

# ***The ABC***

## ***Residential Treatment Program***

### **Performance Outcomes Report**

**(SAMPLE REPORT)**

**For Services Delivered During the Period of:**

**January 1, 2009 to June 30, 2009**

# Performance Outcomes Report

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# Performance Outcomes Report

## EXECUTIVE SUMMARY & USE OF THIS REPORT

A primary objective of the ABC Residential Treatment Program is to assess treatment effectiveness across time, with the goal of steadily improving service delivery from one report period to the next. In order to monitor treatment effectiveness, appropriate measures and targeted outcomes have been selected and are described in detail in this document. This report is generated once per year for review by the Board of Directors and other key personnel.

A best practices approach suggests that one or more outcomes contained in this report be selected and discussed in an upper management or Board of Directors meeting. Following this discussion, an action plan will be developed with the goal of improving the selected outcome(s). Data contained in subsequent reports will be used to determine if the action plan was successful in improving the targeted outcome(s) and revisions to the plan will be made as needed.

The contents of this report are based on information collected on 38 clients (24 active cases and 14 clients discharged) that were served by the ABC Residential Treatment Program between January 1, 2009 and June 30, 2009.

### **Demographics:**

As of June 30, 2009, the program was serving 24 active cases. The average age at admission is 15.2 (up from 14.5 during the prior review period), with an age range of 12 – 16. The majority of active clients are either Caucasian (40.6%) or African-American (28.2%). The most frequent primary diagnosis for current clients is split equally between Bipolar Disorder and Major Depressive Disorder (35.3% each), followed by Posttraumatic Stress Disorder (11.8%). Risk factors identified prior to admission include psychiatric hospitalization for fourteen clients (58.3%), runaway behavior for five clients (20.8%), and physical restraint or seclusion for seven clients (29.1%).

### **Admissions dynamics:**

Between January 1, 2009 and June 30, 2009, there have been a total of 19 clients admitted into the program. The majority of open cases have been placed by Mental Health (66.5%), followed by Social Services (15.9%). The most common prior placement for current clients was another group home or residential treatment facility (41.2%), followed by an emergency shelter (23.5%).

## Performance Outcomes:

### Discharges

From the period of January 1, 2009 to June 30, 2009, the program discharged 14 clients. Eleven clients (78.6%) were discharged in a planned way (e.g., met treatment goals and graduated), up from 75.0% in the prior review period. Two clients (14.3%) were discharged in an unplanned way due to unmanageable behavior (up from 8.3% in the prior review period). Finally, one client (7.1%) was also discharged in an unplanned way, but not related to her behavior (down from 16.7% in the prior review period).

NOTE: The percentage of planned discharges during this review period (78.6%) continues to be favorable relative to industry standards. For example, among a comparable reference sample of adolescents placed in other high level, intensive residential facilities (N = 588), planned discharges accounted for 65.1% of all discharges.

Among the 14 clients who were discharged during this review period, 12 (87.5%) were discharged to lower levels of care (home, foster home, etc), down slightly from 91.6% in the prior review period. The overall average length of stay for both groups combined was 19.0 months (up from 17.2 months in the prior review period), with a range of 2.4 – 38.9 months.

### Behavioral Outcome Measures

Please note that the scores described in this section are obtained by combining (aggregating) the current review period and the previous review periods to boost the overall sample size. In general, there are not enough discharges in a given review period to provide an adequate sample size for statistical comparison. Aggregating scores across time, therefore, allows for a more meaningful assessment of clinical improvement.

Additionally, the sample must be split between planned and unplanned discharges and the two groups must be analyzed separately. Research has shown that clients who exit treatment in a planned way tend to show favorable behavioral and functional changes over the course of treatment, whereas clients who exit in an unplanned way tend to demonstrate no change or a slight worsening of functioning (which is why agencies measure the percentage of planned discharges as a performance outcome and strive to increase this percentage across time).

What does it mean when something is statistically significant? In statistics, a result that is statistically significant is one that is unlikely to have occurred by chance alone. When comparing changes in a client's behavioral or other scores from admission to discharge, it is important to know whether the change is such that it is unlikely to have occurred on its own, i.e., that the change was more likely due to the services the client received while in treatment. What does effect size refer to? Whereas statistical significance (a paired samples *t*-test) tells us that a change in scores is unlikely due just to chance, effect size (Cohen's *d*) is an analysis that tells us the magnitude of the change and its clinical importance, generally reported as either negligible, small, medium, large, very large, or extremely large. If changes in scores do not reach a point of

statistical significance, agencies should strive to achieve this in future reports. If changes reach a point of statistical significance but effect size is negligible or small, efforts should be made to increase scores to achieve an effect size of medium or greater.

## 1. Child Behavior Checklist (CBCL)

The CBCL provides an overview of the child's behavior in terms of normal, borderline, or clinically impaired functioning as compared to a normalized sample of peers. The CBCL is completed at intake and at discharge by a staff member who is familiar with client's behavior, and it summarizes information about the child's specific behaviors on eight Syndrome Scales (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior) and three Problem Scales (Internalizing, Externalizing, and Total Problems). Higher scores represent more serious behavioral dysfunction.

Among planned discharges, four of the eight CBCL Syndrome Scales demonstrate clinical improvement to the point of statistical significance ( $p < .05$ ): Somatic Complaints, Social Problems, Attention Problems, and Rule-Breaking Behavior. One of the two Problem Scales (Externalizing Behavior) also improved to the point of statistical significance, as did the Total Problems Scale, probably the best overall measure of behavioral improvement. It is important to note that all of the remaining scales were in the expected direction (lower), which is suggestive of some clinical improvement. It is also important to note that the sample size continues to be relatively small, and that with a larger sample in subsequent review periods, statistical significance may be achieved. As would be expected, and consistent with the literature, clients who exited in an unplanned way showed increases in almost all of the CBCL scores, five to the point of statistical significance.

## 2. Children's Global Assessment of Functioning Scale (CGAS)

Change in the overall level of client functioning from admission to discharge was assessed via the Children's Global Assessment of Functioning Scale (CGAS) Scale. Scores on the CGAS range from 1 to 100 where higher scores indicate superior functioning. Clients are rated on the CGAS by a staff member who is familiar with the child's behavior.

For clients whose services were terminated in a planned way, changes in CGAS scores from admission to discharge increased to the point of statistical significance (from a score of 42 at intake to a score of 58 at discharge), indicating overall functional improvement from admission to discharge (a very favorable performance outcome). In addition to being statistically significant, this amount of change has a practical, clinical significance as reflected by an effect size of .82, which would be considered a *large* treatment effect. Again, consistent with the literature, for clients whose services were terminated in an unplanned way, changes in CGAS scores indicate a slight worsening of functioning (from a score of 37 at intake to a score of 33 at discharge), but not to the point of statistical significance.

### 3. Changes in Family Functioning

The Family Functioning Scale consists of six items that are rated by a staff member with reasonable knowledge of family members in order to assess the quality of interaction between the client and parents or other primary caretakers. The six rated items are averaged to produce a total Family Functioning Score. Scores range from 0 - 2, with higher scores indicating superior functioning.

For clients whose services were terminated in a planned way, four of the six measures on the Family Functioning Scale showed clinical improvement to the point of statistical significance: Problem Solving, Dealing with Stress/Conflict, Parental and Family Conflict, and Parenting Skills and Physical Discipline, as did the Total Family Functioning Score (probably the best overall measure of clinical improvement). The Total Family Functioning Score increased from an average score of 1.4 at admission to a score of 1.8 at discharge. This indicates an effect size of 1.4, which would be considered an *extremely large* treatment effect. This is another very favorable performance outcome. All of the remaining scores were in a favorable direction (higher), which is suggestive of some clinical improvement. For clients whose services were terminated in an unplanned way, none of the measures on the Family Functioning Scale showed clinical improvement to the point of statistical significance, although changes in all but one of the measures were in a favorable direction.

# Performance Outcomes Report

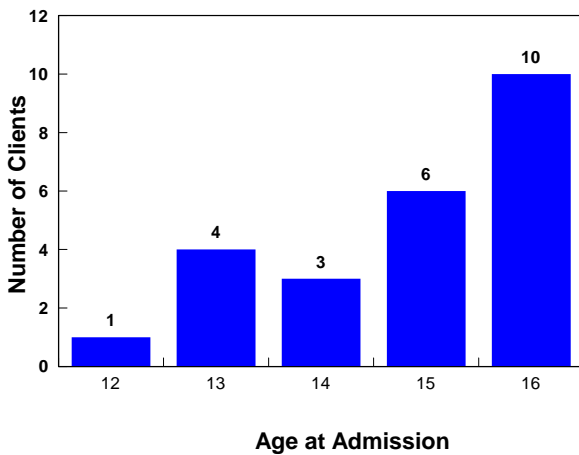
This report is based on information collected on 38 clients (24 active cases and 14 clients discharged) that were served by the ABC Residential Treatment Program between January 1, 2009 and June 30, 2009.

## DEMOGRAPHICS – CURRENTLY OPEN CASES (AS OF JUNE 30, 2009)

As of June 30, 2009, the program was serving 17 active cases. The following describes the demographic characteristics of the current clients.

### 1. Age at Admission

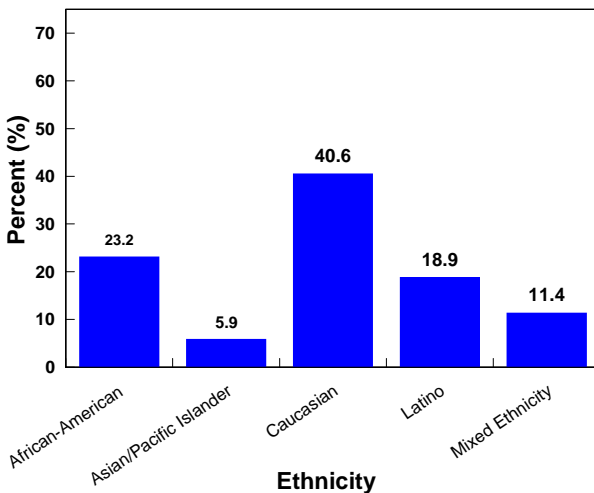
Age at Admission: Active Cases (N = 24)



The average age at admission is 15.2 (up from 14.5 during the prior review period), with an age range of 12 – 16.

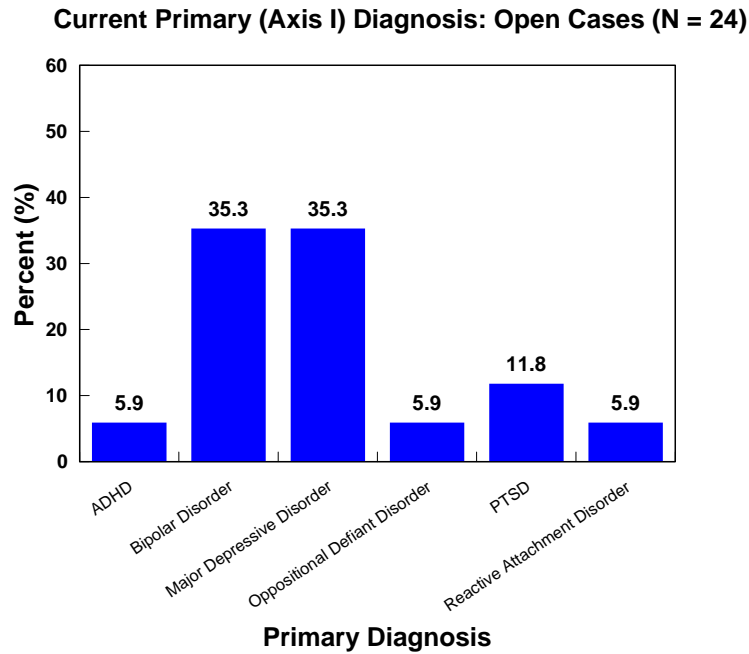
### 2. Ethnicity

Ethnic Composition: Open Cases (N = 24)



The majority of active clients are either Caucasian (40.6%) or African-American (28.2%).

3. Clinical Diagnosis at Admission



The most frequent primary diagnosis for current clients is split equally between Bipolar Disorder and Major Depressive Disorder (35.3% each), followed by Posttraumatic Stress Disorder (11.8%).

4. Risk Factors Identified at Intake for Currently Open Cases

Psychiatric Hospitalization. Fourteen clients (58.3%) have been hospitalized prior to admission, and among these at least nine were hospitalized within 12 months prior to admission. The average number of hospitalizations was four, with a range of 1 - 9.

Runaway Behavior. Five clients (20.8%) have a history of running away from one or more settings prior to admission, and among these at least four have run away within 12 months prior to admission). The average number of runaway episodes was five, with a range of 2 - 10.

Physical Restraint and Seclusion. Seven clients (29.1%) have a history of requiring physical restraint or seclusion prior to admission, and among these at least five have required its use within the 12 months prior to admission.

**In Summary:**

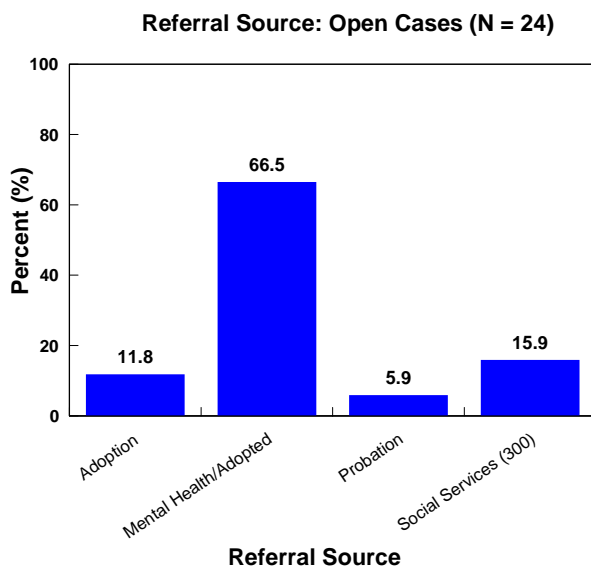
As of June 30, 2009, the program was serving 24 active cases. The average age at admission is 15.2 (up from 14.5 during the prior review period), with an age range of 12 – 16. The majority of active clients are either Caucasian (40.6%) or African-American (28.2%). The most frequent primary diagnosis for current clients is split equally between Bipolar Disorder and

Major Depressive Disorder (35.3% each), followed by Posttraumatic Stress Disorder (11.8%). Risk factors identified prior to admission include psychiatric hospitalization for fourteen clients (58.3%), runaway behavior for five clients (20.8%), and physical restraint or seclusion for seven clients (29.1%).

## ADMISSIONS CHARACTERISTICS

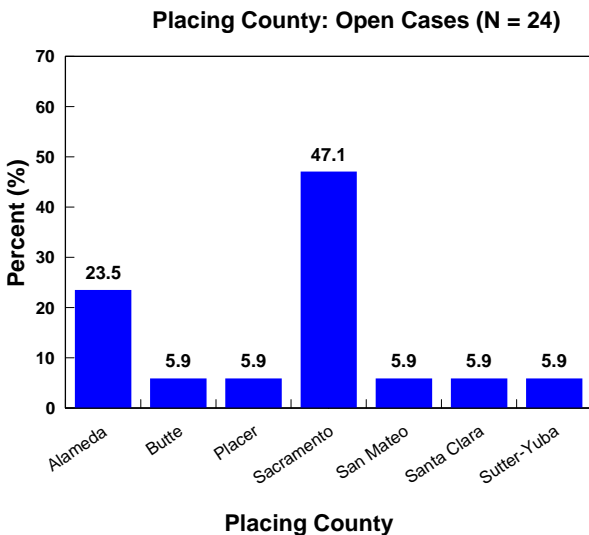
Between January 1, 2009 and June 30, 2009, there have been a total of 19 new clients admitted into the program. This section of the report analyzes placement dynamics and other admission characteristics.

### 1. Referral Source



The majority of open cases have been placed by Mental Health (66.5%), followed by Social Services (15.9%).

### 2. Placing County



Sacramento County continues to place the most clients in the program (47.1%), followed by Alameda County (23.5%)

3. Prior Placements

The table below shows the placements of current clients prior to admission.

Placement	Percentage	Average Number of Placements
Foster homes	17.6%	4
Emergency shelters	23.5%	1
Juvenile hall	11.8%	1
Other group homes/residential settings	41.2%	3

**In Summary:**

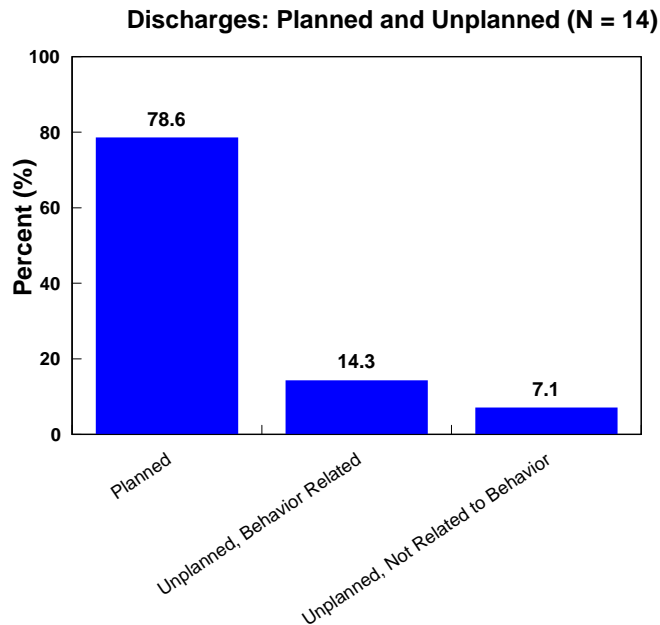
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## PERFORMANCE OUTCOMES

### Discharges

From the period of January 1, 2009 to June 30, 2009, the program discharged 14 clients.

#### 1. Discharges: Planned and Unplanned



Eleven clients (78.6%) were discharged in a planned way (e.g., met treatment goals and graduated), up from 75.0% in the prior review period. Two clients (14.3%) were discharged in an unplanned way due to unmanageable behavior (up from 8.3% in the prior review period). Finally, one client (7.1%) was also discharged in an unplanned way, but not related to her behavior (down from 16.7% in the prior review period).

NOTE: The percentage of planned discharges during this review period (78.6%) continues to be favorable relative to industry standards. For example, among a comparable reference sample of adolescents placed in other intensive, high level residential facilities (N = 588), planned discharges accounted for 65.1% of all discharges.

2. Reason for Discharge

Planned/Unplanned	Reason for Discharge	Number (N)	Percent (%)	Percent in Prior Review Period
Planned Discharges	Client met treatment goals and graduated/exited as planned	8	57.2%	75.0%
	Client made progress, but was moved for continued treatment elsewhere	3	21.4%	0%
<b>Total clients discharged in a planned way:</b>		<b>11</b>	<b>78.6%</b>	<b>75.0%</b>
Unplanned Discharges/Behavior Related	Client's behavior was beyond the control of the facility	2	14.3%	0%
	Client ran away	0	0%	0%
	Client was incarcerated	0	0%	8.3%
<b>Total clients discharged in an unplanned way/behavior related:</b>		<b>2</b>	<b>14.3%</b>	<b>8.3%</b>
Unplanned Discharges/Not Behavior Related	Placement was terminated by the parents	0	0%	16.7%
	Client was removed by the placement worker	0	0%	0%
	Client turned 18 and exited care voluntarily	1	7.1%	0%
<b>Total clients discharged in an unplanned way/not behavior related:</b>		<b>1</b>	<b>7.1%</b>	<b>16.7%</b>

3. Discharge Destination

Discharge Destination	Number (N)	Percent (%)	Percent in Prior Review Period
Parent or relative's home	10	71.4%	58.3%
Foster home	0	0%	0%
Emancipation or independent living	1	7.1%	25.0%

Discharge Destination	Number (N)	Percent (%)	Percent in Prior Review Period
Another residential facility with a lower level of care	1	7.1%	8.3%
<b>Total clients discharged to a lower level of care:</b>	<b>12</b>	<b>85.7%</b>	<b>91.6%</b>
Juvenile detention or youth correction	0	0%	8.3%
Psychiatric or state hospital	1	7.1%	0%
Another residential facility with the same level of care	1	7.1%	0%
Another residential facility with a higher level of care	0	0%	0%
<b>Total clients discharged to a similar or higher level of care:</b>	<b>2</b>	<b>14.3%</b>	<b>8.3%</b>

#### 4. Length of Stay: Closed Cases

The average length of stay for the 11 planned discharges was 20.3 months (up from 20.1 months in the prior review period), with a range of 8.5 – 38.9 months. The average length of stay for the 3 unplanned discharges was 14.2 months (up from 8.3 months), with a range of 2.4 – 25.8 months. The overall average length of stay for both groups combined was 19.0 months (up from 17.2 months in the prior review period), with a range of 2.4 – 38.9 months.

#### ***In Summary:***

From the period of January 1, 2009 to June 30, 2009, the program discharged 14 clients. Eleven clients (78.6%) were discharged in a planned way (e.g., met treatment goals and graduated), up from 75.0% in the prior review period. Two clients (14.3%) were discharged in an unplanned way due to unmanageable behavior (up from 8.3% in the prior review period). Finally, one client (7.1%) was also discharged in an unplanned way, but not related to her behavior (down from 16.7% in the prior review period).

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## **Behavioral Outcome Measures**

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### 1. Child Behavior Checklist (CBCL)

The CBCL provides an overview of the child's behavior in terms of normal, borderline, or clinically impaired functioning as compared to a normalized sample of peers. The CBCL is completed at intake and at discharge by a staff member who is familiar with client's behavior.

#### *Syndrome and Problem Scale scores*

The CBCL summarizes information about the child's specific behaviors on eight Syndrome scales: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior and Aggressive Behavior. *Higher scores represent more serious behavioral dysfunction.*

Syndrome Scale scores vary between 50 and 100:

- 50-64 – normal
- 65-69 – borderline
- 70-100 – clinical range

Problem Scales scores are derived from pertinent Syndrome Scales scores:

- Internalizing Problems – include Withdrawn, Somatic Complaints, and Anxious/Depressed syndromes.
- Externalizing Problems – include Rule-Breaking Behavior and Aggressive Behavior.
- Total Problems scale is a composite of all syndrome scales.

Problem Scale scores vary between 0 and 100:

- 0-59 – normal
- 60-62 - borderline
- 63-100 – clinical range

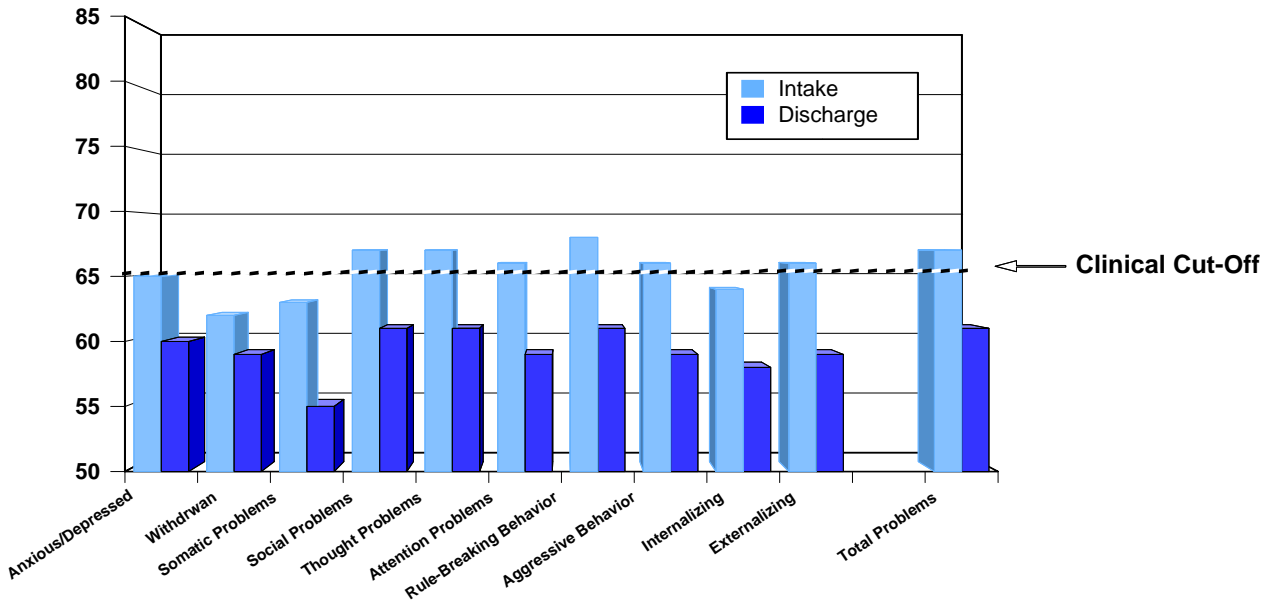
***Changes in CBCL Scores from Admission to Discharge***

(NOTE: Negative changes in scores (decreases) indicate clinical improvement; positive changes indicate a worsening of functioning.)

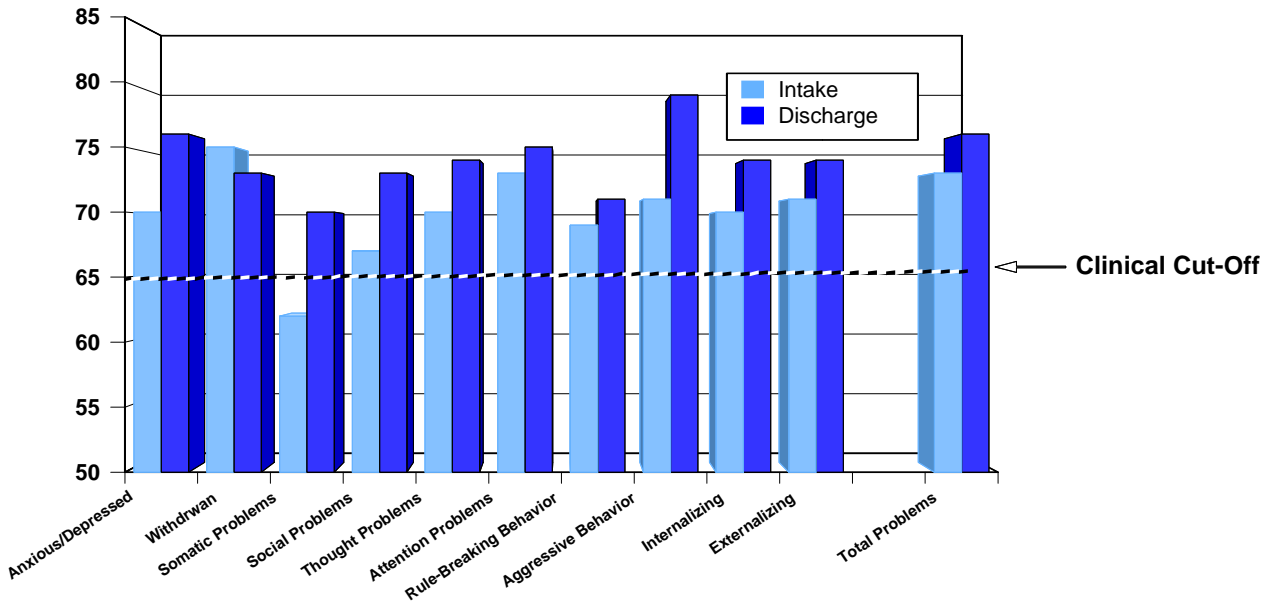
	Planned Discharges (N = 14)			Unplanned Discharges (N = 10)		
	Intake	Discharge	Statistically Significant?	Intake	Discharge	Statistically Significant?
Anxious/Depressed	65	60	No	70	76	Yes
Withdrawn	62	59	No	75	73	No
Somatic Complaints	63	55	Yes	62	70	Yes
Social Problems	67	61	Yes	67	73	No
Thought Problems	67	61	No	70	74	No
Attention Problems	66	59	Yes	73	75	No
Rule-Breaking Behavior	68	61	Yes	69	71	No
Aggressive Behavior	66	59	No	71	79	Yes
Internalizing Problems	64	58	No	70	74	No
Externalizing Problems	66	59	Yes	71	74	Yes
<b>Total Problems</b>	<b>67</b>	<b>61</b>	<b>Yes</b>	<b>73</b>	<b>76</b>	<b>Yes</b>

\*Statistical significance is determined via a paired samples t-test with a *p* value of < .05.

Planned Discharges: Intake to Discharge  
CBCL Scores (N = 14)



Unplanned Discharges: Intake to Discharge  
CBCL Scores (N = 10)



### **In Summary:**

Among planned discharges, four of the eight CBCL Syndrome Scales demonstrate clinical improvement to the point of statistical significance ( $p < .05$ ): Somatic Complaints, Social Problems, Attention Problems, and Rule-Breaking Behavior. One of the two Problem Scales (Externalizing Behavior) also improved to the point of statistical significance, as did the Total Problems Scale, probably the best overall measure of behavioral improvement. It is important to note that all of the remaining scales were in the expected direction (lower), which is suggestive of some clinical improvement. It is also important to note that the sample size continues to be relatively small, and that with a larger sample in subsequent review periods, statistical significance may be achieved. As would be expected, and consistent with the literature, clients who exited in an unplanned way showed increases in almost all of the CBCL scores, five to the point of statistical significance.

#### 2. Children's Global Assessment of Functioning Scale (CGAS)

Change in the overall level of client functioning from admission to discharge is assessed via the Children's Global Assessment of Functioning Scale (CGAS) Scale. *Scores on the CGAS range from 1 to 100 where higher scores indicate superior functioning.* Clients are rated on the CGAS by a staff member who is familiar with the child's behavior.

<u>Score Range</u>	<u>Functional Description</u>
100 - 91	Superior functioning in all areas
90 - 81	Absent or minimal symptoms
80 - 71	No more than slight impairment in functioning
70 - 61	Some mild symptoms
60 - 51	Moderate symptoms
50 - 41	Serious symptoms
40 - 31	Some impairment in reality testing or communication or major impairment in several areas
30 - 21	Inability to function in almost all areas
20 - 11	Some danger of hurting self or others
10 - 1	Persistent danger of hurting self or others

#### *Changes in CGAS Scores Admission to Discharge*

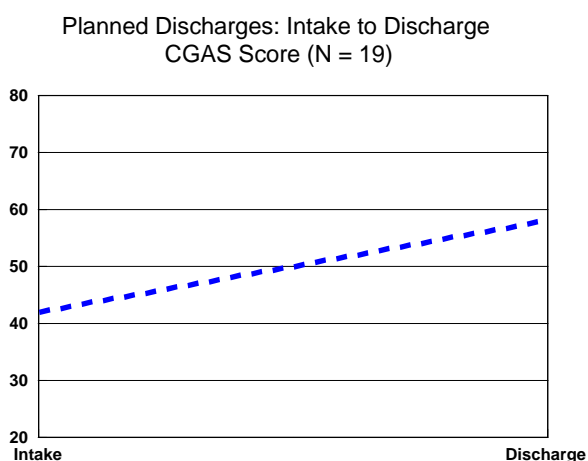
*(NOTE: Positive changes in scores (increases) indicate clinical improvement; negative changes indicate a worsening of functioning.)*

	Planned Discharges (N = 19)				
	Intake	Discharge	Change	p value	Statistically Significant?*
CGAS Score	42	58	+16	<.001	Yes

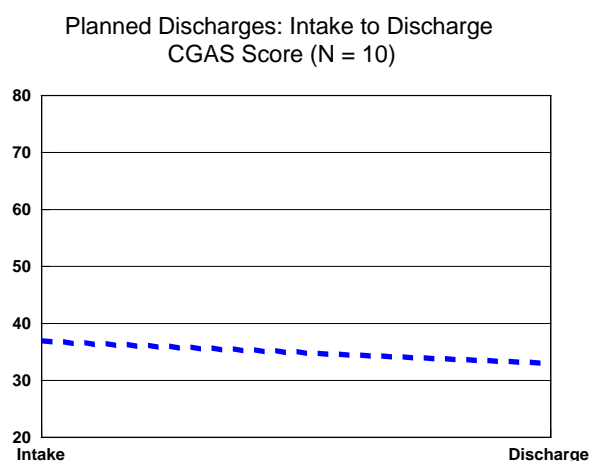
	Unplanned Discharges (N = 10)				
	Intake	Discharge	Change	p value	Statistically Significant?*
CGAS Score	37	33	-4	.45	No

\*Statistical significance is determined via a paired samples t-test with a *p* value of < .05.

### Planned Discharges



### Unplanned Discharges



### In Summary:

For clients whose services were terminated in a planned way, changes in CGAS scores from admission to discharge increased to the point of statistical significance (from a score of 42 at intake to a score of 58 at discharge), indicating overall functional improvement from admission to discharge (a very favorable performance outcome). In addition to being statistically significant, this amount of change has a practical, clinical significance as reflected by an effect size of .82, which would be considered a *large* treatment effect. Again, consistent with the literature, for clients whose services were terminated in an unplanned way, changes in CGAS scores indicate a slight worsening of functioning (from a score of 37 at intake to a score of 33 at discharge), but not to the point of statistical significance.

### 3. Changes in Family Functioning

The Family Functioning Scale consists of six items used to assess the quality of interaction between the client and parents or other primary caretakers. *Scores range from 0 - 2, with higher scores indicating superior functioning.*

The six items rated are:

- Problem solving
- Dealing with stress and conflict
- Parental and family conflict
- Parental social supports
- Parenting skills and physical discipline
- Involvement in case planning

Rated items are averaged to produce a total Family Functioning Score, which has been shown to be highly associated with several child welfare outcomes (e.g., placement stability, planned discharge, behavioral gains in treatment, etc.).

Note: Clients with no primary caretakers (e.g., deceased, incarcerated, whereabouts unknown, etc.) are omitted from analysis.

#### *Changes in Family Functioning Scores from Admission to Discharge*

(NOTE: Positive changes in scores (increases) indicate functional improvement; negative changes indicate a worsening of functioning.)

#### ***Planned Discharges (N = 21):***

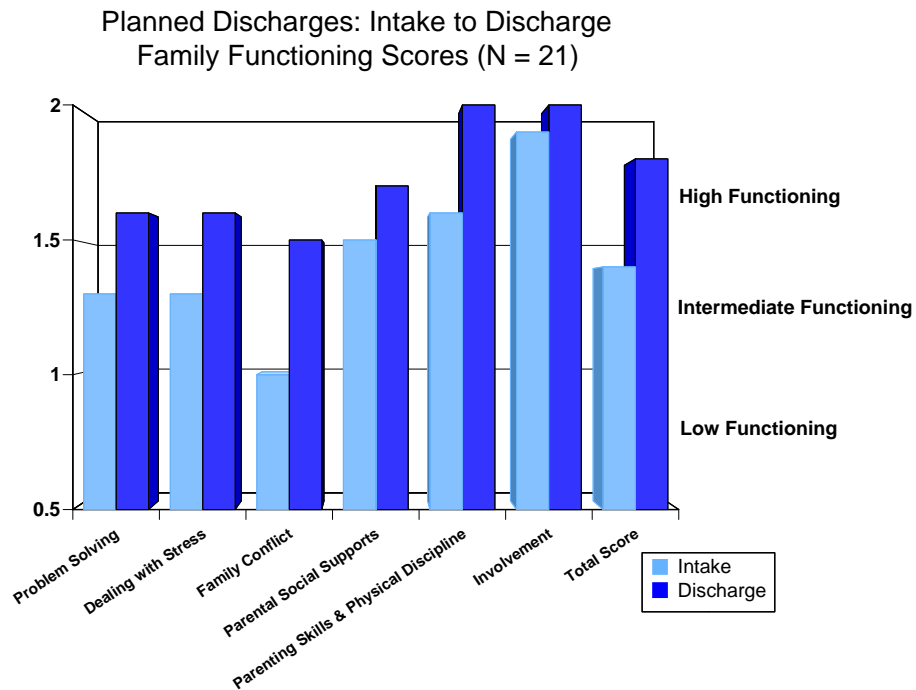
<b>Area of Family Functioning</b>	<b>Intake</b>	<b>Discharge</b>	<b>Statistically Significant?*</b>
Problem solving	1.3	1.6	Yes
Dealing with stress/conflict	1.3	1.6	Yes
Parental and family conflict	1.0	1.5	Yes
Parental social supports	1.5	1.7	No
Parenting skills and discipline	1.6	2.0	Yes
Involvement in case planning	1.9	2.0	No
<b>Total Family Functioning Score</b>	<b>1.4</b>	<b>1.8</b>	<b>Yes</b>

\*Statistical significance is determined via a paired samples t-test with a *p* value of < .05.

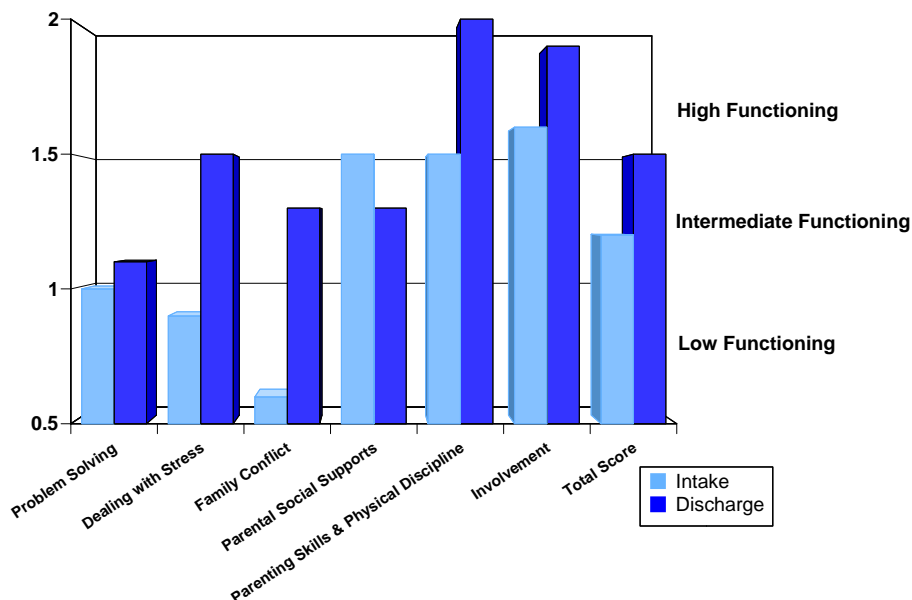
**Unplanned Discharges (N = 8):**

Area of Family Functioning	Intake	Discharge	Statistically Significant?*
Problem solving	1.0	1.1	No
Dealing with stress/conflict	.9	1.5	No
Parental and family conflict	.6	1.3	No
Parental social supports	1.5	1.3	No
Parenting skills and discipline	1.5	2.0	No
Involvement in case planning	1.6	1.9	No
<b>Total Family Functioning Score</b>	<b>1.2</b>	<b>1.5</b>	<b>No</b>

\*Statistical significance is determined via a paired samples t-test with a *p* value of < .05.



Unplanned Discharges: Intake to Discharge  
Family Functioning Scores (N = 8)



**In Summary:**

For clients whose services were terminated in a planned way, four of the six measures on the Family Functioning Scale showed clinical improvement to the point of statistical significance: Problem Solving, Dealing with Stress/Conflict, Parental and Family Conflict, and Parenting Skills and Physical Discipline, as did the Total Family Functioning Score (probably the best overall measure of clinical improvement). The Total Family Functioning Score increased from an average score of 1.4 at admission to a score of 1.8 at discharge. This indicates an effect size of 1.4, which would be considered an *extremely large* treatment effect. This is another very favorable performance outcome. All of the remaining scores were in a favorable direction (higher), which is suggestive of some clinical improvement. For clients whose services were terminated in an unplanned way, none of the measures on the Family Functioning Scale showed clinical improvement to the point of statistical significance, although changes in all but one of the measures were in a favorable direction.