

## EVALUATION AND ASSESSMENT:

These assessment tools will allow you to take advantage of a professionally created survey based on sound evaluative process. They will also allow you to compare your outcomes to youth from similar age groups and demographics. By comparing your results, you will be able to show that your program is equally effective to other well-run programs for youth around the country.

The outcomes from these evaluations will also help you improve your program based on your results. For instance, if your goal is to help the youth in your program improve their self-restraint skills in conflict situations, you can start by using the appropriate assessment tool in this compendium as a baseline evaluation. Later, you can use the same survey again at varying time periods to see if your program enhancements are resulting in improvements.

## HOW TO USE THE OUTCOME DATA:

As always, TMP is happy to support your efforts to evaluate your program. If we can assist you in using these evaluation tools, we will do our best to meet your needs.

You will see the following terms below in our explanation of outcome data as well as in the original articles:

- **Sample** - the subset of the population that is participating in the research  
Unless otherwise specified, you can administer these assessments to any population of youth. However, you should only use the benchmark data listed below as a comparison point for youth that are similar in race, age, gender, etc. to the original sample of youth. For example, you cannot compare data that you have collected on the elementary school students in your program to the data for the DSM Screening for Depression, which has a sample of high school students.
- **Mean (M)** - average score

We hope that you will find these assessment tools helpful as you design and improve your mentoring program.

To access the assessments and additional evaluation tools, see the [CDC compendium](#).

As you will see, this compendium includes additional assessment tools on youth attitudes, psychosocial characteristics, behaviors, and environmental interactions than the ones that we have

listed below.

For additional information to help you understand some key terms written in these articles, see the bottom section of this document.

#### OUTCOMES AND BENCHMARK DATA:

##### **DSM Screening for Depression** (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993)

- This assessment tool can be found in the CDC compendium on pg. 87.
  - [Original article](#)
- Sample included 1,710 high school students
  - Assessed at time 1 and at one year later
  - Sample was representative to census data on gender and ethnicity
- Assessed via interview on DSM III-R depression criteria
- Total prevalence of major depression (at time 1) was 2.57; Higher in females ( $M = 3.37$ ) than males ( $M = 1.71$ )
- Total prevalence of bipolar disorder (at time 1) was .29; Higher in females ( $M = .45$ ) than males ( $M = .12$ )
- Total prevalence of anxiety disorders (at time 1) was 3.16; Higher in females ( $M = 4.7$ ) than males ( $M = 1.47$ )

##### **Restraint - Weinberger Assessment Inventory** (Weinberger & Schwartz, 1990)

- This assessment tool can be found in the CDC compendium on pg. 134.
  - [Original article](#)
- Restraint is a dimension of social-emotional adjustment related to socialization and self-control and refers to the suppression of desires in pursuit of long-term goals. It combines interpersonal (i.e., consideration of others), intrapersonal (i.e., impulse control) and communal (i.e., responsibility) aspects of self control.
- The Weinberger Adjustment Inventory (WAI) was administered to 81 girls and 74 boys with an average age of 11.6, as well as their teachers and peers.
  - 30 items rated on 5-point scale; range of possible scores from 30-150
  - The mean score on the WAI Restraint subscale for all participants' self-reports was 113.84
- Results of this study suggest that the WAI may be more accurate if administered to teachers/peers to report on the target child, rather than for self-reports by the child.

### **Social Competence** (Gouley, Brotman, Huang, & Shrout, 2008)

- This assessment tool can be found in the CDC compendium on pg. 243-245.
  - [Original article](#)
- Sample included 261 pre-K children, representative of gender and race
- Social Competence scale was administered to parents of the children in the sample
- Used only 12 of the items (19 are listed in the CDC compendium)
  - Rated on a 5-point scale
  - Higher scores indicate higher prosocial behavior
- Mean social competence for sample was 2.57

### **Classroom Climate School** (Henry, Tolan, Gorman-Smith & Schoeny, 2012)

- This assessment tool can be found in the CDC compendium on pg. 46.
  - [Original article](#)
- Assessed 5580 students approximately equal across genders and including high levels of minorities
- Academic achievement was measured with the 13-item Teacher BASC Study Skills subscale - includes behaviors likely to result in improved achievement, such as “completes homework”
- One item each to measure attitude toward school (possible range 1-5; 5 is most satisfied) and truancy (possible range 1-6; 1 is never skip school and 6 is 20 skips or more)
- Study skills mean score controlled for gender and race was 16.23
- Truancy mean score controlled for gender and race was 1.13
- School satisfaction mean score controlled for gender and race was 4.86

### **Attachment to Teachers** (Smith, Park, Ireland, Elwyn, & Thornberry, 2013)

- This assessment tool can be found in the CDC compendium on pg. 72.
  - [Original article](#)
- Administered the Rochester Youth Development study to 1000 adolescents ages 14-18 and about 80% of the sample were reassessed in their 20's
- Teacher attachment subscale measured using adolescent self-reports on a 4-question scale
  - Rated on a 4-point scale from strongly disagree (1) to strongly agree (4)
  - Example item: “If you need advice, you would go to one of your teachers.”
  - Possible range of scores from 1 to 4
- Mean final score was 2.86
- Results showed that attachment to teachers is correlated with reduced crime in violence later in adulthood

### **Presence of a Caring Adult** (Anderson, Sabatelli, & Trachtenberg, 2007)

- This assessment tool can be found in the CDC compendium on pg. 151.
  - [Original article](#)
- Sample included youth between the ages of 12-18
  - 354 males (50.3%) and 316 (44.9%) females
- Overall goal of this research was to evaluate the outcome of the police intervention program on development
- Assessed youth on the Presence of Caring Adult subscale at pre- and post- police intervention
  - 9 items with a 4-point rating scale
  - Possible range of scores is 9-36
  - Higher scores means more self-reported access to support
- Pre-intervention, the overall mean score for Presence of Caring for both groups was 20.5

### **Social Health Profile** (Werthamer-Larsson, Kellam & Wheeler, 1991)

- This assessment tool can be found in the CDC compendium on pg. 195.
  - [Original article](#)
- Sample included 1,043 first graders, rated by their first grade teachers
  - 53.3% boys
  - Average age upon entering first grade was 6 years 4 months
- The concentration subscale included 10 items rated using a 6-point frequency-based scale (*almost never to almost always*); Higher scores refer to more maladaptation
- The mean score for concentration was 2.79.

### **Parent/Child Social Competence - Conflict Behavior Questionnaire** (Lundy, Field, McBride, Abrams, & Carraway, 1997)

- This assessment tool can be found in the CDC compendium on pg. 248.
  - [Original article](#)
- Assessed 20 mother-child dyads *in which the child had clinically-relevant diagnoses*
- Mothers took the Parent/Child Social Competence scale, a 20-item measure rated by selecting either true or false
- Possible scores ranged from 0-14; Higher scores indicate greater conflict
- For children with internalizing disorders, the mean score was 9.78
- For children with externalizing disorders, the mean score was 10.90

**Attitudes Towards Violence** (Bosworth, Espelage, & DuBay, 1998)

- This assessment tool can be found in the CDC compendium on pg. 22.
  - [Original article](#)
- Measures attitudes toward violence and its acceptability, particularly in relation to fighting
- Sample included 98 seventh graders, approximately equal across gender
- Teen Conflict Survey used to collect baseline data for research on using technology as an intervention for youth
  - Intentions subscale administered to sample to assess intentions to use various negotiation techniques
- Range of possible scores on 8 items was 8-32; Higher scores means more positive attitudes toward violence
- Mean Intentions score was 16.36

**Attitudes Towards Interpersonal Peer Violence** (Solomon, Bradshaw, Wright, & Cheng, 2008)

- This assessment tool can be found in the CDC compendium on pg. 29.
  - [Original article](#)
- Measures youths’ passive or violent attitude orientation as well as knowledge and skill in resolving conflict non-violently
- Used a modified (shorter) version of the full Attitudes Towards Interpersonal Peer Violence (Slaby, 1989)
  - 6 items long
  - Higher scores indicate attitudes supporting violence
- Sample included 72 parents and adolescents (aged 12 to 17 years, 89% African American)
- Examined parental and youth attitudes toward violence in youth *who had presented with assault-related injuries*
- Mean overall score for youth was 14.19 (3.48)
- The following table presents the percentage of youth in the study that agreed with each of the 6 items used in Solomon et al., 2008.

Item	% of Youth Agreed (n = 72)
1. I don't need to fight because there are other ways to deal with being mad.	83.3
2. When actions of others make me angry, I can usually deal with it	81.9

without getting into a physical fight.	
3. If a kid teases or “disses” me, I usually cannot get them to stop unless I hit them.	18.1
4. If a student hits me first, my family would want me to hit them back.	77.8
5. Anyone who won’t fight is going to be “picked on” even more.	65.3
6. It’s OK to hit someone who hits you first.	72.2

**Attitudes towards Guns and Violence** (Shapiro, Dorman, Burkey, Welker, & Clough, 1997)

- This assessment tool can be found in the CDC compendium on pg. 53.
  - [Original article](#)
- Measures attraction to guns and violence in relation to aggression, emotion, and feelings of power and safety
- Sample included 1,619 youth ages 8-18; 58% of sample was male
- 23 items rated on 3-point scale: 0 (disagree), 1 (not sure), 2 (agree)
- Possible scores ranged from 0-46
- Mean score was 13.8
  - Large range of scores in sample results
  - Results suggest that age and sex impact attraction to guns and violence. Specifically, this survey is appropriate to assess attraction to guns and violence across ages and genders *except* elementary school girls.

**Non-physical Aggression - Pittsburgh Youth Study** (Farrington, Loeber, Stallings, & Homish, 2008)

- This assessment tool can be found in the CDC compendium on pg. 184.
  - To access the original article, go to <http://books.google.com> and search for “Early risk factors for young homicide offenders and victims”.
- Measures non-physical aggressive behavior in terms of arguing, bragging, seeking attention, disobeying parents and teachers, etc.
- Sample included 1,517 boys in Pittsburgh
- Compared initial Pittsburgh Youth Study screenings (from Loeber et al., 1998) with 2008 data on boys in the sample who became homicide victims or offenders
  - Assessed risk and protective factors

- Higher scores indicate more aggressive behavior
- Nonphysical aggression was significantly correlated with being a homicide victim
  - 25% of control participants were rated as actively engaged in nonphysical aggression compared with 55% of homicide victims

**Attitudes Towards Women** (Galambos, Petersen, Richards, & Gitelson, 1985)

- This assessment tool can be found in the CDC compendium on pg. 51.
  - [Original article](#)
- Measures gender stereotyping
- Collected 4 samples
  - 125 White, rural, lower-to-middle-class students - 60 boys and 65 girls
  - mainly White, suburban, middle-class students - 56 boys and 69 girls
  - 139 suburban lower-to-upper-middle-class students - 67 boys and 72 girls
  - two cohorts from middle class suburban school: 188 students (102 girls and 86 boys); 147 students (79 girls and 68 boys)
- 12 items rated on a 4-point Likert-type scale ranging from 1 = "agree strongly" to 4 = "disagree strongly"
- Higher score indicates less traditional attitudes
- The following table presents the results by grade and gender:

Grade	Boys' Mean	Girls' Mean
9-12	2.44	2.98
9-12	2.71	3.22
12	3.02	3.45
6	2.79	3.22
7	2.75	3.31
8	2.71	3.40

- Overall, girls reported significantly less traditional attitudes toward women than did boys
- Among both boys and girls, the rural adolescents endorsed significantly more traditional attitudes toward women.

- **Why this matters**
  - The self-esteem of adolescent girls appears to be mediated by her attitudes about her own sex
  - Boys' attitudes toward women rarely have such a relationship to their self-concepts.
- Additional data from: McHale, Crouter, & Tucker, 1999
  - Interviewed 200 families of fourth and fifth grade students in 16 rural and small urban school districts
  - Included items from the Attitudes Towards Women Scale
  - Found that gender attitudes influenced children's interests and activities (i.e. sewing instead of playing soccer)

**Drug and Alcohol Use - Youth Risk Behavior Survey** (Centers for Disease Control and Prevention, 2004)

- This assessment tool can be found in the CDC compendium on pg. 221.
  - [Original article](#)
- National benchmark sample included 15,214 students - representative across age, gender, race, etc.
  - **Alcohol use**
    - Approximately three fourths (74.9%) of students nationwide had had one or more drinks of alcohol on at least one day during their lifetime
    - The prevalence of lifetime alcohol use was higher among Hispanic (79.5%) than black (71.4%) students and was more likely later in high school than in 9th grade
    - 44.9% of students had had one or more drinks of alcohol on at least one of the 30 days preceding the survey
    - 28.3% of students had had at least 5 alcoholic drinks in a row (i.e., within a couple of hours) on at least one of the 30 days preceding the survey (i.e., episodic heavy drinking)
  - **Drug use**
    - 40.2% of students had used marijuana one or more times during their lifetime (i.e., lifetime marijuana use)
    - the prevalence of lifetime marijuana use was higher among male (42.7%) than female (37.6%) students
    - 22.4% of students had used marijuana one or more times during the 30 days preceding the survey
    - 8.7% of students had used a form of cocaine one or more times during their



lifetime - higher among white (8.7%) and Hispanic (12.5%) than black (3.2%) students

- 3.2% of students had used a needle to inject any illegal drug into their body one or more times during their lifetime
- 12.1% of student had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their lifetime - higher among white (12.8%) and Hispanic (12.7%) than black (7.0%) students
- 6.1% of students had taken steroid pills or shots without a doctor's prescription one or more times during their lifetime
- 3.3% of students had used heroin one or more times during their lifetime - higher among male (4.3%) than female (2.0%) students
- 7.6% of students had used methamphetamines one or more times during their lifetime
- 11.1% of students had used ecstasy one or more times during their lifetime

#### ADDITIONAL INFORMATION:

You may see some of the following terminology as you read the original articles and the CDC compendium.

- **Standard deviation (SD) and standard error (SE)**- shows how much variation there is from the mean; in other words, how spread out the scores are  
The SD helps us see how many participants in the sample have scores within a range of the mean score. For example: if the mean is 5 and the SD is 1, this tells you that the majority of scores fall between 4 (i.e.,  $5 - 1$ ) and 6 (i.e.,  $5 + 1$ ).  
SD and SE are not exactly the same statistically, but are related; SE also shows variance from the mean but takes into account multiple samples of participants.
- **Effect size** - You may note that some articles rate outcomes by noting effect sizes. Effect sizes refer to the strength of the difference in outcome variables (ie: grades, self esteem) between children in the mentoring program and those who were not in the mentoring program. The effect size is named "d" and considered small (.2), medium (.5), or large (.8). You can calculate your program's effect size and compare it to the national average for mentoring (small effect) or to the benchmark for that specific assessment and outcome.

It is important to recognize that “small” effect sizes are *not* unimportant effects. Mentoring typically has a “small” effect, but so do other respected fields such as tutoring (and even some medical treatments). Small effects are *real changes* (*i.e., a true influence on mentee outcomes*) that can only be observed under careful, close observation. Large effects are *not* more important than small effects; rather, large effects can be seen by the naked eye (for example, gender difference in height).

## References

- Anderson, S. A., Sabatelli, R. M., & Trachtenberg, J. (2007). Community police and youth programs as a context for positive youth development. *Police Quarterly, 10*, 23-40.
- Arthur, M. W., Hawkins, J. D., Pollard, J.A., Catalano, R. F., & Baglioni, A. J. (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors: The communities that care youth survey. *Evaluation Review, 26*, 575- 601.
- Bosworth, K., Espelage, D., & DuBay, T. (1998). A computer-based violence prevention intervention for young adolescents: pilot study. *Journal of Adolescence, 33*, 785-795.
- Centers for Disease Control and Prevention (2004). Youth risk behavior surveillance - United States, 2003. *Surveillance Summaries, MMWR, 53*.
- Dahlberg, L. L., Toal, S. B., Swahn, M., & Behrens, C.B. (2005). Measuring violence-related attitudes, behaviors, and influences among youths: A compendium of assessment tools, 2nd ed. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- Eberly, M. B., Montemayor, R., & Flannery, D. J. (1993). Variation in adolescent helpfulness toward parents in a family context. *Journal of Early Adolescence, 13*, 228-244.
- Farrington, D. P., Loeber, R., Stallings, R., & Homish, D. L. (2008). Early risk factors for young homicide offenders and victims. *Violent offenders: Theory, research, public policy, and practice*, 79-96. Retrieved from <http://books.google.com>
- Galambos, N. L., Petersen, A. C., Richards, M., & Gitelson, I. B. (1985). The attitudes toward women scale for adolescents (AWSA): A study of reliability and validity. *Sex Roles, 343-356*.
- Gouley, K. K., Brotman, L. M., Huang, K., & Shrout, P. E. (2008). Construct validation of the social competence scale in preschool-age children. *Social Development, 17*, 380-398.
- Gunter B., & Wober M. (1982). Television viewing and perceptions of women's roles on television and in real life. *Current Psychological Research, 2*, 277-287.
- Henry, D. B., Farrell, A. D., & The Multisite Violence Prevention Project (2004). The study designed by a committee: Design of the Multisite Violence Prevention Project. *American Journal of Preventive Medicine, 26*, 12-19.
- Henry, D. B., Tolan, P. H., Gorman-Smith, D., & Schoeny, M. E. (2012). Risk and direct protective factors for youth violence: Results from the Centers for Disease Control and Prevention's Multisite Violence Prevention Project. *American Journal of Preventive Medicine, 43*, 67-75.
- Johnson, C. D., Messe, L. A., & Crano, W.D. (1984). Predicting job performance of low income workers:

- The Work Opinion Questionnaire. *Personnel Psychology*, 37, 291-299.
- Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., & Andrews, J. A. (1993). Adolescent psychopathology: I. prevalence and incidence of depression and other *DSM-III-R* disorders in high school students. *Journal of Abnormal Psychology*, 102, 133-144.
- Lundy, B., Field, T., McBride, C., Abrams, S., & Carraway, K. (1997). Child psychiatric patients' interactions with their mothers. *Child Psychiatry and Human Development*, 27, 231-240.
- McHale, S. M., Crouter, A. C., & Tucker, C. J. (1999). Family context and gender role socialization in middle childhood: Comparing girls to boys and sisters to brothers. *Child Development*, 70, 990-1004.
- Pogarsky, G., Lizotte, A. J., & Thornberry, T. P. (1993). The delinquency of children born to youth mothers: results from the Rochester Youth Development Study. *Journal of Criminology*, 41, 1249-1286.
- Shapiro, J. P., Dorman, R. L., Burkey, W. M., Welker, C. J., & Clough, J. B. (1997). Development and factor analysis of a measure of youth attitudes towards gun and violence. *Journal of Clinical Child Psychology*, 26, 311-320.
- Solomon, B. S., Bradshaw, C. P., Wright, J., & Cheng, T. L. (2008). Youth and parental attitudes towards fighting. *Journal of Interpersonal Violence*, 23, 544-560.
- Weinberger, D. A., & Schwartz, G. E. (1990). Distress and restraint as superordinate dimensions of adjustment: A typological perspective. *Journal of Personality*, 58, 381-417.
- Weinberger, D. A. (1996). Distorted self-perceptions: Divergent self-reports as statistical outliers in the multimethod assessment of children's social-emotional adjustment. *Journal of Personality Assessment*, 66, 126-143.
- Werthamer-Larsson, L., Kellam, S. G., & Wheeler, L. (1991). Effect of first-grade classroom environment on shy behavior, aggressive behavior, and concentration problems. *American Journal of Community Psychology*, 19, 585-602.