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

Program Evaluation of
Child & Youth Wellness Centre of Leeds & Grenville’s
Community Counselling Program 2005

Made Possible by Program Evaluation Grant
PEG 162606-014

Submitted by:
Dr. Susan E. Meyers
May 3, 2006
Child & Youth Wellness Centre of Leeds and Grenville (CYWC) provides a variety of mental health services to children, youth and their families throughout the United Counties of Leeds & Grenville in their homes, schools, and our local offices. The program that provides the majority of services in our agency is our community counselling program. In this program, individual, group and family therapy are provided by CYWC therapists to children, youth, and their families with various mental health issues.

Although we have two mandated measurement/evaluation tools, the Brief Child & Family Phone Interview (BCFPI) and The Child and Adolescent Functional Assessment Scale (CAFAS), to provide a basis for evaluation of clinical improvement, we have been in the position of having few resources available to use the mass of data generated from them for evaluation of our program. This grant has made it possible to use these tools to begin to evaluate the service provided by the community counseling program at CYWC to determine whether treatment being provided is effective and to develop a structure and format for on-going program evaluation using these tools at CYWC. As well, we began to compare the data generated by BCFPI and CAFAS to see if they provide complementary information for our therapists.

**Method:**

We had hoped to be able to complete post-treatment BCFPI's on a significant portion of the children and youth (approximately 200) who had been discharged after receiving community counseling services in 2005. In the six weeks of the grant, our staff made attempts to contact over 300 families who had received service. Given the transient nature of a good number of our families, we were able to complete only 43 post-treatment BCFPI administrations.

It did not appear that the families we were able to contact were significantly different demographically (location, age of child, gender of child, number of significant problems reported on the initial BCFPI) than the families that were not able to be contacted. Of the 43 families contacted, the identified child or youth was predominantly female (65%) with a median age of 14 years (range 9-19 at time of current contact) and a mean of 5.26 (s.d.=4.5) problem areas on the BCFPI rated above the 98th percentile for children or youth in the general population in their age range.

Of the 43 cases in this sample, both entry and end of treatment CAFAS scores also were available for 38 children and youth. Hence, the following BCFPI and CAFAS results are based on this sample. Given its modest sample size, this evaluation should be viewed as providing us with preliminary data only. Nevertheless, given the strong results even with a small group of clients, it does provide us with some clear direction for further inquiry.

**Outcomes and Deliverables:**

A number of goals were addressed in this evaluation. Results are discussed in terms of each of them.

- *To determine if significant positive clinical change occurred for clients who completed community counseling (CC) treatment in the 2005 fiscal year (April 1 2005-March 31 2006).*
It is clear both from BCFPI and CAFAS data that significant positive change occurred for a majority of CYWC clients from the time of referral to discharge and follow-up.

At discharge, CAFAS exit data indicate that significant reductions in overall level of dysfunction had occurred since entry to treatment. The mean Total CAFAS rating dropped from 49.46 at treatment entry to 19.19 at discharge (t=7.832, p<.000, 2-tailed). This represents a clinically meaningful and reliable amount of change.

Significant decreases in problem severity were seen on the following CAFAS subscales:

- School/Work
- Home
- Behaviour Toward Others
- Moods/Emotions
- Self-Harmful Behaviour

Although reductions in the other clinical scales of Community, Substance Use, and Thinking were noted, they did not reach statistical significance, likely due to their initially low mean ratings (most children and youth were not indicating impairment in those areas at entry to service at CYWC).

At follow-up, both clinically and statistically significant reductions (p<.008 or less) were seen on the following BCFPI scales:

Mental health subscales:
- Regulating Attention, Impulsivity and Activity
- Cooperativeness
- Managing Mood
- Self-harm

Mental Health composite scales:
- Externalizing Composite
- Internalizing Composite
- Total Mental Health Problems

Child Functioning subscales:
- Social Participation
- Global Child/Youth Functioning

Family Functioning:
- Family comfort
- Global Family Situation

This indicates that, at follow-up contact, parents were reporting less overactive and impulsive behaviour by their children/youth, a decrease in non-compliant and defiant behaviour, an increase in interest or enjoyment in life and improvement in mood, and fewer concerns regarding weight-loss, suicidal talk or suicide attempts by their children/youth. Overall, fewer internalizing and externalizing behaviours were being reported, as can be seen by a reduction in the total problems endorsed by parents. As well, children/youth were seen to be participating more with others and showing significantly less overall functional impairment. Parents also were reporting that their child or youth was less likely to be perceived as a source of conflict and anxiety in the family and that there was less impairment in family functioning.
• **To determine if a greater number of presenting problems had an impact on the above clinical change.**

The number of presenting problems on entry BCFPI reports were correlated with clinical change on BCFPI and CAFAS. This was done by examining the number of initial problems with a T-score over 70 on the entry BCFPI with entry-discharge/follow-up change scores on the Internalizing Composite, Externalizing Composite, and Total Mental Health Problems Composite scales of the BCFPI and the change scores on the Total CAFAS scale.

Only BCFPI change was correlated with having a greater number of presenting problems, with greater number of problems being associated with greater clinical change on the Externalizing (r=.505, p<.001), Internalizing (r=.343, p<.024), and Total Mental Health Problems (r=.494, p<.001) scales. Amount of clinical change as reflected on the CAFAS was not associated with a greater number of presenting issues.

• **To determine if significant clinical change on BCFPI and CAFAS were correlated in this sample (and if so, to what extent).**

Correlations were computed for change scores on the Internalizing Composite, Externalizing Composite, and Total Mental Health Problems Composite scales of the BCFPI and the change scores on the Total CAFAS scale. Only a modest correlation was obtained between the clinical change on the Total CAFAS and the Externalizing Composite scales (r=.328, p<.047).

Hence, although significant clinical change was being noted on both BCFPI and CAFAS instruments for this sample, it is likely that they are measuring distinct domains. Further examination of the information being provided by each measure will be undertaken in order to convey more meaningful information to therapists about the positive clinical changes being shown by their clients.

• **To determine if client satisfaction is correlated with positive clinical change.**

As part of the follow-up administration of the BCFPI, parents were asked nine client satisfaction questions in a variety of areas. The vast majority of those surveyed indicated that they felt they received good to excellent service (percentages provided in each survey area below):

- The convenience of the service (100%)
- How long they had to wait for services (84.6%)
- The time of day when services were scheduled (97.5%)
- The courtesy and respectfulness of staff (95%)
- Information they were given to help them understand their child/youth (90%)
- Ways they learned to help their child (87.5%)
- Opportunities to help make decisions about services (87.5%)
- The helpfulness of the service they received (92.5%)
- Overall, their rating of the quality of the service (92.1%)

On a scale from 1 to 5, the modal score in each area was a 5 (excellent).
These satisfaction scores were correlated with the above composite measures of positive clinical change on the BCFPI and CAFAS. In all cases, satisfaction was not correlated with clinical change. Although parents were quite satisfied with CYWC services, this was not tied to outcome (as has been noted in previous research).

This is further evidence that we need to look for outcome measures beyond that of how happy our families are with our service to examine meaningful clinical change. Of course, the good engagement with families as noted in the satisfaction data may set the stage for therapeutic change; other factors such as evidence-based therapeutic practice may need to come into play to create actual clinical change.

- To provide a format (above) for on-going evaluation of BCFPI and CAFAS data to be extended to other programs of the agency.

The process of gathering the above data, obtaining statistical software for analysis, and conducting the preliminary analysis has resulted in a number of agency staff members expanding their program evaluation skills that can be transferred to other programs and other evaluation questions.

The evaluation activities noted above have allowed us to determine, using two standardized measures, that provision of our CYWC community counseling services to children, youth, and their families results in significant clinical change.

A full report is being compiled, as well as a more plain language Powerpoint presentation to discuss these results with our staff. This will allow us to continue our path of moving toward adherence to evidence-based treatment models. As part of this, we will include a comparison of our results to those of the Ontario BCFPI and CAFAS roll-ups that have been disseminated recently. Most importantly, we will be conveying this information to children, youth, and parents about the effectiveness of our service.

This evaluation has provided an initial, small-scale step in examining the relationship of our two mandated measures and their use in providing our agency with useful and helpful data to evaluate our work. It has also set the stage for us to be able to examine our clinical effectiveness throughout our centre using these two tools in a more effective way than we have in the past.

Knowledge Exchange and Dissemination:

This project represents the first steps in developing a clear picture of the effectiveness of our community counseling services on a local level. Results will be circulated to the staff of our agency that:

- Services are effective in creating clinical improvement (as noted by positive change on the two measures).
- Effectiveness still needs to be improved (in regard to those scales in which change was not noted and not limited by low baseline behaviours).
- Families are very satisfied with our services.
- Effectiveness (as measured by positive clinical change) is not related to client satisfaction so we need to continually monitor our effectiveness in other ways.
This will set the stage for us to be more receptive to knowledge transfer in regard to evidence-based practice—and how it relates to our day to day practice. As well, our results will be shared with families (through our newsletter, brochures, and presentations in the community), our area-wide CMH providers (via our local communities of practice), our community partners, and our funders in a spirit of transparency that will allow us to continue to improve and develop services that are effective—based on the continuous feedback from program evaluation.

We are developing a community of practice regarding knowledge transfer in our region, and results and lessons learned may be shared there. We will also post to the BCFPI website that this project was conducted and can disseminate through Children’s Mental Health Ontario’s communities of practice. Opportunities to share results of our project via the Centre of Excellence are also welcomed.
# Accounting Summary of Expenses

Grant PEG 162606-014

<table>
<thead>
<tr>
<th>Eligible Budget Items</th>
<th>Cost per Item ($)</th>
<th>Total Cost ($)</th>
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<tbody>
<tr>
<td><strong>Personnel Costs</strong></td>
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<tr>
<td>Intake Worker (140 hours)—data collection &amp; analysis</td>
<td>$ 4,528.76</td>
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<tr>
<td>Clinical Director (34 hours)—data analysis</td>
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<tr>
<td>Other Staff (47 hours)—data collection</td>
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<td><strong>Consultation Costs</strong></td>
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<tr>
<td><strong>Computer Costs (hardware and software; Max. $3,000)</strong></td>
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<td>SPSS – Software</td>
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<td>ACCESS – Software</td>
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<tr>
<td><strong>Training Tools/Questionnaires</strong></td>
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<td><strong>Administrative Costs (details required; Max. $1,000)</strong></td>
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<td><strong>Office Supplies (Max. $500)</strong></td>
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<td><strong>Web-Design (Max. $500)</strong></td>
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<tr>
<td><strong>Travel (for data collection only)</strong></td>
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<tr>
<td><strong>Total Cost of All Expenses (Max. $10,000)</strong></td>
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<td>$10,000.00</td>
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