UNDERSTANDING SNAP™ ACROSS ONTARIO

TOWARD THE ESTABLISHMENT OF A SNAP™ COMMUNITY OF PRACTICE

Report submitted to The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO

April 29, 2006

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Centre for Children Committing Offences (CCCO)

Established 2001 with the support of the J. W. McConnell Family Foundation

RESEARCH • DISSEMINATION • TRAINING
What are communities of practice?

Communities of practice have been described as “nodes for the dissemination, interpretation and use of information” (Wenger, 1998, p. 252), making them a valuable method of exchanging knowledge. The term community of practice refers to a group of people having expertise in a particular domain who are brought together because of their interest and commitment to that domain (Wenger, 2006). The term implies that members interact with each other regularly, thereby continually participating in the development of their practice (Wenger 1998).

Membership in a community of practice is not synonymous with day-to-day business, and a community of practice does not simply connote a group, team or network (Wenger 1998), given that relations within a network are significantly looser than the relations among community members (Brown & Duguid 2001). Given that the enterprise of a community of practice is never fully determined by an outsider as it evolves organically through the continuous mutual engagement of its members, communities of practice are not the same thing as work groups brought together in order to finish a project defined from the outset (Wenger 1998).

Those who have tried to implement communities of practice across organizations have met with success, allowing for the creation of new social networks (Swan, Scarborough & Robertson, 2002) and facilitating evidence-based practice (Tolson, McAloon, Hotchkiss & Schofield, 2005). When it comes to the widespread implementation of evidence-based mental health programs, Fixsen and his colleagues (2005) argue that a community of practice enables more efficient program replications. They argue that creating a community of practice benefits workforce development as members of the workforce become increasingly knowledgeable not only about the specific program, but also “about the science and practice of implementation” (Fixsen et al., 2005 p. 77).
TABLE OF CONTENTS

BACKGROUND & CONTEXT .................................................................................................................. 3

FOCUS OF THE CURRENT PROJECT .................................................................................................. 4

METHODS ............................................................................................................................................... 5

CHAPTER 1 -- SNAP™ and Related Programs Across Ontario .............................................. 8
  1.1 Who is currently using SNAP™ in Ontario? ........................................................................ 8
  1.2 What factors promote/prevent a successful SNAP™ implementation? ............................... 9
  1.3 Across Ontario, who is SNAP™ currently being offered to? ............................................. 9
  1.4 What other non-SNAP™ alternatives are available in Ontario for antisocial children? ...... 10

CHAPTER 2 -- SNAP™ Outcomes and Evidence Based Practices .................. 12
  2.1 Is SNAP™ producing positive treatment outcomes? ..................................................... 12
  2.2 How is treatment impact/success being assessed in terms of SNAP™? ........................... 13

CHAPTER 3 -- Support for a SNAP™ Community of Practice ...................... 14
  3.1 Is there interest in a SNAP™ Community of Practice in Ontario? ................................... 14
  3.2 How should knowledge be transferred within a SNAP™ Community of Practice? .......... 15

CHAPTER 4 -- Recommendations .............................................................. 17
  4.1 Toward a SNAP™ Community of Practice in Ontario .................................................... 17
  4.2 Summary Recommendations ................................................................................... 20
  4.3 Action Steps.......................................................................................................... 20

REFERENCES................................................................................................................................. 22

APPENDICES ..................................................................................................................................... 23
  A SNAP™ Ontario Licensing Agreements with Child Development Institute ................... 24
  B SNAP™ Community of Practice Survey for SNAP™ Affiliates (Survey 1) ....................... 26
  C Ontario Children’s Mental Health Centers (excluding SNAP™ affiliates) ..................... 31
  D SNAP™ Community of Practice Survey for Non-SNAP™ Affiliates (Survey 2) .......... 33
  E Follow up Telephone Interview with Active SNAP™ Affiliates .................................... 37
  F SNAP™ Evaluation Studies ........................................................................................... 38
BACKGROUND & CONTEXT

STOP NOW AND PLAN (SNAP™) is a cognitive-behavioural strategy that helps children and parents regulate angry feelings by getting them to stop, think, and plan positive alternatives before they act impulsively. The strategy was developed in the late 1970’s as a central component of several of the gender-specific clinical programs offered to children and families by the former Earls court Child and Family Centre, now called Child Development Institute.

SNAP™ has been subjected to rigorous evaluation which has demonstrated positive treatment outcomes among children under the age of 12 with conduct and related behavioural problems. As the cornerstone strategy of the clinical programs for children with disruptive behaviour problems provided by Child Development Institute, SNAP™ has been shown to help children make better choices and control impulsive and aggressive behaviours that could lead to future contact with the police (see Chapter 2 for a brief summary of SNAP™ research findings).

Over the past ten years, interest in SNAP™ has grown. The strategy was fully manualized in 1985 and trademarked in 1998 by Child Development Institute to safeguard against incomplete or improper implementation and use. In the intervening time, thousands of professionals have been trained in its use. To date, 69 SNAP™ licenses have been issued worldwide, the majority of which (N=41) have been issued in Ontario to community, education, mental health and other social service organizations.

Because of a growing demand in SNAP™ from the broader children’s mental health community, Child Development Institute launched the Centre for Children Committing Offences (CCCO) in 2001 with the support of the J.W. McConnell Family Foundation to oversee research, training and dissemination activities related to SNAP™, in addition to evidence-based risk assessment and police-community referral approaches for children under the age of 12 in conflict with the law.
Since 2001, however, it had increasingly become clear that a mechanism was needed to more closely monitor SNAP™ licensees in terms of their use of the SNAP™ model, and to explore opportunities for ongoing research, training and collaboration related to SNAP™. Due to limited CCCO resources and staff, it was typically the case that once an organization received initial SNAP™ training, there was very little ongoing communication unless the licensee initiated contact with the CCCO for specific requests for resource materials, additional training, or case consultation.

The obvious benefit of staying connected with SNAP™ licensees is that the CCCO can more closely ensure fidelity of program implementation and provide ongoing support to those trained in its use. With the expansion of the model throughout the province of Ontario, however, the CCCO has also become aware that there are opportunities for interconnections among SNAP™ licensees in terms of sharing resources and knowledge around applications of SNAP™ that address language, cultural and geographical issues common to their communities. That some of the SNAP™ licensees have already taken the initiative to begin connecting with each other around these issues suggests that there is a demand for this type of activity. It also suggests that the CCCO can play a vital role in advancing local capacity building and knowledge exchange as it relates to SNAP™, while respecting the unique profile and needs of participating organizations and the communities they serve.

**FOCUS OF THE CURRENT PROJECT**

The overall purpose of this project was to assess the extent to which SNAP™ is currently being used by our licensed affiliates, and to gauge the feasibility and interest in developing a SNAP™ Community of Practice to facilitate interconnections among SNAP™ users in the province of Ontario. We did this primarily through two web-based surveys and structured telephone interviews over a six-week period,
beginning early February 2006. This information allowed us to answer a number of key questions which, following a description of the project methods, are presented in three chapters of this report:

**Chapter 1 -- SNAP™ and Related Programs Across Ontario**
1.1 What is the scope of SNAP™ in Ontario?
1.2 What factors promote/prevent a successful SNAP™ implementation?
1.3 Across Ontario, to how many, and what client group(s) is SNAP™ currently being offered?
1.4 What other non-SNAP™ alternatives are available for antisocial children under 12 in conflict with the law?

**Chapter 2 -- SNAP™ Outcomes and Evidence-Based Practices**
2.1 Is SNAP™ producing positive treatment outcomes?
2.2 How is treatment impact/success being assessed in terms of SNAP™?

**Chapter 3 -- Support for a SNAP™ Community of Practice**
3.1 Is there interest in a SNAP™ Community of Practice in Ontario?
3.2 What are the best mechanisms to disseminate knowledge within a SNAP™ Community of Practice?

Building upon information provided by SNAP™ affiliates and children’s mental health service providers in Ontario, we offer a number of recommendations in **Chapter 4** as logical next steps toward the development of a SNAP™ Community of Practice in Ontario.

**METHODS**

To gather information about the questions outlined above, we developed and launched two web-based surveys between February and March of 2006. Survey 1 was created for current users of SNAP™ in Ontario licensed by the Child
Development Institute and monitored by the CCCO (N=41, see Appendix A for a complete listing). Through this survey (see Appendix B) we requested detailed information about use and implementation of the SNAP™ model within each organization. Survey 2 was shorter in length and directed to member agencies of Children’s Mental Health Ontario (CMHO) who were not registered by the CCCO as SNAP™ licensed users (N=55, see Appendix C for a complete listing) to gauge interest in SNAP™ more generally and gather information about programs they offer for antisocial children under the age of 12 (see Appendix D). In order to gain supplementary information about how a SNAP™ Community of Practice might be configured in Ontario, telephone semi-structured interviews (see Appendix E) were completed with Survey 1 respondents who indicated that their organization was actively using SNAP™ (N=16).

In order to maximize response rates for both surveys, we first contacted each of the 96 agencies (i.e. 41 SNAP™ affiliates and 55 non-SNAP™ affiliates) to determine the most appropriate person (i.e., the most knowledgeable person about SNAP™ or alternative services for children) within each organization to respond to our surveys. This was accomplished through an e-mail to each person on the SNAP™ license signatory list in the case of Survey 1 (SNAP™ licensees), and by telephone in the case of the Survey 2 (non-licensed CMHO providers). Table 1 outlines the process that was undertaken to obtain responses to both surveys and the structured telephone interviews.

Obtaining survey responses required a great deal of telephone follow-up over several weeks for both web-based surveys. The deadline for both surveys was extended to accommodate the needs of survey respondents, given the short time frame of the project. For the Survey 1, we received an additional 3 responses as some affiliates operate programs at several geographical locations. The majority of non-responders for Survey 1 were licensed between 2000 and 2003 and a review of internal correspondence revealed that nearly all had not been in contact with the CCCO since their initial SNAP™ training.
Table 1 – Study Methods, Sampling, Timeframe & Response Rates

<table>
<thead>
<tr>
<th>Surveys</th>
<th>SURVEY 1 SNAP™ Affiliates</th>
<th>SURVEY 2 Non-SNAP™ CMHO Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sampling frame</td>
<td>41</td>
<td>55</td>
</tr>
<tr>
<td>Initial phone/e-mail contact</td>
<td>41</td>
<td>53 *</td>
</tr>
<tr>
<td>Web-survey launch date</td>
<td>March 3, 2006</td>
<td>March 15, 2006</td>
</tr>
<tr>
<td>Number of responses received</td>
<td>20 from 18 affiliates</td>
<td>30</td>
</tr>
<tr>
<td>Minimum # of e-mail reminders/site</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Minimum # of telephone reminders/site</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Final # of responses received</td>
<td>33 from 30 affiliates</td>
<td>36</td>
</tr>
<tr>
<td>Survey response rates</td>
<td>30/41 or 73%</td>
<td>36/53 or 68%</td>
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Structured Telephone Follow-up

<table>
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<tr>
<th>No. Approached</th>
<th>16</th>
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</thead>
<tbody>
<tr>
<td>Minimum # of telephone reminders/site</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Final # telephone responses received</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Telephone follow-up participation rate</td>
<td>14/16 or 88%</td>
<td></td>
</tr>
</tbody>
</table>

* Two agencies failed to provide e-mail information for the identified staff member

Given the intensive effort put forth to follow-up non-responders by telephone and email, response rates for Survey 1, 2 and the structured telephone interview were good to excellent, ranging from 68% to 88%. Despite these high response rates, surveys varied in terms of the extent to which complete information was provided for all questions. Where possible, we sought additional information from respondents through correspondence to supplement incomplete surveys.

For each of the chapters that follow, we provide a basic overview of key findings, supplemented by more detailed information generated from the two surveys and telephone follow-up interviews. At the end of each section, where applicable, we take a step back and reflect on some of the lessons learned from the process of dialoguing with SNAP™ affiliates and other Ontario children’s mental health service providers.
CHAPTER 1
SNAP™ and Related Programs Across Ontario

1.1 Who is currently using SNAP™ in Ontario?

Of the 41 Ontario SNAP™ affiliates, 16 (39%) are actively using the strategy, five (12%) indicated that they had used the strategy at some point, but discontinued its use, and four (10%) were trained in SNAP™ but never applied the strategy at their organization. An additional 16 (39%) of the affiliates contacted through our survey were unable to specify whether SNAP™ was in active use.

In terms of the non-SNAP™ children’s mental health service providers, four reported that they are currently using SNAP™ as a program or strategy within their organizations, bringing the total number of known, active SNAP™ sites to 20 in Ontario.

When we asked SNAP™ affiliates why they did not use or discontinued the use of SNAP™ within their organizations, we were told that shortages in funding (i.e., to more fully develop the model within existing programs) and staff turnover were major contributing factors. We explored this issue in greater depth with three specific agencies no longer using SNAP™, but that had made substantial time and financial investments in terms of being trained in the use of SNAP™.

Telephone follow-ups with these agencies confirmed staff turnover as a problem, but we also learned that program staffs’ experience or comfort using previously established models limited their organization’s ability to fully incorporate the SNAP™ model into routine practice. Related to this, we were told by one individual that program staff felt that SNAP™ did not meet the needs of their clients.

Lesson Learned: Centre for Children Committing Offences should establish a mechanism to monitor and nurture its relationship with SNAP™ affiliates to address ongoing implementation issues.
1.2 What factors promote/prevent a successful SNAP™ implementation?

SNAP™ training, in addition to support from community agencies, were important in promoting a successful implementation of SNAP™ while low referrals, staffing issues, limited funding and the inability to maintain relationships with community agencies were identified as hindering its implementation. SNAP™ affiliates indicated that both initial and ongoing training/consultation was necessary to establish the program, and saw the CCCO playing a vital role in performing this function.

Inter-organization linkages with other community partners such as the police, child protection and school boards were also judged as important in terms of routinely generating appropriate referrals.

**Lesson Learned:** Growing SNAP™ within an organization requires ongoing support and communication. The creation of police-community protocols (i.e., that establish reliable referral mechanisms) would also be important.

1.3 Across Ontario, who is SNAP™ currently being offered to?

Based on information from active SNAP™ affiliates, we know that the strategy is being offered to an ethnically diverse client population, although survey respondents could not reliably specify how many children receive SNAP™ on an annual basis. While SNAP™ is being used with 6-11 year old children with conduct problems, it is also being used with other populations. In terms of the demographic and clinical profile of clients receiving SNAP™, we were told that:

- While all affiliates are using SNAP™ with children aged 6-11, 56% reported using the strategy with an older population (aged 12-17), and 19% reported offering SNAP™ to younger children (aged 0-5);
- SNAP™ is being used primarily with children with conduct problems (65%), 18% with children diagnosed with ADHD, and 11% with children suffering from traumatic experiences;
- Children who receive SNAP™ are primarily Caucasian (63%), followed by Aboriginal or First Nations groups (31%), and Asian populations (13%).

One agency reported offering SNAP™ services in French while another offers the strategy using American Sign Language.
Based on these findings, it is clear that SNAP™ is being applied to both older and younger client populations, and to diagnostic groups other than for which it was originally intended, which has potential implications in terms of the model’s effectiveness.

**Lesson Learned:** Once trained in the use of SNAP™, some organizations might apply the model to untested populations. Evaluation of these replications would seem warranted.

### 1.4 What other non-SNAP™ alternatives are available in Ontario for antisocial children?

There are several program alternatives available, but many of these are not specifically designed for children under the age of 12 in conflict with the law. The majority of these programs are not manualized and have not been rigorously evaluated, calling into question their effectiveness. Results from Survey 2 revealed that 58% (representing 21/36 respondents) of children’s mental health centers in Ontario who were non-SNAP™ affiliates reported offering services to children under 12 who display conduct problems.

When responses from both the SNAP™ Community of Practice survey and the Ontario Community of Practice survey were combined, 110 programs for children under 12 displaying conduct problems were tabulated. The following services were the most frequently reported by survey respondents as relevant to this client population:

- Day treatment/section 20 classrooms (13/110 programs)
- Residential treatment (8/110)
- Intensive services (8/110)
- Family therapy, treatment or counseling (8/110)
- COPE (5/110)
- Triple P (Positive Parenting Program) (2/110)
It is worth noting that the above list represents 44 out of 110 programs cited by 46 organizations responding to our two surveys. Based on the level of detail provided by survey respondents, it was not possible to cluster the remaining 66 programs into meaningful categories. Organizations typically described more than one program as applicable to conduct disordered children under the age of 12, although it is somewhat clear from an examination of descriptions of these programs provided on the surveys that most are not specifically designed for children with conduct problems.

With respect to issues of maintaining treatment program integrity and fidelity, we found that only 41% of the programs were reported as having manuals. Moreover, less than half (47%) were reported as being subject to an internal evaluation (i.e., by someone within their organization), and only 24% were evaluated by an external investigator.
CHAPTER 2
SNAP™ Outcomes and Evidence Based Practices

As the central component of the two gender-specific clinical programs offered by CDI -- the Under 12 Outreach Project and the EarlsCourt Girls Connection -- SNAP™ has been subject to rigorous evaluation and research. These evaluations have consistently demonstrated positive treatment changes using standardized measurement tools. (A complete listing of studies is provided in Appendix F.) In general, this research demonstrates:

- Significant improvements after treatment with maintenance of treatment gains at 6, 12 and 18 months in terms of externalizing behaviours (e.g. aggression, delinquency), internalizing behaviours (e.g. anxiety, depression) and social competency (e.g. peer relations, participation in activities);
- Treated children improve significantly more than children receiving an attention only group or delayed treatment; effect sizes are large for boys (exceeding 1.1) and lower for girls (0.38);
- Parents experience less stress in their interactions with their children and increased confidence in managing their children’s behaviour;
- Children report a less positive attitude towards antisocial behaviour, associate with fewer peers whom parents consider a “bad influence” and demonstrate more pro-social skills after treatment with teachers, peers and family members;
- Seventy percent of children who are considered “high-risk” do not have a criminal record by age 18.

2.1 Is SNAP™ producing positive treatment outcomes?

The vast majority of SNAP™ affiliates believe that the SNAP™ program is effective. Of those affiliates currently using SNAP™, 71% reported that they thought that the program is effective in helping children learn self-control and problem-solving skills and in reducing conduct problems. That not all current users believed that the
strategy is effective suggests that there is variation in terms of the extent to which SNAP™ has been formally evaluated.

2.2 How is treatment impact/success being assessed in terms of SNAP™?

Although SNAP™ affiliates generally believe that the program is successful, this is not supported, in the majority of cases, by routine use of standardized outcome measures. Fifty-nine percent of SNAP™ affiliates stated that a lack of personnel supporting basic program evaluation research appears to be a major factor limiting the investigation of SNAP™ effectiveness at these sites. Telephone follow-up indicated, however, an interest in pursuing activities related to measuring SNAP™ outcomes.

Three quarters of affiliates report routinely using screening measures such as the Child and Adolescent Functional Assessment Scale (CAFAS) and the Brief Child and Family Phone Interview (BCFPI) to evaluate the effectiveness of the program. A similar proportion also report using some method of quality assurance or client satisfaction questionnaire to get feedback from parents and children about their SNAP™ experiences.

Only 42%, however, report that they are using a standardized index of child behaviour problems such as the Child Behavior Checklist -- a commonly used measure of program effectiveness for this population of children. A similar proportion stated that research reports documenting the effectiveness of their SNAP™ program were available, although we were told by many respondents that these supporting documents were “informal” and thus, not for wider distribution.

LEssonS LEARNED: Lisbeth Schorr (1997) encourages replication sites to conduct their own evaluations since site-specific characteristics or differences in client populations served may produce results that vary from the original supporting research.

Resources dedicated to research and evaluation are an important aspect of replicating SNAP™ externally. In addition, SNAP™ affiliates would benefit from ongoing collaboration that supports a realistic evaluation strategy.
CHAPTER 3
Support for a SNAP™ Community of Practice

3.1 Is there interest in a SNAP™ Community of Practice in Ontario?

The answer to this question is an unequivocal yes. SNAP™ affiliates currently using the program as well as other Ontario children’s mental health centres said that they would benefit from participating in a SNAP™ Community of Practice by connecting with other organizations to coordinate SNAP™ training and resource allocation.

Seventy-nine percent of affiliates reported that they would find it potentially helpful to be connected with other organizations for the purpose of expanding their abilities to provide SNAP™. Figure 1 describes types of support current SNAP™ affiliates and non-affiliates thought would be useful if they were to participate in a SNAP™ Community of Practice.

Figure 1: Interest in Potential SNAP™ Community of Practice Activities
From Figure 1 we can see that both SNAP affiliates and non-affiliates endorse a wide range of activities. Understandably, SNAP™ affiliates are more interested in receiving support around implementation issues, and would appear to be in a better position to participate in research activities compared to non-affiliate sites. When speaking with SNAP™ affiliates by telephone, we were also told that there was keen interest in sharing experiences from other SNAP™ providers with similar challenges.

**LESSON LEARNED:** Given the desire expressed for connections with other organizations, as well as the need for support in dealing with SNAP™ implementation issues, our findings provide support for the creation of a SNAP™ Community of Practice in Ontario.

### 3.2 How should knowledge be transferred within a SNAP™ Community of Practice?

SNAP™ affiliates and other Ontario children’s mental health centres preferred similar knowledge transfer formats, which reflected a combination of telecommunication, face-to-face, and electronic methods of communication. In terms of forming connections with other agencies, geographical proximity, method of service delivery (e.g., school- versus community-based) and type of population served were suggested as possible ways to organize members within a SNAP™ Community of Practice.

Figure 2 indicates preferred knowledge transfer formats, combining both SNAP™ and non-SNAP™ affiliates. The only notable differences between the two groups were that more of the SNAP™ affiliates preferred web-based resources (82%) and teleconferencing (56%) compared to non-affiliates (52% and 26%, respectively).
Structured telephone follow-up with SNAP™ affiliates indicated that:

- Eight thought it would be helpful to connect with others who were in their geographical vicinity;
- Five affiliates expressed a preference to connect with others providing school-based SNAP™ services;
- Two affiliates wanted to be connected with other providers serving First Nations children;
- One affiliate expressed a strong desire to be connected with those serving a francophone population;
- An additional site indicated that they would like to connect with those serving the deaf. (It is worth noting that since completing this project, two additional sites serving the deaf have become licensed SNAP™ affiliates).

All active affiliates contacted by phone indicated that it would be very useful to have a directory of SNAP™ licensees available to them on Child Development Institute’s website. This directory would be password protected and include information such as geographical location, whether the SNAP™ program is offered in a group, individual or school-based format, as well as information about population ethnicity and the language(s) in which SNAP™ is offered.
CHAPTER 4
Recommendations

4.1 Toward a SNAP™ Community of Practice in Ontario

Based on the feedback provided from survey and telephone interview participants, we propose the following communication model for an Ontario SNAP™ Community of Practice. Figure 3 outlines five basic knowledge exchange activities (including their frequencies) based on a knowledge transfer model in use by Tamarack Institute for Community Engagement.

Figure 3: Communication Model*

These five key communication activities are:

- **All-Ontario SNAP™ meeting**: This activity would take place in different geographical locations in order to maximize accessibility for all SNAP™
affiliates. Respondents indicated that the time and cost associated with this event would prevent them from attending this activity if it occurred more than once per year.

- **Face-to-Face SNAP™ Groupings:** This activity would be open to all SNAP™ affiliates, however, respondents indicated that they were more likely to participate if meetings were held locally and discussion topics addressed their current service delivery challenges (e.g., school service delivery, providing SNAP™ to First Nations’ clients).

- **Teleconference/Videoconference Communication:** Given the ease and cost effectiveness of teleconferencing, this method of interactive communication offers all interested affiliates easy accessibility. Videoconferencing is another interactive mechanism, and given its current widespread use in Northern Ontario, it was identified as an efficient way of communicating with the more geographically isolated affiliates.

- **Web-based Q&A Bulletin Board:** Respondents identified this as the communication method in which they would most frequently participate. This method allows affiliates who are geographically dispersed to communicate with other affiliates experiencing similar service delivery, research and implementation issues. The timely manner in which a wide variety of challenges can be addressed through this activity increases the likelihood that affiliates would utilize this method routinely.

- **Electronic Newsletter:** Given the cost effectiveness and accessibility of this knowledge exchange activity, an electronic newsletter provides an efficient method of keeping SNAP™ affiliates abreast of current practices and major developments.

Within the larger SNAP™ Community of Practice model, it would seem beneficial to include all SNAP™ affiliates in these communication activities. However, feedback from respondents indicated that some of these activities may need to be specifically deployed, taking into account the service modalities and/or settings SNAP™ is delivered in addition to geographical considerations. As a result, affiliates may prefer to build upon collegial sub-groups that are based on either geography and/or common service delivery needs. Some of the subgroups already identified focus on the following key issues:
- Aboriginal or First Nations’ service implementation and cultural adaptation of the SNAP™ model;

- SNAP™ services for francophone populations (since 1999, we have distributed over 4,000 French SNAP™ booklets to over 30 different locations, many of whom are requesting that other resources be made available in French);

- Implementation of school-based SNAP™ services.

Figure 4 provides an overview of existing SNAP™ affiliates and other interested non-SNAP™ children’s mental health centres. Four potential geographical groupings exist in Southern Ontario, with one grouping in Northern Ontario.

**Figure 4 - Geographical Dispersion of Active SNAP™ Affiliates and Non-affiliates Interested in a SNAP™ Community of Practice**
4.2 Summary Recommendations

- The Centre for Children Committing Offences (CCCO) at Child Development Institute (CDI) would like to work in partnership with the two leading centres of excellence for children’s mental health in Ontario: The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO, and Children’s Mental Health Ontario (CMHO). The goal of this collaboration would be to support the development of a SNAP™ Community of Practice and provide support to SNAP™ affiliates and other interested CMHO members interested in advancing best practice models through program evaluation research.

- Training followed by ongoing consultation is necessary to sustain the SNAP™ model within an agency and will address implementation issues such as staff turnover. As part of their SNAP™ licensing agreement, affiliates are currently required to attend intensive training; in the future, this agreement will be expanded to require regular, ongoing consultation with the CCCO.

- That the Centre for Children Committing Offences seek funds to explore and test web-based interactive communication activities (e.g., Q&A Bulletin Board) in support of a SNAP™ Community of Practice.

- To facilitate ongoing evaluation and to better understand how replications of the SNAP™ model can be applied to different client populations, a mechanism that allows for the collection and analysis of treatment and outcome information about children who receive SNAP™ should be implemented.

4.3 Action Steps

As a first step, this report will be distributed to all Ontario based SNAP™ affiliates (N=41) and additional non-affiliate Ontario children’s mental health centres (N=55). Based on respondents’ feedback, packages will also include current information about SNAP™ resource materials and training/consultation opportunities. The creation of a web-based directory of SNAP™ services that would allow members to identify potential collegial subgroups (e.g., by geographical location, service modality, and populations served) is already in process. In addition,
linkages to this report and related developments on Child Development Institute’s website (with relevant links to other sites) are in the process of being developed.
REFERENCES


APPENDICES

A  SNAP™ Ontario Licensing Agreements with Child Development Institute, Centre for Children Committing Offences (CCCO) and Project Participation

B  SNAP™ Community of Practice Survey for SNAP™ Affiliates (Survey 1)

C  Ontario Children’s Mental Health Centers (excluding SNAP™ affiliates)

D  SNAP™ Community of Practice Survey for Non-SNAP™ Affiliates (Survey 2)

E  Follow-up Telephone Interview with Active SNAP™ Affiliates

F  SNAP™ Evaluation Studies Conducted at Child Development Institute
APPENDIX A
SNAP™ Ontario Licensing Agreements with Child Development Institute
Centre for Children Committing Offences (CCCO) and Project Participation

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Date License Issued</th>
<th>Completed Web Survey</th>
<th>Telephone Follow-up</th>
<th>Active SNAP™ Site</th>
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</thead>
<tbody>
<tr>
<td>Family Services of York Region (Formerly-Georgina Family Life Centre)</td>
<td>Sutton West</td>
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<td>YES</td>
<td>N/A</td>
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<td>Aisling Discoveries Child and Family Centre</td>
<td>Scarborough</td>
<td>October 1999</td>
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<td>Richmond Hill</td>
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<td>Hamilton</td>
<td>April 2001</td>
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<td>Date License Issued</td>
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<td>Telephone Follow-up</td>
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APPENDIX B
SNAP™ Community of Practice Survey for SNAP™ Affiliates (Survey 1)

RESPONDENT INFORMATION

1. Name of your Organization:

2. Name of Person Completing Survey:

3. Your Title:

4. Please select ONE of the following options to best characterize your organization:
   hospital/clinic-based/ children’s mental health centre/ community centre/ school/ child welfare/ other (please specify)

PROGRAMS/SERVICES FOR CHILDREN UNDER AGE 12 WITH CONDUCT/DISRUPTIVE BEHAVIOUR PROBLEMS

5. Using the following space, please identify up to five (5) programs or services offered by your organization specifically geared toward children under the age of 12 with conduct problems (e.g., externalizing or disruptive behaviour problems such as aggression, stealing or general destructiveness). Please provide any additional information you think would be helpful to describe the overall goal or mandate of each. Please provide the formal name of each program and assign a number to each program listed. Use this number as a reference in answering the next question which asks you to provide specific details about each program.

6. Using the following matrix, please provide additional details about each program from the drop down menus. If you would like to provide additional details, please do so in the previous question, or you may send us more complete information under separate cover.

   Target group: child/ parents/ siblings/ child and siblings/ child and parents/ entire family/ other

   Format: group/ individual/ combination of individual and group/ other

   Duration: as needed/ less than 1 week/ 1 to 4 weeks/ 1 to 3 months/ 3 to 6 months/ 6 to 12 months/ 12+ months

   Gender specific?: serves boys and girls/ serves boys only/ serves girls only

   Manualized?: No/ Yes—manuals exist

   Program Ever Been Evaluated?: No/ Yes—internally, informally/ Yes—by external investigator

7. Do you have additional written information (e.g., documents, fact sheets, brochures, reports) about the programs identified above? Yes/ No/ N/A

SNAP™ WITHIN YOUR ORGANIZATION

8. Have you EVER used SNAP™ (Stop-Now-And-Plan) as a strategy, program or service within your organization? No/Yes (please indicate the month and year you began using SNAP™)
9. Have any individuals within your organization ever received training on how to use SNAP™?
   Yes/No

10. Who conducted this SNAP™ training? Child Development Institute (or the former Earls court
    Child and Family Centre)/ Other sources (e.g. external service providers, other internal staff
    or indicate N/A).

11. How many people within your organization have received training on SNAP™ directly from
    Child Development Institute (or the former Earls court Child and Family Centre)?

12. How many people within your organization received training on SNAP™ from other sources?

13. Is SNAP™ (Stop Now And Plan) currently being offered as a strategy, program, or service by
    your organization? Yes/No (please explain why)

14. Approximately how many people within your organization are CURRENTLY using SNAP™?

15. Across your organization, at how many different sites/physical locations is SNAP™ offered?

PROFILE OF SNAP™ PROGRAM/SERVICE CLIENTELE

16. What are the admission criteria for children and parents who receive SNAP™ program/services
    at your organization (i.e., what renders them eligible and/or ineligible to receive the
    program/service)?

17. Briefly describe the clinical profile of children and youth who receive SNAP™ at your
    organization (e.g., predominant presenting problems).

18. Please indicate whether your SNAP™ program/service receives referrals from any of the
    following sources:

    Police: Yes/ No/ N/A
    Schools: Yes/ No/ N/A
    Child Welfare: Yes/ No/ N/A
    Children’s mental health centre: Yes/ No/ N/A
    Doctor/hospital: Yes/ No/ N/A
    Parents/relatives/friends: Yes/ No/ N/A
    Other sources: Yes/ No/ N/A

19. For 2005, please indicate the PRIMARY referral source to your SNAP™ program/service.

20. Please indicate the age group(s) of children/youth that SNAP™ is offered to (select all that
    apply):
    0-5/ 6-11/ 12-14/ 15-17/ 18+

SNAP™ FORMAT

21. Do you offer SNAP™ individually (i.e., one-on-one) to children? No/ Yes (please specify the
    age range of children served)

22. Do you offer SNAP™ in a group format to children? No/ Yes (please specify the age range of
    children served)

23. Within SNAP™ children’s groups, what would be the maximum age difference between the
    youngest and oldest child?

24. What is the typical size of SNAP™ children’s groups?
25. Are your SNAP™ children’s groups gender-specific (i.e. are boys and girls served separately)? Yes/ No

26. Do you offer SNAP™ individually (i.e., one-on-one) to parents? Yes/ No

27. Do you offer SNAP™ in a group format to parents? No/ Yes (please specify the typical size of groups)

SNAP™ IMPLEMENTATION & FIDELITY ISSUES

28. What factors or ingredients have FACILITATED a successful implementation of the SNAP™ model within your organization?

29. What factors or ingredients have PREVENTED a successful implementation of the SNAP™ model within your organization?

30. What three things would enhance the quality of the SNAP™ program/service offered by your organization?

ENHANCEMENTS TO THE SNAP™ PROGRAM/SERVICE

31. Is your SNAP™ program/service delivered in a language/modality other than spoken English? No/ Yes (please specify)

32. Briefly describe the cultural/ethnic background/characteristics of children served by your SNAP™ program/service.

33. Do you think that SNAP™ is culturally appropriate/sensitive for the children and families you serve at your organization? Yes/ No (please specify what would make it more culturally appropriate/relevant):

34. What has your organization done, if anything, to make SNAP™ more culturally appropriate/relevant?

35. As part of your SNAP™ program/service, do you offer any additional/other service components? No/ Yes (please specify)

36. Please indicate whether you offer any of the following components:

   Individual befriending or peer mentoring: Yes/ No
   Academic tutoring or homework support: Yes/ No
   School advocacy/support: Yes/ No
   Victim restitution: Yes/ No
   Family counseling (e.g., parent and child session): Yes/ No
   Individual parent work: Yes/ No
   Fire safety/prevention (e.g., TAPP-C): Yes/ No

SNAP™ PROGRAM/SERVICE UTILIZATION IN 2005

37. Approximately how many boys received SNAP™ services from your organization in 2005?

38. Approximately how many girls received SNAP™ services from your organization in 2005?

39. Approximately how many parents received SNAP™ services from your organization in 2005?
40. Approximately how many siblings of target children received some form of SNAP™ training (e.g., through activity groups or family sessions) from your organization in 2005?

41. Approximately how many children other than target children or siblings learned about SNAP™ through activities conducted by your staff in 2005 (e.g., through school advocacy/support)?

42. Has your organization ever provided SNAP™ training in other settings (e.g., schools, after-school programs, recreation centres)? No/Yes (please describe)

OUTCOME MONITORING OF SNAP™ PROGRAMS/SERVICES

43. Is SNAP™ effective in helping children learn self-control and problem-solving skills? Yes/Don’t know/No (please explain)

44. Is SNAP™ effective in reducing children’s conduct problems and aggressive behaviors? Yes/Don’t know/No (please explain)

45. If you answered yes to Question 43 or 44, please describe how you know that it is effective (i.e., what evaluation methods/measures are used to determine effectiveness)?

46. Do you routinely use assessment tools that measure changes in children’s behaviors before and after receiving SNAP™ (e.g., Child Behaviour Checklist)? No/Yes (please specify or describe these tools)

47. Do you routinely use quality assurance, client satisfaction or other instruments to get feedback from children and/or parents on their experience of receiving SNAP™ from your organization? No/Yes (please specify or describe)

48. Do you have any articles, reports or summaries that document the effectiveness (or ineffectiveness) of SNAP™? Yes/No

OUTCOME MONITORING OF PROGRAMS/SERVICES FOR CHILDREN UNDER 12 WITH CONDUCT PROBLEMS

49. Do you have any articles, reports or summaries that document the effectiveness (or ineffectiveness) of other (i.e., non-SNAP™) programs offered by your organization that target children under 12 with conduct/disruptive behaviour problems? Yes/No

50. Do you have research support/personnel within your organization who are, or can participate in routine outcome monitoring for programs within your organization (e.g., conduct pre-post program assessments using standardized measures)? Yes/No

TOWARD THE ESTABLISHMENT OF A SNAP™ COMMUNITY OF PRACTICE

51. What type of support (if any) would you find helpful from the Centre for Children Committing Offences (CCCO) at Child Development Institute in terms of implementing or further developing SNAP™ at your organization?

52. Would you find it potentially helpful to be connected with other organizations for the purpose of expanding your ability to provide SNAP™ and related services?

53. As a member of a SNAP™ Community of Practice (i.e., professionals across organizations providing SNAP™), your organization could potentially access a number of supports/services. Please indicate which of the following would fulfill a need within your organization (select all that apply): Further information about SNAP™, Access to SNAP™ materials and resources
(manuals, videos, booklets, etc.), Information about training and consultation on SNAP™, Participation in SNAP™ related research, Dealing with SNAP™ program/service implementation issues, Other (please specify)

54. If a SNAP™ Community of Practice were to be developed in Ontario, which of the following knowledge transfer formats would your organization be most likely to use/participate in? (select all that apply): Face-to-face meetings that bring together SNAP™ service providers, Periodic teleconferences on specified topics related to SNAP™, The ability to learn from the experiences of other SNAP™ users, Web-based resources (e.g., bulletin boards, downloadable documents), An annual SNAP™ Newsletter, Syntheses of SNAP™ research, Linkages to experts in the field, Research support (e.g., to do program evaluation), Other (please specify)

55. In addition to SNAP™, which of the following would you like to develop/enhance within your organization in order to better respond to children under age 12 with conduct/disruptive behaviour problems?

- Risk assessment tools/methodologies for reliably identifying high-risk children: Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop
- Participation in a police-community protocol (e.g., a referral mechanism with a central intake line): Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop
- Gender specific programs (i.e., specifically targeted at children under 12 in conflict with the law): Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop

SNAP™ RESOURCE MATERIALS

56. Has your agency ever used SNAP™ resource materials? Yes/No

57. Please indicate if any of the following resource materials have ever used by members of your organization (select all that apply):


58. Please indicate if any of the following resource booklets have ever used by members of your organization (select all that apply): English Version/ French Version/ Both Versions/ (Neither/Not Applicable)

- Stealing Booklet, Lying Booklet, Bullying Booklet, SNAP™ Booklet, Brothers and Sisters Learn SNAP™ Booklet, Tips for Troubled Times Booklet

59. What suggestions would you make (if any) to improve SNAP™ resource materials?

COMMUNICATION THE WITH CENTRE FOR CHILDREN COMMITTING OFFENCES AT CDI

60. Please provide candid feedback about your overall experience in dealing with the Centre for Children Committing Offences at Child Development Institute.

61. Do you have any additional comments about this survey or your experience with SNAP™?
## APPENDIX C
Ontario Children’s Mental Health Centers (excluding SNAP™ affiliates)

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<td>Lynwood Hall Child and Family Centre</td>
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<td>Massey Centre</td>
<td>Toronto</td>
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<td>Oolagen Community Services</td>
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<td>Smiths Falls</td>
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<td>Pembroke</td>
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<td>Quinte Healthcare Corporation Parent Child and Youth Clinic</td>
<td>Belleville</td>
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<td>Roberts/Smart Centre</td>
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<td>Kapuskasing</td>
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<td>Services aux Enfants et Adultes Prescott-Russell/Services to Children and Adults</td>
<td>Hawkesbury</td>
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<td>Point Edward</td>
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<td>Etobicoke</td>
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<td>Youthlink</td>
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APPENDIX D
SNAP™ Community of Practice Survey for Non-SNAP™ Affiliates (Survey 2)

RESPONDENT INFORMATION

1. Name of your Organization:

2. Full address of Organization:

3. Webpage:

4. Name of Person Completing Survey:

5. Your Title:

6. Your Phone and Ext:

7. Fax:

8. Please select ONE of the following options to best characterize your organization:
hospital/clinic-based/ children’s mental health centre/ community centre/ school/childwelfare/other (please specify)

PROGRAMS/SERVICES FOR CHILDREN UNDER AGE 12 WITH CONDUCT/DISRUPTIVE BEHAVIOUR PROBLEMS

9. Does your organization serve children under the age of 12? Yes/ No

10. Does your organization offer programs or services specifically to children under the age of 12 with conduct problems (e.g. externalizing or disruptive behavior problems such as aggression, stealing or general destructiveness)? Yes/ No

PROGRAMS/SERVICES FOR CHILDREN UNDER AGE 12 WITH CONDUCT/DISRUPTIVE BEHAVIOUR PROBLEMS

11. Using the following space, please identify up to five (5) programs or services offered by your organization specifically geared toward children under the age of 12 with conduct problems (e.g., externalizing or disruptive behaviour problems such as aggression, stealing or general destructiveness). Please provide any additional information you think would be helpful to describe the overall goal or mandate of each. Please provide the formal name of each program and assign a number to each program listed. Use this number as a reference in answering the next question which asks you to provide specific details about each program.

12. Using the following matrix, please provide additional details about each program from the drop down menus. If you would like to provide additional details, please do so in the previous question, or you may send us more complete information under separate cover.

   Target group: child/parents/siblings/child&siblings/child&parents/ entire family/other
   Format: group/ individual/ combination of individual and group/ other
   Duration: as needed/ less than 1 week/ 1 to 4 weeks/ 1 to 3 months/ 3 to 6 months/
   6 to 12 months/ 12+ months
   Gender specific?: serves boys and girls/ serves boys only/ serves girls only
   Manualized?: No/ Yes—manuals exist
13. Do you have additional written information (e.g., documents, fact sheets, brochures, reports) about the programs identified above? Yes/ No/ N/A

**SNAP™ WITHIN YOUR ORGANIZATION**

14. Have you EVER used SNAP™ (Stop-Now-And-Plan) as a strategy, program or service within your organization? No/ Yes (please indicate the month and year you began using SNAP™)

15. Have any individuals within your organization ever received training on how to use SNAP™? Yes/ No

16. Who conducted this SNAP™ training? Not applicable/ Child Development Institute (or the former EarlsCourt Child and Family Centre)/ Other sources (e.g. external service providers, other internal staff or indicate N/A).

17. How many people within your organization have received training on SNAP™ directly from Child Development Institute (or the former EarlsCourt Child and Family Centre)?

18. How many people within your organization received training on SNAP™ from other sources?

19. Is SNAP™ (Stop Now And Plan) currently being offered as a strategy, program, or service by your organization? Yes/ No

20. If yes, to what age group of children and youth are you providing SNAP™ (select all that apply)? Not applicable/ 0-5/ 6-11/ 12-14/ 15-17/ 18+

21. Approximately how many people within your organization are CURRENTLY using SNAP™?

22. Across your organization, at how many different sites/physical locations is SNAP™ offered?

**OUTCOME MONITORING OF SNAP™ PROGRAMS/SERVICES**

23. Is SNAP™ effective in helping children learn self-control and problem-solving skills? Yes/Don’t know/No (please explain)

24. Is SNAP™ effective in reducing children’s conduct problems and aggressive behaviors? Yes/ Don’t know/ No (please explain)

25. If you answered yes to Question 24, please describe how you know that it is effective (i.e., what evaluation methods/measures are used to determine effectiveness)?

26. Do you routinely use assessment tools that measure changes in children’s behaviors before and after receiving SNAP™ (e.g., Child Behaviour Checklist)? No/ Yes (please specify or describe these tools)

27. Do you routinely use quality assurance, client satisfaction or other instruments to get feedback from children and/or parents on their experience of receiving SNAP™ from your organization? No/ Yes (please specify or describe)

28. Do you have any articles, reports or summaries that document the effectiveness (or ineffectiveness) of SNAP™? Yes/ No
OUTCOME MONITORING OF PROGRAMS/SERVICES FOR CHILDREN UNDER 12 WITH CONDUCT PROBLEMS

29. Do you have any articles, reports or summaries that document the effectiveness (or ineffectiveness) of other (i.e., non-SNAP™) programs offered by your organization that target children under 12 with conduct/disruptive behaviour problems? Yes/ No/ We do not offer services to children under 12 displaying conduct problems

30. Do you have research support/personnel within your organization who are, or can participate in routine outcome monitoring for programs within your organization that target children under 12 displaying conduct problems (e.g., conduct pre-post program assessments using standardized measures)? Yes/ No/ We do not offer services to children under 12 displaying conduct problems

TOWARD THE ESTABLISHMENT OF A SNAP™ COMMUNITY OF PRACTICE

31. As a member of a SNAP™ Community of Practice (i.e., professionals across organizations providing SNAP™), your organization could potentially access a number of supports/services. Please indicate which of the following would fulfill a need within your organization (select all that apply): Further information about SNAP™, Access to SNAP™ materials and resources (manuals, videos, booklets, etc.), Information about training and consultation on SNAP™, Participation in SNAP™ related research, Dealing with SNAP™ program/service implementation issues, Other (please specify)

32. If a SNAP™ Community of Practice were to be developed in Ontario, which of the following knowledge transfer formats would your organization be most likely to use/participate in? (select all that apply): Face-to-face meetings that bring together SNAP™ service providers, Periodic teleconferences on specified topics related to SNAP™, The ability to learn from the experiences of other SNAP™ users, Web-based resources (e.g., bulletin boards, downloadable documents), An annual SNAP™ Newsletter, Syntheses of SNAP™ research, Linkages to experts in the field, Research support (e.g., to do program evaluation), Other (please specify)

33. In addition to SNAP™, which of the following would you like to develop/enhance within your organization in order to better respond to children under age 12 with conduct/disruptive behaviour problems?

  - Risk assessment tools/methodologies for reliably identifying high-risk children: Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop
  - Participation in a police-community protocol (e.g., a referral mechanism with a central intake line): Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop
  - Gender specific programs (i.e., specifically targeted at children under 12 in conflict with the law): Have in place, and is working well/ Have in place, but could be further developed/ Do not have, but would like to develop/ Do not have and do not want to develop

SNAP™ RESOURCE MATERIALS

34. Has your agency ever used SNAP™ resource materials? Yes/ No

35. Please indicate if any of the following resource materials have ever been used by members of your organization (select all that apply):

  - Complete SNAP™ resource kit: Used/ In Use/ Never Been Used
SNAP™ Puppet: Used/ In Use/ Never Been Used
EARL 20-B Version 1 Consultation Edition for Boys: Used/ In Use/ Never Been Used
EARL 20-B Version 2 for Boys: Used/ In Use/ Never Been Used
EARL 21-G Version 1 Consultation Edition for Girls: Used/ In Use/ Never Been Used
SNAP™ Training Video/DVD: Used/ In Use/ Never Been Used
Stopping Stealing Training Video/DVD: Used/ In Use/ Never Been Used
SNAP™ Children’s Group Manual: Used/ In Use/ Never Been Used
SNAP™ Group for Girls Manual: Used/ In Use/ Never Been Used
SNAP™ Parent Group Manual: Used/ In Use/ Never Been Used
SNAPP Stop-Now-And-Plan-Parenting Manual: Used/ In Use/ Never Been Used

36. Please indicate if any of the following resource booklets have ever used by members of your organization (select all that apply):

   Stealing Booklet: English Version/ French Version/ Both Versions/ (Neither)
   Lying Booklet: English Version/ French Version/ Both Versions/ (Neither)
   Bullying Booklet: English Version/ French Version/ Both Versions/ (Neither)
   SNAP™ Booklet: English Version/ French Version/ Both Versions/ (Neither)
   Brothers and Sisters Learn SNAP™ Booklet: English Version/ French Version/ Both Versions/ (Neither)
   Tips for Troubled Times Booklet: English Version/ French Version/ Both Versions/ (Neither)

37. What suggestions would you make (if any) to improve SNAP™ resource materials?

COMMUNICATION THE WITH CENTRE FOR CHILDREN COMMITTING OFFENCES AT CDI

38. Do you have any additional comments about this survey or your experience with SNAP™?
APPENDIX E
Follow-up Telephone Interview with Active SNAP™ Affiliates

1. We know right now that the organizations currently using SNAP™ in Ontario are serving diverse populations. If we were to develop a network of organizations using SNAP™ in Ontario with which agencies would you find it beneficial to be connected? French speaking, First Nations, Deaf community, Geographically matched, School based service delivery, Other

2. Would it be helpful to you if we created a directory on the web of services offered by each of our SNAP™ sites that included information on regional location, program format (group/ individual/ school) and population served (language, cultural/ethnicity)?

3. Would your agency be comfortable being included in a SNAP™ directory of this nature including the above mentioned information?

4. How could we best create this connection? Face to face meetings (clusters based on the above mentioned criteria), Teleconferencing, Video conferencing (do you have this capability?), Web based communication – bulletin board and Q & A, Email newsletters, Annual all Ontario SNAP™ meeting

5. In terms of connecting with other agencies, would you see yourselves as leading the process, or would you prefer that CDI/CCCO facilitate meetings in your community?

6. How many times per year would your organization be able to commit to the following ways of communicating you have suggested above? Face to face meetings (within your community / Toronto based-CDI ), Teleconferencing, Video conferencing, Web based communication / bulletin board and Q & A

7. Would you be interested in partnering with other agencies in submitting proposals for funding to further develop: SNAP™ at your site (Y/N), Conduct research on the effectiveness of SNAP™?

8. Do you have any other comments or questions at this time?
APPENDIX F
SNAP™ Evaluation Studies

Internal Studies


External Studies


**Other Associated Publications:**