Mental Health “Day Treatment Services”
For Adolescents with Emotional and/or Behavioural Problems

Evaluation Planning Grant #1299
Ontario Centre of Excellence for Child and Youth Mental Health

FINAL REPORT

Randal Penney, M.S.W., R.S.W., Project Lead

October 30, 2011
Executive Summary

Organization: Lutherwood (Waterloo, Ontario)

Program Title: Mental Health “Day Treatment Services” For Adolescents with Emotional and/or Behavioural Problems.

Project Lead: Randal Penney, M.S.W., R.S.W.
Assistant Director, Mental Health Services

Summary:
A program evaluation of Lutherwood’s Day Treatment Program for young persons aged 12-16 who exhibit significant mental health problems and behaviour issues that negatively impact their placement in community school. The evaluation is a learning opportunity to develop an evaluation framework as the first step toward increasing our internal capacity to conduct program evaluation.

The Purpose:

- To determine if the Day Treatment Program is reaching its intended target population.
- To determine if the Day Treatment Program provides young persons with increased coping skills by the time of their (discharge) return to community school.
- To build capacity for future ongoing evaluation of this and other programs at Lutherwood.

The Program:

Lutherwood serves young people and families in Waterloo Region, Guelph-Wellington and Grey-Bruce Counties with: Children’s Mental Health Treatment, Youth and Adult Employment, and Housing Services. Treatment approaches are evidence based (e.g., cognitive behavioural therapy), client centered and strengths focused. Evaluation utilizes the Child and Adolescent
Functional Assessment Scale (CAFAS) and Brief Child and Family Phone Interview (BCFPI). Additional tools may be used in some programs.

The Day Treatment Program (for age 12–16 years) is located at our head office in Waterloo and operates within two Section 23 classrooms: (i) *S.T.E.P.S* (School Transitions and Education Programs for Success), for youth exhibiting internalizing behaviours, and (ii) *Daybreak*, for youth primarily exhibiting externalizing behaviours. The overall goal is to transition the young person back to their community school setting better equipped with a range of practical skills and strategies to sustain their success in community school life.

Lutherwood’s overall strategic direction is to build its internal capacity to conduct on-going evaluation and research.

**The Plan:**

Consenting participants completed a series of questionnaires. The *BCFPI* (Brief Child and Family Phone Interview), *CAFAS* (Child and Adolescent Functional Assessment Scale) and a *Customer Satisfaction Survey* are completed by all clients. For the purpose of the evaluation we added the *Family Empowerment Scale* (Koren et al. 1992), and *Family Participation Survey* (Koren et al. 1997) to look at caregiver perception of their ability to understand and advocate for their child’s mental health needs as well as their input and participation in the treatment process. A *Logic Model*, specific indicators, a literature review and pilot test were also completed.

**The Product:**

Project activities included “pre” and “post” administration of each of the measures noted above. While recognizing the limitations of the small sample size (n=7) we found evidence that we are delivering a successful day treatment program. Pilot results suggest we are reaching our
intended clinical population, overall client functioning improved, and outcomes in the domains of school, family and community were enhanced. Families indicated satisfaction with their involvement and gained increased knowledge about their child’s needs, resources available to them, and were a better advocate for their child.

Staff exposure to the concepts and fundamentals of program evaluation has increased both our “knowledge” and “human resource” capacity for doing evaluation. New skills and knowledge were specifically gained through developing a logic model that clarified the inputs, outputs and intended outcomes and served as a compass for keeping the evaluation focused. The process also introduced us to new psychometric measures. We have applied for the ‘doing evaluation’ grant to build upon the knowledge gained and to complete a full evaluation of the Day Treatment Program. Knowledge Exchange activities involved periodic contact and sharing our completed work with five children’s mental health centres across southern Ontario who also have day treatment programs.

Amount Awarded: $18,700.20

Final Report Submitted: October 30, 2011

Region: MCYS Central West
# Table of Contents

1. INTRODUCTION AND LITERATURE REVIEW ................................................................. 6
   (a) Description of the Program .................................................................................. 6
   (b) Logic Model ......................................................................................................... 7
   (c) Purpose of the Evaluation and Questions Asked ...................................................... 8
   (d) Description of the Target Population and Relevant Stakeholders ......................... 9
   (e) Review of Related Research .............................................................................. 10

2. METHODOLOGY .............................................................................................................. 23
   (a) Design ................................................................................................................ 23
   (b) Measures ............................................................................................................ 25
   (c) Analysis of Data and Limitations ..................................................................... 28

3. PILOT RESULTS ............................................................................................................ 29

4. DISCUSSION, CONCLUSIONS, RECOMMENDATIONS & NEXT STEPS ................... 41
   (a) Discussion and Interpretation of Findings ............................................................ 41
   (b) Recommendations ............................................................................................ 43
   (c) Lessons Learned from Evaluation Activities ....................................................... 43
   (d) Impact of Evaluation ......................................................................................... 44
   (e) Next Steps ......................................................................................................... 44

5. KNOWLEDGE EXCHANGE PLAN ............................................................................. 45

REFERENCES .................................................................................................................. 47

APPENDIX A - PROCESS AND OUTCOME MATRICES .................................................. 53

APPENDIX B - EVALUATION MEASURES .................................................................... 61

APPENDIX C - CONSENT FORM ................................................................................... 75
1. Introduction and Literature Review

(a) Description of the Program:

Lutherwood was established in 1970 as an adolescent mental health centre. Its initial residential treatment program included an educational on-site “classroom”. In the mid-1970’s the educational program was redesigned to accommodate treatment services for community youth experiencing emotional and behavioural difficulties primarily in community school but who did not need a residential treatment intervention. Today five (5) on-site classrooms are part of Lutherwood’s treatment centre on Benjamin Road, Waterloo. All classrooms operate under contract with the Waterloo Region District School Board (Section 23 Program) and are staffed by the School Board (special education teachers) with the assistance of a Lutherwood child and youth worker in each classroom. All classroom programs are set up to meet the individual assessed needs of the students, so that treatment interventions take priority over academic activities. Of the five classrooms, two are designated as Day Treatment. Although the youth in these classrooms are housed within the larger milieu environment, and follow the same treatment modalities as the other classrooms, they are differentiated from the other classrooms by their homogeneous makeup (e.g., externalizing and internalizing) as opposed to the more heterogeneous make-up of the classrooms for the residential treatment programs.

Day Treatment, which serves young persons between the ages of 12 – 16, is an intensive voluntary integrated treatment and education program. The overall goal of Day Treatment as a specialized short-term service is to return the young person to their home community school setting equipped with a range of skills to make a better adjustment to life in community school. A copy of our Logic Model follows.
Program Logic Model: Day Treatment Evaluation – Lutherwood, Waterloo ON

Long-Term Goal: Successful reintegration of youth into school and community, and improved family relationships.

**Inputs:**
- Resources that are invested into a program to deliver the program activities, e.g., staff, funding, materials, equipment, and volunteers.

**Outputs:**
- The tangible results of delivering a set of activities
  - Activities are delivered to the targeted population in order to address the issue/problem.
  - STEPS (Stages of Early Transition Program) for youth ages 12-16 for 4-6 months (internalizing behaviors).
  - Daybreak for youth ages 12-16 for 4-6 months (externalizing behaviors).

**Activities:**
- Self-referral
- Referrals from schools, CAS, Physiatrist, Parents, Probation officers
- Intake by Front Door clinician
- Needs assessment conducted
- BCFPI info collected
- Initial goals set

**Recommendations for Programming:**
- Youth placed in STEPS or Daybreak class
- Conducted by program clinician whose goals are clarified, community school is contacted, liaison with clinician and principal designated
- Determine fit
- Keep community school involved
- Academic plans/goals made
- CATAS
- Individual and family therapy (on-site or in family’s home)
- Additional assessments as indicated
- Psychiatric, psychological, medical
- Weekly team meetings/conferences
- Treatment Plan of Care Meeting
- Strategic development and up to 6 goals solidified (related to emotion management and social skills)
- Reviewed Treatment of Care Plan
- Emotion Management Group (12 sessions)
- Social Skills Group
- Individual & family therapy (as indicated)
- Rehearsals (community) and within team
- Weekly team meetings
- Daily goal tracking
- Follow academic routine
- Strategies reviewed
- Celebrations, outings
- Discharge/Transition planning
- Emotion Management Group (12 sessions)
- CATAS at exit
- BCPI at exit
- Customer satisfaction
- Community reintegration follow up (6 and 12 months).

**Components:**
- Funding Foundation
- Recreational therapist
- Music therapist
- Transition worker
- Nurse therapist
- Chaplain

**Outputs:**
- STEPS for ages 12-16 for 4-6 months (internalizing behaviors)
- Daybreak for ages 12-16 for 4-6 months (externalizing behaviors)

**Outcomes:**
- Parents and youth have increased knowledge of community resources
- Parents and youth more comfortable with their diagnosis
- Increased understanding of academic capabilities
- Increased understanding of academic next steps
- Increased skills/strategies around understanding or managing behavior
- Increased understanding of academic capabilities
- Improved knowledge of leisure activities

**Intermediate:**
- Parents and youth are able to access community resources as needed
- Increased follow through with treatment in community
- Increased ability to advocate for school resources and accommodations as appropriate
- Improved family functioning
- Improved involvement with leisure activities
- Increase in self-efficacy (pro-social and learning) to home and school

**Funding Foundation:**
- 1 recreation therapist
- 1 music therapist
- 1 transition worker
- 1 nurse therapist
- 1 chaplain

**Long-Term Goal:**
- Successful reintegration of youth into school and community, and improved family relationships.

**Updated 5/4/2011**
(c) Purpose of the Evaluation and Questions Asked:

One of Lutherwood’s overall strategic directions is to build its internal capacity to conduct evaluation and research. We want to develop both (a) an overall process for conducting internal evaluations of our programs, and (b) benefit from opportunities to increase our internal capacity to conduct program evaluation. Internally, achieving these goals would give us the tools to build internal capacity to evaluate programs, monitor program implementation, examine program impact (outcomes), provide an opportunity for reflection on clinical practice (e.g., evidence based and best practice), inform decision making, support on-going continuous quality improvement activities, staff development and inform our strategic and service delivery decision making.

Externally, program evaluation enables us to responsibly demonstrate accountability and program impact to our funders, stakeholders and the public. Meeting and exceeding Children’s Mental Health Ontario accreditation standards, living up to our public value of service excellence and positioning us to be a recognized “go-to” child and youth mental health organization.

Lutherwood’s most recent Accreditation with Children’s Mental Health Ontario (November 2009), recommended the development and implementation of a system of program evaluation. Supported by our overall strategic plan and the on-going work of Lutherwood’s Continuous Quality Improvement and Best Practices Committees, application was made to the Ontario Centre of Excellence for Child and Youth Mental Health, for assistance in developing an evaluation framework. Being able to demonstrate, short and long term impacts and the implementation of evidence-informed practice would in due course, demonstrate accountability to our stakeholders (e.g., funders, the public), our clients and staff.
The selection of the Day Treatment Program as the exemplar for evaluation was based on three primary factors. First, the Day Treatment Program is perhaps the longest-running program in the continuum of our Mental Health Services. Secondly, Day Treatment had gone through a number of operational changes and restructuring without the benefit of a formal process of evaluation. Finally, the program has experienced the least percentage of staff turnover in the past couple of years. The questions that formed the basis of the evaluation were developed by the overall Day Treatment Team and were placed into the categories of (a) process, and (b) outcome questions.

**Process Questions:**
- Is our program implementing identified key components of other successful Day Treatment Programs in Canada, the United States and/or Europe?
- Are we reaching our intended clinical population?
- Are clients (and client families) satisfied with the services they received?

**Outcome Questions:**
- Are clients successfully reintegrating into school?
- Are clients successfully reintegrating into the community?
- Are clients experiencing improved family relationships?
- Are clients families more knowledgeable about their child’s needs and resources available to them?
- Is there an overall improvement in the clients functioning at discharge?

(d) **Description of the Target Population and Relevant Stakeholders:**

All Classroom Programs offer an academic program, schooling support, psycho-educational, individual and family counseling, life and social skills training. A maximum enrolment of 8 youth per class with up to 32 students served annually. Day Treatment’s
primary components such as, Social Skills, Life Skills, Emotion Management and personal goal development are structured around the Section 23 educational program. All interventions and approaches (e.g., Cognitive Behavioural Theory, Systems and Social Learning, modelling and skills coaching) are delivered within a multi-systemic/multidisciplinary framework and at a level appropriate for the youth served. A variety of therapeutic interventions are available including music and recreational therapy, and individual, group and family counselling. A school transition worker is available to provide limited support to youth returning to community school who are identified as needing additional transition support.

At the time of intake and assessment, young persons are recommended to be placed in the treatment classroom of “best fit” to meet the needs of the young person. Day Treatment’s two contrasting therapeutic classrooms are: (1) S.T.E.P.S (School Transitions and Education Programs for Success) provides transitional support for youth who are experiencing significant mental health issues that are usually masked by internalizing behaviours, (e.g., self-harm, suicidal ideation, school withdrawal, self-isolation, social phobia, etc) resulting in current/recent hospital involvement or a risk of hospitalization; and (2) Daybreak program is directed towards youth who are experiencing significant mental health issues and are primarily displaying externalizing behaviours (e.g., bullying, physical and verbal threats, defiance, substance abuse, intimidation, etc.) as a result.

(e) Review of Related Research:

Introduction:

The provision of mental health treatment to adolescents with emotional and/or behavioural disorders may be delivered within a very broad array of settings as well as within a range of equally diverse service delivery models. Generally, service models are
found on a continuum of intrusiveness (least, to most intrusive), will vary in delivery location (community-based, in-home, school, hospital, etc.), may vary in target population (age, gender), will differ based on diagnosis or presenting issues, will diverge in duration and frequency (number of sessions, weeks, months or years), and will be different in the type and/or number of interventions utilized (individual and group interventions, skill development, behaviour modification, cognitive behavioural, etc). Finally, the mental health treatment model may be delivered by a sole individual, a series of unrelated individuals, and/or a multi-disciplinary team.

This literature review focuses on the provision of mental health treatment to adolescents (age 12-16) with emotional and/or behavioural disorders in a “day treatment” model of service delivery. “Day treatment” is a model of mental health intervention delivered within the context of an education program for adolescents whose difficulties at community school require an individualized intervention within the context of an academic and treatment milieu (Stroul & Friedman, 1986). Thus, the general concept of a “day treatment” program is to provide mental health intervention(s), to address emotional and behavioural difficulties, with skills and strategies that can be successfully utilized by the young person when they return to their home school.

Part of Lutherwood’s continuum of mental health services is a day treatment milieu program where youth and families can access mental health treatment services with minimal disruption to the functioning of daily life. The Lutherwood day treatment program offers two classrooms: (a) Daybreak, primarily serving youth exhibiting primarily externalizing behaviours, and (b) STEPS (School Transitions and Education Programs for Success) serving youth exhibiting primarily internalizing behaviours.
Day Treatment: Common and Dissimilar Elements:

A review of the literature uncovered a great assortment of mental health treatment models under search terms such as, “day treatment”, “school treatment”, “school based mental health programs” and “school behaviour support”. The search revealed several different mental health programs labelled “day treatment” (for treatment of adolescents) such that day treatment was quite a generic concept given the multiplicity of models reflected in the literature. Among the multiplicity of ‘day treatment’ models were some factors that were common to most reviewed “day treatment” models as well as factors that might be considered unique across the various models represented.

Even among common program elements reported in most models (e.g., length of stay, parent/caregiver role, staffing, program environment, etc.), there is great variability in application. The greatest disparity noted was the ‘length of stay’ by program participants, ranging from 45 days (Carpenter-Aeby et al., 2001) to multiple years (Svedin & Wadsby, 2000; Jacobs et al., 2008). The average length of stay in day treatment programs was 143 days (Milin, et al., 2000). Although the setting or location of the programs varied, there were three primary settings in which day treatment occurs: within a community school (Robinson & Rapport, 2002), an off-campus school-type setting (Miller et al., 2005; Carpenter-Aeby et al., 2001; Jacobs et al., 2005; Roberts et al, 2003; Simonsen et al, 2010; Svedin & Wadsby, 2000), or within a hospital unit or health centre (Robinson et al., 1999; Jerrott et al., 2010; McCarthy et al., 2006; Milin et al., 2000; Rey et al., 1998; Robinson, 2000). Given the variety of treatment settings, the actual setting may be less of a factor for treatment success than the operational content of the day treatment program.
The literature demonstrates that many day treatment models incorporate similar treatment components. Common elements, which will be considered here, include “parent or family involvement”, “multi-disciplinary staffing teams” and “individual behaviour contracts”. All of the literature reviewed presented “day treatment models” utilizing various treatment components and models, including cognitive behavioural therapy, positive behaviour support/reinforcement system; group therapies (e.g., social skills, emotion management); individual therapy sessions; and level system or token economy. Three studies (Roberts et al., 1993; Jacobs et al., 2005; Jerrott et al., 2010) mentioned specific relaxation training, which will also be reviewed. We also found information about specific classroom models which could be incorporated into a day treatment setting. These models, known as the Tribes Learning Community (TLC)® and the Responsive Classroom® (RC) integrate social and academic learning to create classrooms that are more conducive to learning (Rimm-Kaufman & Chiu, 2007; Anderson, 2007). These components may or may not comprise part of the programming within the day treatment programs that we reviewed, although they were not mentioned specifically. Given that Lutherwood’s day treatment program emphasizes treatment over academics; we will not review these models within this document.

Role of Parent(s) and /or Caregivers:
Caregiver involvement in a young person’s mental health treatment has been found to be positively influential in creating an atmosphere for change. “Greater caregiver involvement was linked to improvement in child thought processes, increased ability to provide emotional and social supports for the child, and greater overall child functioning at discharge” (Richards et al., 2008). Parents who participate in parenting programs within the framework of their child’s treatment, note improvement in their child’s conduct problems (Dretzke et al., 2009). Many of the programs noted family involvement as a
key component, where “parents are required to be involved in the treatment process: attending parenting groups, completing daily program sheets, and attending scheduled meetings.” (Jerrott et al., 2010). One school program, in which parental involvement was extensive, initiated a Parent Advisory Council in order for parents to participate in school activities and governance (Miller et al., 2005). The Day Treatment program at Lutherwood strongly encourages caregiver involvement in their child’s treatment, including family therapy sessions, monthly progress meetings, and a Parent Advisory Council.

Key to the parent/caregiver’s role within treatment, they are also considered to be part of the multi-disciplinary treatment team. At Lutherwood, this team is comprised of staff from the treatment program (e.g., child and youth counsellors, social workers, teachers, psychologist, nurse, chaplain, etc) the client, client’s family, and external agencies/community resources. The composition of a broad multi-disciplinary team extends the accessible expertise to be utilized in the treatment plan beyond the walls of the facility, into the community and into the family home. Most day-treatment programs reviewed incorporated some form of multi-disciplinary team, some larger and more diverse than others, but teams that included Special Education Teachers, Social workers, Psychologists, Child and Youth Counsellors or other paraprofessionals, and clinical nurses (Milin et al., 2000; McCarthy et al., 2006; Simonsen et al., 2010; Miller et al., 2005; Rey et al., 1998; Carpenter-Aeby et al., 2001; Robinson and Rapport, 2002; Jerrott et al., 2010; Jacobs et al., 2008; Roberts et al., 2003; Jacobs et al., 2005; Robinson, 2000; Robinson et al., 1999; Vanderploeg et al., 2009). In this regard, it would appear that the multi-disciplinary team with Lutherwood’s Day Treatment program would offer a comparable staffing model.
**Therapeutic Elements:**

Most of the day treatment programs reviewed adopted components from various therapeutic models in their work with children and youth. The use of group, family and individual therapy across programs was reported by the authors of the studies. Group therapy included Social Skills training (Robinson et al., 1999; Jacobs et al., 2008; Roberts et al., 2003; Jacobs et al., 2005; McCarthy et al., 2006; Miller et al., 2005; Vanderploeg et al., 2009) and Anger Management training (Jerrott et al., 2010; McCarthy et al., 2006; Robinson and Rapport, 2002), comparable to those groups offered at Lutherwood. Group cognitive behaviour therapy has been shown to be effective in internalizing disorders such as depression and anxiety, in adults (Oei and Dingle, 2008), adolescents (Wilkinson and Goodyer, 2008) and children (O’Brien et al., 2007), in addition to being effective in reducing externalizing behaviours, such as anger expression (Gorenstein et al., 2007). In each of the programs, clients receive additional therapy through one-to-one sessions, to work on their specific treatment goals. This is another core component of Lutherwood’s Day Treatment program.

**Positive Behaviour Support/Reinforcement System/Individual Behaviour Contracts:**

Another component frequently noted in the literature, is the use of Positive Behaviour Support/Reinforcement and/or Individual behaviour contracts. Several of the programs employed the practice of providing constant feedback to reinforce appropriate behaviour (Miller et al., 2005; Simonsen et al., 2010; Robinson, 2000; Robinson et al., 1999; Robinson and Rapport, 2002; Jacobs et al., 2008). Robinson et al., (1999), noted that approximately one verbal/non-verbal praise was given every 2 – 5 minutes. The practice of clearly stating behaviour expectations and providing immediate redirection or feedback was noted as being a multilevel, proactive model of discipline, emphasizing direct intervention. Upon implementation, program personnel noted the practical
difference this made in their daily lives, reducing the need for negative sanctions such as physical restraints (Miller et al., 2005).

Token Economies and Behaviour Modification:

The utilization of level systems and token economies is not a new behaviour modification practice in children and adolescent mental health services. The literature credits Avendano y Cardeñera with the first therapeutic application of this system (Matson & Boisjoli, 2009). Within Day Treatment programs, the practice of earning tangible rewards and/or privileges based on behaviour provides frequent opportunities for reinforcing positive behaviour (Robinson and Rapport, 2002). Token systems are suitable for addressing generalized reinforcement functions (Hackenberg, 2009) and have been shown to effectively decrease disruptive behaviors in classroom settings (Reitman et al., 2004). Miller et al., (2005) reported the implementation of a “more effective token economy tied to a school store” as one of the earliest interventions implemented at Centennial School. School staff reported a marked decrease in the use of physical restraints almost immediately. This was despite the severity of their client population, where the students were identified as being in the first percentile in terms of behaviour extremity (Miller et al., 2005). The use of level systems and token economies has also received negative review in the literature. Studies have shown them to be punitive, as in the case of losing a privilege or dropping a level, where the child or youth may view this action as unfair (Mohr et al., 2006). Point and level systems may not take into account the ability of an individual to display the desired behaviour, based on their social background and developmental capability (Tompkins-Rosenblatt & VanderVen, 2005). Additionally, by delaying the reward until a set number of points are achieved, effective positive reinforcement is not achieved (Mohr et al., 2006).
Relaxation Training:

Several programs have reported including relaxation training as part of their work with clients (Roberts et al., 1993; Jacobs et al., 2005; Jerrott et al., 2010). Goldbeck and Schmid (2003) report that relaxation training, used by itself, can be an effective broadband modality in treating children and adolescents with behavioural and/or emotional problems. Adolescent males who presented with stress and anger issues used progressive muscle relaxation daily for eight weeks (Nickel et al., 2005). They were not actively involved in any other therapies during the eight weeks of the study. Their post measures showed a decrease in State-Anger (subjective state of anger at the time of measurement), Trait-Anger (readiness to react with anger) and Anger-Out (tendency to direct anger) scales, as indicated on the State-Trait Anger Expression Inventory (STAXI). Additionally, they scored higher in the Anger-Control (tendency to control anger) scale after the eight week program. One caution noted in the literature, however, is that the relaxation training or mind-body interventions have been provided by medical health practitioners with extensive experience in these practices (Finger and Arnold, 2002). For our purposes in community based mental health interventions, are these interventions as effective when provided by social workers and other mental health providers who may or may not have extensive training in relaxation techniques?

Admission and Length of Stay:
As noted previously, length of stay was one component that evidenced the greatest disparity between day treatment programs, varying from a few weeks (Carpenter-Aeby et al., 2001) to several years (Svedin & Wadsby, 2000; Jacobs et al., 2008). Certainly the differences in program model and overall treatment approach among programs on both ends of the “length of stay” spectrum would lend itself to an interesting review in and of itself. Many programs, including Lutherwood’s Day Treatment services do not
have the ability to provide lengthy interventions. Lutherwood, like many similar mental health service providers must operate within the limitation of available funding and meet stakeholder and funder service targets. Such realities do not afford a lot of room to alter the number of clients being served and/or the length of stay in program. In our 15-17 week ‘short-term’ treatment program model, (e.g., classroom milieu, individual and family therapy, and the process of reintegration to community school) we provide on-going opportunities for skill development, and cognitive and behavioural change and assistance during community school reintegration.

Day Treatment models are compromised of many variables, not the least of which is ensuring “best of fit – right client” for a specific program model. It makes sense that we want to ensure we are admitting the right youth into a day treatment program, in order to provide the most appropriate services based on the needs of each client family. The literature clearly demonstrates that in the majority of cases the intake process for day treatment programs is initiated by the young person’s home school (Simonsen, 2010; Jacobs et al., 2008; Roberts et al., 2008; Jacobs et al., 2005; Robinson & Rapport, 2002; Miller, 2005; Milin et al., 2000; Carpenter-Aeby et al., 2001; Rey et al., 1998), although referral is also frequently initiated by health professionals (Rey et al., 1998; Carpenter-Aeby et al., 2001; McCarthy et al., 2006; Milin et al., 2000), followed by family members, external agencies, self-referral, and youth justice systems (Carpenter-Aeby et al., 2001).

We found that programs carry out an evaluation or assessment process prior to the young person’s admission into program. The intake process guides the young person’s entry into treatment, by date of referral (Jerrott et al., 2010), by prioritizing of the wait list (Robinson, 2000), or by identifying a prospective candidate as being ineligible for treatment based on exclusion criteria. Specific exclusionary criteria noted in some
programs included: severe delinquency (Rey et al., 1998; Milin et al., 2000), substance abuse (Rey et al., 1998), severe intellectual deficits (Rey et al., 1998; Milin et al., 2000; McCarthy et al., 2006), functional psychoses (Rey et al., 1998; McCarthy et al., 2006), serious physical illness or impairment (Rey et al., 1998; McCarthy et al., 2006), or those not living with adult caregivers (Milin et al., 2000). The intake process may also provide an opportunity for the completion of psychological or psychiatric evaluations (Rey et al., 1998; Robinson & Rapport, 2002; McCarthy et al., 2006), and interviews with the candidate, family, schools and partnering agencies (Rey et al., 1998; McCarthy et al., 2006). This would seem to suggest as a general rule that prior to enrolment in a day treatment program, appropriate screening has taken place to ensure the placement is the most appropriate for the young person’s specific needs.

In a similar manner, Lutherwood utilizes the services of *Front Door*, (a partnership intake centre for children and youth and their families, who are seeking to access mental health services in Waterloo Region, Ontario). The intake process at *Front Door* includes interviews with the family, completion of the *Brief Child and Family Phone Interview* (BCFPI), a Needs Assessment, and review by a Common Intake Committee to determine the most appropriate service for the referred young person. Additionally, upon entry into the Day Treatment program at Lutherwood, the period of time leading up to the young person’s initial Treatment Plan of Care meeting, (usually 30 days after admission), is seen as an on-going assessment time, to determine fit for the classroom, treatment readiness, solidify individual goals, and complete any additional assessments as indicated. As part of this process, the clinician working with the young person will complete an entry *Child and Adolescent Functional Assessment Scale* (CAFAS), rating the youth’s level of functioning across the domains of School/Work, Home, Impact on Community, Behaviour Toward Others, Moods/Emotions, Self-Harmful Behaviour,
Substance Use, and Thinking. This additional assessment provides further information for the development of treatment goals, and can be used again at discharge to measure treatment outcomes (Hodges, 2004).

Despite the referral and admission screening process and attempts made by program staff to engage and facilitate successful admission into program, some young persons, for any number of reasons, are discharged from the program earlier than originally anticipated. In their study of why clients of all ages terminate treatment, Westmacott and Hunsley (2010) found that almost half of their respondents reported one of three reasons for early termination: a barrier to treatment, a dislike of treatment, or wanting to solve problems in a different manner. Specific to the child and adolescent population, youth whose parents report higher levels of parenting stress or life stress, and children or youth with a sibling involved in mental health treatment have been found more likely to be treatment “non-completers” (Pellerin et al., 2009). Family environmental factors, such as low family cohesion, conflict and organization were found to place young people at greater risk for refusal of school-linked mental health services after the intake session (Keeley and Wiens, 2008). This is an area of great interest and one that warrants further exploration. What are the barriers, perceived or actual, that our clients are experiencing as they integrate into programming? How can we work more effectively with families experiencing negative environmental factors, so that their children will be more able to complete treatment?

Client Outcomes:

As we consider client outcomes, and completion of treatment, we want to look at how to gauge (measure) treatment success. In particular, how is treatment success measured: through clinical outcome measures, reported improvement in the young person’s
symptomatology, or reported improvement in behavioural functioning by the client and/or family? Of the studies that we reviewed, both processes were utilized. Specific outcome measures that were administered included the Child Behaviour Checklist (CBCL) (Jerrott et al., 2010; Rey et al., 1998; Milin et al., 2000), Youth Outcome Questionnaire (Y-OQ) (Robinson, 2000; Robinson et al., 1999; Vanderploeg et al., 2009; Robinson and Rapport, 2002), Parenting Stress Index (PSI) (Jacobs et al., 2008; Roberts et al., 2003; Jacobs et al., 2005; Jerrott et al., 2010) Strengths and Difficulties Questionnaire (SDQ) (McCarthy et al., 2006), and the Child and Adolescent Functional Assessment Scale (CAFAS) (Jacobs et al., 2008). Additionally, program specific data collection was generated from client records (Svedin and Wadsby, 2000; Carpenter-Aeby et al., 2001) or climate data (Simonsen, 2010). Within the Day Treatment programs at Lutherwood, the measures currently collected at admission and discharge are Child and Adolescent Functional Assessment Scale (CAFAS), a clinician rated measurement; the Brief Child and Family Phone Interview (BCFPI), a parent rated measurement; and Customer Satisfaction Questionnaires from both parents and youth. Coad and Shaw (2008) support such feedback, as from a customer service perspective it is necessary to recognize that children and youth are important consumers of health care.

Interestingly, parents and youth evaluate their experiences within mental health programs from different perspectives regarding what matters, as well as what was “liked” within treatment. Parents frequently report valuing the coordination of services and information and referrals received, in addition to mentorship for their child (Aarons et al., 2010). Youth report valuing specific services within the treatment program, such as recreation opportunities, school help, and life skills training, in addition to having a counsellor or mentor. Young persons were also more likely than their parents to report
positive outcomes, such as having better self-esteem, and feeling less depressed (Aarons et al., 2010). Adults and young people do agree on the helpfulness of general mental health interventions from individuals such as family doctors, counsellors, support of family and friends, and specific support groups (Jorm and Wright, 2007).

The importance of collecting feedback during and after treatment is significant. Service users are best able to answer questions concerning components of treatment delivery, and whether these components are found to be meeting the clients’ needs (Chamberlain, 2005). By involving the youth participating in treatment, their empowerment is promoted, by which they believe their contribution will make a difference in influencing decision-making (Sinclair, 2004). Research also suggests that adults and youth prefer a collaborative role within the decision making process concerning their health care, rather than being a passive recipient of services or, alternately, being the one in total control (Coad and Shaw, 2008). Given these findings, we would be interested in pursuing the collection of additional data from the youth in our Day Treatment program, particularly concerning their perspectives on goal attainment or treatment success. Although we currently collect client satisfaction measures, we would like to obtain increased information concerning our clients’ experience within treatment; which components were most helpful and which components were less so. The input of our clients, both parents and youth, will insure appropriate and desired change to treatment services.

Conclusion:
As a step in planning the evaluation of our Day Treatment Program (Daybreak and STEPS Classrooms), we set out on this literature review hoping to find day treatment programs similar to our own. What we found was a plethora of treatment models under
familiar search terms such as “day treatment”, “school treatment”, “school based mental health programs” and “school behaviour support”. We found similarities and diversity among programs and even within common elements there were significant differences (e.g., length of stay in a program).

The importance of active parental involvement was acknowledged by virtually all in the quest toward progress and positive outcomes. The completion of a thorough screening and assessment process to determine “best-fit” based on program model is also clearly acknowledged as critical to client success.

Several areas are acknowledged for improvement and further research. The reasons why young people prematurely leave programs need to be further researched. When considering overall treatment success, it will be essential that “length of stay” is also further examined as a crucial variable. The other factor worthy of additional attention is obtaining customer satisfaction feedback from young person’s themselves and not relying solely on parental/caregiver ratings of treatment as the measure of treatment outcome/success.

2. Methodology:

(a) Design:

One of our first steps in participating in the Planning Evaluation Grant was the establishment of an Evaluation Team, consisting of management, front-line staff, program evaluation coordinator, school board partners, and representatives from Lutherwood’s Board of Governors. This team directed the planning of the evaluation framework and was the primary liaison with our Research Associate from the Ontario
Centre of Excellence for Child and Youth Mental Health. In order to develop evaluation questions, we sought input from the larger Day Treatment team. At a team breakaway day, a brainstorming session was held to determine what evaluation questions were identified to be most useful. Although questions were asked about particular interventions, i.e. individual vs. group therapy, or the best use of staff resources, consistent themes emerged: “Are we providing the best services to our youth?” and “Are we admitting the appropriate youth into our program?” Additionally, Lutherwood’s Board of Governors had identified successful client reintegration as an area for study. These themes, along with the intended outcomes from our Program Logic Model were then reorganized into specific outcome and process evaluation questions at our next team meeting. These questions are identified in our Outcome Evaluation Matrix and Process Evaluation Matrix (Appendix A).

The Day Treatment program at Lutherwood has the capacity to serve 32 youth in programming; 8 youth in each of two classrooms each semester. In order to accommodate a smooth transition both entering and exiting from program, Lutherwood typically admits youth coinciding with the Waterloo Region District School Board’s semester schedule. Thus, admissions occur primarily in September and February, and discharges occur primarily in February and June. There are, of course, exceptions to this, as we work with the needs of our client families.

Within the admission process, parents complete the Brief Child and Family Phone Interview (BCFPI) with an intake clinician. This measure, along with a Needs Assessment and identified goal areas from family interviews, form the basis for a recommendation for program, which is approved at a common intake committee meeting. Within the first month of admission, the program clinician completes the Child and Adolescent Functional Assessment Scale (CAFAS). Additionally, we collect youth
questionnaires at admission and discharge to program. Finally, we have incorporated questionnaires designed to provide responses to our specific evaluation questions, both at admission and discharge.

(b) Measures:

Thus, the measures completed for our program evaluation were as follows (copies are included in Appendix B, where applicable):

CAFAS - The CAFAS is a standardized clinician-rated measure of child and adolescent functioning in core domains; School, Home, Community, Behavior towards others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking. CAFAS is completed at admission to and discharge from program. Of particular consideration were the School scale, Community scale, and Home scale, Youth total and composite scores for internalizing and externalizing behaviors. Internalizing score were calculated from a combined Moods and Self-Harm score; externalizing were calculated from combined School, Home, Community and Behavior towards others scores.

BCFPI – BCFPI is a standardized measure which can be administered to parents, adolescents, or teachers. It measures child and family functioning. As noted above, BCFPI is collected from parents as part of the admission process, and is collected again at discharge. To obtain the youths’ perspective of functioning, we administered the Adolescent BCFPI at admission to program, mid-point of program (at approximately 7 weeks), and at discharge from program. From the parent completed measure, of particular interest were the School participation and achievement score, Global family situation score, Family functioning score, and Internalizing – Populations norms and Externalizing – Populations norms. From the adolescent completed measure, of particular interest were the Total Mental Health score.
Family Empowerment Scale – This measure has been tailored from a measure in the literature (Koren et al. 1992), and has been structured to measure caregiver perception of their level of empowerment, or ability to understand their child’s mental health needs and advocate for their child. It is standardized, but does not have norms. The Family Empowerment Scale has a possible score of 60, with higher scores being indicative of greater feelings of competence and/or knowledge by the family. The Family Empowerment Scale was collected from parent(s) at admission and discharge to measure change.

Family Participation Survey – This 14 question measure has also been tailored from a measure in the literature (Koren et al. 1997), and has been structured to measure caregiver input and participation into the treatment process for their child. Completed at discharge by the caregiver, it provides an opportunity to look at concrete signs of participation (asked for opinions about child’s needs; attended meetings about child), in addition to the caregiver’s subjective perspective about participation (input during meetings was considered important; opinion about child was considered important). It is not a standardized measure. A total possible score would be 56; if each question was answered with a “4” or “very much true”. Overall, we identified surveys with a total score in the range of 42 – 56 (or a response of 3-4 on each question) to be considered as meaningful for this measure. Additionally, specific questions, such as “I did attend meetings about my child” were identified as core components of caregiver involvement; the responses to these questions were subjected to additional examination.

Client Satisfaction Surveys – Client Satisfaction Surveys were collected from both caregiver and youth at discharge. This measure consists of both qualitative and quantitative questions. The quantitative portion includes eight questions including areas such as timeliness of service, satisfaction about level of involvement, and staff
availability, rated on a 5-point Likert scale. In the qualitative portion, clients were asked about specific areas for improvement and any areas of dissatisfaction.

Client Reintegration Questionnaire - At two intervals from discharge from program, six and twelve months, client families are contacted for follow-up and for their responses to specific questions regarding family functioning and their child's reintegration into home, school and their community. The Client Reintegration Questionnaire has been developed in-house; it is not standardized, nor does it have norms.

Client Goal ratings – At the time of contracting into program, at each treatment plan of care, and at discharge clients/client families are asked to discuss and agree upon a numeric rating for their current level of functioning on the contracted treatment goals, i.e. school and/or family goal. This rating becomes part of the client’s official documentation within their clinical record. After discharge, the difference between the before treatment and after treatment scores are tabulated.

School transition feedback – At the time of discharge from Lutherwood’s Day Treatment services, it is acknowledged that some youth would benefit from additional support as they transition to their community school. The Mental Health Services Transition Worker is an integral part of the continuum of mental health services to adolescents experiencing significant difficulties in their school setting. In partnership with the youth, family and school system this service offers a time limited, structured environment where youth and families implement new skills and thinking strategies and are supported with their individual treatment goals. For those discharged program clients who were admitted into the Transition Worker program, qualitative feedback from Lutherwood’s School Transition Worker would be obtained 6 – 8 weeks post discharge (for clients who discharge in February), or in late October/early November (for clients who discharge in
June). For those clients who are not working with the School Transition Worker, program staff will check in with the client’s home school in order to obtain qualitative feedback concerning their reintegration to community school.

Quality File Audits – at regular intervals (minimum of quarterly) during a client’s participation in program, and after discharge, the Day Treatment Program Manager conducts a quality file review of the documentation contained within each client’s clinical record. This quality check enables program staff to ensure key components from the logic model have been implemented within the Day Treatment program, such as completion of required assessments, indications of family involvement, goal setting, community referrals and whether specific needs of the client were acknowledged and addressed.

(c) Analysis of Data and Limitations:

In order to analyze quantitative data, we entered all data into MS Excel, which enabled us to look at comparative scores (to norms where applicable) and individual client change scores (from admission to discharge). Qualitative data was also documented and reported as feedback to the evaluation and treatment teams. As the length of stay in program was relatively short-term (average 4.0 months), only the data from admission to discharge was reviewed. Although some measures were collected during a client’s involvement (goal ratings, youth BCFPI, Quality file audits), these measures are used to enhance the treatment process and ensure positive treatment outcomes, and were not used to measure change in this program evaluation.

Several potential limitations were evident when considering the measures to be used. The BCFPI, while standardized, can be subjective and may be impacted by extraneous or environmental factors. Additionally, several measures capture qualitative data. While
this data does provide valuable feedback, especially concerning client experiences in program, it also may be impacted by factors which may not be within the control of the program itself. For example, one family may react quite negatively to a change in program staffing and note this on their client feedback questionnaires. Other families may find the transition to a new staff to be quite seamless, and not indicate it as an area of concern or dissatisfaction.

Ongoing challenges exist around the collection of complete data sets. Families who may transition into or out of the program at an “untypical” time may be missed for some measures, and this variation in admission dates could impact the midpoint of treatment for many youth. Although we did not implement specific strategies to help control the possibility of missing data, we have identified some strategies that could be implemented in the future, such as a discharge evaluation checklist or an electronic reminder in MS Outlook specific to the mid-point of treatment. We have also, in the past, found that the collection of community reintegration data six and twelve months after client families have discharged from program can be particularly difficult, due to the frequently transitory nature of our client families.

3. **Pilot Results**:

For our pilot data the families from STEPS, one of our two Day Treatment classrooms participated. Given the timelines around the selection of data measures, participation was limited to program participants who were admitted in the second semester and also discharged by the end of the school year. Within these clients / client families in program, however, varying admission dates occurred. Seven clients were admitted into program at the first day of the school semester, or February 7th, 2011, although two clients discharged within the first month. Two additional youth were admitted to program
after six weeks, or on March 21\textsuperscript{st}, 2011. One client was admitted on April 26\textsuperscript{th}, but was not scheduled to be discharged at the end of the semester. Thus, seven client families met the criteria for completing pilot data, and consented to participation. As a note: the three youth who were admitted after the original client set were not available to complete the youth BCFPI within the same time parameters as the original group of youth; as a result the youth BCFPI’s for these clients were not included in our pilot data results.

The measures we administered are noted above under Methodology, with the exception of School Transition Worker Feedback, as the clients who were discharged from program have had limited time in their community schools.

Our evaluation questions and preliminary data are as follows:

\textit{Is our program implementing identified key components of other successful day treatment programs in Canada, U.S. and Europe?}

The key components that we identified from our Literature review were caregiver involvement, and specific therapeutic components (individual therapy, group therapy, family therapy and individual behavior contracts). Client families were given the Family Participation Survey at discharge and were asked to return it at their earliest convenience. Four families returned the measure. All of the families met the criteria for successful participation, with an average score of 53 (range 49-56). Answers to specific questions are noted in Figure 3.1.
Figure 3.1 – Family Participation Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Average score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did attend meetings about my child.</td>
<td>4.0</td>
</tr>
<tr>
<td>I was asked for my opinion about my child’s needs.</td>
<td>4.0</td>
</tr>
<tr>
<td>I was involved in developing the service plan for my child.</td>
<td>3.5</td>
</tr>
<tr>
<td>I feel like a partner and active participant in planning and coordinating services for my child.</td>
<td>3.8</td>
</tr>
</tbody>
</table>

The FPS has 14 questions rated on a four point scale, with a maximum possible total score of 56. Higher scores indicate higher levels of participation in service as reported by caregivers. Note – not all questions are included here. N=4

Additionally, all client files were reviewed upon discharge, to ensure file documentation includes information regarding specific therapies, family involvement, and individual behavior contracts, most often safety planning within Lutherwood’s treatment programs. All of the files included specific information about group therapy, individual counseling sessions, family involvement within the treatment setting, and safety planning.

Are we reaching our intended clinical population?

As noted within the literature review, in the STEPS classroom it would be expected that youth would primarily exhibit internalizing behaviours in the BCFPI and CAFAS completed at or near the time of admission to program. We also believed that the Client Satisfaction Surveys would provide information for this question: If we place youth in the most appropriate treatment program, this would be reflected in satisfaction ratings.

The BCFPI, administered as part of the intake process, is used in conjunction with family goals and a completed Needs Assessment to determine the best program fit for the client and their family to achieve their indicated treatment goals. Additionally, within the first month of treatment the clinician completes a CAFAS survey on each youth in
program, in order to ensure the client’s needs/goals are being addressed within the treatment milieu.

From the admission BCFPI data in Figure 3.2, we can see that all seven youth admitted to the STEPS classroom were above the 50th percentile in internalizing behaviour, although only 4 were above the 70th percentile, or in the clinical range. It should be noted that admission to the program considers a number of factors (e.g., psycho-social needs assessment, referral source, etc.) and is not solely determined on the basis of the BCFPI score.

**Figure 3.2**

In a similar manner, the scores from the CAFAS (Figure 3.3, below) indicated higher levels of impairment in the internalizing scales, with the exception of two clients.
In order to fully examine the behaviours clients are presenting with, we compared internalizing and externalizing behaviours from the admission BCFPI and CAFAS, as seen in Figure 3.4 and Figure 3.5. By adding the externalizing scores (shown by squares at the data points in BCFPI; patterned bar in CAFAS) to the internalizing scores (shown by diamonds at the data points in BCFPI; solid bar in CAFAS), we see that all of the youth presented with lower scores on externalizing behaviour compared to internalizing behaviour, except for three youth. One youth presented with a combination of internalizing and externalizing behaviours; the other two presented with higher scores in the externalizing domains. In review of the Needs Assessments for these two youth, it became apparent that these youth outwardly displayed externalizing behaviours for their internalizing diagnoses.
Considering the findings from these measures, we believe we are reaching our intended clinical population.
Are clients/client families satisfied with the services they received?

This question utilized two measures, the Client Satisfaction Questionnaires (both parent and youth) and the Family Participation Survey. Lutherwood has set an organizational target for client satisfaction (parent survey) as 95%. Client satisfaction surveys were considered to determine overall satisfaction with treatment, and whether families felt the services offered had met their needs. Two questions determine overall satisfaction: “In a general, overall sense, how satisfied are you with the service you received?”; and “Would you recommend Lutherwood to a friend who may be in need of similar services?”

Overall satisfaction was rated as 100% for all seven parents, and 92.9% for the youth involved. Additionally, one specific question addressed whether families received the kind of help they wanted and/or did the services they received meet their needs. Six of the seven parents (86%) responded probably or definitely yes, as did 100% of the youth. We also again considered the Family Participation Survey. All of the seven families met the criteria for positive participation, which from our literature review was identified as a key component for family satisfaction.

Are clients successfully reintegrating into school?

We examined several measures to determine whether clients were successfully reintegrating into school. The first measure considered was the School/Work domain of the CAFAS, specifically whether there was a significant change in client score from admission to discharge and whether this domain was rated as minimal or none in impairment at discharge. As shown in Figure 3.6, almost all of the clients had a significant change in CAFAS scores, in accordance with the CAFAS guidelines of a change greater than or equal to 20 points. Additionally, all but one client was rated at minimal or no impairment at discharge.
BCFPI data, as seen in Figure 3.7 showed a similar trend. Most of the clients, six of seven, presented at intake with school participation scores in the clinical range of greater than or equal to 70. At discharge, all of the clients but one had significant improvement in their school participation scores, although two clients remained in the clinical range.
We also considered the direct input of clients and their families concerning their change in level of functioning within a school setting. At the time of setting treatment goals, families are asked to provide a numeric value of the current level of functioning in each goal area, using a scale of 1-5, with 5 being the highest level. All of the client families reported an improvement in the school goal, from one to three points.

Two final measures provided the final information regarding school functioning. These qualitative measures both involve feedback from school workers at six to eight weeks post discharge, and feedback from the parents/caregivers at six and twelve months post discharge. At the time of this report, information was not available from either of these sources.

Are clients successfully reintegrating into community?

In order to measure client reintegration into their community, we again utilized CAFAS. We specifically considered the Community domain of the CAFAS; whether there was a significant change in client score from admission to discharge and whether this domain was rated as minimal or none in impairment at discharge. None of the clients had an impairment in functioning at admission to program, so measurable change in this area was not possible. Additionally, the parent follow-up at six and twelve months would be another measure of improved functioning in the community. It may be, if we expand our evaluation to the Daybreak classroom, where externalizing behaviours are often more apparent, we could be able to measure this evaluation area more fully.

Are clients experiencing improved family relationships?

Four measures were identified to be useful in measuring improvement in family functioning. CAFAS Home domain, BCFPI Global Family Situation and Family
Functioning scores, and the Family Goal rating are qualitative measures, administered at intake or admission and again at discharge. Parent/Caregiver report would also be sought at six and twelve months post discharge.

As in previous evaluation areas, we again looked at the CAFAS Home scale for a significant change in client score from admission to discharge and whether this domain was rated as minimal or none in impairment at discharge. Similar to the community area, none of the clients had an impairment in functioning at admission to program, so measurable change in this area was not possible.

We intended to use the two scales from the Parent BCFPI, but there were no clients with scores in the clinical range at admission for Family Functioning. We did use the Global Family Situation scale; which combines items from the Family Activities and Family Comfort scales. One client family did not complete these sections in their entirety, which resulted in a total score being unavailable. We, therefore, did not use this client’s information at discharge, as a comparison in scores was not possible. As seen in Figure 3.8, at intake, all clients scores were above the 50th percentile; only one client was not in the clinical range of ≥ 70. At the time of discharge, all of the client families, except one, had a significant improvement, or a change greater than 6 points.

In a similar manner to client families rating a school goal, families who identified a family or home goal at the time of setting treatment goals were asked to provide a numeric value of the current level of functioning using a scale of 1-5. Five of the seven client families within the STEPS program identified a family goal to work on in treatment, with an average rating of 2.2 out of a possible rating of 5. At the time of discharge, all families reported an improvement in the school goal, from one to two points, with the average rating of 3.6 out of 5.
The final measure we would use to examine improved family relationships is direct input from the families at six and twelve months after discharge. Specifically, parents or caregivers would be asked, “Since your family finished (Daybreak or STEPS), would you say your family relationships are improved?” Responses would be recorded as “1” for “yes”, “0” for “no”. At the time of this report, follow-up phone calls are not scheduled to be done until December 2011, so this data is unavailable.

*Are client families more knowledgeable about their child’s need and resources available to them?*

Data from the Family Empowerment Scale was reviewed to measure the family’s ability to advocate for their child and the family’s increased ability to access community resources as needed. We did encounter a challenge with this measure, as it was identified as being administered at admission and discharge, in order to determine an
increase in knowledge, etc. As this measure was not selected until after the youth were in program, we looked at discharge score only, identifying that a range of 45 – 60 (a response of 3-4 out of 4 on each question) would indicate an ability to advocate and access resources. Out of a possible seven surveys being returned, we received four. All of the families who completed the survey had a score within the “successful” range, although some individual questions did include responses of “2” (a little bit true). It may be that, as families were not exposed to this questionnaire prior to participating in treatment, their awareness of changes, perhaps subtle, and increased skill development in these areas may have been less than optimal. It is anticipated that having families complete the Empowerment Scale prior to participating in treatment will increase awareness of these areas and families may be more readily able to identify changes in ability and/or knowledge.

Is there an overall improvement in the client’s functioning at discharge?

Two measures were utilized to determine overall improvement in functioning, CAFAS and the youth completed BCFPI. CAFAS was completed on all youth at admission and at discharge. Figure 3.9 represents CAFAS scores at both of these time intervals. At admission, the range of scores was from 20 – 100, with an average score of 60. All of the youth, with the exception of one, experienced a significant decrease in their overall score. At discharge, the range of scores was from 0-70, with an average score of 27.7.

We had also identified the youth completed BCFPI Total Mental Health score as providing meaningful data from the youth’s perspective. Unfortunately, not all youth fully completed the survey, resulting in several missing scores including the score for Total Mental Health. There were three fully completed surveys, but we felt this was not fully representative of the group, so those results have not been included here. A significant
challenge was noted where there was a time delay between the youth completing the measures and the scoring of the measures, as the program staff and Program Evaluation Coordinator were located at different physical locations. This did not make it possible for the missing data to be obtained from the youth after scoring. This is an area that will be addressed during implementation, as all staff and clients will again be located within one physical site.

Figure 3.9.

![Graph showing Youth Total - 8 scales - maximum total score would be 240](image)

4. Discussion, Conclusions, Recommendations & Next Steps:

(a) Discussion and Interpretation of Findings:

From our findings, we are delivering a successful day treatment program; one which is reaching our intended clinical population, that improves overall client functioning, and advances client outcomes in the specific domains of school, family and community. Families indicated that they were satisfied with their involvement, felt like they were
partners in the therapeutic environment, gained an increase in knowledge about their child’s needs, the resources available to them, and were able to better advocate for their child. Families also express overall satisfaction with the services they received. From a staff and agency perspective, participating in the Planning Evaluation did provide us with an opportunity to increase our staff knowledge and capacity in program evaluation. Additionally, staff were better able to understand the relationship between program evaluation and program delivery.

Caution must be taken when interpreting the results of our data analysis. The pilot data was based on a very small sample size; a longer evaluative time period including a greater number of clients would produce an increased amount of data for analysis.

The pilot data results have some implications on program development and/or implementation. Working with client families to further develop their ability to advocate for their child, and identify and access community resources may require a greater focus within treatment. Although many parents or caregivers are strong advocates for their children, they may feel less powerful in working for changes outside the supportive treatment program, in the community school, mental health or medical community. Additionally, ensuring the youth in program are aware of the importance of their input, via the BCFPI survey, is an area requiring greater attention. This may need to become part of the clinical work with the youth – done in a therapeutic setting to ensure clients understand fully what is being asked of them.

As we consider next steps in evaluating the Day Treatment program at Lutherwood, a few positive steps are apparent. Previously, evaluation was done more-or-less outside the program. Families did complete the BCFPI as part of the intake process, but weren’t asked to evaluate other aspects of involvement until the end of treatment. Families were
not as aware of the emphasis placed on evaluation of programs. With the development of a consent to participate in the evaluation process, families will have a greater understanding of the importance of evaluation, the anticipated outcomes of treatment, and will be asked for greater input regarding their feelings of empowerment and level of participation in treatment. Additionally, scheduling the completion of measures within clinical meetings, for both youth and families, may increase the completeness of data available for analysis.

(b) Recommendations:

(i) Continue to increase staff knowledge and exposure to conducting program evaluation thereby building Lutherwood’s internal capacity for evaluation.

(ii) While we have always collected customer satisfaction feedback from young persons and the parents (caregivers), young person’s feedback has historically been regarded as “unreliable” and has not been statistically reported. Right now we do not ask pointed (qualitative) questions of young persons’ perceptions and experiences of “treatment” and its perceived benefits to them in their lives. This is important and we need to have the right “tools” to ask the right questions.

(iii) Develop a process for the implementation of program evaluation recommendations; with parallel procedures to provide for on-going monitoring and feedback of the implementation process.

(iv) Expand a process for broader education of staff on when, why and how we employ program evaluation.
Lessons Learned from Evaluation Activities:

(i) Evaluation activities should be conducted within the “program” (e.g., in the program setting as part of the program activities) rather than conducted outside the program (e.g., material being sent home); or conducted by an external source.

(ii) To ensure complete data collection, have program staff be fully familiar with the data collection task (e.g., aware that the questionnaire is double sided) to avoid later discovery of partly completed questionnaires; and/or the disqualification of data based on time sensitive material.

Impact of Evaluation:

From an organizational perspective, we have developed a clear, credible and solid evaluation framework that will be able to guide future program evaluation projects across the agency. We have increased our internal capacity for evaluation, improved our evaluation knowledge base, and enhanced our awareness of the level of detail, planning and time required to conduct evaluation.

Funders, stakeholders, partners, interest groups and the community at large are placing more focus and expectations on program results and outcome performance. The development of an evaluation framework positions us to responsibly move forward ensuring that we are providing the best possible programs and services for our clients.

Next Steps:

(i) Prior to completion of any measures for evaluative purposes, youth/families will be provided with an information letter explaining the purpose of our research, and will be required to sign a consent form (Appendix C);
(ii) Take steps to ensure that evaluation measures are completed as part of clinical work with client;

(iii) Having used two new measures (e.g., (1) Family Empowerment Scale (Koren et al. 1992), to measure caregiver perception of their level of empowerment, or ability to understand their child’s mental health needs and advocate for their child; and the (2) Family Participation Survey – (Koren et al. 1997), to measure caregiver input and participation into the treatment process for their child), we will have to decide on the merits of continuing to collect this information.

(iv) Feedback mechanism to provide service outcome data to families;

(v) Further increase staff capacity in program evaluation by extending knowledge to other programs;

(vi) Consider development of discharge evaluation checklist or an electronic reminder in MS Outlook specific to the mid-point of treatment.

5. Knowledge exchange plan:

Results and knowledge learned from Lutherwood’s Day Treatment program evaluation will be shared at a number of levels at Lutherwood, with stakeholders in our local community and with the other children’s mental health programs identified in our Knowledge Exchange plan.

At Lutherwood, knowledge from the evaluation (e.g., data, impact, lessons learned) will be presented and discussed:
(a) at all treatment teams at Lutherwood that will involve multidisciplinary teams (e.g., child and youth counsellors, clinicians, psychologists and educational staff with a view to informing future program changes, and/or intervention options for improved services delivery to youth and families.

(b) the final evaluation report will be reviewed at Lutherwood’s next Best Practice Committee in December 2011.

(c) the final report will be placed on Lutherwood’s intranet where it can be accessed by all staff.

(d) a presentation on the Day Treatment Evaluation will be given at upcoming events that are attended by parents (e.g., Graduation Ceremonies in February and June).

(e) the report will be provided to Lutherwood’s Board of Directors.

Results and knowledge gained will also be shared with the collaborating school boards (Waterloo Region District School Board and the Waterloo Catholic District School Board) and in particular with a presentation to the Section 23 special education staff.

Five mental health centres have comprised the core of our Knowledge Exchange Plan: Maryvale Adolescent & Family Services (Windsor), Woodview Adolescent Day Treatment Program (Brantford), Craigwood Youth Services (London), Langs Farm Village Association (Cambridge), and the George Hull Centre (Toronto). Over the course of the Planning Evaluation Grant we communicated with these centres, sending them reports on our progress (e.g., Logic Model, Literature Review) and each will receive a copy of our final report with the option to have any questions answered via a follow-up phone call within 60 days of sending the final report.
References:


Appendix A - Process and Outcome Matrices
<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Inputs / Activities / Outputs</th>
<th>Indicator(s)</th>
<th>Measurement Tool</th>
<th>Method to Collect Data &amp; Frequency</th>
<th>Person responsible for data collection? Data source?</th>
<th>Dates of data collection (specify month/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is our program implementing identified key components of other successful day treatment programs in Canada, U.S. and Europe?</td>
<td>Key components are implemented and documented (Caregiver Involvement; Individual therapy; family therapy; safety plans; group therapies)</td>
<td>Comparison of peer-reviewed academic literature pertaining to day treatment models/practices with current program practices</td>
<td>Peer-reviewed Literature review</td>
<td>Literature review after development of logic model</td>
<td>Evaluation Team</td>
<td>n/a</td>
</tr>
<tr>
<td>Family Participation Survey score at discharge within range of 42-56 (each question response of 3 or 4 out of 4)</td>
<td>Family Participation Survey</td>
<td>Administer questionnaire at discharge</td>
<td>Clinician/Child and Youth Counsellor administer questionnaire; Program Evaluation Coordinator compiles responses</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client File</td>
<td>Quality File Review of Treatment Plan of Care, Monthly Goal Review, Quarterly Review, Discharge Report, Daily Progress Notes</td>
<td>Review of client file at discharge</td>
<td>Program Manager</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Are we reaching our intended clinical population? | Needs Assessment / CAFAS / BCFPI | Youth primarily with internalizing/externalizing behaviours as identified by CAFAS and BCFPI
Internalizing = Moods and Self-Harm scales in CAFAS / InP score in BCFPI
Externalizing = School/Work, Home, Behaviour Towards Others and Community scales in CAFAS / ExP score in BCFPI | CAFAS | Admission and discharge | Clinician inputs CAFAS; Program Evaluation Coordinator compiles responses | Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>BCFPI</td>
<td>At intake and discharge</td>
<td>Intake Clinician inputs before BCFPI; Program Clinician inputs discharge BCFPI; Program Evaluation Coordinator compiles responses</td>
<td>Intakes are completed at point of contact from family; Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client satisfaction surveys</td>
<td>At discharge</td>
<td>Clinician/Child and Youth Counsellor administer questionnaire; Program Evaluation Coordinator compiles responses</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date.</td>
</tr>
<tr>
<td>Are clients/client families satisfied with the services they received?</td>
<td>Parent and youth completion of Client Satisfaction Questionnaire and Family Participation Survey</td>
<td>Satisfaction rating ≥95% (Organizational target)</td>
<td>Parent/Guardian and Youth Client Satisfaction Questionnaires</td>
<td>At discharge</td>
<td>Clinician/Child and Youth Counsellor administer questionnaire; Program Evaluation Coordinator compiles responses</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Family Participation Survey score at discharge within range of 42-56 (each question response of 3 or 4 out of 4)</td>
<td>Family Participation Survey</td>
<td>Administer questionnaire at discharge</td>
<td>Clinician/Child and Youth Counsellor administer questionnaire; Program Evaluation Coordinator compiles responses</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation Questions</td>
<td>Short-Term Outcomes</td>
<td>Indicator(s)</td>
<td>Measurement Tool</td>
<td>Method to Collect Data &amp; Frequency</td>
<td>Person responsible for data collection? Data source?</td>
<td>Dates of data collection (specify month/year)</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Are clients successfully reintegrating into school?</td>
<td>Improved functioning in community school</td>
<td>CAFAS school – at minimal or none</td>
<td>CAFAS School Scale</td>
<td>At Admission and discharge</td>
<td>Clinician inputs CAFAS; Program Evaluation Coordinator compiles responses</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
</tr>
<tr>
<td>BCFPI Global School participation and achievement score ≤ 70 (not in clinical range)</td>
<td>Parent BCFPI SchoolP score</td>
<td>At intake and discharge</td>
<td>Intake Clinician inputs before BCFPI; Program Clinician inputs discharge BCFPI; Program Evaluation Coordinator compiles responses</td>
<td>Intakes are completed at point of contact from family; Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in School Goal rating from admission to discharge</td>
<td>Client file – Treatment Plan of Care &amp; Discharge Report</td>
<td>At admission and discharge</td>
<td>Clinician/Child and Youth Counsellor send data to Program Evaluation Coordinator</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation Questions</td>
<td>Short-Term Outcomes</td>
<td>Indicator(s)</td>
<td>Measurement Tool</td>
<td>Method to Collect Data &amp; Frequency</td>
<td>Person responsible for data collection? Data source?</td>
<td>Dates of data collection (specify month/year)</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Feedback from School Transition Worker (where applicable) and/or check in with school staff</td>
<td>Short-Term Outcomes</td>
<td>Transition Discharge Report</td>
<td>Interview with School Transition Worker / Principal designate / Classroom CYC</td>
<td>Program Evaluation Coordinator</td>
<td>6 – 8 weeks post discharge - Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian indication of improved functioning at school</td>
<td>Short-Term Outcomes</td>
<td>Post-discharge follow-up calls – Is youth attending school or working?</td>
<td>6 and 12 months after discharge</td>
<td>Program Evaluation Coordinator</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
<td></td>
</tr>
<tr>
<td>Are clients successfully reintegrating into community?</td>
<td>Short-Term Outcomes</td>
<td>CAFAS community scale – at minimal or none</td>
<td>CAFAS Community Scale</td>
<td>At admission and discharge</td>
<td>Clinician inputs CAFAS; Program Evaluation Coordinator compiles responses</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date</td>
</tr>
<tr>
<td></td>
<td>Short-Term Outcomes</td>
<td>No police charges</td>
<td>Post-discharge follow-up calls – Has youth had any police charges?</td>
<td>6 and 12 months after discharge</td>
<td>Program Evaluation Coordinator</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date</td>
</tr>
<tr>
<td>Evaluation Questions</td>
<td>Short-Term Outcomes</td>
<td>Indicator(s)</td>
<td>Measurement Tool</td>
<td>Method to Collect Data &amp; Frequency</td>
<td>Person responsible for data collection? Data source?</td>
<td>Dates of data collection (specify month/year)</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Are clients experiencing improved family relationships?</td>
<td>Improved family functioning</td>
<td>CAFAS family scale – at minimal or none</td>
<td>CAFAS Family Scale</td>
<td>At admission and discharge</td>
<td>Clinician inputs CAFAS; Program Evaluation Coordinator compiles responses</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BCFPI Global Family Situation and Family Functioning scores ≤ 70 (not in clinical range)</td>
<td>Parent BCFPI GfsP and FAD scores</td>
<td>At intake and discharge</td>
<td>Intake Clinician inputs before BCFPI; Program Clinician inputs discharge BCFPI; Program Evaluation Coordinator compiles responses</td>
<td>Intakes are completed at point of contact from family; Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change in Family Goal rating from admission to discharge</td>
<td>Client file – Treatment Plan of Care and Discharge Report</td>
<td>At admission and discharge</td>
<td>Clinician/Child and Youth Counsellor send data to Program Evaluation Coordinator</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parent/Guardian report of improved family functioning</td>
<td>Post-discharge follow-up calls – In an overall sense, how are things going? How are family relationships?</td>
<td>6 and 12 months after discharge</td>
<td>Program Evaluation Coordinator</td>
<td>Discharges occur primarily in February and June, although some clients may discharge from program at an alternate date.</td>
</tr>
<tr>
<td>Evaluation Questions</td>
<td>Short-Term Outcomes</td>
<td>Indicator(s)</td>
<td>Measurement Tool</td>
<td>Method to Collect Data &amp; Frequency</td>
<td>Person responsible for data collection? Data source?</td>
<td>Dates of data collection (specify month/year)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Are client families more knowledgeable about their child’s needs and resources available to them?</td>
<td>Increased ability to advocate for child/family and increased ability to access community resources as needed</td>
<td>Increase in Family empowerment Scale score from admission to discharge or score at discharge within range of 45-60 (each question response of 3 or 4 out of 4)</td>
<td>Family Empowerment Scale</td>
<td>At admission and discharge</td>
<td>Clinician/Child and Youth Counsellor administer questionnaire; Program Evaluation Coordinator compiles responses</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
</tr>
<tr>
<td>Is there an overall improvement in the client’s functioning at discharge?</td>
<td>Improved overall functioning of youth</td>
<td>Decrease in overall CAFAS score of 20 (significant improvement as per CAFAS standards) and BCFPI Total Mental Health score of 6 (significant improvement as per BCFPI standards)</td>
<td>CAFAS Total Score</td>
<td>At admission and discharge</td>
<td>Clinician inputs CAFAS; Program Evaluation Coordinator compiles responses</td>
<td>Admissions occur primarily in September and February; Discharges occur primarily in February and June – some clients may be admitted or discharged at an alternate date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B - Evaluation Measures
Family Empowerment Scale

Client Name:                      Caregiver Name:

Date Completed:

Please rate the extent to which you feel each of the following statements is true. Please give a rating from 1 to 4 for each:

1 = not at all true
2 = a little bit true
3 = mostly true
4 = very much true

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel I understand my child’s and my family’s needs.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I am knowledgeable about issues such as the diagnoses and difficulties my child has.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I am knowledgeable about the medications my child takes (if any).</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I understand what interventions or services will help my child and family.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I have the resources to get my child’s needs met.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I am knowledgeable about the services available in my community.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I understand the way that services and systems work in my community.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I know how to access the different professionals involved in my child’s care when we need help.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I am good at communicating with service providers.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I am good at advocating for my child.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I know how to deal with a crisis involving my child’s behaviour or mental health.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I feel I know who to contact to address problems or arrange services and supports.</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>
Family Empowerment Scale

I feel powerful in “making things happen” for my child and family.  

1 2 3 4

I feel competent in overseeing and coordinating services for my child and family.  

1 2 3 4

I feel confident I can handle obstacles and changes relating to my child’s needs that arise in the future.  

1 2 3 4
Family Participation Survey

Client Name: [Client Name]
Caregiver Name: [Caregiver Name]
Date Completed: [Date Completed]

Please rate the extent to which you feel each of the following statements is true. Please give a rating from 1 to 4 for each:

1 = not at all true
2 = a little bit true
3 = mostly true
4 = very much true

I was asked for my opinion about my child’s needs. [Rating] [Rating] [Rating] [Rating]

My opinion about my child’s needs was considered important. [Rating] [Rating] [Rating] [Rating]

I had the chance to include other people to support me in meetings and service planning. [Rating] [Rating] [Rating] [Rating]

I was involved in developing the service plan for my child. [Rating] [Rating] [Rating] [Rating]

I agree with the service plan developed for my child. [Rating] [Rating] [Rating] [Rating]

I was involved in tasks to help carry out the service plan for my child. [Rating] [Rating] [Rating] [Rating]

I had the chance to review written reports about my child. [Rating] [Rating] [Rating] [Rating]

I was invited to attend meetings about my child. [Rating] [Rating] [Rating] [Rating]

I did attend meetings about my child. [Rating] [Rating] [Rating] [Rating]

My input during meetings was considered important. [Rating] [Rating] [Rating] [Rating]

I was involved in monitoring how services were working for my child. [Rating] [Rating] [Rating] [Rating]

I was involved in decisions about services for my child. [Rating] [Rating] [Rating] [Rating]

I feel like a partner and active participant in planning and coordinating services for my child. [Rating] [Rating] [Rating] [Rating]

I contacted our clinician/child & youth counsellor when I needed support. [Rating] [Rating] [Rating] [Rating]
CLIENT SATISFACTION QUESTIONNAIRE - PARENT
STEPS PROGRAM

Please answer the following questions about your experience at Lutherwood.

1. Were you treated with respect by our staff?
   - Definitely Not
   - Probably Not
   - Neutral
   - Probably Yes
   - Definitely Yes

2. Were the staff available when you needed them?
   - Definitely Not
   - Probably Not
   - Neutral
   - Probably Yes
   - Definitely Yes

3. Overall, how satisfied were you with the timeliness of the service?
   - Very dissatisfied
   - Dissatisfied
   - Neutral
   - Satisfied
   - Very satisfied

4. Did you get the kind of help you wanted/did the services you received meet your needs?
   - Definitely Not
   - Probably Not
   - Neutral
   - Probably Yes
   - Definitely Yes

5. How satisfied were you with your level of involvement in this service?
   - Very dissatisfied
   - Dissatisfied
   - Neutral
   - Satisfied
   - Very satisfied

6. Were the facilities appropriate for the service being provided (i.e. accessibility, cleanliness, security, parking, noise level)?
   - Definitely Not
   - Probably Not
   - Neutral
   - Probably Yes
   - Definitely Yes

7. In a general, overall sense, how satisfied are you with the service you received?
   - Very dissatisfied
   - Dissatisfied
   - Neutral
   - Satisfied
   - Very satisfied

8. Would you recommend Lutherwood to a friend who may be in need of similar services?
   - Definitely Not
   - Probably Not
   - Neutral
   - Probably Yes
   - Definitely Yes
Please answer the questions below with your own comments and suggestions concerning our services.

1. Do you feel you have been involved enough in the planning of your child’s treatment program (e.g. goal setting and implementation)? If not, please explain.

2. Do you feel you received enough information about Lutherwood before your family began treatment?

3. If an assessment was completed, were assessment findings communicated in an understandable manner to you and your family?

4. If you were dissatisfied with Lutherwood in any way, please explain which part and why.

5. Please tell us about specific areas where we can improve our services to you.

6. Other comments or suggestions about the services you have received from Lutherwood (add additional sheets if necessary):

Although your response will be handled confidentially, you may choose not to complete this section:
Completed by: ______________________________ Date: __________________
Address: _____________________________________________________________
Telephone Number: ______________________________

If you would like to be contacted to discuss any issues you have relating to the service you received, please check here ______.
CLIENT SATISFACTION QUESTIONNAIRE - YOUTH STEPS PROGRAM

Please answer the following questions about your experience at Lutherwood.

1. Were you treated with respect by our staff?
   - Definitely Not 1, Probably Not 2, Neutral 3, Probably Yes 4, Definitely Yes 5

2. Were the staff available when you needed them?
   - Definitely Not 1, Probably Not 2, Neutral 3, Probably Yes 4, Definitely Yes 5

3. Overall, how satisfied were you with the timeliness of the service?
   - Very dissatisfied 1, Dissatisfied 2, Neutral 3, Satisfied 4, Very satisfied 5

4. Did you get the kind of help you wanted/did the services you received meet your needs?
   - Definitely Not 1, Probably Not 2, Neutral 3, Probably Yes 4, Definitely Yes 5

5. How satisfied were you with your level of involvement in this service?
   - Very dissatisfied 1, Dissatisfied 2, Neutral 3, Satisfied 4, Very satisfied 5

6. Were the facilities appropriate for the service being provided (i.e. accessibility, cleanliness, security, parking, noise level)?
   - Definitely Not 1, Probably Not 2, Neutral 3, Probably Yes 4, Definitely Yes 5

7. In a general, overall sense, how satisfied are you with the service you received?
   - Very dissatisfied 1, Dissatisfied 2, Neutral 3, Satisfied 4, Very satisfied 5

8. Would you recommend Lutherwood to a friend who may be in need of similar services?
   - Definitely Not 1, Probably Not 2, Neutral 3, Probably Yes 4, Definitely Yes 5
Please answer the questions below with your own comments and suggestions concerning our services.

1. Do you feel you have been involved enough in the planning of your treatment program (e.g. goal setting and implementation)? If not, please explain.

2. Do you feel you received enough information about Lutherwood before your family began treatment?

3. If an assessment was completed, were assessment findings communicated in an understandable manner to you and your family?

4. If you were dissatisfied with Lutherwood in any way, please explain which part and why.

5. Please tell us about specific areas where we can improve our services to you.

6. Other comments or suggestions about the services you have received from Lutherwood (add additional sheets if necessary):

Although your response will be handled confidentially, you may choose not to complete this section:
Completed by: ___________________________ Date: ___________________________
Address: __________________________________________
Telephone Number: ___________________________

If you would like to be contacted to discuss any issues you have relating to the service you received, please check here ______.
Client Reintegration Questionnaire – 6 and 12 months post discharge

1. In an overall sense, how are things going since your family finished (insert name of the program)? (Qualitative)

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2. Is (insert child’s name) attending school (or working if applicable age)?

_________ (Yes – score as 1) _____________ (No – score as 0)

3. Has (insert child’s name) had any police charges?

_________ (Yes – score as 0) _____________ (No – score as 1)

(For Day Treatment Clients only)

4. Since your family finished (Daybreak or STEPS), would you say your family relationships are improved?

_________ (Yes – score as 1) _____________ (No – score as 0)
# QUALITY AUDIT
MENTAL HEALTH SERVICES

Client File: _______________________________

Date of Audit: ________ / ______ / ______

Auditor: _______________________________

<table>
<thead>
<tr>
<th>Quality Standards</th>
<th>Finding</th>
<th>Notes/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Content Audits have been performed on this file evidenced by audit checklists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the file. Last Audit: ________ / ______ / ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dd // mm // yy</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>• All required documentation is up-to-date.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. Unique circumstance related to the client are clearly explained: (for example</td>
<td></td>
<td></td>
</tr>
<tr>
<td>but not limited to)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The 30 day timelines (e.g., Plan of Care, MR) were not met but explained in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the report;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medication errors are clearly explained;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non or under-involvement of the family/guardian is explained in the reports;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Planning for any special needs of the client are clearly outlined;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staffing and programming accommodations;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Early termination or withdrawal by client from the program/service is well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>documented;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cultural, ethnic, linguistic, dietary, medical, spiritual needs, etc. are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recorded as part of the overall service plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Client goals are based on assessment recommendations (e.g., psychological/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychiatric assessment, needs assessment, CAPAS, BCFPI, previous counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or treatment, previous discharge recommendations, etc.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b. A clear explanation is provided in the documentation as to why any admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommendations have not been incorporated into the service plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Goals and strategies are uniquely matched to the identified needs and strengths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the client;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4b. Goals, strategies and interventions that are completed, stopped, changed/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>adjusted or added are adequately and appropriately addressed or explained in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reports;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lutherwood
Caring people Strengthening lives.

June 26, 2009
<table>
<thead>
<tr>
<th>Quality Standards</th>
<th>Finding</th>
<th>Notes/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. File clearly demonstrates client involvement with the client's own words and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>phrases quoted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- identification of strengths and needs;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- setting goals;</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- developing strategies;</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- active participation in meetings;</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- early and continuous discussions regarding discharge planning;</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6. “Goals” and “Action Plans” are S M A R T:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S = specific &amp; simple</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>M = measurable &amp; meaningful</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>A = achievable &amp; agreed upon</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>R = realistic &amp; results oriented</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>T = time limited &amp; trackable</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7. Goal achievement provides transferrable skills and strategies applicable to</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>the client’s home, community, school, work place, family, social settings and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationships, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Appropriate recommendations are made at discharge:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Community links and referrals have clear contacts identified (e.g., recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>support group, etc.);</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- Community referrals were initiated prior to discharge;</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- Any follow-up (“booster-sessions”) or “post-discharge” care or support is</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>clearly documented;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. <strong>COMMENTS:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This completed quality audit must be placed permanently in the file*
Introduction

Lutherwood has standards of quality improvement that are meant to influence program and service delivery. Program Evaluation is one method of quality improvement that will help make programs and services more effective, efficient and responsive to client needs. Conducting this Evaluation of the Day Treatment Program will help us:

- see how effective (how helpful ) the program is for youth and their families,
- find ways to improve the program,
- make sure the program is accountable to the clients and the ministry that provides funding (to make sure it is doing what it was meant to do).

In addition to the standard forms and questionnaires you have completed to be part of Lutherwood’s Day Treatment Program, we ask you to complete two other questionnaires over the coming year; we will then use all this information as the data for our evaluation. We are expecting to have about 32 participants in total. All participant information is put together, individual responses are not highlighted or singled out.

As a client of Lutherwood’s Day Treatment Program, you are invited to participate in the evaluation of the program by having information about your services and family participation included in a program evaluation project.

Participation in the evaluation program is voluntary – if you do not wish for you and your family’s information to be included, you may choose not to consent to this and your services will not be affected in any way. You and your family are free to withdraw this consent and to stop participating in the evaluation project at any time. Should you choose to do this and your services or your relationship with Lutherwood will not be negatively affected.

What is involved in participating in the Program Evaluation?

- You will be asked to complete a few questionnaires about you and your family and your experiences with services when you first begin the program and at the end of your involvement with the program, with the help of your Clinician or Child and Youth Counsellor.
- Questionnaires will take anywhere between 5 – 30 minutes to complete with a total time of 60 minutes over the life of the evaluation.
- Program staff may also contact you after you have completed the program to complete a follow-up questionnaire.
- The information is being collected from a number of sources: a) demographic information available in the participants intake/admission package; b) information in
the participants completed psycho-social needs assessment; c) results (changes) from the individual participants monthly goal reviews; d) results from the participants CAFAS and BCFPI questionnaires (pre/post); e) results from the participants Customer Satisfaction Questionnaire (post); f) results (scores) from the completed Family Participation Survey (pre-post); g) results (scores) from the completed Family Empowerment Scale (pre-post).

- Information that you provide will be reviewed, collected and summarized by the evaluation team. Where you have reported any comments and we choose to use those comments in our report, no identifying information (e.g., names or addresses) or any remarks that could identify you will be used.

**Where will the information I provide be kept and who will be allowed to see it?**

- Your responses to the BCFPI and CAFAS are standard measures for all Lutherwood clients that are kept as part of your record at Lutherwood and are accessible to Lutherwood staff who have access to your record for treatment purposes. For the purpose of the evaluation this data will be summarized and entered (along with other participants data) into a computer data base where you and your family will not be identified by name in any further steps in the program evaluation. This data and your file are retained indefinitely.
- Results (scores) from the completed *Family Participation Survey* and the *Family Empowerment Scale* will be entered with other participants data and will then be stored separately from your client record. The data from the *Family Participation Survey* and the *Family Empowerment Scale* will be stored for 10 years past the young person’s 18th birthday.
- All completed questionnaires are stored in a secure storage system to maintain confidentiality. Computer files containing the information are protected by security, passwords and confidentiality measures. Authorized login credentials, and overall network security “firewalls” are used to keep client information secure.
- Only the directly relevant program staff (data entry by Chris Dodd, Program Manager Lisa Gill and the evaluation lead Randal Penney) will be allowed to see the information you provide.
- All information will be stored according to the Personal Health Information Protection Act, 2004.

**What will be done with the information?**

Ultimately, the information collected as part of your service with us will be added to a summary of all participants. The data stored in the computer will be analyzed to answer questions such as:
- whether youth in the program are functioning better and benefitting from the services
- whether families are satisfied with the service
- whether the program is achieving its goals
At the end of the evaluation, a report will be prepared – *individual clients and families are in no way identified in these summaries and reports*. Information from the evaluation reports will be available to participants at a follow-up meeting. For participants who cannot attend the follow-up meeting the Principle Contact for the Evaluation can be contacted to receive a copy of the report.

Non-identifying information collected about you and your family for the purposes of this evaluation may also be used for publication in professional journals or presentations at professional conferences, however, again, all information will be in a summarized format and reported in a group format to ensure that personal identities will not be revealed.

**What are the benefits and risks?**

By agreeing to participate in the Day Treatment program evaluation, you are given the opportunity to:
- provide meaningful and useful feedback about your experience
- identify program strengths and weaknesses
- improve the services
- reflect and notice changes in your family as you complete the questionnaires
- contribute to professional knowledge about what services are helpful for youth and families
- have a voice in shaping services for children and family in your community

By agreeing to share your experiences and input in the program, you will be required to dedicate some time to complete the questionnaires. Assistance with completing the questionnaires is always available. During the course of the evaluation difficult topics may need to be addressed, which can bring up distressing emotions. Every effort will be made to support families during difficult periods. If you are feeling distressed or concerned as a result of your participation you should contact Randal Penney – the principal contact for the Day Treatment Evaluation (519-749-8305 x 221).

**Who can I contact if I want to ask questions?**

If you should have questions or concerns regarding the Day Treatment program evaluation, please contact any of the following;
- Randal Penney – the Principal Contact for the Day Treatment Evaluation.
- Your Clinician
- Your Child and Youth Counsellor
- The Program Manager at your agency
- The Director of Children’s Mental Health Services at your agency

As this is an internal Lutherwood evaluation, the evaluation program and evaluation team operates under the same confidentiality restrictions as all other assessment and treatment activities. To conduct this program evaluation, we require your signed consent.
If you are uncertain or have any questions, please discuss this consent form with your Clinician or Child and Youth Counsellor or ask to speak with a supervisor or program evaluation staff.

The Community Research Ethics Board has reviewed this project and determined that it is ethically sound based on the guidelines of the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans. If you feel you have not been treated according to the descriptions in this consent form/information letter, or your rights as a participant in research have been violated during the course of this project, you may contact the Coordinator or Chair, Community Research Ethics Board, Community Research Ethics Office, 519-741-1318.

STATEMENT OF CONSENT

I/We hereby give Lutherwood consent to use assessment, treatment, and outcome information regarding me and my family, for the purpose of program evaluation. I understand that this information will be used to help to evaluate and improve the Day Treatment Program and to provide summary (non-identifying) information. I understand that evaluation data may be used, from time to time, in professional presentations or publications, but that no identification of participants will be included. I understand that I may withdraw my consent for involvement in the evaluation at any time, and that the Day Treatment Services provided to me will in no way be affected if I choose not to participate.

Youth

Parent or Guardian

Date

Witness