

Psychology Ontario

Advancing psychology through commitment and service



Special Issue: Screening and Outcome Measures in Children's Mental Health Services

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- OPA has launched its new website, www.psych.on.ca

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EDITORIAL

Mario Cappelli, Editor

Effective measurement is a pillar of psychology. It is rooted in virtually all aspects of experimental and clinical psychology and is a key element that psychology brings to mental health practice. Whether the focus is personality, psychopathology, sensation/perception, learning, cognition, behaviour, and environment, there is not an aspect of our work that does not include the application of psychological measurement. In the last few years, measurement has also become increasingly associated with evidence-based assessment, treatment and program evaluation with psychologists being asked to provide a leadership role in many settings such as hospitals, community clinics and educational facilities interested in demonstrating the effectiveness of their clinical services.

More recently psychologists have taken a leadership role in program evaluation and outcome management at a provincial level. This includes many of the mental health services provided to children and youth in Ontario supported by the Ministry of Children and Youth Services. In all these efforts, a key lesson learned is the importance of front-line staff and service providers being able to see the addition of measurement tools to their already busy practices as beneficial.

Recognizing the importance of these issues, the PO has developed this special issue devoted to Ontario's Screening and Outcome Initiative in Children and Youth Mental Health Services. The intention is to inform Ontario psychologists and other mental health practitioners about the initiative, its key screening and outcome measurement tools, and the early results from community health centres, agencies and programs currently using these instruments in their work.

The issue is framed by articles by Dr. Melanie Barwick who provides an overview and rationale for systematic screening and outcome management, as well as an overview of the two key instruments: BCFPI (Brief Child and Family Phone Interview) and CAFAS (Child and Adolescent Functional Assessment Scale). Her articles are complemented by descriptions from various children's mental health centres and programs applying these instruments in their clinical and agency work. The most intriguing aspect of these reports is the evolution of clinicians' view on using these tools from scepticism to acceptance to commitment; so that the tools have become viewed as another important element of their clients' assessment and treatment plan.

The integration of screening and outcome measures into day-to-day clinical practice is a reality that can provide all of us working in the area of child and youth mental health services with an opportunity to demonstrate systematically the value of our work. We at Psychology Ontario offer this special issue as a small contribution to this important aspect of this area of practice.

Finally we would also like to acknowledge the support of the Ministry of Children and Youth Services in the production of this issue.

60th Anniversary Convention of the Ontario Psychological Association **OPA' 07**

“Celebrating our Past: Building our Future”
Renaissance Toronto Airport Hotel
February 21 - 24, 2007

Keynote Speakers

John Arnett, Ph.D., Past President of the Canadian Psychological Association
“Advancing Psychology: Where Do We Need to Go Now?”

Wade Pickren, Ph.D., Official Historian and Former Archivist to the American Psychological Association
“Looking Forward by Looking Back: Sixty Years of OPA”

Norman Doidge, M.D., F.R.C.P., Research Psychiatrist, Psychoanalyst and Author
“The Neuroplastic Revolution, Psychoanalysis and Love”

Louise Plouffe, Ph.D., Senior Technical Advisor in the Aging and Life Course Programme - World Health Organization
“Mental Health and Aging Policy: Adopting the Double Orphan”
Co-sponsored by the Canadian Coalition on Seniors' Mental Health

Peter Szatmari, M.D. Director of Offord Centre for Child Studies, McMaster University
“Asperger's and Autism Spectrum Disorders: From Diagnosis to Intervention with School Age Children and Young Adults”
(Co-sponsored by the Sections on Psychology in Education and Independent Practice)

Jack Naglieri, Ph.D., Professor of Psychology and Director, School Psychology Program, George Mason University

Marie-Josée Gendron, Ph.D., Director of Research and Development, Harcourt Brace
“The Last Word in Non-Verbal Assessment of Ability: Introducing the Wechsler Nonverbal Scale of Ability”
Co-sponsored by the Psychological Corporation

Reverend Raymond Dlugos, OSA, Ph.D., CEO Southdown Institute
“Psychology and Spirituality: Competitors or Collaborators in the Service of Health and Holiness”
(Co-sponsored by the Southdown Institute)

Pre-Convention Highlights

Pre-Convention Workshop

“Stories from the Front: Applying CAFAS and BCFPI in Your Practice”
Co-sponsored by the Ministry of Children and Youth Services

President's Reception
Special Comedy Presentation by
Dr. David Factor

60th Anniversary Banquet

Keynote Speaker
The Honourable James Bartleman
Lieutenant Governor of Ontario

Champagne Reception
Presentation of OPA Awards
Life-Time Achievement Awards
Commemorative Tribute Book

Post-Convention Workshops

Gary Schoener, M.A., Clinical Psychologist and Executive Director of the Walk-In Counseling Centre in Minnesota
“Achieving Personal and Professional Balance: Easier Said Than Done”
Co-sponsored by the College of Psychologists in Ontario and the Ontario Association of Psychological Associates

Scott Millis, Ph.D., Professor and Director of Research, Wayne State University School of Medicine

Lyle Allen III., Author and Researcher with CogniSyst

John Gilman, Ph.D., Psychologist in Clinical Neuropsychology and Rehabilitation with Children, Adolescents and Adults

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Klaus Wiederman, Ph.D., Psychoanalytic Psychotherapist and Senior Candidate, Toronto Institute of Psychoanalysis
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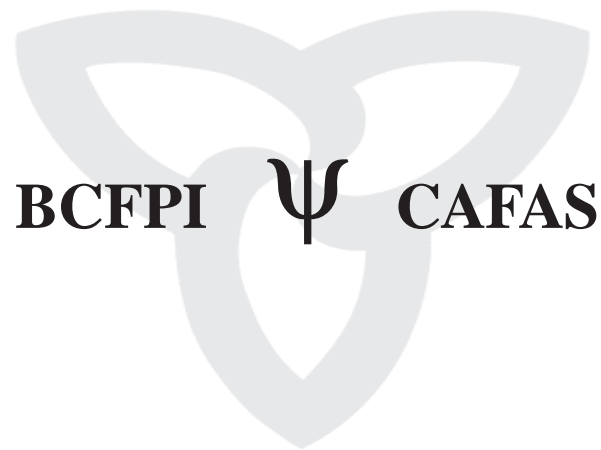
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Ontario's Screening and Outcome Initiative in Children's Mental Health



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Ontario practitioners strive to provide the best services for the most children in the face of limited resources and increasing demand. To do this efficiently and ethically requires that we establish service effectiveness for children and youth with diverse problems and determine how the sector can provide for a greater proportion of children in need, in a timelier manner, given the resources at hand. Standardized *intake screening* can facilitate wait list management by triaging children at greatest risk.

Outcome management can facilitate improved outcomes by verifying whether treatment approaches are producing expected response-to-treatment while clients are still engaged and there is opportunity to modify the treatment approach. *Outcome measurement* can demonstrate the functioning of children upon entering and leaving treatment, and provide an indication of the proportion of children who improve as a result of service.

To this end, Ontario initiated systematic screening and outcome measurement in 1999 as part of a four-point plan for children's mental health that also saw development of intensive child and family services, mobile crisis services, and telepsychiatry. An overview of the initiative and the tools being implemented is provided.

Early History and Goals

The Ontario reality is such that few evidence-based treatments are in use in clinical practice. Moreover, without system-wide measurement using a common metric, there is

little provincial data regarding the types of disorders with which children and youth present for service, and no systematic evidence of outcome. Ontario is hard-pressed to ameliorate the children's mental health (CMH) system in a rational way in the absence of such fundamental knowledge.

A commissioned review of outcome tools appropriate for system-wide deployment (Raphael, Weir, Weston, Lines & Pettingill, 1999), together with a feasibility study (Boydell, Barwick, Ferguson & Haines, 2005), led to the adoption of two instruments in 84 CMH agencies and 23 hospital clinics: 1) a standardized intake instrument to screen morbidity (Brief Child and Family Phone Interview / BCFPI; Cunningham, Pettingill & Boyle, 2000), and 2) a standardized global outcome instrument to assess level of functioning and monitor the effectiveness of service delivery (Child and Adolescent Functional Assessment Scale / CAFAS; Hodges, 2003).

Community-based CMH agencies were selected for participation by their regional offices, as were some hospital clinics that fund CMH services through 'separate vote' dollars from MCYS. Hospitals funding CMH services through their global Ministry of Health and Long-Term Care dollars were not eligible. Another 13 CMH agencies joined the initiative in 2006. Children's Mental Health Ontario, an advocacy organization that promotes the well-being of children, youth, and their families, oversees BCFPI training and implementation with support from

BCFPI Incorporated and the Oxford Centre for Child Studies at McMaster University. CAFAS training and implementation is provided by the Community Health Systems Resource Group at The Hospital for Sick Children. An advisory group of Ontario-based service providers jointly support the implementation teams, as does the Research and Outcome Measurement Branch of the Ministry of Children and Youth Services.

Implementation and Data Management

Ontario's measurement initiative involves substantial organizational and practice change. Changing practice is a formidable task that occurs slowly, requiring changes in clinician knowledge, attitudes, and behavior, program and organizational restructuring, and an infusion of resources (Huang et al., 2003). Following six years of implementation, over 600 intake workers and administrative personnel in 114 organizations have been trained in the reliable administration of the BCFPI. Over 4000 child and youth workers, social workers, psychologists, and psychiatrists have been trained to reliably rate CAFAS in 107 organizations. Data are collected quarterly, analyzed, and reports prepared for individual organizations, serving to motivate continued use of the tools and to exchange valuable client knowledge with staff, management, and agency boards.

Annual aggregate reports were first produced in 2005, and can be located on the web (<http://www.cafasontario.ca/html/related-reports.asp> for CAFAS, and www.bcfpi.org for BCFPI). Future challenges include supporting the clinical utility of the tools through communities of practice, developing a best practice for use of the tools, and working with government and service provider organizations to develop policies and procedures for the collection, analysis, and reporting of aggregate level data. Developers of the tools continue to make improvements and modifications to improve ease and clinical utility. Linkage of data from these tools with other provincial data will continue to be a challenge in the absence of a unique identifier system for the social services, and represents a critical area for focus and development if this initiative is to realize a satisfactory return on investment.

Conclusion

The measurement initiative has achieved several important outcomes over the last six years:

- (1) we have learned important lessons on how best to bring evidence-based practices to the field and how to support the adoption of new and innovative approaches to mental health care for children;
- (2) we have introduced a triage tool that shows great promise for tracking and managing wait for service;
- (3) we have underscored that best practice at the outset of treatment requires comprehensive interviewing and formulation;
- (4) we have learned a great deal about the problems and related dysfunction with which children and youth present;
- (5) we find that gauging response to treatment is worthwhile with respect to improving outcomes.

The lessons learned to date suggest there is a need to build individual and organizational readiness for change for the adoption of evidence-based practices, to improve the state of technological literacy and infrastructure across the sector, and to improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce regarding the state of children receiving mental health service in Ontario. Unique identifiers for social services are also greatly needed in light of these changes and what we have yet to learn about children's needs and the effectiveness of services.

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Initial Screening: The Brief Child and Family Phone Interview

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Screening can assist in identifying need for service and the likely presence of particular disorders and severity of risk (Maruish, 1999). Over time, BCFPI data will provide information regarding shifts in wait time, and first-ever objective evidence that, as suspected, we are seeing more children and youth with mood management problems and severe impairments.

Various organizations in Ontario are using the BCFPI to assist in making triage decisions, to connect families to interim services (e.g., readings, videos, groups), to formulate assessment plans, to obtain standardized measures of treatment outcome for comparison to “benchmarks” in the clinical literature, to support strategic organizational and regional planning, to determine whether children most in need are receiving service, and to examine the distribution of child problems for which services must be developed.

The BCFPI is a structured computerized interview administered to the parents (or teachers) of 3 to 18 year olds at the first point of intake, prior to clinical assessment and treatment. An adolescent self-report form is available. The instrument is also used in Sweden, British Columbia, Alberta, and Nova Scotia and is available in French, English, and Swedish.

Administration takes 30 to 45 minutes and begins with a narrative overview of client concerns. Given the instrument’s ability to capture both narrative and more structured interview data, it is designed to replace rather than add to the traditional intake interview. The instrument gathers standardized information on demographics, common behavioral and emotional problems, impacts on child and family functioning, risk and protective factors, family readiness for service, and potential barriers to service utilization. Online data entry, scoring, and report generation create efficiencies for wait list management and triage (Cunningham, Pettingill & Boyle, 2001).



The BCFPI’s standardized questions were derived from the survey measurement tools of the Ontario Child Health Survey (Boyle, Offord, Racine, Sanford, et al, 1993). Subscale scores are based on normative data from the Revised-Ontario Child Health Study Scales (Boyle, Offord, Racine, Fleming, Szatmari & Sanford, 1993a) for boys and girls aged 6-12 years or 13-18 years in both population and clinical samples. Seven subscales measure common childhood problems and aggregate to form composite scales: (1) Externalizing Behaviour (Regulating Attention, Impulsiveness and Activity Level, Cooperativeness, and Conduct); (2) Internalizing Behaviour (Separation from Adults, Managing Anxiety, Managing Moods). A Total Problems scale is derived from the 36 items comprised in the Externalizing and Internalizing scales.

The extent to which problems have adversely affected the child’s social participation, quality of social relationships, and school participation and achievement are captured in subscales that combine to inform Impact on Child Functioning. Family Functioning is measured by a Family Activities subscale (the extent to which the child’s problems have influenced the family’s relationships with friends and family and/or mobility in the community); a Family Comfort subscale (the extent to which the child’s problems are a source of conflict and anxiety within the family); and a Global Family Situation composite scale (combined items from the Family Activities and Family Comfort subscales.

A Barriers to Service Utilization scale determines whether work schedules, transportation difficulties, or language barriers limit the family’s ability to participate in treatment.

A Readiness for Change scale determines parental interest in a list of potential service options, such as topical literature or video programs, parenting skill building groups, or support groups. New versions of the tool include brief, standardized measures of parental mood and a checklist of concerns such as specific phobias, fire setting, and thought problems.

The psychometric properties of the BCFPI have been evaluated with a community sample of 1,741 children and a clinic referred sample of 1,727 (Cunningham et al., 2001). The factor structure derived from the Ontario Child Health Study Scales – Revised for population and mental health clinic samples was replicated in a large field trial involving 10,916 6 to 18 year old children referred to 74 children’s mental health organizations in Ontario. With the exception of Conduct problems (.68), reliability coefficients for subscales in field trials ranged from .75 to .85 for Problem Behaviour scales and .75 to .77 for Functional Impact scales.

The BCFPI has adequate test-retest reliability, good evidence of sensitivity to change, and good concurrent validity, with correlations between the its subscales and the extended scales from the Ontario Child Health Study’s (OCHS-R) survey diagnostic instrument ranging from .88 to .96. Discriminate validity is evident on comparison of the means of clinic and non-clinic samples that yielded significant differences on all BCFPI subscales.

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The Brief Child and Family Phone Interview (BCFPI) in Hamilton:

Intake Screening, Triage, Outcome Measurement, and Program Management



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McMaster University
McMaster Children's Hospital
Contact Hamilton

This article discusses the use of the Brief Child and Family Phone Interview (BCFPI) (Cunningham, Pettingill, & Boyle, 2006) as a component of Hamilton's integrated children's mental health screening, triaging, outcome measurement, and service management system.

Contact Hamilton: Central Intake

Contact Hamilton is the central point of intake for all families seeking children's mental health and developmental services in the city of Hamilton. Contact Hamilton's Resource Coordinators administer the BCFPI as one part of a more comprehensive intake interview. The results of the BCFPI are used to inform triaging recommendations regarding the most appropriate services available, establish service priorities, and suggest interim service options which parents might consider while waiting. For example, CONTACT Hamilton identifies children with high BCFPI externalizing scores whose parents might benefit from large group parenting workshops, such as COPE. At the completion of the intake interview, Resource Coordinators describe COPE, discuss the potential benefits of participation, review available workshop times and locations, and enroll interested parents. This triaging protocol has increased the percentage of families who enroll in parenting programs such as COPE.

McMaster Children's Hospital

The Child and Youth Mental Health Service at McMaster Children's Hospital is a regional provider of tertiary children's mental health services. This program uses BCFPIs completed by Contact Hamilton to support internal triaging decisions. The BCFPI, in combination with the Child and Adolescent Functional Assessment Scale (CAFAS), is used to determine the characteristics of referrals participating in different services, measure the outcome of specific programs, and inform program planning decisions. Three examples are discussed below.

COPE: The Community Parent Education Program

The Community Parent Education Program provides 10-session large group parenting workshops. COPE workshops are advertised universally in Hamilton via our Community Education Service flyer¹ distributed to all families by local school boards. By administering the BCFPI before and after COPE groups, the program was able to describe the characteristics of families enrolling in COPE's universally accessible workshop, determine the effectiveness of the program, and benchmark the effect size of COPE against other-evidence-based programs. Although COPE is universally available to all families in Hamilton, 53% of the 304

families enrolled reported more externalizing problems, and 67% reported their child's behaviour had a greater negative impact on their families, than 93% of the general population (t-scores of 65 or above).² Families of children with severe problems showed a very significant reduction in BCFPI externalizing problems (effect size = 1.3). These outcomes are comparable to those observed in clinical trials (Cunningham, Bremner & Boyle, 1995) and effectiveness studies of the COPE program (Cunningham, 2006) and are comparable to those reported by other investigators (Sanders, Markie-Dadds & Bor, 2000).

Next, we used the BCFPI to evaluate a new version of the COPE program, COPEing with oppositional teens (COPE-OT). In comparison to referrals to our Child and Youth Mental Health Services, those whose parents enrolled in COPE-OT evidenced higher BCFPI Externalizing t-scores, lower BCFPI Internalizing t-scores, and higher BCFPI functional impairment t-scores. Computing standardized effect sizes suggested that COPE-OT yielded improvements (effect size = 1.2) comparable to those observed in clinical trials of similar programs (Barkley, Edwards, Laneri, Fletcher & Metevia, 2001). Based on this data, we made an organizational decision to continue offering this program.

The Selective Mutism Service

This program provides assessments, consultations, and workshops for parents and professionals working with children who have selective mutism and related social anxiety disorders. This service uses the BCFPI to help identify children who may need more comprehensive assessments, determine the needs of this poorly understood group of children, and to demonstrate the outcome of the program's large group workshops. Children with selective mutism show very high BCFPI social participa-

tion t-scores (e.g. avoiding social activities). In comparison to other outpatient referrals, however, children with selective mutism are much less likely to have elevated cooperation, conduct, anxiety management, or mood management t-scores. Repeating the BCFPI 6 months following the completion of the workshop series has indicated a significant reduction in socially avoidant behaviour.

The Community Family Treatment Program (CFTP)

This program provides home-based services to families of children who have not benefited from less intensive outpatient services. CFTP adopted the BCFPI to better understand the characteristics of the families participating in the program, to determine an optimal period of treatment, and

“The BCFPI provided the “vehicle” to pursue our research objectives and to provide research findings which support our clinical and anecdotal impressions... We now have a data set that describes the families that we work with as well as documenting our effectiveness, which is very exciting.”

to examine the overall outcome of the program. With preprogram BCFPI externalizing t-scores averaging 81.3, child functioning t-scores at 79.3, and Impact on Family t-scores averaging 103.9, CFTP provides service to families of children with very severe problems. Repeating the BCFPI at 6 months revealed a significant reduction in problems (effect size = .9) with an additional

reduction at 1 year of treatment (total effect size = 1.3). Paul Ricketts noted that, “It has been a long-term dream of mine, as supervisor with the Community Family Treatment Service, to research the effectiveness of the program. The BCFPI provided the “vehicle” to pursue our research objectives and to provide research findings which support our clinical and anecdotal impressions. The data that has resulted from the BCFPI with our families has validated the value of our work with the children and youth, which we work with, and allowed us to advocate for the needs of our families with administrators, who may question how long we need to spend with children and their families. We now have a data set that describes the families that we work with as well as documenting our effectiveness, which is very exciting.”

Conclusion

In summary, the BCFPI has proven useful as a central intake screening and triaging tool in the Hamilton region. Examining the BCFPI scores for specific programs at McMaster Children's Hospital validated our internal triaging

¹ <http://www.communityed.ca/parent.cfm>

² <http://www.bcfpi.org/bcfpi/downloads/outcomes/chedoke/cope.pdf>

processes and helped us understand the characteristics of the families we serve. Repeating the BCFPI at treatment termination allowed the computation of standardized effect sizes supporting the effectiveness of locally developed programs. Benchmarking allowed us to determine that these local programs yielded outcomes comparable to evidence-based standards in the field.



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Centralized Access and the Brief Child and Family Phone Interview

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Contact Brant's Resource Coordinators began administering the Brief Child and Family Phone Interview (BCFPI) six years ago as part of a comprehensive intake process. However, the utility of the BCFPI as a screening tool became apparent approximately two years ago when it was adopted in Brant as the primary tool for combating an extensive and growing waiting list for children's mental health services. With the waiting time for non-priority, office-based counselling approaching three years, Contact Brant for Children's and Developmental Services (Brant's centralized intake agency) and Woodview Children's Centre (Brant's primary children's mental health provider) developed a triage model based on children's BCFPI scores that they hoped might improve the waiting times for services.

This model triages children and youth with no clinically significant mental health or functional impairment scores away from clinical services, directs children and youth with high externalizing scores to COPE and other evidence-based groups, and ensures that children and youth with high internalizing behaviour scores be directed to traditional office-based counselling services in a timely manner. Part of the model included re-administering the BCFPI for evaluative purposes. Two years later, Brant has eliminated the lengthy wait for office-based counselling, has a rich dataset that supports the success of this model and has been able to make use of this data to support system changes.

The Worried Well

Prior to initiating the waiting list project, all families requesting mental health services for their children were offered an intake interview, had a BCFPI completed and were referred to the service of their choice. Contact Brant and Woodview agreed to pre-screening using the BCFPI. It was agreed that if a child had no scores in the clinical range, that child would not be offered clinical services. It was theorized that many of these families constituted the "worried well" and that the process of having a comprehensive intake and being waitlisted for clinical services increased anxiety while providing little or no benefit.

Currently, families with no clinical scores are provided with information about parenting groups, books, videos and other community resources. Contact Brant assures these parents that their children are scoring within the "normal" range on all mental health indicators and invites them to call back if their situation changes.

In making triaging decisions, Contact Brant Resource Coordinators take into consideration both the BCFPI mental health scores as well as any other concerns parents or caregivers present during the BCFPI interview. Staff have the capacity to override the BCFPI triage protocol should they be concerned that a parent is under-reporting. Common indicators that a parent might be under-reporting include a referral from a service provider with extensive

knowledge of the child or family, such as child welfare or school personnel, or inconsistency between the parent's dialogue and scoring. In this case, the Resource Coordinators schedule a meeting with the family to gather more information and, if necessary in their judgement, to make a referral to service.

Families who have been screened away from clinical services are contacted in three months to complete a follow-up BCFPI. As hoped, families who are redirected to non-clinical services have lower average scores on all mental health indicators than those referred to clinical services. This group of children has been demonstrated not to deteriorate between BCFPIs and overall parental satisfaction is high.

Children with Clinical Needs

Children who score high on regulation of attention, impulsivity, and activity level (RAIA), cooperation, or total externalizing behaviours, are referred to evidence-based groups for these issues, most commonly COPE. Children attending COPE score very high on the RAIA, cooperation and total externalizing scores and the majority of these children make clinically significant gains in these areas. Contact Brant also refers children with high conduct scores to the COPE program. Although this was not part of the initial triaging project design, it was enlightening to learn that these children also improved.

Although evidence-based groups have been available to families in Brant for a number of years, the message communicated to families has changed significantly. Previously, groups were presented as an option for the families while they waited for counselling, the implication being that they were not the intervention of choice. Currently, families with externalizing problems are referred to evidence-based groups as the "intervention of choice" for their child.

Children with clinical issues related to separation, anxiety, managing mood, internalizing and total mental health are referred to more traditional clinical services. Parental preference and situation both inform the method of service delivery which includes brief office-based counselling (3 to 6 sessions), priority or waitlist office-based coun-

selling, or a home-based intervention. As predicted, children referred to these programs tend to have higher scores in these areas and generally experience clinically significant improvement over time.

Children and youth who exhibit both high internalizing and high externalizing scores are referred both to evidence-based groups and to more traditional counselling programs. Parental preference and availability of service determine the order of intervention.

One interesting finding which supports the Brant triage model is the parental mood score. Generally, parents of children with clinical issues have higher parental mood scores than those with no clinical issues. It is encouraging that after intervention the average parental mood scores show clinically significant improvement.

Using Evidence to Inform Practice

The BCFPI has provided an effective measure of changes in children's mental health overtime. While the absolute number of children waiting is an indicator of efficiency of children's mental health services in Brant, the change in BCFPI scores is a measure of the effectiveness of the interventions.

This evidence strongly supports the request for additional funding for the new Brief Therapy model of intervention and for funding expansion of evidence-based groups in Brant. Government officials appreciate the tangible demonstration of effective use of funding to serve more children more effectively.

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The Use of BCFPI at CPRI



Dr. Jeff St. Pierre
Psychology Professional Practice Lead at CPRI

The Brief Child and Family Phone Interview (BCFPI) was adopted by the intake social workers at CPRI in 2002. Initially, our intake staff were reluctant participants. As a regional tertiary care provider, our intake staff require an extensive understanding of Children's Mental Health Services across 17 counties throughout Southern Ontario. Our intake interview differs from a first time intake, in that a professional assessment has likely occurred, indicating the child is already experiencing academic, emotional-behavioural, or social adaptation failures. Often a report with a diagnosis is on a clinical chart somewhere. Typically, case management, parent training, or mental health treatment such as prescribing psychotropic medication to the child has been attempted with limited success. A BCFPI may already have been completed by a front line agency, and we had to decide whether this needed to be updated.

With this in mind, our social workers were cautious about the need to adopt a "brief" clinical screening tool, on clients that had already been identified by a clinician with an externalizing or internalizing disorder. The BCFPI seemed designed to direct clients to cost effective evidence based tools, such as child behaviour management courses or readings that would prevent ongoing difficulties. In contrast, we were being asked to understand co-morbid disorder profiles and complex multiple agency (multiple Ministry!) case management. Would a "brief" parent report of current symptoms aid our in-

depth multi-disciplinary assessments? Equally important, and of interest in this article, would a brief parent report of symptoms be a good addition to the CAFAS and client satisfaction outcome tools?

We adopted the BCFPI with care, noting the impact of the time on the phone and quality of information gathered during our intake interviews. After a brief adjustment, intake social workers reported that they enjoyed the structure of the interview, and that it served as a solid foundation for the other questions they wished to pursue at intake. Compared to the Achenbach Child Behaviour Checklist (CBCL), which we had adopted in year's past, the English literacy concerns were eliminated, and the telephone interview ensured a higher response rate. Examining the initial scores across all clients confirmed that our community referent partners and our intake staff were doing a good job of directing families with very high needs into service, confirming the BCFPI as a screening instrument for high needs clients.

Regarding outcomes, our residential mental health treatment programs serve youth with multiple risk factors, including breakdowns in home and school placements. They often receive diagnoses indicating long term need for supports, including conduct disorder, bipolar mood disorder, thought disorder, and most behaviour problems are coupled with significant school failures. Our treatment program includes full time school attendance onsite, with

integration back to the family home each weekend. The average length of stay for the cohort of clients between fall 2002 and spring 2005 was four months.

Would the BCFPI tease out any differentiation in such a high needs group? Would we struggle with a ceiling effect? – The term used to describe the problem of scores so high that they can no longer be used in a meaningful fashion to define any statistical or clinical differences between clients. Would a brief parent report of symptoms be sensitive to changes in child behaviour over time?

As seen in Table 1, the early answer to these questions, using CPRI residential data, appears to be yes. Scores pre-admission to residential mental health treatment are very concerning, but note the tight standard deviation in parent report of oppositional behaviour (Cooperativeness – our main referral concern), compared to the large variability in Conduct symptoms, a more serious but less common concern. Clearly, some variability across clients is measured by these few items. Parent report six to eight months after discharge indicates significant decreases in behaviour problems, mood symptoms, family stress and community restrictions needed to keep the child safe. Are these significant treatment effects on the BCFPI subscales, also meaningful to the client’s well-being?

Several pieces of evidence support this. Parent satisfaction ratings with the treatment outcome were on average very high. Clinician ratings on the CAFAS indicated a reduction in risk behaviours and improvement in functioning. Independent teacher ratings also indicated both significant symptom reduction and social skill gains. A teacher BCFPI is available, and while we have not yet switched from other traditional school report measures, we strongly recommend teacher report as an important adjunct in any outcome investigation. As noted succinctly by Dan Offord in his many talks following the Ontario Child Health Study, “child psychiatric disorders should be conceptualized as informant-specific phenomena”.

Concerns remain that the observed decrease was just a “regression to the mean”, and that the gains will not hold beyond a year. From a sensitivity standpoint however it is interesting that the post BCFPI measures indicate outpatient treatment support is still indicated, confirming what we know to be true clinically. Beyond reported child symptoms, note also the parent reports of well-being indicators, such as restrictions on family activities (Table 1). We are interested in understanding the impact

of treatment supports on the whole family, and it is clear that problems continue to impact family activities post-discharge. The BCFPI also allows us to monitor parental depression and drinking, two important risk factors. We are now in the process of conducting two year follow-up data collection, in a joint CPRI-UWO project funded by the Provincial Centre of Excellence for Children’s Mental Health, whereby we will tease out the predictors of long term success using Hierarchical Linear Modelling. To date, the eight-month BCFPI follow-up allowed us to observe no change in reported separation anxiety and a slight anxiety symptom increase, which we need to monitor carefully due to concerns that may be held when the youth is away from the home for tertiary or secure forms of treatment.

At www.bcfpi.org we can compare our intake referral patterns to those of other agencies, by looking at the T scores on the BCFPI. Likewise, while the literature on residential outcomes seldom discusses effect size due to the long term, multi-modal nature of treatments, we can compare our effect sizes to other tertiary care programs in the province. This begins a dialogue we can have with other service providers within our community of practice or the broader system of care. We dream of someday following our high need families across multiple service providers with a few simple reporting tools, such as the BCFPI and CAFAS, that assist us in monitoring child and family well-being over time with fidelity and compassion.

Table 1

Brief Child and Family Phone Interview Mean T Scores ¹						
Mental Health Residential Treatment Programs, CPRI, London						
	Pre-admission			8 months post		
	n	Mean	SD	n	Mean	SD
Regulation of Attention	138	74.71	8.28	138	69.11	9.78
Regulation of Impulsivity & Activity	139	69.91	9.16	139	63.47	9.99
Regulation of Attention, Impulsivity & Activity	140	74.26	8.54	140	67.82	9.73
Cooperativeness	140	76.74	7.89	140	69.76	11.72
Conduct	140	90.44	27.73	140	71.80	26.85
Externalizing	140	82.54	9.55	140	72.62	12.37
Separation from Parents	138	63.14	14.85	138	61.38	15.62
Managing Anxiety	140	61.20	15.70	140	64.18	13.82
Managing Mood	138	76.87	17.90	138	65.00	18.43
6 Mood + 3 Self Harm Indicators	136	80.48	19.32	136	66.57	18.94
Internalizing	136	71.32	14.08	136	66.77	15.26
Total 6 mental health domains	138	80.46	9.29	138	72.42	12.51
Social participation	135	84.52	15.18	135	71.47	18.64
Quality of Relationships	126	76.55	9.76	126	65.06	13.18
School Participation & Achievement	132	79.47	13.80	132	66.93	17.84
Global Functioning	136	86.26	11.05	136	70.81	17.03
Family Activities	113	115.80	32.12	113	88.22	36.06
Family Comfort	113	83.31	13.22	113	73.59	16.69
Global Family Situation	119	102.13	20.27	119	82.66	25.45

¹ All scales in the high range of clinical concern with large (significant, $p < .001$) pre-post changes in parent report except for separation from parents and managing anxiety, both of which began below the clinical range of concern. N variability due to parent report on some scales but not all.

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Outcome Measurement

The Child and Adolescent Functional Assessment Scale

**Melanie Barwick, Ph.D, C.Psych.,
Lead, CAFAS in Ontario,
Community Health Systems Resource Group,
The Hospital for Sick Children**

Outcome measurement leads to improved treatment, enhances clinical science, provides accountability to clients and funders, and maintains the ethical responsibility of practitioners to examine service quality (Barlow, Hayes & Nelson 1984; Ogles, Lambert & Masters, 1996). All too frequently, children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes (Huang, Hepburn & Espiritu, 2003). The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes (Busch 2002; Dishion, McCord & Poulin, 1999) despite evidence that most children who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Chambliss & Ollendick, 2001; JCCP 1998).

Global outcome measures, such as the CAFAS, help to standardize the measurement of quality and provide a common language and metric for comparison across programs, regions, and client populations (Busch 2002). This makes them particularly relevant for system-wide application. Global outcomes provide an index of overall severity that is easier to aggregate than measures that are more disease specific. They also put into

practice NIMH criteria regarding the importance of measuring the impact of interventions on day-to-day functioning in the client's real life (Newman, Ciarlo & Carpenter, 1999).

The CAFAS (Hodges 2003) is designed to rate functional impairment in children and youth who have or may have emotional, behavioral, substance use, psychiatric, or psychological problems. It consists of behavioral descriptions, (e.g., expelled from school) arranged into four levels of impairment - severe, moderate, mild, and no or minimal impairment - across eight domains of functioning (subscales): school or work, home, community, behavior towards others, moods and emotions, self-harmful behavior, substance use, and thinking. The rater reads the items in each subscale, beginning with the severe items, until a description of the client's functioning is found. The score on each subscale is determined by the level of impairment under which the item appears: severe, 30; moderate, 20; mild, 10; no or minimal, 0. Subscale scores are combined to form a total score. Each subscale has an accompanying list of strengths and goals.

Knowing something about the child/youth's initial level of disturbance and early response to treatment helps clinicians to identify potential treatment failures, to improve outcomes, and reduce deterioration in the client (Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). As such, best practice in Ontario involves rating CAFAS:



(1) periodically to *manage* outcome and assess progress; (2) to assist with assessment, formulation, and planning; and (3) to measure overall outcome.

The primary clinician completes the rating, and does so as close to the beginning of treatment as possible, at 3 month intervals to gauge response to treatment, and upon discharge from treatment. Rating the breadth of subscale areas necessitates that clinician's complete a comprehensive assessment and formulation process so that they have at hand sufficient knowledge about the client from which to conduct a rating.

Once familiar with the software, clinicians take an average of 10 minutes to complete the scale. Clinicians for whom comprehensive assessment was the norm prior to CAFAS typically report that use of the tool has not changed their approach to clinical interviewing. Moreover, because the clinician/rater uses information typically collected in clinical service as the basis for rating the CAFAS, and the software produces information required for practice (e.g., assessment and outcome reports, treatment plan), they report that use of the tool is beneficial to their practice.

Interrater reliability is established independently by rating 10 reliability vignettes from the CAFAS Self-Training Manual (Hodges, 2003), thus ensuring that all raters use the same "rules" and definitions of terms. The CAFAS in Ontario office provides training in reliability, software, and data management/interpretation, and trains/supports in-agency trainers. To guard against "rater drift", booster exercises are completed annually. Interrater reliabilities over time, and between clinicians trained by the implementers and those trained 'in-house' are being studied (Barwick, Urajnik, Basnett, in revision).

As a multi-dimensional measure of global functioning the CAFAS demonstrates better reliability in the field than unilateral measures, such as the GAF and CGAS that are prone to rater bias (Herman, 1990). Previous research

has demonstrated the reliability of the CAFAS (Hodges & Wong, 1996) as well as its concurrent and predictive validity. High interrater reliability has been reported across different sites and with both layperson and clinician raters (Hodges & Wong, 1996).

Studies of concurrent validity have found greater impairment on the CAFAS to be associated with: more intensive level of care, more restrictive or therapeutic placement, more serious psychiatric disorders, more problems in social relationships, involvement with juvenile justice, school related problems, and child and family risk factors (Hodges & Wong, 1996; Hodges, Doucette-Gates & Liao, 1999; Manteuffel, Stephens & Santiago, 2002).

Studies of the CAFAS' predictive validity has demonstrated that CAFAS score at intake predicted: cost of services, service utilization, contact with law, poor school attendance, and recidivism at either 6 or 12 months post intake, depending on the study (Hodges et al 1999; Hodges, Doucette-Gates & Kim, 2000; Hodges & Kim, 2000; Hodges & Wong, 1997; Quist & Matshazi, 2000).

The CAFAS has been successfully used to assess outcome for youths varying in degree of impairment, referral source, and diagnosis (Manteuffel et al 2002; Duchnowski, Hall, Kutash & Friedman, 1998; Rosenblatt & Furlong, 1998 Walrath, Mandell & Leaf, 2001) e. No differences have been observed for the total CAFAS score on gender, race/ethnic group (i.e., comparing Caucasians, African-Americans, and Hispanics), or caregivers' education level (Hodges & Wong, 1997).

In Ontario, a supplemental rating guideline has been developed for rating CAFAS with Aboriginal children and youth (Barwick, Ojibway Child and Youth Services, Hodges 2004). Hodges has recently published a compilation of resources and guide for matching CAFAS profiles to evidence-based treatments (Hodges, 2004). There is also a screening interview (15 minutes) that inquires about the youth's functioning and is administered to a caregiver (or other adult informant). A newly developed CAFAS Advanced Child Management Scale examines caregiver functioning in the areas of: providing directions and follow-up; encouraging good behavior; discouraging undesirable behavior; monitoring activities; connecting positively with youth; and problem solving orientation.

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Kelley Johnston
Program Support Manager, CPRI

The Child and Parent Resource Institute (CPRI) is a provincially operated facility located in London, Ontario. CPRI provides services to children and youth with severe mental health and/or developmental disabilities. Highly specialized, interdisciplinary consultation, assessment, research and education services are available and treatment is provided in both residential and non-residential settings. CAFAS and BCFPI have become an integral part of service needs, assessment and program evaluation at CPRI.

The CAFAS rating scale was adopted by CPRI in the early stages of the ministry’s outcome measurement initiative. As an organization, the decision was made to make training mandatory and we embarked on the enormous task of training all our clinicians.

Initially, our staff were reluctant participants; it may have been the word “mandatory” or the skepticism of how this outcome tool could precisely depict our clientele and meaningfully impact our clinical work, but we persevered. Slowly the tables turned and the non-believers began to use the tool to assist with clinical formulations.

One day in a meeting, about a year after initial implementation, a clinical staff member stated, “I use the CAFAS to evaluate my client’s progress”. Wow, we were heading in the right direction! Forging ahead, we began to monitor the timely completion of CAFAS evaluations and this was incorporated as a measurement goal on staff performance plans. Staff complied, but let us know that they needed to see more evidence that the time and effort spent rating CAFAS was of clinical benefit.

In the last 2 years, we have incorporated clients’ CAFAS scores into our Client Information System database as well as on our waitlists. This allows us to examine risk/need factors as part of the referral and also provides objectivity as part of the clinical decision-making process when prioritizing clients.

At a management team level, it was recognized that it was very important for staff to have easy access to BCFPI and CAFAS information. This became a priority and, with the tremendous support of our information technology staff, CAFAS and BCFPI data are now routinely imported into our Client Information System (see Figure 1).

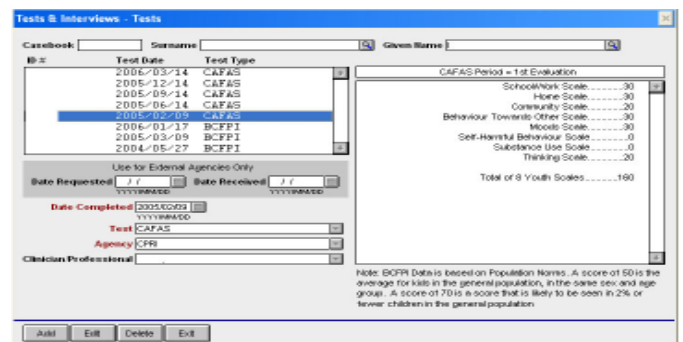
Having easy access to the information has become important to staff. If the import is late, clinicians call asking why a client’s score is not yet visible in the Client Information System. This feature has not only allowed clinicians to view scores easily, but it has also provided an internal vehicle to monitor data quality. Cases with missing data fields will not import into the Client Information System and an internal report is generated. This report is utilized internally to assist in cleaning the data and is part of our ongoing data quality assurance procedures carried out in preparation for the quarterly export to CAFAS in Ontario.

If a specific case does not export successfully into our Client Information System, it alerts a manager that data is missing. It could be anything from a missing subscale score to biographical data that has not been checked off. This export feedback allows our in-house CAFAS trainers to identify areas where extra guidance and support with data entry may be required for individual staff members.

Now that CPRI has set this standard as an organization, the rest has been easy to market to our staff. BCFPI and CAFAS are being used across the organization. It is part of research and program evaluation. CPRI is currently piloting the use of CAFAS and BCFPI with children and adolescents who have dual diagnoses of mental health and developmental disabilities or have Pervasive Developmental Disorder.

Today, we have 65 clinical staff who are certified to provide CAFAS evaluations. Ongoing data management training and examination have kept CPRI support staff busy. Exploring ways to keep making our data useful for our clinicians and the children we serve, as well as meaningful for management, practical to applied research proposals and accurate for export sharing is an ongoing task that has proven beneficial to our organization.

Figure 1: Client Information





CAFAS – Youville Centre

Judith R. Sarginson
Executive Director
Youville Centre

Youville Centre is a social service agency that motivates, educates and nurtures young single parents to become self-sufficient, contributing members of society while providing support and care for their children. In an educational Care and Treatment setting, 48 at-risk teen mothers are given the opportunity to complete their high school education while acquiring strong parenting skills. Our licenced childcare program for 55 infants and toddlers (ages 2 months to 2½ years) provides an environment which promotes positive behavioral, social and mental health development. Support services for these young families include: mental health, addiction and career counseling; housing outreach; parenting classes; breakfast and lunch programs; food bank; life skills and nutrition training; anger management; smoking cessation; personal safety; healthy lifestyles; swap shop; etc.

All of our clients are self-referred. Many have been in more than one high school. Some may have no secondary credits while others may be close to graduation. Many are learning disabled and most have serious mental health needs. All are coping

with the challenges of studying and parenting at the same time.

The risk factors associated with young parents include: need for parenting skills; infant children at risk; 35-50% with previous Child Welfare involvement; family conflict; lack of social relationships; physical, emotional and social abuse; behavioral needs such as aggression, impulsivity, non-compliance; low self-esteem; low frustration/tolerance;

poor peer relationships; significant barriers to educational success including learning disabilities; psychiatric diagnoses (many are undiagnosed) such as depression, mood disorder, personality disorders, suicidal ideations, self-injurious behaviours. Add to these, poverty, substance abuse, legal or

criminal involvement, homelessness or transiency and the profile of the teen parent points to significant care and treatment needs.

In the absence of formal documentation of any kind at the application stage, we welcomed the use of the BCFPI instrument. The information it provided enabled us to form a pre-admission profile of each client and begin to plan for her arrival and her needs. The arrival of the Ontario School Record (OSR) after admission provided additional information

“It is not difficult to see why the BCFPI and CAFAS instruments are so valuable to us. In the absence of documentation describing our client profiles, these tools are beginning points as we assess and evaluate strengths, weaknesses and next steps for our clients.”

which sometimes included psychological or psycho-educational reports.

Although the CAFAS instrument had been available to us for some time, there was a great deal of reluctance on the part of our staff to make use of it. Our staff is comprised mainly of Child and Youth workers; BSW staff gain experience in our setting and quickly move on to better-paying jobs.

The resistance to CAFAS had a variety of reasons: the instrument was initially seen as “too clinical” for a community agency; our clients are both the adolescent and the caregiver; the Home subscale did not suit our clients’ home situations; the pre-treatment ratings appeared overly high, to name a few concerns.

We decided, after much discussion, to address these concerns, train all our staff and strive to use this instrument as a basis for an Individual Treatment Plan (ITP) for all of our clients, regardless of age. Such a treatment plan coupled with the Individual Education Plan (IEP) would allow us to set personal and educational goals for our clients at the outset, monitor progress and evaluate outcomes. We therefore embarked on staff training, the use of the CAFAS instrument with all clients, the formation of individual treatment plans and the use of these plans with the involvement of our clients.

After much effort and many months of CAFAS use, we are converts! We see the value of the CAFAS instrument for our Centre, especially when paired with the BCFPI tool. It serves as the basis for our ITPs and provides our clients with a visual aid to monitor progress and change as they participate in the process of goal setting and outcome achievement.

It is not difficult to see why the BCFPI and CAFAS instruments are so valuable to us. In the absence of documentation describing our client profiles, these tools are beginning points as we assess and evaluate strengths, weaknesses and next steps for our clients. The BCFPI is administered at the application stage and gives us an indication of the challenges we need to meet. The information coupled with the entry CAFAS information enables us to develop and implement an Individualized Treatment Plan for our clients. The client is an active



participant in her ITP which is shared openly with her, bears her signature, is adapted with her collaboration, and follows her through her studies at Youville Centre.

Each of our staff members is comfortable using both the BCFPI and CAFAS scales. We appreciate the information provided by these tools. The ability to utilize the computerized versions is a decided asset. The terminology employed is standardized, the graphs generated complement the data provided and the client profile is invaluable to the client and her support workers. Referrals to other professionals are more easily made, particularly to mental health and addiction counselors on-site.

A challenge remaining concerns the use of the CAFAS “Home / Youth as Caregiver” subscale. The manual version suits our clientele and provides a more realistic rating for them, since they are both youths and caregivers. We would appreciate a computerized version of this subscale and the ability to include it in the overall score.

In conclusion, I would like to express gratitude to the CAFAS staff for their patience, support and encouragement as we have worked and continue to work through the implementation of the CAFAS instrument. Their assistance has been a great resource especially in the absence of psychologists, social workers or mental health clinicians on staff.



“Horse Friends” Partnering Equine Assisted Psychotherapy with Theraplay®

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“Horse Friends” began in April 2005 as a two year pilot program funded in part by the Ontario Trillium Foundation, Blue Hills Child and Family Centre and Horses At Heart Inc..

The “Horse Friends” program combines Theraplay® with an experiential therapy called Equine Assisted Therapy. The Theraplay® element of this program promotes four attributes of healthy relationships; structure, challenge, nurture and engagement. The Equine (Horse) Assisted element of the program reinforces these attributes by forming mutually respectful relationships with horses. This gives children and their caregivers, two opportunities each session to experience the awareness and attunement necessary to build and strengthen personal and interpersonal skills. This program has integrated these two therapeutic modalities to provide a clinically sound, culturally inclusive treatment option to families who have received interventions in the past or who respond more effectively to a “hands on” experiential type of learning.

As prey animals, horses have a well developed and keen sense of awareness. Working with these animals requires that we increase our own awareness by becoming more attuned to ourselves and how we interact with others. Experiencing a relationship with a horse offers larger-than-life metaphors that show the child and parent how they:

- engage in conscious routine
- accept a challenge
- understand boundaries
- relate to others in a nurturing, supportive and respectful manner and,
- take a risk

Models for healthy coping strategies, boundary settings and behaviour management systems are reinforced through the combination of attuned Theraplay® and Equine Assisted Therapy.

Children who benefit from “Horse Friends” typically come to the program with some of the following issues:

- children and parents struggling to manage behaviours related to poor relationships, attachment and boundaries.
- children and/or parents with low self esteem
- children and families who struggle with self regulation
- children and families who struggle with transitions
- children who lack trust
- children who show emotional immaturity
- families with sibling conflict
- families who avoid challenges and fear trying new things
- families who need to work on doing things together
- children who have been deprived of basic needs (physical, emotional including lack of affection)
- families with problems accepting care or nurturing
- families with behaviour management issues
- step-families, reconstituted families, adopted children, foster children
- withdrawn, shy children and passive children who need support to interact with others

Participation in the “Horse Friends” therapeutic program denotes an ongoing therapeutic relationship in the presence of a certified mental health practitioner as well as an equine

educator. There are clearly established treatment goals and objectives.

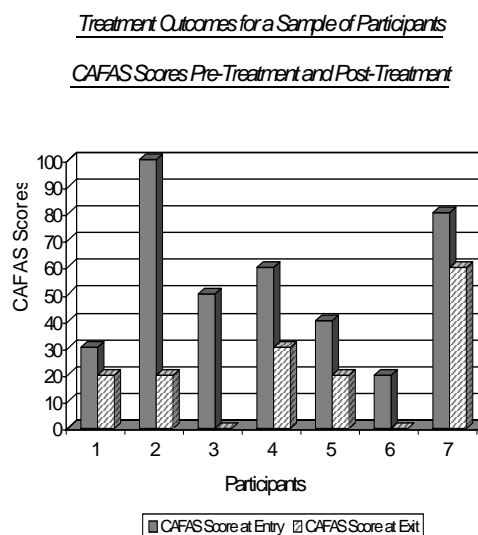
The “Horse Friends” program is typically 12 sessions in duration. During that time families will complete a Marschak Interaction Method assessment both prior to beginning the program and at the end of program completion. Other pre and post assessment tools include an anecdotal description of the child’s behaviours and relationships, the Eyberg, Parenting scale and CAFAS. Choosing CAFAS as a measure for this program was compelling for several reasons. Firstly, as a measure of function we wished to look at whether or not there was a change in how the child functioned outside of the program. This could open doors should we wish to pursue further comparisons with other groups and/or programs. We also felt that given the easy scoring of CAFAS, easy access to reliability rated clinicians and the graphing and statistical abilities of the CAFAS computer program, it would be a good option.

Each “Horse Friends” session begins with 40 minutes learning about and interacting with horses. None of this is done as ‘horseback riding’, but rather as working on the ground grooming the horse and learning the equine body language to ‘speak’ respectfully with the animals while walking them and ‘joining up’ with them on the ground. A 30 minute Theraplay® session follows which reinforces the lessons learned with the horse and allows the family to ‘join up’ with each other and experience how that new skill can make a difference in their family relationships.

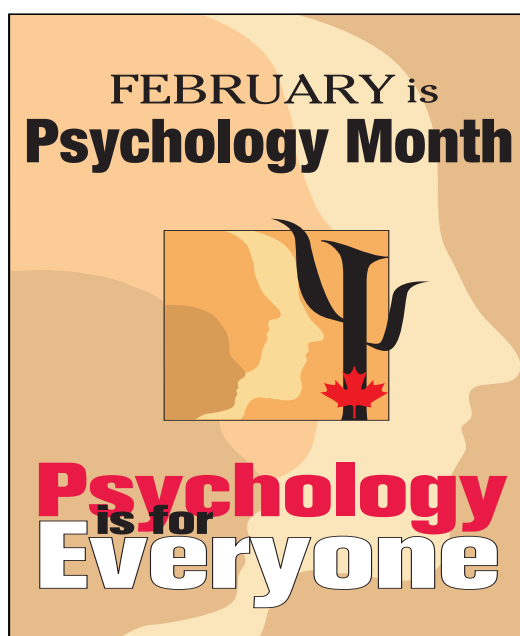
Essentially then, family members learn the body and social language to ‘speak’ respectfully with each other while becoming closer and more attuned. There is then opportunity for some parent debriefing and review of activities for practice during the week.

As this pilot project draws to its close, it is anticipated that families will have benefited from their experiences and participation. An evaluation study led by Georgian College has begun and will provide a review of “Horse Friends”.

Fig. 1: Treatment Outcomes for a Sample of Participants : CAFAS Scores Pre-Treatment and Post-Treatment.



Note: A lowering of CAFAS scores over time indicates an improvement in psychosocial functioning and therefore positive treatment outcomes.



As you may have already heard, psychology month is the annual national campaign to raise Canadians’ awareness of psychology – and it has become a great success story in Ontario. Thanks to the volunteer efforts of psychological representatives in schools and school boards, hospitals, community based agencies, health care facilities – to name a few- more Ontarians have a greater awareness than ever before of the role psychology plays in their lives and in their communities!

OPA is encouraging everyone from the psychology community to make time during February to share with his or her workplace and the general public what it is they do and how it contributes to the overall well-being of the community. We would like to see private practitioners, academics, scientist, and psychologists who work in health, criminal justice, schools, businesses, etc. organize local public education and outreach activities. Psychology Month is an ideal opportunity for psychologists across Ontario to organize and participate in activities that will help promote the discipline. Who is better able to promote psychology than the psychology community itself?

For more information about what OPA has planned for Psychology Month 2007, available materials, and ideas on what you can do, please visit: www.psych.on.ca/index.asp?id1=27

The OPA Information Technology/Website Taskforce is pleased to “officially” announce the launch of the newly revised OPA website (www.psych.on.ca)

Over the past 8 months, the IT/Website Taskforce has worked on improving the OPA website to make it a better resource for OPA members and the public. The changes have been undertaken to create: greater accessibility to our website; improved navigation within the site; increased public information about professional psychologists and how to access their services; expanded information about OPA and its member services; promotion of Early Career Psychologist section within the website; and the On-Line ‘Live Learning Centre’ (for a brief outline of many of the new and improved features of the website see below). The IT/Website Taskforce is continuing to work on maintaining and upgrading the website but we need your feedback as members of OPA. We invite you to visit and explore the new site and send us your feedback about what works, what doesn’t and what suggestions you have to improve it. We will do our best to respond. Please feel free email me directly at andrew.matthew@uhn.on.ca.

I would like to take this opportunity to thank the OPA staff and the taskforce members including Connie Kushnir, Christina Lee, Margaret Weiser, Doug Saunders, Ruth Berman, and Carla Mardonet, for the enormous time and effort they have put in on this project.

We look forward to hearing from you .

Andrew G. Matthew, Ph.D.
Chair, Information Technology/Website Taskforce

CHANGES TO THE WEBSITE:

Goal 1: Increase navigation to the website

- addition of 45 relevant “metatags”
- addition of several relevant “links”
- “Website Link Exchange Proposal” - development of “mutual linking” with relevant organizations

Goal 2: Improve navigation within the website

- development of a new navigational structure featuring:
 - two-tiered tab design with drop-down menus
 - “rapid link” buttons on the homepage for “high priority” topics or functions
 - “clickable” scrolling “Headline News” for fast access to additional high priority information

Goal 3: Resource Update - PUBLIC

- Focus on informing the public about:
What is a psychologist, who may benefit from seeing a psychologist, and how to find and select a psychologist, including access to the OPA referral service

Goal 4: Resource Update - MEMBERS

- Focus on informing members about:
OPA services including Member Benefits, the Referral Service, and the Disaster Response Network
- Addition of the member’s “Brief Bio” link

Goal 5: Highlight the Early Career Psychologist section

- Provide support and resources for ECP’s including peer and mentor contact

Goal 6: Initiation of the “Live Learning Centre”

- now offering continuing education programs online