

# Pine River Institute

2018 Evaluation Report





# Pine River Institute

## 2018 Annual Evaluation Report

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# A NOTE FROM PRI'S CLINICAL TEAM

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The Clinical Team is sincerely grateful for the time and effort the research team invests in creating a user-friendly report, one that is easy to digest and integrate into our awareness, to inform our work. We recognize that without these painstaking efforts, our treatment outcomes would be just anecdotal. We value the credibility the research gives to our therapeutic efforts.

The Annual Evaluation Report informs the clinical team in three main areas: First and foremost, it holds us accountable and assures us that we are doing what we say we are doing to help adolescents and their families grow and get better. Second, it provides us with insight into areas we can improve and challenges us to continually re-examine ways we can be more effective. Last, it propels us to ask deeper and more meaningful questions, such as

“What it is that we do that really makes a difference?” and, “What is the magic that assists adolescents to grow in the program and sustain that growth when they return home?”.

We are so grateful to our adolescents and their parents for their continued participation and contribution to our evaluation efforts. This client-level commitment to our research and evaluation allows for us to be accountable, ever-improving, and engaged in deep therapeutic curiosity.

With sincere appreciation, the Clinical Team embraces the findings of the Annual Evaluation Report.

The Clinical Team

# PINE RIVER INSTITUTE – AN INTRODUCTION

Pine River Institute (PRI) is a residential treatment program for youths 13-19 who struggle with addictive behaviours and often mental, behavioural, and relationship problems. These teens have a complex array of problems spanning criminality, hospitalizations, stalled or abandoned school careers, and profound family dysfunction. When teens come to PRI they are angry, sad, and lost.

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Parents of youth at PRI are desperate. They walk on eggshells to keep peace in their homes, become frantic when their child leaves for days, and many have experienced their teen's suicidal intentions. They wonder how their child found themselves on such a dark path and why, despite all efforts, they have been unable to help.

At PRI, families find a safe and nurturing professional environment where they can begin to heal. Wilderness, residential, therapeutic, and academic programs converge to form our comprehensive treatment model. This model enhances adolescents' maturity, meaning PRI's programming develops emotion regulation, empathy, respectful relationships, a social ethic, and a future orientation. We help families find their way to attuned and supportive open communication, healthy boundaries, and limit-setting.

PRI families move through a comprehensive program that entails four distinct **PHASES**. In Phase 1, the Outdoor Leadership Experience (**OLE**), youths spend several weeks in the wilderness, to develop physical and social skills, and recognize the need for change. They then move to **RESIDENCE** (Phase 2), an academic and therapeutic milieu. As they demonstrate greater levels of maturity and leadership, they move to the third phase, **TRANSITION**, a time to start taking the lessons home. The fourth phase, **AFTERCARE**, is when the youths reside at home but receive support to sustain treatment gains, integrate to the community, and engage with school and/or work.

Parents have a very important role in the therapeutic process and engage in a **Parallel Process**, where they experience growth and development alongside their child. We support parents as they courageously learn about themselves, relationships within their own families, and strategies to begin a new relationship with their child.

# THIS REPORT

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PRI'S Annual Evaluation Report is a tool for quality improvement, risk management, administration, organizational planning, and communications. It provides information for PRI's Board and staff, funders, government decision-makers, practitioners, researchers, potential PRI families and students.

This report provides youth and family **demographics**; **process** information including admissions and program engagement; and **treatment outcomes** that include the mental, physical, behavioural, and relationship health of PRI clients before and after the program.

Full program completion at PRI is recognized by graduation from Aftercare. Aftercare engagement, however, varies across families, so for evaluation, **Completers are seen as students who successfully completed the TRANSITION** from the residential phase of the program. We show treatment outcomes for **Completers** (Cs) and **Non-Completers** (NCs). A red star \* indicates that the differences between Cs and NCs are statistically significant.

Due to the voluntary nature of research contribution, some data are missing. Thus, the findings in this report represent a sample of the Pine River population only (i.e., other youths may not experience the same outcomes). Since January 1, 2010, 275 youths have departed PRI and reached the first data-collection time-point, three months later. We have 203 responses from at least one parent; a **73%** parent response rate. Parents whose youth completed the program represent two-thirds of the responding parents. About one-third (31%) of PRI youths respond to requests to contribute to research, after they have left PRI. Clinicians and staff are in touch with former clients informally, typically

when a youth calls to touch base. Our results are fairly consistent across these respondents, so we provide detailed charts with quantitative **parent** information, narrative reports based on **youth** responses, and open-ended comments provided by **clinicians**.

In **2010**, PRI underwent profound changes. We secured permanent government funding. Our beds were consistently full. We started a waiting list. We implemented our current therapeutic model, our commitment to our family program, our team-based community milieu, and regular professional development. In other words, we increased our treatment fidelity which has forged PRI as we know it today. Therefore, this report is based **only** on youths who were in the program after 2010.

**LOSS OF DATA.** In 2018, we underwent a major data 'renovation', migrating all data to a new, centralized system. In so doing, we upgraded some questions to be more standardized. This resulted in the loss of some data. For example, we used to ask parents 'has your child run away in the most recent three months' (yes or no). If a parent answered 'no', but their child had run away FOUR months prior, we wouldn't know it. The new survey asks 'When, if ever, was the last time your child ran away', with response options spanning the last year and beyond. We were unable to enter some data to this new question, based on a 'no' in the old system. In some cases, qualitative responses or past surveys allowed us to complete this information, but not in all cases. This data loss is most evident on indicators such as running away, contact with police, and hospitalizations.

# SNAPSHOT

## OF THE FULL REPORT

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This snapshot provides an overview of the characteristics of PRI youths, our program processes, and our client outcomes. The full report offers deeper and broader information about our program.

### TYPICAL CHARACTERISTICS OF YOUTH ENTERING PRI (2010 – 2018):

- The average age at admission was 17, about 60% male.
- Half were from the GTA, most others from non-GTA Ontario, a few were out-of-province.
- Most common substances of choice were marijuana and alcohol.
- About 3/4 had a history of suicidal thoughts; about a quarter had attempted suicide.
- Over half of entering youth experienced police contact, over half have run away.
- About 40% were not in school, many others were failing.
- Most experience clinically problematic mental health issues, often across multiple domains, most commonly ADD/ADHD, anxiety, and/or depression.

### INQUIRY AND ADMISSION INFORMATION

30 - 35 youths enter PRI each year, and they stay an average of 376 days. There are always about 200 families on the waitlist; many inquirers indicate that their need is too immediate and choose not to wait. In 2017, clients funded by the Ministry of Health and Long-Term Care waited an average of 559 days. Those paying privately waited 109 days from the time of contact (but often about three weeks once the decision for private-pay is confirmed).

### PROGRAM ENGAGEMENT

Youths who departed during 2018 occupied a bed (including during home visits) an average of **443 days**. 57% of youths completed the **transition** phase of the program (staying an average of 520 days).

### TREATMENT OUTCOMES: PRE AND POST-PRI - REFERENCING 'MOST RECENT THREE MONTHS'

**Substance Use:** **Pre-PRI**, most youths presented with problematic substance use. **Post-PRI**, substance use is reduced, particularly among Cs.

**Academics:** **Pre-PRI**, parents reported that their youths' academics were sporadic, stalled, or abandoned. **Post-PRI**, youths re-engaged with school with good grades and attendance.

**Police Contact:** **Pre-PRI**, 54% of youth had been involved with police, but **Post-PRI** this was less than 11% (for Cs).

**Hospital Visits:** **Pre-PRI**, about 1 in five youths had visited a hospital for substance use or mental health in the most recent three months. **Post-PRI**, less than 6% of Cs had a hospital visit for those reasons.

**Running Away:** **Pre-PRI**, 1/4 of youth had run away in the three months before entry; **Post-PRI**, less than 11% for Cs.

**Family Functioning** increases from below North American 'healthy' levels **before PRI** to the healthy range **after PRI**.

### SATISFACTION WITH TREATMENT

Most parents are 'satisfied' or 'very satisfied' with PRI treatment. Parents gave the highest satisfaction ratings to the Outdoor Leadership Experience (OLE), Front Line Staff, and individual therapy. The lowest ratings were given to transition and aftercare, which were still in the satisfied range.

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# RESEARCH & EVALUATION

PRI Research is emerging as a leader among our peers. We are members of the research consortium for the National Association of Therapeutic Schools and Programs [NATSAP] and serve on their Ethics and Research Boards. We are recognized as a NATSAP's Research Designated Program.

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PRI led a project to foster evaluation among Ontario's youth agencies. We secured over \$570,000 in funding to support this initiative which is now being led by Addictions and Mental Health Ontario.

In 2018, we shared knowledge about youth and family treatment at: Outdoor Behavioural Healthcare Industry Council (Park City, Utah) and Addictions and Mental Health Ontario (Toronto, ON), and with PRI staff, parents, and Board of Directors. In 2018, we attended the NATSAP (Tampa), CMHO (Toronto), and Society for Research on Childhood Development (Philadelphia) Conferences for learning and networking purposes.

We have ongoing relationships with: Dr. Debra Pepler, Distinguished Research Professor of Psychology at York University; Dr. Stephanie Craig (YorkU); Dr. Amanda Uliaszek (U of T); Dr. Jennifer Eastabrook (Trent U); and, Dr. Nevin Harper (UVic). We will continue to work with our partners to build and share knowledge about youth and family treatment. Research articles that are planned for 2019 include:

- Is emotional intelligence related to maturity, treatment completion, and outcomes?
- Does in-treatment family growth foster PRI completion and better youth outcomes?
- Are changes on maturity related to PRI completion and better youth outcomes?

## PRI Peer-Reviewed Publications in 2018

Mills, L., Dionne, A., Bingley, J., & Watson, S. L. (in press). Stumbling along, walking on eggshells, and vicious circles: What happens while families wait for youth substance use treatment. *Canadian Journal of Family and Youth* (accepted December 2018).

Uliaszek, A., Al-Dajani, N., & Mills, L. (in press). Predictors of attrition from residential treatment for youth with addictive behaviors. *Journal of Child & Adolescent Substance Abuse* (accepted Fall 2018).

Riddell, J., Barnes, M., & Mills, L. (2018). Better relationships, mental wellness, and self development: What parents expect from residential treatment for their struggling youth. *Journal of Therapeutic Schools and Programs*, 10, 186-212.

## Governance

PRI's **Board of Directors** has established a **Standing Committee on Research** under the leadership of Dr. Debra Pepler. Members include Claire Fainer, Dr. Faye Mishna, Dr. Mark Greenberg, Dr. Leena Augimeri, Dr. Gillian Mulvale. The Committee has a mandate to advise and monitor on PRI research activities.

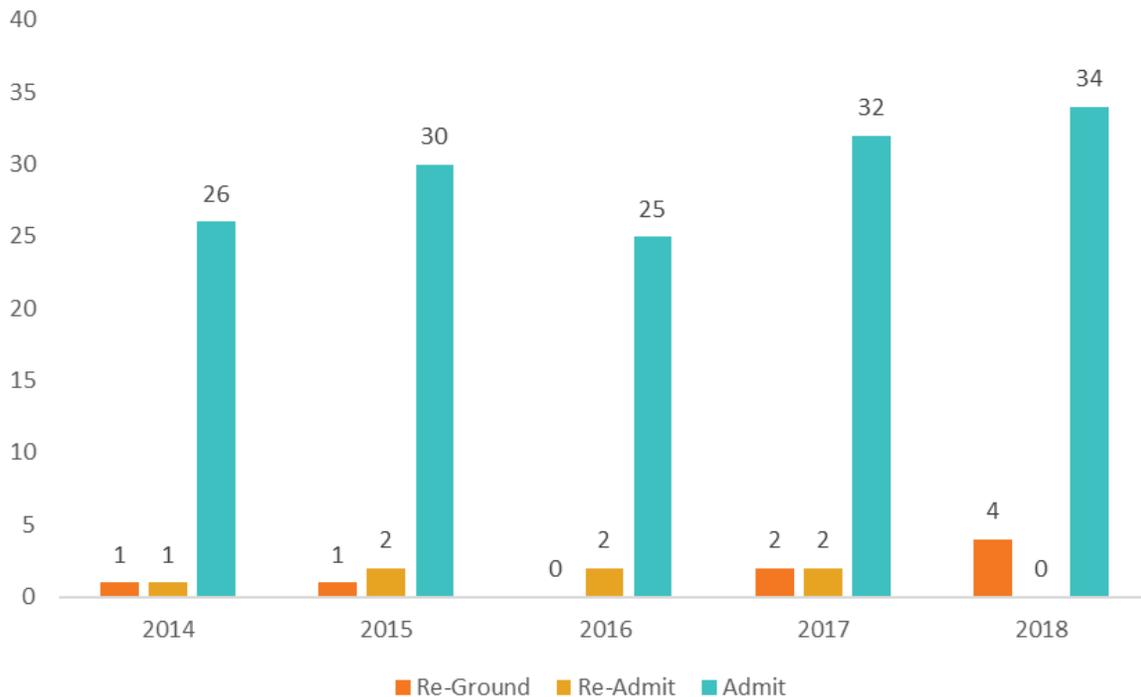
# CLIENT PROFILE

# ADMISSIONS

Each year family members, friends, and professionals working with youth and families contact PRI regarding a struggling youth. Applicable inquirers then complete our online application, submit medical, psychological, and academic documents, and, if appropriate, are placed on our admission wait list.

Families are scheduled for an on-site assessment a few weeks before admission. After the assessment, the youth is admitted when a bed becomes available. In 2018 there were 34 admissions, none were former clients. In some cases, a youth may return to OLE for re-grounding. In 2018, 4 youths returned to OLE for this reason (Figure 1).

**Figure 1. Admission, Readmission & Re-grounding Frequencies 2014-2018.**



In 2018, wait time from inquiry to admission was 559 days for Ministry of Health and Long-Term Care (MOH) clients<sup>1</sup>. Clients funded by MOH wait longer than those who pay privately<sup>2</sup>. Once a family formally agrees to pay privately, the wait time is about three weeks. Our figures below denote the number of days' total wait time from contact to admission, regardless of when they formally indicated private pay engagement. Average wait times for all clients are shown below, by year of admission and type of pay (Table 1).

**Table 1. Average days from Contact to Admission by Year and Type of Pay 2014-2018**

2014		2015		2016		2017		2018	
MOH N=20	PP N=6	MOH N=21	PP N=9	MOH N=17	PP N=7	MOH N=22	PP N=9	MOH N=16	PP N=16
485	206	392	98	462	286	561	139	559	109

*N = Number of Respondents*

*MOH = Ministry of Health funded; PP = private pay*

Over 90% of inquiries are made by a parent, while the rest are from other family members, professionals, or the youths themselves. Inquirers hear about PRI from various sources: about a quarter find us online, about a quarter from a professional or medical doctor; others from PRI alumni, media and communication activities, education consultants, and through friends and family.

## CHARACTERISTICS OF ADMITTED YOUTHS

**Demographics:** The average **age** of youth at admission is 17.3. About half of PRI youth are from the GTA, most of the others are from elsewhere in Ontario; a few (1%) are from outside Ontario. The ratio of **male to female** since 2010 is approximately 2:1, but in the last three years (since the addition of increased female client capacity) is about 60% male, 40% female<sup>3</sup>.

About half of PRI parents live together. Three percent of PRI youths have experienced the death of a parent and 7% were adopted<sup>4</sup>.

**Addictive Behaviours.** PRI youths experience **addictive** behaviour that is part of a complex profile of history and behaviour. A relatively new addiction concerns the use of devices and engagement in virtual relationships. PRI parents reported that their children over-utilize phones and computers and when these are not available, their reactions are extreme and erratic. PRI youths are typically not gamblers.

Concurrent with addictive behaviour, PRI youths typically have experience with one or more **mental health** or **learning** challenges. About two-thirds of PRI youths have experienced previous **treatment** of various types (e.g., counselling, day program, wilderness) and many have been **hospitalized** for reasons of safety, assessment, or stabilization. **Running away** from home and contact with **police** is also common, and typically experienced by about two-thirds of our youths before PRI.

About one in four parents reported that their child was **abused**, either verbally, physically, or sexually. In many cases, the abuse happened when the youth was a young child, but in some cases it occurred later, for example, among abusive peers.

Most (about three quarters) of PRI youths have experience with **suicidality**, one in four had made an attempt to end his or her life before attending PRI. Just over half of PRI parents indicate their child has a history of self-harm (e.g., cutting, burning, removing skin, and banging against walls)<sup>5</sup>, which is often a way some youths cope with intense emotional distress or pain<sup>6</sup>.

**Relationships.** Family lives before PRI were chaotic and oftentimes frightening. Parents lurched from one crisis to the next, walked on eggshells to keep peace in their homes, experienced damaged or stolen property, and worried that one child's troubles would profoundly impact other children in the home. Many PRI youths associated with deviant peers, usually beginning when they transitioned to high school.



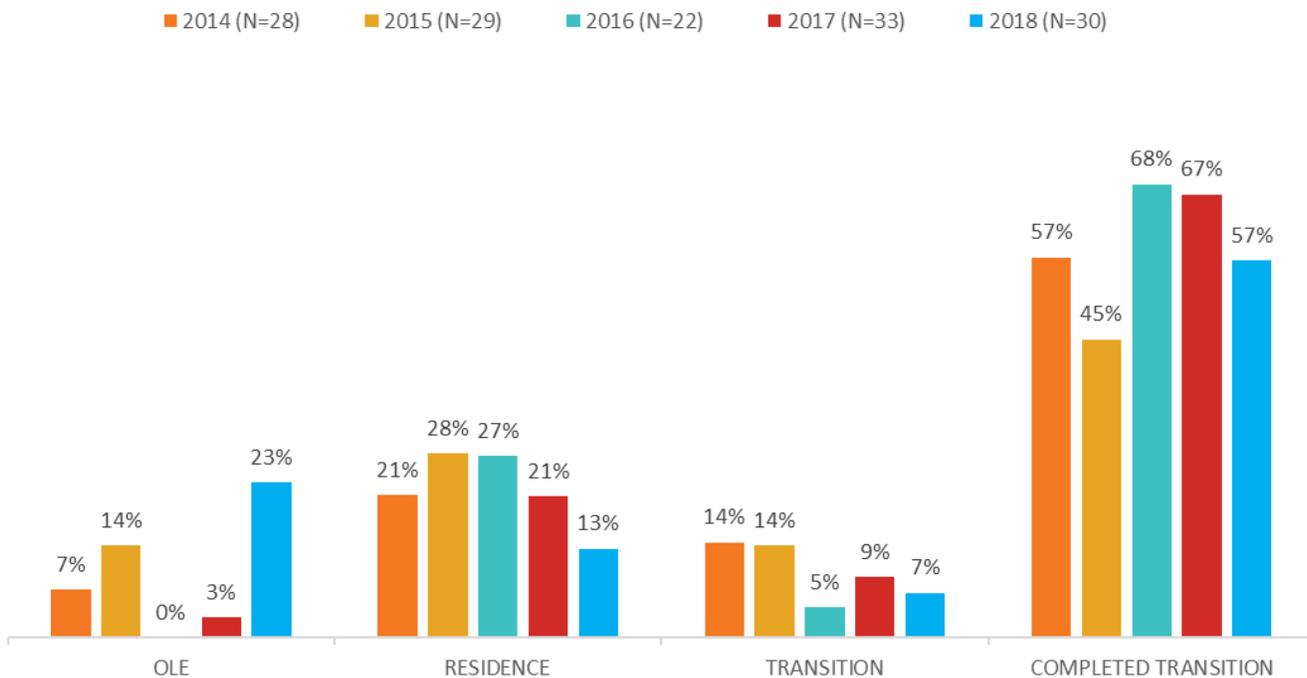
# CLIENT PROFILE

# ENGAGEMENT

## STUDENT ENGAGEMENT

Treatment completion is known to foster healthy outcomes; therefore, we strive to help our youths reach transition completion. Figure 2 details our early departure and transition completion rates for the last five years. In some cases, youths exit the program before completion, based on a mutual client-clinician decision. In 2018, one of the youths who was discharged before completing transition exited based on a clinician-endorsed 'planned early discharge'. In 2017, there were three such departures, and in 2016, there was one.

Figure 2. Phase at Departure by Year of Departure, in Percentages, 2014 – 2018



The average length of stay for youth who completed the program in 2018 was **520 days**. Table 2 details length of stay by year of departure and PRI Completion for the last five years.

**Table 2. Average Length of Stay in Days by Year of Departure and PRI Completion 2014-2018<sup>7</sup>**

	2014	2015	2016	2017	2018
Completers* <sup>8</sup>	527	497	562	552	520
Non-Completers	299	358	380	310	169

This red star means there is a statistically significant difference between completers and non-completers.

## AFTERCARE

When youths complete transition they are encouraged to participate in Aftercare, a fee-for-service option (a grant from RBC partially funds this program, but is not in our funding agreement with MOH). In 2018, 14 of the 17 youths who completed transition participated in Aftercare. Similarly, across the last five years, most or all treatment completers engaged with aftercare.



# PARENT ENGAGEMENT

Parent engagement is core to the program. Once a youth has progressed from OLE to the residence, PRI parents/guardians participate in family group every other Sunday, bi-weekly evening parent groups, one parent retreat during the youth's stay at PRI, and two two-day parent workshops per year. Special arrangements are made for out-of-province families. Figure 3 shows the parental attendance at each program element, for the last five years, for families who progressed further than Stage 1 (OLE). The family member is most often a parent, but in some cases can be a grandparent or other adult guardian. An average of 1.8 family members is involved at each opportunity.

Figure 3. Parent Attendance at Parent Opportunities by Year of Departure (2014 – 2018)



## REPORTABLE INCIDENTS AT PRI

Staff at PRI keep a record of concerning incidents, including events such as absent without leave, property damage, self-harm, and other behaviours requiring discipline and/or medical attention. In 2018, there were **98** reported incidents; in 2017, there were **89**, and in 2016 there were **114**. We track all incidents and utilize the information for risk management and quality improvement. For example, we discuss how to mitigate risks for particular youths who tend to be involved in a high proportion of incidents, as well as for the types of incidents.



# PRI TREATMENT OUTCOMES

A strength of Pine River Institute is its evaluation and research. We are working toward use of standardized tests (which have been tested to ensure they measure what they claim to measure and the results are reliable), and there are 'normed' benchmarks against which we can compare scores from our sample. This move will result in increasingly robust results and evaluation-informed program decisions. At this point, we do not always use standardized measures. Thus, each measurement in the report has a 'robustness rating' based on the strength of measurement, as follows:

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## UNDERSTANDING RATINGS



**Gold Medal:** Indicates a *standardized* measure, *matched* (same person at different times) pre- to post-PRI, to measure change.



**Silver Medal:** Indicates a *non-standardized*, but *matched* measure. Sometimes standardized measures do not ask what we want to know, they can be cumbersome and costly. We use non-standardized questions that resonate with our treatment.



**Bronze Medal:** Indicates a *standardized*, valid, reliable, normed *non-matched* measure. This means that we can take averages or frequencies before and after treatment, but they are not necessarily the same group. Thus, it does not measure individualized change.



**Good Effort:** We used a *non-standardized* measure, and scores were *not matched* pre-PRI to post-PRI.

**Time Anchor:** Respondents are typically asked to reflect on the most recent three months before completing the survey.

You will see results for 'completers' (Cs) – youths who completed Transition, and 'non-completers' (NCs) – youths who departed before completing Transition. When the differences between Cs and NCs are statistically significant, they are noted with a star \*. All statistical notation is indicated in a footnote.

## Limitations

**Generalizability** is when one can expect the results for participants in a study to be experienced similarly by others. With only 35 clients per year, and without a comparison group, we cannot generalize our outcomes to other youths. We can only look at client and family health before and after the program and understand the results apply to our clients.

**Missing Data** is often a problem in clinical data, and PRI is no exception. We are proud of our response rate but caution the reader that the families we cannot contact might have different experiences than those represented here.

**Treatment Changes** occur often in a therapeutic milieu, and many are not tracked in a way that can be captured for program evaluation. For example, a new sport, guest speaker, or new staff may have an impact on youth experience, but our protocol would not be able to identify whether these everyday therapeutic decisions impact the outcomes of PRI clients. We can only say that, in general, the experience at PRI is associated with the outcomes presented here.



# SUBSTANCE USE

## SUBSTANCE USE

Before PRI, parents indicated that PRI youths started using substances at an average age of 13.5<sup>9</sup>. About two-thirds of parents (63%) reported that their child used substances ‘daily’. About two-thirds used nicotine regularly. Before coming to PRI, most youths had tried several types of drugs and were poly-substance users. The most common youth drug of choice as reported by parents over the last three years was marijuana (77%), then alcohol (8%).

For several years, we measured substance use frequency by having respondents choose one of: ‘*abstinent*’, ‘*social/occasional*’, ‘*periodic slips*’, and ‘*consistent & problematic*’. Most (75%) parents would report that youths used in a ‘consistent and problematic’ way before the program. After PRI, most youths (over 80%) were not rated ‘consistent and problematic’, and among those who completed PRI, about 20% were rated as abstinent by parents. This tool is no longer in use at PR because the response options are subjective (i.e., the responses may mean different things to different people) and not quantifiable.



To measure substance use, we now use the standardized and widely-used measure called the Drug History Questionnaire (DHQ)<sup>10</sup>. Since it’s newly implemented, the number of responses at each timepoint are low, so results should only be interpreted for our sample and not generalized (i.e., another youth at PRI may have different results)

**Table 3. Parent-Reported Substance Use Pre- & Post-PRI by Time and PRI Completion**

	PRE-PRI	3-6M Post-PRI		1-2Y Post-PRI	
	N=130	C (N=38)	NC (N=20)	C (N=53)	NC (N=11)
Daily / Multiple Daily Use	63%	10%	25%	15%	36%
None in Last 3 Months	10%	21%	20%	9%	9%

Before PRI, youths reported having started to use substances at an average age of 12.7; two-thirds reported using daily, and most indicated that marijuana was their primary drug of choice. Youth reported substance use after PRI is reduced.

Clinician Comments, Post-PRI Client

**'...He is working full time and has connected well with both of his parents.'**

**'More attuned, supportive peer group.'**



# ACADEMICS

## SCHOOL ENGAGEMENT



Most inquiries to PRI are for secondary school-aged youth. Often, however, their academic careers are sporadic, stalled, or have been abandoned. For example, **before PRI**, parents reported that their child was low on school engagement, with an average of 30 missed school days in the most recent three months (i.e., of 60 school days: N=106 at assessment) and 42% of parents indicating that their youth should be attending school but was not (Table 4.) Reasons for poor school attendance included: behavioural or mental health issues, fatigue, aches and pains, or lack of interest.

**Table 4. Parent Reported School Engagement by Time and PRI Completion**

	Pre-PRI	3M Post-PRI <sup>11</sup>		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	(N=85)	C (N=50)	NC (N=18)	C (N=40)	NC (N=13)	C (N=34)	NC (N=11)	C (N=24)	NC (N=7)
% in School Who 'Should' be in School	58%	98%	86%	95%	85%	91%	82%	96%	86%
	(N=74)	(N=40)	(N=16)	(N=34)	(N=16)	(N=36)	(N=10)	(N=22)	(N=5)
Average Days Missed in 3 Months (60 school days)	30	3	11	5	8	3	11	1	6

About 53% of Canadians have a tertiary education; 36% of youths aged 21 were at a university in 2015-16 (Statistics Canada). After PRI, for youths 20 or older, 38% of PRI completers (26% for non-completers) are in or have completed University or College, 40% Cs (51% NCs) have graduated high school, and 17% Cs (20% NCs) are still in high school.

Some youths were also working or volunteering in varied fields, full or part time, in such areas as landscaping, service, and social services while others were volunteering as coaches or at local or overseas charities.

**Youth** reports align with those of parents, indicating low engagement with school before PRI. After the program, youth typically report engagement with school.

Youth 3 MONTHS after PRI:

**'I got exams coming up and I'm gonna rock them.'**

Youth 3 YEARS after PRI:

**'...I'll be attending law school a year from now.'**

Clinician Comment Post-PRI Client

**'She has completed her first year, with good marks, at McMaster University. She reported being in a healthy dating relationship with a new girlfriend...'**



## ACADEMIC ACHIEVEMENT



**Achievement.** Table 5 shows the historical achievement for PRI clients. Most PRI clients earned A's and B's in early grades, which is consistent with Ontario trends of 60%-75% of students earning A's and B's. PRI applicants' marks deteriorated during later grades.

**Table 5. Parent-Reported Historical Average Achievement for PRI Youths**

	A	B	C	D	Fail
Grade 3 (N=172)	32%	52%	13%	2%	0%
Grade 6 (N=173)	26%	54%	17%	2%	1%
Grade 7 (N=173)	21%	48%	25%	4%	1%
Grade 8 (N=172)	19%	41%	29%	10%	1%
Grade 9 (N=176)	11%	26%	30%	22%	12%
Grade 10 (N=137)	5%	21%	31%	23%	20%
Grade 11 (N=74)	5%	11%	20%	35%	28%
Grade 12 (N=28)	11%	14%	21%	18%	36%



After PRI, Parents reported that their youths earn As and Bs more often than other marks (Table 6).

**Table 6. Achievement Post-PRI All Time Points, Parent-Reported**

	A		B		C		D		Fail	
	Cs	NCs	Cs	NCs	Cs	NCs	Cs	NCs	Cs	NCs
Pre-Treatment (N=155)	1%		14%		24%		30%		31%	
3M Post-PRI (N=73)	47%	27%	45%	19%	6%	23%	2%	4%	0%	4%
6M Post-PRI (N=51)	42%	23%	29%	46%	18%	8%	5%	15%	5%	8%
1Y Post-PRI (N=56)	26%	15%	44%	46%	23%	23%	7%	0%	0%	15%
2Y Post-PRI (N=34)	41%	11%	30%	11%	15%	33%	15%	44%	0%	0%

## Clinician Comments Post-PRI Clients

**'She was accepted into George Brown College and will start a CYC degree this Fall. She is on good terms with her family and is not having mental health or substance abuse issues. She drinks occasionally.'**

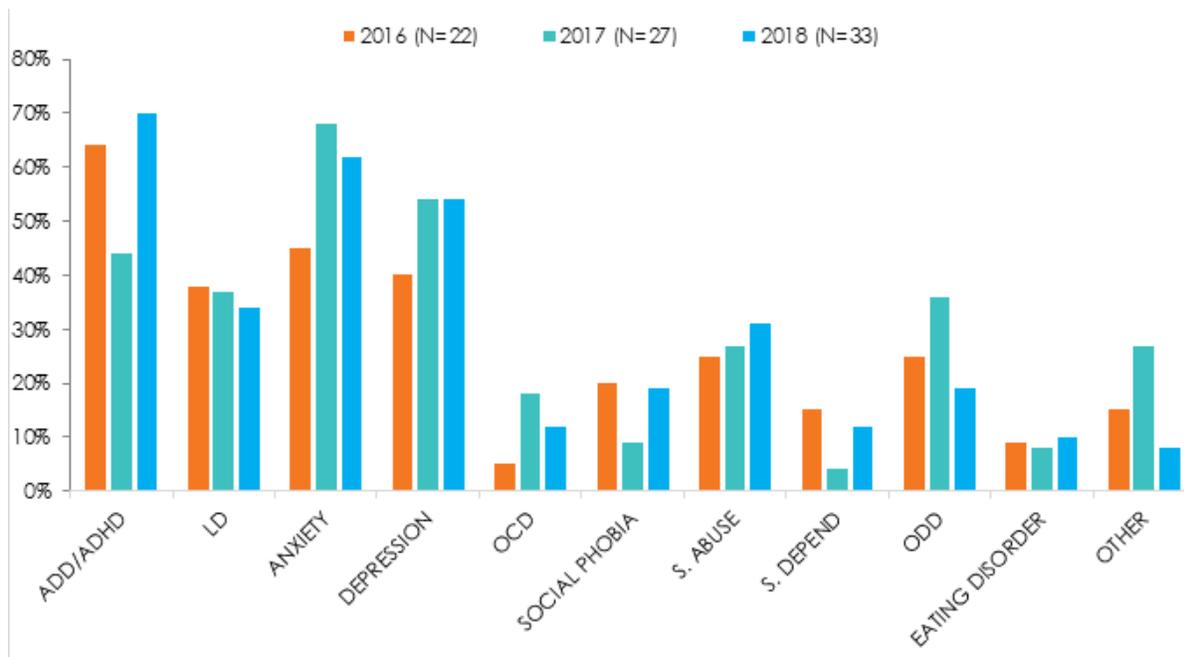
**'She has completed her first year of school but has transferred into nursing. ... stated that she works for the township where she lives and expressed that she enjoys it.'**

**'He is doing well. Sounded happy. Sourced a Therapist for himself and his mom to see'**

# MENTAL HEALTH & LEARNING ISSUES

Between 2010 and 2017, **parent** reports indicated that 69% of admitted youths (N=271) had at least one formally diagnosed mental health disorder<sup>12</sup>. Of those with a diagnosis, 27% were diagnosed with one disorder, 14% were diagnosed with two, and 28% with three or more, to a maximum of eight diagnoses. Figure 4 shows admitted youths from 2016-2018 with parent-reported mental health diagnoses.

**Figure 4. Parent-Reported Youth Mental Health Diagnoses at Application Most Recent Three Years**



OCD: Obsessive Compulsive Disorder; S.Abuse: Substance Abuse ; S. Depend : Substance Dependence ; LD : Learning Disability

**Note:** Substance Abuse or Dependence percentages represent youths who have a formal diagnosis. Most PRI youths would 'qualify' for this diagnosis before PRI but may not have a diagnosis.

**Note:** Over the past three years, 10% or less of parents report their youth as having had a diagnosis of: Panic Disorder, Bipolar Disorder, PTSD, and Schizophrenia. They are summed and displayed as 'other'.

Between 2010 and 2018, parents (N=269) reported that 52% of admitted youths have a formally identified learning issue, with ADD/ADHD (Attention Deficit (Hyperactivity) Disorder) as the most common. It's difficult to separate learning disabilities and ADD/ADHD, in terms of reporting and evaluating. We can estimate that about 40% of admitted youths have a learning disability that was either not identified or non-ADD/ADHD. Those identified include executive and other processing disabilities, non-verbal and communication disabilities, and disorders on the autism spectrum.



We utilize a suite of tools developed by the Achenbach System of Empirically Based Measurement (ASEBA). The parent report tools are called the Child Behavior Checklist (CBCL) and the Adult Behaviour Checklist (ABCL). Scores indicate whether youths have Clinically Problematic, Borderline Problematic, or Non-Problematic<sup>13</sup> mental health and behaviour. The tables below show the percentages of PRI students whose parent-reported scores fall into the **clinically problematic** range for **internalizing problems** (anxious, depressed, and somatic complaints), **externalizing problems** (aggression and rule-breaking), and **other problems** (social, thought, and attention issues). Many youths were experiencing problems in the clinical range across multiple domains before coming to PRI. Most parents report that youth problems were in the non-problematic range after PRI, across most domains, particularly if they completed treatment

**Table 7. Percent of Youths with Clinically Problematic CBCL/ABCL Scores by Time & PRI Completion**

	Pre-PRI	3M Post-PRI* <sup>14</sup>		6M Post-PRI* <sup>15</sup>		1Y Post-PRI* <sup>16</sup>		2Y Post-PRI* <sup>17</sup>		3Y Post-PRI* <sup>18</sup>	
	N=93	C (N=65)	NC (N=32)	C (N=66)	NC (N=29)	C (N=70)	NC (N=29)	C (N=56)	NC (N=28)	C (N=44)	NC (N=28)
Anxious / Depressed	53%	5%	22%	3%	34%	13%	21%	14%	14%	7%	34%
Withdrawn/Depressed	64%	5%	22%	6%	29%	11%	14%	18%	14%	9%	31%
Somatic Complaints	39%	8%	9%	4%	24%	7%	15%	16%	29%	2%	41%
Social Problems	28%	0%	4%	2%	10%	0%	12%	5%	4%	0%	8%
Thought Problems	50%	5%	16%	4%	24%	11%	24%	12%	18%	4%	25%
Attention Problems	43%	8%	16%	8%	24%	10%	11%	5%	7%	2%	13%
Rule-Breaking	84%	5%	27%	6%	25%	10%	21%	12%	15%	9%	30%
Aggression	53%	0%	6%	0%	17%	1%	10%	7%	4%	2%	9%

The youth self-reports version of the ASEBA suite of tools are called the YSR (youth) and ASR (young adult). Youth reports align with adult reports; many are in the clinically problematic score range before treatment and improve to healthy scores after PRI, particularly if they complete the program and especially in the externalizing (rule-breaking and aggression) domains.

## SUICIDALITY & SELF-HARM

Statistics Canada states that in 2009, the suicide rate in Canada for every 100,000 people aged 15 - 24 was 18 (male) and 6 (female). Statistics Canada suggests that for every completed suicide, 20 attempts can be estimated. We can thus roughly estimate that .005 young males and .001 young females attempt suicide in this country. For applicants to PRI, however, suicidality is common. Before coming to PRI, parents report that 74% of youth had suicidal thoughts (51% had these thoughts in the 3 months prior to the survey), 36% had planned how (20% recent), and 24% (11% recent) had made an attempt to end his or her life.

Non-suicidal self-harm is also common among PRI applicants. 53% of parents report lifetime self-harm behaviour for their child; 24% in the three months before completing the application. Self-harm is reduced after PRI, particularly among Completers.

**Table 8. Parent-Reported Recent Suicidality by Time and PRI Completion**

	PRE-PRI	3M Post-PRI* <sup>19</sup>		6M Post-PRI* <sup>20</sup>		1Y Post-PRI	
	(N=53)	C (N=44)	NC (N=13)	C (N=33)	NC (N=16)	C (N=40)	NC (N=11)
Suicidal Thoughts	51%	9%	25%	9%	44%	7%	9%
Suicidal Plan	20%	4%	8%	0%	8%	3%	0%
Suicidal Attempt	11%	4%	0%	0%	0%	2%	0%
Non-Suicidal Self-Harm	24%	5%	27%	2%	21%	7%	9%

### Clinician Comments Post-PRI Client

**'sounded really great on the phone. He is working full time and has connected well with both of his parents. He recently travelled to India to connect with his fathers' family that lives there'**

# CRISIS & BEHAVIOURAL INDICATORS

## HOSPITAL VISITS



**Before PRI**, visits to a hospital<sup>21</sup> were common for PRI youths. Table 8 displays **parent-reported** hospitalization, and reasons for the hospital visit or stay in the most recent three months. The average stay for these hospital visits was 6.6 days (ranging from a few hours to several months). **After PRI**, the proportions of hospital visits were comparatively low (Table 8), particularly for treatment completers within the first year.

**Table 8. Parent-Reported Most Recent 3 Months' Hospitalizations by Time and PRI Completion**

	PRE-PRI	3M Post-PRI <sup>22</sup>		6M Post-PRI		1Y Post-PRI*		2Y Post-PRI	
	N=70	C (N=42)	NC (N=16)	C (N=38)	NC (N=16)	C (N=47)	NC (N=13)	C (N=29)	NC (N=6)
Substance Use	17%	0%	20%	3%	12%	4%	0%	0%	0%
Mental Health	18%	3%	41%	5%	21%	5%	6%	0%	0%

Note that hospitalizations 4 months or more before the survey were reported by 21% of parents for substance use, and 28% for mental health reasons.

## POLICE CONTACT



**Pre-PRI, parents** reported that 54% of youths had police contact in the three months before applying to PRI. Reasons for police contact included mischief, property damage, theft, intoxication, possession / dealing, probation, and parole. **Post-PRI**, contact with police decreased (Table 9). Police contact includes probation, and as such the law-breaking incident may be further in the past than three months from the time of data collection.

**Table 9. Parent-Reported Recent Contact with Police Post-PRI by Time and PRI Completion**

	PRE-PRI	3M Post-PRI* <sup>23</sup>		6M Post-PRI*		1Y Post-PRI*		2Y Post-PRI	
	N=58	C (N=49)	NC (N=19)	C (N=45)	NC (N=24)	C (N=49)	NC (N=20)	C (N=31)	NC (N=10)
Police Contact	54%	10%	42%	11%	38%	6%	15%	6%	10%

**Before coming to PRI** over two thirds of youths reported having had contact with police; **after PRI**, fewer youths experienced police contact, particularly if they had completed the program.

## RUNNING AWAY



Youth on the run are at high risk for being involved with crime, drugs, unprotected or forced sex, prostitution, and contracting sexually transmitted diseases. In North America, about 1 in 7 teens (14%) runs away. By **parent report pre-PRI**, half of youths had run away in their lives; 24% had run away in the three months before application. **Post-PRI**, the percentage of parents who reported that their child had recently (last three months) run away was lower than the North American average if they completed the program (Table 10).

**Table 10. Running Away Pre- to Post-PRI, Parent-Report, by Time and PRI Completion**

	PRE-PRI	3M Post-PRI		6M Post-PRI		1Y Post-PRI* <sup>24</sup>		2Y Post-PRI	
	N=94	C (N=42)	NC (N=17)	C (N=45)	NC (N=18)	C (N=51)	NC (N=15)	C (N=26)	NC (N=5)
Last 3 Months	24%	10%	12%	4%	17%	6%	7%	0%	0%
4-12 Months Ago	17%	0%	12%	4%	11%	4%	13%	4%	0%
Over a Year Ago	8%	33%	35%	36%	39%	35%	67%	42%	80%
Never	50%	57%	41%	56%	33%	55%	13%	54%	20%

**Notes:** Running away becomes a less meaningful health indicator as youth age and move away from home.

## Clinician Comments Post-PRI Client

**'has been enrolled in night school, which he has been attending. He has received an 86% in his English...had a good relationship with his mother, but it has been difficult over the past month.'**

**'... is engaged in aftercare and fully participants on group calls, often pushing others to grow. He has demonstrated mature decision making with regard to his future goals.'**



Youth STAGE 5 During PRI:

**'I have mended my relationship with my dad.'**

Youth STAGE 5 During PRI:

**'Everything has been going really great with my family! We have been super connected and have had no problems since I've been home.'**

**Youth 1 YEAR After PRI:**

**'My parents are not controlling...they let me do whatever I want now, but that is only because I have learned to live within the reasonable parameters of what they're comfortable with. We're happy with things this way. We're also more honest with each other than we used to be.'**

# FAMILY

## FAMILY FUNCTIONING



**Family functioning** is measured with the McMaster Family Assessment Device (FAD)<sup>25</sup>, scored from 4 (most unhealthy) to 1 (healthiest); **scores of 2 or lower are considered non-clinically problematic. Pre-PRI, parents' scores** were significantly above the healthy range. **Post-PRI**, scores improved to, and were maintained, in the healthy range

**Table 11. Parent-Reported Family Functioning by Time and PRI Completion**

	PRE-PRI	3M Post-PRI* <sup>26</sup>		6M Post-PRI*		1Y Post-PRI*		2Y Post-PRI	
	N=167	C (N=73)	NC (N=36)	C (N=72)	NC (N=32)	C (N=78)	NC (N=29)	C (N=47)	NC (N=11)
FAD Average	2.5	1.9	2.2	1.9	2.2	1.9	2.2	1.9	2.2

**Youths'** FAD scores indicated that their perceptions of family functioning were similar to that of their parents, below the 'healthy' range before PRI, and in the healthy range after the program.



**Parents Missing Work.** In the three months before applying to PRI, parents are missing 5-10% of their work due to their child's issues. Fewer days of work were missed for both parents at all time points **Post-PRI** (Table 12).

**Table 12. Number of Days Work Missed for Parents Post-PRI by Time and PRI Completion**

N(moms)/(dads)	PRE-PRI	3M Post-PRI* <sup>27</sup>		6M Post-PRI		1Y Post-PRI	
	(75 / 57)	C (57 / 46)	NC (22 / 17)	C (55 / 41)	NC (20 / 19)	C (59 / 50)	NC (21 / 17)
Moms Avg Missed Work	7.2	0.2	1.6	0.5	0.4	0.3	1.4
Dads Avg Missed Work	5.6	0.8	0.3	0.1	0.7	0.7	0.9

## Clinician Comments Post-PRI Clients

**'Relations with mother remains strong and improving with dad and sister. That's a big shift.'**

**'They are doing very well. With the odd slip comes some family tension but they work through it very well.'**

**'Much improved, increase communication, honesty, feeling, closeness and connection.'**



**Parent Before PRI:**

**'We spend a great deal of time looking for ... ways to mitigate his usage. We have difficulty planning family events as we never know what he will do.'**

**Parent 1 YEAR after PRI:**

**'We are happier and healthier than we have ever been, as individuals and a family unit.'**



# QUALITY OF LIFE

We measure Quality of Life (QOL) with the Personal Well-Being Index (PWI)<sup>28</sup>, which is scored from 0 (very dissatisfied) to 10 (very satisfied); **7–8** is regarded as the North American ‘normal’ range.



The average PWI score for **parental** quality of life **pre-PRI** is close to the normal range, and well into the normal range **post-PRI** (Table 13).

**Table 13. Parental Quality of Life by Time and PRI Completion**

	PRE-PRI	3M Post-PRI* <sup>29</sup>		6M Post-PRI*		1Y Post-PRI*		2Y Post-PRI	
	N=114	C (N=45)	NC (N=24)	C (N=40)	NC (N=14)	C (N=70)	NC (N=25)	C (N=31)	NC (N=10)
PWI Average	6.8	8.2	7.8	7.9	7.4	7.4	7.6	7.9	7.9

**Before PRI, youth** reported a quality of life that is lower than the healthy North American range (average of 5.7). **By the end of the program**, youth QOL scores increase to an average of 7.8.

## Clinician Comments Post-PRI Client

**‘Increased self-awareness; willingness to explore vulnerabilities.’**

**‘Still dealing with effects of Tourettes, OCD, on med and its working well and he’s functioning well.’**

## PHYSICAL HEALTH



**Body Mass Index.** Over two-thirds of PRI youths were in the healthy BMI range before and after coming to PRI, with some variation by time and program completion (Table 14).

**Table 14. Parent-Reported Youth BMI by Time and PRI Completion**

	PRE-PRI	3M Post-PRI* <sup>30</sup>		6M Post-PRI*		1Y Post-PRI*		2Y Post-PRI	
	N=104	C (N=65)	NC (N=31)	C (N=61)	NC (N=26)	C (N=74)	NC (N=24)	C (N=40)	NC (N=12)
Underweight	26%	2%	6%	5%	12%	5%	8%	5%	25%
Healthy	54%	75%	58%	69%	54%	69%	75%	75%	58%
Overweight	15%	23%	32%	20%	27%	22%	12%	20%	17%
Obese	6%	0%	3%	7%	8%	4%	4%	0%	0%

Youth 3 YEARS after PRI:

**'I love the feeling of being independent; it's very satisfying for me. I also love working out – physical activity is key!'**

Youth 5 YEARS after PRI:

**'I am very happy with my life but have worries about after school. I am starting my own business but it's very slow getting started. '**

# SATISFACTION WITH TREATMENT AT PINE RIVER INSTITUTE



Understanding client satisfaction allows us to celebrate successes, and review areas for improvement. Scores range from 1 (Very Dissatisfied) to 5 (Very Satisfied). Parents rated most PRI elements with very high satisfaction.

**Table 15. Parent Satisfaction for Individual Treatment Elements by Time and PRI Completion**

	3-M Post-PRI <sup>31</sup>		6M Post-PRI <sup>32</sup>		1Y Post-PRI <sup>33</sup>		2Y Post-PRI <sup>34</sup>	
	C	NC	C	NC	C	NC	C	NC
OLE	4.8	4.5	4.7	4.3	4.8	4.7	4.8	4.6
Individual Therapy	4.7	4.1*	4.6	3.7*	4.6	4.2*	4.7	3.8*
Front Line Staff	4.7	4.5	4.7	4.2	4.7	4.6	4.8	4.5*
Group Therapy	4.4	3.6*	4.2	3.2*	4.4	3.9*	4.4	3.7
Family Therapy	4.3	2.8*	4.1	3.9	4.2	3.5*	4.4	3.2*
Mentor	3.3	2.2*	3.4	2.0*	3.7	2.9*	3.7	1.9*
Academics	4.4	3.9*	4.4	3.8	4.4	3.9*	4.6	3.4*
Transition	3.9	-	3.8	-	3.7	-	3.6	-
Aftercare	3.3	-	3.1	-	3.4	-	3.3	-

*Note: Family Therapy, Academics, & Mentor, reported for clients who completed OLE. Transition & Aftercare reported if clients completed Transition*

**Among youths,** front line staff had the highest satisfaction ratings; Cs consistently rated PRI higher than NCs.



If you have any questions or comments regarding this report, please contact Dr. Laura Mills, Director of Research & Evaluation at [laura.m@pineriverinstitute.com](mailto:laura.m@pineriverinstitute.com).

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PINE RIVER  
Institute

## NOTES

1. Wait times were different specifically between years 2014-2015 and 2015-2017, ( $p < .05$ ), but in general, across all five years, wait times were similar ( $F(4,130)=1.3$ ,  $p=.29$ , n.s.)
2. Private Pay clients wait fewer days than MOH clients ( $F(130)=71.8$ ,  $p < .001$ ,  $\eta^2=.36$ ).
3. Proportions of male to female students not significantly different 2010 - 2017 ( $\chi^2(7)=13.8$ ,  $p=.06$ , n.s.)
4. Adopted does not include youths adopted by a step-parent.
5. Please note that the data regarding such personal experience as abuse, suicidality, self-harm, etc. may be underrepresented as they are gathered during the admissions process, before youth and parents have developed a relationship with the clinical team at PRI. Therefore, respondents may not feel comfortable disclosing such information.
6. Richardson, C. et al. (2012). The truth about self-harm: For young people and their friends and families [Brochure]. London, U.K.: Mental Health Foundation.
7. Completers stay longer than non-completers across all five years ( $F(1)=53.2$ ,  $p < .001$ ,  $\eta^2=.29$ )
8. 2013 departures had shorter length of stay than 2016 & 2017 departures ( $p < .05$ ), all other length of stay was not different by year. Length of stay longer for completers than non-completers ( $F(1)=63.4$ ,  $p < .001$ ,  $\eta^2=.32$ )
9. No difference on age at first use between males (13.7) and females (14); ( $F(80)=0.6$ ,  $p=.43$ , n.s.)
10. Sobell, L. C., Kwan, E., & Sobell, M. B. (1995). Reliability of a Drug History Questionnaire (DHQ). *Addictive Behaviors*, 20, 233-241.
11. Cell proportions different for C/NC and Attend/No Attend among youths for whom parents indicated they 'should' be in school at 3M Post-PRI ( $\chi^2(1)=4.2$ ,  $p=.04$ ;  $\phi=.24$ ) but no other timepoint (all  $p > .05$ ). More days missed for NCs than Cs at 3M Post-PRI ( $F(24)=5.7$ ,  $p=.02$ ,  $\eta^2=.10$ )
12. Note that even though we specify 'physician diagnoses', some parents might report a disorder without formal diagnosis.
13. Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youths, & Families.
14. 3M-Post PRI (C/NC by Non-Clin/Bord/Clin) proportions were different for Anx/Dep ( $\chi^2(2)=11.3$ ,  $p=.004$ ;  $\phi=.34$ ); WD/Dep ( $\chi^2(2)=7.6$ ,  $p=.023$ ;  $\phi=.28$ ); Thought ( $\chi^2(2)=8.4$ ,  $p=.015$ ;  $\phi=.29$ ); and Rule Breaking ( $\chi^2(2)=9.9$ ,  $p=.007$ ;  $\phi=.32$ ) (all other  $p > .05$ ).
15. Significant proportional differences at 6M-Post PRI (NC/C and Norm/Bord/Clin) on Anx/Dep ( $\chi^2(2)=19.1$ ,  $p < .001$ ;  $\phi=.45$ ), WD/Dep ( $\chi^2(2)=10.9$ ,  $p=.004$ ;  $\phi=.34$ ), Somatic ( $\chi^2(2)=8.3$ ,  $p=.02$ ;  $\phi=.30$ ), Thought ( $\chi^2(2)=18.6$ ,  $p < .001$ ;  $\phi=.44$ ), Rule Break ( $\chi^2(2)=13.1$ ,  $p=.001$ ;  $\phi=.37$ ), and Aggression ( $\chi^2(2)=22.0$ ,  $p < .001$ ;  $\phi=.48$ ). (all others  $p < .05$ ).
16. Significant proportional differences at 1Y-Post PRI (NCs / C and Norm/Borderline/Clinical) on Anx/Dep ( $\chi^2(2)=5.9$ ,  $p=.05$ ;  $\phi=.24$ ), With/Dep ( $\chi^2(2)=10.9$ ,  $p=.004$ ;  $\phi=.33$ ), and Social Problems ( $\chi^2(2)=6.0$ ,  $p=.05$ ;  $\phi=.29$ ) (all others  $p < .05$ ).
17. Differences in 2Y-Post PRI proportions (NCs / Cs by Norm/Borderline/Clinical) were not significant (all  $p < .05$ ).
18. Significant proportional differences at 3Y-Post PRI (NCs/Cs and Norm/Bord/Clinical) on Anx/Dep ( $\chi^2(2)=11.7$ ,  $p=.003$ ;  $\phi=.39$ ), With/Dep ( $\chi^2(2)=13.8$ ,  $p=.001$ ;  $\phi=.43$ ), Somatic ( $\chi^2(2)=18.4$ ,  $p < .001$ ;  $\phi=.49$ ), Thought Problems ( $\chi^2(2)=8.1$ ,  $p=.02$ ;  $\phi=.33$ ), Rule Breaking ( $\chi^2(2)=8.4$ ,  $p=.02$ ;  $\phi=.34$ ), and Aggression ( $\chi^2(2)=9.4$ ,  $p=.009$ ;  $\phi=.35$ ) (all others  $p < .05$ ).
19. Cell proportions different for C/NC and Never/>1Year Ago/4-12M Ago/Past 3 Months 3M Post-PRI for Thoughts ( $\chi^2(4)=22.1$ ,  $p < .001$ ;  $\phi=.68$ ), Plan ( $\chi^2(4)=21.3$ ,  $p < .001$ ;  $\phi=.65$ ), and Attempt ( $\chi^2(4)=17.0$ ,  $p=.001$ ;  $\phi=.58$ ), and Self-Harm ( $\chi^2(4)=12.0$ ,  $p=.02$ ;  $\phi=.50$ ),
20. Cell proportions different for C/NC and Never/>1Year Ago/4-12M Ago/Past 3 Months 6M Post-PRI for Plan ( $\chi^2(4)=14.9$ ,  $p=.005$ ;  $\phi=.55$ ) but not Plan, Attempt, or Self-Harm.
21. The reasons for hospitalization are complicated; 'overdose, injury, or accidents' might be indicative of substance use and/or mental health issues. Respondents may indicate mental health and addiction issues for the same hospital visit.
22. Hospitalization by Yes/No and C/NC four-cell proportions were different for Substance Use at 3M ( $\chi^2(1)=7.3$ ,  $p=.01$ ;  $\phi=.30$ ) but no other timepoints (all  $p > .05$ ) and for Mental Health at 3M ( $\chi^2(1)=9.5$ ,  $p=.002$ ;  $\phi=.33$ )
23. 8-cell (C v NC / Never, >1Y ago, 4-12M ago, 2-3M ago, and in past month) proportions were different at 3M ( $\chi^2(4)=13.6$ ,  $p=.009$ ;  $\phi=.44$ ), 6M ( $\chi^2(4)=18.1$ ,  $p=.001$ ;  $\phi=.51$ ), 1Y ( $\chi^2(4)=16$ ,  $p=.003$ ;  $\phi=.48$   $p > .05$ ; n.s.); numbers for 2Y post-PRI are too few.
24. Proportions between Cs and NCs and all response options was different at 1Y Post-PRI ( $\chi^2(3)=8.8$ ,  $p=.03$ ;  $\phi=.36$ ), no other time-points had significantly different cell proportions.
25. Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). *The McMaster Family Assessment Device: General Function Sub-Scale*.
26. Mean FAD for Cs were less problematic than NCs at 3M ( $F(107)=10.1$ ,  $p=.002$ ,  $\eta^2=.09$ ), 6M ( $F(102)=5.2$ ,  $p=.025$ ,  $\eta^2=.05$ ), 1Y ( $F(105)=7.0$ ,  $p=.01$ ,  $\eta^2=.06$ ), but not at 2Y ( $F(56)=3.0$ ,  $p=.09$ , n.s.).

27. Group size were varied, and group variances were different for Cs and NCs so a Welch test on ranked data was performed. Moms of C's missed fewer days than moms of NCs at 3M Post-PRI ( $W(28) = 9.0, p = .006$ ). No other differences were significant
28. Cummins & Lau, 2005.
29. Means not different for Cs and NCs at 3M, 6M, 1Y, or 2Y (all  $p > .05, n.s.$ ).
30. Proportions are not different for Cs and NCs by BMI category at 3M, 6M, or 1Y (all  $p > .05; n.s.$ ).
31. 3M Post-PRI Satisfaction was higher for Cs than NCs for Indiv ( $F(114) = 11.2, p = .001, \eta^2 = .09$ ); ; Fam ( $F(110) = 28.0, p < .001, \eta^2 = .2$ ); Mentor ( $F(105) = 7.2, p = .01, \eta^2 = .06$ ); Acad ( $F(110) = 5.1, p = .03, \eta^2 = .04$ ); Groups ( $F(113) = 12.3, p = .001, \eta^2 = .1$ ) (all other ps  $> .05$ ).
32. 6M Post-PRI Satisfaction was higher among Cs than NCs for: Individual ( $F(59) = 9.4, p = .003, \eta^2 = .14$ ); : Groups ( $F(61) = 5.8, p = .02, \eta^2 = .09$ ); Mentor ( $F(56) = 4.9, p = .03, \eta^2 = .08$ ) (all other ps  $> .05$ ).
33. 1Y Post-PRI Satisfaction was higher among Cs than NCs for: Individual Therapy ( $F(111) = 4.4, p < .04, \eta^2 = .04$ ); Groups ( $F(111) = 5.9, p = .02, \eta^2 = .05$ ); Mentor ( $F(105) = 5.3, p = .02, \eta^2 = .05$ ); Academics ( $F(111) = 3.8, p = .05, \eta^2 = .03$ ); (all other ps  $> .05$ )
34. 2Y Post-PRI Satisfaction was higher among Cs than NCs for: Individual Therapy ( $F(63) = 8.2, p < .01, \eta^2 = .12$ ); Line Staff ( $F(62) = 6.2, p = .02, \eta^2 = .09$ ); Family ( $F(62) = 10.7, p = .002, \eta^2 = .15$ ); Mentor ( $F(58) = 9.1, p = .004, \eta^2 = .14$ ); Academics ( $F(62) = 12.7, p = .001, \eta^2 = .17$ ); (all other ps  $> .05$ )

A dirt path leads through a dense forest of tall, thin trees. The path is in the foreground, leading towards a bright opening in the distance. The trees are mostly evergreens, with some deciduous trees showing green foliage. Sunlight filters through the canopy, creating dappled light on the path.

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