Evaluating the Effect of an Adolescent In-Patient and
Day Treatment Program on Participants' Self-Efficacy and Well-Being:
Psychological Outcomes and Treatment Process

by

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ABSTRACT

Studies have been conducted evaluating program and service delivery quality of adolescent psychiatric hospitalizations. Few studies measure the effect treatment programs have on adolescent self-efficacy or well-being. Little research has been conducted to determine what the adolescent believes has been effective and how this satisfaction affects efficacious beliefs about self and overall mental well-being. The intent of this research was to conduct much needed participant-based research, highlighting the psychological effects of mental health treatment on the adolescent. This study focused on 19 psychiatric in-patient and day program adolescents in a Canadian mental health hospital. Through the Self-Efficacy Scale and the Bradburn Affect Balance Scale, quantitative data of self-efficacy and well-being were collected to measure treatment effect. A client satisfaction questionnaire was administered to obtain statistical satisfaction results to compare with mean scores of self-efficacy and well-being. Qualitative outcomes of the adolescent participants' treatment experience were obtained through semi-structured interviews, written information from the satisfaction questionnaire, and a follow-up focus group. A repeated measures design examined the quantitative scores of self-efficacy and well-being across three time periods: waitlist (T_1), admission (T_2), and discharge (T_3). Contrasts were made between control and experimental periods, and, accordant with the hypotheses, tests of within subject factors showed T_3 means of both self-efficacy and well-being were consistently higher than both waitlist and pre-treatment means. Adolescent self-efficacy and well-being were also directly correlated with higher levels of satisfaction. Adding to the quantitative

information, and to enhance understanding of the effect and process of treatment on the adolescent, a Grounded Theory method was conducted to analyze the semi-structured interviews (*M*=20mins) on all participants. Twenty open-ended questions, exploring satisfaction, self-efficacy, well-being, and experiences, were examined with thematic interview results enriching the quantitative data obtained. A focus group was also conducted to elicit post-treatment reports of participant self-efficacy, well-being, satisfaction, and retrospection on treatment. Group participants reported high levels of satisfaction, improved self-efficacy, and increased emotional well-being after treatment. Implications and generalizations of the results, limitations found within the current research, and recommendations for future treatment and research in adolescent psychiatry are discussed.

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CHAPTER I

Introduction

Residential in-patient and day treatment psychiatric hospitalization can be an invasive but necessary intervention for the adolescent and his or her family. Concerns about the disruptive effects of removing children from their homes and placing them in an institutionalized environment have been written about in the literature for decades (e.g., Spitz, 1945). Recently, however, dramatic changes in psychiatric services to Canadian children, youth, and families have occurred, with new and creative programs being offered based on family-centred philosophies, which attempt to minimize disruption and maximize benefit.

Health care in Canada traditionally has been a provincial responsibility affected by cost-sharing agreements between the federal and provincial governments. Provincial responsibility is especially true in mental health services (MHS). As a result of federal deregulation, there has been, until recent years, a reduced emphasis on accountability of expenditures. One of the strongest factors affecting the need for MHS evaluation today has been the de-institutionalization and shorter lengths of stay of psychiatric patients.

Historically, services in British Columbia, as in most provinces, have seen a trend toward de-institutionalization. Between 1960-1975 the number of beds in Canadian psychiatric hospitals for children, adolescents, and adults decreased over 60% (Advisory Network on Mental Health, 1997). Since the late 1980s this trend has continued through to 2003 with 'Closer to Home' governmental initiatives to MHS deliveries. The result has been fewer hospitalizations and shorter lengths of stay for patients. In the last few years there has however been a rise in alternatives to residential or in-patient treatment.

Such alternatives include day treatment programs, out-patient programs, individualized treatment deliveries (contract-based deliveries), in-home counselling, and community-based services. Still, while alternatives have begun, in-patient MHS needs have remained constant over the last decade with current child and adolescent mental health admissions on the rise (British Columbia, Ministry of Health, 1998). Wait lists at times last as long as six to eight months in some child and adolescent mental health facilities (Moos, 1997).

Whereas the average length of stay for intensive treatments has dropped dramatically in Canada, and the U.S. in recent years, the acuity of illness of patients treated in such settings has steadily increased (Moos, 1997). There appears to continue to be a need for psychiatric hospitalization despite the reduced admission length. With recent increases in the numbers of admissions to MHS, needs for adolescent and family evaluation have risen sharply. Evaluation of program effectiveness in light of changes and treatment practices has been demanded by the tax-paying public.

Mental health program evaluation research has traditionally focused on quantitative data as measured through questionnaire, survey, or commentary. When interviews are conducted for more qualitative data, the process usually involves interviewing of the parent(s) only (c.f., Godley, Fielder & Funk, 1998; Heflinger, Sonnichsen & Brannan, 1996). Little focus is given to the adolescents, to obtain their perception of the service they received while in hospital. When MHS deliveries are evaluated, few studies research program experience from the adolescent participants' perspective. Furthermore, from a review of the literature, it appears that no studies have attempted to measure the variables of adolescent self-efficacy (SE) and well-being (WB) as a result of psychiatric treatment.

Measurement of patient satisfaction through surveys or questionnaires has often been criticized (Essex et al., 1980; Knox, Hess, Petersen & Hill, 1997; Lebow, 1982, 1983a, 1983b). Reasons frequently given include the following: (a) such questionnaires construed as satisfactory are too encompassing, neglecting detail about the participant's experience; (b) they yield continuous reports of significantly high levels of satisfaction (halo effect); (c) there is an underlying fiscal or political priority to obtain positive evaluation results, and (d) valuable information is lost from those remaining in treatment or from those not responding to the survey. Data that focus solely on qualitative results also fail to satisfy empirical research requirements of validity, reliability, and transferability. As a result, some researchers have recommended a blend of quantitative and qualitative measures as a more thorough way to obtain in-depth and accurate participant focused results (Greenley, Schulz, Nam & Peterson, 1985; Lebow, 1982). The present research study responded to measurement concerns and previous research recommendations through the application of quantitative and qualitative methodologies to obtain comprehensive adolescent participant-specific treatment results.

The Problem Statement

There has been a considerable amount of publication describing treatment interventions for adolescents in MHS (e.g., Lyman & Campbell, 1996; McDermott & Harrison, 1977; Ney, 1985). The field of psychiatry has placed great emphasis on the strategies to be implemented and the outcomes of such interventions. However, little has been studied and recorded about the experience of the patient, in particular the adolescent, with services and treatment received. There is little empirical evidence that the field knows directly about the adolescent participants' specific experience of their

psychiatric hospitalization and how this has affected their sense of efficacy and well-being. This is because the adolescents themselves have not been asked.

Many MHS evaluations which look at program evaluation and patient satisfaction fail to accurately examine the adolescents' interpretation of change as an aspect of treatment outcome (c.f., Crossley, Inch, Thorarinson & Keegan, 1997; Loff, Trigg &, 1987; Perreault, Leichner, Sabourin & Gendreau, 1993). Research has failed to examine from the patient's point of view what the effective psychiatric intervention(s) were that resulted in satisfaction or change for them. A few Canadian psychiatric service evaluations that have been carried out (Crossley et al., 1997; Loff et al., 1987; Perreault et al., 1993) neglect to investigate fully the patient's perception of change, possibly because it is assumed that adolescent psychiatric clients can not voice the change they have experienced. It appears that little research has evaluated the adolescents' self-efficacy and well-being before and after MHS hospitalization. Instead, research has primarily focused on parent's perception of their adolescent's sense of confidence and reduced mental health symptoms. It appears that the parents' level of satisfaction with services rendered for their youth is frequently measured without consideration of how the adolescents' degree of satisfaction affects their self-efficacy and well-being (e.g., Heflinger et al., 1996).

When data are obtained from children or adolescents, the information is usually obtained through closed-ended questionnaire format (see Hoffman, Capelli & Mastrianni, 1997). Such a method has also neglected specific variables such as self-efficacy or well-being, as it evaluates program effectiveness through satisfaction results only. Moreover, little qualitative data exists, since evaluation typically depends solely on questionnaires or

surveys. Subjective experiences, considering the adolescent's perception of change either through individual interviews or adolescent focus group, are also not sought. Combined quantitative and qualitative research, therefore, is necessary to evaluate thoroughly and accurately the effect of a treatment program on the adolescents' mental health (Greenley et al., 1985). Evaluating psychological outcomes of self-efficacy and well-being through scales, questionnaires, interviews, and focus groups will provide valuable comprehensive information that includes treatment process.

An interesting issue in exploring the effects MHS have on adolescents is to compare psychiatrist and adolescent reasons for admission to hospital. Many adolescents do not seek or receive treatment on their own despite their obvious need (Hunter, Higginson & Garralda, 1996; Kazdin, 1993). These same adolescents may underplay, deny, or have little insight into their mental health challenges when initially referred to therapy. In this thesis it will be of additional interest to compare psychiatric diagnosis, as assigned by the psychiatrist prior to treatment, and the adolescents' written record of their understanding for their mental health admission. Is there agreement? Does the adolescent admit to the same reason(s) the psychiatrist records for admission? Having an understanding of the comparison between adolescent and psychiatrist reasons for admission may shed light on the degree of openness (or understanding) the adolescent has to engage in treatment and the overall effect this treatment may have on their self-efficacy and well-being.

Finally, little research has been done to assess the relationship between program services offered (e.g., in-patient, day treatment, out-patient, in-home counselling) and adolescent self-efficacy and well-being. In their comprehensive review of the literature,

Jensen, Hoagwood and Petti (1996) found there were no studies addressing the impact of mental health interventions across programs. Research into the effectiveness of different services is important in understanding the generalizability of programs and services to adolescents. Global assessments of satisfaction that are not program specific may fail to provide detail regarding the variety of service modalities and their effect in MHS, especially for the adolescent.

Rationale for the Study

The rationale behind this study is fourfold. First, while MHS to adolescents continue to be reduced or modified, there remains a public need to determine accountability of services rendered. Second, understanding service delivery is necessary to determine whether the treatment adolescents receive, either in-patient or day program, affects their overall sense of self-efficacy and/or well-being. Third, having an understanding of the psychological outcomes of treatment for adolescents will provide valuable insight into the adolescents' experience. Finally, through an understanding of the psychological outcomes and treatment process, evidence-based practice results can help modify program delivery for future participants. Without such information, valuable data are ignored when research is conducted to obtain measures of treatment outcome, program effectiveness, or patient satisfaction.

Purpose of the Study

Research has left issues that need further investigation. These issues include youth clients' evaluation of satisfaction, self-efficacy, well-being, and feedback on program effectiveness. The purpose of this study is to assess adolescent, self-efficacy, well-being, and experience as a result of psychiatric hospitalization. Satisfaction research

will shed light on psychological outcomes of treatment. In-patient and day treatment program effects on adolescent mental health will be quantitatively and qualitatively evaluated by measuring participants' efficacious beliefs about themselves and overall sense of mental wellness as a result of treatment. The relationship between self-efficacy and well-being will be examined by evaluating the participants' experience, in terms of what meaningful treatment occurred for them, their level of satisfaction with services received, their perception of change, and their feelings of confidence and hopefulness as a result of treatment. Information will be collected through scales, questionnaire, interview, and focus group.

CHAPTER II

Literature Review

The literature review presented in this chapter will examine specific mental health service evaluations, various client satisfaction and program evaluation measures, the adolescents' process of treatment, and the constructs of self-efficacy and well-being. Throughout the review will be an ongoing discussion of why adolescent self-efficacy and well-being are important to study. This chapter will also explore how the outcomes of self-efficacy and well-being are related to the process of treatment and client satisfaction. Finally, the need for adolescent MHS and the kinds of treatment that are effective for adolescents, given the special problems for which they are admitted to psychiatric hospitals, is reviewed within this chapter.

Mental Health Service Evaluation

Historically, MHS in British Columbia have not been systematically evaluated (British Columbia, Ministry of Health, 1998). Within the last decade, however, the tax-paying public has expected a high degree of accountability. Subsequently, the government has placed great emphasis on health facilities, including mental health facilities such as child and adolescent psychiatric hospitals, to provide quality assurance reports. Regulatory boards, such as the Canadian Council on Health Services Accreditation and the Commission on Accreditation of Rehabilitation Facilities are beginning to mandate the implementation of specific performance measurement criteria to improve and validate the quality of mental health programs. Throughout the evaluation process, there is a need for methodologies that can describe in both objective

and subjective terms, the services rendered by the program and corresponding treatment received by the patient.

Too often, psychiatric or residential MHS fail to provide solid outcomes linking treatment services rendered to measurable positive results. At times the understanding of change, or what led to change, is lost in the overall evaluation of patient services. A review of the literature appears to show that current adolescent evaluation attempts only to measure global satisfaction rather than the effects of treatment. The following section outlines various satisfaction measures, which have been and are presently used in mental health.

Client Satisfaction

The concept of satisfaction has to do with whether consumers receiving a service find such service has met their expectation(s). However, being satisfied with a service may or may not be related to whether that service met the person's needs. It is even more complicated in the human service industry of psychiatry. Satisfaction reports for adolescents in psychiatry may simply indicate that the youth client liked the experience, liked the staff or milieu, or liked to give positive comments only. Satisfaction, a predominantly personal subjective perception, becomes difficult to measure when using standard empirical measurements. Any use of questionnaires typically results in a high degree of expressed satisfaction. Lebow (1983b) commented, "It is only the rare study that reports less than 70% of clients satisfied. Indeed, clients most often check the most positive point available in queries about satisfaction" (p. 242).

In mental health the construct of satisfaction remains largely undefined. In the mental health literature, satisfaction has been seen as "a measure of quality", as a

"component of appropriateness" and as "an equivalent to program efficacy" (Brannan, Sonnichsen & Heflinger, 1996, p. 132). No clear or consistent theoretical model or definition has been established which adequately depicts or measures how psychiatric client satisfaction relates to treatment received or, furthermore, how it should be systematically and consistently measured. Lyons, Howard, O'Mahoney and Lish (1997) attempted to demonstrate that there was a strong correlation between perceived clinical benefit and consumer satisfaction with services. Still, definitional problems with the construct of satisfaction make it difficult, especially for those researchers who chose quantitative measures only, to consistently evaluate what satisfies the mental health consumer.

Many researchers have argued that the concept of consumer satisfaction in mental health is complex and, if a survey design is used, it should be measured with multi-dimensional scales (Holcomb, Adams, Ponder & Reitz, 1989; Lebow, 1983a). That is, the questionnaire should address a multitude of feelings, impressions, and concerns regarding the patient's treatment. For example, "How do you feel about the treatment you have received?" or "What was helpful (or not helpful) about your program?" is more specific than the simple question, "Were you satisfied with your program"? Others have argued that patients are unable to discriminate sub-areas of satisfaction in such a questionnaire and thus respond best to one-dimensional scales (Weinstein, 1979). Still, assessing satisfaction as one global construct through multi-dimensional scales or as a single specific criterion through a one-dimensional scale fails to capture the range or depth of perceptions the adolescent has of his/her treatment. What appears to be missing

in the research is a qualitative exploration of the adolescents' experience and how this results in either satisfaction or dissatisfaction for them.

Measuring mental health satisfaction is a challenge no matter what the scale. It appears satisfaction scales typically yield overwhelming positive reports anyhow (Brannan et al., 1996; Lebow, 1983a). It is possible that satisfaction is not a normally distributed phenomenon, but is truly skewed in nature. Typically, a group of dissatisfied clients emerge in most studies researching satisfaction (Lebow, 1983a). Generally, however, complete dissatisfaction is found in less than 20% of MHS patient studies. Only a few studies have found the frequency of dissatisfaction to be above this level. Thus, most consumers of mental health report satisfaction. This appears true for residential, day program, and out-patient services. In studies of out-patient treatment Lebow found 78% of clients express satisfaction. In in-patient studies 76% express satisfaction, and in studies of comprehensive treatment services (multi-service psychiatric facilities), 83% express satisfaction Lebow found (Lebow, 1983a).

Past MHS evaluations of adolescents and adults tend to relate satisfaction to various demographic variables such as age, race, and economic status. Lebow (1983a) argues that such demographic variables are not good predictors of satisfaction because they fail to accurately measure the participants' perspective. Few studies include measures of psychological variables with satisfaction. Client-specific variables that have been investigated and correlated to satisfaction include age (Brannan et al., 1996; Stuntzner-Gibson, Koren & DeChillo, 1995), clinical diagnosis (Carscaddon, George & Wells, 1990; Brannan et al., 1996), gender (Godley et al., 1998), and the length of time in treatment (Gaston & Sabourin, 1992; Lebow, 1982).

Few studies have assessed the correlation between demography and satisfaction resulting from service or program interventions. Stuntzner-Gibson et al. (1995) found a small but significant result from the administration of the Youth Satisfaction Questionnaire (YSQ). They found a relationship between age and satisfaction: as age increased, satisfaction tended to decrease.

How adolescents view MHS may reflect a wide range of factors such as the relationship to the primary counsellor, the level of consultation and consideration given to them, the milieu, or the time of year, to name but a few. However, such information may best be teased out through the use of qualitative means. Accounting for such factors in an evaluation may ultimately provide a different, possibly more complete, view of satisfaction.

Evaluation/Satisfaction Measures

Researchers conducting satisfaction studies have tended to develop their own questionnaires or scales. As a result there are few widely used satisfaction instruments in psychiatry. One scale, the In-Patient Consumer Satisfaction Scale, devised by Holcomb et al. (1989), is intended to measure satisfaction in psychiatric in-patient units. To date, however, little cross validation has been done with this tool and its applicability to the adolescent population is uncertain.

Another scale used often in MHS satisfaction research is the Client Satisfaction Questionnaire (CSQ) (Atkisson & Zwick, 1982). The CSQ, although apparently user friendly, appears to be too general and not program or treatment specific enough to obtain necessary satisfaction evaluation information required when conducting program evaluation.

More recent client satisfaction questionnaires have attempted to measure satisfaction through an evaluation of specific MHS program operations, such as Barner, Lennon, Tate, Vargas and Wiens' (1994) work on the Mental Health Services Pilot Program Evaluation Project (Tate, Lampard, Keyes & Saayman, 2000). This satisfaction tool, the Client Satisfaction Questionnaire-Youth form (CSQ-Y), is a reliable tool which attempts to measure adolescent patient satisfaction to their specific treatment program.

Other researchers (for example, Moos, 1997) have suggested the need to measure a program's social context to accurately evaluate how treatment influences an individual's satisfaction and thereby his or her behaviour and cognition. The Ward Atmosphere Scale (WAS) and the Community-Oriented Programs Environment Scale (COPES) were devised to help examine the integrity or quality of a program's treatment environment (social context) upon the patient's satisfaction with treatment. Whereas, these environmental scales appear to provide contextual evidence in measuring the impact of the program on the individual, Moos (1997) states, "We know relatively little about the specific connections between treatment process and treatment outcomes, thus we need a standardized tool to measure satisfaction" (p. 23). Despite results in the affirmative from the WAS and COPES, little is known about the correlation between therapy and satisfaction. More specifically, little is known about which treatment antecedents result in satisfaction or change for the discharged adolescent from any of the satisfaction measures.

Sederer, Hermann and Dickey (1995) explain that clinical outcome assessments can correlate with satisfaction and should be considered from two principal dimensions: symptomology and patient functional assessment. Instruments measuring mental health

symptoms have been developed for years and include such instruments as the Brief Psychiatric Rating Scale (BPRS), the Beck Depression Inventory (BDI), or the Severity of Psychiatric Illness Scale (SPI). The 36-item Short Form Health Survey (SF-36) and the Child and Adolescent Functional Assessment Scale (CAFAS) are more recent symptomology assessment tools. These surveys are popular examples of assessment tools, which measure patient functioning and goal attainment in relation to their services received rather than satisfaction only.

Of the questionnaires that have been devised to measure satisfaction and patient functional assessment, the Client Satisfaction Questionnaire-Youth form (CSQ-Y) (Barner et al., 1994) appears to address the gaps in the client satisfaction literature quite adequately. The CSQ-Y appropriately asks youth clients, "How are we doing?" and is concerned solely with the adolescent participants' perception and feedback. This adolescent participant-based focus is quite unique in the field of satisfaction surveys within MHS, with the majority of scales obtaining feedback from caregivers or professionals as opposed to adolescents. The CSQ-Y asks youth clients about the quality of their experience in terms of clinical effectiveness and respect during their treatment experience in the program. Thirteen survey questions are designed to have youth participants assess the program, its effectiveness for them individually, how they felt they were treated, and the effect that satisfaction had on them therapeutically. The CSQ-Y seeks to measure satisfaction by asking youth participants' program-based questions about their stay, in an open and inviting manner. Information is obtained through Likert-rated answers to 11 program specific satisfaction questions with three final open-ended questions intended to provide written qualitative feedback to the researchers.

Qualitative and Quantitative Evaluations

For years, patient satisfaction has been measured as an indicator of valid treatment outcomes as assessed by the use of standardized tests (Mahon & Estes, 1997; Webster-Stratton & Herbert, 1993). While outcome satisfaction studies have been conducted, research that has examined the patients' perspective regarding treatment satisfaction and the process of change has been limited. Some researchers argue that the crucial element for improving service delivery is not simply to obtain research results from surveys, but to obtain the clients' opinion of their hospital therapy, with all their subjectivity and personal biases, through qualitative measures (Lebow, 1982). Other researchers urge a more collaborative effort of research methodologies as a valuable and necessary approach to understanding service, satisfaction and change (Bickman, Summerfelt & Bryant, 1996). There is currently a strong argument for a collaborative effort, which should involve the patients' perception of change, recorded through open-ended interview questions, as well as quantitative data obtained through closed-ended questions from a survey or questionnaire. Such an effort might include the use of focus groups as well as individual interviews to more thoroughly evaluate satisfaction and treatment effectiveness post hospitalization.

Despite the potential advantages of a multi-modal research design, from a review of the literature, it appears that evaluation of adolescent patient satisfaction within MHS has continued to focus primarily on the methodological process of quantitative assessments through satisfaction measures administered predominantly to parents. Caregiver-driven results can often be different than the results obtained from adolescents. Godley et al. (1998), for example, conducted a thorough study of 22 community mental

health agencies in Chicago, Illinois. Their results showed that overall global satisfaction scores for parents were significantly higher than for youth. This finding is similar to other studies, such as the Mental Health Services Pilot Program Evaluation Project (Tate et al., 2000), which suggests that parent and youth satisfaction levels are not congruent and should be measured separately. This conclusion was also reached by Stuntzner-Gibson et al. (1995) when examining what kids think of services compared to what their parents thought.

One of the early Canadian researchers of MHS, Lebow (1982), speaks of a general lack of concern about the research method of questionnaire or surveying administration when evaluating consumer satisfaction with mental health treatment. Lebow recommends that surveys be included as part of a multi-modal method of treatment evaluation to seriously explore services received. Few studies include both qualitative and quantitative measures in assessing patient satisfaction. Lebow explains that quantitative measures that report on patient services, to the exclusivity of qualitative experiences, fail to paint an accurate picture of program service and treatment evaluation.

Greenley et al. (1985) did one of the few studies in which both quantitative and qualitative approaches are compared. Their study, assessing 177 psychiatric in-patients, involved the use of paper and pencil closed-ended questions, followed by qualitative efforts (interviews), to obtain satisfaction levels regarding hospitalization. Results from the questionnaire showed a high proportion of extremely satisfied patients, consistent with similar, although lower, levels of satisfaction from data obtained through interview and open-ended questions. Whereas conclusions explained a tedious research process, and results showed that both qualitative and quantitative approaches could produce

similar corroborating results, their recommendation was that where possible both approaches should be used for fuller understanding of the patient's experience.

Perreault et al. (1993) also conducted a large survey of patient satisfaction and claimed to be the first research to compare results from a qualitative and quantitative approach to assessing patient satisfaction with out-patient services. Their main objective was to compare quantitative and qualitative satisfaction measures, to evaluate if high satisfaction scores generally observed from quantitative measures are related to results obtained from qualitative interviewing methods using open-ended questions. Personal interviews (M=38 minutes) were conducted to investigate satisfaction following the administration of two standardized satisfaction scales. Results showed that expressions of dissatisfaction appear mainly in open-ended questions obtained through qualitative measures. Open-ended questions allow patients to evaluate more precisely the aspects of services than general satisfaction scales permit. The data showed scores were not necessarily normally distributed. Both open-ended and closed-ended questions produced negatively skewed distributions (positive satisfaction results). The findings also suggest that the nature of the questions is not the only determinant of the type of distribution obtained.

In conducting mental health research, evaluators historically seem to have followed the methodology of more established social science disciplines such as psychology, anthropology, or sociology. The use of experimental or quasi-experimental research methods, which are grounded in positivistic or post-positivistic traditions, has led, however, to well documented problems (Essex et al., 1980; Lebow, 1982, 1983a, 1983b). As a result many MHS evaluators have been confronted with empirical research

problems of validity (sampling, measurement, and attribution) and reliability (generalizability, consistency, and transferability). The proposed research study avoids these problems by conducting a multi-modal method of research design.

Recent mental health evaluators (Knox et al., 1997; Tinsley, 1997) have pursued more interpretive approaches to evaluation. Such research designs seem to lend themselves uniquely to the mental health care evaluation environment. Many MHS researchers recommend both quantitative and qualitative measures as a comprehensive empirical way of obtaining reliable and relevant research results (Lebow, 1982; Greenley et al., 1985; Perreault et al., 1993). Still, although recent evaluation methods have diversified, even improved over the past ten years, the application in the area of mental health evaluation has had a somewhat restricted methodological focus. Mental health evaluations continue to solely focus on questionnaire methods. This limited focus has led to constraints of empirical findings as well as program application problems (Moos, 1997). It will be the intention of the researcher to address this dilemma through questionnaire, scale, individual interviewing, and a focus group at the conclusion of the data collection period (see Table 3 for a description of the data collection process).

Focus Groups

One of the difficulties in obtaining satisfaction measures through questionnaire methods appears to be that patients are responding to surveys, which are either based on generic criteria or what the service provider conceives as the specific variable which contributes to patient satisfaction. Given this problem of attempting to obtain appropriate satisfaction measures, Elbeck and Fecteau (1990) applied an alternative methodology to surveying psychiatric hospital in-patients. These authors used a focus group method

based on group discussion to establish a satisfaction questionnaire that was patient driven. The researchers interviewed participants in a group discussion format. Patients were invited to describe characteristics of an ideal acute care unit. The resulting data comprised 50 items, which described the attributes of an ideal unit, according to the patients. This information served as a catalyst to then establish a satisfaction survey, which included statement questions such as, "Hospital staff are easy to make friends with", "Hospital staff seem to be genuinely interested in me", and "Staff and facilities are geared to help me". Using such a focus group method will accurately respond to the idiosyncratic concerns of various service settings and their patients' needs (Elbeck & Fecteau, 1990). This approach, Elbeck and Fecteau (1990) argue, would yield satisfaction results that are tailored to reflect the unique perspective of the patient being served by that hospital. Such an approach is also recommended to evaluate participants' experience post treatment (Hostick, 1998). Through the use of focus groups, specific satisfaction results can be obtained despite potential group process restrictions.

In MHS research, the purpose of a focus group is to elicit information to answer research questions and to discuss and comment on, from personal experience in a small informal group format, the topic that is the subject of the research (Powell & Single, 1996). A focus group may also have therapeutic benefits as participants come together to collectively explore a common experience. Concerning health care research, Powell and Single (1996) state, "a focus group can be employed either prior to, concurrently with, or after a quantitative study, or separately to explore complex phenomena not amenable to quantitative research" (p. 500). To date, the use of adolescent focus groups as an

evaluation approach is an untapped research modality that, when used, can enrich other aspects of service delivery evaluation.

Process of Treatment

The term 'process of treatment' refers to the subjective understanding of the adolescent concerning their program experience (Marten & Heimberg, 1995). Researching the process of treatment upon the adolescent is important because such evidence gives a more complete picture of satisfaction evaluation. Understanding what the patient's process was, i.e., the intervention(s) that caused change for him/her, is helpful in not only for evaluating satisfaction and service delivery but for understanding self-efficacy and well-being changes. Having an understanding of the adolescents' treatment experience and feelings, from their perspective, is important to better understand the effects of MHS for youth wellness. Most program evaluation and patient satisfaction research fail to accurately measure change because adolescents are not asked about their experiences. When they are, they are not invited to describe *how* their treatment has affected them. Little data exist which record adolescent self-efficacy or well-being as linked to treatment process. Understanding treatment process gives practical evidence-based feedback to mental health program managers about adolescent self-efficacy and well-being. Such information can prove useful to modify programs and interventions in the future.

Whereas it appears safe to conclude that MHS survey findings show that the majority of consumers are satisfied with services received (Brannan et al., 1996), a more exact delineation of the depth and effect of that satisfaction is necessary to better evaluate and understand MHS treatment. To date, little quantitative, let alone qualitative, research

has addressed the specifics of psychiatric treatment for the adolescent. There is a lack of 'process data', which differentiates between treatment procedures, such as assessing satisfaction with group versus individual therapy, milieu versus therapist relationships, or treatment length and overall satisfaction. Most research work is merely suggestive of change and overall satisfaction and does not elaborate on the specifics of treatment, the process of therapy, or the experience and meaning of the adolescents' treatment (c.f., Crossley et al., 1997; Godley et al., 1998).

The patient's view is an important source of information for practitioners and programmers of MHS. In addition to providing information about levels of satisfaction, the patient is a source of data about attitudes toward mental health illness, expectations for treatment, factors enabling or disabling treatment process, and suggestions for improving treatment.

Participants' Experience, Meaning, and Perception

Canadian MHS programs operate with the psychiatric practitioner (typically Child and Youth Care Workers, Nurses, and Social Workers) seen as instrumental in determining an effective treatment outcome for the adolescent (Crossley et al., 1997). It is often the practitioner's relationship, the timing of the intervention, and the contextual framework (milieu) that leads to meaningful change for the adolescent (Strupp, 1989). Indeed, many child therapists rate the therapeutic relationship as more important than the techniques used in treatment (Kazdin, Seigel & Bass, 1990). With the importance of understanding such aspects of the participant's process of treatment, little direct inquiry into personal experiences has occurred, or at least has been recorded. This omission represents a serious deficit in the literature, given the emphasis on service evaluation,

accountability, health reform, and fiscal restraint in the later 1990's. Although research into adolescent learning and development and psychiatric disorders is important for MHS practitioners, such data is not the central information necessary in the psychiatric treatment of the adolescent. What appears to be helpful is researching the patients' experience while in treatment.

Understanding participants' experience, meaning, satisfaction, or perception can be difficult, especially for adolescents given their stage of development and mental health functioning. During adolescence, teenagers struggle with making sense of their world and the experiences they have. Individual meaning and satisfaction, for them then, provides a conceptually needed bridge between treatment and practice. Practitioners must be concerned with the experience of the adolescents to treat them effectively. Understanding the meaning the adolescent gives to treatment will give youth practitioners information into the patients' interpretive system giving future clinical direction for the therapist. This role of the counsellor, to comprehend meaning from the adolescent, is a vital element in the treatment process of the adolescents' hospitalization. If practitioners can understand how youth make sense of treatment, more assistance can be given to the adolescent to support them in their struggles to maintain mental health.

Self-Efficacy

Individuals possess beliefs that enable them to exercise a measure of control over their thoughts, feelings, and actions. People are more likely to engage in certain tasks when they believe they have the ability to succeed at the experience. This belief about one's capabilities to exercise control over events that affect one's life (Bandura, 1977, 1989) is inherent in all individuals and is the fundamental premise of the construct of

self-efficacy. Unless people believe that they can make a difference through their actions, there is little incentive for them to act.

Individuals who guide their behaviour by efficacious beliefs about their capacity to perform a skill or activity successfully surround themselves with a positive cognitive process that significantly affects behaviour (Bandura, 1997). These individuals use conscious thought to mediate between what they believe to be true and subsequent behaviour. Through reflection, individuals who engage in self-evaluation alter their own thinking and subsequently their behaviour. Reflections on the beliefs we hold about our abilities and about the outcome of our efforts powerfully influence the ways in which we will behave in the future (Bandura, 1997).

According to social learning theorists, self-efficacy affects several aspects of behaviour, including choice of activities, effort, persistence, learning, achievement, aspirations, level of motivation, and satisfaction. Bandura (1993) explains:

> People make causal contributions to their own functioning through mechanisms of personal agency. Among the mechanisms of agency, none is more central or pervasive than people's beliefs about their capabilities to exercise control over their own level of functioning and over events that affect their lives. Efficacy beliefs influence how people feel, think, motivate themselves, and behave (p. 118).

There are a number of sources of self-efficacy beliefs. The four principal ways individuals develop a strong sense of self-efficacy are through mastery experiences, modelling, social persuasion, and judgments of one's physiological state (Wood & Bandura, 1989). Although the evidence is clear that these four kinds of experience

influence efficacious perceptions, the process is by no means simple. In fact, this author proposes it is a rather elaborate cognitive process in which the individual appraises, integrates, and orchestrates these experiences in a way that produces self-confidence. Simply telling yourself that you are capable is not enough, especially when it contradicts your pre-existing beliefs and past experience of success and failure. Improving one's self-efficacy is a complex matter of self-persuasion, will, forethought, retrospective reasoning, personal goals, and strategies.

A Model of Self-Efficacy

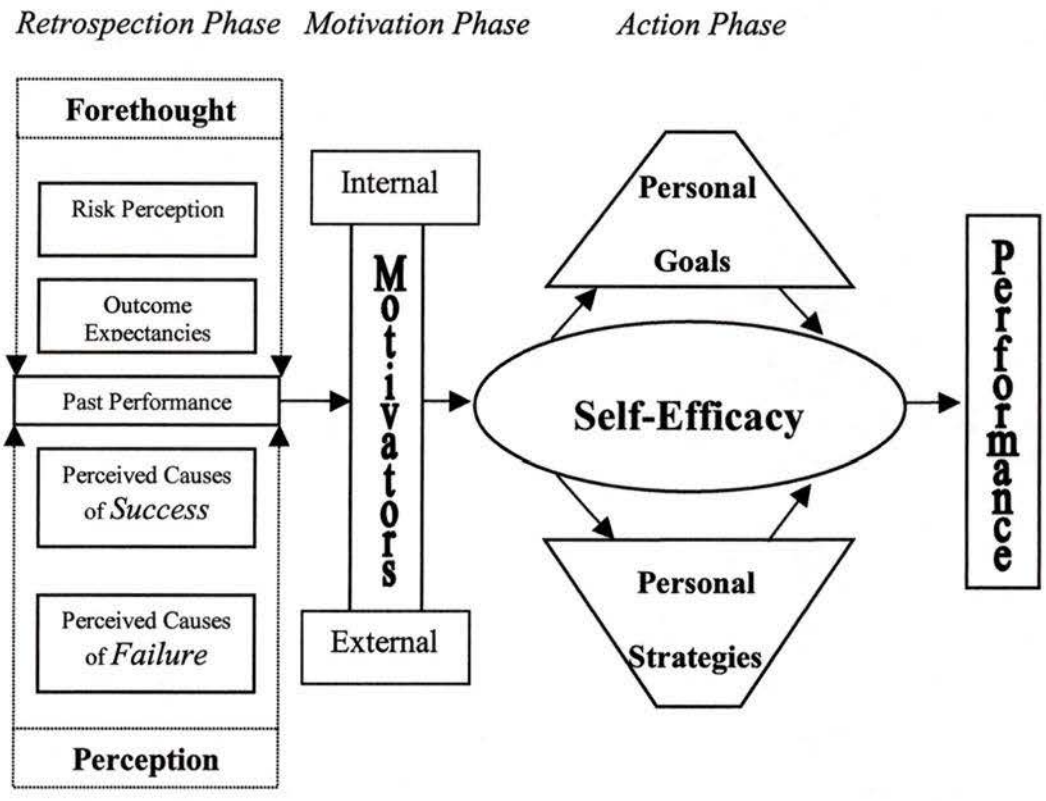
Self-efficacy is a comprehensive and complex phenomenon of cognition, affect, and action. To understand self-efficacy better, it is useful to understand it by way of a schematic. The following representation is an attempt to conceptualize the construct of self-efficacy and chart the course of agency to action. The model presented by this author (see Figure 1) is a schematic process consisting of integrated stages of cognition, motivation, and behaviour. These stages are multi-faceted and inter-connected.

The self-efficacy process consists of three phases namely: retrospection, motivation, and action. The retrospection phase is a complicated cognitive process that involves contemplation of potential risks, outcomes, and causes of success and failure. The influential role of risk perception (or threat) in the retrospection reasoning process can not be underestimated. Expected outcomes will serve as a powerful reinforcer or powerful deterrent to self-efficacy actions. These pre-action cognitions are necessary because otherwise individuals would act impulsively rather than consciously in their efforts. An individual's fear or faith in outcome expectancies appeals directly to his/her level of determination and is framed in a way that allows him/her to exercise coping

skills in order to control future behaviour (Bandura, 1997). It can be argued that a minimum level of threat or concern must exist before people start contemplating the benefits of possible actions.

Figure 1

Schematic Representation of Causal Structures to Self-Efficacy



Note. Adapted from Bandura, 1993; Schwarzer, 1992; Wood & Bandura, 1989

The particular context and one's personal experience also play an important role in the forethought of action and may even change the choice of behaviour. There are a number of causal factors in the retrospection phase that affect the development of self-efficacy. The reasoning of one's performances as the result of perceived causes of

success or failure will significantly determine future efficacious actions and self-beliefs. Previous successes cause a feeling of confidence and establish a belief in one's abilities that one can accomplish the task at hand. Past failures lead to a questioning of capability. Observation of another's successes or failures becomes, in a sense, proxy social persuasion feedback. This also impacts upon self-efficacy actions. The degree to which an individual can be persuaded or reinforced may determine their perception of success or failure and subsequently self-efficacious behaviour.

In the motivation phase, the individual forms an intention to act based on reasoning past performances (having weighed the risks associated with the task) and calculating the known internal and external incentives. Outcome expectancies, as well as motivators, can be seen as precursors to self-efficacy because people usually make assumptions about the possible consequences of their behaviours even before they find out if they can perform the function or not. With increased levels of internal and external motivations determinations to act rise.

The action phase of self-efficacy involves the enacting of personal goals through the implementation of specific strategies in order to achieve desired outcomes. The number and quality of action plans are dependent on one's perceived competence in accomplishing the task as well as past successful performances. When an action is being performed, self-efficacy determines the amount of effort invested and the perseverance necessary for the task. People with many self-doubts are more inclined to anticipate failure, to worry, or to abort their attempts prematurely. On the other hand individuals with an optimistic sense of self-efficacy use persevering strategies to visualize the end result and to act accordingly. Such optimistic self-efficacy guides the action of setting

goals, establishing strategies, and encourages the individual to persevere in the face of adversity (Bandura, 1997).

The Role of Agency

An individual's agency, his/her freedom to choose, is an important mediating influence to the variable self-efficacy. Agency precedes the action phase of self-efficacy as it interplays between thought and action. Bandura (1997) believes an individual's efficacious judgment of him/herself and in his/her skill to perform a given task, is the most influential part of human agency. Such self-judgments play a powerful role in determining the choices people make, the effort they will expend, how long they will persevere in the face of challenge, and the degree of anxiety or confidence they will bring to the behaviour. It is this perceived self-efficacy that helps explain why one adolescent's behaviour differs widely from another's, even when they have similar knowledge and skills. Bandura (1997) argues that what we do and how we behave are better predicted by our beliefs about our capabilities than by what we are actually capable of accomplishing. Adolescents who choose to participate in therapy and apply skills learned in therapy exercise agency to use new strategies to modify thoughts, feelings, or behaviour. These adolescents have greater, healthier perceptions that positive change will occur.

Mental Health Treatment

Self-efficacy is an important quality to address and assess for adolescents who struggle with psychosocial difficulties. Self-efficacy is important to study in adolescent MHS contexts because many clients tend to perceive themselves as incapable of experiencing success or learning coping skills in anything but the simplest of tasks

(Seligman, 1990). In daily living, individuals encounter a variety of threats to their belief in themselves and their ability to perform certain tasks to produce desired outcomes. This is especially true of adolescents and particularly true for those who struggle with mental health issues. For these individuals threats to their efficacious belief to exercise control over situations in their life can be overwhelming, even debilitating. Opportunities and situations that facilitate positive self-affirmation and confidence can help adolescents cope with these threats by facilitating a confident belief system that they have or can obtain, through therapy, the skills necessary to handle difficult situations that come their way.

Self-efficacy theory proposes that human behaviour is the result of an individual's personal mastery and successes (Bandura, 1977, 1997). Our confidence increases as we come to expect task specific outcomes. Accordingly, two types of expectancies exert powerful influence on us: outcome expectancies (the belief that certain learned behaviours will lead to certain outcomes) and behavioural expectancies (the belief that one can successfully perform the behaviour or the effort needed in the face of adversity) (Bandura, 1997). Adolescents who struggle with mental health issues have low expectancies unless they engage in mental health treatment.

Self-efficacy theory (Bandura, 1977, 1989; Schwarzer, 1992) attempts to demonstrate positive correlations between therapeutic changes in behaviour and changes in self-efficacy. With an increase in self-efficacy an adolescent possesses a powerful predictor of future behaviour performance. Adolescents who partner with their counsellor in therapy may increase their outcome and behavioural expectancies. The challenge is convincing the adolescent that certain behaviours will lead to desirable

consequences and will not lead to actual behaviour change unless the patient believes that s/he can perform the behaviour him/herself, outside of the hospital, in the required social situation. Such internalized efficacious self-beliefs will undoubtedly predict that skills can be learned and used in the future. The degree of self-efficacy, then, may indicate future progress for the adolescent. In addition, information on adolescent self-efficacy may have implications for modifying therapeutic interventions and programs.

Well-Being

Psychological well-being can be defined in terms of the absence of manifested psychiatric symptoms or the presence of positive mental health attributes and coping resources (Bradburn, 1969; Diener & Suh, 2000). One of the central beliefs in psychology today is that human happiness or misery is the result of a subjective sense of well-being. Indeed, whereas wealth, social class, recognition, and other objective life qualities may contribute to a satisfaction with life, they are not necessarily determinants of intrinsic well-being. Well-being is a resultant flexible state based much on resiliency, experience, context, and temperament (Lorion, 2000).

One of the major outcomes sought in adolescent psychiatric hospitalization is an increase in mental wellness. This outcome is sought through a stabilization of the disorder(s), skill building, counselling, pharmacology, and/or specific intervention therapy. One way to achieve this desired well-being state is for the adolescent to have a sense of hope, competence, or confidence as a result of his or her treatment. Adolescents receiving MHS can expect to receive an increase in their mental well-being as they participate with their counsellor in their treatment plan.

Despite Bradburn's (1969) early work into understanding psychological well-being, today there is a paucity of research empirically measuring the effect of mental health treatment on adolescent well-being. Part of the problem appears to be a lack of agreement among researchers as to measurement criteria. Whereas some researchers argue, Lorion (2000) for example, well-being can be researched as a stand alone variable, others, such as Bronfenbrenner (1977), recommend a more complex contextual framework of study to examine the complexities of wellness. To measure the ecological and contextual influences of well-being which he proposes, however, is an insurmountable challenge. To understand this fully involves empirical measurements of individual, environmental, and transactional characteristics of wellness development across time, setting, and circumstance. Such a study would be comprehensive, let alone costly and time consuming.

This study is limited to studying the effect of treatment on adolescent well-being within the specific period of treatment (namely, 6 weeks), a specific setting (Ledger House), and the context of the adolescent mental health treatment environment. Lorion (2000) describes this effort as worthwhile:

> Thus, wellness truly represents a conceptual, methodological, and political new frontier for the mental health sciences. Its exploration promises to challenge a significant portion of the major assumptions underlying existing work in our disciplines, to move us closer to our social, behavioural, and physical science colleagues and, especially to bring us to issues of health rather than pathology (p. 23).

Although some studies have been carried out to investigate the family antecedents of adolescent psychological well-being, such as the genealogy of self-efficacy (Hoeltje, Zubrick, Silburn & Garton, 1992), such studies are primarily cross-sectional in nature, making it difficult to examine causal relationships between subjective well-being and positive mental health results. Recently, there have been a number of studies (Diener & Suh, 2000; Diener, Sapyta & Suh, 1999; Pavot & Diener, 1993) exploring people's subjective well-being. These have spawned a new arm of psychology, which attempts to understand people's satisfaction evaluation of their lives and experiences. Researchers in MHS need to strive to understand not just undesirable clinical states of anxiety and depression, but also positive levels of well-being (Bradburn, 1969; Diener & Suh, 2000). Current studies use well-being to explain life satisfaction, emotional status, affective disorders, and stress for adolescents (Ebata & Moos, 1991; Steiner, Pavelski, Pitts & McQuivey, 1998).

Positive well-being is an important variable to mental health during teenage years. Adolescence is a period of development characterized by physical, psychological, social, and relational complaints. An adolescent's emerging sense of positive well-being may be considered a consequence of hope. Hope appears to be a mediating variable in establishing a positive sense of general well-being for adolescents in therapy Diener and Suh (2000) theorize. Hope is an intrinsic motivating factor of emotional well-being. Without hope an individual ceases to strive to seek emotional health. Adolescents who have hope believe in themselves, have elevated levels of self-esteem, and experience a greater subjective sense of well-being (Diener & Suh, 2000).

Self-Efficacy, Well-Being, and Mental Health Treatment

It is often theorized that levels of self-efficacy and well-being differ between distressed (those struggling with mental health issues) and non-distressed populations (Bandura, 1997; Bradburn, 1969; Sherer, et al., 1982). Adolescents who struggle with mental health disorders, it is believed, typically have lower levels of self-efficacy and well-being than their cohorts who are more functional (Seligman, 1990). Adolescents who continue to struggle may be offered mental health services (such as in-patient and day treatment programs) to help them increase their feelings of competency and wellness. It is the intention of most mental health treatment programs to increase levels of self-efficacy and well-being in their clients as a result of treatment (Kazdin, 1993). An increased level of self-efficacy and well-being, it is believed, is thought to predict future healthy choices and behaviours.

Quantitative research has been conducted to measure the effect treatment has on mental health patients' satisfaction, self-efficacy, and well-being. Few studies appear to measure the association of treatment to functioning in all three areas. Bradley and Clark (1993), for example, demonstrated that children's satisfaction and wellness levels were high as a result of in-patient psychiatric treatment. Perreault et al. (1993), when examining the effect out-patient services had on patients, found a correlation between satisfaction and improved mental health. Crossley et al. (1997), who examined day treatment effects, found that mental health treatment does help patients' self-efficacy. O'Leary (1992) examined the effect various treatments had on general health concerns (i.e., smoking, eating disorders, and pain management). Here, it was found that therapeutic interventions were associated with improvements in health and self-efficacy.

Adolescent mental health patients who struggle with low levels of self-efficacy and well-being before treatment are believed to have increased levels when treatment is successful. However, whereas program and treatment evaluations have been conducted, little empirical evidence appears to exist from these treatment programs to confirm the increased levels of self-efficacy or well-being obtained. Whereas Bandura (1997) theorizes self-efficacy increases as a result of treatment intervention, to date there have not been thorough, empirical, or longitudinal studies in adolescent psychiatry to confirm this. Furthermore, while much has been written about the promotion and treatment of well-being in adolescents (Cicchetti, Rappaport, Sandler & Weissberg, 2000), and the belief that adolescent well-being increases with intensive mental health interventions (Van Schuur & Kruijtbosch, 1995), few studies qualitatively investigate this phenomenon.

Recent studies have attempted to show empirically a link between increases in self-efficacy, well-being, and treatment. Hartwig and Myers (2003) strongly recommend a 'wellness paradigm' to treating adolescent in-patients, specifically female patients. Still, their study only promotes the application of the theory as an important way of achieving increased wellbeing for adolescents; it does not pragmatically research this relationship. Muris, Bogie and Hoogsteder (2001) examined the treatment effect of an early intervention program on adolescent participants' resiliency as they struggled with depression and emotional problems. The authors' thorough study, however, relies only on post treatment self-report forms. Pre-treatment measures were not obtained. Whereas the use of questionnaires measured levels of anxiety, depression, and self-efficacy post-treatment, valuable qualitative evidence was not obtained by way of interviews to

complement the quantitative findings obtained. Gilman and Handwerk (2001) conducted a small scale (N=22) pre and post treatment well-being research in a residential mental health care setting. However, only a multidimensional life satisfaction scale was used to determine adolescents' levels of satisfaction and well-being after treatment. Levels of self-efficacy were not obtained nor were interviews conducted on this small sample to empirically determine areas of improvement. Crossley et al. (1997), in their five year study of a Canadian psychiatric day program, neglected to focus on specific self-efficacy indicators when examining the effect the Saskatchewan mental health program had on adolescents' satisfaction and well-being. It appears, whereas social scientists concur that the desired outcome of adolescent psychiatric treatment programs is to have increased self-efficacy and well-being levels, few empirically-based studies show this result. Few have made the effort to combine quantitative and qualitative methodologies.

Adolescents With Psychiatric Needs

The need for adolescent MHS is great and on the increase (British Columbia, Ministry of Health, 1998). In fact, the estimated prevalence of mental health disorders in youths can range any where from 5-31% (Stiffman, Chen, Elze, Dore & Cheng, 1997). Among adolescents with mental health struggles, those with conduct or oppositional disorders are most likely to obtain services, while those with depressive or mood disorders are least likely to obtain mental health assistance (Cohen, Kasen, Brook & Struening, 1991). Despite the obvious need for adolescent MHS, only a small percent of those in need actually receive services. Indeed, Hunter et al. (1996), in their systematic review of the literature, found that "the majority of children [requiring MHS] are not under the care of psychiatric services" (p. 197). Those who require clinical help

sometimes do not receive appropriate treatment. Cohen and associates (1991) found that only 56% of parents whose adolescent had severe psychiatric problems consulted with a mental health professional.

Adolescents with mental health issues struggle with a range of psychiatric difficulties. Some struggle with anxiety disorders, mood disorders, behavioural difficulties, while others wrestle with more serious emerging psychopathologies such as schizophrenia or early on-set psychosis. While many often have only singular diagnoses, co-morbidity among disorders is quite common. Many adolescents struggle with multiple concerns rather than singular problems. For example, an adolescent who suffers from clinical depression might also struggle with an eating disorder or anxiety disorder. Accompanying this may be post traumatic stressors, social or friendship skill deficits, self-management skill needs, and/or learning difficulties. Family and relational conflicts are important factors also in these struggles. Problems can sometimes seem so big to the adolescent or family that they feel unmanageable without some form of therapeutic intervention. Sadly, often only after exhaustive community or paraprofessional service psychiatric intervention is recommended and received.

What Treatment Helps?

Services to adolescents with mental health needs vary. Some adolescents receive treatment through out-patient programs, office visits to a psychiatrist or a counsellor, in-home counselling support, child and youth care contracts, or community-based services. At other times it becomes necessary to refer acute mental health cases to in-patient residential or day hospital programs, when the patient, family and/or community supports have broken down. The purpose of a hospital psychiatric program is not to

institutionalize but is intended to provide care, supervision, and control within a medical model environment for the purpose of intensive child and family centred-mental health treatment (Lyman & Campbell, 1996). Indeed, for many adolescents and families, these psychiatric day and in-patient programs are often the catalyst for behaviour change, increased confidence, and wellness. In a review of the effectiveness of psychiatric treatment with children and adolescents, Weisz and Weiss (1993) found that children and adolescents receiving treatment were better off than 79% of subjects not receiving treatment. Adolescents who receive the opportunity for mental health program treatment benefit over those who do not receive services.

Many of these psychiatric programs offer a multi-disciplinary team approach to mental health treatment for adolescents. These approaches to treatment offer the services of such disciplines as Child and Youth Counselling, Nursing, Social Work, Occupational Therapy, Speech-Language Pathology, Psychology, Neuropsychology, and Psychiatry. Such a multi-faceted treatment paradigm allows for a variety of assessment and treatment approaches to service the adolescent and his/ her family within a short period of time. When offered, these programs deliver assessment, stabilization, consultation, and treatment services to the adolescent in need. Most mental health treatment facilities subscribe to current research findings which promote the bio-psycho-social model of care. This paradigm recognizes and addresses the biological, psychological, and social aspects of illness and disability (Hoagwood, Jensen & Petti, 1996).

To assume that in-patient or psychiatric day program services are a panacea for increased self-efficacy and mental well-being is a gross overestimation of the effectiveness of the intervention. Whereas research shows the benefit of psychiatric

hospital programs through the use of pharmacology and therapy (Weisz & Weiss, 1993), it is often the willingness and determination of the adolescent client to partner in therapy with his/her counsellor that results in improved behaviour change, self-efficacy increases, and positive mental well-being (Advisory Network on Mental Health, 1997; British Columbia, Ministry of Health, 1998).

Research Questions

This study addresses the following questions:

1. What are the effects of the Adolescent and Family Program and the Adolescent Day Treatment Program on adolescent participants' self-efficacy?
2. What are the effects of the Adolescent and Family Program and the Adolescent Day Treatment Program on adolescent participants' sense of well-being?
3. What is the process of treatment as experienced by the adolescent?
4. Is there a relationship between the process of treatment and the outcomes of self-efficacy and well-being?

There are a number of further research inquiries implicit in the qualitative investigation of this research. Established first will be whether or not the adolescent found the psychiatric intervention satisfactory. Second, determining from the adolescents' perspective which interventions were helpful will be explored through the use of retrospection in a semi-structured interview format. With this later focus, the main research question becomes more than simply, "Did the adolescent find the services helpful"? Instead, the research question includes a process of inquiry into *how* the service was helpful for the patient, for example, "Which aspects of the hospitalization were helpful for the adolescent?". Questions pertaining to how the treatment program

was helpful for the participants' self-efficacy and well-being include asking what specific interventions caused change for them; "How has this experience changed the adolescent?" and, "How will this change affect the future confidence of the adolescent?" Such questions of a personal nature include questions of the effect of treatment on self-efficacy and well-being. A further question for the adolescents will include what they need to do to continue to feel confident, thereby maintaining their belief in themselves that they can handle stressful events or changes. These questions are concerned with whether, from the adolescents' perspective, there is an actual improvement of patient functioning as a result of their treatment program. Such an inquiry will determine if there is an increase in self-efficacy and well-being to handle difficulties or stressors as a result of mental health treatment.

Hypotheses

This study tested the following hypotheses. It was predicted that:

1. Adolescents' general self-efficacy would increase as a result of mental health program intervention.
2. Adolescents' overall mental well-being would increase as a result of mental health program intervention.
3. The adolescent would experience the mental health program intervention with greater degrees of satisfaction, self-efficacy, and well-being with positive relationships found among the three attributes.

CHAPTER III

Method

Participants

The current research consisted of 19 adolescents, who, at the start of the waitlist period, ranged in age from 11.6 years to 16.6 years of age. Adolescent participants were primarily from urban areas of South Vancouver Island, B.C., Canada. Three participants lived in more rural areas of South Vancouver Island.

The mean age of adolescent participants (see Table 1) at Waitlist data collection time was 13.9 years (*SD*=1.67). There was an average of 11.05 weeks (*SD*=7.29) wait before the participants' admission to their respective program with their mean age being 14.1 years (*SD*=1.65) upon entry. Once in treatment, the overall average length of stay for adolescents was 6.95 weeks (AFP *M*=6.50, *SD*=.94; ADTP *M*= 8.20, *SD*=2.28) with their average age at discharge being 14.6 years (*SD*=1.72).

Table 1

Mean Participant Ages

Program	**Waitlist (T_1)**	**Admission (T_2)**	**Discharge (T_3)**	**F. Group**
AFP (In-patient)	13.7yrs	13.9yrs	14.4yrs	15.5yrs
ADTP (Day)	14.3yrs	14.6yrs	15.2yrs	16.0yrs
Overall	13.9yrs	14.1yrs	14.6yrs	15.6yrs

Notes. AFP = Adolescent and Family Program; ADTP = Adolescent Day Treatment Program

Fifteen males (78.9%) and four females (21.1%) participated in the study (AFP= 11 male & 3 female; ADTP= 4 male & 1 female). Fourteen participants were Caucasian-Canadian (73.7%), two First Nations (10.5%), and three a mixture of Dutch, Romanian, Irish-Canadian, and Russian racial origin (15.8%). Eight participants had one brother or sister (42.1%), eight others had two or more brothers or sisters (42.1%), one had three siblings (5.3%), and two adolescents had four or more siblings (10.5%). Nine of the 19 participants reported having step-siblings (47.4%).

Of those 19 participants, 16 (84.2%) were currently attending school (two were not attending and one was on correspondence) and 12 (63.2%) were or had been suspended at one point or another from school. Five (26.3%) participants had completed grade 6, five (26.3%) grade 7, four (21.1%) grade 8, four (21.1%) grade 9, and one (5.3%) had completed grade 10.

Of those who participated, only seven adolescents (36.8%) had biological parents who were still married. Three (15.8%) parents were divorced, two (10.5%) separated, four (21.1%) were remarried, one (5.3%) lived common-law, and two (10.5%) were recorded as "other" by the adolescent participant indicating, for example, together with a boyfriend or a girlfriend.

Examination of the participants' living arrangements showed 16 (84.2%) were presently living at home while three (15.8%) were living in a foster care arrangement, although six (31.6%) were either currently in or had been in foster care at some point previously.

Design

To test the hypotheses quantitatively a Repeated Measure Design was used to examine the difference in mean scores of self-efficacy and well-being across time. Three time periods (T_1, T_2, T_3) represented the three separate data collection periods, namely, Waitlist, Admission, and Discharge.

This quasi-experimental time-series design allowed for participants to become their own control and treatment group. In order for participants to act as their own control group, measures of self-efficacy and well-being were obtained at the beginning of the waitlist period, without treatment (*M* waitlist time= 11.05 wks), and then once again at the beginning of the adolescents' treatment period. Measures of self-efficacy and well-being at the beginning of the treatment period (first day or two of the participants' admission to the Adolescent and Family Program or the Adolescent Day Treatment Program) became the end measure of the control period and the beginning measure for the treatment period (*M* admission time= 6.95 wks). Next, measures were obtained at discharge (final day or two of the participants' treatment) to determine final self-efficacy and well-being scores for the treatment group. A client satisfaction questionnaire was also administered at discharge to obtain statistical satisfaction results. Descriptive statistics were obtained for this satisfaction questionnaire (CSQ-Y) by summing weighted responses to 11 questions using the SPSS 11.0 statistical program.

To add to the quantitative information, and to enhance understanding of the effect and process of treatment on the adolescent, a qualitative Grounded Theory design was conducted. The Constant Comparison method (Strauss & Corbin, 1990) was used to analyze qualitative data. Semi-structured interviews were conducted on all 19

participants with 20 open-ended questions asked exploring satisfaction, self-efficacy, well-being, and experiences. Where there may possibly have been a conflict of interest (i.e., the researcher had acted as the patient's primary counselor) a second researcher conducted the interview. Interviews were audio taped and lasted between 10-30 minutes (*M*=20mins). The aim of the interview was to elicit narrative descriptions of patient satisfaction, dissatisfaction, self-efficacy, well-being, and retrospection concerning their treatment experience. Qualitative results were intended to corroborate the quantitative measures. Written qualitative information used for comparison with quantitative results was also obtained from the final three questions included on the CSQ-Y.

Finally, a focus group methodology was used to capture a "Where-are-you-now?" measure and a "Was-this-true-for-you?" reaction to data obtained from the study. Eight of the 19 research clients participated in this informal focus group on July 06, 2002 at Queen Alexandra Centre for Children's Health (QACCH).

Instrumentation

Quantitative Measures

Four quantitative measures exploring different but inter-related constructs are explained here in detail. The Self-Efficacy Scale (SES) (Sherer et al., 1982) was used to measure participants' self-efficacy before and after treatment. A measure of adolescent well-being was conducted using the Bradburn Affect Balance Scale (BABS) (Bradburn, 1969). This measure was given with the self-efficacy scale at waitlist, pre-, and post-treatment periods. The Client Satisfaction Questionnaire-Youth Form (CSQ-Y) (Barner et al., 1994), which is occasionally used for program evaluation, was administered as a satisfaction/evaluation tool to adolescent participants upon discharge from their treatment

program. Finally, the Adolescent Demographic Questionnaire (ADQ), created by the researcher, was administered at waitlist to obtain demographic and admission information on each participant.

Self-Efficacy Scale

Early research by Bandura (1977) theorized that positive correlations between therapeutic interventions and changes in self-efficacy could occur. Subsequent research has suggested that an increased level of self-efficacy is a powerful predictor of behaviour (Bandura, 1997; Schwarzer, 1992). Sherer and associates (1982) developed a measure of self-efficacy that was not tied to specific situations or behaviour (see Appendix 4). Such a scale has useful application in the field of MHS they presented. Their rationale for developing this scale was:

> Since clients enter therapy with differing levels of general self-efficacy, they are differentially influenced by the therapeutic process... A generalized self-efficacy scale might provide a useful index of progress in therapy since expectations of self-efficacy should change during therapy (p. 664).

The scale used in this research project is a revised version of the SES developed by Sherer and associates (1982). Whereas the original scale consisted of two parts, general self-efficacy and social self-efficacy, only those questions of a general self-efficacy nature were incorporated into a revised version and used in this study. These seventeen general self-efficacy questions, complete with a different Likert scale as recommended by Wyatt and Meyers (1987), made the measure consistent with the other scales used in the present study. To control for acquiescence bias, eleven negative

weighted questions were included in the SES questionnaire. Upon SPSS analysis, negatively weighted questions were then recoded to create positive scores. Values for all seventeen questions were then summed to get the total SES score. Higher SES scores reflected higher self-efficacy in research participants.

Sherer and associates' SES shows favorable Cronbach alpha reliability coefficient (X=.86) for the general self-efficacy subscale scores (Sherer et al., 1982). The scale has also been demonstrated to have strong test, re-test reliability results over long periods of time (see for example Kelley, Coursey & Selby, 1997). The SES has also been used with adolescent ages with success as it has with adult-aged populations. Ehrenberg, Cox, and Koopman (1991), for example, used the SES to examine the self-efficacy status of depressed versus non-depressed adolescents (N=356, M=16.29yrs) in Vancouver, Canada. As predicted, results of the SES were negatively correlated to depression, showing high perceived self-efficacy levels which were related to a lack of depression.

Well-Being Measure

The Bradburn Affect Balance Scale (BABS) (Bradburn, 1969) is a measure of emotional well-being (see Appendix 5). This instrument provides a framework for measuring positive and negative affect or, in other words, positive and negative well-being. The BABS indicates affective (or emotional) stability and balance at the time of measurement.

The BABS was one of the first of many measures to evaluate psychological well-being when well-being became a leading mental health construct to research in the 1970's. It has been reported that the BABS is one of the most useful, easily administered, and reliable measures of positive and negative emotional well-being today

(Smith, 1995). Indeed, McDowell and Praught (1982) found significant advantages for the scale over alternative indicators of emotional well-being in general population surveys, because the BABS measures positive affect, negative affect, and affect balance, rather than perceived quality of life only. The scale has often been used by Health and Welfare Canada's Mental Health Division. A review of the literature, conducted by Stacey and Gatz (1991) and Van Schuur and Kruijtbosch (1995), suggest that the BABS, measuring both positive and negative well-being, has strong cross-sectional (longitudinal) reliability across time.

The overall BABS score is derived from five questions that measure positive affect (or well-being) and five questions that measure negative affect. Respondents are asked the 10 questions and given three choices of responses (often, sometimes, and never), indicating the frequency with which they experience each of the positive and negative states. The response options are then weighted with values of 1, 2, and 3, respectively. To obtain the affect balance state, the responses to the positive and negative affect questions are first summed independently of each other. Each of the positive and negative sums has a range from 5-15. If the respondent answers "often" to each of the five positive questions, this will yield a possible high score of 5, indicating a highly positive score. On the other hand, if the respondent answers "Never" to each of the positive questions the resulting score would equal 15. Consequently, any combination of "Often", "Sometimes" or "Never" yields a score ranging from 5-15 (the scoring is the same for the negative affect scale). The BABS overall score is derived from subtracting the positive affect score from the negative affect score. Results indicate the higher the score the greater the positive well-being for the participant.

Satisfaction Questionnaire

The Client Satisfaction Questionnaire-Youth form (CSQ-Y) (Barner et al., 1994) is a youth self-report satisfaction questionnaire (see Appendix 6). This survey asks participants about the quality of their experience while in the program, both in terms of their perceptions of clinical effectiveness and in relation to their feeling respected during treatment planning and treatment delivery. The CSQ-Y was designed by the program coordinators at Mental Health Services (Ledger Building, QACCH), with supplementary commentary from QACCH clinicians and staff. The form focuses on the objectives, service goals, and mission statements that shape the provision of client-centered treatment at QACCH. Areas of inquiry were derived both from the coordinators' experience with children, youth, and families during treatment, and from the literature on parent satisfaction related to children and families receiving service from psychiatric programs (Kotsopoulos, Elwood & Oke, 1989; Patterson, Crosby & Vuchinich, 1992). The questionnaire was designed to measure (a) whether the outcome of treatment was perceived as an actual improvement to the client's mental health; (b) if the patient's ability to access additional community services post-discharge improved; and (c) whether or not the care provided was client and family-centered (i.e., respectful, non-judgmental).

Results from the Program Evaluation Pilot Project at QACCH (Tate et al., 2000), where the CSQ-Y was first administered, showed that adolescents, on average, rated themselves as generally satisfied. On average, in the Pilot Project, teens rated the quality of service as satisfactory but did not rate the program as high in providing the same level of improvement to their family and community relationships.

The 14 questions of the CSQ-Y consist of two parts: (1) a set of pre-determined questions about aspects of care and effectiveness rated on a 5-point Likert scale in terms of satisfaction (terms at either end of the scale were qualified in order to encourage full use of all five steps [Wyatt & Meyers, 1987]), and (2) a smaller number of open-ended questions asking for written feedback/commentary about helpful aspects of the program and about areas where improvements could be made.

Reliability for the rating scale has been examined via Chronbach's alpha. This method of calculating internal consistency reliability of a given measure is based on the average inter-item correlation. The questionnaire has demonstrated acceptable Cronbach alphas with values ranging from .84 to .90 (Tate et al., 2000).

Demographic Questionnaire

To obtain important participant-generated demographic information for this study the researcher created the Adolescent Demographic Questionnaire (ADQ) (see Appendix 3). Information was asked of participants by way of an easily administered written questionnaire which included questions about age, gender, ethnicity, siblings, schooling, parent's marital status, and home living arrangements. Questions were easily readable and needed only to be checked off to answer. The final question was an open-ended written question allowing for the adolescent participants to volunteer what their understanding was for their upcoming admission to the Adolescent and Family Program or the Adolescent Day Treatment Program at Ledger, QACCH.

Drafts of the ADQ were reviewed with the researchers' supervising committee and copies were made available to the Adolescent and Family Program staff for discussion. Three counsellors were selected to provide written feedback. Two

adolescent patients willingly completed the questionnaire and provided feedback as to its use. Changes were made and the form was modified accordingly for use in the research project.

Qualitative Measures

Three means were used to obtain qualitative information namely, written information form the CSQ-Y, semi-structured interviews, and an adolescent focus group. The results of these approaches were compared with the statistical information obtained from the quantitative measures.

CSQ-Y (Open-ended questions)

As previously described, the CSQ-Y also provided some qualitative information from the three written questions included in that measure. The open-ended questions at the end of the Likert-based questionnaire provide the research with valuable adolescent survey-based qualitative feedback. The personal reflection questions included in the questionnaire are:

1. What do you think will stay with you about your experiences in this program?
2. What has been most helpful to you about this program?
3. What changes would make this program more helpful to you?

Interview

Through an informal interview by the researchers, adolescents were given an opportunity to elaborate further than the written responses obtained via the SES, BABS, CSQ-Y, and the ADQ (see Appendix 7 for interview questions) produced. These interviews were conducted in the participants' final week of treatment and constituted the primary qualitative post-treatment evaluation. A variety of questions, predominantly

open-ended, were established through consultation with research committee members, program staff, through internet, and literature review research. Questions were written in open-ended format to maximize verbal responses from research participants. The 20 questions selected were intended to encourage exploration and reflection by the adolescent as inquiry was conducted with respect to satisfaction, dissatisfaction, self-efficacy, well-being, and reflection on treatment experiences.

Focus Group

Near the conclusion of the data collection period a focus group was conducted with adolescent participants from the in-patient and day program who had participated in the research. The purpose of the focus group was to provide an informal group setting for participants to share their experiences and state their level of satisfaction with the service received and to describe their present state of self-efficacy and well-being post treatment. Such a purpose is in agreement with reasons for conducting adolescent mental health follow-up groups as recommended by Elbeck and Fecteau (1990) and Powell and Single (1996). Adolescent participants were encouraged, through open-ended questions by the group facilitators, to evaluate their treatment program experience and determine how they felt about themselves post treatment. Focus group participants were also briefly informed about the results obtained from the study and asked if "This was true for you too". Their input was sought to: (a) determine if the compiled information was true for them, (b) to elicit feedback as to what questions the researchers should ask of future participants when evaluating subsequent service delivery and program operations and, (c) how they felt about the treatment they had received. Such a practical method of research is highlighted by the work of Eash (1985) in his model of service evaluation. This model

provides information to clients and at the same time supplies answers to evaluators while data are obtained from focus group participants concerning the treatment.

Programs

The current evaluation consisted of voluntary adolescent participants (N=19) who provided data related to treatment outcomes from two separate but connected programs: the Adolescent and Family Program (AFP) (n=14) and the Adolescent Day Treatment Program (ADTP) (n=5). These adolescent programs are located in the mental health building (Ledger House) of Queen Alexandra Centre for Children's Health (QACCH). QACCH is a part of the Vancouver Island Health Authority's Maternal, Child, Youth, and Family Services division, providing mental health care to families in Greater Victoria and Vancouver Island, British Columbia.

Adolescent and Family Program

The AFP is a residential hospital-based program, which has a six-bed capacity and treats youth aged 12 to 17 years. Children aged 10 and 11 years old whose presenting concerns are more 'adolescent' in nature may occasionally be admitted to the adolescent program. This is also done at times to reduce the Children and Family program waitlist. The AFP offers a planned admission with a typical two week assessment and a four week treatment plan. There is also a six week follow-up period with the Primary Counsellor principally making telephone calls to the child and family. During the six weeks of in-patient stay, staff encourage parents' participation in the adolescents' program. There is some residential accommodation available for parents whose participation might otherwise be compromised or whose involvement in their adolescents' program is an integral part of therapy. Treatment in the programs is

provided days and evenings by a multi-disciplinary team with adolescents returning home to their caregivers on weekends.

Adolescent Day Treatment Program

The ADTP, which, at the time of study, had a four patient census, treats youth aged 12-17. This day program offers planned admissions with an eight to 12 week length of stay. Generally after eight to 10 weeks at Ledger, the youth is integrated into his/her community school. There is no residential accommodation for participants or parents in this program as youth attend approximately 8am to 4pm Monday to Friday. A school integration emphasis is a large part of the ADTP with Child and Youth Counsellors working closely with Ledger School staff and the youth's community school placement team to ensure academic success where possible.

Both the ADTP and the AFP emphasize parent support and skill building, individual adolescent and group counselling, academic, and social skills remediation, as well as family problem-solving/counselling. Both programs adhere to similar models of treatment. These biopsychosocial models provide for individual and peer group adolescent counselling, family counselling, parent training, classroom management, trauma therapy, and coping skills, as well as milieu therapy. The application of therapy is specific to particular adolescent/family identified needs. The service itself is delivered by individual staff belonging to a multi-disciplinary team, which includes child and youth counsellors, nurses, teachers, social workers, occupational therapists, psychologists, psychiatrists, and members of allied health disciplines. Program Coordinators and Team Leaders monitor the process of service delivery.

In addition to the therapy modalities described above, most children and adolescents are engaged in social problem-solving training and self-management skills teaching, while their parents concurrently receive parent training in the management of their adolescent's behavior and in appropriate ways of negotiating family rules with their teens. This combination of therapy and skill-based training for youth and parent participants has been shown to yield significant improvements on measures of adolescent psychopathology in reviews of cross-sectional and longitudinal studies (Jensen et al., 1996; Kazdin, 1997; McMahon, 1994).

Procedure

A total of 42 invitations (see Appendix 1 for Open Letter) were mailed out to adolescents who were referred to the AFP and the ADTP (see Table 2 for details). Thirty-one adolescents agreed to participate in the study. These adolescents either responded to the open invitation by calling the researcher themselves or received a phone call from the researcher after one week of having received their letter of interest in the mail. In the phone interview, the researcher explained the purpose of the research and asked if they would like to participate. In all cases the researcher obtained permission from the parent or guardian before speaking to the adolescent (see Appendix 2 for the telephone script).

Once verbal consent was obtained over the phone, a written consent form was mailed out to the participant to sign and return (see Appendix 8 for the consent form). Also mailed out in that package was the Adolescent Demographic Questionnaire (ADQ), the Self-Efficacy Scale (SES), and the Bradburn Affect Balance Scale (BABS) (see Appendices 3, 4 & 5). These forms constituted the T_1 data set package.

Table 2

Data Set Report

Program	Invites Mailed	Those Agreed to Participate	Waitlist T_1 Completed	Admission T_2 Completed	Discharge T_3 Completed
AFP (In-patient)	24	20	15	14	14
ADTP (Day)	18	11	7	5	5
Totals	42	31	22	19	19

Of those 31 who agreed to participate, 22 adolescents (AFP: n=15/ADTP: n=7) completed their first set of data and either mailed it back in prepaid envelopes included in the Waitlist package (n=18), dropped it off to the researcher (n=2), or had it picked up by the researcher (n=2). Of the 22 who completed the initial T_1 data set, 19 completed the second T_2 data set when they were admitted to their respective program. The researcher gave basic instructions to the participant who was given a quiet area at Ledger to fill out the T_2 data set.

Concerning the original 31 who said "Yes" to the study and were mailed out the T_1 data sets, 12 did not complete the research. Of those 12, three were reluctant or refused to complete the data and never were admitted to their program. One was withdrawn from the waitlist because she was doing better, four were withdrawn from the waitlist because they refused to come in, three had not returned the waitlist data in time before they were admitted, and one had his Social Worker say "No" to participating in

the research at the admission conference. As a result, those who completed the research totaled 19. Of note is the fact that all 19 completed the third (T_3) set of data at discharge, which included a satisfaction questionnaire (see Appendix 6). When the T_3 data set was completed participants were then given honorariums as promised ($15). All 19 participants were interviewed following the completion of the T_3 data set by the researcher(s) to obtain qualitative information (see table 3 for a breakdown of the data collection procedure).

Table 3

Data Collection Procedure

Program	**Waitlist (Week 1)**	**Admission (approx. wk 11)**	**Discharge (approx. wk 18)**	**Follow-up (approx. wk 30)**
AFP *(In-patient)*	ADQ/SES/ BABS	SES/BABS	SES/BABS/ CSQ-Y/ INTERVIEW	FOCUS GROUP
ADTP *(Day Program)*	ADQ/SES/ BABS	SES/BABS	SES/BABS/ CSQ-Y/ INTERVIEW	FOCUS GROUP

Notes. AFP= Adolescent & Family Program; ADTP= Adolescent Day Treatment Program; ADQ= Adolescent Demographic Questionnaire; SES= Self-Efficacy Scale; BABS= Bradburn Affective Balance Scale; CSQ-Y= Client Satisfaction Questionnaire-Youth form

Individual interviews took place in a quiet interview room of the QACCH hospital following each completion of the T_3 data set (see Appendix 7 for interview questions). Before the interview began, a conscious attempt was made by the researcher to alleviate any apparent nervousness by reminding the participants that they had the choice of

answering any or all of the questions asked of them. They were encouraged to say what they wanted to say freely, for the information was for research purposes only and would not be given to their treatment team or family members. Audio-taped interviews lasted on average 20 minutes. To achieve T_3 data sets complete with interviews, on all 19 participants, the data collection time took approximately 45 weeks to complete. This length of time was due to program closure, admission extensions, and 'droughts' in program admissions.

A follow-up adolescent focus group was then conducted. There were three meetings by the two researchers who conducted the focus group to discuss the structure of focus groups generally, to set the parameters for this group, to determine what research results would be shared with the participants, and to develop questions that would complement the current study and at the same time provide feedback to the Mental Health Operating Group (QACCH management group) as part of their quality improvement activities.

Sixteen adolescents who had participated in the study, of a possible total of nineteen by the end of data collection in October, 2002, were invited to attend the focus group. Only 16 were invited because the focus group was held in July, 2002, two months prior to the completion of the data collection period. Participants were invited by phone and provided with a follow-up letter that included instructions as to the location (see Appendix 10 and 11 for the focus group invitation mail out and map). Parents were also informed either by phone or letter. In this way focus group participants selected themselves. By verbal indication the researchers expected that eleven adolescents would attend the planned focus group.

The focus group was held on a Saturday instead of a week/school night. The plan was to make the group no longer than 1 ½ to 2 hours in total length. An honorarium of $15 was provided (as promised in the initial open letter invitation and consent form) to participants to cover time spent and to encourage participation. Transportation costs (for gas) were made available to two participants traveling long distances. The group was held at Anscomb House, a neutral, friendly, and open spaced building at QACCH.

The questions/statements for the focus group were developed from information that adolescents provided to the researcher from the Client Satisfaction Questionnaire-Youth Form (CSQ-Y), the Bradburn Affect Balance Scale (BABS), the Self-Efficacy Scale (SES), and the participant interviews.

The focal point of the focus group research was to further explore:

- Satisfaction - Was treatment successful? Were the participants overall satisfied with the program? Were there any areas that the participants were dissatisfied with?
- Self Efficacy - Were there improvements in the participants' self-confidence as a result of treatment?
- Well-being - Were there improvements in the clients' sense of well-being as a result of treatment?
- Treatment - How meaningful was the treatment process? What was the experience like for the adolescent?
- Information - What were the adolescents' opinions on treatment? What recommendations did the participants have for future studies?

The data obtained from the focus group questions complemented the data obtained from the research study by providing group evidence-based practical feedback. As well, it provided researchers with data which can be used in conducting future interviews and research with adolescents at QACCH.

Analysis of Data

Final quantitative scores derived from T_1, T_2, and T_3 data sets obtained throughout the collection period (October 2001 to September 2002) were entered into the statistical software program (SPSS v.11.0 for windows) for analysis. To account for data inputting errors completed SES, BABS, and CSQ-Y questionnaires were then re-entered into a new SPSS file and double checked by two researchers for data entry errors. Eight changes were made to the original file for correction. Analysis was then conducted from June 2002 to September 2002 (see Appendix 9 for the SPSS computation commands used).

Qualitative results were derived from various sources including the three open-ended questions from the CSQ-Y (which were analyzed via SPSS), the semi-structured interviews, and the focus group. All interviews were carefully transcribed into Microsoft Word document files, inputting both participant and researcher responses to the twenty questions asked. Interviews were then analyzed for patterns by way of the Constant Comparative method of grouping axial coded themes into categories for interpretation (Glaser, 1993; Strauss & Corbin, 1990). These codes were then grouped according to similarities and differences creating themed categories for analysis. Themed categories, according to Glaser and Strauss (1967), describe the procedure of inferring meaning from the data which establishes categories that then explain the data. In this way theory generation is inductive with themed categories emerging naturally from data analysis

(Strauss & Corbin, 1990). A fellow researcher assisted in the study by analyzing 25% of the interviews to obtain inter-rater reliability. Where differences existed discussion was used to clarify open coding results to obtain consensus of themed categories.

To analyze the data from the focus group the Constant Comparative method was once again conducted to establish micro and macro themes from the audio taped focus group. Both researchers, who facilitated the focus group, separately transcribed and analyzed the audio tape of the group session to establish themes. Researchers then met to examine common themes to establish consensus and inter-rater reliability. Where there was disagreement, discussion was used to clarify and resolve differing interpretations. Conclusions of the focus group were then written up and shared with Mental Health management October, 2002 and Adolescent and Family Program staff in November, 2002.

CHAPTER IV

Results

Quantitative Results

In order to test the null hypotheses (that mean self-efficacy and well-being scores would be the same before and after treatment) a repeated measures analysis of variance (ANOVA) was done across the three time periods: Waitlist (T_1), Admission (T_2), and Discharge (T_3). Two separate analyses were conducted for each of the two dependent variables (self-efficacy and well-being), with time as the independent variable in each case. Tests of within subject factors were conducted to measure mean variable scores of self-efficacy and well-being. For both SES and BABS scales, which respectively measured self-efficacy and well-being, the T_1-T_2 time period became the control period (without treatment) and the T_2-T_3 period became the experimental period (with treatment). Contrasts were made between the control and experimental periods, namely: T_1 vs. T_2, T_2 vs. T_3, and T_1 vs. T_3. The Huynth-Feldt epsilon multiplier was used in order to determine the degrees of freedom (*df*) and the resulting tests of significance (*p* value) in order to account for possible violations of the assumption of sphericity. Accordant with the hypotheses, T_3 means of both SES and BABS were consistently higher than both T_1 and T_2 self-efficacy and well-being means. Therefore, quantitative results supported the hypotheses that adolescent general self-efficacy and overall mental well-being increased as a result of mental health program intervention.

Self-Efficacy

In the first hypothesis, it was expected that adolescents' general self-efficacy would increase as a result of MHS program intervention. Results of the quantitative

analysis showed a significant difference in T_3 mean scores of SES from that of T_1 and T_2 SES scores. A statistically significant main effect for overall SES was found ($F\{1.33,23.96\}=4.96$, $p=.027$, $\eta^2=.22$) in the analysis. Within group contrasts showed that this main effect was accounted for by statistically significant differences between T_2 and T_3 SES scores and between T_1 and T_3 SES scores. Total waitlist and admission self-efficacy scores were lower, as expected, than the total self-efficacy scores for discharge, indicating a significant change in overall mean self-efficacy for adolescent participants in the study. Table 4 presents individual group means and standard deviations.

Table 4

Individual Group Means (*M*) and Standard Deviations (*SD*)

	T_1		T_2		T_3	
	M	***SD***	***M***	***SD***	***M***	***SD***
			Self-Efficacy (SES)			
Total (*N*=19)	35.474[a]	13.958	39.052[a]	10.255	43.579[b]	9.907
In-patient (*n*=14)	36.214[a]	11.866	38.000[a]	10.655	43.214[b]	10.312
Day Prog. (*n*=5)	33.400	20.293	42.000	9.460	44.600	9.711
			Well-Being (BABS)			
Total (*N*=19)	ˉ.895[a]	3.620	.474[a]	3.323	2.684[b]	2.907
In-patient (*n*=14)	ˉ.857[a]	3.461	.071[a]	2.401	2.500[b]	2.907
Day Prog. (*n*=5)	ˉ1.000	4.472	1.600	5.367	3.200	3.115

Note. Means with different superscripts indicate a statistically significant difference.

When conducting tests of within subjects contrasts across time for all participants, T_1 vs. T_2 results showed, as expected, no significant difference between pre-treatment and admission scores of self-efficacy ($F\{1,18\}=1.53$, $p=.233$, $\eta^2=.078$). However, in support of the hypothesis, T_2 vs. T_3 results showed, as expected, a significant statistical difference in self-efficacy results due to treatment ($F\{1,18\}=11.90$, $p=.003$, $\eta^2=.398$). The difference between T_1 and T_3 was also significant ($p=.019$). Because of these differences between mean scores it was concluded that changes in self-efficacy could not be attributed to chance and were directly related to mental health treatment intervention.

When examining the hypothesis by program, results showed Adolescent and Family Program overall SES results were significant ($F\{1.52,19.78\}=3.76$, $p=.052$, $\eta^2=.224$). Tests of within-subjects contrasts indicated there was a statistically significant main effect in self-efficacy scores over time for participants in the adolescent program. The T_1 vs. T_2 results showed, as expected, no significant difference ($p=.575$) while T_2 vs. T_3 results were, as also predicted, significantly different ($F\{1,13\}=11.04$, $p=.006$, $\eta^2=.459$). When examining the difference between waitlist and discharge (T_1 vs. T_3) results were also significant in their change ($p=.036$). The results of the analysis are consistent with the alternate hypothesis that there was a measurable effect in self-efficacy scores as a result of the treatment period.

Regarding the Adolescent Day Treatment Program, however, the results showed no significant difference in self-efficacy ($F\{1.02,4.10\}=1.51$, $p=.286$, $\eta^2=.274$). Contrasts across time also showed no significant difference [(T_1 vs. T_2: $F\{1,4\}=1.57$, $p=.279$, $\eta^2=.282$); (T_2 vs. T_3: $F\{1,4\}=1.17$, $p=.340$, $\eta^2=.227$); (T_1 vs. T_3: $F\{1,4\}=1.50$, $p=.288$, $\eta^2=.273$)]. This may in part be due to the relative weak observed power due to

the few numbers (n=5) of day program participants. As a result there was a great chance of type 2 error skewing the results.

Well-Being

The second hypothesis stated that adolescents' overall mental well-being would increase as a result of MHS program intervention. Consistent with the hypothesis, and consistent with the results of the SES questionnaire, well-being statistics showed a significant difference in T_3 mean BABS scores from that of T_1 and T_2 overall BABS scores. Total waitlist and admission well-being scores were lower, as expected, than the total well-being scores for discharged participants indicating a significant change in their overall mean well-being. As a result, a statistically significant main effect for mean BABS score was found according to the Huynth-Feldt epsilon multiplier ($F\{2.0, 36.0\}=9.21$, $p=.001$, $\eta^2=.339$). Within group contrasts showed that this main effect was accounted for by statistically significant differences between T_2 and T_3 BABS scores and between T_1 and T_3 BABS scores. Table 4 shows individual group means and standard deviations.

When conducting tests of within-subjects contrasts across time, T_1 vs. T_2 results indicated, as expected, no significant difference between scores of pre-treatment well-being and admission ($F\{1,18\}=3.36$, $p=.083$, $\eta^2=.157$). Also as expected, concerning T_2 vs. T_3 results, analysis supported the hypothesis that well-being would increase, showing a significant statistical difference in BABS score due to treatment ($F\{1,18\}=6.49$, $p=.020$, $\eta^2=.265$). When examining the difference between waitlist and discharge (T_1 vs. T_3), results were also significant in their change ($p=.001$) supporting the hypothesis. It

appears changes in well-being could not be attributed to chance, but were highly relational to the effect of treatment the adolescent in their program.

When examining the well-being hypothesis by program, results showed the Adolescent and Family Program overall BABS results were significant ($F\{2.0,26\}=6.99$, $p=.004$, $\eta^2=.350$). Tests of within-subjects contrasts indicated there was a statistically significant main effect in well-being scores over time for participants in the adolescent program. Examination of well-being (T_1 vs. T_2) results did, as expected, show no significant value ($p=.358$), while treatment results (T_2 vs. T_3) indicated significant score changes for well-being ($F\{1,13\}=8.17$, $p=.013$, $\eta^2=.386$). The difference between waitlist and post treatment period (T_1 vs. T_3) well-being scores, according to the overnight stay program, was also highly significant ($p=.004$). The results of the quantitative analysis are consistent with the alternate hypothesis showing there was a measurable difference in well-being scores related to the treatment period.

According to the Adolescent Day Treatment Program, well-being outcomes were consistent with self-efficacy results showing that the results of BABS scores were not overall significant ($F\{1.18,4.73\}=2.24$, $p=.202$, $\eta^2=.359$). Contrasts of well-being across time for the day program did not support the hypothesis [T_1 vs. T_2: ($F\{1,4\}=18.78$, $p=.012$, $\eta^2=.824$); T_2 vs. T_3: ($F\{1,4\}=.416$, $p=.554$, $\eta^2=.094$); T_1 vs. T_3: ($F\{1,4\}=3.18$, $p=.149$, $\eta^2=.443$)]. This lack of support, as found in the SES results, may be due in part to the weak observed power as a result of few participants ($n=5$) for the Day Treatment Program. However, overall results for both programs of well-being and self-efficacy did, as previously cited, show significant results which appear to be related to the hypotheses.

Satisfaction

All 19 participants who completed the final set of self-efficacy and well-being data completed a youth satisfaction questionnaire (CSQ-Y). Mean scores on eleven Likert-based questions (M= 3.02, SD=.82 out of a possible 4 points) indicated above average to high satisfaction with services received. To answer questions on the CSQ-Y, participants circled corresponding numbers indicating how satisfied they were with various aspects of their program. Response options were coded as either: almost never satisfied (0), sometimes (1), often (2), usually (3), or almost always satisfied (4).

The highest collective rating awarded was attributed to participants' feelings that the staff were respectful (Q#10: M=3.47, SD=1.02). The lowest rating was given to the fact that the adolescents did not think the discharge/community care plan would provide the support they needed (Q#11: M=2.63, SD=1.42). Despite this lower satisfaction rating, statistically, the results are still above the mid-point of two. Results are also above average when compared to the satisfaction study conducted previously at Ledger (Tate et al., 2000).

In the present research, results showed adolescent participants were highly satisfied with program outings (Q#7: M=3.26, SD=.93), one to one counselling sessions (Q#9: M=3.11, SD=1.20), and friendship experiences in the program (Q#6: M=3.26, SD=.87). They were also able to see themselves as more worthwhile (Q#8: M=3.05, SD=1.13). Less satisfactory results (but still overall high scores) were given to the belief that it was still hard for the adolescents to talk about their feelings (Q#4: M=2.74, SD=1.05), that they were not fully involved in goal setting (Q#2: M=2.89, SD=1.05), that

they learned better ways to self-manage their behaviour (Q#3: *M*=2.95, *SD*=1.13), and that staff helped them to understand what was bothering them (Q#1: *M*=2.95, *SD*=1.27).

Overall, consistent with findings from the satisfaction research study conducted at QACCH (Tate et al., 2000), teens rated the quality of service received from their mental health program as "usually satisfactory" to "almost always satisfactory". Results showed this satisfactory rating was acquired over 81% of the time. Adolescents did not rate the program as high, however, in providing the same level of improvement in regards to personal issues, family, or community relationships (*M*= 71%). Still, as previously noted, all scores were within the above average range of satisfaction for all 19 respondents.

The relationship between satisfaction, self-efficacy, and well-being was examined quantitatively. Bivariate correlations were conducted to determine if overall high satisfaction scores were correlated with participants' levels of self-efficacy and well-being. Pearson's correlation coefficients indicated strong associations between satisfaction, self-efficacy, and well-being at discharge. Adolescents who were satisfied at discharge tended to have higher levels of self-efficacy ($r = .327$), although this relationship was not statistically significant. In addition, the more satisfied adolescents were at discharge, the higher the level of well-being they reported ($r = .528$, $p=<.05$). As expected, correlations between satisfaction and T_1 self-efficacy ($r = ¯.106$), T_1 well-being ($r = ¯.086$), T_2 self-efficacy ($r = ¯.018$), and T_2 well-being ($r = ¯.096$), were not significant. During these time periods adolescents did not receive therapy. Higher levels of satisfaction among adolescent participants are strongly associated with the higher levels of self-efficacy and well-being at discharge (T_3). A more in-depth examination to explain these correlations can be found in the qualitative analyses.

Qualitative Results

In order to examine the results of the qualitative data, the Constant Comparative method of analysis and its coding procedures (Strauss & Corbin, 1990) were used; first comparing core categories, then drawing up themes and axial codes within each inference, and finally, comparing themed categories for analysis. Responses were analyzed using Grounded Theory methodology (Glaser & Strauss, 1967; Glaser, 1993; Strauss, 1987) which stresses discovery and theory development from qualitative data obtained.

Consistent with the hypotheses, interview and focus group data showed that adolescents in general can describe in detail their treatment experiences, that they do convey relevant information concerning self-efficacy and well-being that is consistent with the significant quantitative scores received from the tests administered, and that they did describe in greater depth their level of satisfaction and/or dissatisfaction with treatment received than what the statistical results showed alone. The qualitative results did show that the participants found the interviews, as well as the focus group, helpful in evaluating and speaking about their experience and the effect that this had on their self-efficacy, well-being, and level of satisfaction with services received. Participants' indicated high levels of satisfaction and were descriptive in their explanations despite mental health restrictions to expressing themselves.

Interviews

Five core categories arose from responses to the 20 questions asked of patients in the interviews, namely; Satisfaction, Dissatisfaction, Self-Efficacy, Well-Being, and Retrospection. Each core category resulted in numerous themes arising from the data

(see Appendix 12 for a synopsis of thematic interview analysis). Themes were established from transcription analysis to 20 openly coded question responses. The following qualitative analyses describe question results.

Parts Liked, Question IA1 (Satisfaction)

In the satisfaction core category, when asked about what parts participants liked, eight themes arose, namely: food, rules and structure, respect, school, social experiences, outing and activities, treatment received and global satisfaction. The majority of parts liked were within three areas: program structure and consistency, outings and activities, and treatment received. Participants were satisfied with the structure and operation of the program commenting about free time, time to relax, allowances, stages of rewards/privileges, the safe environment, natural consequences, and flexible rules. The program outings and activities were also seen as highly satisfactory by seven participants (36.8%), however, a majority of interviewees (10 or 52.6%) specifically singled out the treatment they received (either in 1:1's, group, or milieu therapy) as the most satisfactory experience of their admission. These responses made up 30% of total question IA1 comments made. Some of these comments included, "conquering my fears", "trying to learn", "dealing with my problems", "getting help stopping my bad habits", productive and helpful 1:1's, "controlling my temper", and "group or therapeutic videos sometimes". These were all seen as highly satisfactory comments made by participants about their treatment.

Positive Experiences, Question IA2 (Satisfaction)

Six themes arose from positive responses to experiences participants recalled and reported to the interviewer, namely: therapy, social experiences, staff, school, group

activities, and program experiences. Most of the 28 responses coded (36%) involved positive social experiences in the program. For example, participants reported positive social experiences such as caring support received from others, "getting friends", learning how to be a friend, playing ping pong or guitar, and spontaneous silly play as all positive social experiences found with others. Other responses highlighted therapy as a positive experience ("learning such skills as 'I feel statements'"), school as a positive experience ("science", "math"), staff as a positive experience ("Staff support", "All the staff"), and overall program experiences ("Just being here"; "The whole thing"; "Coming to Ledger").

Counsellor Relationships, Question IA3 (Satisfaction & Dissatisfaction)

Six themes arose from counsellor relationship descriptions by participants, namely: "really good" relationships, therapeutically helpful relationships, "fine" or "good" relationships, a "fair" relationship, a nurturing relationship, and a poor relationship. A majority of participant responses were positive descriptions (32/39 or 82%). Many highlighted that it was the respectful relationship they felt from their primary counsellor that was the main reason for improved confidence and hopefulness. There were eight "really good" relationship explanations, with the majority (12/17) of participants explaining they felt their relationship with their counsellor was fine or good ("Nice usually"; "I could trust them"). Three older participants explained more specifically that the relationship they had with their counsellor was therapeutically helpful because, "They pushed me [in a good way]" and "I learned lots of stuff like anger management, self-esteem, and feelings". Two participants identified the nurturing they received from their counsellor as positive and indicative of a therapeutically helpful

relationship. Three stated the relationship they had was mediocre (i.e., "He sided with my parents more"; "We didn't do much"). There were three unsatisfied participants saying their relationship was poor as they used words such as "harsh", "sour", and even "horrible" to describe their relationship with their counsellor.

1:1 Experiences, Question IA4 (Satisfaction & Dissatisfaction)

Six themes emerged when participants were invited to comment on their 1:1 (treatment) experiences, namely: helpful, fun, talking 1:1's, "Good", "It depends", and poor. For the most part 18/19 participants (94.7%) either enjoyed their 1:1's or felt their 1:1's were helpful in sorting out their problems. One participant however, clearly spoke of the 1:1 times being "Not very good". He did not elaborate much on this explanation. There were eight explanations (26.6%) of the 1:1's being fun with their counsellor (i.e., "Going to the games room", "Playing computer", "Ping pong", "Bike riding"). Five participants (26.3%) specifically highlighted the talking portions of their 1:1's as "enjoyable", "interesting" or "helpful". There were three (15.7%) who, on the contrary, spoke of the talking 1:1 times as being "boring" but "necessary". These participants saw the value of the counselling time but would rather have "played" than "talked". For the most part, the majority of participants enjoyed or found their 1:1's satisfactory and helpful while at Ledger.

Parts Not Liked, IB1 (Dissatisfaction)

Four themes arose from analysis of the first question of the core category dissatisfaction. Here, participants were asked to explain what parts of the program they did not like. Five participants (26.3%) stated either "Nothing" or "Not much" saying, for example, "I liked the program. It really helps kids". Two responses highlighted the

difficulties they had with their peers in the program. However, the majority of responses (76.6%) emerged within two separate and distinct themes: program expectations and program operations. Fifteen responses, themed program expectations, highlighted respondents who struggled with the structure and expectations of the program. Here, three participants spoke of time outs and consequences received for their behaviour as unsatisfactory experiences, two respondents spoke of their treatment expectations as being undue pressure placed on them, and a fair number of responses (9/30 or 30%) highlighted the strictness of the rules and structure of the program stifling their freedom of speech, feelings, or not being able to speak their mind on certain topics. For example, one participant noted she did not like "how everything was so planned out" and appealed for more flexibility and autonomy.

Within the program operations theme, participants commented on a number of dislikes. The range of dissatisfactions included: groups, hockey games, having to sleep overnight at Ledger, quiet time, and school.

Disrespected, Question 1B2 (Dissatisfaction)

When participants were asked whether there were any times they did not feel respected, half of respondents reported "No". One reported, "I don't know" while nine participants (47.3%) reported "Yes" [there were times I did not feel respected]. Of those nine, seven identified issues with staff such as unfair treatment. For example, when the adolescent was given a time out he/she did not agree with he/she felt disrespected. Two adolescents reported disrespect from peers. For example, when they were laughed at by a peer or made fun of.

Negative Experiences, Question IB3 (Dissatisfaction)

Five themes arose when participants were invited to share a negative experience. The themes identified were: negative experiences with staff, with peers, with self, and negative experiences experienced from an activity. Three participants (15.7%) reported no negative experiences at all, whereas six negative comments about staff involved front-line counsellors and teachers. Some of these negative experiences revolved around time outs, misunderstandings, and "feeling judged". Six participants (31.5%) highlighted peer conflicts as negative experiences. And, most unusual were the three respondents who explained that the negative experiences they had were about themselves. These participants explained that, for example, when they themselves teased others, had attitude problems, or had physical ailments to deal with, that these were negative experiences for them.

Changes, Question IB4 (Retrospection)

Four major themes arose for the 34 responses to the question, "If you could make any changes to the program what would they be"? Recommended changes were themed: program structure, program treatment, flexibility, and no changes at all. Changes in the theme, program structure included suggestions such as higher allowances, more stages of rewards, more TV time, more outings, longer activities, shorter groups, and less school. Changes to program treatment included more 1:1's ("Because they usually help out the most", stated one participant), more family work, more groups, and "help with drug and alcohol problems for kids". Participants also wanted staff to be more flexible and less controlling. Here, 10 comments (29.4%) were made in regards to more freedom, more trust, age-appropriate opportunities (i.e., eating in rooms, staying up later, trust walks),

and less time outs. Three participants (15.7%) said that no changes were needed ("I'd keep the program the way it is"). One participant decided not to say what changes she recommended. "I'd rather not say", she commented. For the most part participants appeared to be contemplative and honest in their retrospection as they recommended changes to the program and future treatment to kids at Ledger.

Program Effectiveness, Question IIA1 (Self-Efficacy)

Participants were invited to reflect on the effectiveness of the program for them. Thirty responses were coded into four main themes: very effective, good, so-so, and poor. Fifteen times, or 50% of responses, participants used "Very", "Quite" or "Pretty effective" to describe the effectiveness of the program. Another eight (26.6%) responses included "Good", "Yes", "Yea", or simply "Effective" in their description of the effectiveness of the program for them. Two comments in the So-So category described, "A little bit effective" or "It depends". One participant felt her program served her poorly, answering, "Not very good". She did not elaborate further on the question. The analysis showed participants highlighted five axial coded themes to describe the adjectives "very", "effective", "good", or "so-so". Participants described help with self-regulatory skills (anger management, communication, and assertiveness), social skills (friendships), school, family relationships (parent-child, sibling, and family conflicts), and personal effectiveness (help with attitude, drugs, honesty, stress, anxiety, and respect) as evidence of program effectiveness.

Skill Increase, Question IIA2 (Self-Efficacy)

In the core category self-efficacy, participants commented on strength and skill increases as a result of their program experience. Four themes emerged from 32 coded

responses analyzed, namely: functionality, self-control, relationships, and self-awareness. Participants who spoke of sleeping better, less stress, relaxation skills, improved thought stopping skills, and scholastic improvements were categorized as more functional. Increased self-control was evidenced by four comments on anger management, four comments on increased assertion (i.e., "Saying 'No' to drugs"), and six general comments on overall increased self-control. These self-control comments made up 43.7% of all responses coded. Four comments on relationship enhancements highlighted sibling and parent relationship improvements. Six participants (31.5%) introspectively commented that while at Ledger they had seen improvements to their struggles with dishonesty, bragging, lying, irresponsibility, and unreliability. To note, two participants (10.5%) felt that there really was no change to their skills or strength than prior to admission.

Present Confidence, Question IIA3 (Self-Efficacy)

All 19 participants reported on their present confidence. Eleven (57.8%) reported that "Yes", they feel "more confident now". Five (26.3%) stated "A bit more" and "Kind of". Two (10.5%) admitted they were not sure and one participant said "No", explaining, "Confidence has never been an issue for me". Participants explained their present confidence when invited to elaborate. Answers explained that confidence had helped with social anxiety, that they could see improvements in managing their anger, and that their attitude had improved. School, friendship skills, and improvements in the family were also evidence of present confidence for some participants. The majority of respondents felt their confidence had increased as a result of individual and program treatment.

Future Confidence, Question IIA4 (Self-Efficacy)

When asked whether the participant felt this sense of confidence would last "six weeks from now", most respondents (12, or 63.1%) were less than optimistic. These participants felt "it depends" on various factors such as "practice at home", getting a job, peer relationships, and "managing my feelings". These respondents expressed, "I don't know", "I'm not sure", "I hope"; indicating a less determined optimistic sense of confidence as compared to results from question IIA3 about present confidence. Seven, or 36.8% of participants, did feel "pretty confident" that their confident feeling would remain, however they were quick to add the disclaimer, "as long as I keep doing what I'm doing now". No respondent felt things would be worse six weeks 'from now'.

Coping Skills, Question IIA5 (Self-Efficacy)

Participants probed whether they felt they would have the coping skills necessary to manage their problems when they were "older". Once again, there was a split in opinions on this question. Five participants (26.3%) thought they were "pretty sure" they could cope quite well in the future. As one adolescent commented, "I'm a lot more confident in my future [now]". Others commented, "Because I can problem solve better" or "Because I'll be more mature" to justify why they thought they would cope better when older. Eight (42.1%) felt good that their skills would still be available in the future: to "manage my anger", said one, "so I won't go to jail", said another! There were seven references to self-control (i.e., anger management skills). Four participants (21.0%) however, felt they were unsure that they would retain in the future the skills they had learned at Ledger. One stated that coping skills were never an issue for him and one felt

pessimistic for the future, identifying that his problems had not, and most likely would not, change for him.

Self-Worth, Question IIB1 (Well-Being)

In the core category, well-being, participants were first asked, "How have your feelings about yourself changed since you've been at Ledger". A majority of the 32 responses coded (68.7%) affirmed a positive affective change had occurred for adolescents. Still, there were four participants (21.0%) who felt their feelings about themselves had gone unchanged, making reference to low opinions of self, insecurity, or things remaining the same as they were at pre-treatment. Two (10.5%) were unsure of any affective change, while three (15.7%) explained that although their feelings were the same they had not been a problem prior to coming to Ledger (i.e., "I never really thought bad about myself"). From comments made about positive changes to feelings about themselves, participant responses were coded into three main themes, namely: feeling identification/expression, increased self-beliefs, and relationships. Five (26.3%) respondents specifically identified that they had "sorted their feelings out", had improved feelings for a family member, or could express their feelings more appropriately as a result of their admission. Numerous comments were made (11/32 or 34.3%) about an increased belief in themselves: "more courage", "more self-esteem", better understanding of their disorder, more active, feeling less "abnormal", and less "confused". Concerning relationships, three adolescents (15.7%) felt their feelings about themselves had changed because of improved family relationships during their program stay. The involvement of family, these participants stated, was key to their increased self-worth.

Self-Esteem, Question IIB2 (Well-Being)

The second of the four well-being core category questions requested an analysis of how participants felt the program helped them feel better about themselves. Eight themed categories arose, namely: self-awareness, self-appreciation, self-image, general evaluations, school, family, anger management, and friendships. Those responses entitled, "self-awareness", described a greater awareness of presenting difficulties for the adolescent, increased knowledge, coping skills, and understanding about themselves (i.e., "By giving me knowledge and experience"). Comments within the self-appreciation theme explained: "less put downs", more security, happiness, more confidence, and an increased positive affect for the participant. There were four general responses in the affirmative that the program had helped them (i.e., "It has" or "Quite a bit"). Two respondents (10.5%) were unsure of how the program helped them feel better about themselves. Other minor but important references in the analysis highlighted increased productivity and confidence in school, family relationships, anger management skills, and friendship skills now post treatment as evidences of how the program had helped with feelings of self-worth.

Changes to Self, Question IIB3 (Well-Being)

Five themes arose in the responses from the well-being question, "In what ways are you different now"? These themes include: more self-assured, improved affect, increased self-control, relationship enhancements, and those participants who were "unsure". Participants who were more self-assured (six or 31.5%) reported that they felt more mature, more self-confident, had more courage, were more assertive, more polite, "more clear headed than I was before", and had a positive attitude change. An improved

affect was represented by comments such as "Happier", "I'm more fun", "Less sad", and decreased anxiety. Four adolescents (21.1%) spoke of self-control changes: "Less hyper", "Less quick to anger", and more "Will-power not to fight". Participants explained that learning relationship enhancement skills had improved their relationships with caregivers, increased their social skills, helped with communication skills, and overall these participants felt their friendships had increased significantly. Whereas three were unsure of what ways they were different post Ledger, 84.2% were able to give specific examples.

Hopes, Question IIB4 (Well-Being)

Six themes describe the hopefulness participants had as a result of therapeutic treatment received from their program. Most hopes were those of purpose. Participants spoke of staying focused, keeping positive, and maintaining the success they had experienced as a result of their treatment. For example: "I hope I can try my best and succeed"; "That I will stay like this". Other respondents (five or 26.3%) hoped they would obtain employment or a good career. Five (26.3%) also commented on the new hope they had of making and keeping friends. One participant hoped the relationship she had with her parents would continue to improve and one hoped he would continue to control his anger so, "[I] don't get mad and start breaking stuff or throwing stuff around or tearing up the house".

Reflection, Question III1 (Retrospection)

In the core category retrospection, participants were asked three questions. The first question of reflection invited participants to hypothetically conclude what might happen to them had they not come to Ledger. Responses to this question produced six

themes, namely; a worsening of mental state, peer problems, family problems, anger issues, school difficulties, and an unchanged negative symptomotology. Whereas one participant felt he would still be happy, "playing with friends", most (94.7%) felt their biopsychosocial struggles would have either been the same (21%) or would have worsened (73.6%) if they had not come. Most responses (14/34 or 41.1%) to Question III1 were thematically coded 'mental health' because of the nature of their responses. For example, "I wouldn't talk about my feelings at all" or "I'd be really depressed". Many thought they would still be anxious, lazy, unhappy, untruthful, or unmotivated. Somewhat alarming were five (26.3%) who believed, had they not come to Ledger, their mental state would have worsened: "I probably could have ended up in a straightjacket"; "Suicidal"; or, "Dead".

Four responses (of 34; or 11.7%) spoke of continuing peer problems. These respondents felt they would still have difficulty getting along with others and in making new friends had they not come to Ledger. One participant thought that his family problems would continue and three participants (15.7%) highlighted their school difficulties would possibly get worse ("I think I'd be a wreck trying to still try to do school").

Advice, Question III2 (Retrospection)

Participants were invited to give advice to a friend if, hypothetically speaking, their friend "were coming to Ledger". Sagacious comments were themed: reassuring, "try", fun, and staff. Only one participant advised his/her friend to "not go", whereas all others made encouraging and/or reassuring comments. Most responses were themed reassuring because they advised future patients that Ledger was "helpful", a "great

place", a "good place", and "not a very bad place". Thirty percent of those reassuring comments recognized that being in the program was hard at first "but, it gets better" because they persisted with their program. Advice under the theme, "try", encouraged future clients to "behave", "curb your temper", "don't get into trouble, do your work", and "do what they [the counsellors] tell you and it'll help". There were four comments noting the enjoyment they received from the program. Future clients were enthusiastically advised, "You will have fun" and "The counsellors are nice", by those who had competed their program.

Final Thoughts, Question III3 (Retrospection)

The concluding question was an invitation to share any final thoughts before the close of the interview. This retrospective question surprisingly triggered 27 replies in some of the respondents namely: helpful comments, enjoyable comments, staff related thoughts, and reference to rules. Once again, a majority of comments were favorable, with 10 references to their experience being quite helpful. Some (three or 11.1%) even replied, "I'd come back". One shared how helpful he felt his program was by concluding with an impromptu verse from the song, Amazing Grace, as he sung, "Amazing grace. How sweet the sound. That saved a wretch like me". Eight participants (42.1%) wanted to specifically state how much fun they had at Ledger. Seven (36.8%) comments were made about the effectiveness and niceness of staff.

Satisfaction

Responses to the open-ended questions (Q#12, 13, 14) on the written portion of the Client Satisfaction Questionnaire-Youth Form indicated high levels of satisfaction with overall highly positive comments made. These written responses are consistent with

the quantitative scores of this scale reflecting above average satisfaction with treatment received. When asked what they thought would stay with them about their experiences in the program (Q#12), 84% of respondents made positive comments (n=16). Two participants made no comments (10.5%) and one made positive and negative comments (5.3%). "Nothing, except friends and maybe anger stuff (some)", wrote this participant. Some of the written positive responses to Q#12, *"What do you think will stay with you about your experiences in this program"*, include:

- "I think I will be more assertive".
- I think that my ability to have fun with other kids my own age will stay with me".
- "Everything".
- "Manners and anger management".
- "My 'I feel' statements and how some people in the world can be caring and nice".
- "The skills I learned about respect and negotiating out my problems with my parents will stay with me the most".
- "I think I will do better with school skills and social skills".

Written responses to Q#13 concerning what was most helpful included a high proportion of helpful comments (89.5%, n=17). One respondent (5.3%) made no comment while one recorded both helpful and not helpful comments ("Nothing except anger stuff"). Some of the helpful comments to Q#13, *"What has been most helpful to you about this program?"* included:

- "Learning assertiveness".
- "That I could actually talk to someone else".

- "Learning to keep my cool".
- "The one to one sessions in which I learned more about stopping so that I could better understand the social cues being given to me".
- "I'm off weed".
- "The counsilling (sic) done with my mom, me, and my counsillor (sic)".
- "It has made me a lot happier and less quick to anger".

Participants recorded a variety of written recommendations for the program to Q#14 on the CSQ-Y, *"What changes would make this Program more helpful to you"?* Four adolescents (21.1%) recommended therapeutic changes:

- "More 1:1's".
- "Students opinions being shared".
- "Shorter groups".
- "More family work".

Three (15.8%) participants recommended program or program rule changes:

- "Add more stages".
- "Eat in my room".

One (5.3%) recommended staff changes ("Staff talking too much"). Most (42.1%, n=8) recommended no changes (i.e., "Everything is fine", "Nothing really", "None. This program is perfect for anyone that needs help") while three of the respondents (15.8%) had no written comments recorded, indicating possible satisfaction.

Focus Group

Through the use of Constant Comparison (Strauss & Corbin, 1990), themed results of the focus group supported the overall quantitative SPSS results, the qualitative

CSQ-Y written questions, and the interview results. Participants found the focus group useful in exploring their level of self-efficacy and well-being post-Ledger and further commented on their experiences while in their program. Results are valuable, practical feedback for QACCH staff and management. The following section outlines the outcome and recommendations from the focus group that were shared with the Mental Health Operating Group management (October, 2002) and the Adolescent Program staff (November, 2002) at Ledger, QACCH.

From the 11 research participants expected to turn up for the focus group, eight actually showed. On average, focus group participants waited 12.26 weeks before attending this group with the average age being 14.3 years old on July 06, 2002 when the focus group was held. Seven boys and one girl attended the group which included six Adolescent and Family Program participants and two Adolescent Day Treatment Program participants.

This particular focus group was made up of three older adolescents who were seemingly articulate and interested in exploring their treatment process, wanting to communicate clearly their thoughts about what had worked for them. One participant, slightly younger than this first group, was very articulate and had some important things to offer but at times was distracted by his attentional problems. Two younger participants played off one another and had virtually nothing much to offer. Then, there were two younger peers, one who perhaps was not really attentive, and another who was really unable to communicate very much due to his anxiety. A majority of the comments appeared to be made by the four older adolescents, the three eldest having more or less

positive things to say, the fourth basically not seeing the program as totally helpful as he still struggles with the issues that brought him to Ledger in the first place.

Having previously signed consent forms, focus group participants were asked for their permission to audiotape the group with the understanding that information received was for group leaders only and would be destroyed once a report had been written. Participants were also made aware that any information they provided during the group would be shared with Ledger staff in aggregate form only, with confidentiality strictly maintained.

The group began after introductions and, approximately mid way through the process, was given a break to have pizza and other refreshments. The group reconvened and completed the remaining components quickly.

Prior to presenting each question category, there was a short presentation by one researcher as to some of the quantitative findings found to date in the research. Participants were then asked to hypothesize about mean self-efficacy and well-being scores as a result of their treatment. Participants agreed it could be expected that scores should increase as a result of treatment. They were then given an opportunity to state where they would score themselves post-treatment on a scale of one to ten. The average score for participants was 6.2 (scores ranges from a high of 8.75 to a low of 2.0).

The process of the group at this point involved one researcher sharing an outline of the information gathered from the T_1-T_3 data periods, via the questionnaires and discharge interviews, in six categories. The participants were then provided with a question and/or statement by another researcher and asked for their responses. There was no protocol as to how participants would respond, other than some basic ground rules to

the group. In situations where information was less forthcoming, or required further elaboration, participants were asked by name to respond.

FOCUS GROUP RESPONSES TO QUESTION CATEGORIES

Satisfaction

Focus group participants were informed that the CSQ-Y questionnaire and interviews had indicated that approximately 75% of clients said they were satisfied with their program overall. They were informed that some participants had said they were 100% satisfied while others were said they were 20% satisfied. It was reported that they had been satisfied with staff, the safe environment, helps with fears or anger, the activities, and the outings. The focus group participants were then asked the following:

- Were you satisfied with the help you received?
- Would you say that you are still satisfied now?
- What has stayed with you since discharge?

There was a split within the group as they spoke of their satisfaction post treatment. However, the majority of focus group participants continued to remain satisfied with their program. In response to these questions some of the group participants stated that they were satisfied with the 1:1's and the staff although they would have liked more one to one counselling time. Comments included: "I wasn't getting enough one to one's"; "More time would have helped". Other satisfied participants reported: "I'm still doing anger management", "Great", "Completely satisfied", "I hope I make it", and "Things got better for me part way through". All these indicated to the researchers that the majority of focus group participants were satisfied with their treatment program.

In response to researchers asking what has stayed with them about the program group, participants spoke of: "Music helps", "I'm still satisfied after three months", "Trying to learn more about my disorder", and "Working on relationships helped, but I see this as part of life pattern".

Dissatisfaction

The CSQ-Y questionnaire and interviews indicated that no one was completely dissatisfied. Focus group participants were told that the results showed some clients were dissatisfied with specific things such as the food, quiet time, time outs, strict rules, school/teacher, and so on. The focus group participants were then asked the following:

- Were there things you weren't satisfied with (didn't like)?
- Are you still dissatisfied?
- Are there things you wished had happened/had worked?

Here too there was a split within the group. Two participants were still dissatisfied with specific things; however, most voiced no real overall dissatisfaction with the program. In response to the questions and the list of things that some were dissatisfied with during their stay at Ledger, the group participants who were dissatisfied responded that things like school and food were understood to be things that you had to accept. But one person said that there should be more program choices based on age and need.

Well-being

Most clients had responded to the BABS questionnaire and interviews that their well-being had improved and that they now felt generally happier, not as confused. Whereas some did indicate that things were the same, or that nothing had changed, most

reported that as a result of treatment they were more self-assured, had increased positive affect, better self-control, and increased self-beliefs, for example. The focus group participants were then asked the following:

- Have your feelings about yourself remained the same/changed since you left the program?
- Would you say that you still feel better about yourself?
- Would you say you were able to talk more easily about your feelings now?

Of those who spoke up, the group was split as follows: three participants felt that their sense of well-being had increased, one remained the same, and one had experienced a decrease in his well-being. Some participants commented that, for those who rated their scores the same or higher, their well-being increased because of feeling better about themselves. They had learned useful skills, they reported. One participant spoke of her family changing as well, not just herself. This resulted in a significantly increased sense of well-being for her. For another, it was evidenced by the fact that he and his parents were talking more. One participant responded that he had some positive and some negative feelings since leaving Ledger; however, he felt that his current environment (peer pressure) had contributed to this and that he didn't learn enough skills while at Ledger to deal effectively with his anger. This person did acknowledge, though, that he was more aware of his responses to anger. He also said that he had some further work to do in this area and was more aware of his use of profanity. Another participant said that things had started to get much better and that his well-being was better recently. Another pointed out that the differences between home and Ledger are significant and that comparison is difficult. One young woman said that what made the most difference for

her success was her family involvement in the treatment process. This helped everyone understand each other better. She felt that they had all learned new skills by working together and were able to talk more easily now. Another person said that the program did not influence his level of well-being because it really was not an issue for him personally. This, by the way, was the same response he gave during the interview process.

How confident are you now?

Although the SES questionnaire had indicated a significant increase in self-efficacy, some participants indicated in the interviews that they were not necessarily as confident as they would like to be. Some said they were not sure. Most, however, said they believed they had gained confidence as a result of their program experience. Examples given briefly to the focus group participants were reports of more skills, strength to handle problems, confidence to make friends, ability to handle anger or manage anxiety, in the way that they communicate, expressing feelings, and get along with family members. The focus group participants were then asked the following:

- Has your level of confidence remained the same since leaving the program?
- Would you say that the program was effective in helping you to feel more confident?
- Do you see yourself as continuing to feel confident in future?

The group participants responded that in some cases confidence was not an issue for them to begin with. Several felt that their level of confidence certainly increased over the time they were at Ledger and that it still continues to do so. One person stated that she definitely had much more confidence about attending school and was now seeing school in a more positive light. She also spoke of an increased ability to make friends by

using the skills learned in the program. Someone pointed out that he thought he was becoming more confident as time went by, that it wasn't just because of his time in Ledger but that life experience contributed to the overall development of self-confidence. Other comments of note were participants explaining that self-confidence goes down if you don't use the skills you learned and also if things break down at home.

Experiences

To introduce the category of experiences, focus group participants were informed that research results showed that overall, approximately 90% of those responding to the CSQ-Y questionnaire and the interviews stated that being at Ledger had helped them. Most participants said that their program was a good experience. They felt the program was most effective in helping them with anger, social skills, managing feelings, being more friendly, and sorting out school issues. Other comments included having a better relationship with family, that medication helped, and that they were able to get off drugs.

In the focus group, the responses were mixed, but overall the majority reported that they found the program helpful and had learned from it. Six out of eight stated that they still had improved communication and assertiveness skills now, after Ledger. Some comments about choice and flexibility came up for the older participants in the focus group. Some of the routines of their program were criticized for inflexibility. Things like quiet time seemed immature to older clients. One person pointed out that he did not agree with some things that had been written about him in a report, although he did not register his concern at the time.

There was some discussion about what type of program worked best for individuals. Day programs seem to have a positive effect on some adolescents many

reported because, as some said, not having to live 24 hours a day with others who have more entrenched or difficult problems than they had was easier to handle. One said, being in a day program versus an overnight program might also help mitigate anger directed at another client. A statement was made about greater family involvement with the day program. This particular client found this very helpful for her. It was interesting that in-patient participants also made favorable comments about the effectiveness of a day program when compared to their overnight program experience. These participants indicated they would have preferred such a program to their experience.

Many focus group participants reported that they found the 1:1 sessions helpful. Some found 1:1 sessions more helpful than the group work, which was often seen as too long and even repetitive.

In general there were several comments about the routine and the rules, which were more than most people had in their own homes. Although there was agreement that younger clients likely needed this type of structure it was still a struggle for them to get used to it.

Comments about counsellors were made by focus group participants, who said that the effectiveness of the counsellor depended on who they were working with. Some were better than others, a few noted. Most, however, were helpful and nice, group participants explained. Four group participants still agreed that, on the whole, the program was very helpful and that staff were good and accommodating. Two persons seemed to learn something about their disorder/illness and really benefited from the education and treatment approach provided to them. One comment was made about the

novelty of the program wearing off after the first little while and the length of the remainder of their stay being more tedious.

Follow-up

The group was asked if the right questions were posed by way of the individual interviews and questionnaires. The participants generally agreed that "yes", the right questions were asked. There was nothing to add to the content of questions asked. There was a suggestion that more of "this thing be done", and that the program ought to ask adolescents their opinions more often. When asked whether any changes should be made to the admission process, the group focused on changes they would like to see to the programs. The following comments were made:

- There should be more warnings or suggestions of choice re: frustration (i.e., send them to their room, go for a walk, etc.).
- Adolescents should be trusted more often.
- Groups should be shorter.
- There should be more rewards and reinforcements.
- More options for anger management.
- More individual options (group, 1:1's, parent involvement, day versus overnight admissions).
- Allow things in rooms.
- Individualized programs.
- More 1:1's.
- Add more stages/levels.
- More family work.

When asked if there were other things that group members thought the staff at Ledger should hear, the following comments were offered:

- More support for adolescents who have drug and alcohol problems.
- More specific counselling is needed.
- There should be more opportunity for day program admissions.
- The program needs to expand so that "more people can be helped".
- There needs to be more focus and help for individual living skill.
- More bikes (start a biking group as an activity option).

What Adolescents Say

The former participants who attended the group had some things to say and wanted their impressions to be passed along. The following are the major messages/themes (as inferred by researchers) that group participants wanted to send to the staff and managers at Ledger:

- 'This has helped somewhat, I'm glad I came'.
- 'I'm satisfied'.
- 'If I use my skills my confidence will improve'.
- 'This was a good experience'.
- 'It was a safe place to explore issues and feelings'.
- 'Please understand/listen to me'.
- 'Teach me how to manage my feelings'.
- 'I have some recommendations'.
- 'Be more flexible, tolerant'.
- 'Do more research'.

- 'Help adolescents become more responsible and independent'.
- 'Expand the services to help more kids'.

Cross-Tabulation Results

Descriptive statistics were also examined on the information received by participants when asked in the demographic questionnaire (ADQ), *"What is your understanding of the reason(s) for admission"*. Using the SPSS program, multiple response values to participant responses for their admission were cross tabulated with diagnostic reasons for admission as recorded by the admitting psychiatrist on the patients' intake summary located in their medical chart. When summarized, 18 participant reasons for admission were established (see Table 5). Some of those reasons included anger, depression, coping problems, school difficulties, family problems, and behavioural problems.

Table 5

Participant Reasons for Admission

Dichotomy label	Count	% of Responses	% of Cases
Anger (hate, violence, rage)	3	9.1	15.8
Depression (isolation, suicidal)	4	12.1	21.1
Coping problems	2	6.1	10.5
School difficulties	4	12.1	21.1
Assessment/Observation	3	9.1	15.8
ADD/ADHD	2	6.1	10.5
Self-Confidence problems	2	6.1	10.5
Family problems	3	9.1	15.8
Hallucinations (auditory, visual)	1	3.0	5.3
Learning Disabilities (i.e., NVLD)	1	3.0	5.3

Drug and Alcohol (and cigarettes)	1	3.0	5.3
Desire (recommended or interested)	1	3.0	5.3
Anxiety (worrying)	1	3.0	5.3
Behaviour problems	2	6.1	10.5
Friendship skills	1	3.0	5.3
Attitude	1	3.0	5.3
Weight Problems	1	3.0	5.3
Total responses:	33	100.0	173.7

The psychiatrist reasons, often recorded within Axis I – V of the Diagnostic and Statistical Manual 4th Edition (DSM IV), included 19 differential diagnostic categories. Some of those categories included behaviour problems, social skill deficits, anger problems (Oppositional Defiance Disorder {ODD}, Conduct Disorder {CD}), Learning Disabilities, and family conflicts (see Table 6).

Table 6

Psychiatrist Reasons for Admission

Dichotomy label	**Count**	**% of Responses**	**% of Cases**
Schizoaffective Disorder	1	1.0	5.3
ADD/ADHD	9	8.7	47.4
Behaviour Problems	15	14.6	78.9
Social Skill Deficits	8	7.8	42.1
School Difficulties	6	5.8	31.6
Anger (Rage, ODD, CD)	13	12.6	68.4
Learning Disabilities (NVLD, LD's)	8	7.8	42.1
Suicide Risk (Self-harm, Suicidal)	4	3.9	21.1
Depression (Dysthymia)	6	5.8	31.6
Anxiety (Social, Phobias)	6	5.8	31.6
Family Conflict (Sibling, Parent)	7	6.8	36.8
Hallucinations	2	1.9	10.5

Developmental Delays (ASD, PDD)	3	2.9	15.8
Attachment Disorder	3	2.9	15.8
Friendship Problems	5	4.9	26.3
Tourettes Syndrome	1	1.0	5.3
Mood Disorder (Bi-Polar, AMD)	3	2.9	15.8
Head Injury	1	1.0	5.3
Eating Disorder	2	1.9	10.5
Total responses:	103	100.0	542.1

Examination of the cross tabulation results showed some agreement between participant and psychiatrist responses to reasons for admission. However, most often there was discrepancy between what the adolescent recorded when compared to what the psychiatrist listed as a reason for admission to hospital. For example (see Figure 2), in the case processing summary, Anger, only three matches (agreements) were obtained between participant and psychiatrist. There were 10 cases where anger was not recorded (52.6%) by the participant but was listed by the psychiatrist as significant reasons for admission. Clearly, 10 out of 13 participants with anger problems failed to recognize that anger was one of the major reasons for their admission to Ledger. It may be that the adolescent underplayed or denied the acuity of their struggles at admission or it is possible that the adolescent did not at that point have complete awareness of their issues.

Examinations of behavioural problems as a reason for admission showed only two matches between participant and psychiatrist. In 13 (86.7%) cases where the doctor recorded moderate to severe behaviour problems as reasons for referral, the adolescent participant did not agree. When cross tabulations were done concerning friendship skill problems, not one of the five psychiatrists' recorded reasons matched those of the adolescents. Of the four who were admitted because of the primary diagnosis being

depression, two adolescents recorded this as the main reason for admission as well. Of the six who were admitted for the co-occurring school difficulties reasons, not one participant recorded this as one of their reasons for admission. Two matches of five were obtained when examining family problems as reasons and only one of five agreed that coping problems (anxiety, phobia) were a reason to be admitted to Ledger. Clearly, there was often a difference of opinion between adolescent and psychiatrist as to why the participant was being admitted to hospital for mental health support and treatment.

Figure 2

Anger Cross Tabulation

			Anger (Aggressive, Rage, O.D.D., C.D.)		
			Yes	No	Total
Anger (hate, violence, rage)	Yes	Count	3		3
		% within Anger (hate, violence, rage)	100.0%		100.0%
		% within Anger (Aggressive, Rage, O.D.D., C.D.)	23.1%		15.8%
		% of Total	15.8%		15.8%
	No	Count	10	6	16
		% within Anger (hate, violence, rage)	62.5%	37.5%	100.0%
		% within Anger (Aggressive, Rage, O.D.D., C.D.)	76.9%	100.0%	84.2%
		% of Total	52.6%	31.6%	84.2%
Total		Count	13	6	19
		% within Anger (hate, violence, rage)	68.4%	31.6%	100.0%
		% within Anger (Aggressive, Rage, O.D.D., C.D.)	100.0%	100.0%	100.0%
		% of Total	68.4%	31.6%	100.0%

Note. Figure 2, taken from the SPSS v.11.0 descriptive statistics output, is an example of the 7 cross tabulations conducted.

CHAPTER V

Discussion

The present study addressed the effect the Adolescent and Family Program and the Adolescent Day Treatment Program, at Ledger House, QACCH, had on self-selected participants' efficacious feelings of competence and overall mental well-being. Obtained quantitative psychological outcomes of self-efficacy and well-being were linked to treatment process, as participants described their levels of satisfaction, dissatisfaction, and experience through questionnaire, interview, and focus group. The intent of the research was to conduct much needed adolescent participant-based research, highlighting the effect and experience of mental health treatment, on the adolescent. In the preceding chapter, the hypotheses were addressed as quantitative and qualitative data were reported on all 19 participants represented in this study. The present chapter briefly discusses the implications of those results, focusing on generalizations from the present sample, determining whether the findings fit with previous research cited in Chapter II, and noting contributions made to the field of mental health service evaluation research. A summary of the quantitative and qualitative findings are presented here, recommendations from the adolescents and researcher are listed, and suggestions for future research in mental health are presented for further discussion. The chapter concludes with comments on limitations found within the current research.

Generalizations

Despite some of the unsure comments at times by research participants, adolescent self-efficacy and well-being do appear to increase as a result of program intervention, as evidenced by the in-depth results from the scales, questionnaire,

interviews, and focus group. Indeed, the data from the scales and questionnaire alone showed significant statistical increases in feelings of self-confidence and hopefulness for the adolescent.

Regardless of caveats from previous researchers in mental health, it was clear that adolescents could describe their level of satisfaction and dissatisfaction with services received. The adolescents, through the interview process and focus group, gave competent descriptions to evidence their level of satisfaction with treatment. The qualitative data in this report provided rich in-depth interpretive research results explaining the adolescents' level of satisfaction found through their mental health treatment and the effect this satisfaction played on feelings of confidence and hope.

There is a significant role for the adolescent participant in the overall evaluation of clinical programs. The adolescent's view is an important source of information for practitioners and programmers of MHS. In addition to providing information about levels of satisfaction, the variables of self-efficacy and well-being can provide participant-based information which may help evaluate and modify program effectiveness. Results concerning adolescent participant self-efficacy and well-being do add an understanding of the short-term effect of psychiatric skills acquired and the resulting confidence the adolescent has to use those skills after discharge.

Research results clearly indicate that qualitative self-efficacy and well-being scores are in harmony with results obtained quantitatively. It appears there is a relationship between the process of treatment and outcomes of self-efficacy and well-being for the adolescent. Treatment process was linked to positivistic self-efficacy and well-being results, based on the evaluation of the participants' experience through

interviews and the focus group conducted. Meaningful treatment for adolescents highlighted in detail the participants' level of satisfaction with services received, their perception of change, and the feelings of confidence they had as a result of treatment. It has shown that combined quantitative and qualitative data are rich and more complete than when done separately.

The benefit of conducting both quantitative and qualitative methodological approaches to mental health research is to provide a more comprehensive meaning as to adolescents' level of satisfaction, their feeling of self-efficacy, and the overall emotional well-being received from treatment. These research results enrich data that would have been obtained via one methodology only. It is apparent to this researcher that ongoing research in adolescent psychiatry must investigate the mental health variables of self-efficacy and well-being by way of qualitative and quantitative measures to conduct complete and comprehensive adolescent mental health research.

There appears to be a significant role for the adolescent participant in the overall evaluation of clinical mental health programs. The adolescent's view is an important source of information for practitioners and programmers of MHS. All too often participant-based information is not obtained because adolescents are not asked. In addition to providing information about levels of satisfaction, the variables of self-efficacy and well-being can provide empirically-based information which will help evaluate and modify program effectiveness for future adolescents and families.

Overall, the majority of teens do rate the quality of mental health treatment as satisfactory to highly satisfactory. Adolescents who were satisfied at discharge also had high levels of self-efficacy and well-being. There appears to be a strong association

between satisfaction, self-efficacy, and well-being across time for participants in the program. Changes in adolescent self-efficacy and well-being are directly correlated with higher levels of satisfaction both quantitatively and qualitatively.

No one participant indicated he/she was completely dissatisfied with his/her program. Indeed, whereas there were a few pet peeves, most adolescents were glad they had come to Ledger. Most said they would recommend the service to a friend. This important information helps practitioners realize that despite all of the resistance prior to a typical admission (and even at times during the admission), in retrospect, most adolescents feel their program was worth the effort.

It also appears that adolescent patients, despite some staff or rule enforcement conflicts, do admit to high levels of respect from and for staff. Adolescents, who received in–patient and day program support and help from staff at Ledger, for the most part, were appreciative of the counselling given to them, feeling it helped them "become better".

Program outings and activities were seen as highly satisfactory for many participants. Indeed, in the interviews, the adolescents highlighted certain planned activities (i.e., movies, tag), as well as spontaneous activities (i.e., ping pong, playground play, sports), as enjoyable and a source of great satisfaction for them. Staff need to balance therapy with "fun" in order to continue to keep the adolescents invested in their program. Such a balance works best by inviting the adolescents to voice their interests and desires while at the same time raising areas for them to work on.

Numerous times, either in the CSQ-Y, interview, or focus group, adolescent participants clearly highlighted the 1:1's as being a source of strength for them. It was

during these times that the adolescents felt respected, felt satisfied, learned new skills, had skills reinforced, were able to talk about their problems, and had fun. It appears that a major part of the program experience for the adolescents was the 1:1 therapy that occurred for them. These 1:1 times did not necessarily have to be structured in-depth counselling sessions, the adolescents explained. They were just as productive, the teens reported, when "going for a drive" or "going for coffee".

There appeared to be a split of opinions among the adolescents concerning the strictness of the program. Many adolescents spoke of being restricted, treated young, or feeling stifled by the control of the staff and the rigid program rules. Many also, however, realized that, because of the setting and mix of kids at Ledger, having strict control was a good thing for overall safety and therapy for all. Still, where possible, flexibility was recommended by the older adolescents.

It was often surprising that the adolescent could identify and speak of the coping skills they needed to maintain their new increased mental health. Adolescents often commented in the interview, that they believed if they could continue with their self-management or self-regulatory skills, they would be able to cope better at home, at school, and in the community. Many appeared to know what they needed to do to maintain positive mental health. Many were cautiously optimistic that they could use their skills after discharge.

It appears that the majority of adolescents coming to Ledger have an increased positive affect by discharge. This can be generalized, not only by the difference in well-being scores pre- and post-treatment, but also from the qualitative results obtained from the interviews. In the interviews a majority of responses (68.7%) indicated the

adolescents believed they now had increased self-worth. Many of these participants spoke of improved feeling identification and expression skills, increased positive self-beliefs (courage, esteem, determination), and an overall positive emotional change. Some adolescents in the interviews gave examples of improved relationships, which had helped their sense of hope in themselves increase.

The current research showed a lack of agreement between physician and patient as to the main reasons for participant admissions to Ledger. It may be that before the adolescent was availed the opportunity for treatment they underplayed the reasons that brought them to hospital. This was highlighted by the cross tabulation results found in the SPSS analysis. It is interesting to note that many of these same adolescents who underplayed the necessity of their admission to hospital, admitted to the researcher by way of the discharge interview, that the treatment they received was effective in treating many of these same undisclosed concerns which had brought them to Ledger in the first place: such as struggles with depression, anger, anxiety, relationships, and competency. During the discharge interview it was apparent that the adolescent was much more comfortable speaking about these concerns now and often identified the need to be more honest and determined in using their new skills to maintain positive mental health in the future.

It was somewhat surprising to hear, at discharge, that the majority of interviewed participants (18/19) felt that had they not come to Ledger, they were sure they could have remained struggling with the problems that brought them there, or that the problems could have worsened. Clearly, at this point, the adolescents saw that they needed mental health intervention to help with their struggles. This was different, when compared to the

descriptive statistics, where results indicated that adolescents were not in agreement with psychiatrists' reasons for their admission to hospital. Whether adolescents were minimizing, denying, or simply ignorant about their struggles prior to treatment, now in the discharge interview, it appears the adolescents were willing to admit their struggles were greater than they believed them to be. Now, at discharge, they were willing to admit to themselves that the program treatment was an effective part of their increased self-efficacy and well-being.

Comparisons

The results of the research shown in this thesis may be considered valuable in satisfying some of the requirements of Canadian mental health quality assurance regulatory boards such as the Canadian Council on Health Services Accreditation and the Commission on Accreditation of Rehabilitation Facilities. Strong implications from the data appear to provide necessary hospital performance measurement criteria. Research data and analysis have shown quantitative and qualitative effects of treatment on the adolescent mental health patient, supplying necessary evidence-based feedback to practitioners, and the public, concerning the value of primarily publicly funded mental health programs.

Satisfaction

Outcome from the CSQ-Y and interview questions into satisfaction, support early Canadian mental health research results by Lebow (1982, 1983a, 1983b) as well as later Canadian satisfaction research conducted by Brannan et al. (1996) and Crossley et al. (1997). Lebow's research (1983a, 1983b) found that most mental health studies report 70% or more client satisfaction. He generalized, "rare is the report that shows otherwise"

(p. 242). Although Lebow's research was primarily adult mental health-based, the present research corroborates Lebow's thesis, finding over 80% of adolescent mental health patients were satisfied with the services they received.

As noted in the literature review of chapter II, the construct of satisfaction in mental health is largely undefined. It appears to lack a consensus of evaluation criteria. Despite this deficit, Lyons et al. (1997) demonstrated strong correlations could be found between participant perceived clinical benefits and mental health consumer satisfaction. The present research supports the correlation found by Lyons and associates (1997) as it has comprehensively shown that to study satisfaction, let alone measure satisfaction, there needs to be an investigation into the patient perceived therapeutic benefit from psychiatric treatment, and how this benefit complements perceived levels of satisfaction or dissatisfaction obtained quantitatively, to study adolescent satisfaction accurately. This study has clearly shown this correlation, through the rich qualitative data provided, which explain in detail where the adolescent participant felt their satisfactory feelings lie. Results also corroborate Sederer et al. (1995) thesis that clinical outcome assessments can correlate with satisfaction results as patients' functional assessment experience is researched.

Results have also tended to support Moos (1997) in his findings that, to measure mental health treatment, a program's social context needs to be researched to evaluate more effectively how treatment received influenced the individual's satisfaction. Questions in the interview, as well as the written portion of the CSQ-Y of the present study, probed the adolescents' social context by investigating peer experiences, program structure, activities, therapy, and meaning, the adolescent participant placed on contextual

experiences. Results were comprehensive and meaningful in their evidence to accompany positivistic scores. Results have also complemented the findings of Holcomb et al. (1989) which suggest that participants can discriminate areas of satisfaction, with adolescents expressing greater satisfaction with treatment staff than with the hospital environment.

The present results of the CSQ-Y complement the results obtained by Tate et al. (2000) at Ledger House. Both research studies showed that adolescents receiving mental health treatment from MHS at QACCH rated the programs with high levels of satisfaction. In both studies, when staff were seen as respectful, when participants were involved in setting their own goals, or when program outings were seen as fun for participants, satisfaction measures appeared to rise. Similarly, adolescent participants had fewer beliefs that the program had helped adequately improve personal issues or family or community relationships. Still, as found and reported in both studies, overall satisfaction was above the average range for adolescent participants.

Interviews

Results of the present research support the findings from Greenley et al. (1985) and Perreault et al. (1993) in which both quantitative and qualitative approaches are used successfully to study the effects of mental health program-based treatment. Greenley and associates' (1985) and Perrault and associates' (1993) main objective in their studies was to compare quantitative and qualitative satisfaction measures, determining if high satisfaction scores observed from quantitative measures were related to results obtained from interviews. They found, as has this present study, that the results did confirm the theses. Qualitative measures can confirm high satisfaction levels. Similarly, greater

levels of dissatisfaction and more specific reasons for that dissatisfaction were stated in the interview portions of both the current research and research findings from Perrault and associates (1993). Both studies also appear to show more detailed reasons for high levels of satisfaction, as specific explanations were given by the adolescents in the interview portion of the research.

Qualitative results of the present research, as primarily found within the interview data, also show more intimate details of the theory put forward by Crossley et al. (1997) and Kazdin et al. (1990). Their thesis argued that the relationship of the practitioner, namely the Child and Youth Counsellor and/or the Nurse therapist, is instrumental in determining an effective outcome for the adolescent. Interview results in the present study clearly highlighted this. On numerous occasions, the adolescents mentioned that it was the respect, nurturing, and challenges they received from their counsellor, that was a major catalyst of change for them. The adolescents appeared to have a great deal of respect and appreciation for the front line counsellor and attributed that relationship as a reason for their improved confidence and well-being.

Self-Efficacy

Past research has theorized that self-efficacy is important to study in adolescent mental health because many adolescents tend to perceive themselves as incapable of experiencing success or learning coping skills in anything but the simplest of tasks (Bandura, 1997; Seligman, 1990). Present research, especially results from interviews conducted in this research, have highlighted adolescent retrospection that personal mastery of skills (i.e., anger management, assertiveness skills, friendship skills, anxiety management), and observed successes over the course of their stay in the program, had

powerful outcome expectancies on their self-efficacy beliefs. Many adolescents said they now had the belief that they could successfully perform the behaviour needed (or exercise the effort) to experience success because they had seen gains by practicing the skills learned at Ledger and at home on the weekends. Such efficacious beliefs about one's skill level are congruous with the pioneering theoretical work of Bandura (1977), which demonstrated that positive correlations between therapeutic changes in behaviour can equate to measurable changes in self-efficacy.

Results of the current study have complemented findings from Sherer et al. (1982) and Kelley et al. (1997) which, in appraisals of self-efficacy, show strong statistical significance before and after treatment. The results from this present study also support the use of an altered self-efficacy scale, modified from Sherer and associates' (1982) original scale, as a reliable measure of general self-efficacy change over time in treating adolescents. Such findings are similar to results reported by Mallinckrodt (1992), where Sherer and associates' self-efficacy scale was used in their research, with an altered Likert scale employed.

Well-Being

The current well-being results from this research show similar findings to early well-being results as measured by Bradburn (1969) and more recently by McDowell and Praught (1982) and Smith (1995). The BABS, in this thesis, showed reliable measures of affect balance, showing overall positive emotional well-being results for adolescents. Results also support cross-sectional reliability reports as shown by Stacey and Gatz (1991) and Van Schuur and Kruijtbosch (1995) indicating that the BABS can be used effectively with adolescent populations as well as for adults. As a matter of fact, the

BABS showed to be the easiest scale to complete of all four used with adolescents in this research study, requiring few question explanations. The results of this research clearly show that well-being can be measured quantitatively as well as qualitatively, and should be investigated in future adolescent mental health research.

Focus Group

Hostick (1998) and Powell and Single (1996) recommended that, to evaluate participants' mental health experience post treatment, a focus group would be user friendly, therapeutic, comprehensive, and program specific in its evaluation. Similarly, the results of this study support Hostick's (1998) research, as well as current trends in mental health evaluation today, in bringing together mental health consumers to evaluate their treatment experiences as a group. Despite the value of such groups, to date it appears few adolescent focus groups have been conducted in mental health, making the current focus group results done by the researchers unique and valuable to QACCH management and staff. The adolescent participants who attended the focus group contributed a great deal of rich information and 'food for thought' in a short period of time. Despite the unusual make up of this focus group, many valuable insights were obtained from participants into perceptions of patient functioning and progress post treatment.

Contributions

Many researchers have argued that, because of the complexity of the phenomenon of the effect treatment has on the mental health patient, a satisfaction survey design is insufficient and incomplete to comprehensively evaluate the effect treatment has on the adolescent (Lebow, 1983a, 1983b; Holcomb et al., 1989). The present research

contributes adequately to the field of adolescent mental health research evaluation by providing multi-modal treatment results, measuring the specific criteria of self-efficacy and well-being, along with satisfaction and overall program effectiveness. More specifically, by conducting an adolescent focus group, the present research appears to fill the void noticed in mental health evaluations today. Whereas the results of this focus group complemented findings from the interviews and questionnaires, it was the feedback that participants gave as a whole that such a group evaluation method was helpful and appreciated by most adolescent participants and that in future more focus groups should be done, to ask adolescents their opinion of treatment.

Those who participated in the focus group were asked to comment on the types of questions (and question areas) asked of them in the research study. The teenagers felt that the right questions were asked. Knowing this can help other researchers as they do blended methodologically-based research to evaluate program and treatment effectiveness.

In the present study, it was evident that teenagers felt heard and validated. The adolescents appreciated being asked to participate in the research, not only as evidenced by the high number who said yes to the study (31 out of 42 invitations or 73.8% return rate), but by the many comments made at the end of the interview and in the focus group. This information alone is important to understand, when examining the effect of treatment on adolescent mental health.

Adolescent participants' feedback of their experiences in mental health helps researchers and practitioners understand how treatment is effective and what meaning the

adolescents place upon therapy or skills. The rich data provided to Ledger management and program staff can help to modify or enrich program and individual treatment.

Summary of Findings

Quantitative

There was a significant contrast in self-efficacy results between the control ($T_1 - T_2$) and the experimental period ($T_2 - T_3$). Overall, discharge (T_3) self-efficacy mean score was consistently higher than waitlist (T_1) and admission (T_2) (pre-treatment) self-efficacy scores for adolescents. Similarly, there was a significant contrast in well-being results between the control and the experimental period. Overall, discharge well-being mean scores for all adolescents were consistently higher than waitlist and pre-treatment scores. Repeated measures results by program showed interesting findings. Adolescent and Family Program analysis results showed improved effects in both self-efficacy and well-being mean scores for participants. Adolescent Day Treatment Program self-efficacy and well-being mean scores, however, were not significant.

A summary of the satisfaction data (N=19) resulted in above average to high satisfaction scores (M=3.02, SD=.82). Results showed this satisfaction rating was acquired over 81% of the time. Teens rated the quality of service received from their mental health program as "usually" to "almost always" satisfactory. Most participants were satisfied with the respect received from staff (M=3.47, SD=1.02), program outings (M=3.26, SD=.93), friendship experiences in the program (M=3.26, SD=.87), and the 1:1 counselling times (M=3.11, SD=1.20). Adolescents who were satisfied at discharge also had high levels of self-efficacy and well-being. Higher levels of self-efficacy and well-being are directly correlated with higher levels of satisfaction.

Qualitative

CSQ-Y

Most participants (n=16) wrote positive comments about their program experience in the written portion of the satisfaction questionnaire. Participants noted skill improvements in areas of self-management (i.e., assertiveness, anger management, negotiating skills), social skills, and friendship skills.

INTERVIEWS

Some adolescent participants were dissatisfied with specific idiosyncratic parts of their program. High levels of satisfaction, improved confidence, and hopefulness comments, however, dominated the interviews. Participants liked food, rules, respect, school, social experiences, outings/activities, and the overall treatment received. Participants didn't like program expectations (i.e., time outs, strictness of rules) and some program operations (i.e., groups). Adolescents explained that positive experiences for some were the therapy received, social experiences, staff relationships, school, and group outings and activities. Counsellor relationships were most often positive (82%). The 1:1 times were almost always (94.7%) either enjoyable of helpful. A number of changes (34) were recommended when participants were asked what changes they would like to make to the program (see Participant Recommendations). A majority of participants described the program as being effective in improving self-regulatory skills (i.e., anger management, communication, assertiveness), social skills, school success, and family relationships. Some participants also reflected that the program was effective in helping with attitude, mood, anxiety, dishonesty, stress, and drug problems. Participants described strength and skill increases in the area of functionality, self-control,

relationships, and self-awareness. Eleven (57.8%) reported they felt "more confident now". Participants were guarded about future confidence with the majority of adolescents (63.1%) saying it depended on things like skill practice, relationships, and "managing my feelings". There was a split in participant opinions as to whether they felt they would have the coping skills necessary to manage their problems when they were older. Still, many spoke of staying focused, keeping positive, and hoping to maintain the success they had experienced as a result of treatment. The majority of participant responses (68.7%) believed that their program had caused a positive affective change for them resulting in an increased sense of self-worth. This was manifest in areas of self-awareness, self-appreciation, self-image, school performance, feeling expression, and family relationships. A majority of those interviewed (84.2%) were able to explain and/or give examples of changes to self as a result of treatment. Participants concluded that, had they not come to Ledger, they would have experienced a worsening state of mental health, further peer problems, family problems, anger issues, and school difficulties. Most said that they would recommend their program to a friend.

FOCUS GROUP

Mean self-efficacy and well-being scores (M=6.2/10) for focus group participants (n=8) are representative of lower, but still improved scores of confidence and hopefulness due to treatment intervention. Most reported they still remained satisfied since discharge from Ledger (M=12.26 weeks). They were still specifically satisfied with 1:1's and the staff. Some were still dissatisfied with program idiosyncrasies such as food, quiet time, and time outs. Group participants were split in their belief that their well-being had increased. Those who spoke up described new found confidence in attending school,

making friends, and managing their anger. Some believed it depended on their continued use of skills learned while at ledger. There was some discussion amongst focus group participants about what type of program was more favorable: a day program or an in-patient program. Most, including in-patient participants, concluded that a day program had more advantages when compared to an in-patient program.

Recommendations

Participant Recommendations

There were a number of participant generated recommendations throughout the research. The following recommendations represent some of those heard from the adolescents. In the satisfaction questionnaire, participants recorded that the respect of staff is paramount to treatment efficacy. Relationships and partnering with the counsellor were main reasons for their improved confidence and well-being, the participants emphasized. Adolescents also commented that the activities, such as program outings and 1:1's, were enjoyable and helpful. More of this would have made their stay more manageable, they said. In the written portion of the questionnaire, participants recorded they wanted more 1:1's, shorter groups, and more privileges. Expressions of more family work were recommended by some participants.

The interviews recorded a variety of participant generated recommendations. Many adolescents agreed that the program structure was necessary, given the many adolescents with differing struggles; still, interview participants explained the structure was often stifling and hard to live with. Where possible, they pleaded for more flexibility, fairness, and less control from staff. More outings and activities were also requested as were more 1:1's. These were not only enjoyable but were seen as more

helpful than the therapeutic groups. Adolescents frequently asked for fewer time outs, more flexibility, and more options for negative consequences given. When invited to recommend changes to the program, participants specifically suggested higher allowances, more stages of rewards, more T.V. time, more outings, longer activities, shorter groups, and less school. Program treatment changes recommended by the adolescents included, more 1:1's, more family work, more therapeutic groups, and more drug and alcohol counselling.

Focus group participants also made a number of recommendations. It was clearly heard by the researchers that adolescents appreciated being interviewed and brought back to a focus group to tell researchers what they thought of treatment. Group participants recommended that this should be done more often. Such opportunities gave participants more opportunities to explain their levels of satisfaction, dissatisfaction, confidence from treatment, hopefulness as a result of treatment, and specific experiences. Focus group participants reiterated some previous recommendations heard, namely:

- More warnings before time outs given
- More choices given in consequences
- More trust to kids
- Shorter groups
- More rewards
- Less groups
- More 1:1's
- More parent participation and family work
- Day versus overnight admissions were recommended as more helpful

- Support kids with drug and alcohol problems
- Expand mental health services
- More life and livings skill should be taught

Researcher Recommendations

To obtain the high levels of return of data sets in T_1, T_2, and T_3 time periods, the researcher needed to be highly organized and on top of all participants' admissions. Having a research assistant to co-ordinate this would be an asset in future research into adolescent mental health treatment.

Feedback from the interview concerning advice the participant might give to a hypothetical friend was rich. Collating the answers to this question and making them into a handout for new adolescents would be creative and helpful. Such a handbook might help the new admissions with their anxiety about coming into Ledger, helping them to settle quickly knowing the feelings and advice from a cohort group that experienced the program before them.

Cross tabulation results conducted on patient and psychiatrist reasons for admissions showed little agreement. This interesting outcome encourages future research to tease out differences and examine differences to the overall results. This may prove useful for future research and treatment. For example, interesting questions may be: Do participants, who list (or who do not list) depression as a main reason for admission to a psychiatric hospital, have decreased self-efficacy and well-being scores prior to admission? Do their depression or anxiety levels remain constant throughout the admission period? Or, do they decrease as levels of self-efficacy and well-being

increase? Further research into the meaning of these cross tabulation results would be helpful.

When answering a question in the interview, about future confidence, many participants were less sure about how they would be doing in the future in managing their problems. Many participants felt "it depends" on various factors such as "practice at home", getting a job, peer relationships and "managing my feelings". These respondents (63.1%) expressed, "I don't know", "I'm not sure", "I hope", indicating a less determined optimistic sense of confidence. Research of a more longitudinal nature (i.e., 1 year, 3 years, 5 years) would be helpful in tracking changes and progress of these and future adolescents. Future mental health research might need to be more participant specific. For example, inviting the adolescents to report on how they have done while providing them with individual feedback from the analysis on their scores, interview results, and/or focus group comments obtained. Do they still have the same hopes, feelings, and desires? Are their skills still intact? How are they doing with their family, at school, with friends? How are their feelings of self-worth and confidence? All of these longitudinal follow-up questions would be useful in researching the lasting effect the program and individual treatment has on the adolescent.

Some of the more cogent messages heard from the adolescents included the recommendation that more research be conducted; that adolescents should be asked their opinions more often. Research participants, especially focus group adolescents, suggested that "more of this [kind of research] be done". Adolescents felt the program should ask kids their opinions more often. Adolescents should be asked to comment on their mental health treatment by way of interview and focus group more often, to seek

program evaluation results responsibly. Future research into program evaluation, or into mental health treatment effectiveness for the adolescent, must include the youth clients' perspective to determine results accurately. To be comprehensive, when researching satisfaction, such research must include an examination of the variables of self-efficacy and well-being. Excluding adolescent patients' opinions of these treatment variables, in future mental health research, leaves reports on treatment effectiveness incomplete. Furthermore, research evaluations into adolescent patient functioning, by focusing on parent's feedback only, is inaccurate and incomplete when conducting program effectiveness.

The following four recommendations are excerpted from the focus group report given to management and program staff October and November 2002:

1. Due to the nature and structure of this particular group in general (no choice in who attended), there was difficulty in getting the total group to concentrate. As a result, future MHS focus groups should be structured by age, and if possible, by mix of treatment needs, to ensure greater co-operation.
2. Mental Health Service adolescent focus groups should be no longer than 1 ½ hours. Snacks or foods should be provided either before or after the group.
3. Invitations to focus groups should be specific about the structure of the group. The ground rules should be clarified beforehand and participants should be asked to commit to a code of behavior in order to participate.
4. Mental Health Services should conduct focus groups on a regular basis, perhaps annually, as part of quality improvement and client satisfaction activities. There is an

opportunity to use the present focus group information as a base-line for conducting other adolescent focus groups in the future.

Limitations

Some of the limitations of the current research included the fact that participants involved were self-selected only, rather than randomly assigned to the research. This self-selected research approach was necessary to satisfy research requirements of the hospital, so that participants had a choice to participate or not in the research. As a result, the data collection period took some time to obtain an adequate sample size.

Unfortunately, few program comparisons could be done. Whereas it was not the primary intent of the research to conduct analysis into the difference between programs, it would have been a desirable research outcome. Information about the difference between the day program and in-patient programs' effect upon adolescents' self-efficacy and well-being may support the effectiveness of one program over another. This research may determine value and program cost effectiveness. Future research is still required to establish the effectiveness of the in-patient program compared to the day treatment program.

In collecting the sample for the Adolescent Day Treatment Program, participants' final numbers were fewer than anticipated. There appeared to be greater variability in patient admissions to the day program than to the Adolescent and Family Program. There were more admission cancellations to the Adolescent Day Treatment Program than admissions to the Adolescent and Family Program. There was more 'bumping' of scheduled admissions to the Adolescent Day Treatment Program, due to more emergent cases being referred. These 'replacement' cases had not been on the wait list to come to

Ledger and subsequently could not be included in the study because no T_1 data set was obtained.

Despite the fact that the Adolescent Day Treatment Program well-being and self-efficacy scores were inconclusive, they were simply representative of a very small cohort. Future research should be done to increase the number of these day program representatives, to see if results are in agreement with overall significant self-efficacy and well-being scores obtained for the Adolescent and Family Program. Further research may conclude that SES and BABS results received from the in-patient program are consistent with day treatment program results.

Research time periods may have been too long for some participants, as was the overall length of the adolescent focus group. Some adolescents may have been initially motivated by remuneration from the research, but often after reimbursement of the $15 for the data set information, all interviews appeared honest, contemplative, and insightful. One interviewee stated at the end of the interview he didn't care about the honorarium, he was just glad to tell his story. There were possibly two (of eight) focus group participants who only came because of the promise of pizza and the second $15 honorarium, as evidenced by one participant who needed to be asked to go shoot baskets part way through, due to his disruptiveness in the group.

The multi-modal research method was time consuming and labor intensive, as was the analysis of the qualitative data. Further research into the data obtained for this thesis, by other QACCH researchers, might tease out supplementary research specifics that might prove interesting and useful.

There were a few limitations to the adolescent focus group. This group appeared to last too long for the younger and more active participants. There was "too much thinking", stated one participant. While the group certainly enjoyed the abundance of snacks and pizza, the refreshments did provide an opportunity to sidetrack the discussion. A focus group is different from a therapeutic or subject-based group, and some participants were unsure of how the group would look. Early into the session, it became obvious that there were issues of group control, as some members were unable to take the session seriously. There was some contagion amongst two or three of the younger members and at times it was necessary to point out inappropriate behaviours. The leaders were at times forced into becoming somewhat directive in their group facilitation, which, although necessary in mental health group process, was not the desire of the research group leaders. Even given the above limitations to this focus group, there remains valuable information to be gained from continuing adolescent research groups. For the most part, participants felt that being asked to comment on and be part of a research study, as well as give feedback to the staff and managers at Ledger, was very beneficial for them. Participants felt good about being asked to participate and believed that the information they supplied would be of value. Clients appear to want to give feedback and feel in some cases that this is the right thing to do.

Conclusion

There is a significant role for the adolescent participant in the overall evaluation of clinical programs. The adolescent's view is an important source of information for practitioners and programmers of MHS. In addition to providing information about levels of satisfaction, the variables of self-efficacy and well-being can provide rich

participant-based information which will help evaluate and modify program effectiveness. Results concerning adolescent participant self-efficacy and well-being have added greater understanding of the short-term effect of psychiatric skills taught to adolescents at Ledger House.

In conclusion, the results of the present study support the idea that adolescent self-efficacy and well-being increase as a result of mental health program intervention. The results of this research have also shown that adolescent mental health patients can describe their treatment experience, and that the core categories identified, namely: satisfaction, dissatisfaction, self-efficacy, well-being, and meaningful thoughts, can be successfully linked to quantitative research results obtained. A positive relationship established between the process of treatment and quantitative outcome results of self-efficacy and well-being have added in-depth understanding concerning the effect mental health programs have on these important variables for adolescents. Furthermore, the results of the research obtained from the interviews and focus group have empirically shown that the adolescents did describe in greater depth their level of satisfaction and/or dissatisfaction with treatment received when compared to the results from the questionnaire only. Adolescents, for the most part, found the interviews and focus group helpful in evaluating the effect of their treatment program. Finally, research results have provided valuable, practical, evidence-based feedback for mental health programs and have set the standard for future research into adolescent mental health services.

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APPENDIX 1

Open Letter

"Invitation to Participate in Research at Ledger!"

How do kids feel about themselves?

How hopeful are you?

Will coming to Ledger help?

Are you confident?

We want to know about kids' feelings of confidence, hope and satisfaction. Will you assist us by filling out some questionnaires and answering some questions to help us better serve kids at Ledger?

Please contact Dale A. Ruttan on the Adolescent Unit at 477-1826 ext. 6447 to participate.

- PSSST: You can earn up to $30 by participating in this study

APPENDIX 2

Telephone Call Script to Waitlist Participants*

*Talk with parents/guardians first (because they may have chosen to not inform their child of the pending admission).

- Hello, my name is Dale Ruttan. I am a counsellor and researcher from Queen Alexandra Centre for Children's Health.
- Are you aware that you have been referred to the _____ program at Ledger? How do you feel about this? [Reflect, address concerns, ask questions.]
- Have you received a letter from me inviting you to participate in some research?
- The purpose of my research is to find out how kids feel about themselves and about the service they receive at Ledger. We want to know how you are doing before you come to Ledger and then how you are doing after you leave. This research is not part of the treatment program and is strictly voluntary. Are you interested in participating?
- *[If yes]* I will mail out a consent form for you to sign along with the questionnaires for you to fill out.
- *[If no]* Thank you for your time. We look forward to seeing you when you come in.
- You may call me at 477-1826 ext. 6447 (or mailbox 7041 to leave a message) if you have any questions or concerns.

APPENDIX 3

Adolescent Demographic Questionnaire

Name:_____ **Date:** _____

Date of Birth:_____ **Gender:** ☐ Male ☐ Female

Ethnic Background: *(check as many as apply)* ☐ Asian ☐ Canadian ☐ Hispanic
☐ First Nations ☐ Afro-Canadian ☐ East Indian
☐ Other, please specify _____

Brother's and Sister's: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Step Brother's and step sister's: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

School: ☐ Currently attending school ☐ Not attending school ☐ On correspondence
If not attending school, how long have you been out of school? _____
Have you ever been suspended? _____ Last grade completed: _____

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Re-married ☐ Living together but not married Other: _____

Present living arrangements: ☐ At home ☐ Live with other family members (i.e., grandparents) ☐ Foster home ☐ Other: _____
Have you ever lived in foster care? _____

What is your understanding of the reason(s) for this admission?

_____

_____

_____

_____

_____

_____

APPENDIX 4

Self-Efficacy Scale (Revised)
(Sherer et al., 1982)

Date:_____ Program: _____ Unit #: _____

Please check the appropriate number which best describes you.

Rating Scale:	Never True 0	Sometimes 1	Often 2	Usually 3	Always True 4

1. When I make plans, I am certain I can make them work.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
2. One of my problems is that I cannot get down to work when I should.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
3. If I can't do a job the first time, I keep trying until I can.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
4. When I set important goals for myself, I rarely achieve them.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
5. I give up on things before completing them.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
6. I avoid facing difficulties.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
7. If something looks too complicated, I will not even bother to try.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
8. When I have something unpleasant to do, I stick to it until I finish it.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
9. When I decide to do something, I go right to work on it.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
10. When trying to learn something new, I soon give up if I am not initially successful.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
11. When unexpected problems occur, I don't handle them well.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐

Cont'd

Rating Scale:	Never True	Sometimes	Often	Usually	Always True
	0	1	2	3	4

12. I avoid trying to learn new things when they look too difficult for me.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
13. Failure just makes me try harder.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
14. I feel insecure about my ability to do things.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
15. I am a self-reliant person.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
16. I give up easily.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐
17. I do not seem capable of dealing with most problems that come up in life.	0. ☐	1. ☐	2. ☐	3. ☐	4. ☐

APPENDIX 5

The Bradburn Affect Balance Scale
(Bradburn, 1969)

Here is a list that describes some of the ways people feel at different times. During the *past few weeks*, how often have you felt...

		Often	Sometimes	Never
a)	On top of the world?			
b)	Very lonely or remote from other people?			
c)	Particularly excited or interested in something?			
d)	Depressed or very unhappy?			
e)	Pleased about having accomplished something?			
f)	Bored?			
g)	Proud because someone complimented you on something you have done?			
h)	So restless you couldn't sit long in a chair?			
i)	That things were going your way?			
j)	Upset because someone criticized you?			

APPENDIX 6

QUEEN ALEXANDRA CENTRE FOR CHILDREN'S HEALTH
CHILD, YOUTH & FAMILY MENTAL HEALTH SERVICES
Client Satisfaction Questionnaire (Youth Form, Age 13-17 yrs.)

Date: _____ **Program:** _____ **Unit #:** _____

Please circle the appropriate number which indicates how satisfied you are with the various aspects of our Program.

Rating Scale:	Almost Never 0	Sometimes 1	Often 2	Usually 3	Almost Always 4

1. Did the staff help you to understand what was bothering you?

   0 1 2 3 4

2. Were you involved in setting your own goals?

   0 1 2 3 4

3. Did you learn better ways to manage your behaviour?

   0 1 2 3 4

4. Are you able to talk about your feelings more easily?

   0 1 2 3 4

5. Are your family members/caregivers able to understand you better now?

   0 1 2 3 4

6. Are you able to get along better with kids your own age?

   0 1 2 3 4

7. Were the Program outings and activities fun for you?

   0 1 2 3 4

8. Do you see yourself as a more worthwhile person?

   0 1 2 3 4

9. Were your individual (one-to-one) counselling sessions helpful?

   0 1 2 3 4

10. Were the staff respectful?

    0 1 2 3 4

11. Do you think the discharge/community care plan will provide the support you need when you finish this program?

0 1 2 3 4

12. What do you think will stay with you about your experiences in this Program?

_____

_____

_____

_____

13. What has been most helpful to you about this Program?

_____

_____

_____

_____

14. What changes would make this Program more helpful to you?

_____

_____

_____

_____

APPENDIX 7

Interview Questions

I Satisfaction and Experience

A. *Questions exploring a positive experience and satisfaction?*

1. What parts did you like about the program?
2. Tell me about a positive experience you had?
3. Please describe your relationship with your counsellor(s).
4. What was your experience with your 1:1's like?

B. Questions exploring dissatisfaction and experience

1. What parts didn't you like about the program?
2. Were there any times when you did not feel respected?
3. Tell me about a negative experience you had.
4. If you could make any changes to the program what would they be?

II Effect

A. Questions about self-efficacy

1. How effective has your program been in helping you?
2. How has your experience given you more strength or skills to handle your difficulties?
3. Do you feel more confident now? How so?
4. How confident do you think you will feel in 6 weeks from now? Please explain.
5. In managing your problems how do you think you will be able to cope when you are older?

B. Questions about well-being

1. How have your feelings about yourself changed since you've been at Ledger?
2. How has this program helped you feel better about yourself?
3. In what ways are you different now?
4. What hopes do you have about yourself now?

III Final thoughts

1. If you didn't come to Ledger what would you be like?
2. If a friend was coming to Ledger what would you tell him/her?
3. What else do you want to tell me about your time at Ledger?

APPENDIX 8

Letter of Information and Consent Form

You are being invited to participate in a study entitled, *"Evaluating the Effect of an Adolescent In-Patient and Day Treatment Program on Participants' Self-Efficacy and Well-Being: Psychological Outcomes and Treatment Process"*. This research is being conducted by Dale A. Ruttan. Mr. Ruttan is a graduate student in the department of Educational Psychology and Leadership at the University of Victoria. You may contact him if you have questions by calling 477-1826. As a graduate student, this research is part of the requirements for a Master of Arts degree and is being conducted under the supervision of Dr. Lily Dyson. You may contact the supervisor at 721-7816.

The purpose of this research project is to measure adolescent self-efficacy (i.e., confidence) and well-being (i.e., hopefulness). The effects of the Adolescent and Family Program and Adolescent Day Treatment Program are being evaluated by measuring youth's experience, satisfaction and outcomes to treatment. Research of this type is important because having an understanding of the adolescents' experience and feelings, from their perspective, allows for a better understanding of services to youth. This research will contribute to an understanding (from the adolescent's perspective) of which parts of the program are most and least helpful to youth. This feedback will help staff modify programs and interventions for the future.

You have been invited to participate in this study because we want to know how your confidence and feelings of hopefulness are before you receive treatment and then how you are doing after you leave. If you agree to voluntarily participate in this research your participation will include completing 4 questionnaires at 3 different times. Once while you wait to come into the program, another when you start and then just before you leave Ledger. These questionnaires will take you approximately 5 minutes each to complete. You will also be invited to an interview with the researcher to talk about your experiences in the program. Finally, there will be a focus group that we hope you can attend after you are discharged.

There are no known or anticipated risks to you by participating in this research. As a way to show appreciation for sharing information with us, $15 will be given to you at the completion of the questionnaires and interview. Another $15 will be given to you if you attend the focus group after you leave.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. In addition, should you agree to participate, you have the right to refuse to answer any questions you do not wish to answer. Should you not choose to participate or withdraw from the study at any time, your decision will not affect you in any way or affect any future help you may receive from us. If you do withdraw from the study your data will not be used in the analysis.

You should know that as a researcher I am also a member of the program staff. You are under no obligation to participate should you feel this relationship compromises you. If I act

as a primary counsellor to you in the program another counsellor will be asked to administer and compile the questionnaires.

In terms of protecting your anonymity your identity will be protected and your name will not be used in any data compiled or published. As a result of your willing participation in the focus group your anonymity is limited to those who will participate with you. However, the confidentiality of information learned about you, others, or your experiences will be expected to stay within the focus group and must not be talked about outside of the group time.

Your confidentiality and the confidentiality of the data is also protected. All data details collected will be seen by myself (the primary researcher) and Dr. Lily Dyson (UVic Supervisor). All data will be kept confidential and stored in a locked filing cabinet in the primary researcher's office. Original data from this study will be shredded (electronic files will be deleted) within 5 years. Statistical information compiled from this data will remain the property of Queen Alexandra Centre For Children's Health (QACCH). It will be stored in a password protected research computer in a locked office.

It is anticipated that the results of this research will be presented to a thesis committee and to QACCH Program Management and staff. I will be happy to provide a general summary of this research to you if you are interested at the end of the study.

In addition to being able to contact the researcher Dale Ruttan at 477-1826 (druttan@uvic.ca) or Dr. Lily Dyson, Uvic Supervisor and Professor, at 721-7816 (ldyson@UVic.ca), you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (721-7968).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher(s).

_____ _____

Participant Signature Date

_____ _____

Parent's Signature Date

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY IS TO BE RETURNED TO THE RESEARCHER.

APPENDIX 9

SPSS Computation Commands

Scoring the BABS

```
COMPUTE babs1.x = (babs1.2 + babs1.4 + babs1.6 + babs1.8 + babs1.10) -
(babs1.1 + babs1.3 + babs1.5 + babs1.7 + babs1.9).
EXECUTE.

COMPUTE babs2.x = (babs2.2 + babs2.4 + babs2.6 + babs2.8 + babs2.10) -
(babs2.1 + babs2.3 + babs2.5 + babs2.7 + babs2.9).
EXECUTE.

COMPUTE babs3.x = (babs3.2 + babs3.4 + babs3.6 + babs3.8 + babs3.10) -
(babs3.1 + babs3.3 + babs3.5 + babs3.7 + babs3.9).
EXECUTE.
```

Scoring the SES

```
RECODE
ses1.2 ses1.4 ses1.5 ses1.6 ses1.7 ses1.10 ses1.11 ses1.12 ses1.14 ses1.16
ses1.17 ses2.2 ses2.4 ses2.5 ses2.6 ses2.7 ses2.10 ses2.11 ses2.12 ses2.14
ses2.16 ses2.17 ses3.2 ses3.4 ses3.5 ses3.6 ses3.7 ses3.10 ses3.11 ses3.12
ses3.14 ses3.16 ses3.17  (0=4)  (1=3)  (2=2)  (3=1)  (4=0) .
EXECUTE.

COMPUTE ses1.x = SUM (ses1.1,ses1.2,ses1.3,ses1.4,ses1.5,ses1.6,ses1.7,ses1.8,
ses1.9,ses1.10,ses1.11,ses1.12,ses1.13,ses1.14,ses1.15,ses1.16,ses1.17) .
EXECUTE.

COMPUTE ses2.x = SUM (ses2.1,ses2.2,ses2.3,ses2.4,ses2.5,ses2.6,ses2.7,ses2.8,
ses2.9,ses2.10,ses2.11,ses2.12,ses2.13,ses2.14,ses2.15,ses2.16,ses2.17) .
EXECUTE.

COMPUTE ses3.x = SUM (ses3.1,ses3.2,ses3.3,ses3.4,ses3.5,ses3.6,ses3.7,ses3.8,
ses3.9,ses3.10,ses3.11,ses3.12,ses3.13,ses3.14,ses3.15,ses3.16,ses3.17) .
EXECUTE.
```

Scoring the CSQ

```
COMPUTE csq.x = (csq1 + csq2 + csq3 + csq4 + csq5 + csq6 + csq7 + csq8 + csq9 +
csq10 + csq11).
EXECUTE.
```

APPENDIX 10

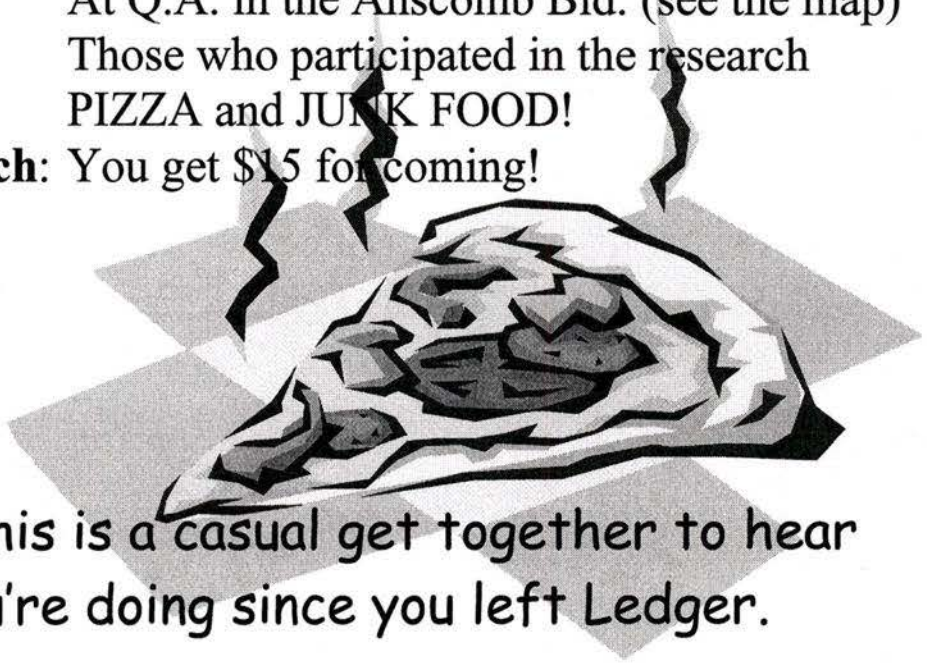
Focus Group Invitation

Hey, good to talk to you again!

I'm glad you can come to the Adolescent Focus Group!

Here's a reminder for you (and your driver):

When: Saturday July 6, 2002 from 4pm to 6pm
Where: At Q.A. in the Anscomb Bld. (see the map)
Who: Those who participated in the research
What: PIZZA and JUNK FOOD!
How much: You get $15 for coming!

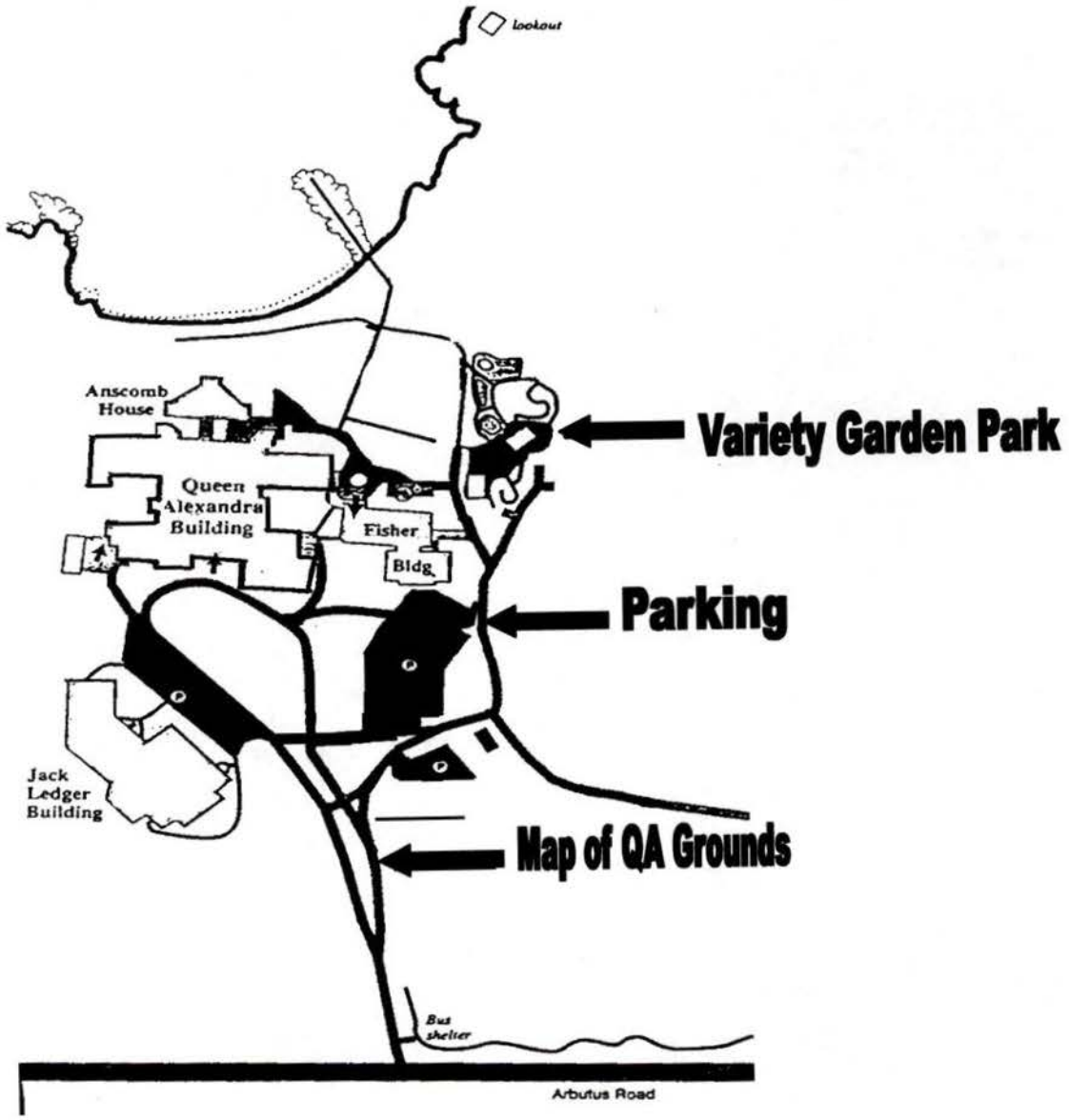


Remember this is a casual get together to hear how you're doing since you left Ledger.

I really want to know what you thought and how things are now!

APPENDIX 11

Focus Group Map



APPENDIX 12

Synopsis of Interview Thematic Analysis

Descriptive Question	Core Category	Theme and Frequency	Axial Code Sample	Response Sample	ID
IA1 (Parts Liked)	Satisfaction	Food (3/40)	Lunches	"I got to bring my own food".	02
(40 Responses Coded)		Rules & Structure (7/40)	Flexibility	"They were pretty flexible in my smoke breaks".	13
		Respect (4/40)	Staff	"…Treated me like family".	30
		School (2/40)	Academics	"School was O.K.".	08
		Social Experience (2/40)	New Friends	"Being around other kids".	30
		Outings & Activities (7/40)	Activities	"Going for coffee and drive around".	18
		Treatment Received (12/40)	1:1's	"Controlling my anger".	08
		Global Satisfaction (3/40)	Admission	"Just coming here is good".	05
IA2 (Positive Experiences)	Satisfaction	Therapy (5/28)	Learning Skills	"Using 'I' statements more".	07
(28 Responses Coded)		Social Experiences (10/28)	Friendship skills	"Getting more friends and learning how to be a friend".	05
		Staff (3/28)	Support	"That I've got a lot of positive feedback on my attitude from the adults".	10
		School (2/28)	Science	"Well, one day in school I did 28 pages of Science".	01
		Group Activities (3/28)	Spontaneity	"Having fun and us all just being ourselves".	22
		Program Experiences (5/28)	Happy	"The fact that I'm a whole lot happier now".	28
IA3 (Counsellor Relationships)	Satisfaction & Dissatisfaction	"Really Good" (8/39)	Respectful	"I really respected them".	24
(39 Responses Coded)		Therapeutically Helpful (4/39)	Challenged	"Pushes me [in a good way]".	04
		"Fine" or "Good" (17/39)	Nice	"I had fun with them".	06
		Fair (4/39)	"So-So"	"Didn't do much".	19

		Nurturing (3/39)	Relationship	"Made me bedtime milk and honey".	05
		Poor (3/39)	"Harsh"	"She can get pretty harsh sometimes".	08
IA4 (1:1 Experiences)	Satisfaction & Dissatisfaction	Helpful (4/26)	Learned Stuff	"He helped me get off weed and the drugs".	13
(26 Responses Coded)		Fun (8/26)	Games and Activities	"Playing pool".	01
		Talking (5/26)	Sorting out problems	"Talked about family stuff".	30
		Good (4/26)	O.K.	"It was good".	19
		"It depended" (4/26)	1:1's changed	"Some were boring; some we got a lot done".	22
		Poor (1/26)	Not good	"Not very good".	02
IB1 (Parts not liked)	Dissatisfaction	Program Expectations (15/30)	Rules	"How everything was so planned out".	22
(30 Responses Coded)		Program Operations (8/30)	Groups	"The groups were too long".	09
		Peers (2/30)	Conflict	"…Difficult being with other kids".	18
		Nothing (5/30)	No dis-satisfaction	"I liked the program. It really helps kids".	24
IB2 (Disrespected)	Dissatisfaction	Yes (9/19)	Unfair (T.O.)	"They're like, 'Go take 5 minutes'!".	13
(19 Responses Coded)		No (9/19)	No	"I always felt respected".	30
		Unsure (1/19)	Don't know	"I don't know".	09
IB3 (Negative Experience)	Dissatisfaction	Staff (6/19)	Teacher	"Dealing with my teacher".	10
(19 Responses Coded)		Peer (6/19)	Conflict	"S_____, fingering me!".	07
		Self (3/19)	Attitude	"…An attitude problem when I first came".	18
		Activity (1/19)	Un-comfortable	"Trying to play Dodge Ball…It was uncomfortable.	04
		Nothing (3/19)	Nothing	"Nothing".	29
IB4 (Changes)	Retrospection	Program Structure (15/34)	Shorter groups	"I find group boring".	08
(34 Responses Coded)		Program Treatment (4/34)	More 1:1's	"Because they usually help out the most".	03
		Flexibility (10/34)	Controlling	"Be more easy going".	05
		No Changes (3/34)	Nothing	"It's fine how it is".	30
		No Comment (1/34)	No comment	"I don't want to say".	02

IIA1 (Program Effectiveness)	Self-Efficacy	Very Effective (15/30)	Self-regulatory skills	"I had an anger management problem".	18
(30 Responses Coded)		Good (8/30)	Social skills	"I'm more friendly".	07
		So-So (2/30)	Depends	"I've learned some skills but not a whole lot".	19
		Poor (1/30)	Poor	"Not very good".	02
IIA2 (Skill Increase)	Self-Efficacy	Functionality (4/32)	Stress	"I can deal with my stress so much better".	18
(32 Responses Coded)		Self-Control (14/32)	Anger	"It's given me strength to be able to hold my anger".	08
		Relationships (4/32)	Sibling	"I'm able to ignore my sister".	30
		Self-Awareness (8/32)	Insight	"I'm more aware. I have more knowledge".	24
IIA3 (Present Confidence)	Self-Efficacy	Yes (11/19)	Attitude	"I'm not going to let anything get in my way".	13
(19 Responses Coded)		A Bit (5/19)	"Kind of"	"I feel a little more confident about some things".	05
		Unsure (2/19)	"I don't know"	"Here I do but when I'm in the community I'm not sure how I'll do".	28
		No (1/19)	No	Confidence has never been an issue for me".	10
IIA4 (Future Confidence)	Self-Efficacy	Yes (7/19)	Determination	"If I keep doing what I'm doing now".	13
(19 Responses Coded)		Depends (12/19)	Feelings	"I might get mad".	08
IIA5 (Coping Skills)	Self-Efficacy	Very Well (5/19)	Hopeful anticipation	"I'm a lot more confident in my future".	18
(19 Responses Coded)		Good (8/19)	Contemplative	"I'll be more mature"	22
		Unsure (4/19)	Maybe	"Hopefully me and my brother will get by the fighting stage".	01
		Poor (1/19)	No	"They (problems) havn't changed".	09
		N/A (1/19)	Not an issue	"I've always coped".	10
IIB1 (Self-Worth)	Well-Being	Unchanged (5/32)	Insecurity	"I'm still insecure"	28
(32 Responses Coded)		Unsure (2/32)	Not sure	"I'm not sure".	06
		Same- N/A (3/32)	Same	"I never really thought bad about myself".	01
		Feeling Identification Expression (5/32)	Expression	"I never used to talk to anyone".	05

		Increased Self-Beliefs (11/32)	Generalities	"I just feel better about myself".	18
		Relationships (6/32)	Friends	"I can make friends easier".	08
IIB2 (Self-Esteem)	Well-Being	Self-Awareness (4/25)	Understanding	"By giving me knowledge and experience".	22
(25 Responses Coded)		Self-Appreciation (7/25)	Security	"I don't have to push people away".	02
		Self-Image (3/25)	Self-image	"I used to always complain that I was fat".	03
		Evaluation (6/25)	Unsure	"I havn't really thought about that".	19
		School (2/25)	Productivity	"It actually brought me up in school".	05
		Family (1/25)	Relationships	"That we don't fight as much".	01
		Anger Management (1/25)	Control	"It's actually easier to control my anger".	08
		Friendships (1/25)	Making friends	"It seems like I'm making friends easier again".	08
IIB3 (Changes to Self)	Well-Being	Self-Assured (8/29)	Focused	"More clear-headed that I was before".	13
(29 Responses Coded)		Improved Affect (6/29)	Happiness	"I'm a lot happier now".	28
		Increased Self-Control (4/29)	Anger Management	"I got more will power not to fight".	03
		Relationship Enhancement (8/29)	Social Skills	"I'm more confident in talking to people".	30
		Unsure (3/29)	Not sure	"I'm not really sure".	01
IIB4 (Hopes)	Well-Being	Purpose (12/30)	Direction	"I hope I can try my best and succeed".	24
(30 Responses Coded)		Employment (6/30)	Job	"...Get a good job".	05
		School (5/30)	Education	"I hope I do better in school".	05
		Friends (5/30)	Friendships	"I hope I can get some more friends".	03
		Family (1/30)	Relationships	"As my relationship with my mom gets better it will with my dad too".	22
		Anger Management (1/30)	Anger	"So [I] don't get mad and start breaking stuff".	06

III1 (Reflection)	Retrospection	Mental Health (14/34)	Depression	"A depressed irritable bastard".	13
(34 Responses Coded)		Peer Problems (4/34)	Friends	"I'd still think that most kids hate me".	07
		School Difficulties (3/34)	School	"Farther behind in school probably	01
		Family Problems (4/34)	Relationships	"I'd still be arguing with my father".	10
		Angry (7/34)	Anger	"I'd still be a very angry guy".	29
		Unchanged (5/34)	Same	"The same as I was before".	19
III2 (Advice)	Retrospection	Reassuring (17/32)	Anxiety	"I'd say, 'Don't be scared. It will help you a lot'".	30
(32 Responses Coded)		Try (7/32)	Effort	"...Cause, if you don't, your not going to get anywhere".	18
		Fun (4/32)	Enjoyment	"You'll have lots of fun".	01
		Staff (3/32)	Counsellors	"Let the counsellors help you".	04
III3 (Final Thoughts)	Retrospection	Helpful (11/27)	Therapeutic	"I think I learned a lot".	04
(27 Responses Coded)		Staff (7/27)	Nice	"I'd like to compliment all the staff".	18
		Enjoyable (7/27)	Fun	"I really had a good time".	24
		Rules (2/27)	Strictness	"This things' like jail".	07

VITA

Surname: Ruttan Given Names: Dale Alan

Place of Birth: Port Alberni, British Columbia, Canada

Educational Institutions Attended:

University of Victoria	1998 to 2003
University of Victoria	1986 to 1988
Camosun College	1985 to 1986
Camosun College	1981 to 1982

Degrees Awarded:

B.A.	University of Victoria	1988

Honours and Awards:

CHR/VIHA	Scholarship	1998, 2001 & 2002
UVIC	Dean's Scholarship	1999, 2003
B.C. Post Secondary Scholarship		1985 & 1986

Publications:

Ruttan, D. A. & Denholm, C. J. (1990). (2nd Ed). *Barnyard bedlam and 149 others: Group leader's handbook of games and activities for children and youth.* Victoria, BC: Flynn Bros. Publishing.

Ruttan, D. A. & Denholm, C. J. (1989). Identification of difficult question domains for child and youth care students. *Journal of Child and Youth Care*, 4, 35-42.

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