11 & Under Initiative (11UI)
Evaluation of Pilot

Draft

Prepared by
Kristi D. Wright, Ph.D.
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EXECUTIVE SUMMARY

Background and Objectives

The 11UI is an initiative focused on supporting children 11 and under who are exposed to risk factors that may increase their tendency to engage in unhealthy behaviour. The program seeks to develop a coordinated method of early identification of children at risk and addressing the challenges faced by their family through appropriate connections and referrals to programs and services in an effort to optimize their health, safety and development. The 13-week empirically supported, cognitive behavior intervention/ prevention program Stop Now and Plan-SNAP® is also a key component of this initiative and is provided to each 11UI client in a group format. SNAP® is also provided to select Grade 3 and 4 classrooms. Coordination of the efforts and commitment from the Regina Public School Board, Regina Catholic School Board, Regina Police Service (RPS), Ministry of Social Services (MSS), Regina Qu'Appelle Health Region (RQHR-specifically Child and Youth Services and Mental Health and Addiction Services), City of Regina (Sports and Recreation Branch), Ranch Ehrlo, YWCA, Regina Open Door Society and 2 Community Elders support this initiative.

Purpose

This evaluation was completed to examine the effectiveness of a pilot of the 11UI in achieving a number of outcomes for 11UI clients including decreasing child risk, decreasing contact with the RPS, improving school engagement, increasing involvement in prosocial activities, and decreasing levels of child psychopathology.

Analyses

Statistical analyses were completed on data collected on both 11UI clients and 'targeted' children in grade 3 and 4 classrooms.

Results

Despite a small sample size, our results suggest that the 11UI pilot was successful on a number of levels. Significant decreases in child risk and contact with RPS was observed for 11UI clients. At the completion of SNAP®, 64% of 11UI clients were engaged in some sort of prosocial programming. Albeit, only three 11UI clients completed SNAP®. In contrast, 78% of targeted children completed SNAP® within the school setting. Although no statistically significant decreases in parent/guardian- or teacher-rated child psychopathology across both 11UI clients and targeted children, there were observable decreases across many CBCL and TRF scales. In terms of school engagement, decreases in the frequency of absences/late attendance were not observed. 11UI clients had limited to no involvement in extracurricular activities at school across both time-points.

Recommendations

Given that our sample size was extremely small it is important to not draw substantive conclusions regarding the nonsignificant results discussed above. It will be critical to obtain a larger sample size with complete data in order to be able to appropriately assess the effectiveness of 11UI in general, and SNAP® more specifically, in evoking change in child psychopathology for both 11UI clients and targeted children.

BACKGROUND AND OVERVIEW

The 11UI is an initiative focused on supporting children 11 and under who are exposed to risk factors that may increase their tendency to engage in unhealthy behaviour (e.g., delinquent behaviour). The program seeks to develop a coordinated method of early identification of children at risk and addressing the challenges faced by their family through appropriate connections and referrals to programs and services in an effort to optimize their health, safety and development. Coordination is achieved by the consolidation of efforts and commitment from the Regina Public School Board, Regina Catholic School Board, Regina Police Service (RPS), Ministry of Social Services (MSS), Regina Qu'Appelle Health Region (RQHR-specifically Child and Youth Services and Mental Health and Addiction Services), City of Regina (Sports and Recreation Branch), Ranch Ehrlo, YWCA, Regina Open Door Society and 2 Community Elders.

Children who are identified as being exposed to risk factors that may potentially increase their risk of developing detrimental behavior patterns are referred by any participating agencies or organizations (listed above) through a single intake point (i.e., 11UI staff). An initial screening is conducted by 11UI staff to examine the child and their family circumstances. Those who meet the criteria of this initiative and consent to participate are reviewed weekly among a working group of the relevant key partners with the objective to avoid duplication of services and increase communication among the service providers. This group arranges for a more in depth assessment of the child and their families needs as well as work to develop a plan that would be implemented with the family's agreement and consent. Regular follow up is conducted to track the progress of individual families. Further, an integral part of the 11UI initiative is the inclusion of the 13-week empirically supported, cognitive behavior intervention/prevention program Stop Now and Plan-SNAP® (Augimeri, Jiang, Koegl, & Carey, 2006).

SNAP® was designed to target symptomatology and associated difficulties including poor self-control and problem solving, bullying, delinquency, aggression and violence, antisocial values and conduct, cognitive distortions, problematic parent-child interactions, school failure, and isolation [Child Development Institute (CDI), 2012]. The effectiveness of SNAP® in decreasing levels of externalizing problems (e.g., aggression, delinquent behaviour) has been demonstrated by numerous investigations of (e.g., Augimeri, Farrington, Koegl, & Day, 2007; Augimeri, et al., 2006; Day, 2003; Koegl, Farrington, Augimeri, & Day, 2008; Lewis et al., 2008; Lipman et al., 2008). The SNAP® School-based model is a newly developed model that was adopted by 11UI to allow for the application within classrooms of the two school systems in Regina as well as for 11UI referred clients within the community.

Children and their parents/guardians referred to 11UI were and will continue to be referred to SNAP® that is delivered in the community by trained facilitators. As suggested by the developers (CDI, 2012), SNAP® was delivered to the 11UI clients separately for boys

and girls in the community. For 11UI clients, their parents/guardians are also provided with parent components of SNAP®. In addition, SNAP® was and will continue to be being delivered by trained facilitators within both school systems in Regina (i.e., Regina Public School Board, Regina Catholic School Board) in selected grade 3 and 4 classrooms. Parents/guardians participating in the school-based delivery of SNAP® were not provided the parent components of SNAP®. Children potentially at risk of future problematic behaviour were identified by school counselors and teachers (described as 'targeted' herein) in both school systems in these selected classrooms and potential behaviour change as a function of SNAP® was monitored (see below for further description). To date, one boy and one girl group (i.e., 11UI clients) delivered within the community was completed. The program was also completed in two classrooms (i.e., one class per school system). The data to be discussed herein represents data from the pilot delivery of 11UI including the application SNAP® within both settings (i.e., the community and school).

Purpose

11UI as a whole identified a number of specific outcomes. The purpose of this evaluation was to determine the effectiveness of 11UI in achieving these outcomes:

(1) decreasing child risk (i.e., as measured by the EARL-PC, EARL-20B, EARL-21G; *Note: for the purposes of this pilot evaluation the scores on the EARL-PC were examined);

(2) decreasing contact with the RPS;

(3) improving school engagement (e.g., improving school attendance, decreasing number of school suspensions/expulsions);

(4) increasing involvement in prosocial activities;

(5) decreasing levels of associated psychopathology (e.g., aggression, conduct disorder problems, rule-breaking problems as measured by the CBCL and TRF).

EVALUATION DESCRIPTION

11UI Clients

Data was gathered from all children and families who were referred to 11UI, met criteria for inclusion in program, and provided consent for their participation. Data was collected to compose a complete picture of the respective children and their families as well as a means to examine the effectiveness of 11UI. Data was obtained via interview with parent/guardian and parent/guardian- and teacher-completed measures (See Table 1 for time-line of data collection). Parents/guardians were interviewed by 11UI staff in an effort to obtain necessary demographic information and to identify their unique needs. The Early Assessment Risk List – Pre Checklist (EARL-PC; Augimeri, Walsh, Jiang, Koegl, & Logue, 2010) was utilized during this process. The EARL-PC is a general checklist designed for those working with young children (under 12 years of age) to identify potential risk/concern for involvement in antisocial behaviour. It aids in guiding users to exercise their best judgment in assessing areas of concern in order to identify and facilitate referrals to appropriate community based services for children most at risk. The EARL-PC was adapted from the Early Assessment Risk Lists [EARL-20B for boys and the EARL-21G for girls; (Augimeri, Koegl, Webster, & Levene, 2001)]. For the purposes of this pilot evaluation of 11UI, the EARL-PC scores were examined. Therefore, scores on the EARL-PC at the entry point to 11UI and following completion of SNAP® were of particular interest. Demographic information obtained throughout the interview process were also examined and included in the present evaluation in an effort to best understand the unique needs of the 11UI clients.

In addition to the EARL-PC, parents/guardians of 11UI clients were asked to complete the Child Behavior Checklist (CBCL; Achenbach, 2001) at the two time-points (i.e., prior to and following completion of SNAP®). The CBCL is a parent-rated measure designed to assess behaviour problems and social proficiency in children. It contains descriptions of 113 behavioural and emotional problems. Parents are asked to rate the child's behaviour over the previous 6 months on a 0 (not true) to 2 (very or often true) Likert scale. Responses are grouped into eight problem scales (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Aggression, Rule-Breaking, Attention Problems, Thought Problems, and Social Problems, Note: the latter three were not available for analysis) that are grouped into two scales: Internalizing Problems (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints), Externalizing Problems (Delinquent Behavior, Aggression), and total problems (sum of all items) (Achenbach, 2001). In addition to the scales described above, the CBCL also provides six DSM-Oriented scales: Affective problems, Anxiety problems, Somatic problems, Attention deficit/hyperactivity problems, Oppositional defiant problems, and Conduct problems. The scores of the items that constitute a scale are summarized (summed raw scores) and transformed into standardized scores (T scores). All scales were examined, however of specific interest to the current project include the CBCL problem scales of Aggression and Delinquent Behaviour, the total of these behaviors captured by the Externalizing Problems scale. The DSM-Oriented scales of Oppositional

Table 1.
Timeline of Data Collection

Measure	Initial Assessment	Pre-SNAP®	Post- SNAP®
11UI Clients			
Interview/ EARL-PC	X		X
CBCL		X	X
TRF		X	X
Targeted Children			
TRF		X	X

Note. EARL-PC = Early Early Assessment Risk List – Pre Checklist; CBCL; Child Behavior Checklist; TRF = Teacher Report Form.

Defiant problems and Conduct problems are also of specific interest. Teachers of these children were asked to complete the compliment teacher version of the CBCL- the Teacher Report Form (Achenbach, 2001) at similar time points. The TRF assesses teacher's reports of children's academic performance, adaptive functioning, and behavioral/emotional problems. Similar problem and DSM-Oriented scale scores are produced by the responses to 113 items on the TRF.

Lastly, data from the participating agencies and organizations identified above were also obtained for 11UI clients in an effort to best support the child and their respective families as well as a means to examine the effectiveness of 11UI. Examples of this data included number of absences from school, contact with the RPS, involvement in prosocial activities, type of contact with MSS, type of contact with Child and Youth Services and or Addictions Services.

Targeted Children in School Setting

As described above, children potentially at risk of future problematic behaviour were identified by school counselors and teachers (described as 'targeted' herein) in both school systems. Teacher-rated data [i.e., Teacher Report Form (TRF); Achenbach, 2001] was obtained prior to and at completion of SNAP® for these targeted children. Brief demographic information for the targeted children was obtained from the completed TRF.

PROGRAM STATISTICS AND RESULTS

DEMOGRAPHIC INFORMATION

11UI Clients

At the time of completion of this evaluation, there were 93 11UI client files, however 79 were deemed inactive (i.e., not engaged with 11UI or had aged out) and remaining 14 were deemed active. Descriptive and outcome data for the aforementioned 14 11UI clients will be explored below. Overall, the average age of active 11UI clients was 10.36 years (*SD* = 1.45; range = 8-13 years). Approximately 64% (*n* = 9) were male (m_{age} = 10.33 years; *SD* = 1.12; range = 9-12 years) and the remainder female (*n* = 5; m_{age} = 10.40 years; *SD* = 2.08; range = 8-13 years). See Table 2 for review of additional demographic information. Type and frequency of contact with MSS and RPS at initial interview can be viewed in Tables 3 and 4, respectively.

Targeted Children

There were 18 children identified as "at risk" across both school systems. Little demographic was collected for this group of children. Overall, the average age of the targeted children was 9.56 years (*SD* = 1.34; range = 7-12 years). Half of the targeted children were male (*n* = 9; m_{age} = 9.00 years; *SD* = 1.23; range = 7-11 years) and the other half female (*n* = 9; m_{age} = 10.11 years; *SD* = 1.27; range = 9-12 years).

OUTCOME TARGETS

Child Risk

Risk for 11UI clients was assessed by scores on the EARL-PC. The EARL-PC was completed at two time-points (i.e., at initial assessment and post-SNAP®) by 11UI staff. Dependent sample t-tests were computed to assess change over time in EARL-PC scores. A significant reduction in EARL-PC scores were observed from time 1 (mean score = 8.69; *SD* = 2.50; range 4-13) to time 2 (mean score = 7.38; *SD* = 2.22; range 3-11), t (12) = 3.77, p = .003.

Contact with RPS

The frequency of contact of 11UI clients with RPS was recorded by RPS at two time-points (i.e., initial interview and post-SNAP®). Dependent sample t-tests were computed to assess change over time in contact with RPS. A significant reduction in contact with RPS was observed from time 1 (mean = 5.84; *SD* = 4.12; range = 0-15) to time 2 (mean = 0.31; *SD* = 0.63; range = 0-2). See Table 4 for frequency and type of contact with RPS at initial interview.

Table 2.
Demographic Information for 11UI Clients

Demographics[a]	Male[b]	Female[c]	Total[d]
Age			
M (*SD*)	10.33 (1.12)	10.40 (2.08)	10.36 (1.45)
	n (%)	*n* (%)	*N* (%)
Living arrangements[d]			
Living with biological parent(s)	5(55.6)	4 (80.0)	9 (64.3)
Living in residential housing or group home	1 (11.1)	1 (20.0)	2 (14.2)
Living with other family member	1 (11.1)	-----	1 (7.1)
School-related information			
Days absent/late			
M (*SD*)	17.43 (13.89)	6.3 (2.86)	12.8 (11.88)
In-school suspensions			
M (*SD*)	0.50(0.84)	0.80 (1.30)	0.63 (1.03)
Out-of-school suspensions			
M (*SD*)	1.30 (2.91)	0.20 (0.45)	0.75 (2.05)
Involvement in extracurricular activities	*n* (%)	*n* (%)	*N* (%)
Sports	1 (11.1)	1 (20.0)	2 (14.2)
Mental health-related information	*n* (%)	*n* (%)	*N* (%)
Involvement with mental health counselor	7 (77.8)	5 (100.0)	12 (85.7)
Type of involvement			
Individual counseling	4 (57.1)	3 (60.0)	7 (58.3)
Parent training	1 (14.3)	-----	1 (8.3)
Family support counselor	-----	3 (60.0)	3 (21.4)
Meeting with Elder	1 (14.3)	-----	1 (8.3)
Involvement with Psychiatry	-----	1 (20.0)	1 (8.3)
Involvement with school counselor/behavioural coach	3 (42.9)	3 (60.0)	6 (42.9)
Diagnosis	2 (22.2)	-----	2 (14.3)
Attention deficit/hyperactivity disorder (ADHD)	2 (100.0)	-----	2 (14.3)
Ministry of Social Service (MSS)-related information			
Contact with MSS	8 (88.9)	3 (60.0)	11 (78.5)
Frequency of contact			
1-3	3 (37.5)	3 (100.0)	6 (42.9)
4-6	3 (37.5)	-----	3 (21.4)

7+	1 (12.5)	-----	1 (7.1)
Regina Police Service (RPS)-related information			
Contact with RPS	7 (77.8)	4 (80.0)	11 (78.5)
Frequency of contact			
1-3	1 (14.3)	-----	1 (7.1)
4-6	3 (42.9)	2 (50.0)	5 (45.5)
7-10	2 (28.6)	2 (50.0)	4 (28.6)
10+	1 (14.3)	-----	1 (7.1)

Note: [a] data is missing variably across demographic data and therefore percentages do not add up to 100% across demographic categories; [b] $n = 9$; [c] $n = 5$; [d] $n = 14$.

Table 3.
Type and Frequency of Contact with MSS

Type of contact	*n* [a] (%)
Investigation	9 (62.3)
Apprehension	3(21.4)
Extrafamilial placement	2 (14.3)
Total number of contacts with MSS	14

Note: [a] number of contacts

Table 4.
Type and Frequency of Offense Recorded by RPS

Type of offense	*n* (%)
Other	7 (28.0)
Mischief	6 (24.0)
Auto theft	3 (12.0)
Abuse	3 (12.0)
Assault	2 (8.0)
Theft	1 (4.0)
Break and enter	1 (4.0)
Carrying toy gun	1 (4.0)
Trespassing	1 (4.0)

Note: A total of 25 offenses were recorded by RPS for 11UI clients for whom we had such data on.

School Engagement

One index of school engagement is attendance. Absence/late attendance was recorded at two time-points (i.e., total in months prior to SNAP® and total during and following SNAP®). Dependent sample t-tests were computed to assess change over time in absences/late attendance. A significant increase in absence/late attendance was observed from time 1 (mean = 12.79; *SD* = 11.88; range = 2-39) to time 2 (mean = 27.85; *SD* = 22.46; range = 2-70). No data was available for suspensions or expulsions at time 2. In terms of engagement in extracurricular activities, two children were engaged in sports associated with school prior to SNAP®. However, no children were engaged in any extracurricular activities following SNAP®.

Prosocial Programming

Approximately 64% (*n* = 9) of 11UI clients were engaged in some sort of prosocial programming at the completion of SNAP®. Only 3 11UI clients completed SNAP® in the community. Approximately 78% (*n* = 14) of the targeted children completed SNAP® either in their classroom or in the community (Note: a small number of children attended SNAP® in the community even though they were not 11UI clients).

Child Psychopathology

Levels of child psychopathology were assessed by completion of the CBCL and TRF for 11UI clients. The TRF alone was completed for the targeted children. Measures were completed at two time-points (i.e., prior to and following the completion of SNAP®; see Tables 5-10). Analyses were completed to examine potential changes over time.

11UI Clients. Only 6 11UI clients had completed data for both time points for the CBLC and therefore analyses were completed with data from these clients. Dependent sample t-tests were computed to assess changes over time in parent/guardian-rated psychopathology (i.e., CBCL). No statistically significant changes were observed for the problem scales, albeit there are observable decreases in scores for Withdrawn Depressed, Somatic Complaints, Rule-Breaking, Internalizing, Externalizing, and Total Problems scales (see Table 5). Further, no statistically significant changes were observed for DSM-Oriented scales, albeit there are observable decreases in scores for Affective, Anxiety, ADHD, and ODD scales (see Table 6). Please interpret the above results with caution as the sample size is too small to draw substantive conclusions.

Only 4 11UI clients had completed data for both time-points for the TRF and therefore analyses were completed for these clients. Dependent sample t-tests were computed to assess changes over time in teacher-rated psychopathology (i.e., TRF). No statistically significant changes were observed for the problem scales, albeit there are observable decreases in scores for Somatic Complaints and Rule-Breaking Problem scales (see Table 7). Further, no statistically significant changes were observed for DSM-Oriented scales, albeit there are observable decreases for Affective and Somatic scales (see Table 8). Please interpret the above results with caution as the sample size is too small to draw substantive conclusions.

Table 5.
Child Psychopathology as assessed by the CBCL Problem Scales at Time 1 and Time 2 for 11UI Clients

CBCL Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Anxious/Depressed	70.17 (4.54)	71.00 (6.39)	-0.225	.831
Withdrawn/Depressed*	71.33 (9.63)	69.83 (10.30)	1.000	.363
Somatic Complaints*	70.67 (7.69)	65.67 (9.61)	1.927	.112
Aggression	72.33 (11.13)	73.00 (14.78)	-0.193	.855
Rule-Breaking*	68.17 (11.81)	65.83 (10.68)	0.826	.446
Internalizing Problems*	73.50 (4.23)	72.17 (4.12)	0.810	.455
Externalizing Problems*	70.33 (10.82)	69.83 (11.29)	0.253	.811
Total Problems*	73.17 (5.46)	72.33 (5.89)	0.822	.448

Note: *denotes decreases in respective scale scores.

Table 6.
Child Psychopathology as assessed by the CBCL DSM-Oriented Scales at Time 1 and Time 2 for 11UI Clients

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CBCL Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Affective*	77.00 (6.60)	74.17 (7.08)	.696	.506
Anxiety*	66.00 (6.69)	65.33 (7.74)	1.287	.234
Somatic	66.83 (7.74)	67.17 (12.86)	.282	.785
ADHD*	64.67 (12.86)	62.33 (2.94)	1.246	.248
ODD*	67.83 (12.08)	66.67 (11.62)	1.136	.289
Conduct	71.00 (12.92)	71.67 (12.94)	.291	.779

Note: *denotes decreases in respective scale scores.

Table 7.
Child Psychopathology as assessed by the TRF Problem Scales at Time 1 and Time 2 for 11UI Clients

TRF Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Anxious/Depressed	65.00 (12.41)	66.50 (12.07)	-0.676	.547
Withdrawn/Depressed	64.75 (10.15)	65.50 (9.81)	-0.454	.681
Somatic Complaints*	60.50 (14.18)	57.50 (15.00)	1.000	.391
Aggression	76.75 (6.85)	81.50 (12.77)	-1.407	.254
Rule-Breaking*	75.00 (8.08)	73.75 (10.66)	0.837	.464
Internalizing Problems	64.50 (19.00)	65.75 (15.06)	-0.620	.579
Externalizing Problems	76.50 (5.45)	78.00 (7.87)	-0.812	.476
Total Problems	75.25 (6.40)	76.00 (7.79)	-0.600	.591

Note: *denotes decreases in respective scale scores.

Table 8.
Child Psychopathology as assessed by the TRF DSM-Oriented Scales at Time 1 and Time 2 for 11UI Clients

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TRF Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Affective*	69.75 (10.11)	65.00 (10.81)	2.01	.137
Anxiety	65.00 (11.23)	67.00 (11.91)	-1.000	.391
Somatic*	59.25 (12.74)	57.50 (15.00)	0.616	.581
ADHD	67.75 (6.60)	68.00 (9.42)	-0.151	.889
ODD	71.25 (2.22)	72.00 (3.56)	-0.388	.724
Conduct	82.50 (12.12)	84.25 (14.93)	-1.219	.310

Note: *denotes decreases in respective scale scores.

Eleven targeted children clients had completed data for both time-points for the TRF and therefore analyses were completed with data from these children. Dependent sample t-tests were computed to assess changes over time in teacher-rated psychopathology (i.e., TRF). No statistically significant changes were observed for the problem scales, albeit there were observable changes for Anxious/ Depressed, Withdrawn/Depressed, Rule-Breaking, Internalizing, Externalizing, and Total Problems scales (see Table 9). Further, no statistically significant changes were observed for DSM-Oriented scales, albeit there was an observable change for the Conduct scale (see Table 10). Please interpret the above results with caution as the sample size is too small to draw substantive conclusions.

Table 9.
Child Psychopathology as assessed by the TRF Problem Scales at Time 1 and Time 2 for Targeted Children

TRF Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Anxious/Depressed*	55.91 (6.67)	55.55 (6.77)	0.226	.826
Withdrawn/Depressed*	59.18 (9.02)	58.18 (6.19)	0.439	.670
Somatic Complaints	54.09 (5.91)	55.64 (5.97)	-1.053	.317
Aggression	65.64 (4.57)	66.82 (7.29)	-0.691	.505
Rule-Breaking*	70.09 (5.97)	68.54 (4.97)	0.822	.430
Internalizing Problems*	55.27 (10.60)	53.82 (11.21)	0.616	.551
Externalizing Problems*	68.36 (4.91)	68.27 (5.55)	0.054	.958
Total Problems*	65.82 (6.26)	65.00 (5.90)	0.463	.653

Note: *denotes decreases in respective scale scores.

Table 10.
Child Psychopathology as assessed by the TRF DSM-Oriented Scales at Time 1 and Time 2 for Targeted Children

TRF Scale	Time 1 Mean (SD)	Time 2 Mean (SD)	t	*p*
Affective	59.45 (8.21)	61.55 (7.20)	-0.757	.466
Anxiety	54.55 (5.41)	54.82 (6.74)	-1.179	.861
Somatic	51.36 (3.04)	52.55 (5.66)	-0.761	.465
ADHD	63.64 (5.78)	65.72 (8.01)	-0.954	.363
ODD	65.45 (3.39)	67.18 (6.52)	-1.009	.337
Conduct*	71.73 (9.14)	70.64 (7.49)	.352	.732

Note: *denotes decreases in respective scale scores.

SUMMARY

The 11UI pilot has been successful on a number of levels. Despite a small sample size, our results suggest that we met or there is an observed trend towards meeting many of the major outcomes identified for this initiative. Specifically, our results demonstrated significant decreases in child risk (as measured by the EARL-PC) for 11UI clients. Although we are unable to make definitive causal links between being involved in 11UI and the observed decreased in EARL-PC scores, our results indicated that at the post-SNAP time-point 11UI clients demonstrated lower levels of risk. Similarly, we observed a significant decrease in contact with RPS for our 11UI clients. In fact, the average frequency of contact with RPS dropped from approximately 5.8 to 0.3 contacts. In terms of involvement in prosocial programming, at the completion of SNAP® 64% of 11UI clients were engaged in some sort of prosocial programming. Albeit, only three 11UI clients completed SNAP®. It is unknown why this number is so low. It is necessary for 11UI staff to explore explanations for the latter and make in-roads to increasing the involvement and engagement of 11UI clients in SNAP® as SNAP® has been identified as a critical piece to similar initiatives. It is important to note that 78% of targeted children completed SNAP® within the school setting. Lastly, although there were no statistically significant decreases in parent/guardian- or teacher-rated child psychopathology across both 11UI clients and targeted children, there were observable decreases across many CBCL and TRF scales. Given that our sample size was extremely small it is important not to draw substantive conclusions from the nonsignificant results in terms of the impact of SNAP® on levels of child psychopathology. It will be critical to obtain a larger sample size with complete data in order to be able to appropriately assess the utility of SNAP® in evoking change in child psychopathology.

In terms of school engagement, we did not see significant decreases in the frequency of absences/late attendance. In fact, we observed an increase in absences/late attendance during and following the completion of SNAP®. At this time, we are unable to determine the cause of this increase. Likely, there are other variables that may contribute to this observed increase. Also, were unable to assess changes in the frequency of suspensions/expulsions due to lack of data for these variables post-SNAP®. 11UI clients had limited to no involvement in extracurricular activities at school across time-points. This may be related to limited opportunities for extracurricular activities at the elementary school level. It may also be the case that more 11UI clients were involved extracurricular activities but those activities were not recorded. It will be important to strive to collect as complete information as possible for all 11UI clients in the future.

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