AN ANALYSIS OF THE CORRESPONDENCE BETWEEN THE MEASURES COLLECTED BY AN AUTISM TREATMENT CENTER AND ITS STATED MISSION GOALS

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This study was a program evaluation for an autism treatment center for the period of April 2008 through August 2011. The study extended previous evaluations of the autism treatment center. The purpose of this evaluation was to determine the degree to which the center’s measures corresponded with its stated mission goals. A number of data sources were reviewed including client records of demographic and outcome information. Findings suggest the center maintained records that allow for the evaluation of most of its mission’s goals. There were, however, difficulties with data collection, storage, and retrieval. The present program evaluation found that missing information and lack of follow-up information hindered efforts toward mission evaluation.
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INTRODUCTION

An organizational mission is important. It can help an organization meet its intended goals, obtain funding and identify clients, in addition to guiding the organization through daily business. To determine the degree to which a program is achieving its mission, programs conduct formal evaluations. Lutzker (1994) identified the main elements of a program evaluation as being outcome measures, social validity, and the cost effectiveness of the program. The purpose of this paper is to provide an overview of a program evaluation carried out for Easter Seals North Texas. The purpose of the evaluation was to analyze correspondence between mission goals and collected measures.

The mission of Easter Seals, a nationwide, non-profit organization that helps millions each year, is to provide “exceptional services to ensure that all people with disabilities or special needs and their families have equal opportunities to live, learn, work, and play in their communities” (Easter Seals, n.d.c.) The north Texas region is home to four of the more than 550 Easter Seals locations nationwide (Easter Seals, n.d.a.). Each of these locations shares the main Easter Seals mission and provides a variety of service options (ex., outpatient rehabilitation, respite care, case management, workforce development, and homemaker services). Two of these locations also offer programs specific to families of children with autism through its Autism Treatment Program (ATP).

The ATP opened in April 2008 through a grant from Texas Department of Assistive and Rehabilitative Services (DARS). During the time of this evaluation, DARS
provided funding and oversight to the ATP and to six other autism treatment sites in Texas. Also, during the evaluation period the ATP has maintained a formal partnership with the Department of Behavior Analysis at the University of North Texas. As part of this partnership, Ph.D. level experts in the field of behavior analysis and autism treatment have provided program oversight; they have overseen research projects developed by students using a scientist practitioner model to benefit ATP; and they have served on a human rights committee made up of community members and professionals who meet to review ATP cases monthly. The ATP has a specific mission “to provide a comprehensive program utilizing evidence-based practices that is culturally responsive and collaborative in nature, for families of all income levels” (Easter Seals, n.d.b.). The specific mission goals are 1) to serve the underserved; 2) to uphold client dignity and maintain a positive, family centered, and culturally responsive atmosphere; 3) to provide evidence-based, effective services and service-learning opportunities; and 4) to create lasting change (Easter Seals, n.d.b.).

Evaluations vary based on type, model of approach, and methods by which they are conducted. Common types of evaluations are outcome-based and process-based. Approaches to conducting evaluations include the behavior engineering model (Gilbert, 2007), the completion of a performance matrix (Gilbert, 2007), and process mapping (Rummler and Bache, 1995). Gilbert’s behavior engineering model (2007, chapter 3) analyzes the environment and the repertoires of people within it paying special attention to information, instrumentation, and motivation while the performance matrix examines models, measures, and methods from six different vantage points. Process mapping
(Rummler & Bache, 1995) identifies disconnects in processes by creating flowcharts that describe processes at different levels (such as the organizational level, the process level, and the job performer level). Methods for conducting evaluations can be quantitative, qualitative, or both. A well planned program evaluation can be done in accordance with the 20-80 rule, conceptualized by Vilfredo Pareto (Hafner, 2001; Jones, 2011) which states that 20% of the effort yields 80% of the results. Some examples of the methods used when conducting an evaluation are observations, questionnaires, interviews, and document review.

There is no single way to run an evaluation nor is there one single purpose for conducting an evaluation. Lutzker (1994) provided several examples of evaluations of the program Project 12-Ways. Other examples include the evaluation of treatment integrity using a mixture of approaches through observation (Jamai, 2007); an outcome-based evaluation for an autism treatment completed by reviewing clinic documents and field research (Brunson, 2010); and an evaluation of agency goals including social validity through the use of questionnaires and document review (Pritchett, 2010). Evaluators should select the type of evaluation and approach based on their purpose for conducting the evaluation.

The purpose of this project was to conduct an evaluation for the ATP based on agency goals which combined processes and outcomes. More specifically, this project was designed to determine if the ATP has collected data and measures in alignment with agency goals and mission. I did not evaluate the agencies fourth goal area, providing lasting change due to the ATP’s lack of follow-up data. I did evaluate three goal areas:
serving the underserved; upholding client dignity and maintaining a positive, family centered, and culturally responsive atmosphere; and providing evidence-base, effective services and service-learning opportunities.

For each of the goal areas I considered relevant research and previous evaluations of ATP (Brunson, 2010; Pritchett, 2010) to assist in the identification of potential data sources related to each of ATP’s goals.

The first goal of the ATP is to serve the underserved (Easter Seals North Texas, n.d.). At the time of this evaluation, current estimates of autism prevalence in the United States are, on average, 1 out of 110 individuals (Rice, 2009). People diagnosed with an autism spectrum disorder may be white, black, rich, or poor (Cuccaro et al., 1996). However, research has suggested that black children, children from lower income families, and children who live in rural areas receive a diagnosis later than white children, children from higher income families, and children living in metropolitan areas (Mandell, Novak, & Zubritsky, 2005; Mandell et al., 2009). Thomas et al. (2007) suggested that even after being diagnosed, families may find it more difficult to access autism services if they live outside of a metropolitan area or if they are from a minority racial/ethnic background. In addition to discrepancies in receiving a timely diagnosis and ability to access services, Dunst (1993) identified correlations between specific factors (such as income, home ownership, parental health, etc.) and childhood outcomes. Pritchett (2010) evaluated the ATP and its progress toward reaching its mission. Pritchett assessed this first goal by analyzing demographic information of ATP staff and clients (including racial/ethnic background and languages spoken) as well as client risk factors. She found
that more action was needed to serve a sample representative of the North Texas general population.

The second goal of the ATP is to uphold client dignity and maintain a positive, family centered, and culturally responsive atmosphere (Easter Seals North Texas, n.d.). Autism is a disorder diagnosed in individuals but it affects families in many small and large ways. For example, morning preparation delays; draining resources; the likelihood of families eating together or of a family member living with and supporting an adult child are all increased when there is a family member with autism (Easter Seals, n.d.a.). When families are included in the intervention process (goal setting, implementation of interventions, selection of disciplinary methods, etc.) the intervention is more likely to align with the families’ cultural practices and beliefs according to findings by Brookman-Frazee and Koegel (2004). Including parents in intervention can also decrease parental stress while increasing child engagement (Brookman-Frazee & Koegel, 2004). In relation to this second goal Pritchett (2010) examined satisfaction of parents of ATP clients and the results of the Autism Program Quality Indicators (APQI; Crimmins, Durand, Theurer-Kaufman, & Everett, 2001) that had been completed by the lead behavior analyst at the ATP; she found that overall, parents of clients were “very satisfied” and that the ATP is a high quality program. Pritchett expressed concern that family involvement, parent training, and a strong curriculum were lacking. She suggested that the ATP include parents, especially on issues of child transitions and activities.

The third ATP goal is to provide evidence-based, effective services and service-learning opportunities (Easter Seals North Texas, n.d.). Many have demonstrated that
through behavioral interventions individuals with autism can learn important and meaningful skills, and in some cases can come to behave more like their typically developing peers (e.g., Lovaas, 1987; Howard et al., 2005). Research suggests that the most effective behavioral interventions have common features including that they: start early (as soon as autism is suspected); are intensive and long lasting (25+ hours per week for at least a year); maximize their teaching and learning opportunities; have low staff to child ratios (preferably 1-to-1); include some sort of parent training and peer interaction; and have repeated measures (e.g., Birnbrauer & Leach, 1993; Cohen, Amerine-Dickens, & Smith, 2006; Myers & Johnson, 2007) to assess the degree of effectiveness and evidence based services, measures of these variables are indicated.

In regards to Goal 3, Pritchett (2010) expressed concern that children did not receive the suggested number of service hours per week, though the ATP did get satisfactory marks on the APQI suggesting that it is a quality program. Brunson (2010) evaluated outcome measures used by the ATP during the first year of service and suggested that the ATP add additional measures such as standardized tests, parent reports, or post-intervention educational placement. Neither Brunson (2010) nor Pritchett (2010) assessed the service learning opportunities offered by the ATP.

The final goal of the ATP is to create lasting change (Easter Seals North Texas, n.d.). Children with autism have trouble carrying skills from the environment in which they were learned into their everyday environment and maintaining the skills after intervention has terminated (Chandler, Lubeck & Fowler; 1992). Brunson’s (2010) assessment of outcome measures did not specifically address measuring generalization or
maintenance of skills and gains made by client families. Some of Brunson’s suggestions, however, such as parental reports, and post intervention educational placement could be applied here to help measure whether ATP provides client families with gains that generalize and maintain to ease the worry often felt by loved ones of those diagnosed with an incurable autism spectrum disorder.

This paper presents the methods and results of my program evaluation for the ATP which aimed to extend the evaluations conducted by Brunson (2010) and Pritchett (2010). I extended the period evaluated by Brunson (2010) and Pritchett (2010) by including data starting with ATP’s opening in April 2008 through August 2011.
METHODS

Setting

At the time of this project the Autism Treatment Program (ATP) provided services in two north Texas locations, one in Carrollton and one in Oak Cliff. All ATP clients participated in direct behavioral therapy in one of the following programs: targeted early childhood program (children under the age of 5 who received less than 20 hours of service per week), comprehensive early childhood program (children under five who received 20 or more hours of service per week), or school age program (school age children who received eight hours of service per week). For the purpose of this study, I categorized clients into a program category of early childhood or school age as that was consistent with ATP’s method of identifying client enrollment for the time period evaluated.

Each ATP location had office hours Monday through Thursday 8am to 6pm: the Carrollton location offered direct behavioral services from 8am to 6pm and the Oak Cliff location offered these services from 10am to 6pm. In addition to direct behavioral services, each ATP site offered the following supplemental services: occupational therapy (OT), physical therapy (PT), speech and language therapy (SL), social work services (SW), and interpretation services. At times, additional auxiliary programs were available for families of children with autism outside of the context of the ATP programs discussed above. These programs included training for parents of toddlers suspected of having an autism spectrum diagnosis (Sunny Starts), training for parents of children with
autism who exhibited food selectivity (Yummy Starts), and a program to encourage play between siblings when one sibling had a diagnosis of autism (SMILE).

Each of the ATP locations provided services in small treatment rooms for direct behavioral therapy sessions and speech therapy sessions, one larger treatment room for 1-on-1 and group behavioral therapy sessions, two gyms for group activities and physical and occupational therapy sessions, a conference room that was used by the social worker for parent support meetings, and an office area where client families could meet with the social worker or case managers. The Carrollton location had large, fenced in playgrounds and a client kitchen (which was used for Yummy Starts as well as during client lunch and snack times). The Oak Cliff location had a separate play room for group programs (Carrollton had a similar play area in their large treatment room) and a library with computers. Pictures of these areas are available in Appendix A.

The ATP provided all services, regardless of the content area, with an approach that was behavior analytic in nature. Board certified behavior analysts (BCBAs) oversaw all cases and a human rights committee including professionals and community members met monthly to review cases. In addition to having a team of BCBAs, with a committee of community members and Ph.D. level advisors, ATP staff included individuals working toward their master’s degree in behavior analysis at the University of North Texas.

Data Sets

Before beginning data collection and at various points throughout the process of data collection I met with a variety of people to determine the best data sources and methods for collecting the data to be evaluated. I met with the vice president of
therapeutic and autism services, the acting director of the ATP, the director of the business office, and one of the speech language pathologists. I also had regular meetings with a Ph.D. level faculty advisor and another graduate student who assisted in data collection efforts. Throughout the data collection process case managers and the individuals mentioned above were invaluable in locating specific documents, understanding detailed processes, and explaining assessments that were beyond my area of expertise.

I accessed a number of sources to evaluate each of the ATP’s goals. To evaluate the ATP’s goal of serving the underserved I examined databases to determine certain client demographic information and client family risk factors. To evaluate whether the ATP upheld client dignity and maintained a positive, family centered, and culturally responsive atmosphere (the agency’s second goal), I examined parent satisfaction surveys. Goal 3 encompassed several areas; I evaluated the evidence based practices of the ATP using results from a modified Autism Program Quality Indicators (APQI; Crimmins, Durand, Theurer-Kaufman, & Everett, 2001); I evaluated the effectiveness of ATP using measures of child progress (standardized test scores, assessment scores, and number of goals taught and mastered); and I evaluated how comprehensive the ATP was by reviewing the number of services hours clients received. I looked at the number of projects and presentations completed by UNT students and faculty through the ATP location, and the number of people who received supervision hours for BCBA certification to analyze opportunities the ATP provided for service learning.
The majority of the information came from the records of ATP clients. I received funding to complete the activities involved in this evaluation and took special measures to protect the privacy of the clients whose data are included in this project. Nothing left the confidential areas of the treatment locations without first being coded so that no personal or identifying information was present on documents. Password protection was added to any electronic documents brought out of the treatment centers. The following sections provide a more in depth explanation of the methods used to analyze each data set.

From April 2008, when the ATP first opened, through August 2011, 120 clients had enrolled in ATP services. All clients had a diagnosis of an autism spectrum disorder or were suspected of having an autism spectrum disorder. This project examined the records of the 98 clients from 91 families who enrolled in the ATP direct child services. I did not examine the records of clients who only received supplemental or auxiliary services.

Many (81%) of the families whose data are included in this evaluation received funding for all services through a grant from the Department of Assistive and Rehabilitative Services (DARS), some (15%) were funded through other mechanisms, while the rest (4%) received services under the DARS grant as well as through other mechanisms. In compliance with the DARS grant contract (Easter Seals North Texas, n.d.), clients funded by DARS were between the ages of 3 and 9 years during their enrollment at the ATP. Clients funded through mechanisms other than DARS were not required to fall within specific age ranges during their enrollment. When clients funded
by DARS became ineligible to receive DARS funds (by turning 9 years old or surpassing two years of DARS enrollment), the clients could reapply for a non-DARS slot in the program. For purposes of this project, all client data were analyzed in the same way unless this was not possible due to information being unavailable (as was the case with standardized tests and service hours).

Goal 1: Serving the Underserved

To determine if the ATP met the goal of serving the underserved, I needed to know more about the ATP clients so I could compare them with the general population. I examined the ATP’s client records and gathered demographic information such as the race/ethnicity of the ATP clients, languages spoken by client families, income of ATP client families, and family risk factors associated with poor child outcomes.

Race/Ethnicity

Parents of ATP clients had a variety of opportunities to provide information regarding their race/ethnicity, though such information was never required. Some parents provided this information to the intake coordinator, others to the social worker during an interview about social history, and some (parents of DARS funded clients) had the option to report this information as part of the Pervasive Developmental Disorder – Behavioral Inventory (PDD-BI) which is a standardized assessment of children with pervasive developmental disorders that uses parent reports. When families provided this information (96.7% did), the person who received the information (the intake coordinator, the social worker, or the speech language pathologist administering the PDD-BI) entered it into the billing system used by the ATP. I obtained information on
client’s race/ethnicity from a report created within the billing system. To make population comparisons, I categorized the client list of race/ethnicity into the U. S. Census Bureau categories (white, black or African American, American Indian or Alaska native, Asian, native Hawaiian or other Pacific islander, and some other race) using the definitions provided in the 2010 Census Questionnaire Reference Book (U. S. Department of Commerce, n.d.). These categories are summarized in Table 1. It is important to note that the U. S. Census defines the classification of “Hispanic” is an ethnic category meaning that a person of any race can be Hispanic but the ATP did not distinguish between race and ethnicity in this way. I included the ATP families who reported being “Hispanic” in the “other” category. When calculating the percentage of ATP families who fell into each racial/ethnic category I used family information. This means that for families with more than one child enrolled in the ATP only the data from one child’s records were counted for this section. I then compared ATP family race/ethnicity with the race/ethnicity of the DFW area. I calculated the comparison data using U. S. Census data from Collin, Dallas, Denton, and Tarrant County information.

Languages

The individual who filled out the client’s applications (usually a parent of the client) wrote in the primary language spoken by each of the client’s parents and in some cases the languages spoken and understood by the child applying for ATP services. I retrieved information regarding the languages spoken by client families from the ATP application (Appendix B) kept in the client charts. I created a list of all the primary languages spoken in the home, as reported by client families. I calculated the overall
percentage of clients who spoke each language in addition to the breakdown of languages spoken by client families based upon the year in which clients first enrolled in the ATP. I used U. S. Census data from the DFW region, which showed that 27.55% of households speak languages other than English, as comparison data (U. S. Census, n.d.a.).

Income

The application for enrollment into the ATP (Appendix B) required that applicants report the adjusted gross income from the most recent tax year. In some instances (ex., if the child left the program and then reapplied or if a DARS funded child switched to alternative methods of payment) a client had more than one application for enrollment which reported different incomes. For the purposes of this project I analyzed the income listed on the application submitted prior to the initial enrollment date. I obtained family income from the client’s application for enrollment which was kept in each client’s clinical chart. To relate client incomes with the general population I averaged values reported by the U. S. Census for each fifth of the population from 2007 to 2010 and rounded to the nearest thousand. This calculation provided income brackets of $0-21,000; $22,000-39,000; $40,000-63,000; $64,000-102,000; $103,000-183,000; and $184,000+. I examined income information on the level of the client by analyzing the income of entering clients per year and overall years.

Risk Factors

The ATP director filled out a form that allowed for weighted prioritization of at risk children (Appendix C). This was done prior to admittance into the program using information provided on the application for enrollment (Appendix B). I obtained these
weighted prioritization forms from the client charts. I counted the following 11 categories of risk factors: single parent family; home ownership; parent education; occupational status; income; medical expenses; transportation; alternative caregiver/outside supports available; number of children in the home; number of children in the home with a disability; and parental health. I also counted two categories recently added by the ATP: functional communication and self-injurious behavior/aggression when this information was available. In some cases the form with this information was missing from a client’s file, when this happened I filled out a form for the client using the information in the client’s application. I then counted the number of risk factors if all information was available; I did not count risk factors if any of the original 11 risk factors were unknown due to missing information on the client application. Each category represented a possible risk factor, therefore a client could display anywhere from 0-13 risk factors. Table 2 outlines the criteria for each category to be counted as a risk factor.

Goal 2: Upholding Client Dignity and Maintaining a Positive, Family Centered, and Culturally Responsive Atmosphere

To assess the degree to which the ATP met their second goal, I examined the results of the Autism Services Satisfaction Survey (Appendix D). DARS administered this survey twice during the time period examined, once in 2009 and once in 2011. DARS contacted parents of clients (current and previous) via mail and over the phone. DARS removed all identifying information before responses were entered into a database by using a coding system. The survey captured basic demographic information about the respondent and the child who received services, information about perceived progress
made by the child, and information regarding satisfaction with services received. The survey measured perceived progress by using a 5-point Likert scale that rated progress from *none* to *excellent* in various domains including communication, self-help, and play skills. A 5-point Likert scale that ranged from *very unsatisfied* to *very satisfied* captured information regarding parent satisfaction with a variety of services such as parent training, in home services, and training on data review and evaluation. Parents also had the option to write in additional comments. These surveys were evaluated to find the percentage of ATP parents who had the same responses. I received the results of the parent satisfaction surveys from the vice president of therapeutic and autism services at the ATP.

Goal 3: Providing Evidence-Based, Effective Services, and Service Learning Opportunities

The third goal of the ATP is a complex one requiring the evaluation of several sources. I assessed how comprehensive the ATP was by examining the number of direct service hours each client received for behavioral services, OT, PT, SL, SW, and interpretation services. To see how effective the ATP was, I examined the results of an assessment of the ATP done by a DARS assessor using an adapted version of the APQI (Crimmins, Durand, Theurer-Kaufman, & Everett, 2001). I assessed the effectiveness of these services by analyzing results of client assessments and standardized tests. I assessed the service learning opportunities by examining the number of student projects and presentations completed at the ATP.
Comprehensive

DARS created a report that summarized the number of service hours received by each DARS funded client including behavioral services and the supplemental services. This report was run manually each month by the director of the business office using the billing system used by the ATP. I received these reports from the vice president of therapeutic and autism services and used them to calculate the percentage of enrolled DARS funded clients who received supplemental services each month. The ATP kept a client list that separated clients into behavioral therapy categories of school age and early childhood. If clients received services in both an early childhood program and the school age program, I categorized that client based on the program in which enrollment was longer. I calculated the average number clients who received behavioral services and supplemental services for each category each month from April 2008 through August 2011. I also calculated the average number of services received by early childhood and school age clients. The number of service hours included behavioral direct and indirect services in addition to supplemental services. The first two monthly reports did not show the number of service hours clients received, so the date range used for this analysis was June 2008 through August 2009.

Effective

I used the results from a number of standardized tests in addition to the Hawaii Early Learner Profile (HELP; Vort Corporation, 2004) assessment as well as the number of goals the ATP taught in comparison to the number of goals clients mastered to measure the ATP’s effectiveness. DARS required that clients who received DARS
funding take standardized tests starting in September, 2009 (DARS, n.d.a). The DARS required assessments included the Peabody Picture Vocabulary Test – 4 (PPVT-4; Dunn & Dunn, 2007), the Expressive Vocabulary Test – 2 (EVT-2; Williams, 2007), the Reynolds Intellectual Assessment Scales (RIAS; Reynolds & Kamphaus, 2003), and the Pervasive Developmental Disorders Behavior Inventory (PDD-BI; Cohen & Sudhalter, 2005) (DARS, n.d.a..). Some DARS clients also took the Psychoeducational Profile (PEP-3; Schopler, Lansing, Reicheler, & Marcus, 2005). DARS clients took these tests upon entry into the program; some took them again after six months of service, and again after each year of service. The ATP administered the HELP assessment, a normed assessment, to all clients (DARS funded and those not funded by DARS) upon entry and on every annual anniversary of enrollment, some clients also went through this assessment at other time intervals (such as 6 months and 18 months). Client scores were included in this evaluation if repeated measures of the test were administered within 2 months of the referenced time periods (ex, intake or after one year of services).

For assessments that yielded age equivalent scores (HELP, PPVT-4, EVT-2, and PEP-3) I used the method of displaying assessment data suggested by Romancyzk (2000) and used by Brunson (2010) and Stahmer and Ingersoll (2004). This method provides three trajectories for comparison: a typical trajectory, a treatment trajectory, and an expected trajectory. The typical trajectory shows that a typically developing child should have a developmental age that is identical to their chronological age. The treatment trajectory shows the development of ATP children from the initial assessment date to follow-up assessment dates using average ages at the time of tests and average scores.
The expected trajectory shows an estimation of the trajectory ATP clients would have followed had no services been provided. To calculate the expected trajectory, I first identified the average rate of development by dividing the average initial score by the group’s average age at the time of the first assessment. Then I multiplied the rate of development by the group’s average age at each follow-up assessment.

HELP Assessment

The HELP is a curriculum-based assessment for children ages 0 to 6 years of age. It is not standardized but it allows for naturalistic assessment of a child’s ability to complete tasks that are categorized across domains such as language, cognitive, fine motor, gross motor, social, and self-help. The HELP allows for adaptation for individuals with disabilities and provides a developmental age range in which skills are generally emerging in typically developing children.

The ATP staff administered the HELP by mixing opportunities for clients to demonstrate the ability to complete skills listed in the HELP Strands with trials of the child’s current programs. The coach marked each skill with “+” (if the child completed actions related to the skill), a “-“ (if the child did not complete actions related to the skill when presented with opportunities to do so), or “+/−“ (if the child approximated actions related to the skill when presented with opportunities to do so). If the staff did not present opportunities for the client to demonstrate the ability to complete a skill, it was either marked “n/a” (as is the case for certain strands related to use of sign language or a wheelchair) or that section of the HELP assessment was sent home to be completed by the client’s parents (as is the case for the self-help and social portion of the assessment).
The only skills reassessed in the future were those for which the child received a “-“ or a “+/-.”

The ATP case managers scored each domain according to the most basic guidelines outlined by Parks (1997) using the developmental age range of the first of three consecutive tasks not completed. If the client performed such that there were not three consecutive incomplete tasks, and the client was assessed with the HELP for children age 0-3 years, then the child was then assessed for that domain using the HELP for children age 3-6 years old. If that domain was already being scored using the HELP for children age 3-6 years old and there were not three consecutive incomplete tasks, then the age range of the last completed skill was used to describe the child’s developmental age. I obtained child HELP scores from the ATP databases when such scores were available. These scores were originally calculated and entered into the database by the case managers or trained ATP staff after administration of the assessment. I scored any HELP assessments that were complete but not entered into the database in the same manner described above. An assessment was considered to be complete if all domain sections had been assessed with enough information to be scored by ATP’s scoring criteria.

DARS Assessments

The speech language pathologist, administered the tests required by DARS, scored them in the standard method, and entered the scores into a database. The PPVT-4 is an assessment tool used to measure receptive English vocabulary. The EVT-2 assesses expressive English vocabulary and English word retrieval. The PPVT-4 and the EVT-2
both provide standard scores with an average of 100, a standard deviation of 15, and percentile ranks have an average of 50. These tests also provide a “growth scale value which is not standardized but shows the change of performance over time” (Pearson Education, 2011), and age equivalent scores that represent the average age range in which the child performed. The PEP-3 consists of ten subtests that yield two composite age scores for communication skills and motor skills. The RIAS is an intelligence test for individuals age 3 to 94 years old that measures verbal intelligence, nonverbal intelligence, and composite intelligence that can be compared with normative data. The PDD-BI is a caregiver report that rates child behavior to assess many types of behavior such as challenging behavior, appropriate social behavior, and learning skills for native English speakers. T-scores have an average of 50 with a standard deviation of 10. The Speech Language Pathologist provided me with client scores for each test which I analyzed and presented over time.

Program Goals

Case managers tracked the number of goals the ATP taught clients and the number of goals clients mastered. These numbers were kept in the clients electronic folders at the ATP. I evaluated the total number of goals taught to and mastered by all ATP clients. I also evaluated these numbers based on the program categories. I also looked at the average number of goals mastered by early childhood clients and school age clients.
Evidence Based

A DARS assessor completed a modified version of the APQI assessment during a review in the summer of 2010 after he examined client records, interviewed the ATP administrators, and observed client treatment sessions. I obtained the scores from this assessment from the vice president of therapeutic and autism services. This program evaluation examined these scores.
RESULTS AND DISCUSSION

The data obtained and analyzed for each of the three goal areas is presented and discussed below and is followed by a general discussion that contains overall findings and recommendations.

Goal 1: Serving the Underserved

*Race/Ethnicity*

For comparison purposes, Figure 1 provides a breakdown of the Dallas Fort Worth (DFW) population race/ethnicity and the race/ethnicity of Autism Treatment Program (ATP) families. Overall, the ATP serves minority populations that reflect white and non-white distributions in the DFW area.

However, the specific composition of race/ethnicity is not similar. “White” families represented 59.34% of ATP’s families and 62.8% of the Dallas Fort-Worth area (DFW) population; 10.99% of ATP’s families reported being “Black” compared to 16.25% in the DFW population; 5.49% ATP families reported being “Asian” compared to 5.96% of the DFW population. No clients fell into the categories of “two or more races,” “American Indian or Alaska Native,” and “Native Hawaiian or Pacific Islander” which make up respectively 2.91%, 0.68% and 0.09% of the DFW population. The “other” category consisted of 34.07% of ATP families compared to 11.21% of the general DFW population. Though ATP families who reported being “Hispanic” were included in the “other” category already discussed, they made up 13.19% of ATP
families; the portion of the DFW population that identify as being from a “Hispanic” ethnicity is 57.81%. It should be noted that ATP and the Census from which I obtained comparison data used different criteria. Although the data sets are difficult to compare due to ATP’s lack of distinction between race and ethnicity, it does not appear that all races/ethnicities are appropriately represented by ATP families. With the exception of the “Asian” and “Other” population, all race/ethnicities appear to be underrepresented by ATP clientele.

Languages

Figure 2 represents the languages spoken by ATP clients. On the top is a composite of all years, below are breakdowns of clients evaluated by the year they entered ATP. The majority of client records (77.55%) reported English as the language spoken in the home and 8.16% of client records showed that Spanish was the next most common language spoken among ATP client families. About 19% of client families spoke the remaining 11 languages: Telugu and Tagalog were each spoken by 3.06% of client families; Bengali, Hindi, Arabic, Urdu, and EleleC Nigeria were each spoken by 2.04% of client families; Chaldean/Aramaic, Russian, Portuguese, and Somali were each spoken by 1.02% of client families. Some families reported speaking more than one language in the home which is why the total of all languages does not equal 100%. I was unable to locate language information for 4.08% of ATP clients.

When looking at the languages spoken by clients entering ATP each year, the only obvious trend is that the percentage of English speaking client families has increased each year (from 70.6% in 2008 to 96.4% in 2011). Spanish was the second most
commonly spoken language in each year except for 2010 when no ATP clients listed it on their applications (ranging from 5.9% and tied with EleleC Nigeria in 2008 to 17.4% in 2009). While the overall percentage of ATP clients from Spanish speaking homes has increased (due mainly to a surge in 2009), the percentage of families who speak Spanish or other non-English languages remain underrepresented. In 2010 the percentage of entering clients who spoke a language other than English was split evenly three ways by those who spoke Portuguese, Telugu, and Urdu (7.7% of the entering population).

Income

Figure 3 provides a composite across years of the percentage of clients in each income bracket and the percentage of clients in each income bracket based on the year they entered ATP. ATP clients represented each of the six income brackets. The largest portion of clients (27.55%) fell into the fourth income bracket of $64,000-102,000, the second largest portion of ATP clients (17.35%) fell within the first income bracket $0-21,000, the third largest portion of ATP clients (16.33%) fell into second income bracket of $22,000-39,000, the third and fourth largest portions of ATP clients (13.27% and 11.22% respectively) fell within the third and fifth income brackets of $40,000-63,000 and $103,000-183,000. The smallest portion of ATP clients (5.10%) fell into the largest income bracket of $184,000+. The remaining 9.18% of clients did not have income listed within their files.

When I analyzed income information for each client based on the year they entered the ATP, the breakdown of clients in each income bracket did not show the same trend as the overall data. In 2008 the largest percentage of clients (35.29%) fell into the
lowest income bracket ($0-$21,000) and the smallest percentages of clients (2.94% each) fell into the income brackets of $40,000-$63,000 and $184,000+. In 2009 the largest percentage of entering clients (39.13%) fell into the income bracket of $64,000-$102,000 and the smallest percentage of entering clients (4.35%) fell into the income bracket of $103,000-$183,000. In 2010 the largest percentage of entering clients (53.85%) fell into the income bracket of $103,000-$183,000, the smallest percentages of clients (7.69% each) fell into $22,000-$39,000 and $184,00+, and no entering clients fell into the income brackets of $0-$22,000 or $40,000-$63,000. In 2011 the largest percentage of entering clients (25%) fell into the income bracket of $40,000-$63,000 and the smallest percentage of clients (3.57%) fell into the income bracket of $103,000-$183,000.

In September of 2010, ATP opened enrollment to clients not receiving funding through the Department of Assistive and Rehabilitative Services (DARS) which may explain the increase of clients with income between $103,000 and $183,000. Even with the inclusion of non-DARS clients, ATP has represented clients within each of the five income brackets created based on U. S. Census information. In 2011 ATP clients were distributed most evenly across income brackets.

Risk Factors

Figure 4 shows the ATP client risk factors with a composite of all years on top and the breakdown by year of entry into ATP. Overall, a majority of families have more than three risk factors. The largest percentage (30%) of client records reflected three risk factors, followed by 15% that reflected one risk factor, 14% that reflected had two risk factors, 13% that reflected 4 risk factors, 5% that reflected zero risk factors, 5% that
reflected five risk factors, 4% that reflected seven risk factors, 3% that reflected six risk factors, and 1% that reflected eight risk factors. No client records reflected more than eight risk factors and 9% of clients records did not have enough information listed in their chart to count risk factors. About 5% of ATP client records did not have the risk factors calculated but contained information that permitted either me or my colleague to count them.

Each year, the largest percentage of client records reflected three risk factors (ranging from 25% entering in 2011 to 32% entering in 2008). In 2008 30% of entering client records reflected less than three risk factors (though none reflected zero), 21% of entering client records reflected more than three risk factors (though none reflected more than six), and there was not enough information to count the risk factors of 18% of clients who entered in 2008. In 2009 53% of entering clients had less than three risk factors, 13% of entering clients had four risk factors, no clients had five, six, seven, or eight risk factors, and 4% of the records for clients who entered ATP in 2009 did not contain enough information to count risk factors. In 2010 53% of entering client records reflected less than three risk factors (23% reflected zero risk factors), 16% of entering clients reflected more than three risk factors (though no one had five or eight risk factors), and all records for clients entering ATP in 2010 had sufficient information to count risk factors. In 2011 18% of entering client records reflected less than three risk factors (though none reflected zero risk factors), 50% of entering client records reflected over three risk factors (21% reflected four risk factors), and 7% of the records for clients who entered the ATP in 2011 lacked information needed to count the risk factors.
Goal 1 Discussion

The ATP’s first goal is to serve the typically underserved population, which includes racial/ethnic minorities, those below the poverty level, and those with additional risk factors (such as mental illness, more than one family member with a disability, and those who display aggression and/or little functional communication). Findings suggest that ATP has served clients that fall into these underserved populations, though improvements could be made within subpopulations.

ATP has served clients of minority racial/ethnic backgrounds though minority groups (especially black and Hispanic individuals) were underrepresented. Many languages were spoken in the homes of ATP clients, however, English was over represented. Pritchett (2010) found that the number of ATP clients from Spanish speaking homes was 3% of client families. This percentage has increased, but ATP still does not mirror the 27.55% of families in the DFW comparison area that speak a (non-specified) language other than English (U. S. Census, n.d.).

There is diversity among ATP clientele in terms of household income. A shift in the DARS funding agreement to require clients with independent or third party payment options may hinder the ATP’s ability to reach that goal. The change in the DARS policy may have affected enrollment of families with lower income levels and higher risk factors. Additionally, the addition of two risk factor categories in 2011 may have had an effect on the changes in risk factors reflected in the 2011 data. Even with those changes, however, most client families had more than three risk factors. This was the case even in
years when large percentages of entering clients came from families with a higher income.

Perhaps it would be prudent for the ATP to reflect back on years when large percentages of clients from underserved populations entered the ATP. This could permit ATP to see if outreach techniques were different, or if changes in policy and funding have hindered the ability of the ATP to serve the underserved populations of the DFW area. Many of Pritchett’s (2010) suggestions still apply such as reaching out in low income areas with large populations of minority families and collecting additional, more specific familial information from applicants. Perhaps the ATP could turn to members of their Human Rights Committee to determine what community and advocate groups might assist in efforts to reach the underserved populations. ATP might also consider distinguishing between race and ethnicity to more accurately evaluate who the agency serves in comparison with the DFW area. This distinction could be made by asking about both race and ethnicity on the application for admission into the ATP.


Demographic Information From The DARS Surveys

Figure 5 provides information about the individuals who responded to the DARS surveys, how long they received services from ATP, and the number of service hours received per week. More mothers responded than fathers during both survey administration periods. The percentages were roughly the same across years with mothers making up about 94% of respondents (93.5% in 2009, 93.8% in 2011) and fathers making
up 6.5% of respondents in 2009 and 6.3% of respondents in 2011. DARS did not receive completed surveys from anyone who was not a parent of the child who received ATP services.

Based on the survey responses, the duration of enrollment by ATP clients increased from 2009 to 2011. In 2009 most respondents reported enrollment of more than four months but less than nine months (enrollment periods of 4-6 months and 7-9 months each consisted of 32.3% of responses), followed by those enrolled for more than nine months which consisted of 22.6% of responses, and lastly those enrolled for less than three months (12.9% of responses). In 2011 87.5% of respondents reported enrollment in the ATP for more than nine months, 6.3% of respondents reported enrollment periods between seven and nine months, 0% of respondents reported enrollment periods between four and six months, and 6.3% of respondents reported enrollment periods of less than three months.

In regards to the number of service hours clients received each week (which was captured using brackets of 0-5, 6-10, 11-20, 21-30, and 31-40), there was some change in responses across surveys. The most dramatic changes were seen in the brackets of 6-10 hours per week and 11-20 hours per week. The percentage of clients who reported 6-10 hours per week increased by 11.3% (38.7% to 50%) while those who reported 11-20 hours per week decreased by 7.4% (38.7% to 31.3%). Also, while 3.2% of responses in 2009 indicated that clients received 31-40 hours of service per week, 0% of 2011 respondents indicated that number.
**Perceived Progress Made By Atp Clients Based On The DARS Surveys**

Figure 6 provides the results of parent responses for child progress within the skill domains of communication, initiating social interactions, play, self-help, disruptive behavior, and family and life activities and overall. Generally speaking, most reported that their child made at least some progress in all domains and all parents reported seeing at least a little progress overall. Parents who responded to the 2011 survey reported more progress than those who responded to the 2009 survey in all domains with the possible exception of the domains initiating social interactions and self-help skills.

The percentage of parents who responded that progress with initiating social interactions was “excellent,” “good,” and “none” increased from 2009 to 2011 (from 45.2% to 50%, from 38.7% to 43.8%, and from 3.2% to 6.3% respectively) and those who responded progress was “fair,” “little,” or “not applicable” decreased from 2009 to 2011 (from 6.5% to 0%, from 3.2% to 0%, and from 3.2% to 0% respectively). The percentage of parents who responded that progress with self-help skills was “excellent” or “fair” increased from 2009 to 2011 (from 32.3% to 75% and from 9.7% to 12.5% respectively), those who responded “good,” “little,” or “not applicable” decreased (from 41.9% to 12.5%, from 6.5% to 0%, and from 9.7% to 0% respectively), and those who reported no progress remained at 0% for both surveys.

**Parent Satisfaction Of Services Based On The DARS Survey**

Figure 7 displays the results of parent responses for satisfaction of services within the domains of in home services, parent training services, and training on reviewing and evaluating child progress and overall satisfaction. Parents reported a high level of
satisfaction with ATP services in both years. Of concern however, is that parents responded that services in each domain were unavailable. Overall satisfaction with services ranged from “neutral” (6.5% of respondents in 2009, 0% in 2011) to “very satisfied” (90.3% of respondents in 2009, 93.8% of respondents in 2011). Responses seemed to improve from 2009 to 2011. When in home services were available to clients and their families, respondents reported the satisfaction level was either “very satisfied” (16.7% in 2009, 50% in 2011) or Satisfied (6.7% in 2009, 6.3% in 2011). Unfortunately, this was the domain that had the largest portion of parents (76.7% in 2009, 43.8% in 2011) report that the services were “not available”. Many parents (45.2% in 2009, 18.8% in 2011) also reported that parent training services were not available but again, those who received those services were either “very satisfied” (35.5% in 2009, 68.8% in 2011) or “satisfied” (19.4% in 2009, 12.5% in 2011). In 2009 some parents (19.4%) reported that training on reviewing their child’s data and evaluating progress was not available, 19.4% reported they were “satisfied” with this service, and 61.3% stated they were “very satisfied”. For this same domain in 2011 6.3% reported “neutral” satisfaction, while 93.8% reported being “very satisfied”.

According to parent responses of both surveys, it appears that that ATP provided services in a manner that was satisfactory to client families. There was no way to tell how many of the 2011 respondents also responded to the 2009 survey or how many of the respondents were current or previous ATP clients. With that in mind, the responses of the two surveys should be compared with caution.
It appears as though perceived child progress, parent satisfaction with services, and duration of enrollment have all increased from 2009 to 2011. The degree of child progress and duration of enrollment could represent improvements in the quality of ATP services or they could represent expected changes that come with longer periods of available services.

Of concern was the percentage of survey respondents each year who reported that in home and parent training services were not available. The percentage of these responses decreased from 2009 to 2011 suggesting that ATP may have improved in this area. ATP should continue to offer services for family member such as in home and parent training and efforts should be made to inform every family of such services.

**Goal 2 Discussion**

Although responses to this survey give some insight into client satisfaction and family involvement, they do not specifically address matters of client dignity, positivity, or cultural responsiveness and they include unrelated information such as client age at time of survey (which was omitted here due to the purpose of this evaluation). ATP may want to consider doing periodic “satisfaction checks” independent of DARS. Perhaps these checks could be done in the form of a qualitative interviews and independent rating mechanisms that address stress, confidence, cultural competence of providers and overall happiness. This would provide the agency with the opportunity to collect information regarding the degree to which ATP is helping with issues specific to familial or cultural values in a non-confrontational manner. Such knowledge could lead to more inclusive, family centered interventions that are beneficial to children and their families.
(Brookman-Frazee & Koegel, 2004). Additionally, the ATP might consider adding measures such as the number of ATP in-home visits and the number of billable hours for parent contact and training to allow for a better evaluation of the availability of such services.

Goal 3: Providing Evidence-based, Effective Services, and Service Learning Opportunities

The following sections pertain to information that is broken into the program categories, early childhood and school age, discussed previously. I identified 54 clients as early childhood clients and 41 clients as school age clients. Ten of the early childhood clients were not funded by the DARS grant and seven of the school age clients were not funded by the DARS grant for at least a portion of their enrollment. There was not enough information provided to classify three clients into a program category. The data below represents only those clients who could be classified into a program category.

*Comprehensive*

Figure 8 displays the average number of early childhood clients who received ATP services by type of service and Figure 9 displays the same information for school age clients. The top graph of each figure represents the average number of clients who received any type of ATP service (behavioral, interpretation, SW, OT, and PT) which was identical to the number of clients receiving behavioral services, the middle graph represents the number of clients who received interpretation or social work services, and the bottom graph represents the number of clients who received SL, OT, and PT services. The social work and interpretation services are generally services that are provided to
parents. It is important to remember that the clients represented here are DARS funded clients; clients funded through other means did not appear on the monthly reports available for this measure.

Early Childhood Clients

Enrollment into the ATP early childhood program began in April 2008 with just one client but grew steadily from that point on. The average number of early childhood clients enrolled per month was 11. The highest periods of enrollment for this program category were from April 2009 through July 2009 when 19 clients received services and the lowest period of enrollment was opening month, April 2008.

The number of clients who received SW and Interpretation services varied from month to month. The number of clients who used interpretation services remained more stable over time than those who used SW services. SW was used by more clients than Interpretation services. The average number of early childhood clients who received SW services per month was about four (range: 0-12). It is important to note that the average number of clients who used SW services per month is skewed by the fact that ATP did not offer SW services from November 2008 to May 2009 due to staffing issues. The average number of early childhood clients who used SW services for the months they were available was about five. The average number of clients who used interpretation services per month was one (range: 0-2).

The number of early childhood clients who received SL, OT, or PT services varied per month. Generally speaking, more clients received SL services than OT or PT services. The number of clients who received OT services was most variable over time.
On average about six early childhood clients received SL services per month (range: 0-11), four used OT (range: 0-9), and one used PT (range: 0-3).

School Age Clients

Enrollment into the school age program started in May 2008 with three clients. The average number of school age clients enrolled per month was ten. The highest period of enrollment for school age clients was March 2009 when 20 clients received services and the lowest periods of school age enrollment was in May 2008.

The number of school age clients who received SW or interpretation varied. More school age clients received SW services than interpretation services. That being said, the number of clients who received interpretation services was more stable than the number of clients who received SW services. On average, two school age clients received SW per month (range: 0-8) and one received interpretation services (range: 0-1). Again, the average number of clients who used SW services per month is skewed by the ATP did not offer SW services from November 2008 to May 2009 due to staffing issues. The average number of school age clients who used SW services for the months they were available was about two.

The number of school age clients who received SL, OT, or PT services varied per month. As was the case with early childhood clients, more school age clients received SL services than OT or PT services. On average, five school age clients received SL services per month (range: 0-10), one used OT (range: 0-5), and less than one used PT (range: 0-2).
Figure 10 reflects the average number and individual range of service hours clients received per month. Children in the early childhood program received more hours of service per month than school age clients. The range of hours received by early childhood clients was also greater than the range of hours received by school age clients.

Early childhood clients received, on average, between 50.65 and 109.5 hours of services per month with an average over all months of 77.91 hours of service per month. School age clients received, on average, between 23.78 and 51.31 hours of service per month with an average over all months of 40.52. The smallest number of hours an early childhood client received per month was .25 in November 2008, the largest number of hours an early childhood client received per month was 139.5 in December of 2009. The smallest number of hours a school age client received per month was 1.5 in May 2009, the largest number of hours a school age client received per month was 103.25 in September of 2009.

**Effective**

This section refers to child progress which ATP measured using a variety of assessments as well as by tracking the number of program goals clients were taught and mastered.

HELP Assessment

Table 3 provides a summary of the Hawaii Early Learner Profile (HELP) assessment records evaluated. Out of all 98 ATP clients, there were 16 client records that contained incomplete HELP assessments, 17 client records contained HELP with no date listed, and 25 client records contained unscored HELP assessments which my colleague
and I scored. A total of 22 client records contained HELP scores at intake and again after one year of services (give or take 2 months), 12 of these records were from early childhood clients and 10 were from school age clients.

Figure 11 provides a visual representation of the composite HELP scores for early childhood and school age children at intake and after one year of service. Both groups of clients improved their composite score at the one year mark. Early childhood clients had a greater average improvement and a larger range of scores than school age children. Children in each program category showed more rapid improvement with services (displayed as the treatment trajectory) than could be expected without services (displayed as the expected trajectory).

The average age of early childhood clients who had HELP scores at intake and after about one year of services was 51.25 months (range: 38.04-60.00) at the first time of the first assessment and 63.41 months (range: 51.00-74.04) at the second assessment. The average composite developmental age yielded for these clients at the first and second assessment according to their scores was 36.5 months (range: 10.7-65.2) and 53 months (range: 27.8-73.6), respectively. The developmental age after one year of services was greater than the developmental age that would be expected had no services been received (45.22 months) by 7.81 months.

The school age clients with scores reported within 2 months of intake and their one year anniversary of intake had an average chronological age of about 70.70 months (range: 36.96-96.96) at the time of the first assessment and 83.20 months (range: 60.00-108.96) at the second assessment. The average composite developmental age yielded for
these clients at the first and second assessment according to their scores was 41.72 months (range: 11.88-66.72) and 52.39 months (range: 14.64-74.04), respectively. The developmental age after one year of services was greater than the developmental age that would be expected had no services been received (49.10 months) by 3.30 months.

Figure 12 displays the average domain specific HELP scores of early childhood clients in comparison to the average scores of their typically developing peers and their estimated average developmental age had no services been provided. It is important to note that in each domain children performed better than would be expected had no services been received. Early childhood clients showed improvements on all HELP domains during their enrollment. Clients showed the greatest improvement (22.29 months) in the Self-Help domain scoring a developmental age 15.27 months higher than could be expected without treatment. Clients showed the least improvement (11.13 months) in the Fine Motor domain scoring .80 months higher than could be expected without treatment.

Figure 13 average domain specific HELP scores of school age clients in comparison to the average scores of their typically developing peers and their estimated average developmental age had no services been provided. In most domains children performed better than would be expected had no services been received. While it appears as though the greatest improvement occurred in the Social domain, that conclusion cannot be definitively made due to the fact that the HELP 3-6 has a ceiling of 74 months (six of the 12 school age clients reached that ceiling in the Gross Motor domain and four of them reached it in the Fine Motor domain).
PPVT-4 Assessment

Figure 14 displays the average age equivalent scores for three of the six early childhood and five of the six school age clients who took the PPVT-4 at intake, after six months of services, and after one year of services. The children whose data is not presented either had records with missing age equivalencies or had age equivalencies of “<2 years” which was not amenable to averaging. Both groups of children performed better than would be expected had they not received any services though the difference between the treatment trajectory and expected trajectory for school age clients was not as great as it was for early childhood clients.

Early Childhood Clients. On average and individually, each of the children whose data are presented in Figure 14 improved their standard scores, their growth scores, and their developmental age scores. The average chronological age of early childhood clients at the first, second, and third assessment was 55.96 months (range: 51.96-57.96), 61.96 months (range: 57.96-63.96), and 67.96 months (range: 63.96-69.96) respectively. The PPVT-4 yielded an average developmental age for these clients at the first, second, and third assessment of 33 months (range: 30-36.96), 42.64 months (range: 36.96-51.96), and 46.68 months (range: 39.96-53.04) respectively.

When looking at the raw scores of all six of the early childhood clients from the first to the last administration of the test, the standard scores improved (by 2-28 points) for four of them, declined (by 13 points) for one of them, and remained the same for one of them. The growth scale value improved from the first administration of the test to the last administration of the test (by 3-53 points) for all six early childhood clients.
**School Age Clients.** Of the school age clients whose data are included in Figure 14, the average chronological age at the first, second, and third assessment was 6.33 years (range: 5.67-8.08), 6.87 years (range: 6.42-8.58), and 7.32 years (range: 6.92-9.08) respectively. The average developmental age for these clients at the first, second, and third assessment according to their scores was 4.64 years (range: 3.67-6.67), 5.06 years (range: 4.08-6.75), and 5.62 years (range: 3.67-7.83) respectively.

Of the six school age clients, the standard scores improved (by 2 and 16 points) for three of them, declined (by 3 and 4 points) for two of them, and remained the same for one of them from the first administration of the test to the last administration of the test. The growth scale value also improved from the first administration of the test to the last administration of the test (by 5-77 points) for these clients.

**EVT-2 Assessment**

Figure 15 displays the average age equivalent scores for two of the six early childhood clients and three of the six school age clients who took the EVT-2 at intake, after six months of services, and after one year of services. The children whose data is not presented either had records with missing age equivalencies or had age equivalencies of “<2 years” or “<1 year” which were not amenable to averaging. Both groups of children performed better than would be expected had they not received any services with the early childhood clients showing a rapid rate of improvement during the first six months of service.

**Early Childhood Clients.** Of the clients whose data are included in Figure 14, the average chronological age of early childhood clients at the first, second, and third
assessment was 54.96 months (range: 51.96-57.96), 63.96 months (range: 57.96-60.96),
and 66.96 months (range: 63.96-69.96) respectively. The average developmental age for
these clients at the first, second, and third assessment according to their scores was 36
months (range: 24.96-47.04), 45 months (range: 42.96-47.04), and 50.04 months (range:
47.04-53.04) respectively. It is important to note that the treatment trajectory is higher
than the expected trajectory which predicted an average developmental age of 39.93
months at the second assessment and 43.86 months at the third assessment.

When looking at the data from all six of the early childhood clients from the first
to the last administration of the test, the standard scores improved (by 20-31 points) for
four of these clients and declined (by 5 and 10 points) for two of these clients. The
growth scale value improved (by 7-35 points) for all six of the early childhood clients
from the first administration of the test to the last.

*School Age Clients.* The average chronological age of school age clients whose
data is presented in Figure 14 at the first, second, and third was 71.04 months (68.04-
74.04), 76.68 months (range: 74.04-78.96), and 82.68 months (range: 82.68) respectively.
The average developmental age for these clients at the first, second, and third assessment
according to their scores was 57 months (range: 42-74.04), 64.36 months (range: 54-
74.04), and 70.68 months (59.04-81.96) respectively. The treatment trajectory was below
the typical trajectory, but above the expected trajectory which predicted an average
developmental age of 61.53 months at the second assessment and 66.34 months at the
third assessment.
Looking at the data of all six children who took the EVT-2 at intake, six months, and one year, five of these clients improved (by 2-18 points) and declined (by 5 points) for one of these clients. From intake assessment to the 1 year assessment, the growth scale value improved (by 6-65 points) for all six clients.

PEP-3 Assessment

Figure 16 provides the composite communication and composite motor age equivalent scores of three early childhood clients who took the PEP-3 assessment. Children showed improvement in both domains but only exceeded the expected trajectory for communication (in the motor domain they performed .23 months below the expected trajectory).

The average chronological age for these clients at the intake assessment and the one year assessment was 64 months (range: 58-70) and 69 months (range: 69-82) respectively. The average developmental age for communication skills for these clients at the time of the first and second assessment was 43 months (range: 27-51) and 60.33 months (range: 43-70) respectively. The average developmental age for motor skills at the intake assessment and one year assessment was 36 months (range: 30-41) and 42.33 months (range: 39-44).

No information is provided for school age clients. Although the ATP administered the test to seven school age clients, there was a lack of repeated measures for multiple clients.
RIAS

ATP administered the RIAS to six of the 54 early childhood clients and obtained repeated measures for four of them. The client’s scores for the Verbal Intelligence Index (VIX) improved (by 4 and 5 points) for two clients, remained the same for one client, and declined by eight points for one client. The client’s scores for the Nonverbal Intelligence Index (NIX) improved (by 10 and 4 points) for two clients, and declined (by 10 and two points) for two clients. The client’s scores for the Composite Intelligence Index (CIX) improved by more than 33 points for one client, and declined (by 1-4 points) for three clients.

ATP administered the RIAS to seven of the 41 school age clients and obtained repeated measures for four of them. The client’s scores for the Verbal Intelligence Index (VIX) improved (by 2-16 points) for three clients, remained the same for one client. The client’s scores for the Nonverbal Intelligence Index (NIX) improved (by 1-34 points) for three clients, and declined by five points for one client. The client’s scores for the Composite Intelligence Index (CIX) improved (by 7- 20 points) for three clients, and remained the same for one client.

PDD-BI

ATP administered the PDD-BI and obtained repeated measures for seven early childhood clients. The client’s Repetitive, Ritualistic, and Pragmatic Problems Composite scores improved (by 3-11 points) for five clients and declined (by 6 and 10 points) for two clients. The client’s Approach/Withdrawal Problems Composite scores improved (by 4-11 points) for five clients and declined (by 1 and 2 points) for two clients. The client’s
Expressive Social Communication Abilities Composite scores improved (by 4-18 points) for four clients, declined (by 3 and 5 points) for two clients, and remained the same for one client. The client’s Receptive/Expressive Social Communication Abilities Composite scores improved (by 3-15 points) for four clients and declined (by 1-6 points) for three clients. The client’s Autism Composite scores improved (by 8-20 points) for four clients, declined (by 6 and 11 points) for two clients, and remained the same for one client.

ATP administered the PDD-BI and obtained repeated measures for seven school age clients. The client’s Repetitive, Ritualistic, and Pragmatic Problems Composite scores improved (by 4-19 points) for three clients and declined (by 1-7 points) for four clients. The client’s Approach/Withdrawal Problems Composite scores improved (by 3-18 points) for four clients and declined (by 2-14 points) for three clients. All seven school age clients improved their Expressive Social Communication Abilities Composite scores (by 3-22 points). All seven school age clients improved their Receptive/Expressive Social Communication Abilities Composite scores (by 3-19 points). The client’s Autism Composite scores improved (by 1-17 points) for six clients, declined (by 4 points) for one client.

DARS completed a statistical analysis of the PDD-BI assessment scores and found that changes were statistically significant for the Autism Composite scores between entry and the six month assessment (sample size of 12). They also found statistically significant changes for the Expressive Social Communication Abilities Composite scores and Receptive/Expressive Social Communication Abilities Composite scores.
scores from entry to discharge (sample size of 7). DARS found that all other changes were not statistically significant (DARS, n.d.b.).

Program Goals

The data collected regarding program goals represents data from 89 clients. Nine of the 98 ATP clients had no information available and that five had not been enrolled in ATP long enough for this information to be documented at the time of this evaluation.

Figure 17 shows the total number of goals ATP clients taught and mastered broken up by program category. The portion of mastered goals to taught goals was higher for the early childhood program than for the school age program. Clients in the early childhood program mastered 58.16% of their goals, clients in the school age program mastered 45.18% of their goals, and all clients included mastered 52.36% of their taught goals. From the time ATP opened in April 2008 through August 2011, 81 clients were taught a total of 11,571 goals and mastered 6,049 goals.

Figure 18 shows the average number of goals mastered per child within the early childhood and school age programs along with the individual ranges. On average, early childhood clients were taught and mastered more goals that their school age counterparts. Early childhood clients mastered 77.64 goals (range: 0-258) and school age clients mastered 60.83 goals (range: 2-174).

While the measurement of goals taught and mastered does give an idea of how ATP helps their clients, it is a difficult measure to use for comparisons. As Brunson (2010) pointed out, the definition and criteria of a goal varies. ATP may consider setting
specific criteria for its staff in terms of what types of things constitute goals and what things are simply approximations to goals.

**Evidence Based**

Figure 19 shows the specific scores for each category of the modified Autism Program Quality Indicators (APQI). ATP performed well on all areas rated with strengths in areas including but not limited to staff training, maximizing progress, instructional activities, and curriculum. The weakest area observed was prompting in which ATP scored between “Needs Improvement” and “Adequate”. ATP scored the highest possible rating (“Good”) for seven of the 17 categories, they scored between “Adequate” and “Good” for three categories, “Adequate” for four categories, and between “Needs Improvement” and “Adequate” for one category. Two categories, challenging behavior and setting transitions, were not observed by the DARS assessor during his visit to ATP. Overall, ATP appears to meet the standards of a quality autism treatment program.

**Service Learning Opportunities**

According to Ala’i-Rosales (2011), the partnership between ATP, DARS and UNT has resulted in a number of successes. Amongst these successes are service learning opportunities for UNT faculty and graduate students that consist of over 2,000 hours (that were not billed to clients or DARS), four publications, and over 20 presentations disseminating what has been learned. In addition to those successes, over 65 professionals have been trained as a part of this partnership.
Goal 3 Discussion

The ATP seems to be on track in terms of providing evidence-based, effective services and learning opportunities. Clients utilized the availability of each service type provided. Generally speaking, more clients received behavioral, SL, SW, and OT services than PT and interpretation services. The number of hours clients received each month varied by program but on average clients did not receive the high number of services hours suggested by the literature (e.g., Birnbrauer & Leach, 1993; Cohen, Amerine-Dickens, & Smith, 2006; Myers & Johnson, 2007). Although the number of service hours received by clients did not meet the suggested amount, clients did make gains on the HELP assessments and on the standardized assessments. The school age clients did not appear to perform as well on the HELP assessments as their early childhood counterparts which may have been the result of a ceiling effect as well as reduced intensity of services.

ATP scored well on the modified APQI with only one area that did not meet the criteria for being “Adequate.” Based on findings by Ala’i-Rosales (2011) ATP has helped not only the clients they serve but a number of students and professionals as well.

There were some areas in which the ATP could improve. One area, previously mentioned by Pritchett (2010) relates to the number of service hours clients received. ATP may want to provide clients with a program option in which children could receive services for the recommended 25 or more of service hours a week. Brunson (2010) suggested that ATP add outcome measures to those they were using. Due to DARS requirement ATP increased the number and type of assessments administered to DARS funded clients. The agency may want to add measures for clients not funded by DARS,
especially for children in their school age program or in a targeted early childhood program (where children receive targeted programming for fewer hours a week). ATP agency should consider assessments that link directly to the areas most frequently targeted by the program goals of these clients as well as assessments that do not have the ceiling effects seen with the HELP scores. The ATP should also consider a systematic way to determine which assessment domains should be counted for each client category, as well as a way to compare scores across domains. Additional issues that revolve around the methods of collecting and recording data and will be addressed in the general discussion that follows.
GENERAL DISCUSSION

The purpose of this study was to conduct a program evaluation for the Autism Treatment Program (ATP). Program evaluations can be conducted for a variety of reasons, from different perspectives, and with an array of methods (Brunson, 2010; Gilbert, 2007; Jamai, 2007; Lutzker, 1994; Pritchett, 2010; and Rummler & Bache, 1995). The reason for this evaluation was to assess the degree to which the ATP measured variables related to the agency mission and goals.

My evaluation was based on a review of the ATP’s documents. To locate the information used in this evaluation I went through the physical and electronic records of the agency. I located demographic information, information regarding client satisfaction, outcome information, and information related to the type of services provided along with the number of service hours provided.

The main goals supporting the ATP mission are to serve the underserved; to uphold client dignity and maintain a positive family centered, and culturally responsive atmosphere; to provide evidence-based, effective services and service learning opportunities; and to create lasting change. For each goal a variety of measures are possible. The agency took measures that aligned with three of the four goals. Though there is fluctuation in the data across years, the ATP has typically enrolled a large portion of clients who were below the poverty level and who had three or more risk factors. The ATP clientele is diverse though the composition of clientele does not mirror that of the Dallas Fort Worth area. This demonstrates that while underserved populations have been
served, improvements could be made in terms of reaching portions of the underserved population. Parents reported high levels of satisfaction with the ATP services when services were available during the time period evaluated. Clients utilized services from each type of provider available, though the number of clients who used each service and the number of service hours received varied. On average clients increased their scores and developmental age (over the age expected had they not received services) on the Hawaii Early Learner Profile (HELP) and other standardized tests, this implies that ATP was effective.

The data presented here provide a picture of who the ATP has helped and some of the things the ATP has done for clients since its opening in April 2008. With such data the agency and its partners can make educated decisions that allow for program improvement in terms of agency policies, processes, and programs. This information may also be beneficial in the planning and implementation of future program evaluations and trend analysis. Completing Gilbert’s (2007) performance matrix was beyond the scope of this preliminary analysis of mission goals and corresponding data, however, I highly recommend this as a next step in further alignment of the ATP mission and outcomes.

While the ATP collected measures that are often lacking in autism treatment literature (Wolery & Garfinkle, 2002), there were some areas in which the ATP could make improvements. Based on collection and review of the data in the context of agency goals, I have several specific recommendations that should allow continued and ongoing assessment of alignment with the agency mission goals. These are specifically in the areas of data collection, storage and analysis; agency sensitivity to cultural differences
and interaction quality; generalization and maintenance of outcomes; and, cost effectiveness of treatment.

Data Systems: Collection, Storage and Analysis

Vilfredo Pareto, an Italian economist, is credited with the conceptualization of the “20-80 rule” which states that 20% of the effort yields 80% of the results (Hafner, 2001; Jones, 2011). This idea is particularly useful in program evaluations. The ATP could utilize the 20-80 rule through a reorganization of the way data is collected and maintained. I would suggest that the ATP allocate resources to the creation of a database in which the information collected by the ATP could be easily entered and retrieved in graphical, analyzable form. The ATP could also benefit from a systematic reorganization of its network server on which client records are kept. This would make reports and client information that have already been created and documented more readily available to those who need it. An organized electronic database and network server might be one way the ATP could prevent a loss of information, an apparent issue with each data set examined in this evaluation. Although the project of creating a database and reorganizing the server may seem like a daunting task, if done correctly, it could make the 20-80 rule a realistic option for the ATP thereby allowing frequent self-evaluations to keep the organization running smoothly and in accordance to their mission goals.

Responsive Client Interactions: Culture and Respect

The ATP strives to serve a diverse group of individuals and to do so in a manner that is inclusive and respectful to cultural and personal beliefs and values. Unfortunately, the current methods for checking the agency’s success in this area are limited. To obtain
more relevant and more frequent measures of client satisfaction in regards to these areas, the ATP might consider conducting satisfaction checks independent of the Department of Assistive and Rehabilitative Services (DARS). These checks could be in the form of a written survey or they could be conducted as part of monthly meetings between case managers and client families. The ATP might consider reviewing Brookman-Frazee & Koegel (2004) for ideas on how to incorporate parents and family members into interventions, thereby creating a more family focused, culturally responsive atmosphere.

Lasting Change: Generalization and Maintenance

Included in the ATP’s mission is the goal to create lasting change. However, the ATP currently has no methods of tracking client progress, placement, or quality of life after enrollment at the ATP. If this continues to be an important goal for the agency, the systematic measures to obtain this information should be considered. Chandler, Lubeck & Fowler (1992) noted that skills acquired in one setting do not easily generalize to other settings, nor do individuals continue to demonstrate such skills after intervention. One method the ATP could use to determine if they succeeded in teaching skills that would generalize and maintain could include scheduled follow-up observation sessions in the clients’ homes and schools. The ATP might also consider creating a follow-up survey, questionnaire, or interview that would allow parents to report information about school placement, demonstration of skill maintenance or regression, and general family wellbeing. Follow-up efforts require resources and time but without them it is unclear whether intervention effects maintain.
Cost Effectiveness

Lutzker (1994) identified cost effectiveness as one of the main areas for evaluation of a treatment program. Such an evaluation was beyond the scope of this project, but is certainly important as it would allow the ATP to compare their program and child outcomes to those of other programs with similar and dissimilar budgets. With such an evaluation the ATP may also be able to make internal comparisons between early childhood and school age client programs and between programs implemented for children funded by DARS and non-DARS sources. This is something the ATP might consider for the future.

In summary, the ATP has four main goals related to its current mission. The agency measures most of these goals with data from at least some of their clients. In the four years since its opening, the ATP has experienced a number of changes. Many professionals have been trained, some have moved on to other locations, clients have come and gone, admission policies have changed, new programs have been provided, etc, but through all of these changes it appears that the ATP has stayed on course with being a quality autism treatment program.
Figure 1. Race/ethnicity. The top portion represents data from DFW. The lower portion represents ATP clients. The larger graph represents race, the smaller ethnicity.
**Figure 2.** Languages spoken in ATP client homes. The top graph represents all ATP clients, the bottom graphs represent ATP clients who entered ATP in the given year. Multi-lingual families account for the total of some graphs being greater than 100%.
Figure 3. Income of ATP client families. The top graph represents all ATP clients, the bottom graphs represent ATP clients who entered ATP in the given year.
Figure 4. Risk factors of ATP client families. The top graph represents all ATP clients, the bottom graphs represent ATP clients who entered ATP in the given year.
Figure 5. Demographic information from DARS surveys. The top two graphs represent the survey respondents, the middle two represent the duration of ATP enrollment, the bottom two represent the number of service hours per week.
Figure 6. Perceived progress made by child based on DARS surveys.
Figure 7. Parent responses about satisfaction with services
Figure 8. Average number of early childhood clients receiving ATP services by service type. Circles represent any ATP service, squares represent interpretation, pluses represent SW, diamonds represent SL, asterisks represent OT, and triangles represent PT.
Figure 9. Average number of school age clients receiving ATP services by service type. Circles represent any ATP service, squares represent interpretation, pluses represent SW, diamonds represent SL, asterisks represent OT, and triangles represent PT.
Figure 10. Average number of service hours received per month. Vertical bars represent the range of hours received by each client.
Figure 11. Average composite HELP scores. The vertical bars represent individual scores.
Figure 12. Average ages for HELP domains for early childhood clients. Vertical bars represent range of individual scores.
Figure 13. Average ages for HELP domains for school age clients. Vertical bars represent range of individual scores.
Figure 14. Average ages for PPVT-4. Vertical bars represent range of individual scores.
Figure 15. Average ages for EVT-2. Vertical bars represent range of individual scores.
Figure 16. Average early childhood ages for PEP-3. Vertical bars represent range of individual scores.
Figure 17. Number of goals taught and mastered by ATP Clients.
Figure 18. Average number of goals mastered per child. Vertical bars represent individual range of goals mastered.
Figure 19. Ratings from the 2010 modified Autism Program Quality Indicators. Adapted by DARS from Crimmins, Durand, Theurer-Kaufman, K, & Everett, J. (2001).
Table 1

*Racial Categories Defined By the U.S. Census* (U. S. Census, n.d.)

<table>
<thead>
<tr>
<th>White</th>
<th>Black, African Am., Negro</th>
<th>American Indian or Alaska Native</th>
<th>Asian</th>
<th>Native Hawaiian or other Pacific Islander</th>
<th>Some Other Race</th>
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Table 2
*Criterion for Counting a Category as a Risk Factor.* Risk factors identified and adapted by ATP from Dunst (1993).

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<th>Risk factor</th>
<th>Criterion</th>
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<td>In-home parental make-up</td>
<td>One parent in the home</td>
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<tr>
<td>Home Ownership</td>
<td>No homeownership, renting</td>
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<td>Parent Education</td>
<td>High school education, GED equivalent or less for one or both parents</td>
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<td>Occupation Status</td>
<td>No job or Employed less than 3 months with current employer</td>
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<td>Income</td>
<td>125% of poverty level (or less)</td>
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<td>Medical Expenses</td>
<td>Above 40% of net income</td>
</tr>
<tr>
<td>Transportation</td>
<td>No car</td>
</tr>
<tr>
<td>Alternative caregivers/outside support available</td>
<td>0-2 alternative caregivers/outside supports available</td>
</tr>
<tr>
<td>Number of children in the home</td>
<td>More than 5 children in the home</td>
</tr>
<tr>
<td>Number of children in the home with a disability</td>
<td>3 or more</td>
</tr>
<tr>
<td>Parental health</td>
<td>Documented psychological disorder, substance abuse, or physical disability for one or both parents</td>
</tr>
<tr>
<td>Self-injurious Behaviors/Aggression</td>
<td>Moderate to severe (at least 2 behaviors, some at moderate to severe intensities – seen or reported by parent)</td>
</tr>
<tr>
<td>Functional Communication</td>
<td>No or limited functional communication (or reported as such by parent)</td>
</tr>
</tbody>
</table>
Table 3

*Summary of HELP Findings.*

<table>
<thead>
<tr>
<th>Program Category</th>
<th>N</th>
<th>Duration of Enrollment</th>
<th>HELP Dates</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood</td>
<td>54</td>
<td>More than 10 Months</td>
<td>Intake and 1 Year</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 22 Months</td>
<td>Intake, 1 Year and 2 Year</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School age</td>
<td>41</td>
<td>More than 10 Months</td>
<td>Intake and 1 Year</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 22 Months</td>
<td>Intake, 1 Year and 2 Year</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>More than 10 Months</td>
<td>Intake and 1 Year</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 22 Months</td>
<td>Intake, 1 Year and 2 Year</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intake, 1 Year, and 2 Year</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Summary of All ATP Client HELP Scores*

| Total            | N=98| Clients with incomplete HELP | 16 |
|                  |     | Clients without dates on HELP | 17 |
|                  |     | Clients with unscored HELP    | 25 |
APPENDIX A

ATP CARROLLTON AND OAK CLIFF LOCATIONS
Oak Cliff Treatment Room

Oak Cliff School & Lunch Room

Oak Cliff OT & Group Play Room

Oak Cliff PT & Group Play Room

Oak Cliff Group Play Room

Oak Cliff Library

80
APPENDIX B

ATP APPLICATION

Reproduced with permission from Easter Seals North Texas.
Easter Seals North Texas
Autism Treatment Program

* In order to ensure prompt processing of your application please complete ALL questions. Thank you!

General Information

Client's Name: ______________________________________________________

Child's Date of Birth: ________________ Child's Age: ________________

Caregiver's Name: ________________________________________________

Address: ____________________________________________ Street  Apt #  City  State  Zip

Home Phone: ________________ Work Phone: ________________

Cell Phone: ________________ Misc. Number: ________________

Email address: ________________________________________________

Preferred method of contact (circle one): Home  Cell  Work  Misc.  Email

Best time to contact you: __________________________________________

Emergency Contact Names and Numbers:

Name: ________________________   Number: ________________

Name: ________________________   Number: ________________

Name: ________________________   Number: ________________

Name: ________________________   Number: ________________

Referral Source (circle one): Early Childhood Intervention (ECI)  School  Physician Parent/friend

Other: ______________________________________________________

Reason for Referral: ____________________________________________
Family Demographics

Parents' Names
Mother: ________________________  Father: ________________________

Marital Status (please circle one):
Married  Divorced  Separated  Other: ________________________

Parents' Current Address
Mother: __________________________________
Street  Apt #  City  State  Zip

Father: __________________________________
Street  Apt #  City  State  Zip

Do you own or rent your current place of residence (please circle one):
Own  Rent  Other: ________________________

Parents' Birthdates
Mother: ________________________  Father: ________________________

Parents' Primary Language Spoken
Mother: ________________________  Father: ________________________

Highest Level of Education Completed (please circle for each parent):
Mother:  Elementary/ Secondary  High School/ GED
         Bachelor's Degree  Master's Degree  Doctorate Degree

Father:  Elementary/ Secondary  High School/ GED
         Bachelor's Degree  Master's Degree  Doctorate Degree

Current Occupation:
Mother: ________________________  Father: ________________________

Length of Employment at Current Position:
Mother: ________________________  Father: ________________________
Estimated Adjusted Gross Income, as reflected on previous year’s taxes:

Mother: __________________________  Father: __________________________

Estimated Out-of-Pocket Annual Medical Expenses for Applicant from past 12 months:

Do you have transportation to get to/from therapy (circle one)?

No       Yes, own a car       Yes, borrow a car       Yes, public transportation

Do you have an alternate caregiver/ outside supports available?  Yes  No

If yes, who/ what? __________________________

**siblings (Gender and Age)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List all individuals and their relationship to the child residing in the home

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

List any family members that have health problems/ special needs

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Child's Demographics

Child's Name: ____________________________________________

Last       First       Middle Initial

Nickname: ________________________________________________

Date of Birth: ____________________ Place of Birth: ____________________

Gender (please circle): Male   Female

Primary Language: Spoken: _______________ Understood: _______________

Diagnosis, Date Received, and By Whom:

Diagnosis: ____________________________________________

Date Rec’d: ____________________ By Whom: ____________________

Diagnosis: ____________________________________________

Date Rec’d: ____________________ By Whom: ____________________

Diagnosis: ____________________________________________

Date Rec’d: ____________________ By Whom: ____________________

Treatment and School History

Early Childhood Intervention (ECI) Services:

Past:     YES  NO     Present:     YES  NO

School Placement: Public   Private   Home   Not enrolled

Name of School: ____________________ District: ____________________

Current Placement: PPCD   Pre-K   K   1st   2nd   3rd

Other: ____________________________________________________________________

Special Services at School (please list frequency):

Speech Therapy: YES   No     Frequency: _______________

Occupational Therapy: YES   No     Frequency: _______________

Physical Therapy: YES   No     Frequency: _______________

Please list any private services your child receives: ____________________________________________________________________
Child Information

How would you describe your child’s ability to communicate?

<table>
<thead>
<tr>
<th>Not Functional</th>
<th>Somewhat Functional</th>
<th>Very Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note all modes of communication that apply to your child:

- Grunting
- Pointing
- Signing
- Leading
- Picture Symbols
- Verbally

If your child exhibits any of the following, please circle and state how frequently the behavior occurs and the severity of the behavior:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Frequency (per day)</th>
<th>Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hitting</td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>Bitting</td>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td>Eloping (running from Caregiver)</td>
<td></td>
<td>Severe</td>
</tr>
<tr>
<td>Head-banging</td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>Spitting</td>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td>Pica (eating non-edible items)</td>
<td></td>
<td>Severe</td>
</tr>
<tr>
<td>Other (please list):</td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe</td>
</tr>
</tbody>
</table>

Is your child toilet trained (please circle the descriptor that best fits)?

- Yes, with complete independence
- Yes, with some assistance
- Yes, but only on a strict schedule
- Family is in early stages of training
- Toilet training has not begun

Goals and Priorities

Overall, what is most important to you for your child?

List some of your child’s strengths:

List some of your family’s strengths:
Describe any issues with eating and food selectivity:


What support/training do you feel would be most beneficial for you and your family over the next 6-12 months?


In each of the following areas, what would you most like your child to learn in the next 6-12 months?

Communication Skills: 


Social Skills: 


Play Skills: 


Self-care Skills: 


Other: 


Program Preferences [circle one]:

Location: 1. Trinity Center (Carrollton) 2. Oak Cliff Center (South Dallas)


*Potential funding for children ages 3-8, Texas residents, with a documented Autism Spectrum diagnosis

Name of Person Completing this form: ____________________________

Date: ____________________________

Once completed, please mail this form to:
Easter Seals North Texas
4443 N. Josey Ln, Ste. 100
Carrollton, TX 75010
Attn: Autism Treatment Program
APPENDIX C

ATP WEIGHTED PRIORITIZATION FORM

Reproduced with permission from Easter Seals North Texas.
EASTER SEALS NORTH TEXAS
AUTISM TREATMENT PROGRAM
Weighted Prioritization Criteria Form

<table>
<thead>
<tr>
<th>Cost Share Slot:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Score:</td>
<td></td>
</tr>
<tr>
<td>Center Preference:</td>
<td></td>
</tr>
<tr>
<td>Program Preference:</td>
<td></td>
</tr>
</tbody>
</table>

Client’s Name: ____________________________________________

Client’s DOB: ____________________________________________

Parent Contact Name/ Number: ________________________________

<table>
<thead>
<tr>
<th>Single parent family:</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single parent family</td>
<td>10</td>
</tr>
<tr>
<td>Two parents in home</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home ownership:</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>No ownership, renting</td>
<td>10</td>
</tr>
<tr>
<td>Own 1 home</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent education:</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>No High School or GED equivalent for one or both parents</td>
<td>15</td>
</tr>
<tr>
<td>High School or GED equivalent for one or both parents</td>
<td>10</td>
</tr>
<tr>
<td>Undergraduate degree for one or both parents</td>
<td>6</td>
</tr>
<tr>
<td>Graduate degree for one or both parents</td>
<td>2</td>
</tr>
<tr>
<td>Higher than a graduate degree for one or both parents</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational status:</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>No job</td>
<td>15</td>
</tr>
<tr>
<td>Employed less than 3 months with current employer</td>
<td>10</td>
</tr>
<tr>
<td>Employed 3-6 months with current employer</td>
<td>8</td>
</tr>
<tr>
<td>Employed 6-12 months with current employer</td>
<td>6</td>
</tr>
<tr>
<td>Employed 12-24 months with current employer</td>
<td>4</td>
</tr>
<tr>
<td>Same job for past 24 months or longer</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income:</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of poverty level</td>
<td>15</td>
</tr>
<tr>
<td>125% of poverty level</td>
<td>10</td>
</tr>
<tr>
<td>150% of poverty level</td>
<td>8</td>
</tr>
<tr>
<td>175% of poverty level</td>
<td>6</td>
</tr>
<tr>
<td>200% of poverty level</td>
<td>4</td>
</tr>
<tr>
<td>Above 201% of poverty level</td>
<td>2</td>
</tr>
</tbody>
</table>
Medical Expenses:
- Above 50% of net income: 15 points
- 40-49% of net income: 10 points
- 30-39% of net income: 8 points
- 20-29% of net income: 6 points
- 10-19% of net income: 4 points
- 0-9% of net income: 2 points

Transportation:
- No personal vehicle: 10 points
- 1 or more cars: 2 points

Alternative caregivers/outside supports available:
- No alternative caregivers/outside supports available: 10 points
- Limited alternative caregivers/outside supports available (1-2): 6 points
- Many alternative caregivers/outside supports available (more than 3): 2 points

Number of children in home:
- 6 or more children in home: 15 points
- 5 children in home: 10 points
- 4 children in home: 8 points
- 3 children in home: 6 points
- 2 children in home: 4 points
- 1 child in home: 2 points

Number of children with disability:
- 3 or more children in home: 15 points
- 2 children in home: 8 points
- 1 child in home: 2 points

Parental Health:
- Documented psychological disorder, substance abuse, or physical disability for one or both parents: 15 points
- None noted: 0 points

Functional Communication:
- No functional communication (no verbal or functional communication or parent report): 15 points
- Limited functional communication (some verbal or functional communication or parent report): 10 points
- Functional communication (functional language use or parent report): 2 points

Self-Injurious Behaviors/Aggression:
- Severe (more than 2 behaviors present, some severe intensity indicated and/or parent report): 15 points
- Moderate (at least 2 behaviors present, some moderate or severe intensity indicated and/or parent report): 10 points
- Mild or not present (less than 2 behaviors present or parent report): 2 points

TOTAL: __________
(between 29-175)
APPENDIX D

DARS AUTISM SERVICES SATISFACTION SURVEY

Reproduced with permission from Texas Department of Assistive and Rehabilitative Services.
Autism Services Satisfaction Survey
Easter Seals North Texas

This first section asks some basic questions about you, your child, and the services that your child received or is receiving. Please answer each question by filling in the blank or placing a check mark (✓) in the box beside the correct answer.

1. What is your relationship to the child receiving services through this provider?
   - Mother
   - Father
   - Legal Guardian
   - Other (please specify: ________________________________)

2. How old is your child? ________ Years

3. For how many months has your child received intervention services through this provider?
   - 0-3 Months
   - 4-6 Months
   - 7-9 Months
   - More than 9 Months

4. How many hours per week does your child receive Applied Behavior Analysis (ABA) services through this provider?
   - 0-5 hours
   - 6-10 hours
   - 11-20 hours
   - 21-30 hours
   - 31-40 hours

5. Have you found any other type of Autism intervention to be as or more beneficial than Applied Behavior Analysis (ABA) with your child?
   - No
   - Yes, another intervention has been as beneficial
     (please specify: ________________________________)
   - Yes, another intervention has been more beneficial
     (please specify: ________________________________)
This second section asks questions about the progress that your child has made in several specific areas. Please place a check mark (✓) in the box below the answer that best expresses how much improvement your child has shown. Please check only one box for each question.

<table>
<thead>
<tr>
<th></th>
<th>Nane</th>
<th>Little</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Which word best describes your child’s improvement in communication skills since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Which word best describes your child’s improvement with initiating social interaction with others since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Which word best describes your child’s improvement in play skills (e.g., playing with toys appropriately, taking turns in games, etc.) since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Which word best describes your child’s improvement in self-help skills (e.g., toileting, washing/drying hands, eating, dressing, etc.) since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Which word best describes the improvement in your child’s disruptive behavior (e.g., reduction in aggression, tantrums, stereotypy, etc.) since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Which word best describes the improvement in your family life and activities since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Which word best describes the overall progress your child has made since beginning intervention with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This third section asks questions about your satisfaction with various services received through this provider. Please place a check mark (✓) in the box below the answer that best expresses your level of satisfaction. Please check only one box for each question.

<table>
<thead>
<tr>
<th></th>
<th>Very Unsatisfied</th>
<th>Unsatisfied</th>
<th>Neutral</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. If your child received services in the home, how satisfied were you with those services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. If you participated in parent training, how satisfied were you with those services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. How satisfied are you with the training you received in reviewing data and evaluating your child’s progress?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. How satisfied are you overall with this provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Do you believe this provider has your child’s best interest in mind?

- [ ] Yes
- [ ] Sometimes
- [ ] No

18. Would you recommend this provider to other parents?

- [ ] Yes
- [ ] No

19. Please feel free to share other comments that you think would be helpful for us regarding your experience with this provider.

________________________________________________________________________

THANK YOU FOR YOUR TIME!
REFERENCES


Department of Assistive and Rehabilitative Services (n.d.a). Easter Seals North Texas. (n.d.a) *Texas Department of Assistive and Rehabilitative Services grant.* (RFA#5382000817) [Grant]

Department of Assistive and Rehabilitative Services (n.d.b) [Preliminary analysis of PDDBI data Easter Seals North Texas.] Unpublished data.


Easter Seals North Texas. (n.d.) *Texas Department of Assistive and Rehabilitative Services grant application: Services to children with autism*. (RFA# 53802C10907). [Grant]


