has taken place. As well, most paradigms demand a pre-treatment test of the client's situation that is subsequently reassessed with standardized procedures upon termination (Newman, 1983; Strupp and Bergin, 1973). Generally, researchers in the field adhere to such a reality, as 85% of surveyed outcome studies (in a variety of psychotherapeutic fields) included at least two ratings of outcome measures, usually at the point of entry for treatment and at discharge or during follow-up contact (Beutler and Crayo, 1983).

Given the general acceptance and support for treatment paradigms that require an empirical understanding of treatment outcomes, this sub-section will address the historical significance of outcome studies as they relate to: (1) follow-up studies; (2) the concept of effectiveness and service accountability; and (3) the evolution of psychology and social work.

I. Follow-up Studies

A distinction needs to be made between outcome and follow-up studies, terms which are sometimes used interchangeably (Orlinsky and Howard, 1986). Outcome studies refer to measured change at, or immediately following treatment end. They are distinguished from follow-up studies, or contact which takes place at significant periods of time
following termination, usually one month after termination. As one might surmise, follow-up contact can have many benefits. The generation of research data is one. Further, Pattison (1970) noted that continued contact with a client after therapy has three important attributes: (1) as a meaningful human relationship; (2) as a therapeutic tool for the patient; and (3) as a means of collecting psychotherapeutic research data. In these respects, follow-up contact resembles outcome studies in their actual purpose.

Much of the research literature related to follow-up contact has examined clinician’s views with respect to such contact irrespective of whether or not any standardized means of assessing the client’s condition was employed. With this in mind, follow-up contact is typically viewed as infrequent (Hannigan, 1974), and in often times, more likely to be initiated by the client than the therapist (Pattison, 1970; Kress, 1985). The nature and effect of contact, and perceived benefit of such may differ among clinicians according to client’s actual condition upon termination (Hannigan, 1974), the gender of the therapist (Kress, 1985) and their theoretical orientations to practice (Firestein, 1982; Dewald, 1982).

For example, researchers found that clinicians identifying with insight-oriented therapies are more likely to view post-treatment contact as counter productive to treatment gains. In this context, follow-up contact is indicative of
unresolved transference or counter-transference issues (Firestein, 1982; Hannigan, 1974), that may disturb what Dewald (1982) refers to as the "final long term resolution of the neurotic process" (p.448). This is in contrast to the opinions of other clinicians who practice more supportive types of therapies, as these clinicians may conversely view follow-up contact as a potentially enriching experience, that can enhance a clinician's personal and professional growth and also maintain the gains a client makes in treatment (Dewald, 1982; Easson, 1971; Kress, 1985). Despite these opposing views, it is not known if the perceived value of initiating follow-up contact with clients is related to the application of measurement indices during such contact.

Follow-up studies are also distinguished from outcome studies in that they are a standardized review of outcome that provide a means of assessing the longitudinal impact of service or treatment intervention (Jacobs et al., 1983; Patterson and Fleischman, 1979; Goldstein et al., 1979; Mash, 1976; O'Dell, 1974). In principle there is a general acceptance in the literature for the integration of follow-up studies in research and practice. If a client's behavior deteriorates after treatment, it is considered beneficial to know the initial effects of treatment (through outcome measures), and the extent to which measured change is maintained over a period of time. As such, this information may assist with the modification of interventions to ensure
more sustained impact (Nicholson and Berman, 1983). In addition, follow-up studies may add to the credibility of psychotherapy research, as Cohen (1979) found that most clinicians believed the inclusion of follow-up data enhanced the scientific merit of their practice and research.

Despite the practical and theoretical value of such studies there is some question as to their actual utility in research and practice. For instance, Luborsky et al. (1971), found few research studies in the literature reporting a follow-up assessment after an outcome evaluation. Similarly, Blythe (1983) reported that only 50% of outcome studies she reviewed in the literature included any kind of follow-up assessment. Thus, recognition of the necessity for conducting an outcome evaluation does not appear to be related to whether follow-up contact with clients will occur at all. Further, the necessity for conducting follow-up studies is minimized by some researchers who have reported high correlations between findings at termination and at various periods following treatment (Cohn, 1979; Luborsky et al., 1971), thus rendering them redundant. In addition, the potential costs and methodological concerns regarding internal and external validity (e.g. controlling for extraneous factors, etc.) of such studies limits their overall practice application (Wolfe, 1981; Nicholson and Berman, 1983; Jacobs et al., 1985; Mash, 1976).
Finally, in this regard, the extent to which standardized measures are employed (at follow-up) in direct practice; their perceived importance in examining treatment impact; and, their relationship to the application of measures during and at the end of treatment, is relatively unknown. Indeed, it is generally acknowledged in the literature that these areas require further exploration. The importance of using any standardized procedures when evaluating treatment and service effectiveness however, has been a main impetus in the evolution of outcome measures.

II. Outcome and Effectiveness

The importance of conducting outcome studies is distinct and irrespective of the criteria established to measure change. What seems important however, is that change is measured and some value (via an assessment) is ascribed to it. Thus, the primary use of measured change is related to evaluating the effectiveness of the intervention or therapy meant to effect change. In turn, it is not the actual degree of change which determines actual effectiveness per se, but more importantly the manner in which such change is interpreted (on theoretical or statistical grounds) in relation to the pre-established goals for treatment (Fischer, 1973).

In this regard, to better understand the relationship between outcome measures and effectiveness, one must
distinguish between measured change and the concept of effectiveness (Lambert and Christensen, 1983). Foremost, as one might surmise, there are considerably different outcomes when one passes through any change system. At one level, there may be no change, or change that may be desirable and/or undesirable. However one perceives of this issue, desired change is usually indicative of what is deemed to be successful outcome and reflects improvement in the quality of life of the client (Sanford, 1962; Kettner and Daley, 1988).

Thus, the level of treatment effectiveness is guided by the extent to which measured change is desired. Therefore, the efficacy of treatment fluctuates in accordance to those variables emphasized as interpretive criteria for desired change. Success or effective practice then becomes a relative concept adapted to the aims and goals of researchers or practitioners. For example, outcome measures may provide empirical data that permit the testing of inferences about the relationship of constructs that shape a theoretical orientation to practice (Shields, 1986). Thus, success or the extent of treatment effectiveness is defined differentially according to the constructs that shape a particular theory. Therefore, as theories of practice differ, so will the determinate of success and the means of measuring them. In this regard, effectiveness is relative to variables emphasized and the means of measuring such variables. Indeed, although measurement is conceptually different from the interpretation
of such, both are inexplicably symbiotic. In this context, Shields (1986) commented that "explanation without measurement is empty; measurement without explanation is meaningless" (p. 379). The inference here is that statements of effectiveness are the explanations that provide meaning to any measurement of change.

The historical importance of evaluating effectiveness and the use of outcome studies to determine such is primarily based on ethical, epistemological and fiscal grounds. Generally, it is considered unethical to subject clients to treatment whose efficacy has not been proven in a manner morally defensible and in the client's best interests (Kane, 1983; Eysenck, 1984; Patti, 1987). There is general consensus (among the therapeutic community) that therapeutic procedures used to help a client must not be assumed but also empirically demonstrate benefit to the client (Laungani, 1984). Further, some have taken the position that those who fail to practice as such may be considered to be practising a "non-existent skill" (Eysenck, 1984, p.60). These beliefs have generally been endorsed by professional associations that regulate the actions of various helping professions. For example, the National Association of Social Worker's (N.A.S.W.) Professional Code of Ethics notes that social workers must be dedicated to the provision of quality (i.e. effective) service that is fitting and sensitive to the clients unique needs (N.A.S.W., 1984). To assist with this the N.A.S.W. suggests
(amongst other things), that practitioners process knowledge and skill in the application and interpretation of social and psychological research methods and techniques (N.A.S.W., 1981). Within this context, outcome studies are considered of primary importance in developing a complete and comprehensive assessment of the impact of service on any client system (Liberman, 1978; Smith et al., 1980).

In addition, the use of such studies in research and practice helps contributes to the generation of knowledge meant to guide psychotherapy practices. Indeed, without quantifiable determinate of efficacy, Laungani (1984) contended there would be a "state of epistemological anarchy with respect to psychotherapy" (p.140). Further, from an administrative perspective, outcome studies may assist with the implementation of cost-effective practice, as such studies may enable the prediction of treatment outcomes in a given situation, thus permitting the efficacy of money, time, energy, and manpower aimed at providing the best service possible (Eysenck, 1984; Carter, 1983; Strupp, 1973). As well, such studies may facilitate administrative decisions regarding the continuation of a program, improving practice and procedures, the allocation of resources among competing programs, as well as assisting program managers with the supervision of clinicians (Carter, 1983; The Child Welfare League of America, 1984). Indeed, within this context, they have been shown to be important in the justification of family
service programs, and at a more macro level with influencing public policy on family issues (Christopher et al., 1976; Alexander, 1973; The Child Welfare League of America, 1984).

III. Outcome Studies and the Legitimization of Helping Professions

One of the earliest and more controversial uses of outcome studies to evaluate therapy effectiveness was Eyzenck's (1952) landmark study which examined various outcome studies that evaluated the treatment of neurotic clients versus no treatment improvements in the absence of therapy. He concluded that there was no empirical evidence to suggest that psychotherapy (from a psychoanalytic framework) enhanced chances of neurotic clients improving when compared with clients who had no treatment at all. This study was significant in that it established a precedent for researchers to use outcome studies as a means of evaluating the effectiveness of various treatment interventions. Despite the fact that later Eyzenck (1984) acknowledged, "the absence of proof of effectiveness is not the same as ineffectiveness" (p. 152), his study launched a longstanding debate that resulted in an impressive accumulation of outcome research meant to address the question of whether psychotherapy was effective or not (Thomlison, 1984). As one might surmise, the majority of outcome research since then have either set out to support Eyzenck's findings (Kazdin and Wilson, 1978; Zilbergeld,
1983), or discredit them (Bergin and Lambert, 1978; Lambert and Christensen, 1983 Smith et al., 1980; Bergin, 1971).

**Psychology’s Evolution.** Outcome research is closely aligned with a quest for scientific status within the field of psychology. As treatment modalities changed or became more advanced, outcome research became a means of substantiating their credibility in given situations. The research design generally accepted as having scientific merit for answering questions of treatment effectiveness involves: (1) the random assignment of clients to different treatments and/or therapists; (2) the inclusion of a matched no treatment control group; (3) the inclusion of other treatment comparison groups; (4) the collection of pre and post treatment data to assess change; (5) the follow-up of treatment outcome; (6) the use of reliable and valid measures and, (7) the use of appropriate statistical analysis (Lorr, 1962).

Basically, this design closely approximates the traditional epistemology of physics and other pure sciences that are grounded in logical positivism where reality is best conceived in a manner that implies linear causality (Gurman et al., 1986). Tomm (1986) noted that "the heart of science is explanation" (p.376). It is this perspective which generally shaped the design of outcome research and provided the structural foundation for guiding the field of psychology toward the recognizable status as a science (Strupp, 1973).
Social Work's Evolution. Where outcome studies are dominant in psychotherapy research to enhance the scientific status and credibility of professional practice, the incorporation of such procedures into social work practice was considered necessary in order for social work to gain greater recognition as a profession. As such, one way for enhancing professional status is accomplished by providing effective services and the attainment of professional autonomy (Laungani, 1984). It has been well acknowledged that social work has an ethical obligation to apply interventions that are empirically validated (Shyne, 1976). In general, social work research (as a specialization area of study and practice) materialized and gained acceptance in the 1950s (Leighninger, 1978). Although initially such research involved the descriptive analyses of agency programs and structures, some emphasis was placed on the analyses of social work treatment techniques and outcomes (Greenwood, 1955; The Social Work Research Group, 1955). In 1955, Charlotte Towle envisioned these trends as movement away from the professions' absorption in a medical orientation toward a more comprehensive view of problem formulation, distinct from the individual pathological view she characterized as a "distortion of social work practice". Here, the incorporation of social science methodologies into education and practice was perceived as a means of viewing the client within the context of their "problem" situation (Pearlman, 1957; Hollis, 1964), thus
enabling a broader recognition of social constructs that affect a clients behaviour (Kadushin, 1959). In this regard, such methodologies not only assisted with treatment evaluation, but also with understanding client needs and potential variables likely to affect therapeutic outcome.

In addition, the incorporation of research techniques into the profession has long been considered mandatory for the production of a knowledge base that is a requisite for professional status. (Meyers, 1959; Bartlett, 1964). So strong is this realization, that Meyers (1959) noted:

"Social work is not entirely at liberty to choose whether it will base its claim to professional standing on a body of scientific knowledge. So pervasive is public insistence on science that social work will almost surely have to support its claim to a body of fundamental knowledge by appeal to science" (pp.328-329).

Without question, then the use of empirical means to evaluate service and skills has become an integral part of social work gaining status as a bonafide profession.

Despite the early recognition of the necessity to evaluate casework practice, it really wasn't until the 1970s that researchers questioned the effectiveness of social work practice, similar to debates on psychotherapy effectiveness initiated by Eyzenck (Briar, 1983; Fischer, 1973; Wood, 1978). Most of the research prior to this time, limited itself to
descriptive evaluations of social work practice in agencies, particularly in the 1960s. Indeed, this was a dynamic decade of change, as vacillating political tides demanded that agencies establish their relevance by demonstrating their program effectiveness (Beck and Jones, 1976). In turn, this led to a general trend of social work evaluation studies that focused on administrative and policy decision-making (Mutschler, 1984).

Ironically, the focus on clinical social work practice was less evident. The most comprehensive reviews of research in the 1970s directed at evaluating the effectiveness of direct social work practice typically involved less than 25 studies most of which were conducted in the United States (Fischer, 1973; Wood, 1978; Reid and Hanrahan, 1982; Rubin, 1985). Earlier reviews summarized controlled experimental studies that consistently reported findings that suggested social work practice methods were ineffective (Fischer, 1973; Wood, 1978). In a later review of studies, Reid and Hanrahan (1982) concluded direct social work practice to have a generally positive impact. Although this study was criticized on methodological grounds (Fischer, 1983; Epstein, 1983), subsequent reviews have reinforced Reid and Hanrahan’s (1982) contention (Rubin, 1985). Regardless of the position supported, these studies exemplify the importance of outcome studies in substantiating practice effectiveness and enhancing the professional credibility of social work.
Emerging Trends in Outcome Research

The following section represents a synopsis of past and current trends and issues in the literature with respect to outcome research as they pertain to: (1) the evolution of outcome measures, (2) measurement issues, (3) assessor preference, (4) variables related to successful outcome, and (5) family therapy considerations. In short, as insights and knowledge into psychotherapy and family therapy became more prominent over time, the complexities associated with both understanding how to evaluate such interventions and the dynamics of determining successful outcome became more apparent to researchers. Little however, is known of the influence identified research trends have had on direct practice situations.

I. Evolution of Outcome Measures. As psychotherapy became more prominent in North America from about 1950 onward, evaluations of treatment outcome became more scientific relying on instruments to measure client change. Most trends in instrument utilization and design reflected in vogue theories of psychotherapy. Indeed, the current number of instruments available is not surprising as more than 250 different orientations to practice have been identified (Herink, 1980; Corsini, 1981). Orlinsky and Howard (1986) categorized instruments in one of four ways, as global evaluations made from: (1) the client’s perspective, (2) the therapist’s
perspective, (3) the diagnosticians perspective (th: includes independent clinical interviews, trained raters, and case supervisors). The final category includes objective indicators, tests and scales (e.g. actuarial data, standardized psychometric tests, inventories, and rating scales) where responses are computed by clients, therapists or independent clinical judges (Orlinsky and Howard, 1986, p.314). In general, (depending on the orientation to practice) such instruments assess change in relation to specific behaviours, cognitions, emotions, intra-psychic processes, and/or environmental circumstances.

As greater emphasis was placed on the importance of the research role toward enhancing the professional knowledge of social work and psychology, emphasis was also placed on empirical and quantifiable data as measures of change. Generally, this enabled a distancing from the earlier psychoanalytic evaluation methods that were concerned with a patient's motivation for termination, guided by the reduction or elimination of transference in a clinical relationship (Kress, 1985). Usually, such criteria were idiosyncratically evaluated by the therapist without using any universally accepted standardized means of evaluation. Further, such attempts to measure change required only the therapist's views with no input from the patient or consideration of any pre-tested measures (Knight, 1941). In keeping with psychoanalytic and psychodynamic orientations, projective tests such as the
Rorschach and Wechsler-Bellevue Scale were the early (1950s) and standard means of clinical diagnosis and evaluation (Rosenberg, 1954). Typically, such projective personality tests were employed and compared against a global rating by the therapist of a client's status and general overall improvement (Roberts, 1954; Hammond, 1953).

As one might surmise, findings from such studies became suspect due to concerns regarding subject variability and therapist bias. As a result, greater reliance was placed on patient self-reports that generally involved satisfaction ratings and global judgments. This corresponded with the development of more "client-centred" practice in the late 50s and 1960s. Initially, most of these measures were retrospective in nature. However, sequential measures collecting data on a pre and post-test basis, received greater attention in the literature as personality tests and symptom rating scales became more prominent in the 1960s (Garfield, 1986).

Subsequently, simpler and more concrete techniques such as Goal Attainment Scaling (G.A.S.) gained credence out of the scepticism placed on the value of using personality assessment devices in outcome studies (Kiresuk and Sherman, 1968; Luborsky et.al.,1972), and the increased support in the literature for the use of objective empirical indicators where results could be aggregated for program/agency evaluations (Seaberg and Gillespie, 1977; Morrison et.al., 1985). In this
regard, the use of behavioural indicators and measures really wasn't prevalent until the late 60s and early 1970s (Strupp and Bergin, 1969). Since then, greater emphasis in the literature has been placed on empirical and quantifiable data as measures of change in outcome studies. Indeed, such indices have been used to demonstrate the superiority of behaviour therapies with a veritable range of problems during the past 25 years (Bergin and Lambert, 1978; Eysenck, 1984; Newman and Rinkus, 1978; Rubin, 1985; Gurman and Kniskern, 1978; Gurman et al., 1986). With behavioral criteria, it has been noted that there is less room for statistic bias, as treatment effects are judged in relation to quantifiable, observable change that are easily measured in relation to pre-established goals. The continued support and popularity of such measures is evidenced by the fact that most texts on outcome assessments deal with such strategies (Kohn and Hopkin, 1970; Hersen and Bellack, 1976; Cimino et al., 1977; Barlow, 1981). In addition, their popularity may have been enhanced because such measures are simple to use, more likely to reflect a client's definition of problem and desired goals, and are considered most useful by direct service practitioners (Siegel, 1984; Mutschler, 1984).

II. Measurement Issues. Most researchers contend that change must be measured multi-dimensionally in order to accurately assess therapeutic effectiveness. Acknowledging that change in
individuals and families is multi-dimensional, some researchers contend that measurement should reflect at least four different areas of functioning within any individual. Namely, the affective, the cognitive, the behavioral and the social/interactive areas of functioning (Lambert, 1983; Lambert and Christensen, 1983). In this regard, others emphasize the importance of evaluating the inter-psychic processes. In addition, Magura (1986) suggested a multi-variable assessment in relation to case status, client status and client satisfaction variables. He deemed that distinguishing these variables is necessary as client satisfaction with service may be positive regardless of change in the client's status or behaviour. It appears that the majority of research supports the use of multi-dimensional assessment techniques (Waskow and Parloff, 1975; Strupp and Bergin, 1969; Beutler and Crayo, 1983). For instance, Strupp and Bergin (1969) stated that "divergent methods of criterion measurement must be used to match divergency in human beings and in change processes that occur within them...any assumptions of uniformity in client characteristics or changes is mythical" (p.55). In this vein, some contend that any other form of evaluation would be "crude" at best (Mayer and Timms, 1970). A multi-dimensional assessment can take place by using a single instrument that tests for change multi-dimensionally or by applying a variety of tests to assess different attributes. The preference for multi-dimensional
assessments may have lead to the development of a wide variety of instruments to measure change. Indeed, instruments vary considerably from one study to the next. For instance, 50 – 75% of studies surveyed in the literature used different instruments to measure change (Meltzoff and Kornreich, 1970; Lambert, 1983). Similarly, Beutler and Crayo (1983) found that 125 different outcome measures were employed in 150 different studies. Thus, it appears there are no standardized devices with wide spread acceptance amongst clinicians and researchers (Lambert, 1983).

Obviously, this situation presents methodological concerns as minimal intra-measurement reliability amongst instruments has been demonstrated (Lambert and Christensen, 1983). Further, few studies have assessed the interrelationship of different instruments that purport to measure the same dimensions (Lambert and Christensen, 1983; Green et al., 1975).

Others have contended that the lack of comparability between studies and instruments exists because no universal criteria or agreed upon external criteria for effectiveness is considered appropriate or meaningful to which instruments can be applied (Garfield et al., 1971; VandenBos and Pino, 1980). Further, external validity, namely generalizability, is also limited by outcome criteria used (Strupp and Bergin, 1969). Construct validity is also difficult to determine as clinicians and researchers may not be sure what is being
evaluated is a true criterion of effectiveness. Despite these limitations, there remains a strong conviction in the literature that change should be measured multi-dimensionally in order to fully comprehend those factors that impact on overall treatment effectiveness.

III Assessor Preference. Evaluation is dependent on both the source of data utilized and the person who is the evaluator. As one might assume, differences exist in scores and assessments depending on the person completing the measurement instrument when conducting the evaluation (Auerbach et al., 1972; Lambert and Christensen, 1983). The potential sources of information may be the client, therapist, trained observer/rater, or community resource.

Traditionally, the therapist has been considered the most reliable assessor as s/he has been viewed as the "committed" participant in the therapeutic exchange. For instance, Berg (1952) considered a client's assessment "... to be almost worthless" (p.46). Some researchers considered a client's evaluation "unsystematic and unreliable" because of a client's unscientific frame of reference, conscious or unconscious distortions of information in order to please the therapist, and a tendency to rationalize any investment of time and money in treatment (Cronholm and Daly, 1983; Magura, 1982; Garfield et al., 1971).

The movement toward more client-centred practice (1950s onward) promoted a greater reliance on client self-reports in
the literature. This occurred as researchers began to question the reliability of therapist ratings. For instance, Morenstein (1973) found client evaluations, when compared against therapist evaluations, to be more reliable and highly correlated with independent judges. As early as 1962, psychotherapists were identified as having definite biases when evaluating outcome. For example, it was demonstrated that a therapist's personal orientation to life and value preferences were likely to be manifested in his/her their therapeutic dynamics (Luborsky and Strupp, 1962). In this context, Strupp and Hadley (1977) demonstrated how mental health professionals imposed their own conception of an ideal state of functioning on clients during an assessment. Psychotherapy then became a way of moving a person toward the goal of 'ideal adjustment' in the therapist that may differ radically from a client's perception (Strep and Hadley, 1977). In this instance, therapists were considered "secular moralists" that promoted change based on their own values, not those imposed by clients or society (Bergin and Strupp, 1970).

Indeed, perceptions of client problems and goals for treatment have been shown to differ significantly between therapists and clients (Mutschler, 1979; Mayer and Timmes, 1968). For instance, clients typically choose goals involving change in their social or physical environment, whereas therapists choose goals related to the personality or psychological environment of the client (Shepperson et al.,
1976). Further, clients may be more concerned with "problems in living", whereas therapists have generally shown greater concern with "overall cure", and changes in the interpsychic structure of the client (Maluccio, 1979). These discrepancies have lead to some criticisms of the social work profession as it deviates from its traditional role of serving the poor. In this context, Mayer and Timms (1970) noted... "in their preoccupation with psychological matters, social workers have tended to develop an occupational blindness to economic realities" (p.141). In addition, McPartlan and Richart (1966) commented that "when the phenomenology of the clinician is evaluated against phenomenology of the patient, it looks like the clinician is playing the wrong game" (p.130).

The difference in perception for the purpose of therapy may account for the differential assessment of success, as research has shown therapists to be less likely than clients to give positive ratings for outcome. As such, Mutschler (1984) found only 31% of therapists compared to 73% of clients perceived the clients situation a 'lot' or somewhat better' following treatment. In this case, should one rely solely on client self-reports for treatment evaluation one may be more likely to substantiate positive change. This lead Mutschler (1984) to suggest that the trend toward heavier reliance on client self-reports may be motivated by desires to substantiate effectiveness, as opposed to a concern regarding the reliability of therapist reports.
Regardless, the discrepancy between client and therapist reports may be entirely natural as Davis (1949) indicated that the nature of communication promotes such discrepancies:

"the essential feature of communication is that one person infers from the behaviour of another (speech, posture or gesture) what idea or feeling the other is trying to convey, he then reacts not to the behaviour but to the idea or feeling this promotes in the observer" (p.149).

Thus, what is intended to be portrayed by the client, may differ from what is being perceived by the therapist. Thus, reliance solely on one participant’s views (especially the therapist’s) may lead to an unreliable assessment of evaluation (Arkes, 1981). The problem perhaps is not one of reliability, but one of incongruence with respect to problem and goal definition between parties involved in therapy. Indeed, Heine and Trosman (1960) found patients who conceptualized expectations more congruent with the therapists role image were likely to demonstrate positive outcome.

To correct any discrepancies and increase the reliability of evaluations, some researchers suggest: (1) a pre-treatment consensus of patient/problem diagnosis with expected outcome; (2) establishing goal setting using target symptom measures; (3) involving independent ratings of two or more judges; and, (4) using standardized scales/instruments on a regular basis (Waskow and Parloff, 1975; Luborsky et al., 1971; Green et

Despite support for the use of multiple assessors, client self-reports have become the preferred method of data collection for researchers. In a survey of recent outcome studies in the literature, only 9% used therapist ratings alone, or in combination with other ratings. Thus, it is assumed researchers place more faith in client self-reports. Indeed, Shrauger and Osberg (1981) found that 75% of research studies they surveyed favoured client self-assessment over other forms of evaluation. In addition, Waskow and Parloff (1975) found researchers preferred patients over mental health professionals to conduct evaluations.

Some suggest this occurs because clients are in the most favourable position to evaluate outcome (Garfield et al., 1971; Mayer and Timms, 1970). Indeed, clients are an indispensable source of information as they know the range and nature of change in their life not disclosed to the therapist (Russell et. al., 1984; Beck and Jones, 1976). Despite this identified trend, little is known of direct practitioners views with respect to client self-reports, or the extent to which client perspectives are accounted for in service/treatment evaluation.

IV Variables Related to Successful Outcome

The primary use of outcome studies has been associated
with generating information regarding those factors/variables likely to impact on treatment outcome. Thus, outcome studies were meant to generate research findings that would shape practice methods. The extent to which they have is less certain. Research literature has examined three areas to draw conclusions as to the predictive factors of outcome. These are: client factors; therapist factors; and process variables reflecting the interrelationship between the client and therapist.

A. Client Factors

Prior to 1970, the majority of studies attempted to assess those characteristics that predisposed a patient to benefit from psychotherapy (Luborsky et al., 1971; Garfield et al., 1971; Frank, 1974). Research related to client factors can generally be divided into findings as they relate to social class, age, gender, and personality variables (Garfield, 1986).

Social class. There is limited research that produces inconclusive findings with respect to the impact a client's socio-economic status (SES) has on treatment outcome. Generally, researchers have found no relationship between these variables (Luborsky et al. 1971, Lorion, 1973). However, some contradictory findings have been cited (Rosenthal and Frank, 1958; Schmidt and Hancy, 1979). In this context, SES appears more significantly related to one's assignment to and the type of treatment received (Kadushin, 1969). For example,
those from middle and upper class backgrounds are more likely to receive therapy from a psychoanalytic or dynamic framework than are lower class clients, who are more likely to receive drug treatment at public outpatient clinics (Shader, 1970; Lorenzen, 1967; Kadushin, 1969). Although research related to outcome and SES is not advanced and findings are incongruent, it is difficult to assume there is no relationship, as a therapist’s attitude regarding SES has been related to the extent to which a client continues in therapy (Jones, 1984; Lerner, 1972). Thus, it may not be the client’s SES but the therapist’s reaction to such that may impact on outcome.

**Age and gender.** Research on age and gender of the client and outcome has also produced inconclusive findings (Garfield, 1988). Although it is generally considered that the aged are less responsive to treatment because of declines in mental functioning and more rigid patterns of interacting and thinking, minimal research on therapy and the aged has produced any conclusive findings about this phenomena (Storandt, 1983; Garfield, 1982).

Further, with respect to gender, early research indicated that females were more receptive to therapy (Seeman, 1954). However, as research methodologies became more advanced no definite relationships between gender and success could be made (Luborsky, Mintz and Christoph, 1979; Jones and Zoppel, 1982).

**Personality variables.** Personality factors have
dominated much outcome research specific to client factors. Garfield (1986), in one of the more comprehensive reviews of outcome research with respect to client characteristics, categorized 13 personality variables tested against outcomes in the literature. Those shown to have a positive impact on outcome included the level of attractiveness, likability, and anxiety demonstrated by the client. Those shown to have no relationship include the intelligence level, motivational level, and extent of somatic complaints reported by the client. Inconclusive findings related to the intensity of disturbance, level of ego strength, client expectations for treatment, and client therapist similarity in personality were apparent in the literature on this issue.

B. Therapist Factors

There is an extensive amount of research that addresses therapist factors and outcome. Beutler et al. (1988) commented: "Virtually every psychotherapy study addresses either directly or indirectly the role of therapist characteristics in affecting change" (p.257). Research findings related to therapist characteristics will be reviewed according to the strength of their association.

Influential factors. Therapist characteristics found to demonstrate a significant influence over outcome include a therapist's gender, emotional well being, relationship attitudes, and treatment expectations.

Specifically, a therapist's gender may impact on the
perception of problems and ratings of success (Jones and Zoppel, 1982). Jones and Zoppel (1988) found female therapists, more so than males, to conceptualize presented problems in sexual and relationship dimensions. With respect to ratings of success, male therapists have been found to rate male clients more so than females clients, to have benefited as a result of treatment. Regardless, research has also shown female therapists followed by gender matched relationships are likely to facilitate more positive outcomes (Jones and Zoppel, 1982; Blase, 1979; Hauser, 1988).

A therapist’s emotional well being, characterized by the level of self-esteem, work functioning, and ability to show warmth and empathy, has been shown to be consistently related to positive outcome among clients. Indeed, clients have shown improvements in mental health (e.g. reduction of the level of depression and defensiveness) when treated by therapists that have low levels of emotional disturbances and are currently receiving therapy themselves (Garfield and Bergin, 1971; Lambert and Bergin, 1983; Parloff et.al 1978; Buckley et.al., 1981; Greenberg and Statler, 1981).

Relationship attitudes are characterized by the therapists ability to create facilitative conditions (i.e. show accurate empathy, non-possessive warmth, congruence, unconditional positive regard) (Rogers, 1957; Rogers et.al.,1967; Cooley and Lajoy, 1980), and also stimulate a therapeutic alliance with the client (Beutler et.al., 1986).
The therapist's skill in developing a close relationship with a client has been consistently related to positive outcome (Horowitz et al., 1984; Marziaali, 1981). Indeed, satisfied clients have been shown as more likely to view their therapist as warm, active, accepting, secure, likable, and easy to know (Gurman, 1977; Nowicki, 1976; Caligor, 1976).

Congruence between patient and therapist expectations may also facilitate improvement (Lacorre, 1977), especially if patient expectations change to accommodate the therapeutic role valued by therapist (Beutler et al., 1986). Researchers have found that positive expectations held by the therapist generally lead to positive treatment effects (Goldstein and Simonson, 1971; Brucato, 1980; Galas, 1974). Thus, expectations of the therapist, especially if they concur with a client's goals, may lead to better outcomes.

Finally, a therapist's work environment has been shown to affect his/her ability to be effective. Specifically, the level of job description, flexibility, quality of review practices, and extent of supervision have shown to impact on case improvement and client satisfaction with a therapist or case worker (Magura, 1980; Newman, 1983).

Less influential factors. Therapist factors shown to exhibit less influence on treatment outcome include the therapist's age, ethnicity, training discipline and theoretical orientation. Although clients (especially the aged and the young) have shown preferences for age specific
therapists (Donnan and Mitchell, 1979; Getz and Miles, 1978), age difference generally exerts a minimal influence on overall treatment outcome (Beutler et al., 1986).

There is also limited research with respect to the effect ethnicity of the therapist has on treatment outcome (Beutler et al., 1986). Much of the literature in this area has addressed the extent to which therapists emphasize ethnic differences in therapy (Griffith and Jones, 1978), and patient preferences for ethnically similar therapists, as such matches appear to enhance a client's participation in treatment (Banks et al., 1967; Ewing, 1974; Proctor and Rosen, 1981).

As well, the training/educational discipline of the therapist (e.g. social work, psychology, psychiatry, etc.) has not been shown to significantly impact although it may likely affect the treatment approach utilized (Orlinsky and Howard, 1975).

With respect to orientations of practice or treatment approaches, behavioural and cognitive therapies have shown greater effect sizes and impact with respect to a broad range of problems (Smith et al., 1980). However, it is difficult to make comparisons between one orientation and another because of different outcome expectations for each theoretical approach (Houts, 1984). Beutler et al., (1986) contended that a specific treatment approach will differ in its effect according to a patient's diagnosis and other contextual variables that cannot be controlled, and thus present a
"methodological nightmare for researchers" limiting the generalizability of research findings (p.295).

Other therapist characteristics for which there is little research knowledge or conflicting findings include: the therapists SES (Parloff et.al., 1978; Luborsky et.al., 1980); professional experience (Smith et.al., 1980); intervention style (i.e. level of directiveness, non-verbal communication, and extent of self-disclosure) (Luborsky et.al., 1980, Goin et.al., 1965); attitudes and values (religious and otherwise) (Beutler, 1981; Lewis, 1983; Propst et.al., 1984); and, personality dissimilarity with the client (Mendelsohn and Geller, 1967; Parloff et.al., 1978; Dougherty, 1976).

Although an extensive amount of research has addressed therapist characteristics, most of the advances in this area occurred prior to 1974 with future studies replicating previous efforts (Beutler et.al., 1986). Since this time, the literature has predominantly focused on process variables.

C. Process Variables

As outcome studies became more advanced (post 1960s), and the object of evaluation shifted, it became apparent that there was a vast array of variables related to individual characteristics of the client and therapist (and their interaction) that impacted on change related to the client system. Process research, in general, has become identified as crucial to the growth of psychotherapy (Greenberg, 1986; Orlinsky and Howard, 1978; Rice and
Among other things, process is dependent upon the interrelationship of client, therapist, and treatment factors. It represents everything that can be observed to occur with the client and therapist during their work together (Orlinsky and Howard, 1986). Process variables do not simply describe interventions and predict results but explain how a particular intervention creates change in a particular therapeutic context.

Rogers (1957) was the first to address the impact of such variables when he found a high probability of positive outcome if a relationship existed between personal values, attitudes, and interests of the therapist and client. In fact, much of the research on process variables has been viewed as an extension of these Rogerian concepts (Orlinsky and Howard, 1986). The call for examining process variables heightened in the late 60s (Strupp and Bergin, 1969) as researchers began to accept the quality of interaction as a major variable in determining outcome success (Strupp and Bergin, 1969; Orlinsky and Howard, 1977).

Conceptually, events related to psychotherapy can be classified as "inputs", "process", and "outputs" (Orlinsky and Howard, 1978). Inputs are potential determinants or influences on therapeutic process. They reflect the context in which therapy takes place and include: (1) the personal and professional characteristics of clients; (2) the personal and
professional characteristics of therapists; (3) the agency and community within therapy takes place; and, (4) the beliefs and value orientations that shape therapy as a meaningful activity (Orlinsky and Howard, 1986). Process variables reflect the dynamic interaction or inputs that influence or shape outcome. Outputs (or outcomes) refer to change or consequences related to process as reflected in: (1) the life of the client; (2) the life of the therapist; (3) the groups and communities they are a part of; and, (4) the systems of belief and values they adhere to. Thus, relying solely on therapist or client variables (inputs) as determinate may be seen as neglecting the interdynamic nature of therapy.

Indeed, in a review of 1100 studies on process variables over the past 35 years (the most comprehensive review of process research to date) 55% of all studies revealed a positive correlation between the variable being studied and the attainment of a positive or desired outcome (Orlinsky and Howard, 1986). This clearly suggests therapeutic process is a primary aspect of treatment related to outcome.

Research findings. As indicated, the literature on process per se addresses a large number of variables using a wide diversity of measures. Orlinsky and Howard (1986) identified five elements that constitute process as such, and generally guide research studies. They are: (1) the therapeutic contract; (2) therapeutic interventions; (3) the therapeutic bond; (4) client self relatedness; and, (5)
therapeutic realizations (pp. 312–313). The following represents a summary of findings in the literature related to the first three categories indicated.

A therapeutic contract represents an understanding between parties engaged in psychotherapy about the respective roles and performance each maintains in relation to another. Such provisions include the number of patients treated at a particular time, the timing of sessions, and the terms of the contract. With respect to these provisions, no significant differences in outcome have been exhibited for clients treated in individual or group therapy (Schmidt, 1982; and Hobbs, 1988). Similarly, the frequency, timing (Cailler, 1981), and duration of treatment (Shlien et al., 1962) have not shown significant results in this regard, although delay in starting treatment on the therapists part has been associated with negative outcome (Lewinsohn and Munoz, 1979). Conversely, conversational behaviour during the development and implementation of a therapeutic contract has been shown to impact on outcome. Specifically, the amount a client talks (McDaniel et al., 1981) and extent to which client and therapist collaborate in equal fashion on role implementation has shown to increase the chance of success in treatment (Cooley and Lajoy, 1980; Jacobz and Warner, 1981).

Variables related to therapeutic interventions found to positively influence outcome include: (1) the level of confrontation, interpretation, and exploration in therapy
(Greenberg and Rice, 1981; Elliott et al., 1982; Suh et al., 1986); (2) the client's experience of negative affect (distress and hostility) (Bottari and Rappaport, 1983); and, (3) the clients ability to express and conceptualize their emotions (i.e. emotional catharsis) (Schamle and Pierce, 1974). No significant relationships have been reported with the amount of reflection, support and advice giving during treatment, as well as the amount of therapist self-disclosure (O'Malley et al., 1983).

Fifty to eighty percent of all findings related to variables associated with the development of a therapeutic bond have shown to significantly enhance positive outcomes (Orlinsky and Howard, 1986). These included: the extent to which the therapist and client are engaged with each other and motivated in therapy (Friedlander, 1981; Jones and Zoppel, 1982); the credibility, confidence and genuineness of the therapist's expressions (Rudy, 1983; Saltzman et al., 1976); the client's perception of therapist's empathy (Cooel and Lajoy, 1980); and, client expressiveness and level of openness vs defensiveness (Hartley and Strupp, 1983). Studies demonstrating the greatest positive effect focus on the level of client and therapist expression of warmth and acceptance toward one another and the global quality of relationship (Braaten, 1984; Bottari and Rappaport, 1983; Rudy, 1983; Jones and Zoppel, 1982; O'Malley et al., 1983). Indeed, Beck and Jones (1974) found the most powerful indicator with respect to
outcome in family service agencies to be the client/counsellor relationship.

The findings in this sub-section convey that the most conducive therapeutic relationship is client centred; where both the therapist and client structure goals and negotiate the constructs of the therapeutic relationship, in a manner that serves to develop a mutual, reciprocal relationship. The research also points to the importance outcome studies (and measures per se) have had in assisting clinicians/researchers with understanding those factors likely to impact on specific outcomes. Research, in this sense, was meant to provide therapists and social service agencies with information that could shape and promote effective practice trends. Awareness of any impact on clinicians' evaluations of practice, and their perspectives on variables likely to impact on outcome is less certain. This has particular significance for research on family therapy, as most of the reviewed studies, to a large degree, exclusively related to individual or group therapy experiences despite the greater prominace family therapy has taken as a viable treatment intervention within the last 15 years.
V Family Therapy as A Trend

Since the 1970s there has been an "explosive impact of family therapy" on the professional mental health scene (Gurman et al., 1986, p.566). Family therapy gained credibility as a bona fide practice orientation as demonstrated by: 1) the increase in professional journals and training programs dealing with this topic (Bloch and Weiss, 1981); 2) the increase in registered family practitioners (Doherty and Baird, 1983); 3) the growing number of practice theories (Gurman, 1986); and, 4) the incorporation of family therapy into many graduate school educational curricula (Christensen et. al., 1989). In many respects family therapy became more prevalent and received greater professional acknowledgement despite establishing it's credibility through efficacy studies.

Generally, there has been minimal research emphasis on the efficacy of family treatment (Jacobson, 1985). In fact, Gurman et al. (1986) noted that there has been no single outcome study of family therapy whose design has been influenced by ecosystemic ideas that shape much of what is perceived as family practice. Although studies on the effectiveness of family therapy date back to the 1950s (with specific reference to schizophrenic processes in families) (Haley, 1978), generally, there was minimal research about family therapy prior to the 1970s, even though it was being practised with some frequency (Luepnitz, 1988).
For example, Gurman (1986) identified only 47 studies between 1970-84 that he believed substantiated family therapy efficacy across various theoretical orientations and specific problems areas (Gurman et al., 1986). Others in the field concur that family therapy has generally established its effectiveness and justified its existence solely on empirical grounds (Thomlison, 1984; Gurman and Kniskern, 1978). These earlier reviews examined the following factors as related to outcome: the impact of treatment duration, therapist style, therapist characteristics, and identified patient characteristics on family therapy, where behaviour therapy was found to be the most effective modality in addressing a broad range of problems. However, many of these research studies have been overtly criticized for lacking methodological rigor providing limited theory development, clinical practice refinement, or public health policy development (Russell et al., 1984; Pinsof, 1981). Considering the above, it appears that treatment trends developed despite the development of research efforts meant to guide their application or substantiate their importance in direct practice. This perhaps was a natural process of evolution in that family therapy has been purported to be in an early developmental stage where self criticism is likely to develop as it matures as a field (Doherty and Burge, 1987). Indeed, current emphasis has been placed on enhancing research efforts toward developing a more comprehensive understanding of treatment impact. This task has
most certainly demanded "a commitment to process as well as structural issues of a family" (Segal and Bavelas, 1983).

The structure of the client system and models of family practice, (specifically systemic and structural theories) it appeared, demanded a contextual understanding of the therapeutic encounter in order to understand the forces that impacted on change within a family involved in any treatment (Doherty and Burge, 1987; Kantor and Kupferman, 1985; Schwartz and Perrotta, 1985). Gurman (1983) detailed how research designs and procedures acknowledge this context, connectiveness, and interdependence of variables impacting on family therapy by: (1) studying the interactive effects of patient, therapist, treatment, and setting variables; (2) using multi-dimensional change measures; (3) using multiple vantage points for assessing change; and (4) using repeated measures to assess extent and pattern of change over time (p.232).

Only a limited amount of studies adhering to these design criteria can be found in the literature. Given this, and the relative lack of outcome research related to families in general, some authors contend that research findings related to individuals and/or groups can be generalized to therapy with families (Russell et.al. 1984). Others disagree with this opinion, Shields (1986) noted that within a family there are "multiple perceptions of reality", where each perception adds to the knowledge of the family system and its overall
operations. Thus, each family member may have different perceptions of interfamilial dysfunction and different reactions to a specific treatment (Sawyer et al., 1988). For instance, Russell (1984) demonstrated that family members occupying different interactional positions within the same family may respond favourably to different therapeutic interventions. In this regard, with happiness as the indicator of purported success, structural approaches proved more effective with fathers and strategic approaches proved more effective with mothers. This lead Russell (1984) to conclude that the most successful therapists "move back and forth between clusters of interventions which jar different parts of the interactional system" (p.250).

As such, it is the dynamic interaction of the therapist with the entire family that is the essence of most family therapy (Tomm, 1986). In this regard, variables impacting on outcome become compounded (thus limiting generalization of findings associated with individual psychotherapy). Indeed, a family therapist is required to examine the combination of intrapsychic processes/experiences of individual family members as well as the role communication and interactional cycles have in problem maintenance and interfamilial change (Johnson and Greenberg, 1988; Floyd, 1989).

To assist with understanding this point, it has been suggested that therapists examine the contingency of behaviours, cycles and frequencies of behaviour, the influence
of power in the family and in therapy, perceived social support, and the parent's perceptions of the marital dyad (Shields, 1986; Floyd, 1989; Kinston and Loader, 1988), in a multi-modal assessment of functioning. Outcome measures may very well assist with this process. Floyd (1989) supports the use of standardized measures meant to assess change in relation to: (1) interfamilial interaction; (2) individual members perception of problem areas; (3) impressions of the quality of family relationships; (4) marital adjustment; and, (5) individual functioning.

Despite the recent development of a variety of instruments to assess interfamilial interaction and family functioning (Carlson and Grotevant, 1988; Grotevant and Carlson, 1987; Markman and Nortarius, 1987; deShazer et al., 1985; Olson, 1985; Olson et al., 1978) only a few studies in the literature have addressed family therapy outcome in such a comprehensive fashion (Johnson and Greenburg, 1988). Thus, questions pertaining to the specific characteristics/variables related to family therapy that contribute to specific outcomes appear unanswered. More importantly, there is limited knowledge with respect to how direct practitioners evaluate outcome and the extent to which outcome measures can assist with this endeavour.
Outcome Studies and Direct Practice

Research findings on psychotherapy outcome have not found their way into practice situations (Barlow, 1981; Rosenberg and Brody, 1974). Generally, it has been determined that practitioners neither produce nor use research findings (Luborsky et al., 1971, Cassem, 1972; Kirt and Fischer, 1976). In fact, most clinicians choose to ignore findings in the literature selecting and refining techniques by trial and error (Barlow, 1981) or using "impressionistic data collected in an unstandardized fashion" (Floyd et al., 1989, p. 271). Indeed, it appears measures and procedures for assessing family functioning are rarely used by family practitioners (Floyd et al., 1989). This sub-section will examine these issues and concerns in greater depth. It is organized into the following: 1) concerns and issues; 2) single case subject designs; and, 3) agency accountability.

I Concerns and Issues.

There are a number of potential reasons contributing to the reality noted above. Specifically, these reasons relate to methodological issues that: (1) prevent replication of research studies in direct practice; and, (2) prevent the generalization of such findings to direct practice. More generally, they address the potential incompatibility of researcher and practitioner roles on epistemological grounds.

Methodological Issues. There appears to be an inability in generalizing research findings to direct practice due to
the lack of replicability of most designs in the literature, and the incompatibility of findings with respect to direct practice situations. As well, problems have been cited with using the traditional research model in direct practice. More specifically, should such studies be applied in a direct practice situation, they may place unnatural requirements on clients and practitioners that interfere with services provided by agencies, thus causing service delays and disruptions (Mutschler, 1979; Mutschler, 1984).

Further, experimental designs can take considerable time and expense in money and personnel. In addition, the availability of a control group to meet design criteria, is limited by administrative constraints and ethical questions regarding the rational for denying control groups service (Morrison, et al., 1985; Gingerich, 1984; Schinke, 1979). For even if control groups can be obtained it is difficult to contain the experimental strategy given the multiple interventions and overlap between models of therapy applied by different therapists, and lack of control over administrative and structural decisions that may cause programs to change over time (Jacobson, 1985; Chommie and Hudson, 1974). Furthermore, the application and replication of studies in direct practice is limited by the fact that most investigations in the research literature do not offer guidelines for application and interpretation of specific techniques in direct practice (Rabin, 1981; Floyd, et al., 1989). Further, in general, report
findings are seldom expressed in clinically meaningful ways (Barlow, 1981; Hugdahl and Ost, 1981).

In addition, research findings are not generalizable due to the differences between populations typically sampled in studies and those who receive service at family service agencies or community clinics (Sawyer, et.al., 1988; Doherty and Burge, 1987). For instance, Garfield (1986) reported that most research studies in the literature provided only a partial picture of who gets psychotherapy. Research populations sampled have been referred to as a "highly sensitive atypical patient population", that are typically sampled from university counselling centres and community mental health centres (Strupp and Hadley, 1977).

Populations traditionally excluded from outcome studies are those experiencing "real world problems ", defined as those families that might receive service from multiple social agencies, be currently involved in family court proceedings, and present multi-problems that can exert an uncontrollable influence in any experimental research design (Strupp and Hadley, 1977). These individuals or families in turn may be a significant part of the traditional client populations serviced in family service agencies. Should this be the case (as it seems to be), then it is not known if the use of outcome measures is considered a feasible or practical exercise in generating useful evaluative information.

There are a number of other reasons that may also explain
the restrictive (or unique) nature of most study populations. Populations serviced in direct practice may present unlimited difficulties for researchers who attempt to control intervening variables in order for relationships between the treatment and client condition to be effectively studied. Others believe that such populations are not surveyed in the research literature because such studies may not demonstrate desired outcomes as servicing of "high risk families" (i.e. identified as those with families dealing with issues of divorce, poverty, depression and unemployment), and therefore, may show a limited amount of success (Patterson and Fleischman, 1979). Here, the threat of potentially not demonstrating success may serve as a determining factor with respect to the use of outcome measures.

Finally, in this regard, such studies generally appeared to have neglected the working class, and the impact of economic and ecological factors on clients (Strupp and Bergin, 1969). Thus, it is not known (in any comprehensive fashion) how practitioners might evaluate success of intervention with client populations that may be identified as "high risk".

**Epistemological concerns.** There is some support for the belief that therapists' rejections of research findings may represent an identification with a new epistemology (Keeney and Sprenkle, 1982; Keeney, 1982) which closely approximates what Annis identifies as contextualism (Annis, 1986). Traditionally, studies are used to compare one treatment vs.
another. Indeed, this bipolar and rather linear investigative model has been the primary basis for most psychotherapy research (Jacobson, 1985). For example, Beutler and Crayo (1983) found 100 of 150 outcome studies surveyed in the literature were comparative studies of one brand of psychotherapy against another. Such investigations tend to answer broad or general questions of effectiveness.

However, as research questions were better refined (mid-60s onward) and attempted to evaluate effectiveness that was situationally specific, so did the methodology to answer these questions. By the 1960’s theorists began to question the appropriateness of measuring one type of psychotherapy against another (Strupp and Bergin, 1969; Paul, 1967). In this respect, psychotherapy is not viewed as a singular process applied to a singular problem. This is particularly evident with the advent of humanistic ideologies that perceived linear attempts of evaluation as reductionistic (Keeney, 1982). It appears therefore that the more appropriate question for research endeavors became what Gordon Paul (1967) phrased: "What therapy is most effective for what problems, treated by what therapists, according to what criteria, in what settings?" (p.111).

In this respect, outcome can be enhanced by tailoring treatment to fit the identified needs of client systems within the context of their current situation and treatment experience. Questions of effectiveness through treatment
comparison were thus considered culpable and naive (Gurman, 1983) as they failed to acknowledge contextual and process variables that impacted on treatment application. Bergin and Lambert note that experiential and contextual variables that address client and therapist characteristics need to be addressed when evaluating treatment effectiveness. Daly (1983) considers such a "truly comprehensive evaluation of psychotherapy outcome" (p.126).

The previously described represents an epistemological change toward a world view based on reciprocal determinism which emphasizes circular or non-linear causality, where there is limited distinction between independent (cause) and dependent (effect) variables. This view confronts the suitability of the linear model by providing a holistic understanding of overall treatment effect (Tomm, 1983; Klein and Gurman, 1980) thus, recognizing the range, diversity, and complexity of the human experience (Garfield et al., 1971). In this respect, the social nature of justification would demand an issue-context analysis of a phenomenon (Annis, 1986). If this view is accepted, then the validity of research findings are related to the context in which they are generated.

Despite support for a reciprocal understanding of treatment impact as such, experimental designs are still used and prevalent in research studies (Kane, 1983; Jacobson, 1985; Patterson and Fleischman, 1979). Gurman (1983) contended that standard research methods can be utilized to make statements
of family treatment efficacy, while acknowledging the multidimensional nature of treatment process and influence, and the specificity of each client systems situation. Others disagree, and criticise the trend in social work to rely on orthodox empiricalism, which is perceived as unable to capture the complexities of important problems relative to social work research (Heinemann-Pieper, 1985). Indeed, Floyd et al., (1989) contended that family clinicians who align with the new epistemology may perceive the use of standardized measure as means that reinforce unidimensional constructs for evaluation, that reject the contextual and ecosystemic factors that make a family unique. He notes:

"These therapists view time invested in data collection as an unnecessary delay that interferes with the therapists true mission of treatment".
(Floyd et. al., 1989, p271-272)

In this respect, studies or methods meant to generate statistically significant information may have limited clinical significance. Golstein (1980) acknowledged this when she wrote:

"So long as research is something done to practice, and engaged in only by those removed from practice concerns, this type of knowledge building runs the risk of being sterile at best and undermining at worst" (pp. 49-50).

Thus, the difference in philosophy and goals for research and practice may serve to limit the use of outcome procedures
in practice. This view receives support should one realize that significant differences have been shown to exist between researchers and clinicians with respect to their values, orientation toward clients, focal objectives and concerns, definition of professional identification and ethics (Luborsky et al., 1971; Crane, Colling and Eezonsky, 1983; Davies and Kelly, 1976; Jacobson, 1985; Brower and Mutshler, 1985).

It is not known if these differences are contributing factors influencing a clinician's use of standardized measures. Regardless, the separation of research and practice has been generally perceived as an impediment to the development and enhancement of clinical practice (Floyd et al., 1989; Goldstein, 1980). To rectify this situation, it has been suggested that research approaches be modified to better address the needs and questions vital to the practitioner (Eisler, 1988; Tomm, 1983; Bloom and Block, 1977). In this respect, the single case subject design has received considerable attention as an approach which is better able to enmesh the roles of both the researcher and practitioner.

II Single Case Subject Designs

There has been a strong push towards integrating research into direct practice over the last 20 years (Grinnell Jr., 1988; Wood, 1980; Briar and Miller, 1971; Siegel, 1984; Schinke, 1979). Wood (1980) noted the importance of integrating the research and practitioner role which would
allow social workers "to think like researchers while acting like compassionate helpers" (p.18). Given the methodological concerns of traditionally used designs and the practical necessity of evaluating the effectiveness of direct service, the single case subject design has received considerable support as an appropriate means of resolving above issues allowing practitioners to evaluate their intervention and make judgments of effectiveness (Hudson, 1982; Hersen and Barlow, 1976).

When using the single case design, each case is viewed as a true experiment. Generalization is assumed only when replication across similar cases occurs (Bergin and Strupp, 1970). The most frequently used single case design in the research literature is an experimental design utilizing a baseline measurement that corresponds with an assessment phase of the treatment paradigm (Rabin, 1981). Changes in behavior or a client's condition are plotted against this baseline as treatment is introduced and depending upon the design subsequently removed and possibly re-applied. Despite its statistical value this design has been considered too cumbersome for direct practice as a client's status may be unpredictable, thus limiting the extensive contact needed to establish a baseline (Herson and Barlow, 1976).

Non-experimental time series designs have thus gained prominence given this evolution in research (Mütschler, 1984). Such designs (in a single case subject context), supports the
uniqueness of a client's situation, permitting for specific
descriptions of particular interventions with specific
clients (Gingerich, 1984). It also supports and accommodates
an integrative perspective toward intervention, as it can
account for contextual variables that differ from one
situation to the next (Bergin and Strupp, 1970). In addition,
it can accommodate different theoretical orientations. There
is also no specificity of treatment and outcome variables to
be utilized as measures of effectiveness relate to initial
measures and treatment goals mutually agreed upon by
practitioner and client during the beginning stages of
treatment, and repeated measures of target problems are made.
The worker can then assess the level of agreement amongst
perceptions of problem situations allowing for workable and
clear goals for treatment and service. In essence, this design
integrates the necessity for contextually specific evaluations
and also the need to evaluate effectiveness from a scientific
frame of reference.

Such benefits seem noteworthy, as there is generally no
imposition on service delivery. Further, this design can be
adapted to any practice method to enhance quality of service
and provide empirical data for future research. In essence,
case specific outcome data is provided that allows for the
continuing assessment of client progress, provides continuing
feedback and encouragement to both parties, and contributes to
a specific workers knowledge base about specific interventions
with particular clients (Jayaratne et al., 1988; Briar and Blythe, 1985). All of these factors, it has been suggested, should make the utilization of single case designs prominent.

Despite their practical significance, there is some question of their actual use (Orcutt, 1990). For instance, only 40% of social work students trained in the use of single case subject design used the techniques in direct practice (Welch, 1983). Given this situation, little is known about the evaluation methods utilized and how such evaluations might differ from those found in research studies in the literature (Gingerich, 1982; Mutschler, 1984). It has been suggested that the influence of working within an organization may impact on practitioners' use and perspective towards the integration of research (more specifically outcome measures) into practice.

III Agency Accountability

There is a prominent trend toward more accountable delivery of service in human service organizations (HSOs). Changes in the political climate and economy over the last 20 years have demanded changes in accountability procedures within service agencies (Brower and Mutschler, 1985). Thus, agency accountability in many respects, is associated with the demonstration of effective services. Traditionally, however, such may not have been the case. Patti (1987) distinguished between effectiveness variables and performance indicators for agencies, where the latter have generally served as primary
indicators for traditional evaluations. Performance indicators include: (1) the quantity of service and whether it is delivered to the appropriate clientele; (2) the efficient use of resources to generate services; (3) the agency's success in obtaining resources from the environment; and, (4) the minimization of budget reductions (Patti, 1987, p. 377). By comparison, efficacy oriented management practices are concerned with how improvements in performance indicators influence service effectiveness. In this respect, service effectiveness is measured by how the organization: (1) succeeds in generating desired change in client systems; (2) implements methods and techniques necessary for achieving service objectives; and, (3) ensures client satisfaction with the quality and effect of services rendered (Patti, 1987).

Thus, accountability has traditionally referred to fiscal responsibility and clients serviced or units of service, rather than client improvement associated with psychotherapy or service plan implementation. In this regard, the traditionally used evaluation methods by agencies addressed issues of efficiency more than overall efficacy. Thus, an efficiently run HSO may not necessarily mean an effectively run or cost-effective operation (Hopps, 1985). The recognition of the necessity for evaluating effectiveness while addressing budget constraints has lead to recent support and popular claims in the literature for cost effective analysis where the generation of outcome data is an essential component (Holosko
et.al., 1989).

Despite these developments, some contend (regardless of program design or accountability procedures) that agencies are unable to ensure that programs will be effective, as it is impossible to predict outcomes of services because service technologies are indeterminant (Hasenfeld, 1983). Others disagree, believing that a judgement of effectiveness can be made should, program design ensure an accurate measurement of inputs, throughputs, and outputs (Patti, 1987 and Kettner and Daley, 1988).

Regardless of the position taken in this regard, there is general acceptance that practitioners and administrators must have an awareness of service impact as it relates to specified objectives (Rosenberg and Brody, 1974). The emphasis for ensuring such has been placed on using standardized measures (Briar and Blythe, 1984; Fischer, 1983; Magura, Silverman and Jones, 1987). In this context, Chommie and Hudson noted:

"the findings of studies of outcome are expected to provide major input into the planning and delivery of services so that decisions about maintaining expanding or terminating programs can be made on more rational and empirical basis"

(Chommie and Hudson, 1974, p.682)
There also appears to be significant support in the literature toward integrating standardized measures of evaluation into administrative practices. Specific references have been made of the single case subject design as a means of measuring program effectiveness (see previous subsection). Such benefits may include: assisting policy-makers in targeting services to new problem areas; assisting with monitoring and improving practice by fostering tentative evaluations of new methods and services; and, providing a quantifiable interpretation of service success to the community and respective funding bodies (Mutschler, 1984).

Gingerich (1984) noted that administrators are first frustrated when considering the single subject design as a means of evaluation, as most administrators do not believe a design tailored to case specific information can be used at an organizational level of management. Single case findings however, can be aggregated by using a relatively simple procedure to address this concern (Jayaratni et al., 1988, Horne and Heerboth, 1982, Robinson et al., 1988).

Thus, direct service practitioners play an important role in evaluating programs. However, this role to a large extent, may depend on agency encouragement and management practices that ensure workers are properly trained and supervised to conduct such evaluations (Patti, 1987; Briar and Blythe, 1985). Indeed, it has been shown that workers are likely to evaluate services for payment and/or accountability reasons
rather than for scientific concerns (Newman, 1981). This point was collaborated by Gingerich (1982) who reiterated that practitioners are more likely to use research procedures if an agency policy requires them. Brower and Mutschler (1985) add that evaluation and monitoring systems must be practitioner oriented, and suggest the development of computer-assisted evaluation systems in providing statistical and clinically significant information. Thus, the incorporation of research practices (i.e. outcome measures) may depend on management policies, attitudes and resources as much as anything else.

Given that most managers and supervisors have been found to lack education or training in research knowledge, one may surmise that there is limited use of outcome measures in family service agencies. Indeed, Magura (1979) found that only 25% of public child welfare agencies surveyed and 48% of private agencies used outcome measures. This may be construed as a low utilization rate as all sampled agencies were members of the Child Welfare League of America (C.W.L.A.) whose standards of practice for members demand the utilization of outcome and follow-up studies as a means of evaluating service (C.W.L.A., 1984). In this study, most measures were found to be developed within the respondent agency. The use of client self-reports was most common among private agencies and non-existent among public agencies. If measures were used their application was not necessarily on a regular basis. This
raises some concerns as measures not used on a routine basis have questionable reliability.

Magura's (1979) study is significant in this regard, in that it appears to be an attempt to generate information describing the structure of agencies that use outcome measures, types of measure used, and those areas considered most important by administrators in measuring outcome. No study however, was found that explored extensively the possible qualitative factors that may impact on utilization of measures by direct practitioners and agency administrators in family service agencies. Similarly, no research has explored the reasons why specific agencies do not employ the use of standardized measures or procedures. In addition, the extent to which practitioners are involved in evaluation procedures, and the recognition or exploration of the compatibility of administrators and practitioners perspectives on the value of measures and variables that define successful outcome was not apparent in a review of the literature in this field. It appears that these additional questions need to be explored in order to come to a comprehensive understanding of the value and perceived necessity of using outcome studies in family service agencies.
Summary

Outcome measures have had a profound historical significance in the evaluation of treatment interventions within the helping professions. More specifically, outcome research has provided a structural foundation for the creation of a professional knowledge base meant to provide credence to psychology and social work as autonomous disciplines. Outcome measures are considered an integral part of efficacy oriented practice, as their application demands a treatment paradigm that requires an empirical understanding of treatment outcome.

With respect to clinical practice, this review sought to demonstrate that although the necessity for using evaluative techniques in social work practice has been acknowledged for over 40 years, the majority of outcome research related to psychotherapy/direct service has been germane to the field of psychology. Psychotherapy outcome research distinctly involves the application of standardized measures that seek to examine the efficacy of treatment approaches, and more specifically those variables likely to impact on the attainment of desired change related to the client system.

Specific trends emerged in the research literature with respect to types of measures used, preferred method of evaluation, and variables analyzed for their effect on outcome. In short, as theoretical orientations to practice became more varied so did the means of measuring their impact.
Specifically, as therapy trends became more client-centred, greater support was noted in the literature for goal directed interventions, relying with greater prevalence on client self-reports that utilized behaviourally specific criteria for success. In addition, methodologies became more advanced to address the complexities associated with measuring outcome, and a growing acceptance of the complexity and interdynamic nature of the therapeutic relationship. This research was meant to provide clinicians with predictive information that could shape and promote effective clinical practice. However, the majority of reviewed research addressed treatment with individuals and groups. A significant void existed in the literature with respect to family therapy outcome research.

Family therapy has grown as an orientation to practice despite substantiating its effectiveness through comprehensive research endeavors. Although research designs and procedures have been developed that acknowledge the context, relationship and interdependence of variables impacting on family therapy, there was no identified published study whose design has been influenced by ecosystemic ideas that shape much of family practice. The manner in which family practitioners evaluate treatment effectiveness, their acceptance and willingness to involve standardized measures in any such evaluation, and factors considered to impact on treatment outcome and their relationship to the current literature are surprisingly relatively unknown.
Research that does exist suggests clinicians seldom incorporate research findings or techniques in their evaluations of practice. A number of possible explanations may contribute to this observation. These include: methodological concerns regarding the incompatibility of research designs with direct practice situations, concerns regarding the external validity of research studies that use restrictive methodologies including study populations, potential epistemological differences between researchers and clinicians, and resource limitations given the organizational or administrative structures clinicians operate under. To address these concerns, methodologies/designs have been adapted in the literature to provide clinically significant information from a scientific frame of reference that is beneficial to both the clinician and administrator. For a more comprehensive understanding of the value and utility of outcome measures, a more extensive exploration of the extent and nature of measure use in the evaluation of practice in family service agencies, and the possible qualitative factors likely to impact on the utilization of such measures is required.
RESEARCH QUESTIONS

This exploratory study is designed to examine the nature, value and utility of outcome measures in direct practice in family service agencies from clinician’s and administrator’s perspectives. The research intends to answer a number of questions which are offered in lieu of formal hypotheses, all of which are derived from the previous literature review.

1. To what extent have standardized measures (and more specifically, outcome measures) become an integral part of treatment and program evaluation?

2. What is the nature and type of measure use?

3. To what extent are practitioner’s evaluations of specific interventions incorporated into an agency’s evaluation of its effectiveness?

4. What means are used to determine the efficacy of practice should outcome measures not be used in any capacity?

5. What resources are available or needed by agencies to conduct evaluations that incorporate the use of outcome measures?

6. What are the socio-demographic characteristics of agencies that employ the use of outcome measures?

7. What characteristics of practice related to theoretical orientation, client type served, and presenting problems addressed are more likely to be associated with the
integration of standardized measures into direct practice?

8. What factors are identified as contributing to the successful outcomes with families by practitioners as compared with administrators?

9. What are the attitudes of clinicians and administrators with respect to the value of integrating outcome measures as part of an evaluation of intervention?
Method

The Setting

The province of Ontario, which is comprised of 54 Counties and Districts, provided the setting for this study. It is the second largest province in land mass, and is the most populated with 9,101,690 people (Statistics Canada, 1987a). This represents 36% of the total population of Canada and is an increase of 5.5% within 5 years. Ontario is boardered by four great lakes, the St. Lawrence River, Hudsons Bay, the provinces of Quebec and Manitoba, and the States of New York, Michigan and Minnesota.

There are four general sizes of communities in Ontario. These are: 1) Metropolitan or large sized cities of over 100,000 people; 2) medium sized cities with populations between 40,000 and 100,000 people; 3) small sized cities with populations between 20,000 and 40,000 people; and 4) rural towns and areas with populations less than 20,000 people (Statistics Canada 1987b).

Metropolitan Toronto is the largest city in Ontario, with a population of 3.4 million people or 37% and 13% of the total population of Ontario and Canada respectively. There are 9 other cities in category one (above) throughout Ontario. They are: Hamilton (557,030), St. Catherines/Niagara (343,255), Kitchener (311,195), London (342,300), Windsor (253,985),
Sudbury (148,875), Oshawa (203,540), Thunder Bay (122,222) and Ottawa (619,050). All metropolitan areas (excepting Sudbury) are within 150km of the United States boarder. In addition, with the exception of Sudbury, Ottawa, Thunder Bay, and Windsor, all major metropolitan areas are within 200km of Toronto (Statistics Canada, 1987a). Ontario is the most urbanized of the Canadian provinces with 82.1% of its population living in urban centers, with the 10 large cities mentioned collectively assuming 69% of the provinces total population. (Statistics Canada 1989a).

There is a wide diversity of industry and trade throughout the Province, which is rich in natural resources and has the largest labour and consumer force in Canada. Major industries include the automotive industry (concentrated in Oshawa and Windsor) and steel industry (Hamilton). Northern and Central Ontario is sparsely population where lumbering and mining (concentrated in Sudbury, Thunder Bay and Timmins) are predominant. The province is also agriculturally rich and has the largest rural farm population (232,790) in Canada (Statistics Canada, 1989c). Toronto is the financial capital of Canada and the major center of manufacturing, construction, business and distribution services for Ontario and Canada (Statistics Canada, 1989b). In addition, Ontario is the largest provider of consumer and social services.

The province is also ethnically diverse. Although the population is predominantly English speaking (77.27%),
4.67% speak French and approximately 15% of the total population collectively speak 54 different languages (including aboriginal) as a first language of choice (Ministry of Citizenship, 1989). There are over 2 million families throughout Ontario, of which 88% are husband and wife families, 51,850 are headed by single parents, and 65% have children (Statistics Canada, 1987a).

Population

The population sampled for this study were administrators or upper level managers and direct service practitioners from each Family Service Agency affiliated with the Ontario Association of Family Service Agencies (OAFSA). The OAFSA was incorporated in 1974, and is a voluntary non-profit association with 48 member agencies. Organizations are both small and large ranging from one-two person operations to agencies with more than 100 staff. The member organizations are dispersed throughout the province serving a wide range of communities of varied sizes. Of the 48 member agencies 21 or 44% are situated in the ten largest metropolitan areas described in the previous sub-section.

The Procedure

Two similar questionnaires were mailed to the executive director of each of the 48 Family Service Agencies that comprised the study population. Addresses were obtained from
the OAFSA registry in Toronto. A phone call was made to each
director or executive secretary one week prior the mailing of
survey material. This was done in order to cross-reference the
mailing address and name of the executive director, and advise
each administrator of the forthcoming study and distribution
of questionnaires. An attached cover letter (see Appendix A)
outlining the study purpose, assurance of confidentiality and
a human subject form (see Appendix B) was enclosed with each
questionnaire.

The cover letter to the executive director was personally
addressed and requested each to randomly select a direct
service practitioner (on site), who would be asked to
similarly complete a separate questionnaire enclosed. A
stamped self-addressed envelope, (with return address the
School of Social Work, University of Windsor) was mailed with
each questionnaire. All questionnaires were mailed on February
19, 1991. Telephone contact was made to verify receipt 10 days
after the questionnaires were mailed out. This also served as
an occasion to answer any questions about the study. A six
week return rate was deemed as a cut-off time for return of
the questionnaires, but it was extended an additional week
upon the request of some of the respondents. Finally, a
follow-up letter (see Appendix C) was sent to each potential
respondent advising of the extension and soliciting the return
of the questionnaire. In addition, direction was given for the
distribution of the questionnaire they received, to another
administrator who was familiar with service plan and budget matters within the agency should they be unable to complete it. All data analyses was conducted with the use of the Statistical Package for the Social Sciences/PC+ (SPSS-PC+).

The Survey Questionnaires

Questions on the survey instruments came from two sources. Questions addressing general and educational background of administrators and practitioners, as well as questions about each agency’s annual budget and funding source were adapted from Dobrowolsky (1986). The remaining were developed by the researcher in consultation with his adviser at the School of Social Work.

Two similar but separate questionnaires were distributed, one to the administrator and one to practitioners in each family service agency as described above. Most of the questions were closed ended or fixed choice. The practitioner questionnaire (see Appendix D) had a total of 31 questions and the administrators (see Appendix E) had 31 questions. Eleven questions (examining twelve variables) were similar for both groups of respondents. Each questionnaire had three subsections. They are as follows:

1. General and Educational Background [Administrator]: i) demographic variables age and gender, ii) formal education including degree, discipline, specialization, and year received, iii) employment experience as a human service
administrator, iv) current membership in professional associations and/or organizations, v) entry level education and training with respect to research and evaluation related skills, vi) continuing educational experience and source of such.

**General and Educational Background [Practitioner]** The above variables were examined in the same fashion with direct practitioners. Questions differed in that their employment experience as direct service practitioners was asked, and the type and frequency at which they review professional journals was explored.

2. **Organizational Characteristics [Administrators]** i) number and type of all employees and educational background of professional staff, ii) caseload averages, case type, and annual sum of all clients serviced, iii) size of community served, iv) annual operating budget and percentage of funds received from funding sources, v) expenditures on evaluative research and research co-ordination activities within the agency, and vi) measurability of service goals and primary criteria for measuring agency effectiveness were all explored.

**Practice Characteristics [Practitioners]** i) percentage distribution of caseload by treatment/service type, ii) theoretical orientation to family practice. Orientations considered are those cited by Gurman et.al. (1986) to be those agreed upon by family therapists and educators to have lasting impact on the thinking and practice of family
therapists. iii) inventory of presenting problems addressed in practice with families within the past six months. Problems/issues identified encompass those adult disorders, child/adolescent disorders, and marital problems cited by Gurman et.al. (1986) to be the main consideration of family therapy outcome research. Additional categories (family violence and family economic/living situation) were added to provide a comparison for examining those problems/issues cited in the literature review as traditionally neglected by outcome research.

3. The Use and Perceived Value of Outcome Measure

Administrator:

i) The use of standardized measures at various times during service delivery, ii) types of outcome measures used, their source of development and extent and nature to which their use is regulated, iii) nature of application of measures including percentage of clients administered to, whether informed consent is received before application, and source of data analysis, iv) a 13 item inventory examining the perceived importance of outcome data for various administrative/service activities within the agency, v) respondents opinions regarding satisfaction with current evaluative practices, variables or measures related to service effectiveness, and factors likely to restrict measure use within agencies were surveyed, and vi) respondents opinions regarding the value of measures in shaping quality of practice and providing useful
information was explored.

The Use and Perceived Value of Outcome Measures

[Practitioner]:

i) The use of outcome measures at various time throughout the treatment paradigm, ii) the frequency and types of outcome measures used, including denotation of those participating in the completion of such measures, iii) extent of use in past employment settings, iv) a 13 item inventory examining perceived importance of outcome data for identified service activity, v) nature of measure application, participant family members, vi) frequency of application at follow-up and percentage of clients used with, vii) 7 questions demanding nominal responses of "yes" "no" or "not sure" examining the perceived value of measures research in shaping practice, viii) a five point scale with choices of "highly unlikely", "unlikely", "somewhat likely", "likely", and "highly likely" was applied to 10 questions that examined perspectives on the ability of measures to provide clinically significant information, ix) a four point scale with choices of "not important", "somewhat important", "important", and "very important" was applied to seven questions focusing on follow-up contact, treatment goals, and empiricism in practice, and finally, x) three open ended questions addressed practitioners views on factors likely to inhibit and contribute to service effectiveness.
RESULTS AND DISCUSSION

The results and discussion of data are presented according to the following sub-sections: 1) general and educational background, 2) organizational and practice characteristics and 3) the use and perceived value of outcome measures. The results pertaining to sub-populations of administrators and clinicians will be presented separately in these subsections followed by the discussion of these data.

I. General and Education Background Data

A. Administrators

Twenty-one of 48 sampled administrators of Family Service Agencies in Ontario responded to the survey. Of those, the age of respondents was widely dispersed with a mean of 46.5 (S.D.=8.42, range 30-61, n=21). The gender of respondents was fairly evenly distributed as 52.4% were female and 47.6% were male.

1. All data were analyzed using a micro computer (AT compatible) at the University of Windsor. The Statistical Package for the Social Sciences/PC+ V3.1 (SPSS Inc., 1989) was used in all analyses. Missing data were excluded from the analysis by item. Thus, sub-population sizes in the various tables are adjusted accordingly.
With respect to experience and educational background, years of experience as a human service organization (H.S.O.) administrator ranged from 2 to 28 years with an average of 10.6 years (S.D.=6.05, n=21).

Administrators, on average, received their last degree or completed their formal education in 1977 (range 1962-1990). Examination of the most recent education or degree receipt and previous formal education outlined in Tables 1 and 2, provides more information into the training and professional orientation of these administrators.
### Table 1
**Education Background of Administrators (n=21)**

<table>
<thead>
<tr>
<th>Degree Type (Most recent)</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. M.S.W. or PhD.in Social Work</td>
<td>13</td>
<td>61.9</td>
</tr>
<tr>
<td>2. Other degree</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>3. M.A./PhD. in Psychology</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>4. M.B.A.</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>5. B.S.W.</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>21</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Note. Degrees identified as 'Other' include Master degrees in Social Administration (2), Theology (1), Religious Psychiatry (1), and Family Therapy (1).*

### Table 2
**Education Background of Administrators (n=18)**

<table>
<thead>
<tr>
<th>Degree Type (Previous)</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Combined Social Work/Other</td>
<td>10</td>
<td>55.6</td>
</tr>
<tr>
<td>2. B.S.W.</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>3. B.A. in Psychology</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>4. M.S.W./PhD. in Social Work</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>5. More than 1 Social Work</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>18</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
As indicated the administrators were predominantly social work trained and educated. Specifically, 61.9% last received a Master or Doctoral degree in social work, and collectively 66.7% of respondents most recent degree achieved was social work related. Only 1 respondent attained (most recently) a Master's degree in business, and 1 respondent possessed a graduate degree in psychology. Further, 23.8% cited receipt of "other" degrees as their most recent. These alternative degrees included Master degrees in: theology (1), social administration (2), religious psychiatry (1), and family therapy (1). With respect to previous education, 83.5% of all respondents received a social work degree alone or in combination with another degree. Finally, in this regard, there was a wide diversity of degrees (generally within the arts or social science disciplines) that were held in combination with a social work degree. These included either undergraduate or masters degrees in: theology (3), psychology (3), sociology (1), english (1), philosophy (1), education (1), and biology (1).

The extent to which administrators received formal education and post graduate training with respect to research and evaluation skill development can be observed in Tables 3 and 4.
### Table 3
Education of Administrators in Family Service Agencies with respect to Research and Evaluation Skills \( (n=21) \)

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Number Reporting Education*</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Statistics</td>
<td>20</td>
<td>95.2</td>
</tr>
<tr>
<td>2. Research Methods</td>
<td>19</td>
<td>90.5</td>
</tr>
<tr>
<td>3. Data Analysis</td>
<td>16</td>
<td>76.2</td>
</tr>
<tr>
<td>4. Evaluative Research</td>
<td>13</td>
<td>61.9</td>
</tr>
<tr>
<td>5. Information Systems</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>6. Computer Applications</td>
<td>3</td>
<td>14.3</td>
</tr>
</tbody>
</table>

*Note.* (*) Categories are mutually exclusive of one another.

### Table 4
Training of Administrators in Family Service Agencies with respect to Research and Evaluation Skills \( (n=21) \)

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Number Reporting Training*</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Computer Applications</td>
<td>10</td>
<td>47.6</td>
</tr>
<tr>
<td>2. Information Systems</td>
<td>10</td>
<td>47.6</td>
</tr>
<tr>
<td>3. Evaluative Research</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>4. Research Methods</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>5. Data Analysis</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>6. Statistics</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note.* (*) Categories are mutually exclusive of one another.
Apart from education in computer applications and information systems as noted in Table 4, the majority of administrators received their formal education in the identified skill areas. Specifically, most were educated in basic research skills, as 95.2% received education in statistics, 90.5% received education in research methods, and 76.2% in data analyses. Of particular note (in Table 3) is the relatively large percentage (61.9%) who were educated in evaluation research techniques. This was a topic only beginning to receive attention in social work curriculum in the mid 70s, when many of the respondents completed their formal education. To further test whether the time educated impacted on specific skill development a Mann–Whitney test for association with a .05 level of significance was conducted and revealed no association between year of completion of studies and whether or not one received training in evaluation research (U=26, n₁=11, n₂=5, P<.8648).

Training since degree completion was limited in most areas. However, those skills least developed in formal education received increased attention following graduation. Specifically, 47% reported post degree training and skill development related to computer application and information systems. Further, over 23% received training in evaluation research, 14.3% in research methods and data analyses, and interestingly 0% received additional training in statistics.
Although it appears there may have been compensation through training with respect to those skills not developed during education, the majority of respondents have not received post degree training in skill areas related to research and evaluation. This finding is further exemplified in findings assessing the degree of skill development by source type outlined in Table 5.

### Table 5
Relative Extent of Skill Development of Administrators by Source Type
(n=21)

<table>
<thead>
<tr>
<th>Source of Skill Development</th>
<th>Mean (X)*</th>
<th>Standard Deviation (S.D.)</th>
<th>Relative Frequency (%) 'none'</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On the Job Training</td>
<td>1.05</td>
<td>.50</td>
<td>9.5</td>
</tr>
<tr>
<td>2. Specialized Seminars etc.</td>
<td>.91</td>
<td>.70</td>
<td>28.6</td>
</tr>
<tr>
<td>3. Personal Study</td>
<td>.81</td>
<td>.68</td>
<td>33.3</td>
</tr>
<tr>
<td>4. Research Consultation</td>
<td>.71</td>
<td>.56</td>
<td>33.3</td>
</tr>
<tr>
<td>5. Professional Associations</td>
<td>.38</td>
<td>.50</td>
<td>61.9</td>
</tr>
<tr>
<td>6. University Courses</td>
<td>.29</td>
<td>.46</td>
<td>71.4</td>
</tr>
<tr>
<td>7. Community College</td>
<td>.19</td>
<td>.40</td>
<td>81</td>
</tr>
<tr>
<td>8. Correspondence Study</td>
<td>.10</td>
<td>.30</td>
<td>90.5</td>
</tr>
</tbody>
</table>

**Note.** (*) Scores were ranked either '0=none, 1=somewhat, 2=very much'.
Each respondent was also asked to indicate the extent to which each identified source was part of their research and evaluation skill development since completion of their formal education. As indicated, responses ranged from 0="none", 1="somewhat", and 2="very much". The overall average of means was .55 indicating a minimal rate of skill development. Further, when responses were scored and summed the overall mean score (within a range of 0-16) was 8. On-the-job training was most likely to be reported to be "somewhat" (76.2%) or "very much" (14.3%) a source of skill development; although specialized seminars were reported by more respondents (19%) to be "very much" a source of skill development. Those areas receiving the lowest rating included university courses (X=.29), community college (X=.20), and correspondence study (X=.10). As well, 61.9% responded that they did not receive any training through professional associations, although 38.1% indicated they were "somewhat trained" by this source. Regardless, the majority of respondents belonged to some professional association(s). Collectively, 61.9% belonged to 2 or more professional associations and 23.8% belonged to only one association. The average amount of memberships was 1.6 (S.D.=.87) with a mode of 2. In this context only 3 respondents did not list any such memberships.

With respect to the type of associations with which they are affiliated, 55.6% of the respondents belonged to those
exclusively related to social work, 27.8% belonged to a mix of social work and associations not exclusively social, and 16.8% belonged to those identified as non-social work.

B. Practitioners

Twenty-one of 48 (44%) direct service practitioners responded to the questionnaire, of which 13 (61.9%) were female and 38.1% were male. The mean age of respondents was 40.5 (S.D. = 8.27, range 28-57 years). There appeared to be a wide diversity of work experience among the practitioners ranging from 1 to 23 years with a mean of 8.9 years (S.D. = 5.93). On average, practitioners completed their formal education in 1981 (S.D. = 7.58 years, range 1963-1990). The majority (66.7%) were employed full-time compared to 33.3% part-time. Most were predominantly social work educated, as 76.7% last received a Masters’ degree in social work. Tables 6 and 7 detail the educational background of respondents according to most recent and previously held degrees achieved.
Table 6
Education Background of Direct Service Practitioners
(n=21)

<table>
<thead>
<tr>
<th>Degree Type (Most recent)</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. M.S.W. or PhD.in Social Work</td>
<td>16</td>
<td>76.2</td>
</tr>
<tr>
<td>2. B.S.W.</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>3. Other</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>4. M.A. or PhD. in Psychology</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>21</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note. Degrees identified as 'Other' include Master degrees in Family Therapy (2).

Table 7
Education Background of Direct Service Practitioners
Previous Education
(n=18)

<table>
<thead>
<tr>
<th>Degree Type (Previous)</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Combined Social Work/Other</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>2. B.S.W.</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>3. B.A.</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>4. M.A./PhD. in Psychology</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>18</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Collectively, 86.2% reportedly received a social work degree as their most recent. With respect to previous education, 62.7% of respondents possessed a social work degree alone or in combination with another degree. Another 27.3% possessed a BA, and 1 respondent previously obtained a MA in psychology.

Tables 8 and 9 present levels of research and evaluation skill development of respondents during formal education and as a result of post degree training.
Table 8
Education of Direct Service Practitioners in Research and Evaluation Skills (n=21)

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Number Reporting Education*</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Research Methods</td>
<td>19</td>
<td>90.5</td>
</tr>
<tr>
<td>2. Statistics</td>
<td>15</td>
<td>71.4</td>
</tr>
<tr>
<td>3. Data Analysis</td>
<td>13</td>
<td>61.9</td>
</tr>
<tr>
<td>4. Evaluative Research</td>
<td>11</td>
<td>52.4</td>
</tr>
<tr>
<td>5. Computer Applications</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>6. Information Systems</td>
<td>3</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Note. (*) These are mutually exclusive categories.

Table 9
Training of Direct Service Practitioners in Research and Evaluation Skills (n=21)

<table>
<thead>
<tr>
<th>Skill Areas</th>
<th>Number Reporting Training</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Computer Applications</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>2. Information Systems</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>3. Evaluative Research</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>4. Research Methods</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>5. Data Analysis</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>6. Statistics</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
With respect to skill development, 90.5% of respondents were educated in research methods, 71.4% in statistics, 61.9% in data analyses, and 52.4% in evaluation research. Upon first comparison of Tables 3 and 8, apart from education related to computer applications, administrators were as likely or more likely than practitioners to receive education and training in all identified skill areas.

Practitioners on average, graduated 4 years later than their administrator counterparts, yet received less education and training in research methods and evaluation related skill development. In all instances, less than 20% of respondents received any post degree training related to skill development. This was iterated in Table 10 which outlines the sources of skill development amongst practitioners.
Table 10
Relative Extent of Skill Development of Direct Service Practitioners by Source Type (n=21)

<table>
<thead>
<tr>
<th>Sources of Skill Development</th>
<th>Mean (X)*</th>
<th>Standard Deviation</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personal Study</td>
<td>.73</td>
<td>.77</td>
<td>42.9</td>
</tr>
<tr>
<td>2. Specialized Seminars etc.</td>
<td>.71</td>
<td>.85</td>
<td>52.4</td>
</tr>
<tr>
<td>3. On the Job Training</td>
<td>.62</td>
<td>.67</td>
<td>47.6</td>
</tr>
<tr>
<td>4. Research Consultation</td>
<td>.43</td>
<td>.60</td>
<td>61.9</td>
</tr>
<tr>
<td>5. Professional Associations</td>
<td>.33</td>
<td>.49</td>
<td>66.7</td>
</tr>
<tr>
<td>6. University Courses</td>
<td>.24</td>
<td>.54</td>
<td>81.0</td>
</tr>
<tr>
<td>7. Community College</td>
<td>.19</td>
<td>.51</td>
<td>85.7</td>
</tr>
<tr>
<td>8. Correspondence Study</td>
<td>.19</td>
<td>.40</td>
<td>81.0</td>
</tr>
</tbody>
</table>

Note. (*) Scores were ranked either '0=none, 1= somewhat, 2=very much'

Although the rankings in Table 10 are similar to administrators (see Table 5), (with the exception of 'personal study' having the largest mean response rate of .73 for practitioners), all of the ratings indicated limited skill development amongst practitioners since graduation.

Practitioners, like the administrators were likely to be affiliated with professional associations. Sixty-two percent of the respondents belonged to 2 or more associations, 28.6% belonged to one, and only 9.5% did not belong to any. With respect to the type of association, 61.9% of respondents belong exclusively to social work associations, 14.3% a mix of social work and organizations not exclusively social work, and
14.3% belonged to those identified as non-social work. Further, the majority of respondents (95%) read between 1 and 6 professional journals on a monthly or bi-monthly basis, for a monthly mean of 2.14 journals (S.D.=1.459, n=20). Forty percent of those who read journals read a mixture of family therapy and social work related journals, 35% specifically read those relative to family therapy, 15% were exclusively social work, and 10% were identified as other types. One may speculate, these findings suggest that practitioners in this sub-population are exposed to current literature trends. In part this may account the ranking of personal study as the highest source of skill development. Regardless, despite affiliations with associations and exposure to current knowledge via professional journals, there was limited research training/education and evaluation skill development since receiving a professional degree.

**Discussion of Background Data for Administrators and Practitioners**

The presented data serves as a base of limited yet poignant descriptive information regarding demographic and knowledge resources that will serve as independent variables in additional statistical analyses presented later in the chapter. For the purposes of this sub-section the discussion will centre on variable relationships relative to the descriptive trends previously presented. Due to the relatively
small sample size being analyzed non-parametric procedures were used, specifically in regard to measures of association for variable relationships.

The distribution of administrators by gender differs from that observed in other research, where males have been principle described as the primary power stakeholders within Human Service Organizations. Dobrowolsky (1986) found 58.8% of H.S.O. administrators to be male with 80% holding executive director positions. His study surveyed administrators in social service agencies throughout southwestern Ontario and may provide a relative comparison for some of this study’s data. However, only 13% of respondents in his study were identified with Family Service Agencies and thus his study may not serve as a reliable comparison. Of those recently surveyed and identified as executive directors by the Ontario Association of Family Service Agencies 18 or 37.5% of the total population are women. In this study, 11 or 52% of the respondents were female. Thus, male administrators were underrepresented in this study.

Historically, women have been underrepresented at the administrative/upper management levels (Patti, 1976; Dobrowsky, 1986). Dobroloowsky (1986) concluded that equity in this regard had not been fully achieved despite changing personnel practices encouraging greater representation of women in HSOS. The number of women who occupy executive director positions may suggest that major advances have not
been made to increase the proportionate representation of women in management positions within the family service sector. This is not surprising given the demonstrated inequality within the profession as it relates to placement of women in executive positions (Martin et al., 1983; Dressel, 1987; Ezell et al., 1989). This is ironically in contrast to what has been acknowledged by some as a steady increase of women assuming HSO administrative responsibilities (Austin, 1989; Alexander and Kerson, 1980). For instance, Ezell (1989) found 69.4% of directors of hospital social work departments to be women. With respect to the sub-population of practitioners, the percentage distribution by gender found in this study closely approximates that typically observed within social service related agencies (Martin and Chernesky, 1989).

To examine the similarity of variable distributions between sub-populations according to gender, age, and related experience, a Kolmogorov-Smirnov two sample test was conducted utilizing a two-tailed significance level of .05. No significant difference was observed with respect to gender distribution between the sub-populations tested. However, significant differences were observed for age (D=.926, m=21, n=21, P<.05) and years of experience (D=.617, m=21, n=21, P<.05) of respondents. Thus, administrators on average, were six years older and possessed 2 additional years of experience relative to their current job role assignment than practitioners. The mean age of administrators was 46 which was
slightly higher than the average of 42.5 observed in other studies (Dobrowsky, 1986; Ezell, 1989).

A Masters degree was the most frequently reported educational achievement of respondents in both sub-populations. Both sub-populations were predominantly social work educated and trained. The percentage distribution of administrators with graduate degrees was proportionately higher than that reported for administrators in H.S.O.s in other studies which did not exceed 55% (Dobrowsky, 1986; Ezell et al., 1989). Both administrators and practitioners, in this regard, appeared well educated and experienced social workers. However, comparisons of Tables 6 and 11 (on page 100), which denoted percentage of distribution of total professional staff reported by administrators may suggest the sample distribution of practitioners is not representative. Specifically, comparisons of these tables suggested that respondent practitioners with M.S.W.s maybe overrepresented, those with degrees in psychology appear underrepresented, and those without degrees are not represented at all. The ability to obtain a representative sample of practitioners was limited by the sampling procedure which will be addressed in the limitations of the study (later on).

With respect to skill development through education and training, administrators were more likely to receive training in computer applications (D=.926, m=21,n=21, P≤.05), and information systems (D=.926, m=21,n=21, P≤.05) following their
graduation. In addition, administrators reported a higher levels of education in statistics \( (D=0.772, m=21, n=21, P \leq 0.05) \), although the relative percentages were high for both sub-populations. Relatively speaking however, administrator and practitioner education regarding research and evaluation skills were highly comparable at all identified levels. Compatibility of educational experiences, given the strong social work orientation, may serve as one explanation.

As noted, administrators were more likely to receive post degree training in computer applications and information systems. This may be a result of a greater exposure to skill development resources. Utilizing the Kolmogorov-Smirnov test of association, the administrators significantly reported higher levels of training as a result of on-the-job training \( (D=1.234, m=21, n=21, P \leq 0.05) \), specialized seminars \( (D=0.772, m=21, n=21, P \leq 0.05) \), and research consultation \( (D=0.926, m=21, n=21, P \leq 0.05) \). Practitioners did not report any training at rates significantly higher than administrators. The reported differences may be related to job responsibilities for it has been well acknowledged that a key role of administrators in advancing program evaluation is with the expansion of the capability of the organizations management information systems (Briar and Blythe, 1985). In addition, computer assisted evaluation systems and data banks that are "user friendly" have received greater attention as cost-effective means of providing information valuable to
administrators (Brower and Mutschler, 1985; Mutschler, 1983; and Boyd et al., 1978). Despite additional attention in the literature, their prevalence has not been determined in research studies. However, although limited use has been associated with high manpower and resource costs incurred by agencies where systems were not tailored to user needs, and failed to respect organizational and power structures within H.S.O.s (Mutschler and Cnaan, 1985).

With respect to practitioner ratings, one may speculate that their job roles may not predispose them to such training. In addition, the low rate of development of such skills amongst respondents may be explained by limited exposure to these topics in social work curriculae as well as widespread "technology anxiety" documented amongst social workers (Nurius and Mutschler, 1982). Regardless, the rate of post degree training was low for both sub-populations.

A number of variables were examined for their possible impact on reported skill development due to education and training. These variables included association type (categories collapsed to i) social work and ii) non-social work and mixed), gender, year last degree received (collapsed categories 1960s, 1970s, and 1980s), type of last degree (social work vs. non-social work) and type of previous degree (social work vs. non or mixed). A chi squared test of association was typically applied, however the Yates Correction Statistic was used when expected cell frequencies
were less than 5, and a Fisher's Exact Test Probability when the total number of responses was less than \( n=20 \). No significant associations were determined in this regard apart from findings relative to respondents with previous degrees that were non social work or a mix. Here it was observed they were more likely to receive education in computer applications than those with only a social work background (\( b = .04 \)). When the Kendall test was applied, a high level positive correlation (\( r = .83 \)) between these two variables was observed. This finding is reinforced by Nuruis and Mutschler (1982) who found limited application of computers in social work curriculae, in general.

II. Organizational and Practice Characteristics

A. Organizational

Each organization was surveyed according to structural characteristics relative to resources (staffing, funding type and amount), service demand and caseload size, expenditures on research activities, and criteria and measurability of service goals.

There appeared to be much diversity of human resources among the respondent agencies. The mean number of total employees was 22.5 (S.D.=20.3). The number of employees ranged from 4 to 87 with modes of 9, 10, 15, and 22. The greatest diversity was among number of full time professionals with a mean of 13.95 and standard deviation of 15.7, followed by
full-time support staff (X=5.4, S.D.=8.2) and part-time support staff (X=7.14, S.D.=7.9). The least amount of diversity was among part-time support staff (X=1.76, S.D.=3.5). A breakdown of professional staff by formal education (University degree type) is outlined in Table 11.

<table>
<thead>
<tr>
<th>Staff Education</th>
<th>Mean (%)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. M.S.W.</td>
<td>57.3</td>
<td>27.5</td>
</tr>
<tr>
<td>2. B.A./M.A. in Psychology</td>
<td>12.8</td>
<td>22.5</td>
</tr>
<tr>
<td>3. B.S.W.</td>
<td>12.3</td>
<td>18.2</td>
</tr>
<tr>
<td>4. No Degree</td>
<td>8.1</td>
<td>11.3</td>
</tr>
<tr>
<td>5. Other Degrees</td>
<td>6.0</td>
<td>12.8</td>
</tr>
<tr>
<td>6. PhD. in Psychology</td>
<td>.1</td>
<td>.4</td>
</tr>
</tbody>
</table>
Administrators were requested to provide a descriptive outline by percentage of professional staff educational background. As observed in Table 11 the average percentage of professional staff that hold a Master of Social Work degree is 57.4%. Collectively (with B.S.W.s), 69.6% of all professional staff hold University degrees in social work. The percentage distribution is wide amongst agencies for M.S.W. (S.D.=27.5%), B.A. or M.A. in psychology (S.D.=22.5%) and B.S.W. (S.D.=18.2%). In addition, 10 of 21 administrators reportedly employ professional staff without university degrees. The distribution regarding the compilation of staff without professional degrees ranged from 8% to 44% with an overall mean of 8.14%. Regardless, the majority of Family Service Agencies employed professionals that were social work educated or trained. Only one agency reportedly employed registered psychologists although the mean average of professional staff with a B.A. or M.A. in psychology was 12.76%.

Respondents were then asked to note the exact operating budget for 1990. Responses were categorized in an ordinal fashion as follows: 0 = $0-199,999; 1 = $200-499,999; 2 = $500-999,999; 3= $1-1,999,999; 4 = $2-4,999,999; 5 = $5 million+. With respect to overall operating budget, 66.7% of the agencies had operating budgets under 1 million dollars. The mean budget size was $1.5 million and a mode of $200-499,999.

Table 12 reveals all the funding sources for respondent
agencies, the average of proportions by percentage of funds received and the actual percentage of agencies that received funds from identified sources.

<table>
<thead>
<tr>
<th>Funding Source</th>
<th># of F.S.A.s received from source</th>
<th>Mean (X) of Proportion received</th>
<th>Standard Deviation (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provincial Government</td>
<td>18</td>
<td>42.1</td>
<td>29.9</td>
</tr>
<tr>
<td>2. United Way</td>
<td>18</td>
<td>21.0</td>
<td>15.8</td>
</tr>
<tr>
<td>3. Other Sources*</td>
<td>10</td>
<td>14.6</td>
<td>23.0</td>
</tr>
<tr>
<td>4. Municipality</td>
<td>14</td>
<td>9.5</td>
<td>12.9</td>
</tr>
<tr>
<td>5. Direct Fees for Service</td>
<td>17</td>
<td>7.2</td>
<td>8.8</td>
</tr>
<tr>
<td>6. Third Party Payments</td>
<td>5</td>
<td>1.9</td>
<td>4.6</td>
</tr>
<tr>
<td>7. Private Donations</td>
<td>12</td>
<td>1.7</td>
<td>2.5</td>
</tr>
<tr>
<td>8. Federal Government</td>
<td>3</td>
<td>1.7</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Note: (*') 'Other' sources consist of donations from religious organizations (n=6, range 25-70%), investment income (n=2, range 16-19%), fund raising (n=1, 10%). These categories are not mutually exclusive.
The ranking of funding sources closely approximates that observed for most human service agencies in Ontario (Dobrowolsky, 1986) in that the Provincial Government and the United Way appeared to be the principle contributors. In this regard, the average proportion contribution by the Provincial Government is 42.1% (S.D.=29.9) and the United Way 21% (15.8). Over 86% of all agencies received funding from these sources. The low percentage of funds from the federal government (5.6%) may be underrepresented as by arrangement between the Provincial and Federal Governments, through Health and Welfare Canada, the Federal Government shares 50% of funding provided by the Provincial Government. In addition, 38% (n=8) of agencies reported receiving funds from "other" resources for a proportionate mean of 14.6%. Percentage contributions to individual agencies ranged from 10 to 70% with the high level contributions being made by religious organizations (i.e. Catholic Charities, the Toronto Jewish Congress). Three agencies reportedly received monies from fund raising, investment income, and facility rental revenues. In most HSOs, the degree of decision making power is associated with the level of funds held by the funding source (Dobrowsky, 1986; Whetter, 1981). In this respect, one would assume the Provincial Government, United Way and cited religious organizations may have a significant impact on service operations of the sampled respondent agencies.
From the reported budgets only seven agencies allotted funds for research or evaluative purposes. Over 60% of agencies had no money allotted for such activities. Of those that did three spent less than $2,000, and 3 spent more than $10,000 with a mean between $2,000 and $4,999.

Of those reporting expenditures on research/evaluation only 4 of 7 had designated personnel responsible for coordination of such activities. In three (75%) of the cases, the executive director fulfilled this role. An outside research consultant from a Department of Psychology at a local University was employed part-time in the other instance. With respect to service goals 23% of all respondents indicated that service goals are not stated in evaluative terms, 57% stated "some are", and only 19% indicated all goals are stated in evaluative terms. Further, 34.4% of agencies allotted money for research purposes. When examining the extent to which research money was budgeted may be related to the extent to which service goals are stated in evaluative terms. To test this assumption a chi-square test statistic was calculated as 24.8, (d.f.=2) indicating no significant association between the allotment of money for research purposes and the possession of evaluative service goals.

Given the somewhat limited use of evaluative goals for service plans questions exist regarding the methods that are being used to evaluate effectiveness within family service agencies. Respondents were asked an open ended question that
attempted to delineate the criteria used to measure effectiveness within their agency. Twenty (95%) administrators made 42 ($X = 1.8$) responses to this question. Twelve general areas for evaluating effectiveness are identified in Table 13.
<table>
<thead>
<tr>
<th>Criteria for Measuring Service Effectiveness</th>
<th>Number of Responses</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client Satisfaction/Feedback</td>
<td>17</td>
<td>40.5</td>
</tr>
<tr>
<td>2. Therapist Assessment/Satisfaction</td>
<td>5</td>
<td>11.9</td>
</tr>
<tr>
<td>3. Statistical/Standardized Measures</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>4. Community Satisfaction</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>5. Measurable Behaviour Change</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>6. Goal Attainment (Program and Treatment)</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>7. Supervisory Assessment</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>8. Popularity of Agency</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>9. Number of Clients Served</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>10. Number Units of Service Provided</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>11. Client follow-up</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>12. Program Evaluation from Outside Consultants</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>42</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Of particular note is the significance at which client satisfaction variables and feedback are considered as primary criteria for assessing service plan effectiveness. Specifically, over 38% of all responses noted this, followed by therapist assessment or degree of satisfaction which involved 11.9% of responses. Although only three administrators cited the use of standardized measures for examining the efficacy of service delivery, this number may be under represented as respondents did not specify one way or the other if practitioner or client satisfaction variables were measured via standardized measures.

Indeed, of the 13 measures reportedly used by seven agencies six of those measures were client satisfaction/feedback inventories. Thus, although Table 13 outlines criteria used for determining efficacy, the specifics regarding how such information was obtained and interpreted was not ascertained. However, it appears likely that although such information may not be collected in any standardized fashion, formal procedures may guide administrators in arriving at statements of efficacy. For instance, one administrator indicated that the level of client satisfaction was determined by the amount of letters received from clients indicating pleasure with service, as well as information provided by clients who were invited to attend regular public meetings with representatives of the administration and Board of Directors.
Another area examined was service demands and caseloads within each agency. There was a wide diversity/significant variance between average monthly caseloads of full-time professions and the annual number of clients receiving service at each agency. Specifically, the average monthly caseload was 34.2 (S.D.=10.9). The range of caseload size varied between 15-65 cases per month with a mode of 25 cases. Between 144 and 22,900 cases were seen on an annual basis by respondent agencies. The annual average amount was $238.2 (S.D.=6486.2) with a mode of 800. Fifty-seven percent of agencies in the sub population served less than 800 clients in 1990 and 90.5% served less than 8,550 clients in 1990. Two agencies served greater than 20,000 clients creating a skewed distribution. The number of clients serviced on an annual basis was positively related to monthly caseloads (r=.71, p<.01).

The actual distribution of sampled agencies compared proportionately to respondent agencies according to community size is outlined in Table 14.
Table 14
Comparison of Sampled and Respondent Agencies
According to Size of Community Served

<table>
<thead>
<tr>
<th>Community Size</th>
<th>Sampled Population (n=48)</th>
<th>Actual Respondents (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Relative (%)</td>
</tr>
<tr>
<td>1. 100,001 +</td>
<td>23</td>
<td>48</td>
</tr>
<tr>
<td>2. 40,001 to 100,000</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>3. 20,001 to 40,000</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>4. 20,000 or less</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>48</td>
<td>100</td>
</tr>
</tbody>
</table>

From Table 14, one notes that agencies situated in communities with populations of less than 40,000 are underrepresented in the sub-population of respondents. Those agencies in communities larger than 100,000 were proportionately over represented and those in communities between 20,000 and 40,000 were proportionately under represented.

With respect to waiting lists all but one agency reported having a waiting list for prospective clients. The average waiting time was 15.2 weeks (S.D.=11.6 weeks). The range of
waiting period (among those with a waiting list) was between 4 and 52 weeks. No associations between length of wait list time and total clients served by agencies or average monthly caseload was determined when tested statistically.

Table 15 presents the percentage of clients served by case type. Surprisingly, the family service agencies surveyed predominantly provided service for individuals (X = 58.72%, S.D. = 16.098, n = 20), followed by couples (X = 24.39%, S.D. = 11.57, n = 20) and then families (X = 15.61, S.D. = 8.94, n = 20).

<table>
<thead>
<tr>
<th>Case type</th>
<th># of cases</th>
<th>Mean (%)</th>
<th>Standard Deviation (%)</th>
<th>Range (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual Adult</td>
<td>18</td>
<td>58.7</td>
<td>16.1</td>
<td>35-86</td>
</tr>
<tr>
<td>2. Marital/Couples</td>
<td>18</td>
<td>24.4</td>
<td>11.6</td>
<td>5-50</td>
</tr>
<tr>
<td>3. Families</td>
<td>18</td>
<td>15.6</td>
<td>8.9</td>
<td>2-30</td>
</tr>
</tbody>
</table>

Table 15
Percentage Distribution of Clients Served by Family Service Agency by Client Type (n = 21)
B. Practice Characteristics

Practice characteristics were examined at three levels: 1) with respect to the respondents' orientation to practice, 2) the percentage of current caseload by case type, and, 3) the frequency of problem type on caseload.

Respondents were asked to indicate from a list of 15 practice orientations that which most accurately represented their orientation to practice. Table 16 details the relative percentage (%) of respondent choice of orientation.
Table 16
Relative Percentage Distribution of Direct Service Practitioners Perceived Theoretical Orientation to Practice
(n=21)

<table>
<thead>
<tr>
<th>Orientations to Practice</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychodynamic-Eclectic</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>2. A Mix of Two</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>3. More Than Two</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>4. Strategic</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>5. Milan Systemic</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>6. Contextual</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>7. McMaster PCSTF</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>8. Psychoeducational</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>9. Other (Brief Therapy)</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>21</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Of fifteen choices, only six were chosen as a primary orientations with the psychodynamic approach cited by 23.8% as their primary orientation to practice. Another six (behavioural, humanistic, multigenerational, Bowen, and symbolic-experiential) of the remaining nine orientations were cited in combination with one or more orientations. Over 33% of all respondents identified with a combination of more than one practice orientation as their own. [This occurred despite being asked to choose only one of the orientations cited.] Those orientations not identified at all included
triadic, functional, and M.R.I. approaches.

When responses are further broken down according to orientations cited regardless if primary or in combination with other orientation (see Table 17), the psychodynamic orientation relatively maintains the same influence (24.3%) followed by the strategic approach (16.3%).
Table 17
Relative Percentage Distribution of all Identified Theoretical Orientations to Practice Regardless of Groupings by Direct Service Practitioners

<table>
<thead>
<tr>
<th>Orientation to Practice</th>
<th>Number</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychodynamic-Eclectic</td>
<td>9</td>
<td>24.3</td>
</tr>
<tr>
<td>2. Strategic</td>
<td>6</td>
<td>16.3</td>
</tr>
<tr>
<td>3. McMaster PCSTF</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>4. Psychoeducational</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>5. Humanistic</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>6. Contextual</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>7. Milan Systemic</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>8. Bowen F.S.T.</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>9. Multigenerational</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>10. Other*</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>11. Behavioral</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>12. Structural</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>13. Symbolic-Experiential</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>37</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note: (*) "Other" identified orientations included "feminist" and "brief therapy".

The Humanistic approach was cited 8.1% of the time but only in combination with other theories, notably the Bowen Family Systems Theory (F.S.T.) and the Feminist therapy orientation identified in the "other" category. In addition, the McMaster PCSTF and Psychoeducational orientations were more likely to be cited in combination with other approaches.
whereas the Milan systemic was not cited in combination with
any other orientation. Over 60% of the responses included
psychodynamic, strategic, McMaster PCTF, and psychoeducational
approaches to practice.

Apart from the relatively significant identification with
the psychodynamic orientation, no theoretical prominence was
noted unless cited in combination with other orientations. Of
specific reference here is the limited cited influence or
identification with predominantly family based theories.

This finding may be further explained when examining the
percentage distribution of caseload by case type outlined in
Table 18.
<table>
<thead>
<tr>
<th>Casetype</th>
<th>$%$ of cases</th>
<th>Mean (%)</th>
<th>Standard Deviation (%)</th>
<th>Range (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual Adult</td>
<td>21</td>
<td>39.0</td>
<td>24.5</td>
<td>7-99</td>
</tr>
<tr>
<td>2. Marital/Couples</td>
<td>18</td>
<td>22.1</td>
<td>14.7</td>
<td>0-50</td>
</tr>
<tr>
<td>3. Families</td>
<td>17</td>
<td>20.6</td>
<td>18.5</td>
<td>0-56</td>
</tr>
<tr>
<td>4. Other*</td>
<td>9</td>
<td>11.8</td>
<td>18.2</td>
<td>0-50</td>
</tr>
<tr>
<td>5. Individual Child</td>
<td>9</td>
<td>3.8</td>
<td>6.2</td>
<td>0-25</td>
</tr>
<tr>
<td>6. Advocacy</td>
<td>6</td>
<td>2.4</td>
<td>4.0</td>
<td>0-10</td>
</tr>
<tr>
<td>7. Family Life Education</td>
<td>2</td>
<td>.7</td>
<td>2.4</td>
<td>0-10</td>
</tr>
<tr>
<td>8. Sibling Therapy</td>
<td>1</td>
<td>.6</td>
<td>2.8</td>
<td>0-13</td>
</tr>
</tbody>
</table>

**Note.** (*)

'Other' consists of Groups for incest survivors (6), men who are violent (1), and time allotted for management or supervisory duties (2).

On average, over 81% of practitioner caseloads involved individual adults, marital/couple therapy, and families. Further, individuals appeared more likely ($X=39\%, S.D.=24.54$) than couples ($X=22.1\%, S.D.=14.7$) or families ($X=20.6, S.D.=18.5$) to be serviced in family service agencies. This may in part explain the moderate reliance on orientations specific to family based practice. However, factors impacting on this situation require further exploration. For instance, it was not known if the percentage distribution of caseload by
casetype reflected the percentage distribution of case types seeking service; if individual therapy is the preferred choice of the client system or recommended treatment orientation by the therapist; if individual treatment is conducted with the expectation of progressing into family based work; or if such treatment is perceived as family based by practitioners. All these areas would require examination before any definitive statements about this finding could be made. Regardless, only 20.6% of the practitioner caseload is occupied by family therapy cases. Another 11.8% (S.D. = 6.2, range 0–25) were identified as "other" types of intervention. Among the responses under this category seven respondents lead groups, six of which addressed sexual abuse/incest related issues, one was for male batterers. Two other practitioners identified some supervisory/management responsibilities as part of their caseload. Individual child (X = 3.8, S.D. = 6.2) advocacy (X = 2.4%, S.D. = 4), family life education (X = .71, S.D. = 2.4), and sibling therapy (X = .62, S.D. = 2.8) were practised at a significantly less rate than others indicated.

With respect to other issues addressed in practice, respondents were asked to rate the extent to which 13 identified problem areas occupied their caseload within the past six months. Responses were scored as follows: 0 = "none", 1 = "1–5 cases", 2 = "6–10 cases", 3 = "10+ cases". A list of the most frequently cited problems is provided in Table 19.
### Table 19
Mean Frequency Distribution of Problem Type on Practitioners Caseload within Past Six Months (n=21)

<table>
<thead>
<tr>
<th>Problem Types</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Violence</td>
<td>2.40</td>
<td>.93</td>
</tr>
<tr>
<td>2. Other Problems*</td>
<td>2.20</td>
<td>.83</td>
</tr>
<tr>
<td>3. Divorce Adjustment</td>
<td>1.50</td>
<td>1.00</td>
</tr>
<tr>
<td>4. Substance Abuse</td>
<td>1.40</td>
<td>1.10</td>
</tr>
<tr>
<td>5. Family Economic Living Situation</td>
<td>1.20</td>
<td>1.10</td>
</tr>
<tr>
<td>6. Anxiety Disorders</td>
<td>1.10</td>
<td>.76</td>
</tr>
<tr>
<td>7. Affective Disorders</td>
<td>95</td>
<td>.89</td>
</tr>
<tr>
<td>8. Conduct Disorders</td>
<td>.75</td>
<td>.85</td>
</tr>
<tr>
<td>9. Mixed Disorders</td>
<td>.70</td>
<td>.92</td>
</tr>
<tr>
<td>10. Medical Illness</td>
<td>.60</td>
<td>.82</td>
</tr>
<tr>
<td>11. Death of a Family Member</td>
<td>.60</td>
<td>.60</td>
</tr>
<tr>
<td>12. Juvenile Delinquency</td>
<td>.55</td>
<td>.62</td>
</tr>
<tr>
<td>13. Psychosomatic Disorders</td>
<td>.45</td>
<td>.62</td>
</tr>
<tr>
<td>14. Schizophrenia</td>
<td>.15</td>
<td>.49</td>
</tr>
</tbody>
</table>

**Note.** (*) Those problem types identified as "other" include sexual abuse (8), Sexual problems/dysfunction (3), Extra Marital Affairs (1), and Job Related Stress (1).

Family violence was cited as the most frequently occurring problem (X=2.4, S.D.= .93) with more than 60% of respondents citing this problem/issue as being the main focus of intervention in more than 10 current cases in the past six months. "Other problems" were identified by 13 respondents to
be of primary focus within practice. Of those identified, eight involved sexual abuse/incest related problems, 3 addressed sexual problems/dysfunction, 1 focused on job related stress and 1 dealt with extramarital affairs. Other problem areas that commanded considerable focus included divorce adjustment (X=1.5, S.D.=1), substance abuse (X=1.4, S.D.1.4), family economic situation (X=1.2, S.D.=1.1), and anxiety disorders (X=1.1, S.D.=.76). Eight of 11 identified problem areas cited as main considerations of family therapy outcome research (Gurman, 1986) were not identified with any significance.

Discussion of Organizational and Practice Characteristics

Apart from the under representation of agencies situated in communities populated by less than 40,000 people, the sampled organizations had much diversity in their budget sizes, staffing resources, and percentage distribution of funding source by type. Further, few agencies were actively involved with incorporating research or standardized evaluation procedures as part of their agency protocol. This was evident by the relatively few agencies that had budgeted money for such purposes and the low percentage that had structured their service goals in evaluative terms.

An independent t-test was used to determine if funding sources had any impact on service goal development.
The percentage contribution of funds to agencies by each source type was sub-grouped according by those that had no goals stated in evaluative terms against those that had some or all of their service goals stated in evaluative terms. The mean distribution of funds contributed by the Province to those agencies without any service goals was 56.2%, compared to an average of 37.8% contributed to those with at least some goals stated in evaluative terms. This was in contrast to the percentage distribution of funds received from the United Way by agencies without service goals (9.6%), where those with at least "some" evaluative goals had a higher rate of funding contribution with a mean average of 24.5%. The differences between goal establishment and percentage contribution of budget from funding source did not prove significant in any instance when \( p < .05 \). However, the differences proved significant with a level of \( p < .10 \) for funds contributed by the United Way (\( t = -1.98, \text{ df} = 19, p < .09 \)) suggesting that this funding source may place somewhat greater emphasis on contributing to organizations with goal oriented service plans.

It has been shown that the extent to which quantifiable judgements of program effectiveness can be made are limited by the extent to which program goals ensure an accurate measurement of outcomes (Patti, 1987). This is not supported by data generated from this study. A chi squared test revealed no level of association between the extent to which an agency
possessed service goals and the allotment of funds for research/evaluative purposes. Considering this, it appears that agencies have not structured their service plans or implemented accountability procedures in line with what has been suggested to be most useful within the literature. This raises some questions regarding what impact, if any, have fiscal constraints amongst H.S.O.s that receive public vs. private funding impacted on or contributed to the quality and type of service evaluations conducted by family service agencies.

When budget size was treated as an interval variable, the average budget was $1.5 million (S.D. = $2.1 million). Fourteen of the 21 respondent agencies had operating budgets under $1 million and seven had budgets greater than $1 million. Budget size was collapsed into these two categories and compared against specific resources for possible associations, tested by a two tailed Mann-Whitney test of association. As was expected, budget size was positively associated number of paid employees (U=7.5, n_a=14 n_b=7, P<.001), as well as percentage of full-time staff employed (U=1.5, n_a=14 n_b=7, P<.0004). It was not significantly associated with the average monthly caseload of professional employees (U=15, n_a=11, n_b=6, P>.07), or when using a Fischer’s Exact Test, the prevalence of research money allocated for research or evaluation purposes (b=.62, P>.05).

Irrespective of the establishment of quantifiable service
goals, respondents appeared to possess a conceptualization of what needs to be examined in order to ascertain the organizations' effectiveness. Although 12 variable indicators were identified as such, over 40% focused on client satisfaction and feedback, possibly suggesting a strong identification amongst administrators with client-centred service orientations and consumer-based evaluation ideologies. Only two responses addressed performance indicators traditionally perceived as criteria for service evaluations, which do not necessarily address efficacy related issues (Patti, 1987). Given the average number of factors examined ($X=2.2$), and emphasis on client-centred variables, it appeared that administrators have seriously embraced the notion that effectiveness should be examined in light of client improvement based on service application.

With respect to practice characteristics, individuals were more likely to be seen in family service agencies surveyed than were families. No corroborative study could be obtained to provide a comparison by case type of those typically seen in other family service agencies. In addition to factors already discussed earlier in this chapter, certain theories and practice situations may predispose practitioners to entering into professional relationships with individual client systems. Further, some theoretical orientations propose family treatment can be conducted with individual family members. Of particular note is systems based theories which
have been adopted and well integrated into psychodynamic orientations (Will and Wrate, 1985; Kirschner and Kirschner, 1986; Pearse and Friedman, 1980) and which are cited by respondents to be that orientation most reported as their primary orientation. In addition, the nature of problems may necessitate that family sub-systems or individuals be seen in lieu of the entire family. The most cited problem addressed in practice was family violence, followed by "other" problems which most commonly addressed sexual abuse issues. The sensitive and at times volatile nature of these issues may serve to further explain the high prevalence of individual based work.

Another explanation may be that many practitioners employ an approach, that although adapted to family practice, has been a main proponent of individual psychotherapy trends. Many orientations considered to be in the forefront as "pioneers" of family therapy (Olson et.al., 1980) were not identified as influential orientations for practitioners. Of particular note is Structural Family Therapy (Minuchin, 1974), Bowen F.S.T. (Bowen, 1978), as well as Experiential Family Therapy (Napier and Whitaker, 1978) and the Mental Research Institutes Communication Approach (Bodin, 1981). The Behavioural approach also received limited attention despite it relatively high rate of proven effectiveness within the literature when compared to other forms of family therapy (Gurman et.al.,1986; Olson et.al., 1980). This coupled with the cited reliance on
client satisfaction variables when making judgements of effectiveness, may suggest limited reliance on measurable behaviour as indices of change.

As well, in this regard, psychodynamic family therapy has been classified as an integrative approach combining in most situations systems theory into an orientation for practice. It is not known if respondents identified with this category in the manner it has been presented in family therapy literature within the past 10 years, or as a frame of reference related to individual psychotherapy. The identification of "eclectic" with "psychodynamic" was meant to reinforce its adaptation to family practice. In this sense, its presentation as a given choice may have been appealing to respondents who did not identify with one orientation to practice. In this sense, it would appear that family service practitioners are more apt to employ an integration of a variety of techniques or orientations into their practice. Practitioners were asked to identify one approach which closely resembled their orientation to practice, yet 33% checked more than one. One respondent candidly explained her/his response: "When doing psychotherapy I have to use several orientations as needed". Another respondent similarly shared the sentiments indicating "It's too hard to identify with just one orientation (when working) with families". The reported levels of more than one identified orientation to practice may have been higher if it had been suggested that more than one orientation could be
chosen. In this sense, there may be an acceptance among practitioners of situationally tailoring their approach to the context of the clients situation.

III. The Use and Perceived Value of Outcome Measures

A. Administrators

Administrators were asked to indicate the extent to which standardized measures were used at various stages of the service/treatment paradigm. A comparative outline of responses by administrators and practitioners is provided in Tables 20 and 23.

Table 20
Relative Percentage Distribution of Standardized Measure Use Amongst Family Service Agencies Reported by Administrators (n=21)

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Number Who Use</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intake/Assessment</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>2. At Termination</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>3. During Follow-up Contact</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>4. Intervention</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>5. Within One Month After Termination</td>
<td>1</td>
<td>4.8</td>
</tr>
</tbody>
</table>
With respect to the administrator’s responses, the use of standardized measures did not exceed 20% in any given measurement period. This indicated a relatively low response rate of use by family service agencies. Seven agencies reported the use of at least one measurement tool at termination or at periods following treatment end. A total of 14 measures were used by these agencies for an average application rate of 2 instruments per agency. Ten of the 14 indices were internally developed, one was adopted from another agency and three were obtained from outside resources. Seven were client satisfaction inventories. Measurement use was mandated in only one agency, however 8 of the identified 14 measures used were required of practitioners by agency policy. Although use may be required by practitioners, the application to clients is not always uniform.

One agency required the application of outcome measures with every client, whereas the remaining agencies applied outcome measures to a mean average of 33.4% of clients (S.D.=25.7, range 3-80). Further, administrators were asked an open-ended question that sought to understand reasons that may contribute to the limited utility of outcome measure in family service agencies. Seventeen of 21 respondents answered this question providing the 36 responses categorized into eight areas outlined in Table 21.
Table 21
Relative Percentages of Factors Considered by Administrators to Limit the Use of Standardized Measures within Family Service Agencies (n=21)

<table>
<thead>
<tr>
<th>Contributing Factors Limiting Measurement Utility</th>
<th>Number of Responses*</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of Funds</td>
<td>11</td>
<td>30.5</td>
</tr>
<tr>
<td>2. Limited Staffing Resources</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>3. Time Limitations</td>
<td>6</td>
<td>19.4</td>
</tr>
<tr>
<td>4. Lack of Training in Measurement Use</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>5. Concerns regarding Validity and Reliability of Measures</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>6. Staff Mistrust of Measure Use</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>7. Administrators don’t Support Use</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>8. Limited data analysis Resources</td>
<td>1</td>
<td>2.8</td>
</tr>
</tbody>
</table>

**TOTALS**                                           **36**               **100**

Note. (*) Responses are not mutually exclusive of one another.
As indicated in Table 21, 30.5% of the responses cited a lack of funds as a primary contributor. Collectively, limited resources (funding, staffing, and data analyses) embodied 52.7% of administrator responses to this question. Time limitations related to the application of such measures was cited 19.4% of the time, and 19.5% of the responses questioned the suitability and credibility of instruments and lack of support by professionals for their integration into actual practice situations.

Administrators generally appear to desire regulated measurement use as 66.5% did not permit therapists to use instruments not required by agency policy. Another 25% expressed no reservations in permitting the independent use by therapists, and 11.1% indicated therapists are "sometimes" restricted from such use.

Formal client consent is not always required before measurement application. Specifically, 44.4% reported formal consents are not required, 44.4% indicated they are, and 11.1% indicated they were "sometimes" required. Regardless, in every (100%) reported situation, clients were advised as to the reasons and purpose of measurement application and data use.

To assess the relative importance of outcome data generated from instruments, respondents (who utilized such measures) were asked to rate the relative importance of data for 13 identified organizational and service activities. Responses were ordinaly ranked as follows 0= "not important", 
1 = "somewhat important", 2="very important". Ratings of the average levels of importance for each activity are presented in Table 22.

**Table 22**

Administrator Ratings of Mean Level of Importance for Outcome Data Use Amongst Varied Professional Activities *(n=9)*

<table>
<thead>
<tr>
<th>Professional Activities</th>
<th>Mean* (X)</th>
<th>Standard Deviation (S.D.)</th>
<th>Relative (%) rated as &quot;very important&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Evaluation</td>
<td>1.9</td>
<td>.33</td>
<td>88.9</td>
</tr>
<tr>
<td>2. Casework Supervision</td>
<td>1.3</td>
<td>.71</td>
<td>44.4</td>
</tr>
<tr>
<td>3. Improving Practice</td>
<td>1.3</td>
<td>.50</td>
<td>33.3</td>
</tr>
<tr>
<td>4. Program Planning</td>
<td>1.2</td>
<td>.67</td>
<td>33.3</td>
</tr>
<tr>
<td>5. Management Reporting</td>
<td>1.2</td>
<td>.67</td>
<td>33.3</td>
</tr>
<tr>
<td>6. Interpreting Service to the Community</td>
<td>1.2</td>
<td>.83</td>
<td>44.4</td>
</tr>
<tr>
<td>7. Budget Preparation</td>
<td>.89</td>
<td>.78</td>
<td>22.2</td>
</tr>
<tr>
<td>8. Cost-Effective Analysis</td>
<td>.89</td>
<td>.79</td>
<td>22.2</td>
</tr>
<tr>
<td>9. Allocating Resources</td>
<td>.89</td>
<td>.93</td>
<td>33.3</td>
</tr>
<tr>
<td>10. Clinical Decisions</td>
<td>.78</td>
<td>.83</td>
<td>22.2</td>
</tr>
<tr>
<td>11. Assessing Client Needs</td>
<td>.78</td>
<td>.83</td>
<td>22.2</td>
</tr>
<tr>
<td>12. Policy Influence</td>
<td>.78</td>
<td>.44</td>
<td>0</td>
</tr>
<tr>
<td>13. Case Management</td>
<td>.78</td>
<td>.83</td>
<td>22.2</td>
</tr>
</tbody>
</table>

**Note.** (*) Scores were rated as such: '0=not important, 1=somewhat important, 2=very important'
Those areas in Table 22 with a mean ranking over 1 ("somewhat important") included 'Program Evaluation' (X=1.9, S.D.=.3), 'Casework Supervision' (X=1.3, S.D.=.7), 'Improving and monitoring practice' (X=1.3, S.D.=.5), 'Program Planning' (X=1.2, S.D.=.7), 'Management reporting' (X=1.2, S.D.=.67) 'Interpreting service to the community' (X=1.2, S.D.=.83). The ranked scores were then summed and on a scale between 0-26 the scores ranged from 6-24 with a mean ranking of importance of 14 (S.D.=5.3), and median of 13 indicating an evenly distributed ranking of overall importance for data use amongst the respondents.

To address the overall relative value of measurement use, all respondents were asked if they believed data collected within their agency accurately measured service effectiveness. Thirteen answered this question of whom 11 (84.6%) indicated that data did not measure the agency's ability to be effective. In addition 55.5% indicated outcome research was "unlikely" or only "somewhat likely" to improve service provided by clinicians. Despite the perceived inability to improve direct practice or assist with measuring service effectiveness, 61.1% of the respondents indicated standardized measures were "likely" or "highly likely" to provide useful administrative information.
B. Practitioners

Practitioners, like administrators were asked to indicate the extent to which standardized measures are used at various stages of the treatment paradigm. An outline of responses by practitioners is provided in Table 23.

Table 23
Relative Percentage Distribution of Standardized Measure Use Amongst Direct Service Practitioners (n=21)

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Number Who Use</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intake/Assessment</td>
<td>8</td>
<td>38.1</td>
</tr>
<tr>
<td>2. Intervention</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td>3. At Termination</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>4. Within One Month After Termination</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>5. During Follow-up Contact</td>
<td>3</td>
<td>14.3</td>
</tr>
</tbody>
</table>
The rate of use exceeded that reported by administrators (in Table 20) at all stages. Specifically, 44% of practitioners used standardized indices at some point during service. Over 38% of respondents utilized standardized instrument during assessment/diagnosis; 28.6% employed such during intervention; 23.8% utilized measures at treatment termination; 14.3% within one month following treatment end; and, 23.8% during follow-up contact. A total of 19 outcome measures were identified which addressed 12 general areas. Instruments cited that were used by more than one respondent included: indexes of family relationships and process (4), Hudsons scales (3), client satisfaction inventories (2), and the Child Behaviour Checklist (2).

Eighteen of 19 identified measures were completed by the client. Two measures were completed by the practitioner, one of which was in combination with a client's completion of the same measure. No instruments were completed by "other sources", indicating a relatively homogenous reliance on primary client generated outcome data. Of those respondents utilizing measures with families, 57.1% attempted to employ them with every family member, 28.6% cited they would use measures with those parents acting in a primary parenting capacity, and one respondent preferred to use measures only with a father. The application to the number of clients appears widely dispersed amongst respondents. Measures were applied to between 2 and 100% of client systems serviced for
a mean of 26.4% (S.D.=33.5%) and mode and median response of 20%. It appears, therefore, that the use of such measures may be valued by those currently employing them, as 57.1% indicated they would use the measures if they were not required to do so by agency policy, and another 85.7% indicated that the use of such measures does not hinder their actual practice with clients.

To further assess the relative importance of outcome data generated from instrument use, respondents (who utilized measures, n=9), were asked to rate the relative importance of data for 13 previously identified organizational and service related activities. [This scale and its rankings was the same one applied to administrators]. Ratings of the average levels of importance for each activity are presented in Table 24 and can be compared against administrators responses noted in Table 22.
Table 24
Practitioners Ratings of Mean Level of Importance
for Outcome Data Use Amongst Varied
Professional Activities (n=9)

<table>
<thead>
<tr>
<th>Professional Activity</th>
<th>Mean* (X)</th>
<th>Standard Deviation (S.D.)</th>
<th>Relative (%) rated as very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Evaluation</td>
<td>1.30</td>
<td>.50</td>
<td>33.3</td>
</tr>
<tr>
<td>2. Program Planning</td>
<td>1.30</td>
<td>.71</td>
<td>44.4</td>
</tr>
<tr>
<td>3. Cost-Effective Analysis</td>
<td>1.20</td>
<td>.83</td>
<td>44.4</td>
</tr>
<tr>
<td>4. Clinical Decisions</td>
<td>1.10</td>
<td>.60</td>
<td>22.2</td>
</tr>
<tr>
<td>5. Improving Practice</td>
<td>1.10</td>
<td>.60</td>
<td>22.2</td>
</tr>
<tr>
<td>6. Case Management</td>
<td>1.10</td>
<td>1.10</td>
<td>22.2</td>
</tr>
<tr>
<td>7. Budget Preparation</td>
<td>1.00</td>
<td>1.00</td>
<td>44.4</td>
</tr>
<tr>
<td>8. Assessing Client Needs</td>
<td>.89</td>
<td>.73</td>
<td>22.2</td>
</tr>
<tr>
<td>9. Management Reporting</td>
<td>.78</td>
<td>.67</td>
<td>11.1</td>
</tr>
<tr>
<td>10. Casework Supervision</td>
<td>.67</td>
<td>.71</td>
<td>11.1</td>
</tr>
<tr>
<td>11. Interpreting Service</td>
<td>.56</td>
<td>.73</td>
<td>11.1</td>
</tr>
<tr>
<td>12. Policy Influence</td>
<td>.56</td>
<td>.53</td>
<td>0.0</td>
</tr>
<tr>
<td>13. Allocating Resources</td>
<td>.44</td>
<td>.53</td>
<td>0.0</td>
</tr>
</tbody>
</table>

*Note. (*) Scores were rated as such: '0=not important, 1=somewhat important, 2=very important'
Those areas with a mean ranking over 1 ("somewhat important") included: 'Program Evaluation' (X=1.3, S.D.=.5), 'Program Planning' (X=1.3, S.D.=.71), 'Cost-Effective analysis' (X=1.2, S.D.=.83), 'Clinical Decisions' (X=1.1, S.D.=.60), 'Improving and Monitoring Practice' (X=1.1, S.D.=.6), 'Case Management' (X=1.1, S.D.=1.1), 'Budget Preparation' (X=1, S.D.=1.0). The ranked scores were summed and provided a dependent measure for further statistical analyses. On a scale from 0-26 scores the level of importance ranged from 8 to 19 with a mean ranking of 12.1 (S.D.=4.4), and mode and median of 9 indicating a positively skewed distribution.

In order to examine the perceived importance of standardized measures in shaping practice trends, respondents were asked four questions where a fixed response of either 0 = "no", 1 = "not sure", or 2 = "yes" was required. These questions and the average response figures are presented in Table 25.
### Table 25
Practitioner Ratings of Mean Level of Value
for the Use of Standardized Measures
in Shaping Practice Trends
(n=19-20)

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Response (X)*</th>
<th>Standard Deviation (S.D.)</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If giving advice to another clinician would you recommend the integration of standardised measures into practice?</td>
<td>1.5</td>
<td>.61</td>
<td>2</td>
</tr>
<tr>
<td>2. In your opinion, is it therapeutically inappropriate to subject a client system (i.e. individual, couple or family) to a treatment approach which has not demonstrated it's effectiveness through empirical means?</td>
<td>.68</td>
<td>.82</td>
<td>0</td>
</tr>
<tr>
<td>3. In your opinion, is it unethical to subject a client system (i.e. individual, couple or family) to a treatment approach which has not demonstrated it's effectiveness through empirical means?</td>
<td>.47</td>
<td>.77</td>
<td>0</td>
</tr>
<tr>
<td>4. In your judgement, can family therapy be deemed effective or not solely on the basis of empirical data generated by standardized measures.</td>
<td>.21</td>
<td>.71</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note.** (*) Responses to questions were scored as follows: 0 = "No", 1 = "Not Sure", 2 = "Yes".
Although respondents would likely recommend to other clinicians the integration of standardized measures into practice (X = 1.5, S.D. = .61, mode = 2), they were less likely to suggest it "inappropriate" (X = .68, S.D. = .82) or "unethical" (X = .47, S.D. = .77) to subject clients to treatments that have not demonstrated their efficacy empirically. The value of measurement use and its relation to measuring treatment effectiveness appears somewhat weak among respondents who indicated that family therapy can not be judged effective solely on the basis of outcome data (X = .21, S.D. = .71, mode = 0). Indeed, as one may assume, this may suggest that additional variables or considerations apart from empirical justification shape practitioners choice of treatment interventions, practice orientations, and methods of evaluation.

To further explore the extent to which outcome measures are perceived to provide clinically significant information, respondents were asked a series of questions where responses were ranked accordingly: 0 = "highly unlikely", 1 = "unlikely", 2 = "somewhat likely", 3 = "likely", 4 = "highly likely". The questions and the mean response rates to such are provided in Table 26.
Table 26
Practitioner Ratings of Mean Level of Significance
for the Use of Standardized Measures
(n=20-21)

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Response (X)*</th>
<th>Standard Deviation (S.D.)</th>
<th>Mode M0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent do you feel knowledge of research findings related to psychotherapy outcome are likely to enhance the quality of service provided by clinicians to families.</td>
<td>2.6</td>
<td>.76</td>
<td>3</td>
</tr>
<tr>
<td>2. To what extent are the use of standardized measures likely ...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. To provide a comprehensive understanding of a client's progress?</td>
<td>2.0</td>
<td>.87</td>
<td>2</td>
</tr>
<tr>
<td>4. To provide an accurate assessment of whether therapy was effective or not?</td>
<td>2.0</td>
<td>.60</td>
<td>2</td>
</tr>
<tr>
<td>5. To determine whether or not any significant change in the client (or client system) has taken place?</td>
<td>2.3</td>
<td>.64</td>
<td>2</td>
</tr>
<tr>
<td>6. To determine the usefulness of service?</td>
<td>2.4</td>
<td>.51</td>
<td>2</td>
</tr>
<tr>
<td>7. To provide an accurate assessment of a clients' current situation?</td>
<td>2.1</td>
<td>.89</td>
<td>2</td>
</tr>
<tr>
<td>8. To provide information that can be used in a meaningful way at an administrative or supervisory level?</td>
<td>2.5</td>
<td>.81</td>
<td>3</td>
</tr>
<tr>
<td>9. To have aggregate results with respect to one client generalized to other client situations?</td>
<td>2.1</td>
<td>.85</td>
<td>2</td>
</tr>
<tr>
<td>10. To enhance the credibility of the helping professions in general?</td>
<td>2.7</td>
<td>.90</td>
<td>2</td>
</tr>
<tr>
<td>11. To assist you in particular in becoming an effective clinician.</td>
<td>2.2</td>
<td>1.2</td>
<td></td>
</tr>
</tbody>
</table>

Note. (*) Responses to questions were scored as follows: 0 = "highly unlikely", 1 = "unlikely", 2 = "somewhat unlikely", 3 = "likely", 4 = "highly likely".
No question (in Table 26) received a mean response rate equal to or higher than 3 ("likely"). Those questions with the lowest rankings indicated practitioners perceived it "unlikely" or "somewhat likely" that the use of standardized measures could provide an accurate assessment of treatment efficacy (X=2.0, S.D.=.6); could provide a comprehensive understanding of client progress (X=2.0, S.D.=.87); or provide an accurate assessment of a client's current situation (X=2.1, S.D.=.89). Those questions receiving a more favourable response rate involved areas that were more generally related to direct practice. For instance, 52.4% of respondents felt standardized measures were "likely" or "highly likely" to enhance the credibility of the helping professions, as well as provide useful administrative information. More notably, 60% of respondents indicated that it was "likely" or "highly likely" that measurement use would enhance service quality. It appears practitioners surveyed, although less likely to value measures in providing specific information that is clinically significant, acknowledged some general value for measurement use in advancing professional credibility and structuring service plans.

With respect to the issue of effectiveness, the respondents were asked to openly identify those variables they examine to determine if they are effective with clients. Seventeen practitioners made a total 26 responses denoting 9
variables that were considered to be significant indicators of treatment efficacy. The relative percentage distribution of variables denoted are summarized in Table 27.

Table 27
Relative Percentages of Variables Considered by Practitioners to be Significant When Evaluating Treatment Effectiveness (n=21)

<table>
<thead>
<tr>
<th>Variables Related to Service Effectiveness</th>
<th>Number of Responses</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduction of presented problem to client satisfaction</td>
<td>8</td>
<td>31.0</td>
</tr>
<tr>
<td>2. Improvement in family interactive skills</td>
<td>7</td>
<td>26.9</td>
</tr>
<tr>
<td>3. Each members level of functioning and coping</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>4. Improvement maintained at follow-up</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>5. Rate of appointment cancellations.</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>6. Family attitude toward therapy</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>7. Quality of marital relationship</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>8. Well being of children</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>9. Goal achievement</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>26</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
As evidenced in Table 27, three variables embodied 73.3% of all responses. They were: 1) 'the reduction of presented problems to the client systems satisfaction' (31%); 2) 'the improvement of family interactive skills' (26.9%); and 3) 'each individual family members perceived level of functioning' and 'coping ability' (15.6%).

Given the reported literature that uses outcome measures to assess those factors likely to impact on desired change, the respondent were also asked open-ended questions aimed at variable relationships perceived to improve and inhibit family improvement once they begin treatment. These data are reported in Tables 28 and 29.
<table>
<thead>
<tr>
<th>Contributing Factors To Family Improvement</th>
<th>Number of Responses</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Motivation of Family to Change</td>
<td>7</td>
<td>19.4</td>
</tr>
<tr>
<td>2. Quality of relationship with Therapist</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>3. Therapist skills related to treatment approach</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>4. Clients ability to use personal resources</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>5. Client awareness of problems and dysfunction</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>6. Therapists ability to emphasize</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>7. Communication skills of client system</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>8. Level of Self esteem</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>9. Level of equality and respect within family</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>10. Assessment skills of therapist</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>11. Morality of therapist</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>12. Continuity of service</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>13. Therapists ability to enhance affective expression in family</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>14. Positive reframing of problems</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>15. Goal definition</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>16. Therapists ability to stimulate change</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>17. Level of family isolation</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>36</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Inhibiting Factors To Family Improvement</td>
<td>Number of Responses</td>
<td>Relative Frequency (%)</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>1. Family unwillingness or fear of change</td>
<td>9</td>
<td>27.3</td>
</tr>
<tr>
<td>2. Poor choice or use of treatment modality</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>3. Relationship quality with therapist deteriorates</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>4. Irregular attendance or dropout</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>5. Inability to share feelings/be honest</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>6. Poor therapist-family match</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>7. Counter transference issues</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>8. Undisclosed sexual or physical abuse</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>9. Inability to pay for service</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>10. Breakup of marriage</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>11. Unrealistic expectations of family</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>12. Therapist imposing agenda</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>13. Improper assessment</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>14. Lack of structured treatment relationship</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>33</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
With respect to factors likely to enhance improvement, 52.8% of the responses addressed three issues relative to client, therapist, and process/relationship variables. Further, 19.4% of the responses indicated the rate of motivation of the client system is positively related to improvement. Another 11.7% attributed improvement to therapist utilization of skills, and 16.7% of the responses examined the level of "quality" within the treatment relationship. In this respect, the practitioners embodied a multi-dimensional understanding of the treatment relationship and of possible outcomes.

Similarly, with respect to factors likely to inhibit improvement, 51.5% of the responses addressed three issues relative to the client system, therapist, and process/relationship variables. The family's "unwillingness" to change entailed 27.3% of all responses. In addition, 12.1% of all responses addressed the therapist choice or inappropriate use of treatment techniques. Further, 12.1% of the responses rated a deterioration in the process or relationship between the therapist and family as a contributing factor that would inhibit client progress.

Having determined how effectiveness is measured and variables perceived to be related to client improvement, the practitioners were asked what they perceive is needed to enhance their effectiveness. A variety of responses were offered by respondents. Seventeen practitioners offered 27
responses identifying 13 activities or situations needed to enhance treatment efficacy. These are summarized accordingly in Table 30.
Table 30
Relative Percentages of Response Type by Practitioners Re: Factors Needed to Enhance Their Effectiveness (n=17)

<table>
<thead>
<tr>
<th>Factors Needed to Enhance Practitioner Effectiveness</th>
<th>Number of Responses</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff Education/Ongoing Training</td>
<td>4</td>
<td>14.8</td>
</tr>
<tr>
<td>2. Peer Consultation/Team Supervision</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>3. Familiarity with a Diversity of orientations</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>4. Rich Life Experiences/Personal Growth</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>5. Awareness of Self</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>6. More Time/Less Demands</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>7. Skill Development</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>8. Professional Reading</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>9. Self Appraisal</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>10. Stable Funding Source</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>11. More Experience</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td>12. More Structured Assessment</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td>13. Verbal Feedback from clients</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>27</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Five significant areas noted in Table 30 included activities specific to organizational resources and responsibilities of agencies. These entailed 44.4% of all responses and included: 'staff education and ongoing training', 'peer consultation/team supervision', 'more time/less service demands', 'a stable funding source', and a 'better structured assessment period'. However, collectively 51.8% of responses addressed activities or skills specific to the practitioner. These, included: 'a familiarity with diverse treatment approaches', a 'high level of self-awareness', 'a certain quality of life experiences and openness to personal growth', 'greater skill development', 'continued reading of professional journals', 'self appraisal', and 'increased work experience'. Regardless, those activities receiving the greatest number of responses are those within the control and direction of administrative personnel. Thus, it appears the practitioners may perceive that the organizational structure has as much to do with creating an environment conducive to enhancing their effectiveness, as anything else.
Table 31
Practitioner Ratings of Mean Level of Importance of Issues Related to Follow-Up Contact and Standardized Evaluation of Practice (n=19–21)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Mean Response (X)</th>
<th>Standard Deviation</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To respond to a client who attempts to initiate follow-up contact?</td>
<td>2.7</td>
<td>.56</td>
<td>3</td>
</tr>
<tr>
<td>2. For you to initiate follow-up contact with clients?</td>
<td>1.1</td>
<td>1.00</td>
<td>0</td>
</tr>
<tr>
<td>3. To use standardized measures during follow-up?</td>
<td>1.0</td>
<td>.65</td>
<td>1</td>
</tr>
<tr>
<td>4. For you to know a client's state of functioning after treatment has been terminated?</td>
<td>1.6</td>
<td>.67</td>
<td>2</td>
</tr>
<tr>
<td>5. To have pre-tested measures in order for outcome evaluations to have meaning for your practice?</td>
<td>1.3</td>
<td>.95</td>
<td>1</td>
</tr>
<tr>
<td>6. For you to establish measurable treatment goals at the onset of therapy with clients?</td>
<td>2.1</td>
<td>1.00</td>
<td>3</td>
</tr>
<tr>
<td>7. To demonstrate your usefulness as a clinician through empirical means?</td>
<td>.90</td>
<td>.89</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. (*) Responses to questions were scored as follows: 1 = "not important", 2 = "somewhat important", 3 = "important", 4 = "very important"
Discussion Regarding Utility and Perceived Value of Measurement Use (Administrators and Practitioners)

The use of standardized instruments appeared somewhat limited among the family service agencies. A study by Magura (1980) which utilized a sample size of 443 child welfare and family service agencies provided comparative data on measurement use for this study. Reports of measure use by administrators (33%) was less than that observed by Magura (43%). However, practitioner rate of use (44%) was comparable to previous research findings. The percentage of measures internally developed in this study (71%), was comparable with Magura’s findings of 70%, although Magura found the measure most frequently used was one adopted from a professional association. Although respondents in both sub-populations reported strong affiliations with professional associations, only two instruments reported by administrators were said to have been obtained from outside sources. The Ontario Association of Family Service Agencies (OAFSA) has developed a client satisfaction scale for use amongst member agencies. Because specific information regarding instrument design and construction was not collected in this study, it is not known if variations of the OAFSA instrument are those considered internally developed by respondent agencies.

Although efforts were made to ascertain those factors respondents perceived determined service or treatment
effectiveness, the extent and manner to which methods of evaluation examine such was not explored. Thus, although administrators most likely reported the use of client satisfaction instruments each may differ in design construction and variable of focus (e.g. global vs. specific variables).

The use of client self reports/satisfaction inventories was fairly common amongst administrators who employed standardized measures. Specifically, 50% of administrators reported the standard use of client satisfaction variables compared to 41% in Maguras' (1980) research. However, practitioner reports of such instruments was substantially lower (15%) than administrators. Such discrepancies may be accounted for by the representative nature of the sub-population of practitioners, or by concerns regarding the extent to which practitioners accepted and implemented those measures endorsed by administrators. The fact that the majority of respondent administrators do not permit non regulated measure use may suggest concerns regarding sampling procedure of practitioners. However, the majority of respondents (57%) that use measures indicated that they are likely to use measures not required by agency policy.

Indeed, practitioners reported a more veritable range of instrument types. Various indices assessing family relationships and processes were cited most often (4), followed by Hudsons Scales (3), client satisfaction
inventories (2), and the Child Behaviour Checklist (2). The differences in measure types reported by both sub-populations may suggest differences of opinion between administrators and practitioners on the practical use of and focus of measurement that should take place.

An examination of the differences in average ratings of importance for data use across professional activities between both sub-populations may be helpful in exploring this notion. A Kolmogorov-Smirnov two sample test was used for each identified activity according to sub-population category. Significant differences in ratings were observed for all but 3 identified activities. The actual test statistic results are detailed in Table 32.
Table 32
Results of a Kolmogorov-Smirnov Two Sample Test of Association between Rating of Importance for Data Use Between Administrators and Practitioners

<table>
<thead>
<tr>
<th>Professional Activities</th>
<th>Test Statistic (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Evaluation</td>
<td>1.18</td>
</tr>
<tr>
<td>2. Case Management</td>
<td>.71</td>
</tr>
<tr>
<td>3. Casework Supervision</td>
<td>.71</td>
</tr>
<tr>
<td>4. Influencing Clinical Decisions</td>
<td>.71</td>
</tr>
<tr>
<td>5. Interpreting Service to the Community</td>
<td>.71</td>
</tr>
<tr>
<td>6. Allocating Resources</td>
<td>.71</td>
</tr>
<tr>
<td>7. Influencing Policy Decisions</td>
<td>.47</td>
</tr>
<tr>
<td>8. Cost-effective Analysis</td>
<td>.47</td>
</tr>
<tr>
<td>9. Budget Preparation</td>
<td>.47</td>
</tr>
<tr>
<td>10. Management Reporting</td>
<td>.47</td>
</tr>
</tbody>
</table>

One might expect some incongruence in expectations and perceived value of data use given different roles and responsibilities each sub-population maintains within the organizational structure. However, some differences between ratings are interesting and require some elaboration. In both sub-populations program evaluation received the highest mean rating of importance. However, administrators rated "casework supervision", "improving direct practice", higher than practitioners. Whereas practitioners rated "cost-effective
analysis", "management reporting", and value for "budget preparation" higher than administrators. Although both acknowledged the value of standardized instruments for administrative purposes, it appears practitioners may be likely to assume data is valuable for administrative activities administrators do not rate high in importance. Further, administrators may value their use for service/treatment improvements not with the same intensity by practitioners.

These discrepancies may suggest that within the organizational structure, it may be possible that administrators and practitioners engage or support such research and evaluation activities out of the perceived benefit it may have for the other party. Indeed, ratings of clinical significance varied greatly amongst respondent practitioners. In addition, practitioners most commonly rated it was "not important" to demonstrate their usefulness empirically. Thus, there may be limited perception of any value or significance such measures may have by each sub-population. The low rate at which data is used for budget preparation, cost-effective analyses, the allotment of resources and policy influence amongst administrators was interesting. These activities have been identified in the literature as important for the application of measurement indices at the administrative level (Mutschler, 1984; Carter, 1983; C.W.L.A., 1984). This raises some questions regarding
the extent to which family service agencies are responsible or accountable to funding bodies by way of quantifiable data that demonstrates effectiveness. Many of the activities reported to be important areas for measurement use by administrators relate to influencing or shaping direct practice within their agency as well as internal service (not fiscal) accountability procedures or activities.

It appears that when instruments are used they are predominantly client self reports irrespective of type of instruments. In this regard, measurement use closely approximates trends acknowledged within the literature (Shrauger and Osberg, 1981), however doesn't approximate design recommendations to ensure their reliability and generalizability (Magura, 1986; Newman, 1983). Although some practitioners reported securing assessments from multiple family members when utilizing family interactive/process scales, most did not illicit multiple assessors. However, multiple instrument use was reported by many who use measures. In addition, the establishment of treatment goals was considered a high priority amongst practitioners irrespective of whether service goals were established.

With respect to factors impacting on measurement use, the administrators identified limited resources (funds, staffing, data analysis limitations and time constraints) as primary impediments to the incorporation of standardized research and evaluation techniques within their agency. Less emphasis was
placed on epistemological questions regarding the suitability of research to practice situations. Although limited training, practitioner scepticism and access to reliable and valid measures were cited 28% of the time, it was not clear if time constraints refer to those placed on administrators or clinicians. In this regard one may speculate that administrators perceive the establishment and coordination of such activities place additional and undesired responsibilities on them (Cnaan and Mutschler, 1985). Or that such use may create additional burdens for practitioners carrying full case loads with high risk clients. Regardless, when practitioners were asked if they perceived time invested in outcome measure use hindered the extent and quality of involvement with other clients, 85.7% indicated "it didn’t" and 14.3% said they were "not sure". This would seem to suggest that use at the direct service level is not seen as an impediment as such.

Additional statistical analyses using non-parametric procedures and group mean comparisons was conducted to assess the extent to which a number of variables of both sub-populations impacted on the reported use of standardized instruments at each identified measurement period, as well as collectively. Addition analyses was conducted to determine possible variable relationships with each practitioners overall rating of clinical significance scores which were derived from response totals to questions detailed in Table
26.

With respect to possible associations between independent variable identified with the administrator and measurement use, no findings of association were determined by any statistical test. However, a few require mentioning. Those approximating significance included wait list length, and the percentage of staff employed with other degrees. An independent t-test was constructed between reported length of time clients wait to receive service grouped by whether or not the agency employs standardized measures at any period. The average wait period for clients seeking service from agencies that use measure was 9.8 weeks compared with 18.6 weeks for those seeking service from agencies that do not utilize measures in some capacity. When tested at a $\alpha = .10$ the differences prove significant ($t = 1.74$, df 18) However, results are not significant when $\alpha = .05$. These findings suggest that further exploration is required to ascertain what impact measurement has with respect to treatment interventions. It may be possible use promotes time efficient application of resources and tailoring of treatment approaches, thus permitting less service demands due to increase in volumes of client seen. Or to the contrary, it may be possible those agencies with less time constraints due to service demands are more likely to be inclined to invest time in evaluation activities.

Percentage distribution of professional staff by degree
type was collapsed into 4 categories of BSW, MSW, Psychology degrees and "other" degree. Each was separately grouped according to general use of measures. Those agencies that had a higher rate of employment of professionals with degrees other than social work and psychology appeared less likely to employ standardized measures in practice ($t=2.22 \text{ df}=12 \text{ P}.046)$. The mean percentage of employees with "other degrees" employed by agencies that don't use measures was 9.6% compared to .13% by those that do. However, given the low sample population, a Mann–Whitney test was constructed and no level of significance was observed ($U=30$, $n_a=13$, $n_b=8$).

Another area requiring further exploration examines the percentage distribution of funds by source type and possible associations with measurement use. Earlier it was shown that the rate of contribution of funds by the united way appeared associated with the extent to which measurable goals were constructed within the agency. Percentage distribution of funds did not prove significantly associated with actual measure use. Therefore the extent to which funds are related to measurable goals does not appear to be of the same emphasis on the establishment of quantitative evaluation techniques. When a Fischers Exact test was applied no significant rating association between goal establishment and measurement use was determined ($b=.21$). Thus, no variables relative to resources, service demands, socio-demographic background of administrators (who control service activities) could be found.
to be significantly related to measurement use.

With respect to variables relative to direct practice, no relationships or significant levels of association/differences could be found between groups who use measures and those who don’t. This indicates that measurement use is indiscriminately applied by practitioners irrespective of their orientation to practice, problem types of focus, sociodemographic data, education and training, and caseload demands.

To determine possibly contributing factors to a practitioners perception of the extent to which measurement use can provide clinically significant information, a number of statistical procedures compared independent variables against respondents total rated score for questions detailed in Table 26. Significant associations were observed for the type of association belonged to, and whether or not the respondent received post degree training in research and evaluation skills. Association memberships were grouped as 1) social work, and 2) non-social work or mix. Those belonging exclusively to social work related associations mean rating of clinical significance was 23.7 compared to those belonging to a mix of associations by type that scored 18.3. These differences proved significant ($t=2.4, \text{df}=17, p<.025$). However, those likely to receive post degree training in research and evaluation systems were likely to rate the degree to which measurement use provides clinically significant information at
a lower rate. Those with additional training were not likely to perceive measurement use to have significant value at a level greater than those who did not receive post degree training. Given that the highest rating of training is personal study future efforts should examine the means by which practitioners educate themselves and the extent to which agencies can support the useful and practically valued integration of such procedures into practice. Findings provide some indication that practitioners may not perceive measure use of being significant for their job roles and responsibilities.
CONCLUSIONS

The findings of this study will be organized according to: 1) conclusions related to the literature; 2) findings of the study; 3) limitations; and 4) recommendations.

I. Conclusions Related to the Literature

This study sought to explore the prevalence and perceived value of utilizing standardized instruments (and more specifically, outcome measures) amongst administrators and practitioners in family service agencies in Ontario. There has generally been widespread consensus and convincing arguments in the literature supporting the use of standardized means for evaluating clinical and service/program effectiveness. However, despite the strong push toward the integration of researcher practitioner-model of practice the literature has been less convincing in demonstrating acceptance of this model by those in the family service sector. This study represents the first known research that specifically attempts a comparative analysis of potential factors relative to direct practice and organizational management that may impact on the utility of standardized instruments and evaluation procedures.

The profession of social work has embarked on a period of critical self-analysis within the past 20 years, in a manner similar to that observed in psychology. These efforts,
motivated by attempts to increase the professions' credibility, were demonstrated through research endeavours that attempted to examine practice and service effectiveness. The encouragement of a research/practitioner model of practice, the perceived necessity of integrating research endeavors into practice (in an effort to shape practice trends), goal directed and client centred treatment were outgrowths of increased attention to accountability through quantifiable evaluation methods. A plethora of studies emerged that utilized outcome measures for generating information regarding variable relationships that may impact on outcome given different treatment approaches. This, it was hoped would shape efficacy oriented practice trends. However, as family based practice received increased legitimacy in the past twenty years as a preferred method of treatment, a significant void in the literature regarding variable relationships that impact on successful family treatment existed.

This study attempted to provide insights into professional attitudes and orientations to practice, as well as possible trends that may exist relative to measurement use. The implications for this are directed toward shaping future efforts at increasing incorporating research designs into practice as well as directing future studies that attempt to examine variable relationships likely to impact on family therapy outcomes.
II. Findings of the Study

This research study was exploratory in nature. Given the relatively small sample size for both sub-populations, and the potentially unrepresentative nature of respondents who are practitioners, findings cannot be generalized to all administrators and practitioners within the family service sector in Ontario. However, the findings provide an impetus for future studies related to this topic. The following is a presentation of results and observed trends which attempt to provide answers to research questions posed on pages 69-70.

1. With respect to the extent to which measures have become an integral part of treatment and program evaluations, despite encouragement in the literature and relative exposure to current literature, and influence of professional associations, it does not appear standardized evaluation is utilized in any convincing fashion by administrators or practitioners within family service agencies. The reported rate of use by practitioners was limited and comparable to past studies (Magura, 1980), yet the use of measures reported by administrators may suggest limited reliance on standardized instruments for accountability purposes.

Only a few reported agencies budgetted for such purposes, despite a majority that rate at least "some" of their agency service goals in evaluative terms. It appears emphasis on goal
establishment may not necessarily be extended to measuring the extent of goal attainment.

2. Questions are raised regarding the emphasis, if any, to which funding sources desire or place requirements for quantifiable evaluation techniques on family service agencies. This requires further exploration to determine if funding bodies are not requiring such, or agencies feel budgets received do not justify such expenditures to ensure accountability. Noting that the most frequently cited impediment to the incorporation of standardized evaluation techniques by administrators, was limited funds and contributing resources. In this instance, further exploration regarding the extent to which agencies feel they are properly funded (given service demands) to incorporate research into agency protocol must be determined.

3. Measures, when used, are predominantly client self-reports, although instrument focus/type varies according to sub-population. Administrators most commonly reported application of client satisfaction inventories, where practitioners employed a more veritable range of measures. Application of more than one instrument was common, and when utilizing them with families practitioners appeared to desire input from all family members. There was limited reliance on third party assessments.

4. Practitioners may not use those measures typically endorsed by administrators or agency policies. Given the lack of
knowledge regarding population parameters of practitioners, reliability and validity of comparisons are suspect. However, despite administrators stated desire to control research endeavours, practitioners reported that they would employ measures not endorsed by their administrators. There was also a possible incompatibility with respect to perceived purpose and value for measurement use between administrators and practitioners. This was exemplified in findings of importance for outcome data use amongst those employing such measures. Specifically, the perceived values differed significantly with both sub-populations suggesting limited identification or value for measures relative to each sub-populations perceived job roles.

5. Although administrators did not utilize standardized measures, there was some awareness of criteria for determining service effectiveness. That criteria most typically utilized was related to client based factors and satisfaction variables. Specifics regarding how such information is ascertained (apart from standardized measures) was not collected in any depth.

6. Both sub-populations were predominantly social work educated and trained, as well as experienced with respect to their current job roles. Agencies presented diversity in budget size, staffing resources, and percentage distribution of funding source type. No trends could be identified with respect to agency characteristics and utility of research or
standardized evaluation procedures. A number of variables related to education and type of training of administrators, current resources, service demands, and case types served were all examined and shown to demonstrated limited associations with measurement use. Perhaps greater exploration of attitudes of administrators toward research, and specific information regarding the type of evaluation training received, may provide additional information helpful in determining factors impacting on limited utility on standardized instruments.

7. Although practitioners were likely to read journals related to family practice, they were less likely to see families as opposed to individuals and couples within the confines of their agency. The family service agencies surveyed predominantly provided service to individuals. Many practitioners employed integrative treatment approaches, suggesting a reliance on a variety of techniques given the diversity of client types and issues addressed in practice. Practitioners were more likely to encounter family treatment issues not typically identified in family therapy outcome research.

8. Finally, the findings suggested that practitioners may not perceive that it is unethical to subject clients to treatments whose efficacy has been determined in quantifiable manner. It appears practitioners acknowledge the value in determining effectiveness but perhaps not in a standardized linear fashion.
Limitations

The limited response rate resulted in a modest sample size (n=21) for both sub-populations. The potentially disproportionate distribution of questionnaires to practitioners subsequently limits the generalizability of the study’s findings or observations. Further, the use of a mailed questionnaire limited the extent to which the researcher could determine why some questionnaires were not returned. Possible conditions prohibiting the completion of the questionnaire may also impact on the limited use of standardized evaluation methods in agencies. For example, time constraints that may prevent the integration of research into direct practice, may have been a primary variable impacting on limited response to a questionnaire that is part of a research study. In addition, those likely to respond to this questionnaire may be more motivated to report the use of such measurements.

The questionnaires sent out were not pre-tested. This may have assisted in restructuring and refining questions that may have been interpreted as confusing or inappropriate by respondents. Of particular note was the structuring of the question that attempted to ascertain the orientation to practice of practitioners. The provision for checking multiple perspectives may have provided a more comprehensive understanding of the extent to which multi-dimensional orientations are incorporated into practice to address those issues addressed in servicing families.
Given the small sample size, tests assessing the internal consistency reliability coefficients amongst questions outlined in Table 26 could not be conducted. These questions were constructed with the intent of measuring the extent to which practitioners perceive standardized measures can provide clinically significant information. The reliability of this measure is thus held in suspect until utilized with a larger sample size.

In addition, it is not known if the rate of measure use may be overrepresented. Although it is difficult to postulate why specific individuals did not respond, it is possible potential respondents may have been reserved to disclose they did not use measures. Further, the distribution of questionnaires to practitioners was not researcher controlled to ensure randomness. Although administrators were requested to randomly select a practitioner, no instruction for such a procedure was provided. These factors make the population parameters less certain, and further limits the extent to which respondents are representative of all family service administrators and practitioners.

**Recommendations**

Further research should be undertaken to corroborate the findings and trends observed and build upon the data base established by this research study. Instruments should be re-tested, scrutinized and refined, and employed with other data
collection techniques. Specifically, the use of one-to-one interviews should be utilized with respondent sub-populations, as well as with representatives of funding sources in order to ascertain the depth and inter relatedness of factors, at various levels that impact or potentially determine the extent to which standardized evaluation techniques are employed in family service agencies. A detailed examination of preferred accountability procedures and service priorities of funding sources, as well as documented fiscal constraints relative to the issue of service effectiveness should be examined. Preferably this study should be constructed at a national level with a proportionate sampling of practitioners relative to administrators.

In addition, the actual type of research and evaluation techniques respondents are educated and trained in, should be more closely examined in future studies. The quantity of training is not necessarily related to the quality or type of training. The extent of training relative to techniques that have received recent support in the literature (e.g. single case design) and are amenable to practice situations should be examined for their relative impact on measurement use in service agencies. Further, the compatibility of value and perceived purpose for integrating research into practice should be examined in light of administrators and practitioners level of job satisfaction, and perceived quality of management-worker relationships.
Finally, should future studies reinforce that standardized evaluation methods and research techniques are not incorporated into practice, or accepted as legitimate means of providing significant information for practitioners of human service administrators; the social work profession should re-examine the emphasis and orientation toward integrating quantitative research designs into practice for evaluative purposes, in lieu of advancing possible qualitative methods (supervision, talking with colleagues, etc) perhaps already in use.

In addition, findings suggesting a relative awareness and education in research techniques, yet limited incorporation of such techniques into practice may have implications for social work education. Further research should examine the compatibility of organizational constructs and practice situations with the integration of a research/practice model of intervention. Efforts should also be made to examine the relative effectiveness of teaching methods utilized within social work curricula that are meant to enhance the integration of research into practice. In this respect, the extent to which field settings hold potential for research activities, and the extent to which practice courses are grounded in research and empiricism should be examined.
Appendix A

COVER LETTERS
February 13, 1991

Dear Direct Service Practitioner:

I am a graduate student at the University of Windsor conducting a thesis in the Master of Social Work program.

The purpose of this study is to assess the extent to which standardized measures or instruments are incorporated into agency protocols and direct practice with families. A random sample of one administrator and one practitioner from each family service agency in Ontario is being selected for participation. The major areas of study include: 1) general background and education of administrators and practitioners, 2) socio-demographic characteristics of agencies, 3) characteristics of direct practice, and 4) the actual prevalence of measure(s) used and respondents attitudes toward them. This study will contribute to a distinct literature void in this area.

Could you please assist me in this matter by completing the attached questionnaire and forwarding it to me in the enclosed self-addressed stamped envelope within 3 weeks of its receipt.

Although it may be possible to identify individuals from data collected, I wish to assure you that all information collected from the survey will be treated in the STRICTEST CONFIDENCE. No individual will be singularly identified in the reporting of the findings. All information collected will be analyzed in group data form only. In addition, I would be most willing to provide you with a copy of published results and discuss these results with you should you desire.

Thank-you for your anticipated cooperation in this matter. If you have any questions or concerns, please do not hesitate to contact me through 'the School of Social Work at the University of Windsor at (519) 253-4232 or by fax (519) 973-7036.

Sincerely,

Robin Perry
M.S.W. Student
February 13, 1991

Dear Administrator/Upper Level Manager:

I am a graduate student at the University of Windsor conducting a thesis in the Master of Social Work program.

The purpose of this study is to assess the extent to which standardized measures or instruments are incorporated into agency protocols and direct practice with families. A random sample of one administrator and one practitioner from each family service agency in Ontario is being selected. The major areas being studied include: 1) general background and education of administrators and practitioners, 2) socio-demographic characteristics of agencies, 3) characteristics of direct practice, and 4) the actual prevalence of measure(s) used and respondents attitudes toward them. This study will contribute to a distinct literature void in this area.

Your participation is requested because of the experience and expertise you possess in the administrative/management field. Could you please assist me in this matter by completing the attached questionnaire and forwarding it to me in the enclosed self-addressed stamped envelope within 3 weeks of receipt. In addition, could you please distribute the remaining questionnaire to any practitioner (at random) providing direct service to clients within your agency.

Although it may be possible to identify individuals from these data, I wish to assure you that all information collected from the survey will be treated in the STRICTEST CONFIDENCE. No individual will be singularly identified in the reporting of the findings. All information collected will be analyzed in group data form only. In addition, I would be most willing to provide you with a copy of published results and discuss these results with you should you desire.

Thank you for your assistance in this matter. If you have any questions or concerns, please do not hesitate to contact me through the School of Social Work at the University of Windsor at (519) 253-4232 or by fax (519) 973-7036.

Sincerely,

Robin Perry
M.S.W. Student
Appendix B
Human Subject Form
INFORMED CONSENT FORM FOR RESPONDENTS
SURVEY OF ADMINISTRATORS AND
DIRECT SERVICE PRACTITIONERS

I, the undersigned, understand that the purpose of this research being conducted is to collect data and information regarding the extent to which standardized measures of evaluation are incorporated into agency protocol and direct practice.

I, understand that the information collected from me will only be used as a part of a large amount of similar information provided by other equally anonymous individuals and reported in group numerical or statistical form only. Thus, confidentiality will be safeguarded.

I, agree to voluntarily participate in this study by completing the attached questionnaire and returning it to the investigator within three weeks of receipt.

I, understand that this survey is a research undertaking being supervised through the School of Social Work and the Faculty of Graduate Studies at the University of Windsor.

Date __________________ Signature ____________________

Name (print) __________________

THANK YOU

Please check [✓] for receipt of the published results. [   ]
Preferred address where results may be sent:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Please note that this sheet will be detached from the rest of the questionnaire upon receipt of the information.**
Appendix C
Follow-up Letters
March 15, 1991

Dear Direct Service Practitioner:

I am a graduate student at the University of Windsor conducting a thesis in the Master of Social Work program.

Within the past 3 weeks you received a questionnaire relating to a study meant to assess the extent to which standardized measures or instruments are incorporated into direct practice with families.

If you have already completed the questionnaire, I wish to thank you for your time and effort. If not, your assistance in completing this questionnaire and mailing it by April 05, 1991 would be greatly appreciated.

I wish to assure you that although it may be possible to identify individuals from data collected, all information collected from the survey will be treated in the STRICTEST CONFIDENCE. No individual will be singularly identified in the reporting of the findings. All information collected will be analyzed in group data form only. In addition, I would be most willing to provide you with a copy of published results and discuss these results with you should you desire.

Thank you for your anticipated cooperation in this matter. If you have any questions or concerns, please do not hesitate to contact me through the School of Social Work at the University of Windsor at (519) 253-4232 or by fax (519) 973-7336.

Sincerely,

Robin Perry
M.S.W. Student
March 15, 1991

Dear Administrator or Upper Level Manager:

I am a graduate student at the University of Windsor conducting a thesis in the Master of Social Work program.

Approximately 3 weeks ago you received a packet containing 2 questionnaires relating to a study meant to assess the extent to which standardized measures or instruments are incorporated into agency protocols and direct practice with families. A random sample of one administrator and one practitioner from each family service agency in Ontario was being selected.

Your participation was requested because of the experience and expertise you possess in the administrative/management field. If you have already completed the questionnaire, I wish to thank you. If not, your assistance in completing the questionnaire and mailing it by April 05, 1991 would be greatly appreciated. Recognizing that most administrators must contend with time constraints, please feel free to distribute the questionnaire to another administrator/manager who is familiar with service plan and budget matters within your agency. In addition, could you please provide the direct service practitioner who was chosen to complete the second questionnaire with the attached letter.

Thank you for your assistance in this matter. If you have any questions or concerns, or require any additional questionnaires please do not hesitate to contact me through the School of Social Work at the University of Windsor at (519) 253-4232 or by fax (519) 973-7036.

Sincerely,

Robin Perry
M.S.W. Student
Appendix D
QUESTIONNAIRE
for
DIRECT SERVICE PRACTITIONERS
SURVEY OF DIRECT SERVICE PRACTITIONERS/CLINICIANS

DIRECTIONS

**The purpose of this study is to assess the extent to which standardized measures of evaluation are incorporated into direct practice.**

**Please try and complete all of the questions to the best of your ability.**

**The information you provide will be held in the STRICTEST CONFIDENCE and will be presented in group numerical form only.**

SECTION I: GENERAL AND EDUCATIONAL BACKGROUND

1. Year you were born: _____  2. Sex: 1 = male  2 = female

3. Employment Status [circle one]: 1 = full-time  2 = part-time

4. Education: Please list your educational degree/diploma starting with the most recent.

<table>
<thead>
<tr>
<th>Degree/Diploma [e.g. B.S.W., M.S.W.]</th>
<th>Discipline [e.g. psychology, business, social work]</th>
<th>Specialization [e.g. casework, administration]</th>
<th>Year Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. How many years of experience do you have as a direct service practitioner? _____ (total years)

6. Please list the main professional associations you belong to.

1.                                               
2.                                               
3.                                               
7. a) Did you have any courses in your professional education with respect to the following: [check [✓] the appropriate box [yes or no] for each subject area].

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Research methods.</td>
<td></td>
</tr>
<tr>
<td>b) Statistics.</td>
<td></td>
</tr>
<tr>
<td>c) Data analysis.</td>
<td></td>
</tr>
<tr>
<td>d) Evaluation research.</td>
<td></td>
</tr>
<tr>
<td>e) Computer applications.</td>
<td></td>
</tr>
<tr>
<td>f) Information systems.</td>
<td></td>
</tr>
</tbody>
</table>

b) Since obtaining your last degree/diploma have you received any subsequent training in the following:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Research methods.</td>
<td></td>
</tr>
<tr>
<td>b) Statistics.</td>
<td></td>
</tr>
<tr>
<td>c) Data analysis.</td>
<td></td>
</tr>
<tr>
<td>d) Evaluation research.</td>
<td></td>
</tr>
<tr>
<td>e) Computer applications.</td>
<td></td>
</tr>
<tr>
<td>f) Information systems.</td>
<td></td>
</tr>
</tbody>
</table>
8. Please list in the spaces provided below any professional journals that you are likely to read on a monthly or bi-monthly basis.

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

9. Since obtaining your last degree/diploma, to what extent have you been involved in research skill development due to: [check [✓] one column (none, somewhat, very much) for each learning source below].

<table>
<thead>
<tr>
<th>Learning Source</th>
<th>None</th>
<th>Somewhat</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On-the-job training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Continuing education from any professional associations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Specialized seminars, courses, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Community college courses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. University courses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Correspondence study</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Personal study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Research Consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION II: PRACTICE CHARACTERISTICS

1. Specify the percentage that each of the following represents your current caseload:

____% Family counselling and therapy
____% Individual adult therapy
____% Individual child therapy
____% Sibling therapy
____% Marital or Couple therapy
____% Family life education
____% Advocacy
____% Other (please specify)

2. Which type of family therapy most typically represents the orientation you use in practice [check the primary one [✓] that applies].

____ Behavioral
____ Bowen F.S.T. (Family Systems Theory)
____ Contextual
____ Functional
____ Humanistic
____ McMaster PCSTF (Problem Solving Systems Therapy)
____ Milan Systemic
____ MRI International (Mental Research Institute)
____ Multigenerational
____ Psychoeducational
____ Psychodynamic - Eclectic
____ Strategic
____ Structural
____ Symbolic - Experiential
____ Triadic
____ Other (please specify)

_________________________
3. Below is a list of presenting problems which occur in direct practice. If any have been the main focus of your work with couples or families within the past six months identify [by checking [✓] one box for each presenting problem in the categories listed: None, 1-5, 6-10, 10+].

<table>
<thead>
<tr>
<th>PRESENTING PROBLEM</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NONE</td>
</tr>
<tr>
<td>1. schizophrenia</td>
<td></td>
</tr>
<tr>
<td>2. substance abuse</td>
<td></td>
</tr>
<tr>
<td>3. affective disorders</td>
<td></td>
</tr>
<tr>
<td>4. anxiety disorders</td>
<td></td>
</tr>
<tr>
<td>5. psychosomatic disorders</td>
<td></td>
</tr>
<tr>
<td>6. juvenile delinquency</td>
<td></td>
</tr>
<tr>
<td>7. conduct disorders</td>
<td></td>
</tr>
<tr>
<td>8. mixed disorders</td>
<td></td>
</tr>
<tr>
<td>9. divorce adjustment</td>
<td></td>
</tr>
<tr>
<td>10. death of a family member</td>
<td></td>
</tr>
<tr>
<td>11. medical illness</td>
<td></td>
</tr>
<tr>
<td>12. family violence</td>
<td></td>
</tr>
<tr>
<td>13. family economic/living situation</td>
<td></td>
</tr>
<tr>
<td>14. other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

________________________________________

________________________________________

________________________________________
SECTION III: OUTCOME MEASURES

The purpose of this section is to determine the actual use or non-use of research and evaluation instruments or scales within your practice.

In this section, the following definitions are used:

"Standardized measure(s)" refer to any tests, scales, rating forms, questionnaires, interview schedules that are completed by or administered to staff, clients or third parties which have been tested for their reliability and validity.

"Reliability and validity" refer to the psychometric properties of instruments determined by standardized tests that enable data to be used for comparative purposes.

"Outcome measures" are standardized measures applied at discharge or immediately following the termination of service with a client (within one month).

"Follow-up measures" involve the collection of data from clients at least one month after discharge or termination.

1. Have you used standardized measures in your current job position during any of the following times: [ check [✓] either (yes or no) ].

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Intake/assessment ..........</td>
<td></td>
</tr>
<tr>
<td>b) Intervention................</td>
<td></td>
</tr>
<tr>
<td>c) At termination .............</td>
<td></td>
</tr>
<tr>
<td>d) Within one month after termination .............</td>
<td></td>
</tr>
<tr>
<td>e) During follow-up contact.................</td>
<td></td>
</tr>
</tbody>
</table>

(one month after termination)

If you checked either c, d, or e in the above question, please continue. If not skip to question 11 on page 10 (look for §).
2. In the space provided below, please list any measures that you have used in your current position within the past 6 months that meet the criteria of what is defined as an outcome measure. Please indicate [check all that apply] who typically completes the identified measure (therapist, client, or other party). For instance, in the example below, the Child Behaviour Checklist was a measure typically completed by family members and a teacher of a child experiencing difficulty in a family.

Example:

MEASURES

A) Child Behaviour Checklist

B) ___________________________________________________________________

C) ___________________________________________________________________

D) ___________________________________________________________________

E) ___________________________________________________________________

WHO TYPICALLY COMPLETES

worker client other

/  

3. Have you ever completed or administered outcome measures in previous employment settings? [circle one]

1 = Yes  2 = No
23 b) If 'Yes' (for question above), in the space provided below, list the measures and your job title.

<table>
<thead>
<tr>
<th>Measures Used</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

4. In your opinion, how important is data generated from outcome measures (in your present employment setting) for each of the following. [check [✓] either very important, somewhat important, or not important]

<table>
<thead>
<tr>
<th></th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. program evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. case management decisions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. program planning</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. casework supervision</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. management reporting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. budget preparation</td>
<td></td>
<td></td>
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<tr>
<td>7. cost-effective analysis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. clinical decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. monitor and improve practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. interpretation of service to community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. assessing client needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. allocation of resources within the agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. influencing public policy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. If outcome measures are used in your practice with families, which family members typically participate in outcome evaluation (please list in descending order of participation in the spaces provided below).

1)  
2)  
3)  
4)  
5)  
6)  

6. If outcome measures are used during follow-up contact what specific period of time after treatment has ended are clients typically contacted?

_________ (number of months)

b) If measures are administered during follow-up, how are clients typically contacted? (check all that apply)

____ mail  
____ telephone  
____ personal contact  
____ other (please specify)

7. Normally, is measurement at termination a prerequisite before measures are applied during follow-up contact? (circle either)

Yes  No  Sometimes

8.a) In your agency, are outcome measures used with every client?

Yes  No

b) If not, generally, what percentage of clients are they used with?

_________

9. Would you use outcome measures if they were not required by agency policy or part of your job description?

Yes  No  Not sure

10. Do you find that the time invested in outcome evaluations hinders the extent and quality of involvement you have in direct practice with other clients?

Yes  No  Not sure
11. Are you aware of any other direct service personnel in your agency who use standardized measures in their practice?  

Yes  No  Not sure

12. If giving advice to another clinician would you recommend the integration of standardized measures into practice?  

Yes  No  Not sure

13. In your opinion, is it therapeutically inappropriate to subject a client system (i.e. individual, couple or family) to a treatment approach which has not demonstrated it’s effectiveness through empirical means?  

Yes  No  Not sure

14. In your opinion, is it unethical to subject a client system (i.e. individual, couple or family) to a treatment approach which has not demonstrated it’s effectiveness through empirical means?  

Yes  No  Not sure

15. In your judgement, can family therapy be deemed effective or not solely on the basis of empirical data generated by standardized measures.  

Yes  No  Not sure

16. For the next series of questions, please note your response accordingly:  

[ circle one response per question ]

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>highly unlikely</td>
<td>somewhat likely</td>
<td>likely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unlikely</td>
<td>likely</td>
<td>likely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a) To what extent do you feel knowledge of research findings related to psychotherapy outcome are likely to enhance the quality of service provided by clinicians to families.  

1 2 3 4 5

To what extent are the use of standardized measures likely ...  

i) To provide a comprehensive understanding of a client’s progress?  

1 2 3 4 5
To what extent are the use of standardized measures likely ...

ii) To provide an accurate assessment of whether therapy was effective or not?  
1  2  3  4  5

iii) To determine whether or not any significant change in the client (or client system) has taken place?  
1  2  3  4  5

iv) To determine the usefulness of service?  
1  2  3  4  5

v) To provide an accurate assessment of a client's current situation?  
1  2  3  4  5

vi) To provide information that can be used in a meaningful way at an administrative or supervisory level?  
1  2  3  4  5

vii) To have aggregate results with respect to one client generalized to other client situations?  
1  2  3  4  5

viii) To enhance the credibility of the helping professions in general.  
1  2  3  4  5

ix) To assist you in particular in becoming an effective clinician.  
1  2  3  4  5
17. For the next series of questions, please note your responses accordingly: (circle one response per question)

<table>
<thead>
<tr>
<th></th>
<th>not important</th>
<th>somewhat important</th>
<th>important</th>
<th>very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<td>3</td>
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<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

How important is it...

1) To respond to a client who attempts to initiate follow-up contact?

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11) For you to initiate follow-up contact with clients?

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111) To use standardized measures during follow-up?

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11v) For you to know a client's state of functioning after treatment has been terminated?

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1) To have pre-tested measures in order for outcome evaluations to have meaning for your practice?

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11vi) For you to establish measurable treatment goals at the onset of therapy with clients?

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11vii) To demonstrate your usefulness as a clinician through empirical means?

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18. In the space provided list the main factors you feel enhance and contribute to the improvement of a family's situation once they have begun to participate in therapy.
19. In the space provided, please list the main factors you feel are likely to inhibit or reduce a family's progression toward improvement after they have begun therapy.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

20. Please list the main factors or variables which you feel should be examined in order to determine if therapy with families in your agency has been effective at all.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

21. Finally, in concise terms, what do you feel is needed to enhance your overall effectiveness with clients.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Thank you very much for your cooperation. If you would like to make any further comments about this questionnaire or anything else, please do so below or attach them. When you have finished, please return the questionnaire in the enclosed envelope.

If you are willing to be contacted by telephone for a follow-up interview with respect to your opinions on this research survey please check [✓] the box below.

[ ]
Appendix E

QUESTIONNAIRE

for

FAMILY SERVICE AGENCY
ADMINISTRATORS
SURVEY OF ADMINISTRATORS/UPPER LEVEL MANAGERS

DIRECTIONS

** The purpose of this study is to assess the extent to which measures of evaluation are incorporated into direct practice.

** Please try and complete all the questions to the best of your ability.

** The information you provide will be held in STRICTEST CONFIDENCE and will be presented in group numerical form only.

SECTION I: GENERAL AND EDUCATIONAL BACKGROUND

1. Year you were born: _____  2. Sex: 1 = male  2 = female

3. Education: Please list your educational degree/diploma(s) starting with the most recent.

<table>
<thead>
<tr>
<th>Degree/Diploma [e.g. B.S.W., M.S.W.]</th>
<th>Discipline [e.g. psychology, business, social work]</th>
<th>Specialization [e.g. casework, administration]</th>
<th>Year Received</th>
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</thead>
<tbody>
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</tbody>
</table>

4. How many years of experience do you have as a human service administrator (excluding supervisory duties)? _____ (total years)
5. Please list the main professional associations you belong to?

1. 

2. 

3. 

6. a) Did you have any courses in your professional **education** with respect to the following: [check [✓] the appropriate box (yes or no) for each subject area].

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>a) Research methods</td>
<td></td>
</tr>
<tr>
<td>b) Statistics</td>
<td></td>
</tr>
<tr>
<td>c) Data analysis</td>
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<tr>
<td>d) Evaluation research</td>
<td></td>
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<tr>
<td>e) Computer applications</td>
<td></td>
</tr>
<tr>
<td>f) Information systems</td>
<td></td>
</tr>
</tbody>
</table>

   b) Since **obtaining** your last degree/diploma, have you received any subsequent training in the following:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Research methods</td>
<td></td>
</tr>
<tr>
<td>b) Statistics</td>
<td></td>
</tr>
<tr>
<td>c) Data analysis</td>
<td></td>
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<tr>
<td>d) Evaluation research</td>
<td></td>
</tr>
<tr>
<td>e) Computer applications</td>
<td></td>
</tr>
<tr>
<td>f) Information systems</td>
<td></td>
</tr>
</tbody>
</table>
Since obtaining your last degree/diploma to what extent have you been involved in research skill development due to: [check (✓) one column (none, somewhat, very much) for each learning source]

1. On-the-job training
   - None
   - Somewhat
   - Very Much

2. Continuing education from any professional association
   - None
   - Somewhat
   - Very Much

3. Specialized seminars, courses, etc.
   - None
   - Somewhat
   - Very Much

4. Community college courses
   - None
   - Somewhat
   - Very Much

5. University courses
   - None
   - Somewhat
   - Very Much

6. Correspondence study
   - None
   - Somewhat
   - Very Much

7. Personal study
   - None
   - Somewhat
   - Very Much

8. Research Consultation
   - None
   - Somewhat
   - Very Much

SECTION II: ORGANIZATIONAL CHARACTERISTICS

1.a) What is the total number of paid employees in your agency? ___________ (number)

   Full time
   - None
   - Somewhat
   - Very Much

   Part time
   - None
   - Somewhat
   - Very Much

b) How many support staff are ................. _______ _______
   How many professional staff are ............ _______ _______

2. What percentage of professional staff that provide direct service to clients have the following degrees?

   _____% B.S.W.'s
   _____% M.S.W.'s
   _____% B.A. or M.A.'s in psychology
   _____% Ph.D.'s in social work
   _____% Ph.D.'s in psychology
   _____% have no university degree
   _____% other (please specify)
3. What was the average monthly caseload of a typical full-time direct service practitioner in your agency in the past year? ________

4. Approximately how many clients were serviced by your agency last year? ________

5. Generally, what percentage of clients last year were seen:
   a) on an individual basis ________%,  b) as couples ________%
   c) as families ________%

6. Does your agency currently have a waiting list? Yes____ No____
   a) If 'Yes', what is the average length of time clients wait to receive service? ________ (weeks)

7. What is the approximate geographic size of the community your agency serves? (please check [✓] one)
   ____ 20,000 or less  ____ 20,001 to 40,000
   ____ 40,001 to 100,000  ____ 100,000 or more

8. What is the total annual operating budget of your agency? $________

9. What percentage of the annual budget is directly received from the following sources:
   ____ % Federal government  ____ % Provincial government
   ____ % Municipal government  ____ % United Way
   ____ % Direct fees for service  ____ % Third party payments
   ____ % Private donations  ____ % Other (please specify)
10. In the past year, how much money was spent in supporting evaluative research within your agency (e.g. purchasing computers with research capability, education or training of staff in research and evaluation activities, hiring research and evaluation consultants, purchasing inventories/scales or measures for use within your agency, etc.).

$ ______________

11. Is there any person(s) within your agency involved in the co-ordination of research activities for the overall agency? Yes _____ No _____

b) If ‘Yes’, what are their position(s)

________________________

________________________

12.a) In your judgement, are agency service goals and objectives stated in evaluative terms (i.e. can they be measured). (circle one)

Yes _____ No _____ Some are/Some aren’t

b) From your own perspective, what do you deem to be the main criteria for measuring service effectiveness within your agency?

________________________

________________________

________________________

________________________
**SECTION III: OUTCOME MEASURES**

The purpose of this section is to determine the actual use or non-use of research and evaluation instruments or scales within your agency.

In this section, the following definitions are used:

"Standardized measure(s)" refer to any tests, scales, rating forms, questionnaires, interview schedules that are completed by, or administered to staff, clients or third parties which have been tested for their reliability and validity.

"Reliability and validity" refer to the psychometric properties of instruments determined by standardized tests that enable data to be used for comparative purposes.

"Outcome measures" are standardized measures applied at discharge or immediately following the termination of service with a client (within one month).

"Follow-up measures" involve the collection of data from clients at least one month after discharge or termination.

1. Does your agency currently use any standardized measures during any of the following times? [check [✓] either (yes or no)]

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>a) Intake/assessment</td>
<td></td>
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<tr>
<td>b) Intervention</td>
<td></td>
</tr>
<tr>
<td>c) At termination</td>
<td></td>
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<tr>
<td>d) Within one month after termination</td>
<td></td>
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<tr>
<td>e) During follow-up contact</td>
<td></td>
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</tbody>
</table>

If you checked 'Yes' for either c, d, or e please continue. If not, please skip to question 9 on page 10 (Look for ☑️).
2. In the space provided below please list any measures that are used within your agency that meet the criteria of what is defined as an outcome measure. Please check [✓] if the measure was developed within the agency, if it was adopted from another agency or professional association, or if it was obtained from another outside source (e.g. research literature, consultant, etc.). Further indicate [✓] the appropriate box if use of the identified measure is mandated or required. For instance, in the example below, the Child Behavior Checklist was purchased. Although clinicians are required to employ the measure as part of their intervention, the agency is not mandated to use this measure.

Example:

<table>
<thead>
<tr>
<th>ORIGIN</th>
<th>MANDATED</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>within agency</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>another agency</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>outside source</td>
<td>yes</td>
<td>no</td>
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</table>

**MEASURES**

A) Child Behavior Checklist

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<tr>
<th>ORIGIN</th>
<th>MANDATED</th>
<th>REQUIRED</th>
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</thead>
<tbody>
<tr>
<td>within agency</td>
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<td>no</td>
</tr>
<tr>
<td>another agency</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>outside source</td>
<td>no</td>
<td>no</td>
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</table>

A) ____________________________

B) ____________________________

C) ____________________________

D) ____________________________

E) ____________________________
3. Who typically analyzes data generated from outcome measures? [check the main one only]

____ worker/direct service personnel  ____ supervisor
____ administrator  ____ computer personnel
____ outside agency source (e.g. consultant etc.)
____ other (please specify) __________________________

4. Are outcome measures used with every client?

Yes    No

b) If 'Not', what percentage of clients are they typically used with?

____%

5. Are client's formal consent required before outcome measures are administered? [circle one]

Yes    No    Sometimes

6. Are clients advised with respect the reason(s) such information is collected?

Yes    No    Sometimes

7. Generally, are direct service practitioners permitted to use standardized measures not mandated agency policy or management practices?

Yes    No    Sometimes
9. How important is data generated from outcome measures for each of the following: (check [✓] one box (very important, somewhat important, not important) for each activity.)

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<th>Very Important</th>
<th>Somewhat Important</th>
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<tr>
<td>1.</td>
<td>program evaluation</td>
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<td>2.</td>
<td>case management decisions</td>
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<td>3.</td>
<td>program planning</td>
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<td>4.</td>
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<td>5.</td>
<td>management reporting</td>
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<td>budget preparation</td>
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<td>7.</td>
<td>cost-effective analysis</td>
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<td>8.</td>
<td>clinical decisions</td>
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<td>9.</td>
<td>monitor and improve practice</td>
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<td>10.</td>
<td>interpretation of service to community</td>
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<td>assessing client needs</td>
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<td>12.</td>
<td>allocation of resources within the agency</td>
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<td>13.</td>
<td>influencing public policy</td>
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9. In terms of outcome data generated in your agency, are you satisfied that the data collected accurately measures effectiveness within your agency? [circle one]

   Yes    No

b) If 'No', what other outcome measures or variables need to be considered.


10. In your opinion, what factors are likely to contribute to the limited or restricted use of outcome measures in a family service agency?


11. For the next two questions, please note your responses accordingly:
   [ circle one response per question ]

   1  2  3  4  5
   Highly unlikely somewhat likely highly likely

   a) To what extent do you feel knowledge of research findings related to psychotherapy outcome are likely to enhance the quality of service provided by the clinicians in your agency?
      1  2  3  4  5

   b) To what extent are the use of standardized measures likely to provide information that can be used in a meaningful way at an administrative level?
      1  2  3  4  5
Thank you very much for your co-operation. If you would like to make any further comments about this questionnaire or anything else, please do so below or attach them. When you have finished, please return the questionnaire in the enclosed envelope.

If you are willing to be contacted by telephone for a follow-up interview with respect to your opinions on this research topic please check [✓] the box below.
SELECTED BIBLIOGRAPHY


Christensen, D; Brown, J; Rickert, V. and Turner, J. (1989). Rethinking what it means to specialize in MFT at the Masters Level, Journal of Marital and Family Therapy, 15, 81-90.


Vita Auctoris

Robin E. Perry was born in Toronto, Ontario on August 16, 1964. After completing his secondary education at Neil McNeil High School in Scarborough, Ont., he attended the University of Windsor. Following receipt of a Bachelor of Social Work degree from the University of Windsor in 1987, he was employed as a family service/protection worker at the Children's Aid Society of Essex County. In 1989 he entered the Master of Social Work program at the University of Windsor where he secured a 12 month placement at the Center for the Child and the Family at the University of Michigan. In June, 1991, he accepted a position at Hiatus House (a shelter for battered women in Windsor, Ont.) at which time he was assisting in the development of a treatment program for children who are victims or witnesses to interfamilial violence.