Evaluation of Coping Power within CONNECT:
The effectiveness of an evidence-based treatment for aggressive behaviour as implemented within an existing children’s mental health program

Peel Children’s Centre

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Executive Summary

The present study evaluated the effectiveness of implementing Coping Power, an evidence-based program for late elementary-aged children with aggressive and disruptive behaviour, within the CONNECT program, a therapeutic and recreational after-school program for children with severe behavioural and emotional challenges. Specifically our objective was to understand the impact of an integrated Coping Power-CONNECT program on children’s behaviour, social competencies and problem-solving skills and on parental competencies and skills. We hypothesized that the children who participated in the combined program would show decreased disruptive behaviour, improved social competencies and increased adaptive problem-solving and that the caregivers who participated would report increased parenting competence, satisfaction and skill.

We were also interested in understanding whether bringing the two programs together was viable, whether it would be possible to maintain the integrity of each program and whether there would be an impact on client participation and satisfaction and clinician satisfaction.

Coping Power is an evidence-based practice (EBP) developed by Dr. John Lochman and his colleagues (Lochman & Wells, 2004) which addresses both child-specific factors (i.e., poor social problem-solving and decision-making, poor self-regulation and poor ability to resist peer influences) and contextual factors (i.e., nature and extent of parental involvement and discipline of the child) thought to mediate the development of externalizing and antisocial behaviour (Lochman & Wells, 2002). Coping Power employs cognitive-behavioural, behavioural and adult education approaches in a structured, skills-based curriculum for coordinated children’s and parents’ groups.
CONNECT is a therapeutic and recreational after-school program for children with severe behavioural and emotional challenges. Operated three days a week for approximately four hours each day, it offers an intensive milieu that seemed the ideal practice ground for skills learned through Coping Power.

An implementation team worked intensively over a four-month period to master the Coping Power curriculum and map Coping Power onto CONNECT. Modifications to each program were necessary in order to develop an integrated Coping Power-CONNECT program. We narrowed the age range of CONNECT to better fit the parameters of Coping Power. We trained child and family clinicians (i.e., MSWs) and child and youth workers to deliver Coping Power with frequent consultation by two psychologists and a multidisciplinary team that met regularly to support their work. To fit into the four-month CONNECT cycle the frequency of Coping Power group sessions were intensified from once to twice a week for children and from once every three weeks to once a week for caregivers. Great care was taken to maintain the integrity of the curriculum and the correspondence of the themes covered by the child and parent groups.

To date, there have been four sessions of the integrated Coping Power-CONNECT program with data available for 23 child participants, a majority of whom were boys (n=21). Of these, 83 per cent were diagnosed with ADHD, 22 per cent with ODD, and 70 per cent were being treated with psychotropic medications. Mean behavioural and social impairment ratings at the beginning of the program confirmed the need for intervention. Measures were completed by children and their caregivers pre- and post-program.
Of primary interest in this evaluation was the impact of the integrated Coping Power-CONNECT treatment program on children’s disruptive behaviour. Results showed a number of significant and important positive changes in child behaviour with treatment. First, caregivers reported large decreases in their children’s overall behavioural difficulties with treatment. As such, caregivers’ global impressions were that their children had improved with treatment. Second, children showed reductions in specific aspects of disruptive behaviour including hyperactivity and conduct problems. Third, reductions in the negative impact (i.e., impairment) of the child’s behaviour on the family, on the parent-child relationship, on the child’s academic progress and on the child’s self-esteem were reported. As both behavioural symptoms and impairment are known to be significant mediators of future functioning, these findings are extremely important.

Also of interest was the impact of the integrated program on children’s social competencies. Results showed marginal increases in children’s prosocial behaviour and peer interaction skills and statistically significant reductions in children’s social impairment with peers and with siblings after treatment. Because social behaviours are believed to moderate the relationship between negative social influences and long-term functioning, it is hoped that participation in Coping Power-CONNECT will better equip participants to manage future social challenges.

In addition, findings showed statistically significant reductions in parental reports of inconsistent discipline and marginally significant increases in parental sense of efficacy. Although not statistically significant, caregivers reported greater use of positive parenting practices, more parental satisfaction and a decrease in poor supervision with treatment.
Although teachers’ reports of children’s social competence showed increases post-treatment, these differences were not statistically significant possibly because unlike parents, teachers were not directly involved in the program.

The present investigation demonstrated that Coping Power can be implemented with fidelity and result in positive treatment outcomes when delivered by child and youth workers and child and family clinicians (i.e., MSWs) with consultation and guidance from psychologists. Findings also demonstrate high rates of client participation and high levels of clinician and client satisfaction with program implementation. These findings underscore the feasibility of implementing an evidence-based practice (EBP) within a community mental health centre provided that it is staged and done planfully. The implementation activities documented describe a series of steps taken to engage staff, obtain feedback and maintain the core components of the EBP and the mental health program (i.e., CONNECT) in order to successfully merge the two programs.
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Introduction

The purpose of this study was to evaluate the effectiveness and viability of implementing Coping Power developed by Dr. John Lochman and his colleagues at the University of Alabama (Lochman & Wells, 2003, 2004) within the Connect Program (CONNECT), an existing children’s mental health program at Peel Children’s Centre in Mississauga, Canada. The overall objective of the study was to evaluate the impact of an integrated Coping Power-CONNECT program on specific parent and child behaviours and competencies. In addition, we were interested in better understanding how well Coping Power, as an evidence-based intervention, fit within the overall structure of CONNECT specifically with respect to training, fidelity, client participation and satisfaction.

Coping Power

Coping Power is an evidence-based practice (EBP) for late elementary school-aged children with aggressive and disruptive behaviour problems (Lochman & Wells, 2004). Aggressive and disruptive behaviours are among the most stable problem behaviours of childhood and are known to have a developmental trajectory that can lead to more severe problems of behaviour and conduct in adolescence (Crick, 1996; Loeber, 1991). Within a contextual social-cognitive model of externalizing behaviours (see Figure 1), antisocial behaviour in childhood and adolescence is believed to be mediated by two broad categories of factors (Lochman & Wells, 2002): 1) child level factors pertaining to poor social problem-solving and decision-making, poor self-regulation and poor ability to resist peer influences as perceived; and 2) contextual factors related to the nature and extent of parental involvement and discipline of the child. Coping Power addresses both sets of factors in coordinated interventions
that use cognitive-behavioural, behavioural and/or direct teaching or adult education approaches in step-wise group programs for the children and their parents.

Figure 1. Contextual social cognitive model: Factors postulated to moderate children’s externalizing behaviour problems

The Coping Power child curriculum, consisting of 36 child group sessions, progresses through a series of topics such as feelings identification, cognitive and emotional coping, perspective-taking and the interpretation of situations to build up to a model of problem-solving. The curriculum then applies the model within a broader social context including situations involving friends and peer pressure. Each child develops specific behavioural goals (which are adjusted from time to time) for which they earn points; points are also allocated for positive participation in the group.
The Coping Power parent curriculum, consisting of 16 parent group sessions, progresses through topics such as academic support in the home, stress management, social learning theory and praise for positive behaviour, ignoring minor disruptive behaviour, giving good instructions, establishing rules and expectations, discipline and negative consequences, building family cohesion, family problem-solving and family communication.

Empirically, large scale evaluations of Coping Power have demonstrated favourable outcomes for children who have participated, including lower rates of delinquency in the short- and long- term in comparison to control group children (Lochman & Wells, 2003, 2004; Van De Wiel, Mathys, Cohen-Kettenis, & Van Engeland, 2003).

The Connect Program

CONNECT is an intensive, after-school program developed in 2004 through a community partnership between the Peel District School Board, Dufferin-Peel Catholic District School Board, Peel Children’s Aid Society and Peel Children’s Centre (PCC) to address the needs of elementary school-aged children with serious behavioural and emotional difficulties – in particular, those at risk of losing their home or school placements. Most of the children attending CONNECT have high rates of externalizing behaviours and many have diagnoses of disruptive behaviour disorders (e.g., Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder). Staff in CONNECT attempt to address these difficulties through a three-day-a-week after-school program which includes recreation and socialization, opportunities to develop children’s social skills, support in completing homework, free time and life skills programming. Caregivers’ of children were asked to participate in a weekly relationship-based group with their children. Because CONNECT is an adjunctive service that
serves as a resource to all the programs of Peel Children’s Centre, all CONNECT clients receive concurrent and coordinated service by another program within the agency. Additionally, each client has a primary child and family clinician (i.e., case manager) who is responsible for the child’s overall treatment planning. CONNECT staff, case managers/clinicians and a consulting psychologist meet on a monthly basis to evaluate treatment goals and discuss each child’s progress. CONNECT staff is available to provide individualized support in a child’s school, if needed. Support is determined in conjunction with the child’s child and family clinician, parents and school personnel.

Coping Power in CONNECT

Clearly the objectives of Coping Power and CONNECT are similar. Both target children’s disruptive behaviour and seek to build peer relationships, social competence and life skills as a way of addressing problem behaviours. As can be seen in Table 1, the two programs have many features in common. Both include a component aimed at improving parenting practices. Both programs work intensively with small groups of children who are reinforced for obtaining desired behavioural goals. Each program offers support beyond the confines of the program and links are maintained with the child’s classroom.

However, in Coping Power, the development of social skills is accomplished through a formal, step-wise program that explicitly teaches skills related to the kinds of difficulties experienced by children. In addition, the Coping Power curriculum was created for a specific age group (described in the manual as late elementary or approximately grades four to six), and children were selected for participation based upon teacher nominations and parent and teacher psychometric ratings of aggressive and disruptive behaviours. In our original Connect Program,
a more naturalistic environment or milieu, adult support and mentoring was offered, and a broader age range (7 to 15 years) and wider variety of presenting problems (related to school and home placements being ‘at risk’).

The proposed investigation was designed to explore the feasibility and effectiveness of delivering Coping Power groups within CONNECT, specifically addressing the question of whether or not client outcomes would be enhanced in this combined program format. In particular, it was hoped that the Coping Power curriculum could be effectively delivered within CONNECT and if the CONNECT milieu would provide an effective training ground for the practice and reinforcement of skills learned through Coping Power. As an evidence-based practice, Coping Power was expected to provide structured and systematic programming in regard to both child level factors, such as social problem-solving and peer relations, and contextual factors, such as parenting skills and competencies, which are presumed to moderate the development of externalizing behaviour problems (see Figure 1). It was anticipated that the skills-based curriculum of Coping Power would serve to sharpen the focus of the parent and child group components of CONNECT while capitalizing on the richness and intensity of the milieu setting. As such, it was expected that implementing Coping Power within CONNECT would enhance the effectiveness of the overall program.

In addition, it was hoped that the structure and step-wise programming of Coping Power would improve CONNECT attendance and reduce drop-out rates. Given the substantial commitment of agency and client resources to the original Connect Program, it was considered important to explore options to maximize client participation and motivation.
Modifications to Coping Power and CONNECT

Bringing together the two programs required modifications to each program. In particular, we realized that it was important to narrow the age range of the Connect Program clients (from 7 to 15 years to 8 to 13 years) to match the target group of the Coping Power curriculum. Although clinician referrals continued to be accepted with screening for suitability by the program supervisor, nevertheless we found that a fairly high percentage of the children referred to the Coping Power-CONNECT did in fact show externalizing behaviours, and many met criteria for diagnoses of ADHD and ODD.

A modification to the delivery of Coping Power involved the use of child and family clinicians (i.e., MSWs) and child and youth workers to run treatment groups. The original evaluation of Coping Power primarily used psychology trainees and early career Ph.D. psychologists to conduct groups. With Coping Power CONNECT, the group leaders were supported by a consulting psychologist and a multidisciplinary team that met weekly to review each child’s goals, conduct fidelity checks regarding the children’s and parents’ groups and trouble shoot issues arising in the groups and the larger program. Goals developed in Coping Power were extended to the activities-based milieu, and a unified incentive (points) system was instituted for goal attainment and positive participation within the overall program.

Additional, modifications were required to fit the Coping Power curriculum within the four-month cycle of CONNECT:

1) The Coping Power children’s group was run twice weekly rather than once weekly;
2) The 34-session children’s group was condensed into 27 sessions with care taken to ensure that core material was included;

3) Parent groups were held weekly instead of every three weeks as in the original evaluation of Coping Power. To allow parents to attend, a supervised activities program for child participants was developed. In addition, as per the Connect program, childcare for siblings, dinner and assistance with transportation were made available to reduce barriers.

4) The 16-session parents’ group was condensed into 13 sessions with care taken to ensure that themes covered in the children’s group corresponded with the appropriate themes covered in the parents’ group.

Table 1 summarizes the respective characteristics of Coping Power, the original Connect Program and Coping Power as implemented within CONNECT. Table 2 depicts the sequence of coordinated themes covered in the parent and children’s groups.
Table 1

*Comparison of Coping Power with the Connect Program*

<table>
<thead>
<tr>
<th></th>
<th>Coping Power Program</th>
<th>Connect Program</th>
<th>Coping Power within CONNECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>- School-based program</td>
<td>- Children’s mental health program</td>
<td>Children’s mental health program</td>
</tr>
<tr>
<td><strong>Child Participants</strong></td>
<td>- Children with high levels of disruptive and aggressive behaviour as identified by teacher nominations and parent and teacher ratings</td>
<td>- Children with emotional and behavioural problems referred by their clinicians on the basis of their ‘at risk’ status (i.e. at risk of losing school or home placement). Screening by the program supervisor.</td>
<td>- Children with emotional and behavioural problems referred by their clinicians on the basis of their ‘at risk’ status (i.e. at risk of losing school or home placement). Screening by the program supervisor. Children from 8 to 13 years</td>
</tr>
<tr>
<td></td>
<td>- Late elementary-aged children</td>
<td></td>
<td>- There is a high rate of disruptive behaviour disorders (including ADHD, ODD and Conduct Disorder) among referred children.</td>
</tr>
<tr>
<td><strong>Size of group</strong></td>
<td>- Four to six children</td>
<td>- Six children</td>
<td>- Six children</td>
</tr>
<tr>
<td><strong>Children’s Program</strong></td>
<td>- Step-wise program of 34 sessions conducted weekly after school</td>
<td>- Recreation, opportunities for socialization and homework support are offered in an informal, naturalistic setting Three days a week (3:30 to 7:30 p.m.) Open program with children joining throughout</td>
<td>- Step-wise, modified Coping Power program of 27 sessions conducted twice weekly Coping Power sessions are usually 60 minutes Milieu program is three days a week (3:30 p.m. to 7:30 p.m.) offering the opportunity to rehearse skills learned in the Coping Power component Children are able to join up to the four-week mark and are given individual make-up sessions</td>
</tr>
<tr>
<td></td>
<td>- Sessions are usually 50 to 60 minutes long</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Closed group format that allows children to be added up to the half-way point provided they are given individual make-up sessions</td>
<td></td>
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</tr>
<tr>
<td><strong>Parents’ Program</strong></td>
<td>- Step-wise program of 16 sessions</td>
<td>- 60-minute weekly play and activity-based group for parents and children</td>
<td>- Step-wise, modified parents’ Coping Power Program of 13 sessions Usually 60 minutes in length Held weekly</td>
</tr>
<tr>
<td></td>
<td>- Usually 60 minutes in length</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Held every three weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coping Power Program</td>
<td>Connect Program</td>
<td>Coping Power within CONNECT</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Group leaders</td>
<td>- Master’s level training or early Ph.D. psychologists</td>
<td>- Child and Youth Workers</td>
<td>- Children’s group: Child and Youth Workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Child and Youth Workers with mentoring by a Ph.D.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Parents’ Group: MSW clinician paired with lead Child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and Youth Worker</td>
</tr>
<tr>
<td>Individual Sessions</td>
<td>- Individual sessions with a group leader every 4 to 6</td>
<td>- Individual in-school visits by the lead CYW at least</td>
<td>- Intensive one-on-one work during the after-school</td>
</tr>
<tr>
<td>for Children</td>
<td>weeks</td>
<td>once over the course of the program.</td>
<td>milieu</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Individual in-school visits by the lead CYW at least</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>once over the course of the program.</td>
</tr>
<tr>
<td>Goal setting</td>
<td>- Group leaders meet with parents and teachers to identify</td>
<td>- Program supervisor and lead CYW meet with parents and</td>
<td>- Parents complete a narrative description of the child</td>
</tr>
<tr>
<td></td>
<td>behavioural goals</td>
<td>children in to identify areas of focus for each child.</td>
<td>with their clinician as input to the goal-setting process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Child and Youth Workers obtain child’s input into the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>goal-setting process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- A multidisciplinary team including the Child and Youth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workers, the Child and Family Clinician and the consulting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>psychologist meets regularly to set and review goals.</td>
</tr>
</tbody>
</table>
Table 2

*Coping Power Modified for CONNECT*

<table>
<thead>
<tr>
<th>Week</th>
<th>Children’s Group Session</th>
<th>Parents’ Group Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group rules and point system&lt;br&gt;Short- and long-term goal-setting</td>
<td>Introductions and overview&lt;br&gt;Academic support in the home</td>
</tr>
<tr>
<td>2</td>
<td>Reinforcing goals&lt;br&gt;Study skills</td>
<td>Academic support in the home</td>
</tr>
<tr>
<td>3</td>
<td>Feelings identification and thermometer</td>
<td>Stress management – time management and relaxation</td>
</tr>
<tr>
<td>4</td>
<td>Feelings identification and thermometer&lt;br&gt;Anger coping and self-control</td>
<td>Stress management – time management and relaxation</td>
</tr>
<tr>
<td>5</td>
<td>Self-statements for anger coping</td>
<td>Social-learning theory and praise for positive behaviour</td>
</tr>
<tr>
<td>6</td>
<td>Practice anger coping statements&lt;br&gt;Emotional coping - relaxation</td>
<td>Ignoring minor disruptive behaviour</td>
</tr>
<tr>
<td>7</td>
<td>Practice emotional coping&lt;br&gt;Perspective-taking</td>
<td>Giving good instructions</td>
</tr>
<tr>
<td>8</td>
<td>Interpreting situations&lt;br&gt;Practice interpreting situations</td>
<td>Establishing rules and regulations</td>
</tr>
<tr>
<td>9</td>
<td>Interpreting intentions&lt;br&gt;Problem-solving model – PICC Model</td>
<td>Discipline and negative consequences</td>
</tr>
<tr>
<td>10</td>
<td>Practice problem-solving model&lt;br&gt;Broader social problem-solving</td>
<td>Discipline and negative consequences</td>
</tr>
<tr>
<td>11</td>
<td>Friends&lt;br&gt;Peer Pressure</td>
<td>Building family cohesion</td>
</tr>
<tr>
<td>12</td>
<td>Review and reinforce problem-solving</td>
<td>Family problem-solving</td>
</tr>
<tr>
<td>13</td>
<td>Review and reinforce problem-solving</td>
<td>Family communication</td>
</tr>
<tr>
<td>14</td>
<td>Strengths&lt;br&gt;Wrap-up party and graduation</td>
<td>Wrap-up party and graduation</td>
</tr>
</tbody>
</table>

**Logic Model and Hypotheses**

A logic model and an evaluation plan were formulated to guide in the development of hypotheses for this evaluation (see Appendices A and B).

It was hypothesized that children in Coping Power-CONNECT would show improved behaviour and emotional functioning, increased understanding of adaptive strategies to manage
conflict, improved social problem-solving skills, and increased social competence at home and school at the conclusion of their participation in the program.

It was also hypothesized that their caregivers would report increased parenting skills and competence, specifically increased positive parenting, better consistency with discipline and better supervision at the conclusion of the program.

Methodology

1. Participants

Twenty-three children and their caregivers participated in the project. Twenty-one (91%) of the children were male and two (9%) were female.

Child participants ranged in age from 8 to 13 years old ($M = 10.2$, $SD = 1.2$) with the greatest frequency (35%) being 9 years (see Figure 2). Children ranged from grade 3 to 8 with the greatest frequency of children in grades four and five (see Figure 3).

Figure 2. Age of clients at admission.
Figure 3. Grade level of clients while attending CONNECT

Figure 4 shows the most prevalent mental health diagnoses among the 23 children.

Eighty-three percent of children had diagnoses of ADHD (i.e., 19 children) and 22 per cent (i.e., 5 children) had diagnoses of ODD. Thirty-five per cent of children had co-morbid diagnoses. Twenty-one of the 23 child participants (70%) were being treated with psychotropic medications and some children were taking more than one medication. Table 3 illustrates the breakdown of medications among program participants.

Figure 4. Mental health diagnoses of child participants. Note: that child participants may have more than one diagnosis.
Table 3

Percentage of Clients (n=23) prescribed Psychotropic Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adderall</td>
<td>17% (n=4)</td>
</tr>
<tr>
<td>Clonidine</td>
<td>4% (n=1)</td>
</tr>
<tr>
<td>Concerta</td>
<td>30% (n=7)</td>
</tr>
<tr>
<td>Dexedrine</td>
<td>4% (n=1)</td>
</tr>
<tr>
<td>Prozac</td>
<td>4% (n=1)</td>
</tr>
<tr>
<td>Risperdal</td>
<td>26% (n=6)</td>
</tr>
<tr>
<td>Ritalin</td>
<td>9% (n=2)</td>
</tr>
<tr>
<td>Seroquel</td>
<td>4% (n=1)</td>
</tr>
<tr>
<td>Strattera</td>
<td>9% (n=2)</td>
</tr>
</tbody>
</table>

Pre-treatment caregiver ratings of impairment showed clinically-significant concern in a number of social domains including peer, sibling, parent-child, academic, self-esteem and family (see Figure 5). Mean impairment scores indicate a clear need for intervention.

![Pre-Treatment Impairment Rating Scale Scores](image)

Figure 5. Mean pre-treatment impairment rating scores. Note: Ratings greater than “3” indicates a likely need for further assessment/intervention.
A majority of child participants (18 children) resided in sole-caregiver homes. Of the remaining participants, one child lived in a two-parent adoptive family and four children lived with both biological parents.

The majority of female caregivers (71%) completed secondary school education and thirty per cent of those also completed college or university.

2. Measures

An evaluation plan was developed specifying the following child and parent-specific outcome measures (see Appendix B).

i. Measures of Near-term Child Outcomes

**Problem-solving Measure of Conflict (PSMC).** The PSMC is a measure of children’s social problem-solving abilities in which the child is read the beginning and end of 6 social vignettes in which a peer-related challenge occurs (Lochman & Lampron, 1986). The child is asked to provide as many potential solutions (or the middle portion of the story) as they can think of. For the purposes of the present investigation, solutions were coded as Help Seeking, Non-Confrontation, Physical Aggression, Verbal Aggression, Compromise, Bargaining, Verbal Assertion, Negative Verbal Assertion, Direct Action and Negative Direct Action. The PSMC has been shown to be both reliable and valid in past research (Lochman & Lampron, 1986; Lochman & Wells, 2002).

**Outcome Expectations Questionnaire (OEQ).** The OEQ is a measure of children’s social problem-solving abilities in which the child is read 12 short vignettes containing social challenges ending with a positive or negative action (Lochman & Wells, 2002). Using a
multiple choice format, the child is asked to rate their certainty of the effectiveness of the solution presented (i.e., “very sure” or “pretty sure” of a positive outcome or “very sure” or “pretty sure” of a negative outcome). Responses are scored and result in two subscales (Reducing Aversive Treatment and Attaining Tangible Rewards) and a Total Outcome Expectations score.

**Walker-McConnell Scale of Social Competence and School Adjustment (WMS).** The WMS is a 43-item rating of children’s social behaviours (Walker & McConnell, 1995). The WMS is positively worded and the questions target easily observable social and behavioural skills. Sample items include: “shows sympathy for others” and “shares laughter with peers”. All items are rated on a 5-point Likert scale ranging from 1 (“never”) to 5 (“frequently”). The WMS provides an assessment of children’s social behaviour in relation to teacher’s expectations and their social adjustment with peers. Three subscales were derived from the WMS: (1) Teacher-preferred Social Behaviour; (2) Peer-preferred Social Behaviour; (3) School Adjustment Behaviour and a Total Social Competence scale. The Teacher-preferred Social Behaviour, Peer-preferred Social Behaviour and Total Social Competence scales were used in the present study. The WMS has been widely used in large-scale research projects (e.g., Second Step program) to identify treatment effects. Its validity and reliability have been well documented as described in the published manual (Walker & McConnell, 1995).

**ii. Measures of Mid-term Child Outcomes**

**Impairment Rating Scale (IRS).** The IRS measures the child’s current functioning and need for treatment in several developmentally important areas including peer relationships, teacher and parent relationships, academic/school functioning, self-esteem and overall
adjustment (Fabiano, et al., 2006). Items are evaluated using visual-analogue scales that are scored using a 0 (no problems/no need for treatment) to 6 (severe problems/definitely needs treatment) metric. Scores above 3 indicate a need for further investigation and possible intervention. Alphas are not reported for the IRS since each item is scored separately, but the reliability and validity of the IRS have been supported in several samples. For instance in one sample (Fabiano, et al., 2006), one-year test-retest reliability correlations for teacher ratings on the IRS ranged from .40 to .67 and inter-rater (parent and teacher) reliability correlations ranged from .47 to .64 with criterion validity correlations ranging from .44 to .80.

**Strengths and Difficulties Questionnaire (SDQ).** The SDQ is 25-item parent and teacher report measure of disruptive behaviour and prosocial behaviour (Goodman, Ford, Simmons, Gatward, & Meltzer, 2003). Items are rated on a 3 point Likert scale (“not true”, “somewhat true” and “certainly true”). This measure provides scales assessing Prosocial Behaviour, Conduct Problems, Emotional Problems, Hyperactivity-Inattention and Peer Problems. The scale is widely used as a measure of treatment outcome (Goodman, et al., 2003). Coefficient alphas measuring internal consistency of scale scores range between .63 and .77 (Bourdon, Goodman, Rae, Simpson, & Koretz, 2005).

**Pittsburgh Modified Conner’s Rating Scale (CRS-M).** The CRS-M has a parent and teacher completed version comprised of items from the IOWA Conners Teacher Rating Scale (CTRS) (Loney & Milich, 1982), the Abbreviated CTRS (Goyette, Conners, & Ulrich, 1978) and the Swanson Nolan and Pelham (SNAP) Rating Scale (Atkins et al., 1985). Items 1 through 5 are summed to provide a score on the IOWA Inattention/Overactivity (IO) subscale of the Pittsburgh Modified Conners Rating Scale; items 6 through 10 are summed to
provide a score on the IOWA Oppositional/Defiant (OD) scale of the Pittsburgh Modified Conners Rating Scale (Loney & Milich, 1982). Items 1, 3, 4, 5, 8, 11, 12, 13, 14 and 15 comprise the Abbreviated Conners Rating Scale (Goyette, Conners, & Ulrich, 1978). Items 8, 16, 17, 18, 19, 20 and 21 are items taken from the SNAP Peer Interaction category. Items are rated as “not at all” (scored 0), “just a little” (scored 1), “pretty much” (scored 2) and “very much” (scored 3). For screening purposes in classroom settings, a total score of 8 on the IO scale would indicate referral for further assessment, as would a total score of 5 on the OD scale.

iii. Measures of Near-term Parent/Caregiver Outcomes

**Parent Sense of Competence Scale (PSC).** The PSC is a 17-item parent-completed measure which assesses two aspects of parental competencies: feelings of satisfaction and efficacy in their parenting role (Johnston & Mash, 1989). Questions are rated on a 6-point Likert scale ranging between “strongly disagree” to “strongly agree”. The measure shows adequate test-retest reliability and an inverse relationship with Child Behavior Checklist Scores (Johnston & Mash, 1989).

**Alabama Parenting Questionnaire- Short (APQ-S).** The APQ-S is a 9-item, parent-completed instrument measuring three parenting constructs: (1) Positive Parenting, (2) Poor Monitoring/Supervision and (3) Inconsistent Discipline. Questions are rated on a 5-point Likert scale ranging between “never” and “always”. The instrument has been used widely to measure parenting behaviour change with intervention (Shelton, Frick, & Wootton, 1996).
3. Procedure

i. Program Recruitment

Participants for Coping Power CONNECT were recruited externally from the Children’s Aid Society (CAS) and internally from the roster of registered clients of Peel Children’s Centre (PCC). Clients are between the ages of 8 and 13 years old and have moderate to severe disruptive behavioural difficulties which have put them at risk of losing their home or/and school placement and warranted a more intensive treatment intervention. All internal clients were referred directly to the program by their PCC clinicians and all external clients were assigned a PCC clinician. Once received, the clinical supervisor of CONNECT reviewed referrals for appropriateness and convened a screening interview to further assess the program’s suitability for the particular child and family. At this interview, the child and family were provided with information about the program and the program evaluation.

ii. Research Recruitment

To date, there have been four sessions of Coping Power-CONNECT, beginning with the first session in the fall/winter of 2008 and extending to the most recent session in the winter/spring of 2010. Each session lasted four months and operated on a variant of a closed group model\(^1\) with approximately six child participants per session. As one family elected not to participate in the research component, there were 23 child participants over the two-year span for whom data is available.

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\(^1\) Children were allowed to join up to the fourth session and were given individual make-up sessions to cover the material they had missed.
The voluntary nature of the evaluation was emphasized and assurance was given that participation in the program did not require participation in the research. Formal written consent for participation including permission for the collection of data from teachers and the use of demographic and clinical information from the child’s clinical record was obtained by the research assistant at the first meeting of the parents’ group. (See Appendix C for written materials and the consent form discussed with parents.)

In addition, the research assistant met with the child participants at the beginning of the CONNECT to explain the nature of the evaluation and to request their consent for participation and the use of their personal health information in this evaluation research. The research assistant rather than program staff reviewed the study with children to ensure that their decision to participate was made freely without undue influence. Caregivers and child participants were made aware that data collected was for research purposes and would not be held in their clinical record. It was also explained that copies of the final report would be made available to interested parties upon conclusion of the project.

iii. Design

The study utilized a pre-test, post-test paired comparisons design.

iv. Outcome data collection

The research assistant administered caregiver measures with the exception of the Impairment Rating Scale (IRS) at the beginning and at the conclusion of the parents’ group. The Impairment Rating Scale (IRS) was completed by the parents in meetings with their
clinicians prior to beginning Coping Power-CONNECT and at the conclusion of the program.

CONNECT staff administered measures to the children during the first week of Coping Power and in the last two weeks of the program.

CONNECT staff hand-delivered measures to teachers accompanied by a letter describing the evaluation, a signed parental consent, an envelope with pre-paid postage and a $5.00 Tim Horton’s gift card to thank them for their participation. The measures were distributed to the teachers after parental consent and child assent were obtained and at the end of the program.

v. Process data collection

Process data included outputs as shown in the logic model which include attendance and program fidelity. In addition, client satisfaction information was collected from the parents, children and the clinicians/case managers at the conclusion of the program.

Attendance for the children’s and parents’ groups was tracked on a regular basis by the CONNECT staff and parent group leaders.

Fidelity checklists were completed weekly for both the parents’ and the children’s Coping Power groups to assess the degree of fidelity to the Coping Power model as modified for Coping Power-CONNECT (see Table 1). These checks were completed by the consulting psychologist based upon input provided by the group leaders and the interdisciplinary treatment team.
Feedback surveys were administered by program staff to parents, children and case managers. Surveys were accompanied by self-addressed envelopes to ensure the responses remained confidential.

vi. **Method of Analysis**

Paired sample t-tests were computed comparing pre- and post-program subscale scores on administered measures. Significant (p<.05) and marginal (p<.10) findings are reported along with 95% confidence intervals and standardized effect sizes (Cohen’s d). In all analyses, Time (pre- post) is the within subjects variable. Results are reported using the a priori evaluation plan as a guide (see Appendix B).

**Results**

1. **Outcome Data**

   i. *Children’s behaviour and emotional functioning*

   Results showed significant decrease post-treatment in caregiver report of the total behavioural difficulties \( t(16) = 2.18, p < .05, d = 6.84, 95\% \text{ CI } [0.08, 6.03] \), global severity of children’s behaviour \( t(16) = 2.21, p < .05, d = 0.54, 95\% \text{ CI } [0.01, 0.46] \), the negative impact of behavioural difficulties \( t(16) = 3.10, p < .05, d = 1.05, 95\% \text{ CI } [0.15, 0.79] \), hyperactive behaviour \( t(16) = 1.80, p = .09, d = 1.86, 95\% \text{ CI } [-0.14, 1.78] \) and total conduct problems \( t(16) = 2.30, p < .05, d = 2.5, 95\% \text{ CI } [0.09, 2.14] \) on the SDQ (see Figure 6).

   Similarly, on the CRS-M, parents indicated significant reduction in the global severity of children’s behaviour \( t(9) = 2.25, p = .05, d = 1.34, 95\% \text{ CI } [-0.003, 1.20] \). On the IRS, caregivers’ report of children’s overall behavioural impairment \( t(15) = 3.58, p < .01, d = \)
3.35, 95% CI [0.60, 2.39] and negative impact of their child’s behaviour on the family $t(15) = 3.58, p < .01, d = 4.20, 95\% CI [0.75, 2.99]$, parent-child relationship $t(14) = 3.96, p < .01, d = 4.63, 95\% CI [0.95, 3.18]$ and their child’s academic progress $t(15) = 1.90, p = .07, d = 2.80, 95\% CI [-0.14, 2.64]$ was significantly decreased with treatment (see Figure 7).

Likewise, the negative impact of children’s disruptive behaviour on the child’s self-esteem was significantly diminished post-treatment $t(15) = 4.06, p < .01, d = 3.78, 95\% CI [0.80, 2.57]$. Although teacher’s report of children’s behaviour showed reductions post-treatment, these changes were not statistically significant.

![Mean Results for Caregiver SDQ](Figure 6: Mean scores for caregiver report on the Strength and Difficulties Questionnaire taken at pre- and post- treatment. Error bars illustrate standard deviations.

*($p < .05$)
Figure 7. Mean impairment rating scores pre- and post-treatment. Error bars illustrate standard deviations. A rating greater than “3” indicates clinically-significant concern.

*(p < 0.05)

**ii. Children’s understanding of strategies to manage conflict and social problem solving skills**

Pre- post- treatment changes measured by the Outcome Expectation Questionnaire were not statistically significant; however post-treatment scores showed a trend towards a decreased belief in the effectiveness of aggressive solutions. On the PSMC, post-treatment results showed an increase in the frequency of prosocial solutions to problems (see Figures 8-9).
iii. Children’s social competence

On the SDQ measure, caregivers reported increased prosocial behaviour $t(16) = -1.76, p = .09, d = -1.32, 95\% \text{ CI } [-1.29, 0.11]$ demonstrated by children post-treatment. Results from
the caregiver completed IRS showed significant post-treatment reduction in children’s social impairment with peers $t(15) = 4.09, p < .01, d = 3.62$, 95% CI $[0.78, 2.47]$ and with siblings $t(12) = 4.01, p < .01, d = 3.96$, 95% CI $[0.80, 2.73]$. Although teacher’s report of children’s social competence showed increase post-treatment, these changes were not statistically significant.

**iv. Parenting Skills and Competence**

Results from the APQ-S showed significant reduction in parental inconsistent discipline post-treatment $t(16) = 4.07, p < .01, d = 1.71$, 95% CI $[0.87, 2.77]$. Although not statistically significant, positive parenting scores increased and poor supervision scores decreased with treatment (see Figure 10). Similarly, on the PSC scale, caregivers reported greater parenting efficacy post-treatment, although these findings were not statistically significant.

**Figure 10.** Mean pre- and post-treatment scores on the APQ-S. Error bars indicate standard deviations. *$p<.05$.

<table>
<thead>
<tr>
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<th>Pre</th>
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<tr>
<td>Positive Parenting</td>
<td>12.5</td>
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<tr>
<td>Inconsistent Discipline</td>
<td>8.8</td>
<td>6.9*</td>
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<td>Poor Supervision</td>
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Process Data

i. Attendance

Figure 11 illustrates the mean percentage of days attended for the children’s and parents’ groups for the four sessions of Coping Power-CONNECT combined.

Figure 11. Percentage of days participants attended Coping Power-CONNECT.

ii. Fidelity

Fidelity was assessed against objectives modified from the original Coping Power program (see Table 1). Objectives were not included for omitted sessions or for omitted components of sessions (e.g., videotaping towards the end of the children’s group). Figure 12 illustrates combined data for all four sessions and shows high rates of fidelity.

Figure 13 shows the percentages of modified objectives that were achieved for each session of the child and parent groups. As can be seen in Figures 12 and 13, fidelity to the program was consistently high.
iii. Client, Caregiver and Case Manager Feedback Data

As part of Peel Children’s Centre’s continuous quality improvement strategy, feedback surveys are regularly distributed, and responses are used to generate quality assurance reports. For the two most recent Coping Power sessions, youth and parent questionnaires
were redesigned with input from program staff to capture opinions specifically about the Coping Power groups as well as about the overall program (see Appendix D). Exceptionally high ratings of overall satisfaction by both caregivers and case managers indicate their belief that Coping Power-CONNECT was a high quality service (see Figure 14). In addition, 87% of caregivers reported that the services being provided were effective in helping them with their problems, and 83% reported that these services helped with their relationships with their children (Appendix D).

Figure 14. Percentage of ratings on quality dimensions as reported by clients (n=24), caregivers (n=10) and case managers (n=11)
3. Implementation Activities

The first step in the implementation of this project was to research and identify an evidence-based program that would be a good fit for clinically-identified children, many of whom had disruptive behaviours, within an after-school children’s mental health program. Once Coping Power was selected, we pulled together a development and implementation team that included the supervisor of the program, a PCC staff psychologist, a PCC consulting psychologist and the front line CONNECT team. This team met on a weekly basis for a four-month period in order to familiarize themselves with the theoretical underpinnings of Coping Power, review and develop a thorough understanding of both the child and parent components of the Coping Power program and engage in discussion and inquiry. The team then mapped Coping Power onto the CONNECT program, making modifications to both the Coping Power curriculum and the CONNECT Program as needed. This was done in consultation with Dr. John Lochman, the developer of the Coping Power program. He provided information and materials to help us in our decision-making. This process also allowed us time to refine the inclusion criteria for CONNECT; in particular, we narrowed the age range for children attending the program from 7 to 15 years to 8 to 13 years. Working together as a team throughout allowed everyone to take ownership of the project and to share in the excitement of implementing an EBP into work that we were already doing. We went on to develop a plan for capacity building within the organization that included training, mentoring and ongoing coaching of identified staff (i.e., child and family clinicians and child and youth workers) to familiarize as many people as possible with the Coping Power curriculum. The training and mentoring of staff was provided in-house by the PCC staff and
consulting psychologists, the CONNECT Program supervisor and front-line staff from the
CONNECT Program.

The project team then moved to the program evaluation phase. A proposal for a pilot study
was written and the project underwent an internal ethics review in order to be able to conduct
research that involved human subjects. A consent/assent form/process was created to clearly
outline the project and its purpose both to the parents and child clients, allowing us to collect
pre and post data from parents, children and the children’s teachers. The team then mapped
processes for the implementation and evaluation of the project and created a logic model and
an evaluation plan. The selection of appropriate psychometric measures was done by the
psychologists and, with the support of PCC’s Clinical Standards and Development
Department, the team created a feedback survey for children, parents and case managers. It
was at this time that the team applied for and was successful in being awarded an Evaluation
Grant through the Centre of Excellence, allowing us to include a research assistant to support
the evaluation.

After the initial introduction of Coping Power into the CONNECT Program, weekly team
meetings were held to provide ongoing consultation and support, to review and adjust the
children’s goals and to complete fidelity checks regarding both the parent and child groups.
Team meetings also provided a forum for shadowing and mentoring of other clinicians, child
and youth workers and psychologists in the agency. The belief was that this model of
training, mentoring and shadowing would have a ‘multiplier effect’ whereby knowledge of
the program would be held widely and not by a select few, thus contributing to the
sustainability of the project within the organization over time.
Discussion

The present study evaluated treatment effects of implementing Coping Power within the CONNECT program, a therapeutic and recreational after-school program for children with severe behavioural and emotional challenges. Our team was interested in understanding whether implementation of an evidence-based program within CONNECT would contribute to the delivery of a more efficient clinical service, positive treatment outcomes for clients and high satisfaction. Specifically our objectives were to understand the impact of Coping Power on 1) children’s behaviour, 2) children’s social competencies and skills and 3) parental competencies and skills. It was hypothesized that children who participated in the integrated treatment program would show decreased disruptive behaviour, increased social competencies and increased adaptive problem-solving abilities. Similarly it was hypothesized that caregivers would report increased parenting competence, satisfaction and skill. As will be discussed, data strongly supported these hypotheses and demonstrated robust and positive outcomes.

Of primary interest in the present study was the investigation of the impact of the integrated Coping Power-CONNECT program on children’s disruptive behaviour. Findings showed a number of significant and important positive changes in child behaviour with treatment. First, caregivers reported significant and large decreases in children’s overall behavioural difficulties with treatment. As such, caregivers’ global impressions were that children improved over all with participation in treatment. Second, children showed reductions in specific aspects of disruptive behaviour including hyperactivity and conduct problems. Importantly, each of these forms of behaviour difficulties has been associated with numerous short- and long-term mental and behavioural health conditions. Third, children showed reduced
Impairment in many critical areas of functioning. Caregivers endorsed reductions in the negative impact of children’s behaviour on the family, on the parent-child relationship, on children’s academic progress and children’s self-esteem. Because impairment, in addition to behavioural symptoms, has been shown to be a significant mediator of later functioning, this finding is extremely important.

The positive impact of Coping Power on children’s behavioural functioning is consistent with large scale investigations. The present study used a modified version of Coping Power which was adapted to fit within the CONNECT program. These similar findings using the modified version in the context of an after-school program further broadens the applicability and utility of Coping Power. Additionally, by implementing Coping Power within CONNECT there was opportunity to reinforce treatment goals and provide broader reinforcement for appropriate behaviour. Because Coping Power has typically been utilized in a school-based context, its application to a milieu setting is especially promising.

Much research has documented the significant negative short- and long-term consequences of disruptive behaviour. Disruptive children are at risk for a number of mental, behavioural and physical health concerns including peer relationship difficulties, adjustment difficulties, underemployment, antisocial behaviour and bodily injury from accidents. Interventions such as Coping Power which reduce children’s disruptive behaviour and build adaptive problem-solving skills potentially reduce these short- and long-term negative consequences. Although beyond the scope of the present investigation, follow-up of program participants to determine longer term impact would be informative.
A second objective of the present study was to investigate the impact of the integrated Coping Power-CONNECT program on children’s social competencies. Results showed marginal increases in children’s prosocial behaviour and peer interaction skills and statistically significant reductions in children’s social impairment with peers and with siblings. These social behaviours have been theorized to partially moderate the relationship between negative social and behavioural influences and long-term functioning (see Figure 1). As such, positive social abilities may “buffer” negative environmental influences and contribute to greater resilience. Findings from the present study show that children who participated in the intervention showed greater social competencies post-program and as such may be better equipped to manage social challenges.

Additionally, children with peer relationship challenges likely encounter more negative life challenges and fewer adaptive social interactions compared to their well-functioning classmates. Social interaction provides a “training ground” where children learn and develop many of their social abilities. Adaptive social interactions help children develop cognitive and behavioural strategies which help them interact more effectively with their social environment. Conversely, children with dysfunctional peer relationships are more prone to deviant peer associations and antisocial behaviour. Coping Power was designed to reduce factors which contribute to deviancy and, although results from the present study are with a small group of participants, effects are sufficiently large to warrant continued evaluation.

Parental competencies and skills are another domain thought to moderate children’s longer-term functioning (see Figure 1) and a target for development in Coping Power and CONNECT. During the pre-adolescent years, parents have a tremendous influence on children’s
behaviours. The parenting component of the program targets caregivers’ stress, skills, competencies and family problem-solving abilities. This focus is deliberate given the documented association between parenting practices and disruptive behaviour. Findings from the current investigation show statistically significant reductions in parental report of inconsistent discipline and marginally significant increases in parental efficacy. Although not statistically significant, caregivers reported greater positive parenting practices, parental satisfaction and decrease in poor supervision with treatment.

In contrast, inconsistent discipline has been shown in numerous past studies to predict childhood conduct problem behaviour. Children with parents who show inconsistent caregiving strategies are more likely to be aggressive, oppositional and disruptive. As such, reduction of inconsistent discipline strategies paired with facilitation of positive parenting, efficacy and satisfaction are an important step towards modifying the harsh-punitive style of parenting documented to exacerbate disruptive behaviour in numerous past studies.

Of note in the present study is the lack of significant pre-post-treatment change in teacher’s report of child behaviour and social functioning. Although a trend in the data showed lower teacher-rated negative behavioural scores post-treatment, these changes were not as marked as those reported by caregivers. This finding (or lack of finding) is important in a number of ways. First, much research has described inconsistencies between parent and teacher reports of behaviour. Findings from the present study may be an artefact of this difference. Second, teachers, as compared to caregivers, were not directly involved in the project and, as such, did not actively modify the classroom environment to facilitate skills reinforcement. Children may not have demonstrated as clear behavioural changes at school because these were
not supported by environmental changes (i.e., classroom structures, reinforcement programs etc.). Finally, it is possible that the measurement strategy lacked adequate sensitivity to behavioural change in the classroom; however, this explanation is unlikely given the validity and reliability of measures used. Regardless, based on the findings of the present study further investigation which involves teachers and school staff may benefit the overall evaluation process and impact of the intervention program. Further strengthening the partnership with the board of education to help build these connections may be important in the future.

The present investigation demonstrates that Coping Power can be delivered with fidelity and result in positive treatment outcomes when delivered by child and youth workers and child and family clinicians (i.e., MSWs) with consultation and guidance from psychologists. Results from the present study demonstrate clear clinician and client satisfaction with program implementation and highlight that the implementation of an evidence-based practice (EBP) within a community mental health centre can be successful if done in a planned, staged process. In addition, with the added structure and content of Coping Power, attendance to CONNECT increased by 50%. The implementation activities previously described list a series of steps taken to engage staff, obtain feedback and maintain the core components of the EBP and the mental health program (i.e., CONNECT) in order to successfully merge the two programs.

Study Limitations

The present investigation demonstrated a number of positive effects associated with implementing Coping Power within the CONNECT program; however, a number of study limitations should be considered. First, the investigation used a pre-post design and did not incorporate a control condition. As such, although positive gains were demonstrated in a number
of treatment domains, these cannot be compared to a “no treatment” or alternative condition. Second, Coping Power was implemented (and integrated) within the larger CONNECT program so we cannot definitively identify whether client gains are due to Coping Power, CONNECT or their combination or a larger treatment plan. Third, sample size limitations preclude analyses of client or program characteristics which predict or mediate treatment outcomes. This information would be of tremendous value to refine aspects of the program.

**Future Directions**

Findings from the present investigation highlight the benefits derived from the implementation and evaluation of Coping Power within CONNECT. Continued implementation of the project with evaluation is important in order to continue to investigate program findings with more participants. Additionally, the structured Coping Power approach may also be of benefit in other program areas within the Peel Children’s Centre. For example, a modified version of Coping Power may be beneficial within the Day Treatment and Residential services or within the intensive in-home services given that these programs primarily serve children with disruptive behaviour challenges.

Involving teachers and school personnel (i.e., school psychologists, child and family clinicians, child and youth workers) in the delivery and maintenance of the program may be an activity essential to allow children to transfer skills to the classroom. Developing strategies to engage school staff, provide information about the program, and support with skills transfer may be essential.
Knowledge Transfer

From the onset of this project, the implementation team has been mindful of keeping others apprised about the implementation and evaluation of Coping Power within CONNECT. This was to ensure that the project was understood by PCC and our community partners and that an atmosphere was created that would be receptive and supportive of the changes over the long term. Members of the team have participated in many knowledge transfer activities over the past two years through presentations, emails, trainings, team meetings and news letters.

In 2008, a process of knowledge transfer was begun with our community partners by presenting to head social workers from the Peel school boards, (Dufferin-Peel Catholic District School Board and Peel District School Board) about Coping Power and the implementation of an EBP within CONNECT. In January, 2009, the supervisor and the full-time CONNECT staff member also presented an overview of Coping Power-CONNECT to all of Peel Children Centre staff, explaining the purpose of the project and providing information about the Evaluation and Implementation Grant that we had received from the Centre of Excellence. Now that the project has been completed, it is the plan of the team to present the findings and information about our experiences with implementing Coping Power within CONNECT at a children’s mental health conference. A poster board has been created to present the results of the project and will be used both internally and externally.

Additionally, we have used team meetings as a way of transferring knowledge to other clinical staff within the agency and, as stated above, will continue to use a mentoring/coaching approach to do so. We also hope to reinforce links to schools in future by attending school meetings, when possible, to inform school staff about the program and provide them with
information about the children’s goals and progress. CONNECT staff will also send out weekly e-mails in future to teachers and clinicians to inform them about the material that is being taught that week in the Coping Power groups. It is believed that, by communicating more frequently and comprehensively with the other professionals involved in the child’s life, collaboration can become more effective and clients will benefit over time. The CONNECT supervisor also endeavours to communicate widely about the program, sending out e-mails four times a year to promote the program within the agency and to solicit referrals. Coping Power-CONNECT has been featured within the Peel Children’s Center Newsletter which is circulated to the Centre’s Board of Directors and to all PCC staff.

Other knowledge transfer activities have occurred through participation in focus groups and Webinars. In October 2009, the Program Supervisor participated in a focus group about the implementation of evidence-based practices within children’s mental health centres across Ontario. The evaluation team also took part in a number of webinars sponsored by the Centre of Excellence to support implementation and evaluation of EBPs, affording us the opportunity to learn about the experiences of others in mounting similar evaluation projects and to share some of our own experiences as the process unfolded.

Since the conclusion of the project, we have presented our findings to staff at PCC and have begun the implementation of Coping Power into other programs within the agency. This expansion of Coping Power within the agency will be evaluated through another Centre of Excellence grant, Doing Evaluation, which the team has received for 2010-2011.

Finally, in September 2010, seventeen PCC staff attended formal training in the Coping Power program provided by Dr. John Lochman’s team from the University of Alabama. The
training was co-sponsored by the Centre for Addiction and Mental Health’s Child, Youth and Family Program and Peel Children’s Centre. This training marked the beginning of a community of practice across both sites and offers opportunities for joint consultation with Lochman’s team. It also opens up opportunities to collaborate with other organizations using the model and the possibility of future research and evaluation initiatives.

Conclusions, Recommendations and Lessons Learned

The implementation of the project has resulted in a number of important lessons which will inform this and other program evaluations. Primarily the implementation and evaluation team benefited from an approach which built on the strength of the existing CONNECT program. Coping Power and its associated contingency management program was adapted to fit within the structure of CONNECT. As such, modifications to both Coping Power and CONNECT resulted in an integrated and well functioning program. Of equal importance, program staff were directly involved and provided input towards program modifications, participated in the selection of evaluation measures and played a role in process design. Additionally, staff were provided with ongoing support and training towards delivery of the evidence-based practice and evaluation protocol. Inclusion of frontline staff in program development and evaluation, along with the provision of support to them, were envisioned as essential components for ensuring the success and continuity of the program. However, the inclusion of multiple perspectives and modifications resulted in a longer timeline and a more gradual implementation. This approach, sometimes referred to as “scaffolding”, has demonstrated itself to be initially effective in the present project.
The combined Coping Power–CONNECT program resulted in many important and statistically significant reductions in areas of children’s disruptive behaviour and facilitation of children’s adaptive social behaviour and parental skills. Additionally, the program (and evaluation plan) was met with great enthusiasm and satisfaction by staff and clients. The initial success of the program has created an energy and excitement around its processes and is the basis of the following recommendations. First, it is recommended that the modified Coping Power–CONNECT program continue with the existing evaluation framework. Continuity of the existing process will allow additional data gathering and consolidation of processes. Second, it is recommended that upon completion of the program, an evaluation of the clinical utility of measures be completed to choose those that best fit the program structure and demands with burden on clients and caregivers. This is important to facilitate evaluation continuity. Third, it is recommended that PCC investigate the feasibility of implementing Coping Power within other aspects of the milieu services and outpatient services for children with disruptive behaviour, thus broadening the scope of the evaluation initiative. Fourth, it is recommended that information be shared with management and the senior executive at PCC to ensure their awareness of outcomes and benefits. Fifth, it is recommended that partner organisations be contacted for information sharing. Additionally, further discussion of partnership-building activities including the potential involvement of school board staff in supporting the program delivery is recommended.
Appendix A

Program Logic Model: Sustaining the evaluation framework of the Coping Power Program as implemented within the Milieu Services at the Peel Children’s Centre

Program Goal: To reduce disruptive behaviour and build social problem-solving skills by implementing the Coping Power program within the Milieu Services for children aged seven to twelve

**Inputs**
- **Staff:**
  - 6 FTE CYWs
  - 3 FTE Supervisor
  - 2 MSW Parent Group Leader
  - Multidisciplinary consultation (Psychology and Child and Family Clinicians)
- **Resources:**
  - Transportation
  - Therapist manuals and client booklets (parents and children)
  - Child Care for Parents’ Group through Volunteer Services
- **Funding:**
  - Training
- **Community Partnerships:**
  - Peel District School Board
  - Peel Catholic District School Board
  - Peel Children’s Aid Society

**Components**
- **Child Component**
- **Parent Component**
- **Partnership Component**

**Activities**
- **Child Component**
  - Twice weekly, one-hour children’s group teaches:
    - Affect Regulation
    - Social Problem-Solving
  - Skills reinforced in broader therapeutic program:
    - Recreational
    - Academic skills
    - Life skills
  - Weekly, one-hour parents’ group teaches:
    - Stress Reduction
    - Cognitive aspects of parenting
    - Family problem-solving
- **Parent Component**
  - Ongoing consultation:
    - With Child and Family Clinicians
    - With community partners regarding referrals and program
    - With school staff regarding specific children

**Outputs**
- **Target Group**
  - Children aged seven to twelve with elevated externalizing behaviours as indicated by BCFPI profiles, impairment ratings and file reviews
  - Parents and caregivers of the above children

**Outcomes**
- **Near-term**
  - Children demonstrate improved understanding of strategies to manage conflict.
  - Children demonstrate improved social problem-solving skills.
- **Mid-term**
  - Children demonstrate improved social skills.
  - Improvement in children’s behaviour at home
  - Improvement in children’s behaviour at school
  - Parents/caregivers report:
    - Less stress
    - More self-confidence about parenting
    - Increased positive parenting
    - Decreased inconsistent discipline
    - Better supervision

Peel Children’s Centre May 18, 2010
### Appendix B

#### Evaluation Plan

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Source of data</th>
<th>Method to collect data</th>
<th>Who collects data?</th>
<th>When is data collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Near-term Child Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children demonstrate improved understanding of strategies to manage conflict.</td>
<td>Increase in total score</td>
<td>Problem-solving measure of conflict (PSMC)</td>
<td>Individually-administered measure</td>
<td>CONNECT Child and Youth Worker</td>
<td>Beginning and end of program</td>
</tr>
<tr>
<td>Children demonstrate improved social problems solving skills.</td>
<td>Increase in total score</td>
<td>Outcome expectations questionnaire (OEQ)</td>
<td>Individually-administered measure</td>
<td>CONNECT Child and Youth Worker</td>
<td>Beginning and end of program</td>
</tr>
<tr>
<td>Children demonstrate improved social skills.</td>
<td>Increase in total score and scaled scores (teacher-preferred and peer-preferred social behaviour)</td>
<td>Walker-McConnell Scale of Social Competence and School Adjustment</td>
<td>Individually-administered measure</td>
<td>In-person delivery by CONNECT Child and Youth Worker and return by mail</td>
<td>Beginning and end of program</td>
</tr>
<tr>
<td><strong>Near-term Parent/Caregiver Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/Caregivers report increased sense of competence about parenting</td>
<td>Increase in sense of competence</td>
<td>Parenting Sense of Competence</td>
<td>Group administration</td>
<td>Research assistant</td>
<td>First and last sessions</td>
</tr>
<tr>
<td>Parents/Caregivers report increased positive parenting.</td>
<td>Decreased score on positive parenting subscale</td>
<td>Alabama Parenting Questionnaire</td>
<td>Group administration</td>
<td>Research assistant</td>
<td>First and last sessions</td>
</tr>
<tr>
<td>Parents/Caregivers report decreased inconsistent discipline.</td>
<td>Decreased score on inconsistent discipline subscale</td>
<td>Alabama Parenting Questionnaire</td>
<td>Group administration</td>
<td>Research assistant</td>
<td>First and last sessions</td>
</tr>
<tr>
<td>Parents/Caregivers report better supervision.</td>
<td>Increased score on supervision subscale</td>
<td>Alabama Parenting Questionnaire</td>
<td>Group administration</td>
<td>Research assistant</td>
<td>First and last sessions</td>
</tr>
<tr>
<td><strong>Mid-term Child Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/Caregivers report improvement in children’s behaviour at home.</td>
<td>Decreased overall impairment and impairment in academic, peer, sibling and parent-child domains</td>
<td>Impairment rating scale completed by parents</td>
<td>Individually-administered</td>
<td>Clinician</td>
<td>Prior to first and after last session</td>
</tr>
<tr>
<td></td>
<td>Decreased total score and decreased scale scores for Emotional Symptoms, Conduct</td>
<td>Strengths and Difficulties Scale completed by parents</td>
<td>Group and self-administration by parents (at)</td>
<td>Research assistant and by telephone for follow-up</td>
<td>First and last sessions</td>
</tr>
</tbody>
</table>

(Elements such as “CONNECT Child and Youth Worker,” “Beginning and end of program,” “In-person delivery by CONNECT Child and Youth Worker and return by mail,” and “Clinician” are placeholders for actual entities and contexts.)
### Problems, Hyperactivity and Peer Problems; Increased scale score for Prosocial Behaviours
Decreased scale scores on Inattention/Overactivity and Aggression

| Teachers report improvement in children’s behaviour at school. | Decreased total score and decreased scale scores for Emotional Symptoms, Conduct Problems, Hyperactivity and Peer Problems; Increased scale score for Prosocial Behaviours | Decreased scale scores on Inattention/Overactivity and Aggression | Pittsburgh Modified Conners rating scale completed by parents | Self-administration by teachers | Research assistant by mail | After first and last sessions |

#### Process

<table>
<thead>
<tr>
<th>Process question</th>
<th>Indicator</th>
<th>Source of data</th>
<th>Method to collect data</th>
<th>Who collects data?</th>
<th>When is data collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the program being delivered according to the modified Coping Power Model?</td>
<td>High fidelity scores</td>
<td>Modified Fidelity measure</td>
<td>Completed during weekly team meeting</td>
<td>Clinical Consultant and Program Supervisor</td>
<td>Weekly</td>
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<tr>
<td>What are the clinician impressions</td>
<td>Clinician Satisfaction measure</td>
<td>Satisfaction Survey</td>
<td>Self-administered</td>
<td>CSD department</td>
<td>End of session</td>
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<td>Utilization</td>
<td>Satisfaction survey results</td>
<td>Satisfaction survey</td>
<td>Self-administer</td>
<td>CSD Department</td>
<td>After the last session</td>
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<td>Client participation</td>
<td>Attendance</td>
<td>Attendance records</td>
<td>Attendance log</td>
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<td>Ongoing</td>
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Peel Children’s Centre  May 18, 2010
Appendix C

Information and Consent Form

Study Title: Evaluation of the implementation of the Coping Power program, an evidence-based program for children with disruptive behaviour problems, within an existing after school treatment program

Investigators: Susan Elbe, BA (Clinical Supervisor)
Brendan Andrade, Ph.D., C.Psych (Research Consultant)
Nancy Schmidt, Ph.D., C.Psych (Consultant Psychologist)

Introduction
You and your child are being invited to take part in the program evaluation study named above. It is important that you understand the purpose of the study, how it may affect you and your child, the risks and benefits of taking part in the project and what you and your child will be asked to do, before you decide if you want to take part. This information and consent form is to help you decide if it is in your best interest to take part in this project. You do not have to participate and if you choose to participate, you and your child may withdraw from the project at any time. Taking part is entirely voluntary (your choice). Your child’s treatment will not be affected by whether or not you participate. Participating in the study might not benefit you, but we might learn things that will benefit others and the programs at Peel Children’s Centre. If you have any questions that this form does not answer, the study investigators will be happy to give you further information.

Purpose of Study
This study is designed to better understand whether a structured program for children with behavioural and emotional challenges can be implemented within the Connect program at Peel Children's Centre. You and your child will be given questionnaires before the onset of the program, and after completion of the program. We will also be asking for your permission to have some questionnaires sent to your child’s teacher so that we can better understand the needs of your child. We are seeking to answer two questions. First, is the Coping Power program a helpful service for children and families? Second, are there specific aspects of your child’s behaviour or emotional functioning that are impacted most by the Coping Power program?

Study Design
The responses provided by caregivers, teachers, and children will be compared before and after completion of the Coping Power program to determine how effective the program is. Your satisfaction with the program will be assessed upon program completion.

Who can Participate in the Study
You can participate in this study if you are a caregiver with a child attending the Connect Program at Peel Children’s Centre.
Who will be conducting the Research
Ms. Susan Elbe will have oversight and primary responsibility for the collection of questionnaires from children, parents and teachers. Staff in the Connect Program and within the department of Clinical Standards and Development at the Peel Children’s Centre will assist in the explanation of questionnaires, collection of questionnaires, data entry and analysis.

What you and your child will be asked to do if you choose to participate in the study
Four brief questionnaires that take approximately 5 – 10 minutes each to complete will be given to you. The parent questionnaires contain questions about your child’s behaviour, peer relationships, emotional functioning, and your views on parenting and effective parenting skills. In addition, your child’s teacher will be asked to complete three questionnaires. Teacher questionnaires take about 5 – 10 minutes each to complete. The teacher questionnaires are very similar to those for parents and contain questions about your child’s behaviour, peer relationships, and emotional functioning while at school. The Connect Program staff will be responsible for delivering these questionnaires to your child’s teacher.

Children participating in the study will be asked to complete two questionnaires. Both questionnaires describe children in a variety of social situations. Your child will be asked about outcomes they expect from each of these situations. Questions will be read to your child and responses recorded by staff at the Connect Program. This will take approximately 5 – 10 minutes.

In addition we will collect and use for the purpose of this research the following information from your child’s Peel Children’s Centre clinical record:
- Information that you provided at intake.
- Information about your child’s diagnosis contained in Peel Children’s Centre documentation.
- Information about your child’s medication contained in Peel Children’s Centre documentation.

Potential Risks and Discomforts
Participation in this study will not in any way affect your child’s treatment at the Peel Children’s Centre. There are no apparent risks to completion of the questionnaires.

Potential Benefits
There are no direct benefits to either you or your child for participation in this research. However, because results will potentially lead to the implementation of more effective and efficient programs for children with similar needs, other parents and children will benefit from your involvement because we will learn about the program’s effectiveness.

Confidentiality
Information gathering from you and your child will take place at the Peel Children’s Centre. Teachers will be asked to complete the questionnaires and mail these to Peel Children’s Centre using pre-addressed, postage-paid envelopes. After you and your child complete the study, both of your names will be removed from all of the research files and replaced with numbers so that no one will be able to identify who gave us the information. Participants will not be identified by name in any reports or presentations. The results of the study will be presented in group form. Data maintained on computer files will be identified by participant number. All data will be stored at the Peel Children’s Centre in locked filing cabinets. Only the primary investigators listed above and staff of Clinical Standards and Development Department, directly involved in the study will have access to the data.

Questions
You and your child have the right to ask questions about this study by contacting Ms. Susan Elbe at 905-795-3500 ext. 2275.
Study Title: Evaluation of the implementation of the Coping Power program, an evidence-based program for children with disruptive behaviour problems, within an existing after school treatment program

Parental or Guardian Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study. I understand that I have the right to withdraw myself and/or my child from the study at any time and it will not affect my child’s treatment at Peel Children’s Centre in any way. I have received a copy of the Information and Consent form for future reference. I freely agree to participate in this program evaluation study.

Name of Child:______________________________________
Name of Parent:_____________________________________
Relationship to the Child:______________________________
Child’s Date of Birth:  ____ / _____ / ______    Gender: □ Male □ Female
Day        Month         Year
Signature of Parent: _______________________________   Date:_________________

Child Assent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study. I understand that I have the right to withdraw from the study at any time and it will not affect my treatment at Peel Children’s Centre in any way. I freely agree to participate in this program evaluation study.

Signature of Child: _________________________________   Date:___________________

STATEMENT BY PERSON PROVIDING INFORMATION AND OBTAINING CONSENT ON STUDY

I have explained the nature and demands of the study and judge that the Parent / Guardian / Child named above understands the nature and demands of the study. I have explained the nature of the consent process to the participants and judge that they understand that participation is voluntary and that they may withdraw from the study at any time.

Name (Print): ______________________________________
Signature: ______________________________________   Date: _____________________
Dear Teacher,

My child is participating in the Connect Program at Peel Children’s Centre. This year, Peel Children’s Centre is conducting a formal program evaluation of the Coping Power Program that is utilized within the Connect Program. The purpose of the evaluation is to better understand whether an evidence-based structured program for children with behavioral and emotional challenges can be effective within the Connect Program.

For that reason, I give you permission to fill out the following three measures in relation to my child at the beginning and end of the program. The enclosed measures for this evaluation include:

- Strengths and Difficulties Questionnaire
- Walker-McConnell Scale of Social Competence and School Adjustment
- Pittsburgh Modified Conners Teacher Rating Scale

These measures will be used to provide information on the social and behavioral functioning of my child while he/she is at school.

Peel Children’s Centre is hoping that with your help, by completing these measures, they will be able to provide a more effective and efficient program for the parents and children they serve.

If there are any questions or concerns, please contact Susan Elbe, Clinical Supervisor, at (905) 795-3500 ext. 2275. Thank you for your assistance and time.

Name of Child: _________________________________________ (Please Print)

Name of Parent/Guardian: _________________________________________ (Please Print)

Signature of Parent/Guardian: _________________________________

Date: __________________________
Service Quality Report August 2010

Connect Program: Coping Power Sessions January & June 2010
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Introduction

Peel Children’s Centre is committed to providing high quality mental health services. The centre’s framework for evaluation and continuous quality improvement is entitled QUaity Enhancement STRATEGY (QUEST©). The ultimate goal of QUEST is to demonstrate in a measurable way that we provide “high quality” services to children, youth and their families.

Continuous Quality Improvement (CQI) is a main component of QUEST. CQI focuses on how we do our work. CQI is a philosophy and system that involves management and staff in the continuous improvement of work processes to achieve better outcomes for consumers. One aspect of the centre’s CQI processes used to gather feedback on the quality of our services involves our clients.

To measure “high quality” services, quality must be broken down into its components or dimensions. These dimensions are adapted from Accreditation Canada, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and are congruent with our values. See Appendix A on page 10 for the dimensions of quality and their definitions.

For the most recent two Coping Power sessions, youth and parent questionnaires were redesigned with input from program staff to capture opinions about both the program in general and the group-specific sessions. Refer to the Appendix B, C and D on pages 11-13 for the Coping Power questionnaires and the quality indicators and dimensions the survey items reflect.

Clinical and research staff conducted the survey with youth and their parents and case managers at the end of each of the two sessions ~ in January for sessions between September and January, and in June for sessions between February - June. Our methodology ensures confidentiality and anonymity.

Acknowledgement

These reports rely on the willingness of our clients and their parents to participate in our service quality survey process, and our staff’s commitment to this quality improvement process. Their continued involvement in the centre’s pursuit of excellence is sincerely appreciated.
Response Rates

As shown in Table 1, response rates for youth, parents and case managers were excellent at 100% for the first Coping Power session. For the second session, two parents were not available to be surveyed and one case manager survey was not returned. However, the response rate for youth was terrific at 100%.

<table>
<thead>
<tr>
<th>Survey Sample</th>
<th>September 2009 - January 2010 session</th>
<th>February - June 2010 session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number eligible</td>
<td>Number returned</td>
</tr>
<tr>
<td>Youth</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Parents</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Case Managers</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Service Quality Analysis

Numeric ratings (percentages) on the indicators and dimensions of quality are presented in sample-specific charts. For this analysis, given the small sample sizes for each session, the data have been combined. Program management has been provided with individual item responses for each session in order to develop less lengthy parent and youth questionnaires, yet provide meaningful and useful information for improvement planning.

Written feedback is grouped by similar comments and listed under the headings entitled, Favourable Comments and Suggestions for Improvement. These qualitative data help explain the quantitative data, and can enrich the analysis by revealing patterns of responses that substantiate what we are doing well, and point out areas for improvement. When patterns emerge, it is recommended that program staff determine if the pattern is prevailing and develop action plans, as appropriate.
Youth Results - about the program

As displayed in Figure 1, the “total” quality rating across all indicators is 84%. Youth rated the quality dimension of respect the highest at 92%, indicating that they had been well-treated by staff. In terms of the effectiveness of, 86% reported that the fun activities and having time to do homework after school had been helpful. 78% considered that the program had helped improve their relationships by helping them get along better with family, friends and teachers. On acceptability, 82% reported that they had received “the kind of help they wanted”, and 81% were “extremely satisfied” with the overall program.

Figure 1: Youth Ratings on Quality Dimensions
Coping Power Program - January & June 2010 (N=12)
Youth Results - about the group

Figure 2 indicates that, although 69% of youth reported being highly satisfied with the Tuesday and Thursday group sessions, a large majority perceived the sessions to be effective. Specifically, 86% reported that the topics were helpful (e.g., learning to cope with anger and to problem-solve). 78% considered that practicing skills learned during group helped them at home, school and with friends.

![Bar chart showing Youth Ratings on Quality Dimensions](chart)

<table>
<thead>
<tr>
<th>What youth liked MOST</th>
<th>What you did NOT like</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The way staff treated me.</td>
<td>- Quiet time,</td>
</tr>
<tr>
<td>- The staff</td>
<td>- I cannot play with friends at home.</td>
</tr>
<tr>
<td>- Where I learned a lot about stuff. How I learned</td>
<td>- Group.</td>
</tr>
<tr>
<td>how to control my anger.</td>
<td>- Group, sort of.</td>
</tr>
<tr>
<td>- It was helpful.</td>
<td>- Having to have group and solid, cold carrots and celery. Some of the groups.</td>
</tr>
<tr>
<td>- Activities, people foosball, ping pong., Wii,</td>
<td>- Strikes.</td>
</tr>
<tr>
<td>talking, food. I like the staff but you guys</td>
<td>- Somewhat Coping Power.</td>
</tr>
<tr>
<td>should add more staff and kids. We should go out</td>
<td>- Rainy days.</td>
</tr>
<tr>
<td>more.</td>
<td>- That it was only 3 days a week. &lt;strong&gt;(implies a positive experience)&lt;/strong&gt;</td>
</tr>
<tr>
<td>- Playing the Wii.</td>
<td>- Nothing. &lt;strong&gt;(implies a positive experience)&lt;/strong&gt;.</td>
</tr>
<tr>
<td>- It’s fun and I get toys.</td>
<td>- Free time and dinner.</td>
</tr>
<tr>
<td>- Wednesday, going to the park on the swings.</td>
<td>- Gym.</td>
</tr>
<tr>
<td>Going to the gym and the friends.</td>
<td>- Prize box (2 comments).</td>
</tr>
<tr>
<td>- Prize box (2 comments).</td>
<td>- Nothing.</td>
</tr>
<tr>
<td>- Free time and dinner.</td>
<td>- Gym.</td>
</tr>
<tr>
<td>- Gym.</td>
<td>- Nothing.</td>
</tr>
</tbody>
</table>
Parent Results - about the program

As displayed in Figure 3, the “total” quality rating is excellent at 92%! Parents rated respect and caring and their own satisfaction with the program the highest at 100%. Also, 95% of parents reported being extremely satisfied with the service their children were receiving. 88% of parents considered the Coping Power Program to be the kind of service they expected (acceptability), and 85% perceived that the program had met their needs (appropriateness). In terms of effectiveness, 83% reported that being in the program had improved their child’s behaviour at home, at school and in the community. Quality ratings are higher than those for youth, e.g., Overall, quality ratings are higher for parents than youth (refer to page 3). For example, the “total” quality rating for parents is 92% versus 84% for youth.

Figure 3: Parent Ratings on Quality Dimensions
Coping Power Program - January & June 2010 (N=10)

To also reflect the dimension of effectiveness, parents were asked if having a break while their child attended the program had been helpful to them. 88% answered “yes” and some parents provided the following reasons why:

- It has allowed me to spend some time with my other children.
- I have other children at home and when [my son] is home, I am mainly focused on him.
- I’m more relaxed about the homework and his attitude.
- My son is having a break from home too, in a positive environment.
- I have quiet moments, where I can rest and organize the week’s activities.
- It gave me some time for myself.
- It gives me a break.
Comments about the Program and Suggestions for Improvement

- Connect is a good program for parents and kids. Kids love Connect ~ like playing with toys and meeting.
- It’s a GREAT program. I can’t see any improvements needed!
- I really think this program is wonderful. It treats the children in the program with a lot of respect. I really just think the program should be every day.
- The staff are terrific and have a wealth of knowledge, which I as a parent can draw on. What would be of benefit is that the worksheets were provided on a CD, making using them easier.
Parent Results - about the group

As shown in Figure 4, the vast majority of parents (95%) were extremely satisfied with their group experience. Most (95%) reported that the information and materials were helpful. 93% considered the skills learned helped them to deal more effectively with their child’s behaviour, and 83% responded that the session topics had been very helpful. That parents felt the group to be beneficial is substantiated by their reasons for coming back to group (see below).

The parent questionnaire included the question, “what kept you coming back to group?” The following are reasons written by some of the parents:

- My commitment to my child’s welfare and to learn from what the program had to offer. I found the discussions with other parents engaging and helpful.
- It was very helpful for me in regards to being on the right track in being able to deal with outbursts at home and proper consequences. Very good support for parents who have trouble punishing their children.
- The lessons, support and advice from the other parents and Connect workers.
- I hoped to learn about additional tools to help manage my children’s behaviour. I enjoyed sharing and getting feedback from the other parents. It has been good to be able to sound off my issues to the staff and get their viewpoint.
- The hope that there will be positive changes in our family.
- Hoping to learn the skills needed to cope with raising my child and coping with stress.
- The people, fun atmosphere, private.
- Free pizza!! No, seriously, interacting with the other parents and we were told we HAD to!!
- It’s good.
Comments about the Group and Suggestions for Improvement

- Parent group is good for both kids and parents.
- Allow more time for the chapters so parents aren’t rushed and are able to fully utilize both staff and each other’s views.
- Serve wine!! Joking!! The only thing I could suggest is LONGER sessions, because we seem to need more time to discuss things.
Case Manager Results – about the program

As illustrated in Figure 5, the quality rating of 98% is outstanding on respect and satisfaction. Similarly, ratings are extremely high on acceptability (93%) and appropriateness (89%), indicating that Coping Power was the kind of service expected by case managers and they perceived the program was helping to meet their client’s needs. Taken together with the written remarks below, it is clear that case managers endorse the Coping Power program and are working collaboratively with Connect staff for the benefit of clients.

Figure 5: Case Manager Ratings on Quality Dimensions
Coping Power Program - January & June 2010 (N=11)

Written Feedback

- Excellent communication with staff. Helpful, practical advice.
- Review meetings were helpful. Great caring, resourceful and dedicated staff members. Thanks for supporting the client with reaching his goal!
- Great job! Maybe bi-weekly meetings due to the intensity of the program.
- I found the parent portion could have been extended. There often was not enough time fully discuss the topics. Other than that I was very impressed with the program.
- More education and ongoing communication with the schools from the start. Provide written information to schools about “Coping Power”.
Appendix A: Dimensions of Quality

Acceptability
The degree to which all clinical services provided meet the expectations of clients, funders, and other stakeholders, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of clients are paramount... Do our clinical services meet clients' expectations?

Accessibility
The degree to which clients can obtain clinical services at the right place and at the right time, based on their needs... How easy is it for clients to receive clinical services when needed?

Appropriateness
The degree to which clinical services provided are relevant to clients' needs, based on established standards and given the current state of knowledge... Do our clinical services meet clients' needs?

Competence
The degree to which the knowledge and skills of clinical staff are appropriate to the service being provided... Do we recruit and retain highly competent staff?

Continuity
The degree to which clinical services are coordinated across programs, among providers, among organizations, and over time... Are clinical services coordinated?

Effectiveness
The degree to which clinical services provided achieve the desired outcomes for clients, given the current state of knowledge... Are the desired outcomes achieved?

Efficiency
The degree to which the desired outcomes are achieved for clients with the most cost-effective use of resources... Are clinical services provided in the most cost-effective manner?

Respect and Caring
The degree to which clients are involved in their own service decisions, and to which those providing services do so with sensitivity and respect for the clients' needs, expectations, and individual differences... Are clients involved in service decisions? How are clients treated by staff?

Timeliness
The degree to which clinical services are provided to clients at the most beneficial or necessary time... Are clinical services provided in a timely manner?
## Appendix B: Youth Questionnaire

### Questions about the Connect “Coping Power” Program in general

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Did you get “excellent help at the Connect Program?” Quality</td>
<td></td>
</tr>
<tr>
<td>2) Did you get the kind of help you wanted at the Connect Program? Acceptability</td>
<td></td>
</tr>
<tr>
<td>3) If a friend needed this kind of help, would you tell them about Connect? Quality</td>
<td></td>
</tr>
<tr>
<td>4) Has the Connect Program helped you get along better with your family? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>5) Has the Connect Program helped you get along better with your friends? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>6) Has the Connect Program helped you get along better with your teacher? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>7) Was having time to do your homework after school helpful? Effectiveness (activities)</td>
<td></td>
</tr>
<tr>
<td>8) Was having time to do fun activities helpful? Effectiveness (activities)</td>
<td></td>
</tr>
<tr>
<td>9) Do you like coming to the Connect Program? Overall Satisfaction</td>
<td></td>
</tr>
<tr>
<td>10) Did you like the way you were treated by the Connect staff? Respect</td>
<td></td>
</tr>
</tbody>
</table>

### Questions about the Tuesday & Thursday Group sessions

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>11) Did the group help you learn about your feelings? Effectiveness (skill-building)</td>
<td></td>
</tr>
<tr>
<td>12) Did the group help you cope with your anger better? Effectiveness (skill-building)</td>
<td></td>
</tr>
<tr>
<td>13) Did the group help you get better organized for school? Effectiveness (skill-building)</td>
<td></td>
</tr>
<tr>
<td>14) Did the PICC model help you solve your problems better? Effectiveness (skill-building)</td>
<td></td>
</tr>
<tr>
<td>15) Did the “prize box” help you with your goals? Effectiveness (skill-building)</td>
<td></td>
</tr>
<tr>
<td>16) Has practicing the skills you learned in the group helped you at home? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>17) Has practicing the skills you learned in the group helped you at school? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>18) Has practicing the skills you learned in the group helped you with friends? Effectiveness (relationships)</td>
<td></td>
</tr>
<tr>
<td>19) Did you like the Tuesday &amp; Thursday group? Overall Satisfaction</td>
<td></td>
</tr>
</tbody>
</table>

Items are rated using a 4-point scale, where:
- 4 denotes excellent service
- 3 denotes good service
- 2 denotes fair service
- 1 denotes poor service

The questionnaire includes an open-ended question regarding “what youth liked the most about the program” and “what they did not like”.

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**Service Quality Report for Coping Power Program, 2009-10 - August 18, 2010**
## Appendix C: Parent Questionnaire

### Questions about the Connect “Coping Power” Program in general

1. How would you rate the quality of the Connect Program? **Quality**
2. Did you get the kind of service you expected at the Connect Program? **Acceptability**
3. To what extent has the Connect Program met your needs? **Appropriateness**
4. How satisfied are you with the way you have been treated by our Connect staff? **Respect**
5. If a family was in need of similar help, would you recommend the Connect Program? **Quality**
6. Overall, how satisfied are you with the service you have been receiving at Connect? **Overall Satisfaction**
7. Overall, how satisfied are you with the service your child has been receiving at Connect? **Overall Satisfaction**
8a. Do you think that being in Connect has improved your child’s behaviour at home? **Effectiveness (relationships)**
8b. Do you think that being in Connect has improved your child’s behaviour at school? **Effectiveness (relationships)**
8c. Do you think that being in Connect has improved your child’s behaviour in the community? **Effectiveness (relationships)**

### Questions about the Connect “Coping Power” Parent Group sessions

11. How would you rate the quality of the Parent’s Group? **Quality**
12. Overall, how satisfied are you with the Parent’s Group? **Overall Satisfaction**
13. Was the information and materials you received during the Group sessions helpful? **Effectiveness (informative)**
14. Have the skills you learned helped you to deal more effectively with your child’s behaviour? **Effectiveness (skill-building)**
15. How helpful did you find the topic about….. **Effectiveness (topics)**
   
   - academic support in the home
   - stress management
   - Praising positive behaviour
   - Ignoring minor disruptive behaviour
   - Giving good instructions
   - Establishing rules & expectations
   - Discipline & negative consequences
   - Building family cohesion
   - Family problem solving

Items are rated using a 4-point scale, where:
- 4 denotes excellent service
- 3 denotes good service
- 2 denotes fair service
- 1 denotes poor service

The questionnaire includes additional questions:
- **Q9**: “do you think having a break while your child attended Connect’s After School program has been helpful to you?”. Y/N ~ includes an open-ended field if response is “yes” (reflects effectiveness).
- **Q10**: open-ended item re: comments & suggestions for improvement (program in general).
- **Q16**: opened-ended item ~ “what kept parents coming back to the group”.
- **Q17**: open-ended item re: comments & suggestions for improvement (group).
### Appendix D: Case Manager Questionnaire

#### Questions about the Connect “Coping Power” Program in general

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>How would you rate the quality of service your client recently received in the Connect program? <strong>Quality</strong></td>
</tr>
<tr>
<td>2)</td>
<td>Do you feel the Connect program supported your client’s treatment plan in the way you expected? <strong>Acceptability</strong></td>
</tr>
<tr>
<td>3)</td>
<td>Do you feel the Connect program helped your client towards achieving his/her goal(s)? ** Appropriateness**</td>
</tr>
<tr>
<td>4)</td>
<td>Would you recommend the Connect program to another clinician? <strong>Quality</strong></td>
</tr>
<tr>
<td>5)</td>
<td>Have the services your client received helped you to deal more effectively with him/her? <strong>Effectiveness</strong></td>
</tr>
<tr>
<td>6)</td>
<td>How satisfied are you with the communication and feedback you received from the Connect staff? <strong>Respect</strong></td>
</tr>
<tr>
<td>7)</td>
<td>Overall, how satisfied are you with the Connect program? <strong>Overall Satisfaction</strong></td>
</tr>
</tbody>
</table>

Items are rated using a 4-point scale, where:
- 4 denotes excellent service
- 3 denotes good service
- 2 denotes fair service
- 1 denotes poor service

The questionnaire includes an open-ended item for comments and suggestions for improvement.
References


