The
Brief Child and Family Phone Interview (BCFPI-3)

A Computerized Intake and Outcome Assessment Tool

Interviewers Manual

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Preface

This Manual provides an introduction to Version 3 of the Brief Child and Family Phone Interview (BCFPI)'s Parent, Adolescent Self Report and Teacher Scales. Chapter 1 provides an overview of Version 3 of the Brief Child and Family Phone Interview. Version 3 includes broader cultural content in protective recreational items, a French language version of the BCFPI, a new Teacher interview, a consolidated Standard Parent Report, a battery of automated aggregate Excel reports, and an easily generated Access summary database. Version 3.2 includes a standardized Informant Mood and Family Functioning scales. Chapter 2 describes the conduct of the BCFPI and discusses the use of the BCFPI's Other Concerns Checklist that allows interviewers to record a wide range of other issues which emerge during the interview. Version 3 introduces a Selective Mutism screening scale, the first of a planned series screening questions allowing interviewers to explore other presenting concerns in greater detail. Chapter 3 provides a step-by-step introduction to the interpretation of the BCFPI. Chapter 4 discusses the BCFPI's Evidence-Based Service Planning Report, which is introduced in Version 3. Chapter 5 is a new chapter exploring the use of the BCFPI as an outcome measure. The BCFPI includes a new multi form reporting capability, which plots the profiles from several interviews on a single form. This allows interviewers to compare reports from mothers and fathers, parents and teachers, parents and adolescents, or before and after service. Chapter 6 suggests steps organizations need to complete to implement the BCFPI. Chapter 7 suggests how the BCFPI might be used for organizational planning. Chapter 8 discusses the integration of the BCFPI with your current clinical intake and assessment processes. Chapter 9 discusses the development of the BCFPI and presents psychometric data on the reliability and validity of the BCFPI's Parent Report Scale. Data from recently completed BCFPI field trials is now presented. Chapter 10 summarizes psychometric data on the reliability and validity of the BCFPI's Adolescent Self Report. Chapter 11 summarizes the psychometric data from the BCFPI's new Teacher Report.

To ensure that the BCFPI is conducted accurately and consistently, this manual should be used in combination with an approved Brief Child and Family Phone Interview training program.

The manual is updated regularly to provide additional detail, respond to frequently asked questions, document modifications, or describe new features of the BCFPI. The date of this edition can be determined from the title page or the footer for each page. Manual updates, paper versions, answers to frequently asked questions (FAQs), and a forum to discuss implementation and interpretation of the BCFPI, is available at our website, www.bcfpi.com.
Chapter 1: Overview of the BCFPI

What is the Brief Child and Family Phone Interview?

The Brief Child and Family Phone Interview (BCFPI) is an abbreviated (e.g., 30 minute) standardized or structured interview administered by phone to parents, teachers, or adolescents.

The Brief Child and Family Phone Interview:

- Begins with a narrative overview of Basic Concerns
- Asks Mental Health questions regarding common behavioural and emotional problems
- Determines the impact of these problems on Child Functioning
- Estimates the Impact on Family functioning
- Records Other Problems discussed in the interview
- Measures Informant Mood and Family Functioning
- Provides optional questions regarding Risk and Protective Factors including abuse
- Determines the family’s Readiness for different services
- Identifies potential Barriers to service utilization
- Gathers Basic Demographic data with established links to outcome
- Includes a Service Satisfaction Scale
- Generates a battery of Individual and Aggregate Reports
- Generates an Evidence-Based Service Planning Report

When is the BCFPI Administered?

The BCFPI is completed at the point of intake prior to clinical assessment and treatment. The BCFPI may be administered during the first phone contact with a client or scheduled for a time that is convenient for the family.

The BCFPI may also be administered during treatment, at the completion of service, or as a follow-up measure. Comparing BCFPI scores before and after services yields change scores or outcome estimates.

What Organizations ShouldAdminister the BCFPI?

The BCFPI is designed to be administered within children’s mental health centres, hospitals, or related service delivery organizations providing services to children aged 3 to 18. Organizations utilizing the BCFPI should be accredited or accreditable by a relevant body such as Children’s Mental Health Ontario (CMHO) or
the Canadian Council on Health Services Accreditation (CCHSA). These organizations have staff with the professional qualifications, clinical experience, supervision, and administrative support needed to utilize the BCFPI effectively and responsibly.

Who Administers the Interview?

The BCFPI is designed to be administered by a clinical interviewer with formal children’s mental health training. Interviewers should have a degree or certificate in a discipline (e.g. social work, psychology, child and youth worker) providing training in child development, children’s behavioural and emotional problems, clinical interviewing, and service provision. Before using the BCFPI, prospective interviewers must complete an approved BCFPI training program and successfully complete an Interviewer Certification check. Interviewers should review updated versions of the manual, check the project website (www.bcfpi.com), and have access to ongoing supervision and support.

Who is Interviewed?

The BCFPI is typically administered to the parents and teachers of 3 to 18 year olds. An adolescent self-report interview is available for youth aged 12 to 18. Utilizing parents, teachers or adolescents as informants, rather than professional referral sources, ensures:

- That informants know the child and family well
- That informants are aware of issues of particular concern to the family
- The family is ready for and actively involved in the screening process

Why is the Interview Administered over the Phone?

The BCFPI is typically administered over the phone. Phone interviews:

- Record child and family functioning at the first service contact
- Reduce data loss incurred when mailed questionnaires are not returned
- Eliminate reading problems paper questionnaires pose for some clients
- Allow clients speaking different languages to be interviewed more easily
- Capture narrative information missed by paper and pencil tools
- Allow immediate, flexible, exploration of emerging issues
- Facilitate follow-up to measure service outcome

Why is the Interview Standardized?

The BCFPI’s questions were derived from the survey measurement tools developed for the Ontario Child Health Study, a large epidemiological study of children in the Province of Ontario conducted by the Canadian Centre for the Study of Children at Risk (Boyle et al., 1987; Boyle, et al., 1993a, b; Offord, et al., 1987; 1992).
Most research suggests that standardized or structured interviews provide a more reliable source of information than less structured clinical interviews (Hughes, et al., 2000).

A standardized or structured interview:

- Ensures consistency across interviewers and organizations
- Allows the selection of a reliable and valid set of questions
- Ensures that interviews are comprehensive
- Compares scores to children in similar age groups (6-12 & 13-18)
- Compares scores to children of the same sex
- Allows comparisons with general population or clinical data bases

**What is a Computerized Phone Interview?**

The BCFPI operates on Windows compatible desktops or laptop computers. The interview can also be conducted from any computer equipped with BCFPI software and connected to a local area network running the network version of the BCFPI.

The BCFPI supports direct, interactive computer entry:

- Optional sets of questions appear in a Windows Explorer-type menu
- Individual questions and optional responses appear on the screen
- Transitional statements are suggested between sets of questions
- Client responses are entered by a simple key stroke
- Important information emerging during the interview can be recorded in narrative boxes adjacent to each question
- The program saves information to a secure data base

Computerizing the BCFPI allows:

- Immediate online data entry
- Online scoring during the interview
- Online feedback to interviewer regarding problem severity
- Graphical and textual reports of individual cases
- Quick access to detailed aggregate reports describing referrals
- Encrypted reports to be e-mailed to other centres using the BCFPI

**Is a Paper and Pencil Version of the Interview Available?**

The BCFPI’s parent, adolescent and teacher interviews may be administered in person with the interviewer recording responses on a paper version of the BCFPI. Alternately, individual clients (adolescents only) or groups of clients (adolescents) can complete a paper and pencil version of the BCFPI. These adolescent self-reports are typically used with prevention oriented community programs, provided at
schools and similar community settings. At discharge and follow-up, self-reports can be completed by parents, teachers and youth. In all of the preceding situations, responses can be entered and scored using BCFPI software at a later point in time.

Is the BCFPI Available in Other Languages?

Version 3 of the BCFPI includes a French screen version and French paper versions of the parent, adolescent and teacher interviews. A BCFPI cornerstone is the ability to link its results to those of studies conducted by the Canadian Centre for the Study of Children at Risk, particularly the Ontario Child Health Study. Many of the items in the BCFPI were originally translated for those projects. To maintain comparability, those same translations were used, wherever possible. For details on these studies, go to http://www-fhs.mcmaster.ca/cscr/ and follow the ‘Past Research’ link.

Is BCFPI Data Secure?

A secure password is required to access the BCFPI software. The BCFPI database is encrypted.

As an added level of security, we recommend that computers from which the BCFPI is conducted are accessed by secure password available only to those staff authorized to administer the interview or access your centre’s database.

In addition, it is recommended that users activate Microsoft Windows screen saver option with a password reentry. This ensures that, if a user leaves the desk briefly, unauthorized access to the computer will be denied.

All external BCFPI reports should be exported anonymously as aggregate data files with client names and potentially identifying information deleted.

Does the BCFPI Record Presenting Concerns?

The BCFPI begins with a series of open-ended questions to determine client concerns. In the interview software, this information is recorded in the box labeled Comments. The Comments box is printed at the top of most BCFPI reports.

While the content of this section of the interview will vary in different organizations, examples of clinical screening questions might include:

- General presenting concerns
- Factors prompting the referral
- Professionals recommending referral
- Types of services being requested
- Other services which the client may be receiving
What Problems does the BCFPI Explore?

Once client concerns are identified and recorded, interviewers administer the BCFPI’s child behavioural and emotional adjustment questions. In the interview software this section is labeled **Mental Health**. Clusters of questions in this section of the interview address:

- Regulation of Attention, Impulsivity, and Activity Level (RAIA)
- Cooperativeness (CO)
- Conduct (CD)
- Separation from Parents (SP)
- Managing Anxiety (MA)
- Managing Mood (MM)
- Self Harm (SH)

This section of the interview is designed to:

- Explore the client’s concerns in greater detail.
- Identify problems which may not have emerged in Basic Concerns section of the interview
- Provide information which may help:
  - Estimate clinical severity
  - Consider issues requiring follow-up assessments
  - Explore service options
  - Develop an *Interim Service Plan*

Does the BCFPI Explore Child Functioning?

This section of the interview includes 8 normed questions examining the impact of the problems discussed in the Mental Health section on the child’s social relationships with parents, peers and teachers, participation in social activities, and academic functioning.

Does the BCFPI Explore Family Functioning?

The BCFPI includes 7 normed questions that explore the impact of child problems on family activities, relationships, anxiety, and conflict and a 6-item standardized measure of family functioning.

Does the BCFPI Record Other Problems?

Concerns regarding other issues often emerge in the context of the BCFPI interview. The interviewer may record degree of concern, if any, regarding any of the following items. Items should be selected which seem to be of concern to the informant or interviewer.
• **Bullying:** Repeatedly bullies, teases, harasses or excludes other children from social activities
• **Cruelty to Animals:** Cruel to animals, hurts and/or teases animals repeatedly
• **Fire:** Inappropriate involvement with fire, matches, etc.
• **Substance Use:** Recurrent use of alcohol or drugs leading to impaired functioning (e.g., substance-related absences, suspensions, or expulsions from school)

• **Specific Fear:** Unusually strong and persistent fear of something specific (e.g. animals, needles, heights)
• **Social Phobia:** Persistent fear and avoidance of social situations with peers, or social performance demands due to a fear of embarrassment or scrutiny
• **Obsessions:** Recurrent thoughts or impulses cause distress or impair functioning
• **Compulsions:** Repetitive behaviours (e.g. hand washing, ordering, or checking) cause distress or impair functioning
• **Movement Problems:** Recurrent movements (tics) or vocalizations cause stress or impairment
• **Thought Problems:** Delusions, hallucinations, paranoia, disorganized speaking or behaviour resulting in significant impairment
• **School Refusal:** Persistent unwillingness or refusal to regularly attend school due to anxiety or a fear of separation
• **Selective Mutism:** Consistent failure to speak in some situations (e.g. school) but speaks comfortably in other situations (e.g. home)

• **Victimized/Bullied:** Is repeatedly bullied, teased, harassed, or excluded from social activities by others
• **Trauma:** Experienced or witnessed an event(s) that threatened death or serious injury to self or others resulting in intense fear or helplessness. Re-experiences the event, attempts to avoid similar settings and shows increased arousal (sleep difficulties, irritability, etc.)

• **Speech Difficulties:** Significant difficulty speaking or understanding speech
• **Development Problems:** General development significantly below age
• **Learning Problems:** Academic progress significantly below ability. Record examples in ‘comment’ section

• **Sleep Difficulties:** Persistent difficulty falling asleep, staying asleep, awakening from anxiety-provoking nightmares, or prolonged sleep during the day which causes stress or impairment
• **Eating Problems:** Not maintaining weight, significant loss of weight, fear of being overweight, disturbed thinking about body shape or weight
• **Urination Problem:** Urinates in bed or clothing several times per week
• **Bowel Movement Problem:** Bowel movements in inappropriate places (e.g., clothes, floor) several times over a three-month period
• Sexual Problems: Problems with sexual behaviour or identity which cause distress or impairment

Does the BCFPI Explore Risk Factors?

The BCFPI can quantify risk in several ways. First, the BCFPI includes a series of demographic measures that are important risk indicators. These include parental marital status, education, and income. Limited education, poverty, and single parent status are markers of long-term risk. Second, the number of BCFPI mental health subscales that are elevated (t-scores above 70) is a good predictor of longer term mental health problems. Third, the number of elevated (t-scores above 70) child or family functional impairment subscales is an important predictor of longer term impairments in child or family functioning. Fourth, the BCFPI includes a 6-item Informant Mood scale. Finally, the BCFPI includes 4 abuse questions.

How Does the BCFPI Determine Readiness for Service?

Interviewers ask a series of questions to determine whether parents might be interested in resources that give them the knowledge and skills to understand or cope more effectively with their child’s problems. This optional section is useful in identifying interim resources that encourage parents to begin working while waiting for other services. This section includes questions addressing parental interest in:

• Readings
• Videotapes
• Brief workshops
• Parenting courses
• Parent support groups

In field trials, a considerable majority of parents are interested in these types of resources. Research in this area suggests that these types of resources are often of significant benefit.

How Does the BCFPI Identify Barriers to Service Utilization?

This section of the interview determines whether common barriers such as child care, transportation, or work schedules might prevent families from utilizing available services.

What Demographic Information Does the BCFPI Record?

Interviewers gather standard demographic information. In the BCFPI interview software, this section is labeled Basic Demographic questions. Most interviewers address questions regarding parental education, income and family status at the completion of the interview when more rapport has been established. Examples of demographic questions include:
Does the BCFPI Measure Outcomes?

The BCFPI may be administered during the course of a service contract (e.g. midway through treatment), at service termination, or as a service follow-up measure. Comparing pre service and post service scores provides information regarding impact of service on different dimensions of child and family functioning. Comparing pre service with follow-up scores provides information regarding a program’s longer term impact. The use of the BCFPI as an outcome assessment tool is discussed in Chapter 5.

What are the Benefits of the BCFPI at the Individual Case Level?

The BCFPI offers service providers:
- A quick screen for common presenting problems
- An opportunity to gather additional narrative information
- A framework which organizes complex child and family problems
- Clues to issues best followed up in clinical assessments
- Information supporting evidence-based service planning decisions
- Scores which can be compared over time to assess progress
- A standard set of information to follow a client to new centres

What are the Benefits of the BCFPI for Organizations?

The Brief Child and Family Phone Interview:
- Ensures consistency across multiple interviewers and organizations
- Increases efficiencies by reducing redundant interviews
- Provides a centre-wide description of all referrals
- Allows comparisons of who is referred versus who is served
- Reports the proportion of referrals with common problems
- Describes common comorbid difficulties
- Provides more objective estimates of problem severity
- Provides pre-service indicators which can be repeated at service termination to estimate service outcomes
- Permits benchmarking comparisons with other provincial centres
- Allows information from the epidemiological, longitudinal, and treatment
outcome studies using Ontario Child Health Study measures to contribute to an organization’s understanding of its clients

In Addition to Benefits to Individual Organizations, What are some other Benefits of a Standardized Interview for Provinces?

The BCFPI allows regions or provinces to answer a number of important questions:

- Who is utilizing available services?
- Are children most in need accessing services?
- Are expensive services being reserved for those most in need?
- Are services used equitably by all demographic groups?
- Are referral patterns changing?
- How does the outcome of our services compare to benchmarks?
- Who benefits most from existing services?
- What is the outcome of promising or innovative new services?

Will the BCFPI Increase Intake Workloads?

The BCFPI was designed to replace traditional unstructured intake interviews. If used as an alternative to existing intake interviews, the BCFPI should not increase workloads.

There are several ways in which the BCFPI can increase efficiency.

First, the BCFPI can reduce repeat questioning by providing a single standardized set of information.

Second, the BCFPI can reduce extended questioning on a given topic. The BCFPI’s brief subscales provide a quick but reliable estimate of child and family functioning in different domains. This allows clinicians to comfortably discontinue a line of questioning and pursue a broader more comprehensive intake interview.

Third, the BCFPI can reduce the administration and scoring of redundant questionnaires that often proliferate in service providing organizations.

Fourth, the BCFPI’s online data entry and scoring software reduces data entry time incurred using many paper and pencil questionnaires.

Fifth, the BCFPI’s automated Standard Parent Reports reduce the time needed to prepare intake summaries.

Sixth, the BCFPI’s ability to generate aggregate organizational data reduces time devoted to annual reports.
Chapter 2: Conducting the BCFPI

This chapter provides an introduction to the conduct of the Brief Child and Family Phone Interview. A step-by-step description of the interview process is presented.

The reader should refer to instructions in the software manual for more detail on the use of the BCFPI software. Once operation of the software is mastered, it should provide an unintrusive support to an attentive and responsive interview.

The sample interview below outlines key steps in the BCFPI. The dialogue represents one example of the way in which the interview might be conducted. The exact wording of the introduction will vary across individual interviewers and organizations.

Step 1: Start the BCFPI and Enter Client Data

Step 2: Introduce Yourself

*Intake Interviewer:* Good afternoon, this is John Adams of the Child and Family Centre Intake Department. How may I help you?

*Parent:* My name is Janice McDermott. I am calling because I am having serious difficulties with my 8 year old son, Jason.

Step 3: Determine whether Case is Appropriate to Your Centre

If a referral is not consistent with your organization's service mandate, help the family contact a more appropriate service.

Step 4: Ensure the Caller can Complete the Interview

*Intake Interviewer:* To help us understand your concerns, I will ask some questions about your son, Jason. This will take approximately 30 minutes. Is this a convenient time for you?

*Parent:* Yes. I want to get help for Jason as soon as I can.

Step 5: Provide an Overview of the Screening Interview

*Intake Interviewer:* I will begin by asking you to tell me what your concerns are about Jason. Next, to help me understand your concerns, I will ask you questions that we ask about all children who come to our centre. After these
questions, I’ll ask whether we have missed anything important. Then we will talk about the next steps we will be taking.

Parent: That’s fine.

Step 6: Ask What Concerns Prompted this Referral

Click on the Comments section of the software. Begin by asking the parent what concerns prompted this referral. These questions will, of course, vary across different types of organizations. Record the concerns and other relevant information presented by the client in the Comments section of the Interview Software. For example:

Intake Interviewer: In a moment I’ll ask you some detailed questions about your son, Jason. Before we begin, could you give me a brief picture of your concerns regarding Jason?

Parent: Jason is having trouble at school. He has always had a lot of difficulty completing his work. Last year he barely passed second grade. He doesn’t have any friends and gets teased a lot by other children. He was suspended last week for fighting. The school suggested I talk to my Family Physician. I took Jason to see Dr. Smith last week. Dr. Smith said Jason was healthy and suggested that I call the Child and Family Centre.

Step 7: Determine Whether an Immediate Response is Needed

Some phone calls will reveal situations requiring an immediate response (e.g. risk of abuse, self harm, or imminent danger to others). Each organization using the BCFPI should develop a list of presenting concerns requiring an immediate response. A standardized protocol for dealing with these situations should be developed and followed.

Step 8: Inform Client of Next Steps

- If you will be completing the entire BCFPI, skip to step 9.
- If another person will conduct the BCFPI, ask the client to hold while you check whether an Interviewer is available.
- If an interviewer is available, forward the call.

If an interviewer is not available, inform the caller that they will be contacted by the next available Interviewer who will complete a more comprehensive review of their concerns. If possible, schedule the next call at a time that is convenient for the client.

Provide clients with a contact number in the event of an emergency. For example:
**Intake Interviewer:** If a significant problem occurs while you are waiting for us to contact you, call your family physician or go to the emergency room at your local hospital.

**Step 9: Complete the Phone Interview**

- Begin with the BCFPI subscale that most closely matches the concerns identified in Step 6 above which you recorded in the Comments section at the top of the screen. For example, since the parent in the example above was concerned that her son was not completing his work at school, the interviewer might begin with *Regulating Attention, Impulsivity, and Activity Level* questions. Since the parent also noted problems regarding fighting at school, the interview might, alternately, begin with *Cooperativeness* questions. The table below summarizes suggested starting points for common presenting concerns.

<table>
<thead>
<tr>
<th>Presenting Concerns</th>
<th>Suggested Starting Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty listening at school</td>
<td>Regulating Attention, Impulsivity, and Activity</td>
</tr>
<tr>
<td>Does dangerous things, doesn’t think about what might happen</td>
<td>Regulating Attention, Impulsivity and Activity</td>
</tr>
<tr>
<td>Defiant at home and school</td>
<td>Cooperativeness</td>
</tr>
<tr>
<td>Talks back to everybody</td>
<td>Cooperativeness</td>
</tr>
<tr>
<td>Violent Behaviour</td>
<td>Conduct</td>
</tr>
<tr>
<td>Steals things at school</td>
<td>Conduct</td>
</tr>
<tr>
<td>Is afraid to go to school</td>
<td>Separating from Parents</td>
</tr>
<tr>
<td>Worries all the time</td>
<td>Managing Anxiety</td>
</tr>
<tr>
<td>Just stays in his room, not interested in his friends anymore, seems sad</td>
<td>Managing Mood</td>
</tr>
</tbody>
</table>

- A simpler approach, preferred by some BCFPI interviewers, is to begin with the general section of the interview, Internalizing problems or Externalizing problems, which matches client concerns. If the interview begins with Internalizing problems, complete all three Internalizing Problem subscales in sequence (Separation from Parents, Managing Anxiety, and Managing Mood). Make a brief transitional statement, and then complete Externalizing problems in sequence (Regulating Attention, Impulsivity and Activity Level, Cooperativeness and Conduct).

- The questions in the BCFPI are standardized. When posing a question, compose a sentence combining the child’s name with the *exact wording of the question*. For example:
**Intake Interviewer:** Do you find that Jason “Argues a lot with adults?”

- Read the response options to each question. For example:

  **Intake Interviewer:** Do you find that Jason “*Jumps from one activity to another?*”

  **Parent on Phone:** Oh yeah, that’s Jason.

  **Intake Interviewer:** Is that sometimes true or often true?

  **Parent on Phone:** Often true!

- **Complete all questions** in every domain. Missing questions will reduce the reliability of this brief interview. To ensure a minimum level of reliability, the BCFPI software will not calculate scores unless all of the questions in an individual subscale are completed.

- If you begin the interview with an Externalizing subscale such as Regulating Attention or Cooperativeness, complete all externalizing questions before moving to Internalizing questions (Separating from Parents, Managing Anxiety, or Managing Mood). Similarly, if you begin with an Internalizing subscale, complete all Internalizing subscales before moving to Externalizing subscales.

- Give **transitional statements** between each subscale. For example, after asking the 6 questions regarding the Regulation of Attention, Impulsivity and Activity Level, the interviewer might note before proceeding to Cooperativeness questions:

  **Intake Interviewer:** It sounds like you have concerns about problems with concentration and overactivity. Let me ask you some other things that are sometimes a problem for boys/girls this age.

- Record relevant parental comments in the **comment** box below each question. Note that, as the general comment box is printed at the top of all BCFPI reports, information that you want individuals reviewing the BCFPI Standard Report to read should be entered in this section. This contextual narrative often suggests problems that need to be explored in follow-up interviews, factors increasing the severity of the presenting problem (*most of the arguments we have seem to be about school work*) or areas of strength that may support service planning. Narrative comments are highly valued by clinical staff. Examples of narrative details which often emerge in the interview, are important to assessment, formulation, priority setting, and service planning, and might be recorded in the comment box below each question might include:
The Brief Child and Family Phone Interview

- Date of the onset of problems
- Factors associated with the onset of problems
- Settings or activities in which the child functions well
- Strategies which helped solve problems
- Potential loss of school or home placement
- Economic distress (e.g. job loss)
- Social isolation (e.g. no one to talk to about this)
- Caregiver distress or illness
- Ongoing or pending custody and access processes
- Legal proceedings (e.g. child is going to court)
- Substance abuse
- Domestic violence
- Child abuse

- It is helpful to **copy** key information from the comment box below particular questions and **paste** this in the general **comment** section at the top of the screen. Since the general comment box is printed at the top of each BCFPI report, this ensures that critical comments are easily noted by staff. Highlight the item specific comment, Edit | Copy; mouse click at desired location in top COMMENT- box, press Edit | Paste.

**Step 10: Complete Self Harm Questions**

- If high scores are recorded for the 6 Mood Management items, complete the 3 **Self Harm** branching questions regarding suicidal ideation and behaviour. It is recommended that these questions be presented if t-scores are 65 or greater, you have concerns regarding self harm, or your agency elects to present these questions to all clients.

**Step 11: Complete Child Functioning Questions**

- Read the transitional statement leading into the **Child Functioning and Impact on Family** questions. For example:

  **Intake Interviewer:** Now I’ll ask you a few questions about how (name of child)’s is doing at home and school and how the problems we have discussed may effect your family. Does (child’s name) have difficulty with . . .

- Ask the 8 questions regarding the **Child’s Social Participation**, **Quality of the Child’s Relationships**, and **Child’s School Participation and Achievement**.

- Present three response options (none, a little, a lot). For example:

  **Interviewer:** How much has Jason withdrawn or isolated himself as a result of these problems? Would you say none, a little or a lot?
Step 12: Complete Impact on Family Questions

- Read the transitional statement leading into the 7 Family Activities and Family Comfort questions.
- Record each response on a 4 point scale (never, sometimes, often, always). For example:

  Interviewer: How frequently have you quarreled with your spouse regarding Jason’s behaviour? Would you say never, sometimes, often, or always?

Step 13: Complete the Family Functioning Scale

- If you elect to use Family Functioning Scale go to the Risk Factors section of the BCFPI and click on Family Functioning. This subscale is normed on parents (mostly mothers) from the Revised Ontario Child Health Study (Boyle et al., 1993). Higher t-scores are associated with dysfunctional family relationships.
- Begin by reading the introductory statement.
- Informants respond to the 6 items on this scale by answering whether the item by indicating that they strongly disagree, disagree, agree, or strongly agree.

Step 14: Complete the Informant Depression Scale

- If you elect to use Informant Depression scale go to the Risk Factors section of the BCFPI and click on informant depression. This subscale is normed on parents (mostly mothers) from the Revised Ontario Child Health Study (Boyle et al., 1993). Higher t-scores on this measure are associated with more depressive symptoms.
- Begin by reading the introductory section.
- Informants respond to the 6 items on this scale by answering whether the symptom was experienced less that 1 day, 1-2 days, 3-4 days, or 5 to 7 days in the last week. For example:

  Interviewer (after reading the introductory section): “I could not get going”. Would you say that was less than 1 day, 1-2 days, 3-4 days, or 5 to 7 days a week?

Step 15: Enter Other Problems Available for Inquiry, if applicable

During the BCFPI interview, information regarding other problems, which are not captured by standard BCFPI questions, may emerge. The BCFPI includes an Other Concerns checklist for recording these problems. The Other Concerns checklist provides a brief description of each problem area and 3 response options reflecting
the degree of concern to the interviewer or informant: ‘none’, ‘a little’, and ‘a lot’. 

The Other Concerns checklist includes:

- **Bullying**: Repeatedly bullies, teases, harasses or excludes other children from social activities
- **Cruelty to Animals**: Cruel to animals, hurts and/or teases animals repeatedly
- **Fire**: Inappropriate involvement with fire, matches, etc.
- **Substance Use**: Recurrent use of alcohol or drugs leading to impaired functioning (e.g., substance-related absences, suspensions, or expulsions from school)

- **Specific Fear**: Unusually strong and persistent fear of something specific (e.g. animals, needles, heights)
- **Social Phobia**: Persistent fear and avoidance of social situations with peers, or social performance demands due to a fear of embarrassment or scrutiny
- **Obsessions**: Recurrent thoughts or impulses cause distress or impair functioning
- **Compulsions**: Repetitive behaviours (e.g. hand washing, ordering, or checking) cause distress or impair functioning
- **Movement Problems**: Recurrent movements (tics) or vocalizations cause stress or impairment
- **Thought Problems**: Delusions, hallucinations, paranoia, disorganized speaking or behaviour resulting in significant impairment
- **School Refusal**: Persistent unwillingness or refusal to regularly attend school due to anxiety or a fear of separation
- **Selective Mutism**: Consistent failure to speak in some situations (e.g. school) but speaks comfortably in other situations (e.g. home)

- **Victimized/Bullied**: Is repeatedly bullied, teased, harassed, or excluded from social activities by others
- **Trauma**: Experienced or witnessed an event(s) that threatened death or serious injury to self or others resulting in intense fear or helplessness. Re-experiences the event, attempts to avoid similar settings and shows increased arousal (sleep difficulties, irritability, etc.)

- **Speech Difficulties**: Significant difficulty speaking or understanding speech
- **Development Problems**: General development significantly below age
- **Learning Problems**: Academic progress significantly below ability. Record examples in ‘comment’ section

- **Sleep Difficulties**: Persistent difficulty falling asleep, staying asleep, awakening from anxiety-provoking nightmares, or prolonged sleep during the day which causes stress or impairment
- **Eating Problems**: Not maintaining weight, significant loss of weight, fear of being overweight, disturbed thinking about body shape or weight
• **Urination Problem:** Urinates in bed or clothing several times per week
• **Bowel Movement Problem:** Bowel movements in inappropriate places (e.g., clothes, floor) several times over a three-month period
• **Sexual Problems:** Problems with sexual behaviour or identity which cause distress or impairment

The interviewer should pursue these issues in the narrative interview, record details in the comments box below each question, and paste important information into the general comments text box at the top of the screen. Review the Other Problems Checklist at the end of each interview and record any issues that emerged during the interview. These problems will be listed on the BCFPI’s Standard Parent Report and can be included in the BCFPI’s aggregate reports.

This checklist also includes a 6 item Selective Mutism screening scale that allows a brief, standardized exploration of the severity of selective mutism symptoms. This is the first of a series of brief scales that will allow problems on the Other Concerns checklist to be explored in more detail.

**Step 16: Complete Readiness Questions (Optional)**

- Readiness questions determine whether parents are interested in a range of widely available service options (books, video tapes, support groups, and parenting workshops). Since parents may not be fully aware of these resources, this section of the BCFPI may enhance parental readiness by increasing familiarity with opportunities to begin working on solutions immediately. This capitalizes on the momentum present when parents first contact a service provider and provides options for families assigned to waiting lists. A significant majority of clients are interested in these resources. Clinical trials suggest they can have a significant positive impact. The interviewer, therefore, should provide parents with information on how each option they are interested in can be accessed.

- Since all organizations do not have the full range of services outlined in the Readiness section, this is an optional component of the interview.

- If you elect to use this section of the interview, ask the 5 Readiness for Service questions. For example:

  **Interviewer:** Would you be interested in reading about the issues you described?

  **Parent on Phone:** Yes, that would be helpful.

  **Interviewer:** (Record each response as no, maybe, or yes). We have a resource library with books, videotapes, and other materials you can borrow. It is located on the 4th floor of the Child and Family Centre and is open from 9
till 5 every day and on Tuesday evenings until 9:00. Our resource librarian will suggest books, videotapes, or internet sites which you might find helpful. We’ll also provide you with information regarding workshops for parents that might be of interest.

Step 17: Complete Barriers to Service Utilization Questions

Simple logistical barriers such as the location in which services are provided, the time services are available, transportation difficulties, or child care problems prevent many families from using or completing children’s mental health services (Cunningham, Bremner & Boyle, 1995; Cunningham, et al., 2000; Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997; Spoth, Redmond, Hockaday, & Shin, 1996). The Barriers section of the interview is designed to determine whether several common barriers might prevent clients from using services and to help clients find solutions to these barriers.

- Ask each of the Barriers questions. For example:

  **Interviewer:** How much of a problem would it be to get to the centre?

  **Parent on Phone:** It would be difficult because we live in the east end of town and don’t have a car.

  **Interviewer:** Would that stop you from attending?

  **Parent on Phone:** No, I would try and take the bus.

- Record each response as none, a little, a lot but can participate, or too much to participate.

- If difficulties are identified, discuss how these might be resolved in service planning. For example:

  **Parent on Phone:** I have a lot of trouble getting baby sitters for my son.

  **Interviewer:** I will note that you might have difficulties getting child care. Our staff will try to take this into consideration. We do have groups for parents that offer child care.

- If appropriate, suggest ways in which barriers might be overcome.

  **Parent on Phone:** I work during the day.

  **Interviewer:** We have a number of services available in the evening. We also have videotapes and books in our Family Resource Library that you can check out and use at home. Many parents find these helpful.
or

**Parent on Phone**: I live in the east end of town, it would be a long drive.

**Interviewer**: Some of our services are offered at a location that is closer to your home.

**Note**: If your organization does not charge parking costs, simply delete or modify this question. For example:

**Interviewer**: Would you have difficulty finding parking near our centre?

**Step 18: Gather Abuse Data**

In Ontario, questions regarding abuse are a mandatory component of the Ontario Minimum data set. These four items are found in “Risk” section, under “Abuse”. Narrative details regarding abuse should be recorded in the Comments section at the top of the screen. Concerns emerging in this section of the interview must, of course, be reported according to provincial laws and your agency’s guidelines.

**Step 19: Gather Basic Demographic Information**

Most interviewers prefer to ask for demographic information, particularly questions regarding marital status, parental education, and family income, as the last step in the BCFPI. Information regarding family status often emerges during the course of the interview. Questions regarding income, an important marker of risk, utilization, and outcome, seem most comfortably addressed towards the end of the interview when trust and rapport have been established.

At the point in the interview where you decide to administer these questions, click on the **Basic Demographics** section of the interview software and complete all questions. For example:

**Interviewer**: Before we close, I’d like to ask a few basic background questions about Jason and your family. We ask these questions of all families calling our Centre. Are you a single parent or do you live with a spouse or partner?

**Parent on Phone**: I live with my husband, John.

**Step 20: Ask Whether You Have Missed Anything Important**

The Brief Child and Family Phone Interview is not a comprehensive assessment. In most cases, additional clinical assessments will follow. Before closing the interview, however, ask whether we have missed any important information.
Record this information in the **Comments** box at the top of the screen. For example:

**Interviewer:** You’ve given me a very helpful picture of your concerns regarding your son, Jason. There will be opportunities to explore these concerns in more detail. Before we finish today, however, have we missed anything important?

**Step 21: Inform the Client of Next Steps**

Following the completion of the BCFPI, inform the client of the next steps in your organization’s service delivery process. In one Child and Family Centre, for example:

**Interviewer:** I will present the information you have given me at our next intake team meeting on Monday at 12:00. We will review your concerns and identify services you might want to consider. We will contact you Monday afternoon to discuss the results of this meeting and plan our next steps. In the interim, there are several books and a video in our family resource library that may be helpful. There are also several brief workshops for parents that many family’s find helpful. If significant problems occur while you are waiting, please contact your family physician, or the Emergency Psychiatric Service (gives phone number)

**Step 22: Print Standard Parent Report**

Once the interview is completed, generate a Standard Parent Report. Note that Version 3 of the BCFPI introduces a single **Standard Parent Report** consolidating three previous reports. The Standard Parent Report includes:

- Comment section
- A graph, combining Mental Health, Child Functioning, and Family Functioning subscale t-scores based on population norms.
- A list of all questions, answers, and narrative comments recorded by the interviewer.
- T-scores for all scales derived from both population norms and clinic norms.

In addition to ensuring that all BCFPI data is available in a single report, the Standard Parent Report simplifies the report generating process: one rather than three reports needs to be produced and distributed.

Other reports available in the BCFPI’s Version 3 report menu include:

- **Evidence Based Service Planning Report** This report describes psychosocial interventions that have proven effective for different clusters of problems on the BCFPI, lists references to trials evaluating the effectiveness of
each intervention, and provides information on how to access the training and materials needed to conduct the program

- **List/table** A list of all items and responses in the form

- **Single Graph / Clinical norms.** This report includes a graphical presentation of mental health, child functioning, and family functioning scores, a list of all questions, client responses and narrative entries. T-scores in this report are computed using clinical norms comparing a child’s scores to those of other children referred for children’s mental health services.

- **Comparative Graph.** This report plots data from several selected forms on a multi-line graph. It would typically be used to plot change over time (pre service profiles versus post service profiles) or to compare several informants’ views of the same case at a single point in time (parent versus teacher).
Chapter 3: Interpreting the BCFPI

Who Should Interpret the BCFPI?

As an interview tool with standardized scores, the BCFPI is designed to be interpreted by mental health professionals who have a graduate degree. Graduate coursework should have provided a knowledge of child development, an in-depth understanding of childhood behavioural and emotional problems, training in the psychometric principles on which this measure is based, and knowledge of evidence-based service options for the types of problems the BCFPI addresses. Individuals interpreting the BCFPI must be certified as a BCFPI interviewer and have access to supervision, consultation, and support. The Brief Child and Family Phone Interview is best interpreted by a team with expertise in children’s mental health difficulties, psychometric measures, and evidence-based best practices.

Limitations to Interpretation of the BCFPI

It is important that several limitations be considered when interpreting the BCFPI:

- **The BCFPI is not a diagnostic tool**

In labeling the BCFPI's subscales, we have used terms that describe the behaviours and processes measured by the questions composing the subscales. For example, the Managing Anxiety subscale reflects the extent to which the child worries about a variety of situations. High scores reflect more difficulty with the management of anxiety. The individual subscales of the BCFPI do not yield sufficient information to make a diagnosis. The diagnosis of childhood disorders requires more comprehensive information, data from multiple informants, evidence regarding the duration of these problems, an estimate of the functional impact of symptoms, and the exclusion of other potential explanations for the child’s difficulties. In the Province of Ontario, the communication of a diagnosis is a protected act reserved for Registered Psychologists and Physicians.

- **The BCFPI is a descriptive measure**

The BCFPI provides descriptive information that does not reflect assumptions regarding the etiology or cause of the child's problems. High scores on the Regulation of Attention, Impulsivity and Activity level, for example, may reflect disruptions in the child’s life (e.g. change in schools), learning disabilities, anxiety disorders, depressive disorders, medical conditions, or ADHD. Follow-up assessments are necessary to establish a diagnosis, formulate hypotheses regarding the etiology of the child’s problems, and to consider the best available
service options.

- **The BCFPI is not a comprehensive assessment**

The BCFPI’s questions are designed to screen for common referral concerns, estimate their impact on child and family functioning, consider interim service options, and anticipate barriers which might prevent a family from using a potentially helpful services. The BCFPI’s standard questions will not detect all potential referral problems. For example, the BCFPI does not have questions regarding thought disorders, Tourette’s Syndrome, or obsessive compulsive behaviour. These problems are often identified during discussions regarding the client’s general concerns or may emerge in the context of the interview. Many of these problems can be recorded in the BCFPI’s Other Concerns Checklist and noted in the Comments section. A series of branching questions designed to explore lower prevalence concerns is being developed for later versions of the BCFPI.

- **The BCFPI will yield both false positive and false negative results**

Like all standardized measurement tools (and clinical interviews), the BCFPI will yield both false positive and false negative results. Some children with t-scores below 70 on an individual BCFPI subscale may well have difficulties in that area. This is referred to as a false negative result. For example a percentage of children with t-scores below 70 on the BCFPI’s Managing Anxiety subscale may actually have significant difficulties with anxiety.

On the other hand, children with t-scores above 70 on an individual BCFPI subscale may not have difficulties in that area. This is referred to as a false positive result. For example, a child with a t-score of 70 or above on the BCFPI’s Mood Management Scale may not have difficulties with mood. The percentage of children showing false positive and false negative results may vary across ages, subscales, or organizational settings. The BCFPI should not, therefore, be used as a stand-alone screening, triaging, or treatment decision making tool.

- **The BCFPI reflects the perspective of the informant completing the interview**

Fathers, mothers, and teachers observe children in different situations. The activities, rules, and people present in the classroom are different from those in the home. Parents and teachers have different perspectives regarding the types of behaviours that are common at different stages in the child’s development.

Moreover, youth completing the BCFPI’s adolescent self report interview often have a different perspective on their feelings and behaviour. Parents and teachers, for example, may not be aware of issues that are a source of anxiety to youth. The reports of parents, teachers, and youth, therefore, may vary and should often be
considered in follow-up clinical assessments.

- **The BCFPI is normed on 6 to 18 year olds**

The norms for the BCFPI were derived from the epidemiological studies conducted to develop the Revised Ontario Child Health Study Scales (OCHS-R). The sample in the OCHS-R norming study was aged 6 to 18. Currently, therefore, BCFPI software calculates scores for 3 to 5 year olds on the basis of comparison data for population or clinic samples of 6 to 12 year olds.

**If the BCFPI is administered to parents of 3 to 5 year olds, scores need to be interpreted very conservatively and cautiously.** Analysis of the Revised Ontario Child Health Study data for 6 to 12 year olds suggests that, for most of the BCFPI scales, very little variation is accounted for by changes in age. For most scales, changes over the 6 to 12 year old range are not statistically significant. Several scales, however, do evidence very slight developmental shifts. Scores on the regulating attention, impulsivity, and activity level (RAIA), for example, decline very slightly as children get older. This is consistent with longitudinal studies of children with ADHD. This suggests that scores on the BCFPI's RAIA scale may provide a slight over estimate of difficulties with attention, impulse regulation, and activity level among 3 to 5 year olds.

Scores on several Internalizing scales increase slightly with age. Managing Anxiety and Managing Mood scores, for example, increase over the 6 to 12 year range. This suggests that BCFPI scores may slightly underestimate problems with anxiety and mood among 3 to 5 year olds.

**Interpreting T-Scores**

The BCFPI's *Standard Parent Report* (see example, pg. 40) compares an individual child's scores to a random *population sample* of children from the Ontario Child Health Study's revised measurement project (Boyle et al., 1993a). Population norms should be employed when interpreting the BCFPI.

A supplementary *clinic sample* report compares a child's score to a sample referred to children's mental health centres. This supplementary score should only be used after scores based on population norms have been examined.

The BCFPI compares a child's score to those of boys or girls who are either 6 to 12 or 13 to 18 years of age. As noted above, the scores of children aged 3 to 5 are based upon normative data from 6 to 12 year olds and must be interpreted cautiously.

The BCFPI's *Standard Teacher Report* compares a child to a population sample of school aged children. The BCFPI's *Standard Adolescent Self Report* compares scores to a population sample of 12 to 18 year olds. Supplementary Clinic Norms
comparing scores to children referred to mental health centres are available for Teacher Reports and Adolescent Self-Reports.

The results of the BCFPI are summarized as t-scores. T scores are standardized measures based on a distribution with a mean of 50 and a standard deviation of 10. The average score for the population on which the score is based is 50.

A t-score of 50 corresponds to a percentile score of 50. The scores of 50% of the population are lower than a t score of 50. On BCFPI graphical reports, a t-score of 50 is depicted by a bolded horizontal line.

The scores of approximately 84% of the population are lower than a t score of 60.

The scores of approximately 93% of the population are below a t score of 65. On BCFPI graphical reports, a t-score of 65 is depicted by a dashed blue line. A score at or above the 65th but below the 70th percentile is considered a borderline score. When a child’s score reaches a t-score of 65, the title of the subtest in the BCFPI interview map changes from green to blue.

The scores of approximately 98% of the population are lower than a t score of 70. On the BCFPI graphical reports, a t-score of 70 is depicted by a dashed red line. When a child’s score reaches a t-score of 70, the title of the subtest in the BCFPI interview map changes to red.

The BCFPI: Mental Health Subscales

As noted above, the BCFPI’s subscales do not yield diagnoses. The diagnoses of childhood disorders require information from multiple informants, information regarding age of onset, significant impairment, and evidence that the symptoms are not secondary to other disorders.

- **Regulating Attention (RA)** These 3 items describe the child’s ability to sustain attention, complete tasks, and avoid distractions. High scores on this subscale correspond to the types of problems experienced by children with the predominantly inattentive type of ADHD as described by DSM-IV. High scores on this subscale are sometimes associated with anxiety or mood management difficulties.

- **Regulating Impulsivity and Activity Level (RIA).** These 3 items describe the child’s ability to regulate activity level and impulsive responding. High scores on this subscale correspond to the types of problems experienced by children with the predominantly impulsive-hyperactive type of ADHD as described in the DSM-IV.

- **Regulating Attention, Impulsivity and Activity Level (RAIA).** This 6 item subscale is composed of the three Regulating Attention questions and the three
Regulating Impulsivity and Activity Level questions. High t-scores on this scale reflect overactive and impulsive behaviour. The items on this subscale correspond to the types of problems evidenced by children with the combined type of ADHD described in DSM-IV.

- **Cooperativeness (CO).** This 6 item subscale is composed of items reflecting the extent to which the child is engaged in cooperative relationships with others. High t-scores reflect noncompliant, defiant, resentful relationships with adults and peers. These behaviours correspond to Oppositional Defiant Disorder in the DSM-IV.

- **Conduct (CD).** This 6 item subscale reflects serious rule violations and antisocial behaviour. Because the items on this scale occur infrequently in nonclinical normative populations, high t scores will result when a small number of items are endorsed or several items are endorsed at a low level. These questions correspond to the Conduct Disorder Scale in the DSM-IV.

- **Separating from Parents (SP).** This 6 item subscale reflects the extent to which the child is able to separate comfortably from parents. High t-scores reflect difficulties separating from parents and correspond to Separation Anxiety Disorder in the DSM-IV.

- **Managing Anxiety (MA).** This 6 item subscale is composed of items reflecting the extent to which the child worries about past, present, and future events. High t-scores on this subscale reflect difficulties with anxiety and correspond to Anxiety Disorder in the DSM-IV.

- **Managing Mood (MM).** This 6 item subscale is composed of questions reflecting interest or enjoyment of life and general mood. High t-scores on this scale suggest that the child may be losing interest in activities and relationships that have previously been a source of pleasure.

- **Self Harm.** The 3 item Self Harm subscale reflects concerns regarding weight loss, suicidal talk, or suicide attempts. This subscale may be administered when elevated scores on the Managing Mood subscale are reported or routinely to all children. The Self Harm score is based on these 3 Self Harm questions plus the previous 6 Managing Mood questions. This 9 item composite scale corresponds to the DSM-IV’s Major Depressive Episode.

**The BCFPI: Composite Scales**

- **Externalizing Behaviour.** This 18 item scale is composed of the 6 item Regulating Attention, Impulsivity, and Activity Level subscale, the 6 item Cooperativeness subscale, and the 6 item Conduct subscale. An Externalizing score is computed only if all 3 BCFPI Externalizing subscales have been computed.
• **Internalizing Behaviour.** This 18 item scale is composed of the 6 item Separation from Parents subscale, the 6 item Managing Anxiety subscale, and the 6 item Managing Mood subscales. An Internalizing score is computed only if all 3 BCFPI Internalizing subscales have been computed.

• **Total Problems.** This 36 item scale is composed of the 18 item Externalizing Problems Scale and the 18 item Internalizing Problems Scale. A total problem score is computed only if all 6 BCFPI Mental Health Scales have been computed.

**Child Functioning Scales**

The Child Functioning Scales reflect the extent to which the Mental Health problems reviewed above are perceived to adversely affect the child’s social participation, social relationships, and academic performance. High t-scores on the Child Functioning Scale’s subscales reflect more severe functional impairment.

• **Child’s Social Participation.** High t-scores on this 3 item subscale suggest that the child may be withdrawing or spending less time with other children.

• **Quality of the Child’s Social Relationships.** High t-scores on this 3 item subscale reflect poor relationships with parents, teachers, or peers. To determine which area contributed to high scores on this subscale, the response to each item should be examined by reviewing the list of questions printed with the Standard Parent Report.

• **School Participation and Achievement.** This 3 item subscale reflects school attendance and grades. The score for this scale is based on a question regarding attendance, a question regarding grades, and a 3rd question regarding relationships with teachers. High t-scores suggest attendance problems, academic difficulties, and/or poor relationships with teachers. To determine which area contributed to high scores on this subscale, the response to each item should be examined in the listing of questions printed with the Standard Parent Report.

• **Global Child/Youth Functioning.** This 8 item composite scale combines questions from the Social Participation, Quality of Relationships, and School Performance/Achievement Subscales described above. It provides a global estimate of Child Functioning with higher scores reflecting more impairment.

**Impact on Family Functioning Scales**

• **Family Activities.** This 4 item subscale reflects the extent to which the child’s problems are perceived to have influenced the family’s external social networks. These include the extent to which the child’s behaviour influences visits from friends and relatives, the family’s ability to use child care, and the family’s ability
to take the child on shopping trips or visits. High t-scores on this subscale suggest that the child is perceived to limit the family’s relationships with friends and family and/or the family’s mobility in the community.

- **Family Comfort.** This 3 item subscale reflects the perceived impact of the child’s problems on more internal family functioning. High t-scores on this subscale suggest that the child is perceived to be a source of conflict and anxiety within the family.

- **Global Family Situation.** This 7 item composite scale combines items from the Family Activities and Family Comfort scales. High t-scores on this scale reflect greater impairment in family functioning.

**Risk Factors.**

- **Informant Mood.** This 6 item subscale is derived from the Centre for Epidemiologic Studies - Depression (CES-D) 20 item scale. High t-scores reflect symptoms of depression such as depressed mood and activity, attentional problems, sleep difficulties, and loss of appetite.

- **Family Functioning.** This is a 6 item subscale derived from the McMaster Family Assessment Device’s (FAD) 12 item General Functioning scale (Epstein, Baldwin, & Bishop, 1983). High t-scores on this subscale suggest difficulties with problem solving, communication, support, attachment, or general relationships.

- **Child Abuse.** The BCFPI’s 4 child abuse questions focus on physical abuse, sexual abuse, neglect, and exposure to domestic violence. In Ontario, these are mandated questions. Interviewers must consider legal reporting requirements if these questions are endorsed.

**Barriers to Service Utilization**

This Barriers scale determines whether work schedules, transportation difficulties, child care requirements, or language barriers may limit the family’s ability to participate in service. This scale yields a simple unstandardized total score with higher scores reflecting more significant barriers to service utilization. Families with high barriers to service utilization often have difficulty engaging in traditional clinic based services (Kazdin, et al., 1997).

**Readiness**

Readiness for change can be assessed by asking individuals about their interest in specific service options. The BCFPI Readiness scale determines parental interest in a list of potential service options. These include readings, videos, parenting workshops, groups, and support groups. The content of these options may vary.
across different service settings.

Interpreting the Brief Child and Family Phone Interview

A sample first page of a BCFPI Standard Parent Report is printed at the end of this chapter (pg. 40).

Step 1: Consider Limits to the Interview.

It is important to remind yourself of the limits of this brief interview. As noted above, the BCFPI does not constitute a comprehensive assessment, does not yield diagnoses, reflects the perspective of a single informant, and inevitably yields a certain percentage of false positive and false negative results. Parents, for example, may have more difficulty judging the severity of a child’s anxiety or mood disorders and may be unaware of antisocial behaviour such as theft or substance abuse. Other problems, such as Attention Deficit Hyperactivity Disorder, are often most evident in classroom settings. Parental mood may influence child behaviour directly, or effect ratings indirectly by influencing parental perceptions of child problems (Boyle & Pickles, 1997a,b).

Step 2: Review Narrative Description of Presenting Concerns

Print the BCFPI’s Standard Parent Report. Review the problems identified by the informant and accompanying narrative details recorded in the Comments section at the top of the BCFPI’s Standard Parent Report. The Comments section should include important contextual information such as a recent divorce or custody dispute, additional concerns emerging during the interview, specific service requests, etc.

Step 3: Review Background Information and Demographic Data

Review the demographic information summarized in the BCFPI’s Standard Parent Report. Demographic measures often act as general risk or protective factors. Limited education, economic disadvantage, and single parent status, for example, may increase child risk (Offord, Boyle, & Racine, 1990) and reduce the odds of service utilization (Cunningham, et al., 2000; Offord et al., 1987). Higher educational and economic levels, in contrast, may act as protective factors and may be linked to improved service utilization.

Step 4: Review the Composite Scores

Using the Standard Parent Report, review the BCFPI’s composite 18 question Externalizing, 18 question Internalizing, and 36 Item Total Composite Problem t-scores. Composite scores are more reliable measures of child functioning than individual subscales. They often constitute better estimates of overall risk, better measures of service outcome, and better predictors of the longer term course of child problems than individual subscales.
Step 5: Examine Patterns of Composite Scale Scores

Examine the pattern of composite Externalizing and Internalizing child problem t-scores. Epidemiological research consistently yields three clusters of clinical problems: (1) High Externalizing problems and Low Internalizing problems, (2) High Internalizing problems and Low Externalizing problems, (3) a combination of High Externalizing and High Internalizing problems, or Low Externalizing and Low Internalizing. These clusters are important to the estimation of risk, design of service plans, the measurement of outcome, and the prediction of long term outcome.

Step 6: Review Individual Mental Health Subscale Scores

Review individual Mental Health subscale scores (e.g. Cooperativeness, Managing Anxiety, Managing Mood, etc.). T-scores of 70, higher than 98% of the norming population, are generally considered to be a significantly elevated score. A t-score of 65 (greater than 93% of the population) might be considered a borderline score.

Step 7: Examine Patterns of Subscale Scores

Next, examine t-score. Many children present with combinations of the BCFPI’s subscale scores (Offord, et al., 1987). For example, approximately 40 to 50% of children who have difficulty regulating attention, impulsivity and activity level, also have difficulty establishing cooperative relationships with adults and peers (Szatmari, Boyle, & Offord, 1989). Children who have difficulty regulating attention, impulsivity and activity level often evidence problems managing their anxiety or moods (March, et al., 2000). Combinations of problems influence risk, treatment selection, response to treatment (March, et al., 2000), and long term outcome.

Step 8: Review Item by Item Responses

Examine responses to individual BCFPI questions and clusters of questions. What questions contributed to t-scores above 70? Which items accounted for borderline scores. Pay particular attention to high risk questions such as those on the Conduct, Self Harm, and abuse scales.

Step 9: Review Contextual Narrative

Read the contextual narrative comments recorded by the interviewer in the text box below each question. The contextual narrative of the BCFPI may suggest other problems that need to be explored in follow-up interviews, situational influences on child behaviour, precipitating factors, or clues regarding potentially useful interventions.
Step 10. Consider Child Functioning Scores

Review the Global Child Functioning score. This score provides an overall estimate of the impact of the problems discussed in the BCFPI interview on the child’s extracurricular, social, and academic functioning. Higher t-scores reflect higher overall levels of functional impairment. These scores provide an important check on the severity of the problems noted in the BCFPI’s behavioural and emotional subscales.

The levels of impairment associated with different problems vary considerably. For example, high t-scores on the BCFPI Mood Management subscale are typically associated with higher levels of impairment than high scores on the Managing Anxiety subscale. Next, examine individual Social Participation, Social Relationship, and School Participation subscale scores. High t-scores on child functioning subscales may suggest important targets for intervention. A child whose social participation has been limited as a result of difficulties managing mood or anxiety, for example, may benefit from an intervention designed to increase participation in enjoyable extracurricular activities and establish new friendships.

Low t-scores on Child Functioning scores may reflect child strengths. For example, a child whose School Participation and Achievement does not appear to have been affected by difficulties in other areas has assets that can be capitalized upon when planning interventions.

Step 11: Examine Impact on Family Scales

Review the Global Family Situation Score. This score provides an overall estimate of the impact of the problems discussed in the BCFPI interview on family functioning. Higher t-scores reflect higher overall levels of functional impairment and risk. This score is, again, important in understanding contextual factors that may influence service planning and outcome.

Next, examine the Impact on Family subscales: Family Activities and Family Comfort. These subscales describe the extent to which problems may be associated with a breakdown in family networks, conflict between partners, or overall distress regarding the child. These scores provide clues regarding issues that need to be addressed in follow-up assessments, potential targets for intervention, and family strengths. For example, if the child’s behaviour has become a source of conflict between partners, interventions (readings, books, videos, or workshops) designed to improve problem solving and conflict resolution skills may be helpful.

Step 12: Check for Abuse

Examine the 4 BCFPI questions devoted to emotional abuse, physical abuse, sexual abuse, and exposure to domestic violence. Positive responses to these questions require narrative follow-up and may necessitate a report to child protective services.
Step 13: Examine Informant Mood

Examine Informant Mood t-scores. Note that high t-scores on this scale are associated with more depressed mood.

Step 14: Examine Family Functioning

Examine t-score for Family Functioning. Note that the positively worded items on this subscale are reversed when the BCFPI software computes t-scores. High t-scores on this scale are associated with more dysfunctional family relationships.

Step 15: Other Items Available for Inquiry Problems

Review responses to the Other Items Available for Inquiry questions. Determine whether other issues emerging during the interview must be followed up with more detailed clinical assessments. For example, in a proportion of children with difficulties managing anxiety, concerns regarding obsessions or compulsive behavior may be noted. Others report very specific fears or phobias. Some children who have difficulty regulating attention, impulsivity and activity level, may evidence learning problems or in some cases movement problems such as tics or vocalizations.

Step 16: Readiness for Service

Using the Standard Parent Report, examine response to questions on the BCFPI Readiness subscale. The client’s response to these questions will provide suggestions regarding potential interim service recommendations (e.g. books, videos, or parenting workshops) and information regarding service delivery preferences. Most parents are interested in reading about or watching a videotape about their concerns and a considerable majority are interested in skill building groups. A growing body of evidence suggests that these resources have a significant clinical impact (Montgomery, 2002).

Step 17: Barriers to Service Utilization

Using the Standard Parent Report, review client responses to the BCFPI’s Barriers subscale. Determine whether transportation difficulties, the location and time of your services, family work schedules, child care demands, and other logistical factors might prevent or limit utilization of your services. Note that barriers are often higher in cases with other demographic risk factors such as economic disadvantage or limited parental education. Formulating individual service plans or developing organizational service delivery models that reduce barriers will improve the utilization and effectiveness of your services.
Step 18: Consider Service Priorities

The BCFPI does not yield a simple formula for determining service priorities. However, a clinician with the training and experience needed to interpret the BCFPI can utilize BCFPI scores, in combination with available narrative information, to consider service priorities. Several factors should be taken into account when considering service priorities.

- Higher t-scores generally suggest a higher level of risk than lower t-scores.

- With some notable exceptions, children with high t-scores on several BCFPI subscales may be at higher risk than those with a single problem. For example, children with high t-scores on both the Regulation of Attention, Impulsivity, and Activity level and Cooperativeness subscales may be at higher risk than those with either problem alone.

- Children with higher t-scores on the BCFPI’s Child Functioning Scales are at higher risk than those with lower scores. Within these scales, poor social relationships may be a particularly significant predictor of longer term difficulties (Offord et al., 1990; Offord, et al., 1992). Note that some of the BCFPI’s subscales are correlated with higher functional impairment than others. Table 18 in Chapter 9, for example, shows that, in clinic samples, Managing Mood, Cooperativeness, and Regulating Attention, Impulsivity and Activity Level are more closely linked to Child Functioning scores than Separation from Parents or Managing Anxiety.

- Children with higher Global Family Situation scores may be at greater risk than those with lower scores (Offord, et al., 1990; Offord, et al., 1992). Table 19 in Chapter 9 shows that Externalizing problems seem to be associated with higher Global Family Situation scores (more family impairment) than Internalizing problems. Among Internalizing problems, Managing Mood is associated with higher Global Family Situation scores than Separation from Parents or Managing Anxiety.

- Certain demographic factors may be associated with an elevation of childhood risk. For example, economic disadvantage, limited education, or single parent status, appear to be associated with higher risk and poorer outcomes (Offord, Boyle, & Racine, 1990; Offord, et al, 1992) and a lower probability of service utilization (Cunningham, et al.,1995; 2000).

- Other variables may act as protective factors. For example, while economic disadvantage or limited education may constitute risk factors, higher income and education may represent protective factors. Similarly, while poor peer relationships are a significant risk factor, good peer relationships appear to act as a preventive factor (Offord, et al., 1990). Other evidence suggests that participation in sports and extracurricular activities, optional questions on the
Step 19: Plan Follow-up Assessments

Reviewing the BCFPI data for an individual client prior to conducting clinical assessments allows interviewers to plan questions or select assessment tools that pursue concerns identified during the phone interview. This contributes to a cohesive service delivery process and uses valuable clinical time efficiently. For example, narrative comments, individual subscale t-scores, and combinations of scores may suggest problems that should be pursued in more detailed differential diagnostic assessments. The possibility of a depressive disorder, for example, should be considered when parents report high t-scores on the BCFPI’s Managing Mood or Self Harm subscales.

Step 20: Consider Correlated Problems

Given knowledge of the literature on childhood behavioral and emotional problems, the BCFPI may suggest comorbid difficulties that are not addressed in this brief interview but should be considered when planning follow-up assessments. For example, children with high t-scores on the BCFPI’s Regulating Attention, Impulsivity and Activity Level subscale may be at increased risk of obsessive compulsive disorder or Tourette’s syndrome. Interviewers should be alert to the possibility of these correlated difficulties and should record them in the BCFPI’s Other Items Available for Inquiry checklist.

The BCFPI’s individual subtest scores may also suggest correlated family problems that need to be pursued in follow-up assessments. The types of oppositional behaviours measured in the BCFPI’s Cooperativeness subscale, and the antisocial behaviours reflected in the BCFPI’s Conduct subscale, for example, may be associated with ineffective discipline, marital conflict, domestic violence, or parental depression. One question regarding quarreling between partners in the BCFPI’s Family Comfort subscale may provide clues regarding difficulties in this area. The Family Functioning scale provides additional information regarding family functioning. While the BCFPI’s Risk and Protective Factor subsections screen for these difficulties, concerns in these areas should be pursued with more detailed clinical assessments and considered in the development of service plans.

Step 21: Consider Interim Service Plans

In many cases, clients must wait for more comprehensive assessments and services. In the interim, however, the BCFPI Readiness subscale may suggest resources which parents can use while waiting. These might include books on child development, videotapes on child management, community based parenting groups (Cunningham, Bremner, & Boyle, 1995), local parent support groups, or websites. Accumulating evidence suggests that these types of resources can make a meaningful contribution to client change (Andrews, Swank, Foorman, & Fletcher,
Developing interim service plans capitalizes on the readiness for change and momentum that is often present when families initiate service contacts.

**Step 22: Consider Optional Service Plans**

The BCFPI may also suggest different interventions that might be considered when developing more detailed assessment and service plans. Much of the literature on evidenced-based treatments is linked to the effectiveness of interventions for specific groups of children and their families (Kazdin & Weisz, 1998). Many of the most promising evidenced-based interventions are manualized for specific problem clusters included in the BCFPI (Chambless & Hollon, 1998). Clinical trials, for example, suggest that different cognitive-behavioural, family, and pharmacological interventions are helpful for children with attention deficit disorder (MTA Cooperative Group, 1999), conduct disorder, anxiety disorders (Labellarte, et al., 1999; Silverman, et al., 1999), and mood disorders (Kolko, Bren, Baugher, Bridge, & Birmaher, 2000).
Example of Graph appearing at beginning of Standard Parent Reports
Chapter 4: The BCFPI’s Evidence-based Service Planning Report

The BCFPI's Evidence-Based Service Planning Report lists psychosocial interventions that have proven effective at different ages for each mental health subscale on which parent, teacher, or adolescent self reports yield a t-score of 70 or above. The BCFPI's mental health subscales and the associated clinical problems for which evidence-based interventions were compiled are summarized below:

<table>
<thead>
<tr>
<th>BCFPI Mental Health Subscale</th>
<th>Associated Clinical Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating Attention, Activity Level, and Impulsivity</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>Conduct</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>Separation Anxiety Disorder</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>Anxiety Disorder</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>Depressive Disorder</td>
</tr>
</tbody>
</table>

The Evidence-Based Service Planning Report includes the name of the intervention, lists the goals of the intervention, gives a brief description of the intervention, notes the ages for which the intervention has proven effective, provides a reference to the manuals used to conduct the intervention, and cites references to clinical trials evaluating the effectiveness of the intervention.

Selecting Evidence-based Interventions

The interventions included in the BCFPI's Evidence-Based Service Planning Report were selected according to a three stage process. First, the BCFPI Research and Development team searched medline, psychlit, and ERIC data bases to compose a list of psychosocial interventions for each Mental Health problem area. In this version of the BCFPI's Evidence-Based Service Planning Report, pharmacological approaches were not included.

Next, we identified interventions that met American Psychological Association task force criteria as either well established or probably efficacious. Probably

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1 This BCFPI report will be dimmed and unavailable as of December 2001 to agencies whose use of BCFPI is funded under MCSS's 2001-2003 contract with CMHO. It is available to those who are using BCFPI under other auspices. A listing of evidence-based interventions is also available on BCFPI's website at http://www.bcfpi.com/
efficacious interventions must include a treatment manual, outperform a no
treatment control group in randomized trials conducted by at least two independent
research teams, or prove effective in a large series of controlled single case designs.
Well established interventions include a manual and have outperformed an
alternative treatment or placebo control in at least two independently conducted
randomized trials, or a large series of controlled single-case designs.

Each intervention was categorized according to the age of the children for which it
has proven effective.

Next, we assembled an Expert Resource Group to review the list of evidence-based
interventions compiled for each of the BCFPI’s Mental Health subscales. Our expert
resource group included clinicians and researchers with established expertise in
each of the BCFPI’s Mental Health problem areas. The group was asked to
address the following questions. First, does the intervention meet the evidence-
based criteria noted above? Second, was the description of the intervention
accurate? Third, are there other interventions that should be included?

At the recommendation of the review teams, we have listed interventions that
include a manual and are supported by a clinical trial, are closely related to well
established or probably efficacious approaches, and are innovative, cost effective, or
widely used.

Utilizing the Evidence-Based Service Planning Report

- Limits of the BCFPI Evidence-Based Service Planning Report

The limits of the BCFPI’s Evidence-Based Service Planning Report are summarized
with each report. We note that:

```
The following services are listed as examples of the types of manualized,
evidence-based, nonpharmacological interventions that might be considered if
the problems noted in the Brief Child and Family Phone Interview are
confirmed on clinical assessment. This does not represent an individualized
service plan. An individualized service plan must be composed by a clinician
who has completed a comprehensive assessment. Note this is not a
comprehensive listing of evidence-based interventions. There are often
several closely related versions of evidence-based interventions that may
yield similar outcomes. These interventions require training, manuals, and
expertise in each area. They are not successful with all children, may not
result in complete problem resolution, and must often be combined with other
services.
```

- Applications to Individual Children
The BCFPI’s Evidence-based Service Planning Report is intended to be a resource to clinician’s considering optional interventions for different problems. Assuming the concerns listed in the BCFPI’s Standard Parent Report are verified on clinical assessment, clinicians might begin by considering each of the interventions listed in the BCFPI’s Evidence-based Service Planning Report.

The BCFPI often lists a combination of evidence-based interventions for an individual child. For example, both parent training and classroom behaviour management strategies are listed as evidence-based interventions for children who show t-scores above 70 on the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale. In this case, the interventions listed by the BCFPI address problems at home and school. It might be assumed that a comprehensive intervention that deals with problems in different situations would yield better outcomes than those addressing problems in only one setting.

In many cases, children evidence t-scores above 70 on more than one of the BCFPI’s Mental Health subscales. In these cases, the BCFPI will often list a combination of interventions addressing each area of difficulty. For example, if a child with high scores on the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale also had a high score on the Management of Anxiety subscale, the Evidence-Based Service Planning Report would include interventions designed to improve both the Regulation of Attention, Impulsivity, and Activity level (e.g. parent training) and Managing Anxiety (e.g. cognitive behavioural therapy).

- **Organizational Applications: Building Complex Service Models**

Much of the research on effective treatments for childhood problems has focused on the utility of specific interventions for specific childhood problems. For example, how effective is parent training as a treatment for oppositional disorder. The BCFPI’s Evidence-Based Service Planning Report, for example, lists effective interventions for children with attention-deficit hyperactivity disorder, oppositional-defiant disorder, conduct disorder, anxiety and separation anxiety disorder, and depression. A review of the BCFPI’s aggregate reports in most centres, however, reveals that referrals to children’s mental health centres often present with more than one area of difficulty.

The BCFPI’s Evidence-based Service Planning Report lists effective interventions for each Mental Health problem (e.g. Managing Anxiety or Managing Mood) with a t-score of 70 or above. This provides suggestions regarding how interventions which are useful in the treatment of different problems might be combined to address the more complex needs of many referrals.

**Organizational Case Study: Designing Services For Children With Complex Problems**

Ch. 4 Evidence-Based Service Planning Report © BCFPI Inc., Oct 2006
Organizational Case Study: Designing Services for Children with Complex Problems

A Southern Ontario children’s mental health centre noted that Children with high BCFPI Mood Management scores often evidenced difficulties in other areas. For example, 56% of children with high Mood Management scores had t- scores above 70 on the BCFPI’s Cooperativeness subscale. A review of the BCFPI’s evidence-based service Planning Report shows that cognitive-behaviour therapy (CBT) and interpersonal psychotherapy (IPT) have proven to be effective approaches to childhood depression. The oppositional defiant behaviour reflected in the BCFPI’s Cooperativeness subscale, in contrast, is effectively dealt with via parent training programs. This suggests that combining a CBT for depressed children with a parent training program would yield better outcomes for children with mood and oppositional problems than either intervention alone.

Organizational Applications: Building Interim Service Models

A review of the BCFPI’s evidence-based service planning reports, as well as a review of the literature on the course of different childhood disorders can provide information useful in designing interim services. For example, organizations might consider pre-service educational interventions that help parents understand:

- The benefits of being knowledgeable about childhood problems
- The cause, course, and consequences of different childhood problems
- The types of services which have proven effective for given problems
- The different ways in which interventions may be delivered (e.g. individually, in groups, readings, or videotapes)
- Factors which improve the outcome of interventions
- The limits of most available interventions

Organizational Case Study: Building Interim Services
Organizational Case Study: Building Interim Services

An organization which provided services to children with a wide range of developmental, behavioural, and emotional problems noted that waiting lists for services were often long. The organization also reviewed epidemiological data from the Ontario Child Health Study suggesting that many children with significant mental health problems do not receive service. In an effort to make service more readily available, and to allow parents to begin working upon problems more quickly, the organization designed a Community Education Service which provided a range of services which families could utilize while waiting for more traditional clinic-based services. These included a Family Resource Library, large group introductory sessions, and large group parenting workshops. The Family Resource Library provides access to brochures, books, videotapes, and internet sites giving parents and children the information needed to understand different childhood problems and their treatment. At introductory sessions, experts in different areas provide information about the etiology, course, and treatment of different childhood problems (e.g. mood disorders). Brief, large group, 1 to 3 session workshops introduce useful parenting skills such as COPEing with sibling conflict or COPEing with homework. Large group parenting programs provide a more comprehensive skill building opportunity for parents of children at different developmental levels. An updated listing of the Community Education Service’s courses and workshops is available at www.communityed.ca.

- Organizational Applications: Continuing Educational Planning

The BCFPI Evidence-Based Service Planning Report can be useful when organizations are considering continuing professional education programs. An example of an approach to organizational continuing educational planning is summarized below:

Step 1. Organizations might begin the continuing education planning process by generating a complete set of BCFPI aggregate reports describing the children and families seeking service.

Step 2. The continuing education planning team might examine the most prevalent mental health referral problems children at different ages show. This information is available in BCFPI Version 3’s aggregate reports summarizing the proportion of referrals with high scores (equal to or greater than a t-score of 70) on the following Mental Health subscales:

- Regulating attention, impulsivity, and activity level
- Cooperativeness
- Conduct
- Separating from Parents
- Managing Anxiety
- Managing Mood
- Self Harm

Organizational Case Study: Reviewing Referral Patterns

A Southern Ontario children’s mental health’s review of annual BCFPI aggregate reports found that Mood Management problems were the organization’s most frequent referral problem. More than 54% of referrals showed t-scores of 70 or above (higher than 98% of the norming population) on the BCFPI Mood Management subscale. A substantial difference was noted between adolescent boys and girls with 71% of girls versus 53% of boys evidencing Mood Management difficulties.

Step 3. A review of mental health problems should also examine aggregate reports summarizing clusters of other difficulties children with any given mental health problem present and consider the impairments in child and family functioning associated with each disorder.

Organizational Case Study: Reviewing Referral Problems (continued)

A review of associated problems showed that children with elevated mood management scores evidenced difficulties in other areas. For example, 55% of children with mood management difficulties also had significant difficulties with Cooperativeness, 47% had difficulties with the Regulation of Attention, Impulsivity, and Activity level, and 31% had difficulties with Conduct. An additional 40% evidenced difficulties with the management of anxiety and 30% evidenced difficulties separating from parents.

A review of the BCFPI’s functional impact scales found that 65% of children with elevated mood management scores evidenced significant functional impairments (social participation, social relationships, or academic work). An additional 59% evidenced significant impairments in family functioning (social participation or conflict and anxiety).
Step 4. Next, the organization might review the BCFPI's Evidence-based Service Planning reports to identify new services that best match the needs of referrals. It is important to note that, while the interventions listed in the BCFPI’s Evidence-based Service Planning Report represent good examples of potentially useful approaches, this does not constitute an exhaustive review. Other empirically supported interventions might also be considered.

Step 5. Note that the logistical demand and costs organizations incur conducting different evidence-based interventions vary considerably. Many evidence-based interventions, for example, can be conducted successfully in either individual or more cost effective group formats. Since the need for mental health services greatly exceeds available resources, organizations should emphasize interventions that optimize cost-effectiveness.

Step 6. The outcome or effect sizes of evidence-based interventions vary considerably. A careful reading of the articles supporting each intervention should allow a comparative estimate of relative effect sizes of different evidence-based interventions. Selecting those interventions that appear to yield larger effect sizes may maximize the impact of clinical services. A simple estimate of effect size can be computed according to the following formula:

\[
\text{Effect size} = \frac{\text{Pre Treatment Mean} - \text{Post Treatment Mean}}{\text{Average Pre Treatment & Post Treatment Standard Deviation}}
\]

Effect sizes of .2 are typically considered small but possibly significant. Effect sizes of .4 are typically considered moderate. Effect sizes of .8 or above might be considered large.

Step 7. Once a cost effective, logistically manageable intervention with proven effectiveness has been identified, organizations can contact the authors to determine how the training and materials needed to conduct the intervention might be acquired. The BCFPI’s Evidence-Based Service Planning Reports provide contact information for all interventions listed.
Chapter 5: The BCFPI as a Service Outcome Assessment Tool

In this chapter we explore the use of the Brief Child and Family Phone Interview to measure service outcome. We begin with a discussion of the rationale for employing the BCFPI as a service outcome tool. Next, we consider the design of a BCFPI Outcome Measurement Program. Finally, we provide a brief organizational Case Study describing the development of a BCFPI Intake and Outcome Assessment Unit.

Organizational Case Study: The Intake and Outcome Assessment Unit

Organizational Case Study: The Intake and Outcome Assessment Unit

A children’s mental health service provider affiliated with a large children’s hospital decided that standardized outcome assessments should be a component of the organization’s quality improvement programs. The BCFPI was completed at intake by the parents of all 3 to 18 year olds seeking service for behavioural or emotional problems. The organization determined that administering the BCFPI to a random sample of 150 of the approximately 1500 clients completing services annually would provide a reliable estimate of outcomes for all clients. The organization elected to phone clients at the termination of their service to complete the BCFPI’s Mental Health, Child Functioning, and Impact on Family subscales. It was estimated that this abbreviated version of the BCFPI would take approximately 15 minutes.

Organizational Case Study: measuring the Outcome of Parent Training
Organizational Case Study: Measuring the Outcome of Parent Training

An organization providing large group, community based COPE parenting programs decided to use the BCFPI to better understand the children of parents participating and to evaluate the outcome of the COPE program. All parents participating in COPE parenting courses completed a paper and pencil version of the BCFPI (available at BCFPI.com) on session 1 of a 10 session COPE program. On session 10, parents again completed a paper and pencil version of the BCFPI. Parents who were unable to attend the final session were contacted by phone to complete the BCFPI. The data from paper and pencil versions of the BCFPI were then entered into the organization’s computerized BCFPI program.

Why Utilize the BCFPI for Outcome Assessment?

- **Reliability**
  
  A review of the psychometric properties of the BCFPI in Chapter 9 suggests that this measure has the internal consistency, test-retest reliability, and sensitivity to change needed to detect improvements in children and families receiving mental health services.

- **Comprehensiveness**
  
  The BCFPI provides broad coverage of common Externalizing problems, Internalizing problems, and related domains of child and family functioning.

- **Multiple Independent informants**
  
  The BCFPI’s parent, teacher, and adolescent forms allow independent information from multiple informants. The BCFPI, therefore, can provide information regarding the extent to which the outcome of interventions is observed in different settings such as the home and school.

- **Standardized Norms**
  
  As a standardized measure with norms for age and sex, the BCFPI yields t-scores comparing an individual child to both population and clinic samples. At the individual level, standardized measures allow users to determine whether a child’s scores in various mental health and functional domains differ from those of population or clinic samples. As an organizational outcome measure, standardized scores allow users to determine the amount of improvement for all children receiving
service, outcome for selected subgroups (e.g. children with mood management problems), or outcome for children receiving a specific service (e.g. cognitive-behavior therapy for anxiety disorders.

Standardized scores allow the application of commonly accepted criteria to determine the magnitude of the changes occurring during treatment. For example, are the effects of an intervention small (e.g. a .2 standard deviation change), medium (a .4 standard deviation change) or large (e.g. a .8 standard deviation change)? This can be helpful when comparing different approaches to a common problem or comparing the effectiveness of an organization’s services to well established evidence-based interventions.

• **Clinically Meaningful Outcomes**

The BCFPI Standardized t-scores allow organizations to determine whether treatment programs have resulted in clinically significant outcomes. For example, what proportion of the children referred to a given program received elevated BCFPI t-scores before treatment, and what proportion have shifted into the normal range after treatment.

• **Convenience and Cost effectiveness**

The BCFPI provides a convenient approach to outcome measurement. Outcome assessments can be completed in approximately 15 minutes. In contrast to BCFPI intake interviews, which require approximately 30 minutes, outcome assessments do not require demographic information or exploratory narrative interviews.

Version 3 of the BCFPI automatically generates a wide range of individual and organizational outcome reports. For individual children, the BCFPI generates a multiform report plotting two or more profiles. This report allows the comparison of interviews completed before and after service, the comparison of parent and teacher reports, or the comparison of parent and adolescent reports. For more detailed analysis, the BCFPI's software exports data into standard databases, such as Microsoft Excel. An Excel 2000 utility explores data in more detail and information can be easily read by statistical programs such as SPSS.

• **High Completion Rate**

The BCFPI provides a more reliable measure of service outcomes than many alternative approaches. Telephone interviews, such as the BCFPI, provide a higher completion rate than would be expected if outcome measures were mailed to clients with a return envelope. Moreover, phone interviews allow contact with clients who fail to engage in or discontinue services and do not return. The availability of a paper and pencil version of the BCFPI provides added flexibility.

• **Research Links**
The individual questions, mental health subscales, functional impairment measures, and demographic data from the BCFPI's parent, adolescent, and teacher interviews are derived from the measurement tools developed for the Ontario Child Health Studies. There are literally hundreds of epidemiological studies, longitudinal studies, and clinical trials that describe the prevalence, correlates, and longitudinal course of versions of the BCFPI's measures in population and clinic samples. This information can be useful in understanding complex combinations of problems, the role of associated risk factors, or the planning of prevention and intervention programs.

**Organizational Applications: Ensuring Quality of Existing Programs**

- **Within Organizational Benchmarking**

Organizations employing the BCFPI as a standard approach to outcome assessment can compare the effectiveness of different approaches to a common problem. For example:

**Organizational Case Study: Benchmarking Evidence-Based Interventions**

<table>
<thead>
<tr>
<th>Organizational Case Study: Benchmarking Evidence-Based Interventions</th>
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| A Southern Ontario children’s mental health centre identified interventions designed to help children manage anxiety as a goal for organizational development. Two approaches to the management of anxiety disorders in early adolescents listed in the BCFPI’s Evidence-Based Service Planning Report were considered. In an effort to increase the availability of services, the organization selected interventions for children with anxiety disorders that could be conducted effectively in groups. A review of the randomized trials supporting these programs suggested one of the programs listed in yielded a greater reduction in anxiety. As a part of the organization’s annual continuing professional education plans, a full day workshop on cognitive-behavioural interventions by an author of one of the programs was scheduled. The manuals for both programs were acquired. A team of therapists piloted both programs over the next year.

To compare the outcome of the two programs, the piloting team administered a standard measure of childhood anxiety before and after each group was conducted. The team computed effect sizes by subtracting post test scores on a standardized measure from pretest scores. The average change scores of the two approaches were compared.
As noted in published trials, one of the interventions yielded a significantly greater reduction in anxiety scores. This intervention was also judged to offer better integrated child and parenting components. The organization selected this approach as the standard for children with anxiety disorders.

• Between Organization Benchmarking

Because the BCFPI is used by many children’s mental health service providers, it is possible to compare the outcome of services provided by different organization to similar groups of children. Cross organizational benchmarking can contribute to the improvement of service quality by identifying and learning from sites which accomplish significant treatment effect sizes with different problems.

• Benchmarking With a Standard Evidence-Based Intervention

The BCFPI's outcome assessment capabilities can be used to ensure that the services offered by an organization yield outcomes that are comparable to the best available evidence-based interventions. This can be accomplished by administering the BCFPI before and after service, computing change scores for selected BCFPI subscales (e.g. BCFPI Pre Service - BCFPI Post Service), and comparing change scores from local programs to those obtained in clinical trials of programs listed in the BCFPI’s Evidence-Based Service Planning Report. This type of comparison may yield several options:

1. The agency’s program yields change scores or effect sizes that are comparable to evidence-based alternatives and the cost of the two programs are similar. This analysis would provide strong support for the effectiveness of the organization’s program.

2. While the costs of the two programs are comparable, the agency’s program yields change scores that are substantially smaller than an evidence-based alternative. This agency might consider modifying its programs or adopting an evidence-based alternative.

3. If the agency’s outcomes are superior or costs are significantly lower, the agency should share the results with colleagues and consider a more formal evaluation of their program.

Organizational Case Study: Outcome Benchmarking
Organizational Case Study:
Outcome Benchmarking

The effectiveness of a program can be determined by comparing the effect size achieved by a service provider to an established benchmark. The example below compares the performance of services offered by sites using the BCFPI to an established benchmark in the treatment of conduct problems, the Incredible Years parenting program. See the evidence-based service planner for details on this program.

Step 1. This case study begins by selecting a BCFPI measure (parent reported Externalizing Score) that is comparable to measures used in studies of the effectiveness of the Incredible Years program (e.g. the Child Behavior Checklist parent reported Externalizing score).

Step 2. Next, this case study selected referrals that were of comparable severity to those included in trials of the Incredible Years program (e.g. children with Externalizing t-scores of 70 or greater).

Step 3. We calculated change scores or effect sizes by subtracting post program BCFPI Externalizing t-scores from pre program t-scores and dividing by the t-score standard deviation (10). A similar calculation was computed to derive effect sizes for the Incredible Years study.

The figure compares the change scores for BCFPI sites to change in the untreated control groups studied by Webster-Stratton and colleagues and the effect sizes for children participating in the Incredible Years parenting program. The effect sizes for BCFPI sites are large and probably do not differ statistically from those for the benchmark Incredible Years program. Moreover, the effect sizes for the BCFPI sites are significantly greater than
those for untreated controls from the Incredible Years study. This provides strong support for the effectiveness of the services these programs are providing to children with externalizing programs.

- **Benchmarking Evidence-Based Interventions**

If an organization adopts an evidence-based intervention, it is important to ensure that local attempts to implement the program yield outcomes similar to those obtained by the authors. A number of studies, for example, suggest that, if treatment manuals are not followed carefully, the outcomes of interventions may be compromised.

To compare the results of local applications to those obtained by the author, it will be helpful to collect pre and post treatment BCFPI data on a series of cases, calculate change scores or effect sizes, and compare these to those obtained by the authors of the program.
Chapter 6: Implementing the BCFPI

This chapter outlines suggested steps to implementing the BCFPI in your organization. A BCFPI Implementation Planning Form is available in the Appendix.

Step 1: Identify a BCFPI Implementation Project Manager

Identify a member of your organization who will assume responsibility for the successful implementation of the BCFPI.

Step 2: Compose a BCFPI Implementation Team

Identify a team of individuals who will meet regularly to plan, implement, and support the implementation of the BCFPI. This team should include the Project Manager, BCFPI Interviewers (or representative interviewers), professionals with the training needed to interpret the BCFPI, local Information Technology resources, and representative clinical stakeholders who will use BCFPI reports.

Step 3: Schedule Weekly BCFPI Implementation Team Meetings

Our experience with the BCFPI suggests that weekly Implementation Team Meetings allow the advance planning, implementation problem solving, and longer term support you will need to integrate the BCFPI into your organization's clinical processes.

Step 4: Establish a Time Line

Establish a timeline setting projected completion dates for each task in this implementation chapter. Assign responsibility for the completion of each step to a member of the Implementation Team. Review progress on these steps at weekly Implementation Team meetings.

Step 5: Identify Potential BCFPI Interviewers

List the staff who might conduct the BCFPI in your organization. The BCFPI can be administered by dedicated interviewers or by staff who conduct interviews on a rotating basis. Dedicated interviewers simplify training, enhance the consistency of BCFPI interviews, and develop considerable expertise administering the BCFPI. Rotating responsibility for interviews allocates this task more equitably, builds natural links between intake data gathering and clinical services, and increases the likelihood that BCFPI data will be understood and utilized by a broader range of staff. A pool of potential BCFPI interviewers allows organizations to deal with interviewer absences and vacations and provides the flexibility needed to respond to
periodic increases in referral volume.

As noted in Chapter 1, the BCFPI is designed to be administered by clinical interviewers with formal children's mental health training. Interviewers should have a degree or certificate in a discipline (e.g. social work, psychology, child and youth worker) that provides training in child development, children’s behavioura and emotional problems, clinical interviewing, and service provision.

BCFPI Interviewers will require keyboarding skills and a basic understanding of the Microsoft Windows operating environment. If prospective interviewers are unfamiliar with Windows, or lack comfort and skill in the utilization of Windows programs, complete the Microsoft Windows tutorial and practice using the mouse. Games in the Accessories section of Windows (e.g. solitaire) software provide an excellent way of strengthening Windows and mouse skills.

**Step 6: Determine Where the BCFPI will be Conducted**

As the BCFPI can be conducted from any office equipped with a computer and a telephone, interviews can be administered in a dedicated intake office, or in the offices of individual staff members.

**Step 7: Ensure Computers are Available**

Ensure that a Windows compatible computer with a minimum Pentium II with 32 MB of RAM is available.

**Step 8: Install Telephone Head Set**

Administration of the BCFPI is best accomplished with a hands free telephone headset.

**Step 9: Arrange Internet Access**

Internet access will be required to download updated manuals, software updates, and utilize the BCFPI’s online support at BCFPI.com.

**Step 10: Schedule a BCFPI Training Workshop**

Enroll up to 3 of your interviewers in a 1 day BCFPI Interviewer Training Workshop. Register at BCFPI.com, call Brian O’Hara at Children’s Mental Health Ontario (416-921-2109) or contact Peter Pettingill (905-659-0800).

**Step 11: Install BCFPI Software**

When you register for a BCFPI Training Workshop, you will receive a BCFPI Manual and a training version of the BCFPI software. Note that you will not be able to copy
data from your training database into your live database.

**Step 12: Read the BCFPI Manual**

Read the BCFPI manual and practice utilizing the training software.

**Step 13: Complete One Day BCFPI Training Workshop**

This workshop will provide an introduction to the development of the BCFPI, evidence regarding the reliability and validity of the BCFPI, hands on training in the use of the BCFPI software, and an opportunity to practice the conduct and interpretation of the BCFPI.

**Step 14: Practice Administering the BCFPI**

When you return to your organization following the workshop, practice operating the BCFPI software and conducting BCFPI interviews. Ask a colleague to play the role of a parent while you conduct the interview. Practice until the operation of the software is automatic and you are familiar with each stage of the BCFPI interview.

**Step 15: Schedule an Interviewer Certification Phone Call**

Contact the BCFPI Implementation Team at 905-659-0800 to schedule a certification interview. A member of the implementation team will contact you at a convenient time. The Implementation Team certification interviewer will play the role of a parent while you conduct the interview. You will be rated according to the criteria listed in the *Brief Child and Family Phone Interview: Performance Rating Scale* in the Appendix of this manual. The certification interviewer will provide you with feedback regarding your interview and determine whether you are ready to “go live”. If the certification interviewer determines that you would benefit from additional practice, you will be provided with suggestions and asked to repeat the certification interview at a later date. You may participate in the certification interview as many times as is necessary to master the BCFPI.

**Step 16: Finalize Your Implementation Date**

Set a date to go live. Notify key agency partners and stakeholders regarding any changes in your intake process.

**Step 17: Determine How the BCFPI will be Used in Your Organization**

- Determine how the BCFPI will fit into your organization’s clinical and business processes. To *eliminate redundant questions* and ensure efficiency, you should determine whether questions you are currently asking as a part of your intake or clinical data gathering process might be replaced by BCFPI items. This task is addressed in detail in Chapter 8.
• Determine whether you should add some of the BCFPI’s optional questions to the Minimum Ontario data set. For example, some organizations have determined that administration of optional questions regarding family functioning, parental mood, discipline strategies, domestic conflict, and substance abuse represent a cost effective addition to the organization’s front end clinical data gathering process. These measures provide a more comprehensive, in-depth view of the complexity of the problems referred to your center.

• Using the framework discussed in Chapter 7, determine how the BCFPI might contribute to priority setting in your organization.

• Determine how the BCFPI might be used to develop interim service plans. For example, make a list of all available books, videotapes, parenting workshops, websites, and support groups which might be available to your clients. Decide which resources would be most useful for clients with different profiles. Determine how these interim plans will be communicated to your clients.

• Determine how the BCFPI might contribute to your organization’s triaging and service planning decisions.

Organizational Case Study: Triaging and Interim Service Planning

Organizational Case Study: Triaging and Interim Service Planning

A Southwestern Ontario centre providing comprehensive mental health services to children and their families administers the BCFPI to all referrals. Referral information and BCFPI data are reviewed at weekly pathway triaging meetings. Senior clinicians representing the organization’s treatment programs make preliminary decisions as to which of several general clinical pathways might best meet the assessment and intervention needs of each family. For example, a referral might be directed to a mood disorder program, an anxiety disorder program, or a behaviour problem program. At this meeting, clinicians also consider interim service plans. Clients receive a comprehensive list of potentially useful workshops, parenting courses, and support groups in which they can enroll while on the centre’s waiting list. Families also receive information regarding books and videotapes that can be checked out from the centre’s Family Resource Library.

• Determine how the BCFPI might be used to evaluate the outcome of your services. For example, the BCFPI could be administered before and after service to a sample of all clients. Alternately, individual clinicians might administer the BCFPI at points during the service delivery process to selected
clients. An organization might select innovative programs for more careful
evaluation by administering the BCFPI before and after service delivery or
require that each individual program in the organization be evaluated at least
once during a given period of time. The utilization of the BCFPI as an outcome
measure is discussed in chapter 5 of this manual.

Step 18: Go Live!

Some organizations prefer a graduated implementation of the BCFPI. For example,
you might begin by conducting one interview each morning and one each afternoon
in week 1. In week 2, you might conduct 2 interviews each morning and 2 each
afternoon, etc. Others prefer a quicker shift to the BCFPI.

Step 19: Support Implementation

Ensure that a team is available to provide interpretive support, solve problems, and
ensure continuity during vacations, absences, and staff turnovers. For example,
selected members of the implementation committee might meet on a weekly basis
during the first several months of implementation.
Chapter 7: Using the BCFPI for Organizational Planning

Over a period of time, organizations using the BCFPI will gather a very useful database of information regarding their referrals. The BCFPI generates a wide range of aggregate reports (MS Excel) that can inform organizational planning. Data can be exported into SPSS for more detailed analysis.

Establish a BCFPI utilization team

Identify individuals in your organization who might meet regularly (annually, semi annually, or monthly) to review the aggregate BCFPI data for your organization.

Consider the demographics of your referrals

How might knowledge of the demographics of your referrals inform the design of the services you provide? What ages are your referrals? What proportions of your referrals come from different language groups? What proportion of your referrals are single families? Are the demographics of your referrals shifting? Are certain demographic groups less likely to utilize or benefit from your services? What demographic groups are at highest risk or most in need of service?

What barriers to service utilization do your clients report?

Examine the barriers to service utilization identified by your clients. Are work schedules posing problems? Do your clients experience transportation difficulties? What proportion of your clients feel that child care may limit participation? To what extent do the services you provide anticipate and reduce each of these barriers? Do barriers effect demographic subgroups in different ways. For example, does transportation and child care pose a greater barrier to economically disadvantaged single parents?

What types of assessments are required by your clients?

Examine the types of problems identified by the clients referred to your organization: Mood management, management of anxiety, conduct, etc. Does your organization have the expertise to assess the types of problems suggested by the BCFPI? What new resources need to be developed? What partnerships might be established?

What are the best available interventions for your referrals?

The BCFPI's Evidence-based Service Planning Report provides a listing of the interventions that have proven effective in the management of different childhood
problems. Does your organization provide the best available evidence-based treatments for the problems described by your clients? Can this information assist in your organization’s continuing educational program planning? The BCFPI’s Evidence-Based Service Planning Report is discussed in a separate chapter of this manual.

Organizational Case Study: Organizational Service Planning

**Organizational Case Study**
**Organizational Service Planning**

A Southwestern Ontario centre providing comprehensive mental health services to children and their families administers the BCFPI to all referrals. This data is aggregated periodically to examine the types of problems referred for service. A review of this data revealed that 54% of the Centre’s referrals evidenced BCFPI Mood Management t-scores of 70 or greater (above the 98th percentile). This figure rises to 71% among adolescent girls. Functional Impact scores showed that high Mood Management scores are associated with very significant impairment in child and family functioning. To deal effectively with this population, the centre reviewed evidence regarding the best available assessment measures and interventions for children with mood disorders. These findings were incorporated into continuing educational activities and staff recruiting plans. Moreover, given the high prevalence of these referrals, an innovative new series of larger group workshops was developed.

What combinations of problems do your clients describe?

Many children referred to children’s mental health service providers evidence multiple problems. Increasing evidence suggests that interventions that address each problem yield better outcome. For example, the MTA found that children with ADHD and anxiety disorders responded more favourably to a combination of pharmacological and psychosocial interventions (March, et al., 2000). Do your service plans and treatment resources address the needs of clients with multiple problems?

What resources might best meet the needs of clients on your waiting lists?

The severity of the problems experienced by children referred to children’s mental health service providers varies greatly. Many of these families will wait for available services. Review the interim resources that might best meet the needs of the clients referred to your organization. Do clients referred to your organization have access to the best available books and videotapes for the problems they are describing on the BCFPI? Can you determine which of these materials might be available in your local library? Can your organization develop a family resource library allowing convenient access to these materials? Can you develop
introductory sessions and workshops that may address the needs of clients on your waiting list?

**Who fails to utilize your services?**

Entering a service utilization code into the BCFPI database for each referral allows your organization to determine the characteristics of clients who do not utilize available services. What does a careful analysis of the demographic characteristics, barriers, and problems described by clients who do not utilize available services suggest regarding service redesign? Comparing service to this data over time will provide evidence regarding the outcome of your efforts to improve utilization.

**Who is being seen by other service providers in your area?**

If applicable, meet with other service providers in your area. Compare the clients referred to and the services provided by different agencies. What does this information suggest regarding the configuration of service partnerships in your community?
Chapter 8: Integrating the BCFPI With Current Intake Practices

The BCFPI is a required core Intake tool for funded providers of children’s mental health services in Ontario, Canada. (MCSS, MOH-LTC; April 2000 - March 2003). It is expected that the BCFPI will increasingly replace many current Intake tools. It is expected that the BCFPI will involve an enhanced way of using current Intake and clinical resources, rather than a net added Intake and clinical resource cost. The funding Ministries and the BCFPI project team are committed to enhancing the BCFPI, to the fullest extent allowed by project funding, to fill significant gaps which may be identified in the tool’s coverage, while at the same time expecting immediate optimum use of the tool as initially provided.

- The BCFPI is designed to elicit and then report significant strengths and concerns regarding a child’s Behaviour and Emotional adjustment, along with the Child and Family’s Functioning. Standardized t-scores are provided in these domains, describing the relative strength of the child and family’s adjustment or difficulties. (Standardized scores allow accurate, objective, assessment of these areas of strength and difficulty in comparison to population general and clinic child population from Ontario).

- The BCFPI can also provide descriptive information regarding basic parent demographics, protective factors, risk factors, the child and family’s readiness for service, and possible barriers to service utilization. All except the latter (Barriers) are optional items. The interview and system reports can also include unlimited free text narrative, regarding the parent’s concerns and interviewer’s impressions. All of these items, taken together, should be very helpful in developing a service plan with a client. (The BCFPI is a very efficient method for attaining a standardized and broad picture of the child and family’s situation, complimented by additional structured and free text information addressing particular agency needs.)

- The structured BCFPI interviews can efficiently cover a consistent and broad set of domains, and should be a major aide to assist agencies to obtain the data they need to plan services for cases and manage their programs. (Covering the same breadth as the BCFPI with a less structured or narrative approach is likely to take more time and/or be less comprehensive than the BCFPI).

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*See example reports, at end of chapter*
• Case data and the agency's BCFPI data is stored in the BCFPI data base immediately upon collection, and can be easily retrieved by the agency for future analysis. *(as opposed to being in hard copy case record only).*

**Implementing the BCFPI as a core element of the Intake process**

1. Review attached list (table following) of BCFPI items, and identify those that the agency wishes to implement immediately...
   - You can 'shrink or expand' this list at any time, based on your experience to that time.
   - Some 'Required' items must be collected by all agencies (in Ontario). These items, with identifying data removed, will be used by CMHO and / or funding Ministries (MCSS & MOH / LTC) for planning purposes. These items are marked 'RS' *(Required data, Standardized)* or 'RD' *(Required data, Descriptive)* in the attached list. In general, these are the Mental Health, Functioning, Risk \ Abuse and 'Barriers to Service' items.

2. Identify items selected in #1 above, which are gathered in same or similar form with agency's current Intake process, and shift process to use the BCFPI to gather these items.

3. Identify critical items currently gathered by agency's Intake, not available from BCFPI, and highlight these as needing to be continued outside of BCFPI.

4. 'Re-design' agency intake process to smoothly integrate 1, 2 and 3, above into a single coherent Intake process.

5. Review results of #4 with in-house stakeholders quarterly, and revise accordingly.

6. Review #3 with BCFPI planning and users groups, regarding whether these should be implemented broadly, dropped by agency, or kept as unique feature of agency's system.

Note: the attached list of BCFPI Parent items includes 4 columns for categorizing the items for your implementation planning purposes.

- The first column codes the type of data provided by the BCFPI.
- The first character of this code is 'R' or 'O'.
  - 'R' is used for items Required by the funder.
  - Optional items, expected to be deemed routinely useful by many but not all agencies are marked 'O'.
- The second character in the code is 'S' or 'D'.
  - This indicates whether the item provides a Standardized or Descriptive score.
- Columns 2 - 4 are blank. You can use column #2 to record if an equivalent item
is collected in your current Intake, #3 to record if you plan to henceforth collect the item in BCFPI, and #4 for items not in the BCFPI that you plan to gather in your Intake, outside of BCFPI. If helpful for your planning process, you can write these latter items in at the end of the table in the attached item summary.

This integration guide is available from CMHO, (416-921-2109) as an e-file if needed.

<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type&lt;sup&gt;3&lt;/sup&gt;</th>
<th>In current Intake&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Do in BCFPI&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Do in new Intake&lt;sup&gt;6&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Basic Concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free text narrative, fully formatted, any length, completed at beginning,</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>throughout or at end of interview. Can be supplemented by comments attached to specific items.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2 Basic demographics</td>
<td></td>
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</tr>
<tr>
<td>1. Are you a single parent, or do you live with a spouse or partner?</td>
<td>RD</td>
<td></td>
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<tr>
<td>2. What language is most often used in your home?</td>
<td>RD</td>
<td></td>
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<tr>
<td>3. What is the highest level of education you've completed?</td>
<td>RD</td>
<td></td>
<td></td>
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<tr>
<td>4. What is the highest level of education your spouse or partner has completed?</td>
<td>RD</td>
<td></td>
<td></td>
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<tr>
<td>5. Could you tell me which of following describes your total family income over the past year?</td>
<td>RD</td>
<td></td>
<td></td>
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<tr>
<td>3 Behaviour and Emotional Adjustment</td>
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<tr>
<td>A. Regulation of Attention, Impulsivity, &amp; Activity</td>
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<tr>
<td>1. Distractible, has trouble sticking to an activity.</td>
<td>RS</td>
<td></td>
<td></td>
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<tr>
<td>2. Fails to finish things he starts</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Has difficulty following directions or instructions</td>
<td>RS</td>
<td></td>
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<tr>
<td>4. Impulsive, acts without stopping to think</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Jumps from one activity to another</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Fidgets</td>
<td>RS</td>
<td></td>
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<tr>
<td>B. Cooperativeness</td>
<td></td>
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</tr>
<tr>
<td>1. Cranky</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Defiant, talks back to adults</td>
<td>RS</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<sup>3</sup> RS = Required item which provides standardized score.
<sup>4</sup> RD = Required item, descriptive data, standardized scores under development, where feasible.

**Note that clients can refuse to answer any or all items. 'Required' means that clinicians should make attempts to obtain all required data, while respecting expressed client sensitivities and privacy needs.**

OD = optional item, descriptive data, standardized scores under development, where feasible.

<sup>4</sup> Check 4 if this item is collected in your pre-BCFPI intake system.
<sup>5</sup> Check 4 if you plan to collect this data henceforth in BCFPI, once implemented.
<sup>6</sup> Check 4 if you plan to collect this data outside of BCFPI system.
<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type¹</th>
<th>Do in current Intake?²</th>
<th>Do in BCFPI?³</th>
<th>Do in new Intake?⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Blames others for own mistakes</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Easily annoyed by others</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Argues a lot with adults</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Angry and resentful</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D. Conduct**
1. Steals things at home           | RS    |
2. Destroys things belonging to others | RS    |
3. Engages in vandalism            | RS    |
4. Has broken into a house, building or car | RS    |
5. Physically attacks people       | RS    |
6. Uses weapons when fighting      | RS    |

**E. Separation from Parents**
1. Worries bad things will happen to loved ones | RS |
2. Worries about being separated from loved ones | RS |
3. Scared to sleep without parents nearby | RS |
4. Overly upset when leaving loved ones | RS |
5. Overly upset while away from loved ones | RS |
6. Complains of feeling sick before separating | RS |

**F. Managing Anxiety**
1. Worries about doing better at things | RS |
2. Worries about past behaviour | RS |
3. Worries about doing the wrong thing | RS |
4. Worries about things in the future | RS |
5. Is afraid of making mistakes | RS |
6. Is overly anxious to please people | RS |

**G. Managing mood**
1. No interest in usual activities | RS |
2. Gets no pleasure from usual activities | RS |
3. Has trouble enjoying self | RS |
4. Not as happy as other children | RS |
5. Feels hopeless | RS |
6. Unhappy, sad or depressed | RS |

>>> ASK THE NEXT 3 QUESTIONS IF THERE IS ANY CONCERN RE POSSIBLE DEPRESSION OR SELF-HARM (items 7, 8, 9 required only if concern appropriate)

7. Has lost a lot of weight without trying | RS |
8. Talks about killing himself / herself. | RS |
9. Deliberately harms self or attempts suicide. | RS |

**4 Child Functioning & Impact on Family**

**A. Child’s Social Participation**
1. Withdrawn or isolated him/her self | RS |
2. Doing things less with other kids | RS |
3. Enjoying life less | RS |

**B. Quality of Child’s Relationships**
1. Getting along with his teachers | RS |
<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type&lt;sup&gt;4&lt;/sup&gt;</th>
<th>In current Intake&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Do in BCFPI&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Do in new Intake&lt;sup&gt;6&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Getting along with you and your partner.</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Being irritable or fighting with friends</td>
<td>RS</td>
<td></td>
<td></td>
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<tr>
<td><strong>C. Child’s School Participation &amp; Achievement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Getting along with his / her teachers</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Missing school</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. With his / her grades going down</td>
<td>RS</td>
<td></td>
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<tr>
<td><strong>D. Family Activities</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>1. How frequently has xx's behaviour prevented you from taking him / her out shopping or visiting?</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How frequently has xx's behaviour made you decide not to leave him / her with a babysitter?</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. How frequently has xx's behaviour prevented you from having friends, relatives or neighbours to your home?</td>
<td>RS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How frequently has xx's behaviour prevented his / her brothers or sisters from having friends, relatives or neighbours to your home?</td>
<td>RS</td>
<td></td>
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<tr>
<td><strong>E. Family Comfort</strong></td>
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</tr>
<tr>
<td>1. How frequently have you quarreled with your spouse regarding xx's behaviour?</td>
<td>RS</td>
<td></td>
<td></td>
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<tr>
<td>2. How frequently has xx's behaviour caused you to be anxious or worried about his / her chances for doing well in the future?</td>
<td>RS</td>
<td></td>
<td></td>
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<tr>
<td>3. How frequently have neighbours, relatives or friends expressed concerns about xx's behaviour?</td>
<td>RS</td>
<td></td>
<td></td>
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<tr>
<td><strong>5 Other Items available for inquiry, if applicable</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bullying</td>
<td>OD</td>
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<td></td>
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<tr>
<td>Cruelty to Animals</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fire</td>
<td>OD</td>
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<tr>
<td>Substance Use</td>
<td>OD</td>
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<tr>
<td>Specific Fear</td>
<td>OD</td>
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<tr>
<td>Social Phobia</td>
<td>OD</td>
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<tr>
<td>Obsessions</td>
<td>OD</td>
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<tr>
<td>Compulsions</td>
<td>OD</td>
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<tr>
<td>Movement Problems</td>
<td>OD</td>
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<tr>
<td>Thought Problems</td>
<td>OD</td>
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<tr>
<td>School Refusal</td>
<td>OD</td>
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<tr>
<td>Selective Mutism</td>
<td>OD</td>
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<tr>
<td>Victimized/Bullied</td>
<td>OD</td>
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<tr>
<td>Trauma</td>
<td>OD</td>
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<tr>
<td>Speech Difficulties</td>
<td>OD</td>
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<tr>
<td>Development Problems</td>
<td>OD</td>
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<tr>
<td>Learning Problems</td>
<td>OD</td>
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<tr>
<td>Sleep Difficulties</td>
<td>OD</td>
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</tr>
<tr>
<td>Eating Problems</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urination Problem</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**BCFPI Item**

<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type</th>
<th>In current Intake?</th>
<th>Do in BCFPI?</th>
<th>Do in new Intake?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Movement Problem</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Problems</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**6 Developmental Status**

These items are not part of current Ontario project.

**7 Risk Factors**

A. **Health- Parent (& Partner)**

1. Are you (your partner) limited, in carrying out normal activities, at home, at a job, or in school, because of a medical condition or health problem? OD

B. **Mood – Informant**

1. I did not feel like eating; my appetite was poor. OD
2. I had trouble keeping my mind on what I was doing. OD
3. I felt depressed. OD
4. My sleep was restless. OD
5. I felt sad. OD
6. I could not get going. OD

**Mood- Partner**

1. During the past week, how often have you (your partner):...felt sad ? OD
2. During the past week, how often have you (your partner):......had crying spells? OD
3. During the past week, how often have you (your partner):......been unable to 'get going'? OD

C. **Alcohol-Parent (& partner)**

1. Your drinking is a source of tension or disagreement in your home. OD

D. **Family Functioning**

1. In times of crisis we can turn to each other for support. OD
2. Individuals(in the family) are accepted for what they are. OD
3. We express feelings to each other. OD
4. We are able to make decisions about how to solve problems. OD
5. We DON'T get along well together. OD
6. We confide in each other. OD

E. **Couple relationship**

1. Overall, how would you rate the relationship between you and your spouse or partner? OD

F. **Discipline style (how often do you…)**

1. Reason with xx or explain to xx? OD
2. Send xx to his/her room? OD
3. Take away xx's privileges OD
4. Spank xx with your hand? OD
5. Spank xx with a belt, brush, or something else? OD

G. **Abuse**
### BCFPI Item

<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type</th>
<th>In current Intake</th>
<th>Do in BCFPI</th>
<th>Do in new Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To your knowledge, has xx ever been physically abused?</td>
<td>RD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. To your knowledge, has xx ever been sexually abused?</td>
<td>RD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. To your knowledge, has xx ever been neglected to that extent that seemed to impair his/her emotional or physical well-being</td>
<td>RD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. To your knowledge, has xx ever witnessed verbal or physical violence amongst the adults who have been involved in parenting him/her?</td>
<td>RD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 8 Protective Factors

#### A. Supervised activities

1. Outside of regular physical education classes, did ___ take part in any sports during the past year that involved adult coaching or instruction? (If yes, record number and details in comments for this question).  
   - OD

2. Outside of regular classes in school, did ___ take any lessons or instruction during the past year in music, dance, or other non-sport activities? (If yes, record number and details in comments for this question).  
   - OD

3. During the past year, did ___ belong to any clubs or groups with adult leadership, such as cubs, scouts, brownies, a church group or community programs? (If yes, record number and details in comments for this question).  
   - OD

#### B. Skills

1. Does your child have any good academic, arts, social, sports, or technical skills or talents? (If answer is 'yes', record which one(s) in comments section of this question.)  
   - OD

#### C. Family Recreation

1. How often have all or most of the family participated together in any recreational activities, such as walks, games, fishing, etc., in the past 6 months?  
   - OD

#### D. Spiritual

1. How often does ___ attend religious services or cultural ceremonies?  
   - OD

#### E. Child confidant

1. Does xx have anyone in particular he/she talks to or confides in? (If answer is 'yes', record relationship of confidant to child and impact of sharing on child’s coping in comment section for this question.)  
   - OD
### F. Parent confidant

1. Do you have anyone in particular that you can talk to or confide in about yourself or issues you are concerned about? (If answer is 'yes', record relationship of confidant to parent and impact of sharing on parent's coping in this comment section.)

### 9 Readiness, Barriers & Conclusion

#### A. Readiness

1. Would you be interested in reading about the problems you described?  
2. Would you be interested in watching a videotape about the problems you have described?  
3. If there are a group of parents meeting together to discuss similar problems, would you be interested in attending?  
4. If workshops were available to learn about things you could do as a parent, would you be interested in attending?

#### B. Barriers

Let me ask you about some things that may affect your ability to work with us. We are located at... (describe location client would attend) Do you know where that is?

1. How much of a problem would it be for you to get to the Centre? Would that stop you from attending?  
2. Would parking costs be difficult for you? Would that stop you from attending?  
3. Would it be a problem if services were only during the day? Would that stop you from attending?  
4. Would it be a problem if services were only during the evening? Would that stop you from attending?  
5. How much of a problem would baby sitting be if you were to come to the Centre? Would that stop you from attending?  
6. Would it be difficult for you to read and fill in a questionnaire? Would that stop you from attending?

### Items In Current Intake Not Available In BCFPI

<table>
<thead>
<tr>
<th>BCFPI Item</th>
<th>Type</th>
<th>In current Intake?</th>
<th>Do in BCFPI?</th>
<th>Do in new Intake?</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Parent confidant</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you have anyone in particular that you can talk to or confide in about yourself or issues you are concerned about? (If answer is 'yes', record relationship of confidant to parent and impact of sharing on parent's coping in this comment section.)</td>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ch. 8: Integrating with Current Intake - © BCFPI Inc., Oct 2006
### Examples of BCFPI Reports

The purpose of these examples is to provide Intake planners with information regarding the scope of available BCFPI reports to assist with planning implementation of the BCFPI as a primary agency Intake tool. We hope that much of this planning (and also software installation) will be complete prior to hands-on interviewer training, so that live implementation can then proceed soon after hands-on training is completed.

**NOTE:** BCFPI training, the manual and ongoing support will provide guidance re interpreting reports such as those presented below, and how to apply the results to case planning.
Example 1: Summary graph

- The example below provides standardized scores for the listed Mental Health domains, composite Externalizing and Internalizing scores, as well as the child's Social Participation, Quality of Relationships and School Participation and Achievement, Family Activities, Family Comfort and a composite of Child Functioning and Family Functioning. Computed scores are derived from responses to items. Note that this graph uses 'population norms'. This means that the child's scores are being compared to the average scores of a random sample of Ontario children.

![Standard Parent Report](image)
Example 2: 1 page from a list report of BCFPI questions and client responses
The BCFPI also provides a detailed listing (multi-page) of all questions, answers, item specific comments and standardized scores.

- Note the pairs of computed scores also included in this format. The 1st uses population norms, and the 2nd uses clinic norms. The latter compares the child to other children attending Ontario mental health clinics.

Note that when/if the interviewer records an item specific comment, it appears with the item in this list report. In this example, the interviewer copied and pasted this comment from the item to the general comment section at the top of the form so that the important comment re self-harm would appear with the general narrative that appears on all graphs.
Example 3: Aggregate pre and post Mental Health data for an Index Agency versus 33 CMHO agencies

- This report exemplifies BCFPI's pre-post measurement and data export capacity.
- The 1st bar in each group of 4 is % of Ontario cases with scores >70 for difficulties listed across bottom of graph, at start of service.
- The 2nd bar in each group of 4 is % of a specific agency's cases with scores >70 for difficulties listed across bottom of graph, at start of service.
- In general, the agency's cases have above average rates of difficulties, compared to cases being seen in other agencies.
- The 3rd bar in each group of 4 is % of Ontario cases with scores >70 for difficulties listed across bottom of graph, at end of service.
- The 4th bar in each group of 4 is % of a specific agency's cases with scores >70 for difficulties listed across bottom of graph, at end of service.
- The solid line is the average decrease in rate of each problem for 33 Ontario agencies.
- The dotted line is the average decrease in rate of each problem for a specific agency.
- The graph highlighted a more challenging caseload than average for subject agency, but also less success.
- This information was used by the agency, together with the funder to seek improved resources and outcomes for these cases and this agency, and similar future reports will be used to track progress.
Example 4: Aggregate Family Income data for Index Agency versus 33 CMHO agencies.

- This report exemplifies BCFPI descriptive demographic reporting capacity.
- In this example, it shows that 70% of the families coming to the index agency had incomes of $30K or less, while for all 33 agencies the % with an income of $30K or less was 43%.
- More of this agency's families (70%) seem to have relatively low family incomes (<$30K per year) than the average for CMHOs (43%).
- This may imply an unusual need that the agency and funder need to consider when planning and resourcing the agency's services.
Chapter 9: Evaluating the BCFPI: Parent Interview

Item Selection

The questions employed in the BCFPI were selected from the Revised Survey Diagnostic Instruments developed in the context of the Ontario Child Health Study (Boyle et al., 1993a, 1993b). It was our opinion that the Revised Ontario Child Health Study (OCHS-R) provided the best available measurement tools and normative data for children in the Province of Ontario.

Our goal in developing the BCFPI was to compose a standardized interview tool that could be administered in approximately 30 minutes. To develop a brief interview, we narrowed the broad array of questions available in the Revised Ontario Child Health Study Scales to items that would be most useful for clinical screening, triaging, preliminary service planning, priority setting, and the description of the children seeking services. Next, we developed abbreviated versions of the longer scales used in the OCHS-R by selecting a smaller number of questions which provided the best measurement of each construct.

While rarer problems are of importance clinically, it is difficult to screen reliably for low prevalence disorders. The Ontario Child Health Study focused on the most prevalent clusters of childhood problems. While version 1 and 2 of the BCFPI are restricted to clusters of problems included in the Revised Ontario Child Health Study Scales, future versions will include additional scales which are important to service providers.

In considering potential questions for inclusion, we began with items that measured constructs of interest (e.g., anxiety management). Items that were rarely endorsed or applicable only to restricted age ranges were discarded (Streiner & Norman, 1995). For items describing clusters of child behaviour problems, we selected questions that mapped onto current descriptions of childhood problems as reflected in the DSM-IV. The BCFPI’s final question sets were derived via factor and reliability analyses (Streiner & Norman, 1995).

Factor Analyses

The BCFPI Mental Health subscales described in Chapter 3 were derived via principal components factor analyses with varimax rotations (Tabachnick & Fidell, 1996) on a community sample of 1751 children from the Revised Ontario Child Health Study (OCHS-R) (Boyle, et al., 1993a,b). For the BCFPI child behaviour
questions, factor analysis yielded 7 interpretable factors with eigenvalues greater than 1 in the population sample (Tabachnick & Fidell, 1996).

The BCFPI’s basic factor structure was replicated in a consecutively referred clinic sample of 1896 children from the OCHS-R measurement study. In the clinic sample, 6 interpretable factors with eigenvalues greater than 1 were extracted. Note that, while the population sample yielded two Conduct factors (overt and surreptitious antisocial behaviour), the clinic sample yielded a single Conduct factor. To increase measurement reliability, a single 6 item Conduct factor was included in the BCFPI.

The BCFPI factor structure derived from the OCHS-R population and mental health clinic samples was replicated in a large field trial involving 10,916 6 to 18 year old children referred to 74 children’s mental health service providers in the Province of Ontario.

Table 1 illustrates the age distributions for the population, clinic and BCFPI field trial samples.

<table>
<thead>
<tr>
<th>Age distribution</th>
<th>population</th>
<th></th>
<th>clinic</th>
<th></th>
<th>BCFPI field trial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample n</td>
<td>%</td>
<td>Sample n</td>
<td>%</td>
<td>Sample n</td>
</tr>
<tr>
<td>6-12</td>
<td>1021</td>
<td>59.9</td>
<td>892</td>
<td>57.2</td>
<td>7371</td>
</tr>
<tr>
<td>13-18</td>
<td>684</td>
<td>40.1</td>
<td>668</td>
<td>42.8</td>
<td>3545</td>
</tr>
</tbody>
</table>

Tables 2 through 9 show the factor loadings for BCFPI Mental Health subscales in the OCHS-R measurement study’s population and clinic samples. Factor loadings are listed in descending order for the population sample on which the BCFPI’s subscales were based.

Factor loadings show the strength of the relationship between an individual item and the factor. Factor loadings might be thought of as a correlation between an individual item and the overall factor score. Items with higher factor scores provide a purer estimate of the construct thought to be measured by that factor (Tabachnick & Fidell, 1996). It has been suggested that questions with factor loadings above .71 provide an “excellent” measure of a construct. Those with factor loadings of .63 to .71 are “very good”. Factor loadings from .55 to .62 are “good”. Factor loadings from .45 to .54 are “fair” and those from .32 to .44 are “poor” (Tabachnick & Fidell, 1996). Note that most of the BCFPI’s items show stronger factor loadings in the clinic sample, where items are more frequently endorsed and the range of scores is greater.

In allocating individual questions to the BCFPI’s subscales, we required that: (1) factor loadings exceed .35 (Tabachnick & Fidell, 1996), (2) questions load higher on
that scale than other scales, and (3) that questions be consistent with the structure of problems described in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV). Items with loadings of greater than .35 on more than one scale are noted below.

Regulating Attention, Impulsivity and Activity Level

Table 2 below presents the factor structure of the BCFPI’s Regulating Attention, Impulsivity, and Activity Level subscale. All items show good to excellent factor loadings in both the population and clinic sample. The question “distractible, has trouble sticking to an activity” shows the strongest relationship to the general factor which we have named Regulation of Attention, Impulsivity, and Activity Level.

Note that one question, “Impulsive, acts without stopping to think”, a central construct in current models of attention deficit hyperactivity disorder (Barkley, 1997), also shows a lower but significant loading on the BCFPI’s Cooperativeness scale for population (.369), clinic (.361), and BCFPI field trial samples (.400).

Table 2
BCFPI Parent Report Factor Structure: Regulating Attention, Impulsivity, and Activity Level

<table>
<thead>
<tr>
<th>Regulating Attention, Impulsivity and Activity Level</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>BCFPI Question</td>
<td></td>
</tr>
<tr>
<td>Distractible, has trouble sticking to an activity</td>
<td>.758</td>
</tr>
<tr>
<td>Jumps from one activity to another</td>
<td>.717</td>
</tr>
<tr>
<td>Has difficulty following directions or instructions</td>
<td>.675</td>
</tr>
<tr>
<td>Fidgets</td>
<td>.648</td>
</tr>
<tr>
<td>Fails to finish things he/she starts</td>
<td>.620</td>
</tr>
<tr>
<td>Impulsive, acts without stopping to think</td>
<td>.606</td>
</tr>
</tbody>
</table>

Cooperativeness

Table 3 shows factor loadings for the BCFPI’s Cooperativeness subscale. In the population sample, 4 of 6 questions show a very good to excellent loading while 2 evidence a fair loading. All questions show very good to excellent factor loadings for the clinic and field trial samples.

One question which shows a fair relationship to the Cooperativeness factor in the population sample (“Blames others for own mistakes”) shows a lower but significant cross loading on the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale for the population (.457) but not clinic or BCFPI field trial samples. Note that this item corresponds closely to the diagnostic criteria for Oppositional Defiant Disorder in the DSM-IV.
Table 3
BCFPI Parent Report Factor Structure: Cooperativeness

<table>
<thead>
<tr>
<th>Cooperativeness</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCFPI Question</strong></td>
<td><strong>Population</strong></td>
</tr>
<tr>
<td>Argues a lot with adults</td>
<td>.745</td>
</tr>
<tr>
<td>Defiant, talks back to adults</td>
<td>.734</td>
</tr>
<tr>
<td>Angry and resentful</td>
<td>.625</td>
</tr>
<tr>
<td>Cranky</td>
<td>.615</td>
</tr>
<tr>
<td>Easily annoyed by others</td>
<td>.508</td>
</tr>
<tr>
<td>Blames others for own mistakes</td>
<td>.474</td>
</tr>
</tbody>
</table>

Conduct

Table 4 shows factor loadings for the BCFPI's Conduct subscale. Note that factor loadings are higher in clinic and field trial samples where these items are endorsed more frequently.

Factor analyses in the population sample and BCFPI field trial samples suggest that the Conduct subscale is composed of two factors: overt antisocial behaviour (physically attacks people and uses weapons when fighting) and surreptitious antisocial behaviour (engages in vandalism and broken into a house, building or car). A single Conduct factor emerges in the clinic sample. In the BCFPI field trial, the factor loading on the surreptitious antisocial behaviour scale is .803 for broken into a house, building or car, .541 for steals things at home, and .521 for engages in vandalism. One question in the clinic sample, physically attacks people, shows a cross loading on the BCFPI Cooperativeness subscale, (.465).

Table 4
BCFPI Parent Report Factor Structure: Conduct

<table>
<thead>
<tr>
<th>Conduct</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCFPI Question</strong></td>
<td><strong>Population</strong></td>
</tr>
<tr>
<td>Uses weapons when fighting</td>
<td>.704</td>
</tr>
<tr>
<td>Physically attacks people</td>
<td>.648</td>
</tr>
<tr>
<td>Destroys things belonging to others</td>
<td>.389</td>
</tr>
<tr>
<td>Steals things at home</td>
<td>.364</td>
</tr>
<tr>
<td>Engages in vandalism</td>
<td>.207*</td>
</tr>
<tr>
<td>Broken into a house building or car</td>
<td>.084*</td>
</tr>
</tbody>
</table>

* These questions represent a second factor, surreptitious behavior.

The Table below shows the factor structure of the BCFPI Conduct subscale in
BCFPI field trials. This analysis yields two factors: Overt Antisocial Behaviour and Surreptitious Antisocial Behavior. Overt antisocial behaviour includes destroying things, attacking people, and using weapons. Surreptitious Antisocial Behaviour includes stealing things at home, vandalism, and breaking into houses or cars. The factor structure of this scale corresponds closely to the DSM-IV Conduct Disorder sub clusters, which include Aggression to People and Animals, Destruction of Property, Deceitfulness or Theft, and other Serious Rule Violations such as truancy. Interestingly, Vandalism loads on both factors.

Table 5
BCFPI Parent Report Factor Structure: Conduct-Field Trials

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Overt Antisocial Behaviour</th>
<th>Surreptitious Antisocial Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses weapons when fighting</td>
<td>.788</td>
<td>-.006</td>
</tr>
<tr>
<td>Physically attacks people</td>
<td>.723</td>
<td>-.001</td>
</tr>
<tr>
<td>Destroys things belonging to others</td>
<td>.612</td>
<td>.282</td>
</tr>
<tr>
<td>Broken into a house building or car</td>
<td>-.055</td>
<td>.803</td>
</tr>
<tr>
<td>Steals things at home</td>
<td>.242</td>
<td>.541</td>
</tr>
<tr>
<td>Engages in vandalism</td>
<td>.469</td>
<td>.521</td>
</tr>
</tbody>
</table>

Separation From Parents

Table 6 shows factor loadings for the BCFPI's Separation from Parents subscale. In the population sample, 4 of 6 items evidence very good to excellent factor loadings. Two items evidence fair factor loadings. In the clinic sample, all items evidence good to excellent factor loadings. In the BCFPI field trial, 5 of 6 items show good to excellent loadings.

One item, “worries bad things will happen to loved ones”, shows a lower but significant cross loading on the BCFPI’s Managing Anxiety subscale for the population (.387), clinic (.397), and BCFPI field trial samples (.402).
Table 6
BCFPI Parent Report Factor Structure: Separation from Parents

<table>
<thead>
<tr>
<th>Separation from Parents</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>Overly upset while away from loved ones</td>
<td>.760</td>
</tr>
<tr>
<td>Overly upset when leaving loved ones</td>
<td>.751</td>
</tr>
<tr>
<td>Complains of feeling sick before separating</td>
<td>.669</td>
</tr>
<tr>
<td>Worries about being separated from loved ones</td>
<td>.651</td>
</tr>
<tr>
<td>Worries bad things will happen to loved ones</td>
<td>.493</td>
</tr>
<tr>
<td>Scared to sleep without parents nearby</td>
<td>.457</td>
</tr>
</tbody>
</table>

Managing Anxiety

Table 7 shows factor loadings for the BCFPI’s Managing Anxiety subscale. In the population sample, 4 of 6 items evidence good to excellent factor loadings and 2 showed fair factor loadings. All items evidenced good to excellent factor loadings in the OCHS-R clinic and BCFPI field trial samples. No cross loadings greater than .350 were noted for this scale.

Table 7
BCFPI Parent Report Factor Structure: Managing Anxiety

<table>
<thead>
<tr>
<th>Managing Anxiety</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>Is afraid of making mistakes</td>
<td>.739</td>
</tr>
<tr>
<td>Worries about doing the wrong thing</td>
<td>.735</td>
</tr>
<tr>
<td>Worries about doing better at things</td>
<td>.665</td>
</tr>
<tr>
<td>Worries about things in the future</td>
<td>.545</td>
</tr>
<tr>
<td>Is overly anxious to please people</td>
<td>.532</td>
</tr>
<tr>
<td>Worries about past behaviour</td>
<td>.476</td>
</tr>
</tbody>
</table>

Managing Mood

Table 8 shows factor loadings for the BCFPI’s Managing Mood subscale. In the population sample, where Managing Mood questions were endorsed less frequently, 4 of 6 items show good to excellent factor loadings. In the OCHS-R clinic and BCFPI field trial samples, all items show good to excellent factor loadings.

In the population sample, three items, “Unhappy sad or depressed” (.481), “Not as happy as other children” (.396) and “feels hopeless” (.356), showed significant loadings on the Cooperativeness subscale.

In the clinic sample, only one question, “feels hopeless”, showed a significant cross
loading to the Managing Anxiety subscale (.455). No cross loadings with Cooperativeness greater than .350 were noted in the clinic sample.

In the BCFPI field trials there were no cross loadings greater than .350.

Table 8
BCFPI Parent Report Factor Structure: Managing Mood

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Population</th>
<th>Clinic</th>
<th>BCFPI Field Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>No interest in usual activities</td>
<td>.745</td>
<td>.724</td>
<td>.725</td>
</tr>
<tr>
<td>Gets no pleasure from usual activities</td>
<td>.705</td>
<td>.752</td>
<td>.764</td>
</tr>
<tr>
<td>Has trouble enjoying his/her self</td>
<td>.632</td>
<td>.692</td>
<td>.739</td>
</tr>
<tr>
<td>Not as happy as other children</td>
<td>.568</td>
<td>.656</td>
<td>.696</td>
</tr>
<tr>
<td>Feels hopeless</td>
<td>.405</td>
<td>.570</td>
<td>.621</td>
</tr>
<tr>
<td>Unhappy, sad, or depressed</td>
<td>.343</td>
<td>.623</td>
<td>.681</td>
</tr>
</tbody>
</table>

The Table below shows the factor structure of the BCFPI’s composite Managing Mood and Self Harm subscale. This analysis yields three factors: Depressed Mood, Suicidal Ideation, and Weight Loss. The item content and factor structure of this scale corresponds to five of the DSM-IV’s nine Major Depressive Episode sub clusters: Depressed Mood, Diminished Interest, Recurrent Thoughts of Death, and Weight Loss. Two questions, feels hopeless, and unhappy, sad, or depressed cross load on the Suicidal Ideation factor.

Table 9
BCFPI Parent Report Factor Structure: Managing Mood – Self Harm-Field Trial

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Depressed Mood</th>
<th>Suicidal Ideation</th>
<th>Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gets no pleasure from usual activities</td>
<td>.788</td>
<td>-.073</td>
<td>.192</td>
</tr>
<tr>
<td>No interest in usual activities</td>
<td>.749</td>
<td>-.093</td>
<td>.240</td>
</tr>
<tr>
<td>Has trouble enjoying his/her self</td>
<td>.737</td>
<td>.077</td>
<td>-.047</td>
</tr>
<tr>
<td>Not as happy as other children</td>
<td>.645</td>
<td>.271</td>
<td>-.130</td>
</tr>
<tr>
<td>Unhappy, sad, or depressed</td>
<td>.598</td>
<td>.388</td>
<td>-.080</td>
</tr>
<tr>
<td>Feels hopeless</td>
<td>.527</td>
<td>.418</td>
<td>-.032</td>
</tr>
<tr>
<td>Talks about killing self</td>
<td>.125</td>
<td>.723</td>
<td>.046</td>
</tr>
<tr>
<td>Deliberately harms self or attempts suicide</td>
<td>.052</td>
<td>.722</td>
<td>.187</td>
</tr>
<tr>
<td>Lost a lot of weight without trying</td>
<td>.183</td>
<td>.147</td>
<td>.468</td>
</tr>
</tbody>
</table>
Child Functioning

Table 10 shows the factor structure for the Child Functioning Scale. The population sample yields one factor for all 8 questions. In the OCHS-R clinic and BCFPI field trials (using an eigenvalue of .9) 3 interpretable factors emerged: (1) Child’s Social Participation, (2) Quality of Child’s Relationships, and (3) Child’s School Participation, and Achievement. One question, getting along with teacher, loads on both quality of child’s relationships and school participation and achievement subscales. This item, therefore, is used in computing both subscale t-scores.

Table 10
BCFPI Parent Report Factor Structure:
Child Functioning

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Functioning</strong></td>
<td><strong>Population 1 factor</strong></td>
</tr>
<tr>
<td><strong>Social Participation</strong></td>
<td>*</td>
</tr>
<tr>
<td>Life has become less enjoyable</td>
<td>.772</td>
</tr>
<tr>
<td>Withdrawn or isolated him/her self</td>
<td>.758</td>
</tr>
<tr>
<td>Doing things less with other kids</td>
<td>.724</td>
</tr>
<tr>
<td><strong>Quality of Child’s Relationships</strong></td>
<td>2nd factor</td>
</tr>
<tr>
<td>Being irritable or fighting with friends</td>
<td>.705</td>
</tr>
<tr>
<td>Getting along with his / her teachers</td>
<td>.684</td>
</tr>
<tr>
<td>Getting along with you and your partner.</td>
<td>.651</td>
</tr>
<tr>
<td><strong>Child’s School Participation &amp; Achievement</strong></td>
<td>3rd factor</td>
</tr>
<tr>
<td>Missing school</td>
<td>.736</td>
</tr>
<tr>
<td>With his / her grades going down</td>
<td>.727</td>
</tr>
<tr>
<td>Getting along with his / her teachers</td>
<td>.684</td>
</tr>
</tbody>
</table>

*all 8 items yield one component – solution not rotated

Impact on Family

In the OCHS-R population, OCHS-R clinic & BCFPI field trial samples, using an eigenvalue of .9, two interpretable factors emerged: Family Activities and Family Comfort. Table 11 shows the factor structure for the Family Activities subscale.

In the OCHS-R population sample and the BCFPI field trial, one item, prevented you from taking him/her out shopping, cross loads on Family Comfort, (.511 & .384 respectively).
The Brief Child and Family Phone Interview

Table 11
BCFPI Parent Report Factor Structure:
Impact on Family – Family Activities

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on Family – Family Activities</strong></td>
<td>Population</td>
</tr>
<tr>
<td>behaviour prevented siblings from having friends, relatives or neighbours to your home?</td>
<td>.800</td>
</tr>
<tr>
<td>behaviour prevented you from having friends, relatives or neighbours to your home?</td>
<td>.771</td>
</tr>
<tr>
<td>behaviour made you decide not to leave him / her with a babysitter?</td>
<td>.464</td>
</tr>
<tr>
<td>behaviour prevented you from taking him / her out shopping or visiting?</td>
<td>.443</td>
</tr>
</tbody>
</table>

Table 12 shows the factor structure for the Family Comfort subscale. In the OCHS-R clinic and BCFPI Field Trial samples, the item, *friends, neighbours, relatives expressed concerns about your child’s behaviour*, cross loads on Family Activities (.420 & .433 respectively).

Table 12
BCFPI Parent Report Factor Structure:
Impact on Family – Family Comfort

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on Family – Family Comfort</strong></td>
<td>Population</td>
</tr>
<tr>
<td>behaviour caused you to be anxious or worried about his / her chances for doing well in the future?</td>
<td>.795</td>
</tr>
<tr>
<td>quarreled with your spouse regarding child’s behaviour?</td>
<td>.707</td>
</tr>
<tr>
<td>neighbours, relatives or friends expressed concerns about child’s behaviour?</td>
<td>.678</td>
</tr>
</tbody>
</table>

Informant Mood

The Table below shows the Informant Mood Scale that was introduced in Version 3.2.6 of the BCFPI. The 6 questions included in BCFPI Informant Mood Scale were derived, with permission, from the Centre for Epidemiological Study of Depression Scale (Radloff, 1977). Norms for this scale are from parents, mostly mothers, participating in the Revised Ontario Child Health Study Scales norming study’s population sample (Boyle et al., 1993). On the Informant Mood scale, higher t-scores reflect poorer functioning. The Table below shows OCHS-R population and
clinic sample factor loadings for the 6 items included in this scale. Factor loadings in the OCHS-R population sample range from good to very good. Factor loadings in the clinic sample range from good to excellent.

Table 13
BCFPI Parent Report Factor Structure: Informant Mood

<table>
<thead>
<tr>
<th>Informant Mood</th>
<th>Factor Loading*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>I felt depressed</td>
<td>.781</td>
</tr>
<tr>
<td>I felt sad</td>
<td>.767</td>
</tr>
<tr>
<td>I had trouble keeping my mind on what I was doing</td>
<td>.684</td>
</tr>
<tr>
<td>I could not get going</td>
<td>.678</td>
</tr>
<tr>
<td>My sleep was restless</td>
<td>.669</td>
</tr>
<tr>
<td>I did not feel like eating; my appetite was poor</td>
<td>.614</td>
</tr>
</tbody>
</table>

*1 factor - unrotated

Family Functioning

The Table below shows the BCFPI’s Family Functioning Scale. On this scale, higher t-scores reflect greater family dysfunction. The Family Functioning scale was introduced in Version 3.2.6 of the BCFPI. The 6 questions included in BCFPI Family Functioning Scale were derived, with permission, from the McMaster Model of Family Functioning Family Assessment Device’s General Functioning Subscale (Miller, Epstein, Bishop, & Keitner, 1983). Norms for this scale are from parents, mostly mothers, participating in the Revised Ontario Child Health Study Scales population sample (Boyle et al., 1993). The Table below shows that, in the OCHS-R population sample, factor loadings for 5 of 6 questions ranged from good to excellent. Factor loadings for all questions ranged from good to excellent in the OCHS-R clinic sample.

Table 14
BCFPI Parent Report Factor Structure: Family Functioning

<table>
<thead>
<tr>
<th>Family Functioning (FAD)</th>
<th>Factor Loading*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>We confide in each other</td>
<td>.777</td>
</tr>
<tr>
<td>We express feelings to each other</td>
<td>.752</td>
</tr>
<tr>
<td>We are able to make decisions about how to solve problems</td>
<td>.745</td>
</tr>
<tr>
<td>In times of crisis we can turn to each other for support</td>
<td>.723</td>
</tr>
<tr>
<td>We don’t get along well together. (scoring is reversed)</td>
<td>.678</td>
</tr>
<tr>
<td>Individuals (in the family) are accepted for what they are</td>
<td>.662</td>
</tr>
</tbody>
</table>

*1 factor - not rotated
Reliability Analyses

Table 15 shows internal consistency scores (Cronbach’s alpha) for the BCFPI’s Mental Health subscales. These data are derived from the OCHS-R population, OCHS-R clinic samples, and BCFPI children’s mental health center field trial samples. Cronbach’s alpha represents the average of all possible split half reliabilities (correlating half of the subscale with the other half of the subscale). Cronbach’s alpha scores should generally fall between .70 and .90 (Streiner & Norman, 1995). Scores above .90 suggest that the scale contains redundant questions and may describe a construct too narrowly. Scores below .70 suggest a more heterogeneous set of questions that reflect more than one construct (Streiner & Norman, 1995). Note that, since reliability is proportional to the number of items in a scale, composite Internalizing and Externalizing scales provide a more reliable measure of child functioning than the BCFPI’s brief 6 item subscales (Streiner & Norman, 1995).

With the exception of Conduct problems (.56), which are too infrequent to measure reliably in community samples, Cronbach’s alpha (internal consistency) scores in a community sample ranged from .75 to .83 for Mental Health Subscales. Internal Consistency scores for the BCFPI’s Mental Health subscales in the OCHS-R clinic sample ranged from .73 to .85. In BCFPI field trials, internal consistency scores for 7 of 8 scales ranged from .77 to .86. One scale, Conduct, was at .68.

<table>
<thead>
<tr>
<th>BCFPI Scale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating Attention, Impulsivity, and Activity Level</td>
<td>.83 .84 .82</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.82 .85 .83</td>
</tr>
<tr>
<td>Conduct</td>
<td>.56 .73 .68</td>
</tr>
<tr>
<td>Total Externalizing Problems</td>
<td>.87 .88 .86</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>.75 .81 .78</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.77 .82 .77</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.78 .85 .84</td>
</tr>
<tr>
<td>Managing Mood + Self Harm (9 items)</td>
<td>.76 .83 .80</td>
</tr>
<tr>
<td>Total Internalizing Problems</td>
<td>.86 .88 .85</td>
</tr>
</tbody>
</table>

Table 16 shows internal consistency scores for the BCFPI’s Child and Global Family Situation scales. Cronbach’s alpha (internal consistency) scores in community samples were .86 and .69. Internal Consistency scores for Child and Global Family Situation subscales in the Revised Ontario Child Health Study clinic sample were .74
and .78. In BCFPI field trials, scores for Child and Global Family Situation subscales ranged from .75 to .77.

Table 16 also shows internal consistency scores for the Informant Mood and Family Functioning scales introduced in Version 3.2.6 of the BCFPI. For Informant Mood the internal consistency scores are .79 for the population sample and .81 for the clinic sample. For the Family Functioning scale the reliability scores are .83 for the population sample and .94 for the clinic sample. Field trial analyses of the Informant Mood and Family Functioning scales are in progress.

| Table 16 |
|------------------|------------------|------------------|------------------|
| BCFPI Parent Report Reliability Analysis: |
| Internal Consistency Scores |
| Functioning and Informant Mood Scales |
| **Cronbach’s Alpha** | **Population** | **Clinic** | **BCFPI Field Trial** |
| BCFPI Subscale | | | |
| Child Functional Impact | .86 | .74 | .75 |
| Impact on Global Family Situation | .69 | .78 | .77 |
| Informant Mood (CES-D) | .79 | .83 | -- |
| Family Functioning (FAD) | .81 | .84 | -- |

Content Validity

The Content Validity (Streiner & Norman, 1995) of the BCFPI’s child behaviour questions was ensured by selecting items that map onto the descriptions of common clinical problems in the Diagnostic and Statistical Manual of the American Psychiatric Association version IV (DSM-IV). For example, the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale contains 3 items that are consistent with the DSM-IV’s predominantly inattentive type of ADHD and 3 items describing the DSM-IV’s predominantly hyperactive-impulsive type of ADHD.

Concurrent Validity

The BCFPI employs abbreviated 6 item versions of the Revised Ontario Child Health Study (OCHS-R) Survey Diagnostic Instrument’s much longer scales. For example, the OCHS-R scale for Attention Deficit Hyperactivity Disorder is composed of 14 questions. Table 17 shows that the BCFPI’s brief subscales correlate highly with the extended scales from the Ontario Child Health Study’s (OCHS-R) survey diagnostic instrument.

Note that the correlation between the BCFPI’s 6-item Managing Anxiety subscale and the OCHS-R’s longer Overanxious Disorder scale is somewhat lower than other scales. This may reflect the fact that the OCHS-R scale included a series of questions regarding somatic concerns. In current diagnostic models (e.g. the
DSM-IV) somatic concerns are not included in the description of generalized anxiety disorders. Somatic concerns in the DSM-IV are included as symptoms of a separate disorder, Somatization Disorder. Somatic complaints were not, therefore, included in the BCFPI’s Managing Anxiety Scale.

Table 17
Concurrent Validity of the BCFPI Parent Report:
Correlations with Ontario Child Health Study Scales

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Clinic</td>
</tr>
<tr>
<td>Regulating Attention, Impulsivity, and Activity Level</td>
<td>.91</td>
<td>.91</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.95</td>
<td>.95</td>
</tr>
<tr>
<td>Conduct</td>
<td>.81</td>
<td>.89</td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.96</td>
<td>.96</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>.95</td>
<td>.96</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.83</td>
<td>.84</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.75</td>
<td>.78</td>
</tr>
<tr>
<td>Managing Mood + Self Harm</td>
<td>.77</td>
<td>.82</td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.92</td>
<td>.92</td>
</tr>
</tbody>
</table>

Construct Validity: Developmental Differences

Child research suggests a series of conceptual predictions that provide a test of the construct validity of the BCFPI (Streiner & Norman, 1995). For example, longitudinal studies suggest that scores on measures of activity level, inattention, and impulsivity decline with age. In both population and clinic samples, total scores on the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale are lower for adolescents than preadolescents.

Longitudinal studies, in contrast, suggest that depression scores increase with age. In both population and clinic samples, total scores on the BCFPI’s Mood Management subscales are significantly higher in adolescents than preadolescents.

Construct Validity: Sex Differences

Previous studies suggest that boys score higher than girls on Externalizing problem scales. Girls, in contrast, score higher than boys on Internalizing scales. As expected, parents rate boys significantly higher than girls on the BCFPI’s Regulation of Attention, Impulsivity, and Activity Level subscale. Girls, in contrast, are rated significantly higher than boys on the BCFPI’s Separation Anxiety and Anxiety scales.

Construct Validity: Child Functional Impact

Correlational analyses showed a predictable relationship between child behaviour
and functional impact scores with Mood Management scores in clinic samples most closely associated with greater impairment in Child Functioning and Cooperativeness (r = .52) most closely linked into Child and Global Family Situation scores. Separation from Parents and Anxiety scores were associated with lower levels of child and family impairment.

Table 18
BCFPI Parent Report Construct Validity: Correlation of BCFPI Subscales with Child Functioning Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating Attention, Impulsivity, and Activity Level</td>
<td>.322</td>
<td>.405</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.349</td>
<td>.518</td>
</tr>
<tr>
<td>Conduct</td>
<td>.306</td>
<td>.363</td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.390</td>
<td>.540</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>.178</td>
<td>.155</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.184</td>
<td>.276</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.352</td>
<td>.613</td>
</tr>
<tr>
<td>Managing Mood + Self Harm</td>
<td>.374</td>
<td>.603</td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.292</td>
<td>.457</td>
</tr>
</tbody>
</table>

Construct Validity: Impact on Family

The BCFPI’s child behaviour subscales are also linked to higher scores on the BCFPI Family Impact scale. In both clinic and population samples, total Externalizing scores are more closely related to impairments in Family Functioning than Internalizing scores. Regulating Attention, Impulsivity and Activity Level, Cooperativeness and Conduct Problems are more closely linked to Family Impairment than Separating from Parents and Managing Anxiety.
Table 19
BCFPI Construct Validity:
Correlation of BCFPI Subscales with Impact on Global Family Situation Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation Population</th>
<th>Correlation Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating Attention, Impulsivity, and Activity level</td>
<td>.509</td>
<td>.477</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.589</td>
<td>.494</td>
</tr>
<tr>
<td>Conduct</td>
<td>.449</td>
<td>.496</td>
</tr>
<tr>
<td>Total Externalizing Problems</td>
<td>.631</td>
<td>.603</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>.237</td>
<td>.147</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.307</td>
<td>.044</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.503</td>
<td>.347</td>
</tr>
<tr>
<td>Managing Mood + Self Harm</td>
<td>.517</td>
<td>.348</td>
</tr>
<tr>
<td>Total Internalizing Problems</td>
<td>.431</td>
<td>.235</td>
</tr>
</tbody>
</table>

Table 20
Brief Child and Family Phone Interview Questions
Versus
OCHS-R Complete Scale Questions
Test-retest Correlations (1-3 Months)
for 6-11 and 12-16 Year Olds
Using Revised Ontario Child Health Study Population Sample

<table>
<thead>
<tr>
<th></th>
<th>Age 6-11 BCFPI</th>
<th>Age 6-11 OCHS-R</th>
<th>Age 12-16 BCFPI</th>
<th>Age 12-16 OCHS-R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation of Attention</td>
<td>.78</td>
<td>.85</td>
<td>.78</td>
<td>.76</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.72</td>
<td>.87</td>
<td>.78</td>
<td>.84</td>
</tr>
<tr>
<td>Conduct</td>
<td>.66</td>
<td>.71</td>
<td>.54</td>
<td>.79</td>
</tr>
<tr>
<td>Separation</td>
<td>.70</td>
<td>.65</td>
<td>.58</td>
<td>.55</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.71</td>
<td>.65</td>
<td>.72</td>
<td>.73</td>
</tr>
<tr>
<td>Mood</td>
<td>.66</td>
<td>.65</td>
<td>.62</td>
<td>.64</td>
</tr>
<tr>
<td>Mean 6 Subscales</td>
<td>.71</td>
<td>.73</td>
<td>.67</td>
<td>.72</td>
</tr>
</tbody>
</table>

Sensitivity to Change

The test-retest analyses discussed above suggest that BCFPI scores are stable and reliable over a period of 1 to 3 months. Measuring service outcomes also requires that the BCFPI is sensitive to change resulting from successful interventions.

The Figure below shows that the BCFPI is sensitive to changes occurring as a result of treatment in children’s mental health centres. The outcome data in the Figures below are based on a sample of children whose parents completed BCFPI telephone interviews before and after service in a variety of children’s mental health settings. The Figure below presents average t-scores before and after treatment. Change
scores are computed by subtracting post service BCFPI scores from pretreatment scores. In Figure 1, we selected children who presented problems with Anxiety Management, which we defined as a BCFPI Managing Anxiety t-score of 70 or greater. Anxiety is a common referral problem, often complicates other disorders, such as ADHD or depression, and places children at risk for significant longer term negative outcomes.

**BCFPI Outcome Measurement Pilot – Managing Anxiety**

The Figure above shows that the BCFPI scores for children with high managing anxiety scores declined from a pre service score of 80.4 to a post serviced score of 69.8. Since t-scores have a mean of 50 and a standard deviation of 10, this is a mean reduction of 10.6 t-score points, or more than 1 standard deviation. It is generally agreed that a change of .2 standard deviations is a small effect size, a change of .4 standard deviations is a medium effect size, and a change of .8 is a large effect size. These data confirm that the BCFPI is sensitive to the large to very large service outcomes effect size improvements accomplished by these centres.

The figure below shows that the BCFPI’s Managing Mood subscale is also sensitive to change. This figure shows children with t-scores greater than or equal to 70 on the BCFPI Managing Mood scale. On average, these children evidenced t-scores of 80.9 before receiving service. After service BCFPI t-scores declined to 65.3, a very large improvement of 15.6 t-score points.
The BCFPI’s Child Functional Impact scores are also sensitive to the interventions provided by children’s mental health services. The figure below shows the impact of
children’s mental health services on children who present with significantly impaired functioning. High scores on the BCFPI Child Functional Impact scales suggest that these children have difficulties in their interpersonal relationships with parents, teachers, and peers, a tendency to disengage from social and recreational activities, and a deterioration in school performance. This sample of 318 children was selected as having child functioning t-scores of 65 or greater. On average the t-pre service t-scores of this sample was 77.5. This declined to 66.4 following service, a change of 11 t-score points. The BCFPI is sensitive to these large improvements in child functioning.

**Measuring Service Outcome: Impact on Child Functioning**

*Sample: 318 Clients with Impact on Child Functioning >65*
Chapter 10: Evaluating the BCFPI: Adolescent Interview

The Brief Child and Family Adolescent Phone Interview:

- Begins with a narrative overview of Basic Concerns
- Asks Mental Health questions regarding common behavioural and emotional problems
- Determines the impact of these problems on Youth Functioning
- Asks questions regarding Abuse
- Collects information regarding Substance Abuse
- Gathers Basic Demographic information

The questions employed in the BCFPI's adolescent self report were selected from the Revised Survey Diagnostic Instruments developed for the Ontario Child Health Study (Boyle et al., 1993a,b). The items included on the BCFPI Adolescent Self Report are virtually identical to those employed in the Parent Report. This allows a direct comparison of perspectives of parents and adolescents on a standardized set of questions.

Tables 1 through 6 show the factor loadings for BCFPI Adolescent Self Report subscales in the OCHS-R measurement study's population and clinic samples. As in Chapter 9, factor loadings are listed in descending order for the population sample on which the BCFPI's subscales were based.

As noted above, factor loadings show the strength of the relationship between an individual item and the factor. Factor loadings might be thought of as a correlation between an individual item and the overall factor score. Items with higher factor scores provide a purer estimate of the construct measured by that factor (Tabachnick & Fidell, 1996).

It has been suggested that questions with factor loadings above .71 provide an “excellent” measure of a construct. Those with factor loadings of .63 to .71 are “very good”. Factor loadings from .55 to .62 are “good”. Factor loadings from .45 to .54 are “fair” and those from .32 to .44 are “poor” (Tabachnick & Fidell, 1996). Note that, like the Parent Report scale, most of the BCFPI's Adolescent Self Report items show stronger factor loadings in the clinic sample, where items are more frequently endorsed and the range of scores is greater.

In allocating individual questions to the BCFPI’s Adolescent Self Report subscales, we required that: (1) factor loadings exceed .35 (Tabachnick & Fidell, 1996), (2)
questions load higher on that scale than other scales, and (3) that questions be consistent with the structure of problems described in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV).

Regulating Attention, Impulsivity, and Activity Level

Table 1
BCFPI Adolescent Self Report Factor Structure: Regulating Attention, Impulsivity, and Activity Level

<table>
<thead>
<tr>
<th>Regulating Attention, Impulsivity and Activity Level BCFPI Question</th>
<th>Factor Loading Population</th>
<th>Factor Loading Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fail to finish things you start</td>
<td>.694</td>
<td>.632</td>
</tr>
<tr>
<td>Easily distracted, have trouble sticking to an activity</td>
<td>.648</td>
<td>.687</td>
</tr>
<tr>
<td>Jump from one activity to another</td>
<td>.623</td>
<td>.628</td>
</tr>
<tr>
<td>Have difficulty following directions or instructions</td>
<td>.606</td>
<td>.533</td>
</tr>
<tr>
<td>Are impulsive, act without stopping to think</td>
<td>.480</td>
<td>.458</td>
</tr>
<tr>
<td>Fidget</td>
<td>.259</td>
<td>.522</td>
</tr>
</tbody>
</table>

Cooperativeness

Table 2
BCFPI Adolescent Self Report Factor Structure: Cooperativeness

<table>
<thead>
<tr>
<th>Cooperativeness BCFPI Question</th>
<th>Factor Loading Population</th>
<th>Factor Loading Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argue a lot with adults</td>
<td>.660</td>
<td>.711</td>
</tr>
<tr>
<td>Are defiant, talk back to people</td>
<td>.629</td>
<td>.666</td>
</tr>
<tr>
<td>Are easily annoyed by others</td>
<td>.571</td>
<td>.555</td>
</tr>
<tr>
<td>Are cranky</td>
<td>.553</td>
<td>.542</td>
</tr>
<tr>
<td>Angry and resentful</td>
<td>.498</td>
<td>.558</td>
</tr>
<tr>
<td>Blame others for your own mistakes</td>
<td>.413</td>
<td>.295</td>
</tr>
</tbody>
</table>

Conduct

Table 3
BCFPI Adolescent Self Report Factor Structure: Conduct

<table>
<thead>
<tr>
<th>Conduct BCFPI Question</th>
<th>Factor Loading Population</th>
<th>Factor Loading Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Destroy things belonging to others</td>
<td>.657</td>
<td>.496</td>
</tr>
<tr>
<td>Steal things at home</td>
<td>.594</td>
<td>.466</td>
</tr>
<tr>
<td>Damage school or other property</td>
<td>.473</td>
<td>.740</td>
</tr>
<tr>
<td>Physically attack people</td>
<td>.197</td>
<td>.551</td>
</tr>
<tr>
<td>Use weapons when fighting</td>
<td>.148</td>
<td>.679</td>
</tr>
<tr>
<td>Broken into someone else’s house, building or car</td>
<td>No</td>
<td>.718</td>
</tr>
</tbody>
</table>
### Separation from Parents

**Table 4**

**BCFPI Adolescent Self Report Factor Structure:**

**Separation from Parents**

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overly upset while away from loved ones</td>
<td>.815</td>
<td>.799</td>
</tr>
<tr>
<td>Overly upset when leaving loved ones</td>
<td>.788</td>
<td>.792</td>
</tr>
<tr>
<td>Feel sick when being separated from loved ones</td>
<td>.749</td>
<td>.757</td>
</tr>
<tr>
<td>Worry about being separated from loved ones</td>
<td>.645</td>
<td>.597</td>
</tr>
<tr>
<td>Worry bad things will happen to loved ones</td>
<td>.526</td>
<td>.533</td>
</tr>
<tr>
<td>Scared to go to sleep without your parents nearby</td>
<td>.303</td>
<td>.495</td>
</tr>
</tbody>
</table>

### Managing Anxiety

**Table 5**

**BCFPI Adolescent Self Report Factor Structure:**

**Managing Anxiety**

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are afraid of making mistakes</td>
<td>.770</td>
<td>.803</td>
</tr>
<tr>
<td>Worry about doing the wrong thing</td>
<td>.690</td>
<td>.708</td>
</tr>
<tr>
<td>Worry about things in the future</td>
<td>.622</td>
<td>.609</td>
</tr>
<tr>
<td>Are overly anxious to please people</td>
<td>.619</td>
<td>.640</td>
</tr>
<tr>
<td>Worry about doing better at things</td>
<td>.586</td>
<td>.626</td>
</tr>
<tr>
<td>Worry about past behaviour</td>
<td>.547</td>
<td>.602</td>
</tr>
</tbody>
</table>

### Managing Mood

**Table 6**

**BCFPI Adolescent Self Report Factor Structure:**

**Managing Mood**

<table>
<thead>
<tr>
<th>BCFPI Question</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get no pleasure from your usual activities</td>
<td>.712</td>
<td>.188</td>
</tr>
<tr>
<td>No interest in your usual activities</td>
<td>.664</td>
<td>.108</td>
</tr>
<tr>
<td>Not as happy as other children</td>
<td>.651</td>
<td>.596</td>
</tr>
<tr>
<td>Have trouble enjoying yourself</td>
<td>.582</td>
<td>.498</td>
</tr>
<tr>
<td>Are unhappy, sad, or depressed</td>
<td>.540</td>
<td>.626</td>
</tr>
<tr>
<td>Feel hopeless</td>
<td>.517</td>
<td>.556</td>
</tr>
</tbody>
</table>
Reliability Analyses

Table 7 shows internal consistency scores (Cronbach's alpha) for the Adolescent Self Report's Mental Health subscales. As noted in Chapter 9, Cronbach's alpha represents the average of all possible split half reliabilities (correlating half of the subscale with the other half of the subscale). Streiner and Norman (1995) suggest that Cronbach's alpha scores fall between .70 and .90. Scores above .90 suggest that the scale contains redundant questions and may describe a construct too narrowly. Scores below .70 suggest a more heterogeneous set of questions that reflect more than one construct (Streiner & Normal, 1995). Note that, since reliability is proportional to the number of items in a scale, composite Internalizing and Externalizing scales provide a more reliable measure of child functioning than brief 6 item scales (Streiner & Norman, 1995).

With the exception of conduct problems (.61), which are too infrequent to measure reliably in community samples, Cronbach's alpha (internal consistency) scores in a community sample ranged from .70 to .80 for Mental Health Subscales of the Adolescent Self Report. Internal Consistency scores in the OCHS-R clinic sample ranged from .72 to .83.

Table 7
BCFPI Adolescent Self Report Reliability Analysis: Internal Consistency Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>Regulating attention, impulsivity, and activity level</td>
<td>.70</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.74</td>
</tr>
<tr>
<td>Conduct</td>
<td>.61</td>
</tr>
<tr>
<td>Separating from parents</td>
<td>.80</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.79</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.78</td>
</tr>
</tbody>
</table>

Table 8 shows internal consistency scores for the BCFPI's Adolescent Report on Child Functional Impact scale. Cronbach's alpha (internal consistency) scores were .80 in the community sample and .74 in the clinic sample.

Table 8
BCFPI Adolescent Self Report Reliability Analysis: Internal Consistency Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>Child Functional Impact</td>
<td>.80</td>
</tr>
</tbody>
</table>

Concurrent Validity

The BCFPI Adolescent Self Report employs abbreviated 6 item versions of the Revised Ontario Child Health Study (OCHS-R) Survey Diagnostic Instrument’s much longer scales. For example, the OCHS-R scale for Attention Deficit Hyperactivity Disorder is composed of 14 questions. Table 9 shows that the BCFPI’s brief Adolescent Self Report subscales correlate highly with the extended scales from the Ontario Child Health Study’s (OCHS-R) survey diagnostic instrument.

Table 9
Concurrent Validity of the BCFPI Adolescent Self Report:
Correlations with Ontario Child Health Study Adolescent Scales

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating Attention, Impulsivity, and Activity Level</td>
<td>.867</td>
<td>.852</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.921</td>
<td>.913</td>
</tr>
<tr>
<td>Conduct</td>
<td>.819</td>
<td>.873</td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.943</td>
<td>.939</td>
</tr>
<tr>
<td>Separating from Parents</td>
<td>.956</td>
<td>.957</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.841</td>
<td>.849</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.746</td>
<td>.757</td>
</tr>
<tr>
<td>Managing Mood + Self Harm</td>
<td>.794</td>
<td>.821</td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.916</td>
<td>.928</td>
</tr>
</tbody>
</table>

Construct Validity: Child Functional Impact

Correlational analyses showed a relationship between adolescent self reports of behavioural and emotional problems and measures of personal functioning. As for parental reports, Mood Management, Mood Management + Self Harm, and Cooperation with Others scores are most closely associated with self reported functional impairment. Regulating Attention, Impulsivity, and Activity Level scores are associated with moderate levels of functional impairment.
### Table 10
BCFPI Adolescent Self Report Construct Validity:
Correlation of BCFPI Adolescent Subscales with Adolescent Child Functional Impact Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating attention, Impulsivity, and activity level</td>
<td>.488</td>
<td>.411</td>
<td></td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.575</td>
<td>.510</td>
<td></td>
</tr>
<tr>
<td>Conduct</td>
<td>.396</td>
<td>.264</td>
<td></td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.616</td>
<td>.501</td>
<td></td>
</tr>
<tr>
<td>Separating from parents</td>
<td>.373</td>
<td>.405</td>
<td></td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.425</td>
<td>.431</td>
<td></td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.601</td>
<td>.605</td>
<td></td>
</tr>
<tr>
<td>Managing Mood + Self Harm</td>
<td>.641</td>
<td>.631</td>
<td></td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.575</td>
<td>.582</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 11: Evaluating the BCFPI: Teacher Interview

The Brief Child and Family Teacher Phone Interview:

- Begins with a narrative overview of Basic Concerns
- Asks Mental Health questions regarding common behavioural and emotional problems
- Determines the impact of these problems on Child Functioning
- Collects information regarding pro-social behaviour in the school setting
- Provides information on the availability of in-school support programs
- Gathers ratings of the child’s academic functioning

The questions employed in the BCFPI’s Teacher Report were selected from the Revised Survey Diagnostic Instruments developed for the Ontario Child Health Study (Boyle et al., 1993a,b). The items included on the BCFPI Teacher Report are virtually identical to those employed in the Parent and Adolescent Report, except for one new item on the Conduct scale, “cuts classes, skips school”. This allows a direct comparison of perspectives of parents and adolescents on a standardized set of questions.

Tables 1 through 5 show the factor loadings for BCFPI Teacher Report subscales in the OCHS-R measurement study’s population and clinic samples. As in Chapter 9 and 10, factor loadings are listed in descending order for the population sample on which the BCFPI’s subscales were based.

As noted above, factor loadings show the strength of the relationship between an individual item and the factor. Factor loadings might be thought of as a correlation between an individual item and the overall factor score. Items with higher factor scores provide a purer estimate of the construct thought to be measured by that factor (Tabachnick & Fidell, 1996).

Tabachnick and Fidell (1996) suggest that questions with factor loadings above .71 provide an “excellent” measure of a construct. Those with factor loadings of .63 to .71 are “very good” measures of a construct. Factor loadings from .55 to .62 are “good”. Factor loadings from .45 to .54 are “fair” and those from .32 to .44 are “poor” measures of a construct. Note that, like the Parent and Adolescent Report scale, most of the BCFPI’s Teacher Report items show stronger factor loadings in the clinic sample, where items are more frequently endorsed and the range of scores is greater.
In allocating individual questions to the BCFPI’s Teacher Report subscales, we required that: (1) factor loadings exceed .35 (Tabachnick & Fidell, 1996), (2) questions load higher on that scale than other scales, and (3) that questions be consistent with the structure of problems described in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV).

Factor Analysis

Regulating Attention, Impulsivity, and Activity Level

Table 1
BCFPI Teacher Report Factor Structure:
Regulating Attention, Impulsivity, and Activity Level

<table>
<thead>
<tr>
<th>Regulating Attention, Impulsivity and Activity Level</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>BCFPI Question</td>
<td></td>
</tr>
<tr>
<td>Distractible, has trouble sticking to an activity</td>
<td>.795</td>
</tr>
<tr>
<td>Jumps from one activity to another</td>
<td>.775</td>
</tr>
<tr>
<td>Fidgets</td>
<td>.750</td>
</tr>
<tr>
<td>Has difficulty following directions or instructions</td>
<td>.728</td>
</tr>
<tr>
<td>Fails to finish things he/she starts</td>
<td>.690</td>
</tr>
<tr>
<td>Impulsive, acts without stopping to think</td>
<td>.599</td>
</tr>
</tbody>
</table>

Cooperativeness

Table 2
BCFPI Teacher Report Factor Structure
Cooperativeness

<table>
<thead>
<tr>
<th>Cooperativeness</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
</tr>
<tr>
<td>BCFPI Question</td>
<td></td>
</tr>
<tr>
<td>Argues a lot with staff</td>
<td>.744</td>
</tr>
<tr>
<td>Angry and resentful</td>
<td>.736</td>
</tr>
<tr>
<td>Cranky</td>
<td>.700</td>
</tr>
<tr>
<td>Defiant, talks back to staff</td>
<td>.699</td>
</tr>
<tr>
<td>Easily annoyed by others</td>
<td>.687</td>
</tr>
<tr>
<td>Blames others for own mistakes</td>
<td>.651</td>
</tr>
</tbody>
</table>

Conduct

One item, “cuts classes, skips school”, shows a significant loading on the BCFPI Managing Mood subscale for both the population (.472) and the clinic (.406) sample.
In the clinic sample, “physically attacks people” also loads onto the Cooperativeness (.563) subscale.

Table 3
BCFPI Teacher Report Factor Structure: Conduct

<table>
<thead>
<tr>
<th>Conduct</th>
<th>Factor Loading</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vandalism</td>
<td>.795</td>
<td>.780</td>
<td></td>
</tr>
<tr>
<td>Destroys things belonging to others</td>
<td>.751</td>
<td>.724</td>
<td></td>
</tr>
<tr>
<td>Uses weapons when fighting</td>
<td>.716</td>
<td>.617</td>
<td></td>
</tr>
<tr>
<td>Steals things at home</td>
<td>.539</td>
<td>.719</td>
<td></td>
</tr>
<tr>
<td>Physically attacks people</td>
<td>.532</td>
<td>.544</td>
<td></td>
</tr>
<tr>
<td>Cuts classes, skips school</td>
<td>.178</td>
<td>.106</td>
<td></td>
</tr>
</tbody>
</table>

Managing Anxiety

Table 4
BCFPI Teacher Report Factor Structure: Managing Anxiety

<table>
<thead>
<tr>
<th>Managing Anxiety</th>
<th>Factor Loading</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worries about doing the wrong thing</td>
<td>.800</td>
<td>.804</td>
<td></td>
</tr>
<tr>
<td>Is afraid of making mistakes</td>
<td>.766</td>
<td>.775</td>
<td></td>
</tr>
<tr>
<td>Worries about doing better at things</td>
<td>.723</td>
<td>.769</td>
<td></td>
</tr>
<tr>
<td>Is overly anxious to please people</td>
<td>.700</td>
<td>.740</td>
<td></td>
</tr>
<tr>
<td>Worries about things in the future</td>
<td>.605</td>
<td>.653</td>
<td></td>
</tr>
<tr>
<td>Worries about past behaviour</td>
<td>.554</td>
<td>.549</td>
<td></td>
</tr>
</tbody>
</table>

Managing Mood

Table 5
BCFPI Teacher Report Factor Structure: Managing Mood

<table>
<thead>
<tr>
<th>Managing Mood</th>
<th>Factor Loading</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gets no pleasure from usual activities</td>
<td>.705</td>
<td>.788</td>
<td></td>
</tr>
<tr>
<td>No interest in usual activities</td>
<td>.697</td>
<td>.704</td>
<td></td>
</tr>
<tr>
<td>Has trouble enjoying his/her self</td>
<td>.665</td>
<td>.739</td>
<td></td>
</tr>
<tr>
<td>Not as happy as other children</td>
<td>.652</td>
<td>.714</td>
<td></td>
</tr>
<tr>
<td>Unhappy, sad, or depressed</td>
<td>.578</td>
<td>.706</td>
<td></td>
</tr>
<tr>
<td>Feels hopeless</td>
<td>.543</td>
<td>.538</td>
<td></td>
</tr>
</tbody>
</table>
Social Skills

Table 6
BCFPI Teacher Report Factor Structure: Social Skills

<table>
<thead>
<tr>
<th>Social Skills</th>
<th>Factor Loading</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Clinic</td>
</tr>
<tr>
<td>Sympathy to those who err</td>
<td>.865</td>
<td>.817</td>
</tr>
<tr>
<td>Praises work of less able kids</td>
<td>.839</td>
<td>.798</td>
</tr>
<tr>
<td>Helps those who are having difficulty</td>
<td>.799</td>
<td>.775</td>
</tr>
<tr>
<td>Invites bystanders to join games</td>
<td>.767</td>
<td>.717</td>
</tr>
<tr>
<td>Tries to be fair in games</td>
<td>.724</td>
<td>.672</td>
</tr>
<tr>
<td>Tries to stop quarrels</td>
<td>.701</td>
<td>.653</td>
</tr>
</tbody>
</table>

Reliability Analyses

Table 7
BCFPI Teacher Report Reliability Analysis: Internal Consistency Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Cronbach’s Alpha</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Clinic</td>
</tr>
<tr>
<td>Regulating attention, impulsivity, and activity level</td>
<td>.896</td>
<td>.887</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.901</td>
<td>.898</td>
</tr>
<tr>
<td>Conduct</td>
<td>.702</td>
<td>.735</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.808</td>
<td>.838</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.862</td>
<td>.873</td>
</tr>
<tr>
<td>Child Functional Impact</td>
<td>.841</td>
<td>.807</td>
</tr>
<tr>
<td>Social Skills</td>
<td>.874</td>
<td>.833</td>
</tr>
</tbody>
</table>

Concurrent Validity

Table 8
Concurrent Validity of the BCFPI Teacher Report: Correlations with Ontario Child Health Study Scales, Teacher Report

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Clinic</td>
</tr>
<tr>
<td>Regulating Attention, Impulsivity, and Activity Level</td>
<td>.937</td>
<td>.921</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.967</td>
<td>.965</td>
</tr>
<tr>
<td>Conduct</td>
<td>.915</td>
<td>.932</td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.970</td>
<td>.971</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.855</td>
<td>.868</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.846</td>
<td>.829</td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.892</td>
<td>.901</td>
</tr>
</tbody>
</table>
### Construct Validity

#### Table 9
BCFPI Construct Validity: Correlation of BCFPI Teacher Subscales with Teacher Child Functioning Scores

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating attention, Impulsivity, and activity level</td>
<td>.679</td>
<td>.585</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>.704</td>
<td>.644</td>
</tr>
<tr>
<td>Conduct</td>
<td>.546</td>
<td>.534</td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>.768</td>
<td>.706</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.277</td>
<td>.268</td>
</tr>
<tr>
<td>Managing Mood</td>
<td>.734</td>
<td>.695</td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>.613</td>
<td>.591</td>
</tr>
</tbody>
</table>

#### Table 10
BCFPI Construct Validity: Correlation of Teacher BCFPI Subscales and Teacher Reported Child Functioning with Social Skills

<table>
<thead>
<tr>
<th>BCFPI Subscale</th>
<th>Correlation with Social Skills</th>
<th>Population</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulating attention, Impulsivity, and activity level</td>
<td>-.477</td>
<td>-.361</td>
<td></td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>-.433</td>
<td>-.363</td>
<td></td>
</tr>
<tr>
<td>Conduct</td>
<td>-.313</td>
<td>-.267</td>
<td></td>
</tr>
<tr>
<td>Total Externalizing</td>
<td>-.490</td>
<td>-.405</td>
<td></td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>.035</td>
<td>.197</td>
<td></td>
</tr>
<tr>
<td>Managing Mood</td>
<td>-.385</td>
<td>-.284</td>
<td></td>
</tr>
<tr>
<td>Total Internalizing</td>
<td>-.207</td>
<td>-.066</td>
<td></td>
</tr>
<tr>
<td>Child Functioning</td>
<td>-.477</td>
<td>-.383</td>
<td></td>
</tr>
</tbody>
</table>
References


Appendix

Interviewer Rating form - March 2004
## Telephone Screening Interview: Performance Rating Scale

<table>
<thead>
<tr>
<th>Interviewer:</th>
<th>Observer:</th>
<th>Interview Duration:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background:</strong></td>
<td><strong>Observer:</strong></td>
<td><strong>Interview Duration:</strong></td>
</tr>
<tr>
<td><strong>Agency:</strong></td>
<td>Date</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Clinical and Organizational Prerequisites
- BCFPI Interviewer has children's mental health degree/certificate
- BCFPI Interviewer has supervisor with graduate clinical training in child development, child psychopathology, and psychometrics
- BCFPI Interpreters have requisite expertise (graduate clinical training in child development, child psychopathology, treatment, and psychometrics).
- Accreditable organization with supporting clinical and organization infrastructure (CHMO, CHSA or equivalent)

### Software Management Skills
- Sets up new client and agency date(s) correctly, using default agency.
- Can record referral to other agencies.
- Is aware of how to set up programs and register case in programs, if applic.
- Sets up new profile form
- Records informant correctly
- Edits data in client record (e.g. DOB, sex).
- Edits profile form header data (e.g. informant type, form stage)
- Records selected responses and relevant comments with questions.
- Can describe when and how clients and profile forms can be deleted
- Creates and prints Standard Parent Report
- Cuts and pastes between form comment and word document
- Saves forms
- Can create comparative graph, Evidence-based report, report w clinical norms
- Rebuilds data base
- Creates custom table report

### Conducting the Screening Interview: Content
- Records overview of client concerns
- Regulating Attention, Impulsivity&Activity Scale completed
- Cooperativeness Scale completed
- Conduct Scale completed
- Separates from Parents Scale completed
- Managing Anxiety Scale
- Managing Mood Scale
- Self Harm Scale completed if t score > than 65 (or agency threshold)
- Child Impact Scale completed
- Family Impact Scale completed
- Appropriate use of 'Other Concerns' items.

### Conducting the Screening Interview: Process
- Interviewer gives standard overview of interview
- Opening questions follow client concerns
- Exact question wording employed
- Interviewer gives scale description (never, sometimes, . . .)
- Child’s Name employed when posing questions
- Interviewer reflects client statements
- Appropriate follow-up questions posed
- Interviewer keeps interview on task
- Transitional statements between scales
- Interviewer asks if we have missed anything
- Interviewer summarizes next steps

### Interpreting the Screening Interview
<table>
<thead>
<tr>
<th>Knows % of population falling below t score of 50, 60, 65, &amp; 70</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows population on which norms are based</td>
<td></td>
</tr>
<tr>
<td>Software Score:</td>
<td>Content Score:</td>
</tr>
</tbody>
</table>

Interviewer Rating form - March 2004
## BCFPI Implementation Planning Sheet

<table>
<thead>
<tr>
<th></th>
<th>Implementation Milestones</th>
<th>Team Member Responsible</th>
<th>Notes</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Executive Directors attend Introductory Workshop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify <strong>potential benefits</strong> of using the BCFPI in your organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify a local <strong>BCFPI Implementation Project Leader</strong> who will attend training workshops in Hamilton and supervise implementation of the BCFPI in your organization</td>
<td>Team Leader:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compose an <strong>Implementation Team</strong></td>
<td>Team Members:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schedule <strong>Weekly Implementation Team Meetings</strong></td>
<td>Time:</td>
<td>Location:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Determine whether your organization should <strong>integrate the BCFPI and CAFAS</strong> projects. For example, should you designate different project leaders or the same individual, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify who in your organization might conduct the BCFPI. Interviewers should have formal clinical training and access to adequate supervision. Should these phone interviews be completed by dedicated staff or shared more broadly among staff? What are some of the advantages and disadvantages of each alternative.</td>
<td>Potential BCFPI Interviewers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Determine in what location the BCFPI interviews should be completed in your organization. The BCFPI can be installed on any PC or on a local area network.</td>
<td>Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Install a Windows Compatible computer (Pentium II with 32 meg RAM)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Install internet access for access to the BCFPI Website (BCFPI.com), project manuals, updates, and online support.

Consider how your organization might restructure your intake/assessment processes to integrate the BCFPI. At what point in the intake assessment sequence should the BCFPI be completed?

Use **Integration Planning Sheets** to determine which existing intake or assessment activities that the BCFPI might replace?

You must administer all Core (CS) questions. Using the **Integration Planning Sheet** determine which, if any, of the optional questions (OD) and measures you will employ. Determine at what point in the data gathering process these will be used (first point of intake contact, during more comprehensive clinical assessments, etc.)

Discuss how the BCFPI might be integrated into your community. How will you coordinate activities with other organizations using the BCFPI. How will you coordinate the BCFPI with Making Service Work for People’s Single Point of Access.

If you have completed prerequisite steps, **schedule a BCFPI training workshop** for project leader and interviewers in Hamilton. You will then receive the BCFPI Manual and Practice Software

Study the BCFPI **Implementation Manual**

Install the BCFPI Software

Attend one day BCFPI training workshop in Hamilton

Practice operating BCFPI software

Role play several phone interviews

Rate yourself on the **Interview Integrity Rating Scale** (try for 90%!)
<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact the Implementation Team to schedule a <strong>reliability phone check</strong> (you'll complete an interview with a member of our team playing the role of a parent.)</td>
<td></td>
</tr>
<tr>
<td>Determine how BCFPI might contribute to your intake and service planning decision making. What are some specific ways in which BCFPI information might be used in your organization. For example, recommending interim service plans, setting priorities, making triaging decisions, or evaluating outcome.</td>
<td></td>
</tr>
<tr>
<td>Schedule a presentation by your BCFPI Implementation Team to the staff in your organization</td>
<td></td>
</tr>
<tr>
<td>Continue Meeting Weekly to Support Implementation</td>
<td></td>
</tr>
<tr>
<td>Develop an Implementation Plan. You might, for example, employ a graduated implementation (e.g. during week 1, you might begin with one BCFPI per day. During week 2, you might conduct one BCFPI in the morning and one in the afternoon. Etc.)</td>
<td></td>
</tr>
<tr>
<td>Go Live!</td>
<td></td>
</tr>
</tbody>
</table>