

Pine River Institute

2019 Evaluation Report



Pine River Institute

2019 Annual Evaluation Report
(Representing cumulative data from
January 1, 2010 - December 31, 2019)

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A NOTE FROM PRI'S CLINICAL TEAM

Pine River Institute's Annual Evaluation Report represents our commitment to provide evidence-based treatment for the youth and families who come to us for help.

It also represents the strong collaboration between PRI's research and clinical teams. We work closely together to determine what should be measured to best understand our effectiveness.

It fuels our curiosity to identify areas for improvement, and it validates what we know from experience. In short, after PRI:

- Youths' mental health, family relationships, and academics improve
- Youths' substance use, criminality, running away and hospitalizations decrease
- Family dynamics improve for youth and their parents
- Youths who complete the program do better across mental, behavioural and relationship outcomes than those who do not complete the program.

This research would not be possible without the participation of our youth and their parents. Their commitment to research and evaluation allows us to be accountable to all of our stakeholders. The outcome data also informs our research contributions to the broader community in our field — this year it has appeared in several peer-reviewed journals internationally.

We value the credibility this research gives to our therapeutic efforts and we thank the research team for its hard work and dedication to providing this valuable outcome data.

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.

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 ended up 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

PRI'S Annual Evaluation Report provides youth and family **demographics**; **program** information including admissions and program engagement; and **treatment outcomes** such as the mental, physical, behavioural, and relationship health of PRI clients before and after the program. This 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.

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.

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**.

Due to the voluntary nature of research contribution, some data are missing. Thus, the findings in this report should be considered to represent the Pine River population only (i.e., other youths may not experience the same outcomes). Since January 1, 2010, 306 youths have departed PRI and reached the first data-collection time-point, three months later. We have 214 responses from at least one parent; a **71%** parent response rate. About one-third 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**.

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

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.

PRI YOUTH CHARACTERISTICS & TREATMENT OUTCOMES (2010 – 2019):

The average age at admission was 17, about 55% male. Half were from the GTA, most others from non-GTA Ontario. Most youths had problematic substance use before, which is reduced Post-PRI. The most common substances of choice were marijuana and alcohol.

Before PRI, most youths experienced clinically problematic mental health issues, often across multiple domains, most commonly ADD/ADHD, anxiety, and/or depression. Mental health symptomology is significantly reduced after PRI. Before PRI, almost two thirds of youths had visited a hospital for substance use or mental health in their lifetime. Post-PRI, less than 8% of PRI Completers had a recent hospital visit.

Before admission, parents reported that about 3/4 of PRI youths had a history of suicidal thoughts in their lifetime; one in three had attempted to end his or her life. Incidents of suicidality are significantly reduced after PRI.

Before PRI, parents reported that their youths' academics were sporadic, stalled, or abandoned; 40% were not attending, those who were going missed about half their school days. Post-PRI, youths re-engaged with school with good grades and attendance.

Family functioning improves from unhealthy levels before PRI to the healthy range after PRI.

62% of PRI youths were involved with police Pre-PRI. This was significantly lower Post-PRI. About 1/3 of youth had run away in the three months before entry; this was less than 9% for Completers after PRI.

INQUIRY AND ADMISSION INFORMATION

Over the past 5 years, 25 - 34 youths entered PRI each year, and they stayed an average of 442 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 2019, clients funded by the Ministry of Health and Long-Term Care waited an average of 503 days. Those paying privately waited 124 days from the time of contact (but about three weeks once the decision for private-payment was confirmed).

PROGRAM ENGAGEMENT

Youths who departed in 2019 occupied a bed an average of **469 days**. 66% of youths completed the **transition** phase of the program (staying an average of **560 days**). Our parents are highly engaged; in addition to family therapy sessions, parents participate in one retreat, bi-annual workshops, and parent groups.

SATISFACTION WITH TREATMENT

Most parents are 'satisfied' or 'very satisfied' with PRI treatment. Youth satisfaction scores are slightly lower than parents but 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 and were recently nominated to serve as Vice Chair on their Research Committee.

In 2019, we engaged in knowledge exchange about youth and family treatment at: Outdoor Behavioural Healthcare Industry Council (Park City, Utah), NATSAP (San Antonio), Canadian Centre on Substance Use & Addiction (Ottawa, ON), Addictions and Mental Health Ontario (Toronto, ON), and with PRI staff, parents, and Board of Directors.

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. Projects 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?
- 3-5 year trajectories of PRI youths versus a comparison group (Grant Application)

Peer-Reviewed Publications in 2019

Harper, N., Mott, A. J., & Obee, P. (2019). Client perspectives on wilderness therapy as a component of adolescent residential treatment for problematic substance use and mental health issues. *Children & Youth Services Review*, 105.

Uliaszek, A., Hamdullahpur, K., & Mills, L. (2019). Examining the effectiveness of residential treatment among adolescents with problem substance use. *Journal of Child & Adolescent Substance Abuse*, DOI: 10.1080/1067828X.2019.1682736.

Kelly, E. & Mills, L. (2019). On being a treatment detective: How progress monitoring offers clues to treatment mysteries. *Journal of Therapeutic Schools & Programs*, 11.

van Ryn, L. & Creighton, V. (2019). The call for an integrated family systems model. *Journal of Therapeutic Schools & Programs*, 11.

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 and Dr. Gillian Mulvale. The Committee has a mandate to advise on and monitor PRI research activities.

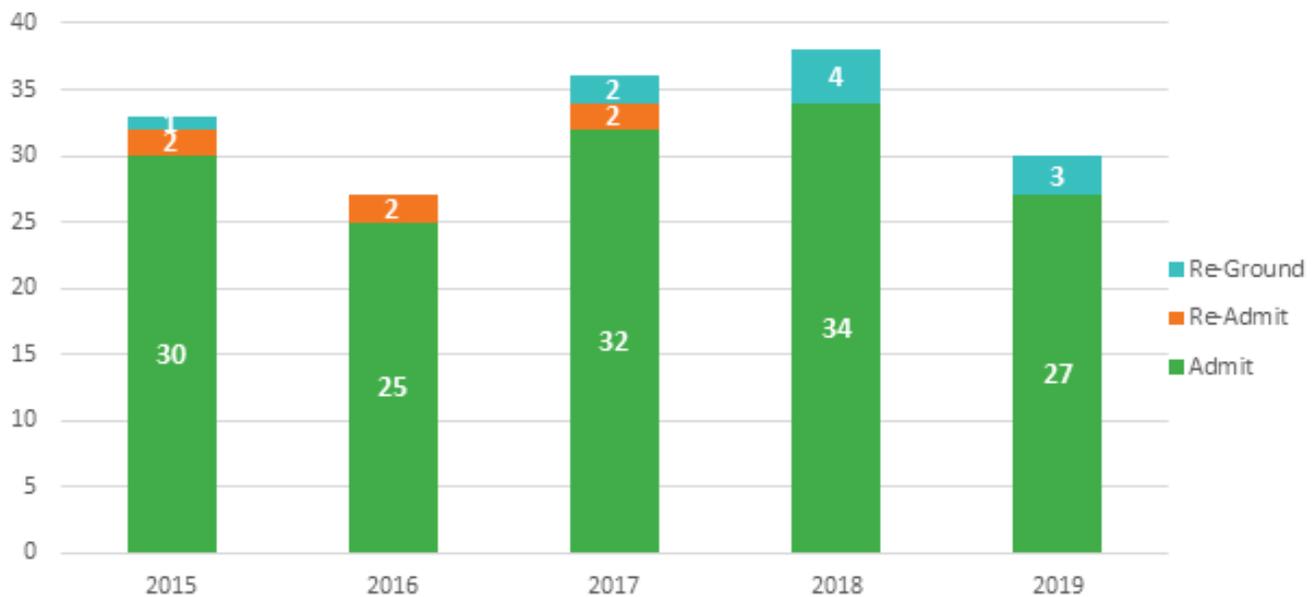
CLIENT PROFILE

ADMISSIONS

Each year family members, friends, and professionals contact PRI regarding 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 assessment a few weeks before admission and admitted when a bed becomes available. In 2019 there were **27** admissions. Sometimes, youths return to PRI for treatment re-entry, but there were no re-entrants in 2019. In some cases, however, a youth may return to OLE for a few weeks of ‘re-grounding’. In 2019, there were 3 such cases (Figure 1).

Figure 1. Admission, Re-admission & Re-grounding Frequencies 2014-2019.



In 2019, wait time from inquiry to admission was 503 days for Ministry of Health and Long-Term Care (MOH) clients¹. Clients funded by MOH wait longer than those who pay privately². Once a family formally agrees to pay privately, the wait time is about three weeks, but below are the total days from contact to admission. Average wait time is shown by year and type of pay (Table 1).

Table 1. Average days from Contact to Admission by Year and Type of Pay 2015-2019

2015		2016		2017		2018		2019	
MOH (N=21)	PP (N=7)	MOH (N=18)	PP (N=5)	MOH (N=22)	PP (N=9)	MOH (N=18)	PP (N=17)	MOH (N=16)	PP (N=11)
392	98	462	286	561	139	528	62	503	124

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 17.2. About half of PRI youth are from the GTA, most of the others are from elsewhere in 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 55% male, 45% female.

About half of PRI parents live together. Two percent of PRI youths have experienced the death of a parent and 7% were adopted³.

Addictive Behaviour. PRI youths experience **addictive** behaviour as a part of their complex profile. 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.

Mental Health. 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 half to two-thirds of our youths before PRI.

Suicidality & Self-Harm. About three quarters of PRI youths have experience with **suicidality**; one in three had made an attempt to end his or her life before attending PRI. About a third of PRI parents indicate their child has a history of self-harm (e.g., cutting, burning, removing skin, and banging against walls)⁴, which is often a way these youths cope with intense emotional distress or pain⁵.

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.



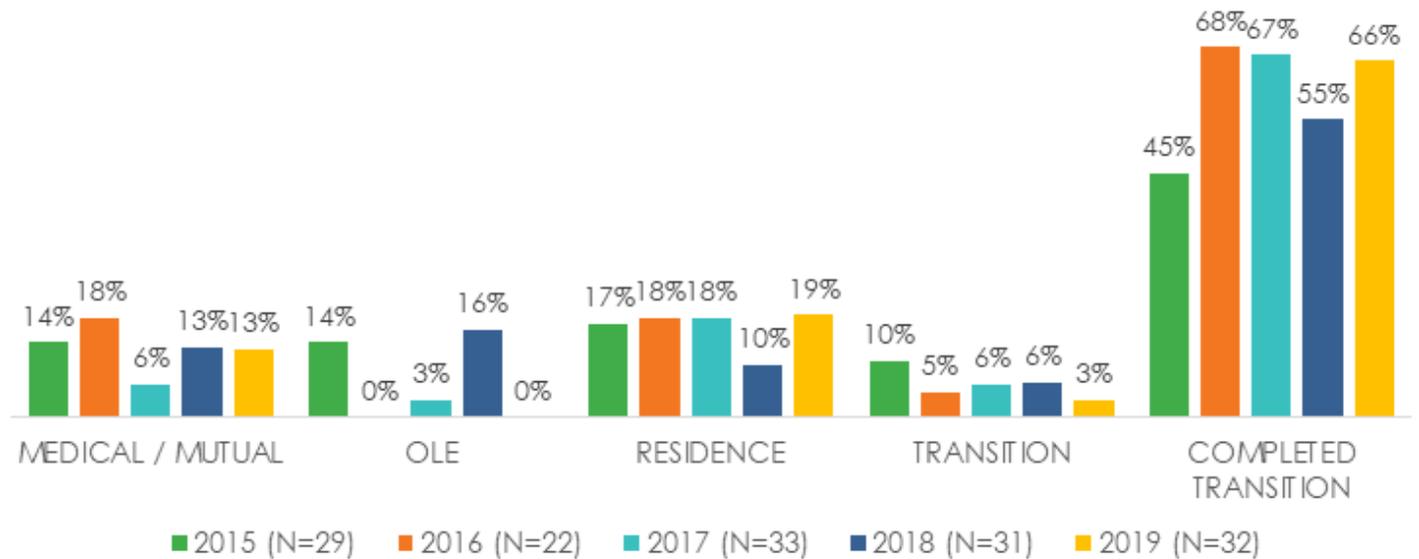
CLIENT PROFILE

ENGAGEMENT

STUDENT ENGAGEMENT

Treatment completion is known to foster healthy outcomes; therefore, we strive to help our youths reach transition completion. The figure below details our completion rates for the last five years. In some cases, youths exit the program before completion, based on a mutual client-clinician decision or for medical or psychiatric reasons which cannot be addressed at PRI. In 2019, there were 2 early discharges for medical reasons, and 2 youths discharged based on a clinician-endorsed 'planned early discharge'. These types of departures are shown as 'Medical / Mutual' in Figure 2.

Figure 2. Phase at Departure by Year of Departure, in Percentages, 2015 – 2019



The average length of stay for youth in the program for 2019 was 469 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 2014-2019⁶

	2014/2015 (N=29)	2016 (N=22)	2017 (N=33)	2018 (N=31)	2019 (N=32)
Completers ^{*7}	521	569	553	521	560
Non-Completers	332	342	311	184	317

* This red star means there is a statistically significant difference, here, in the number of days in program between Completers and Non-Completers.

Aftercare

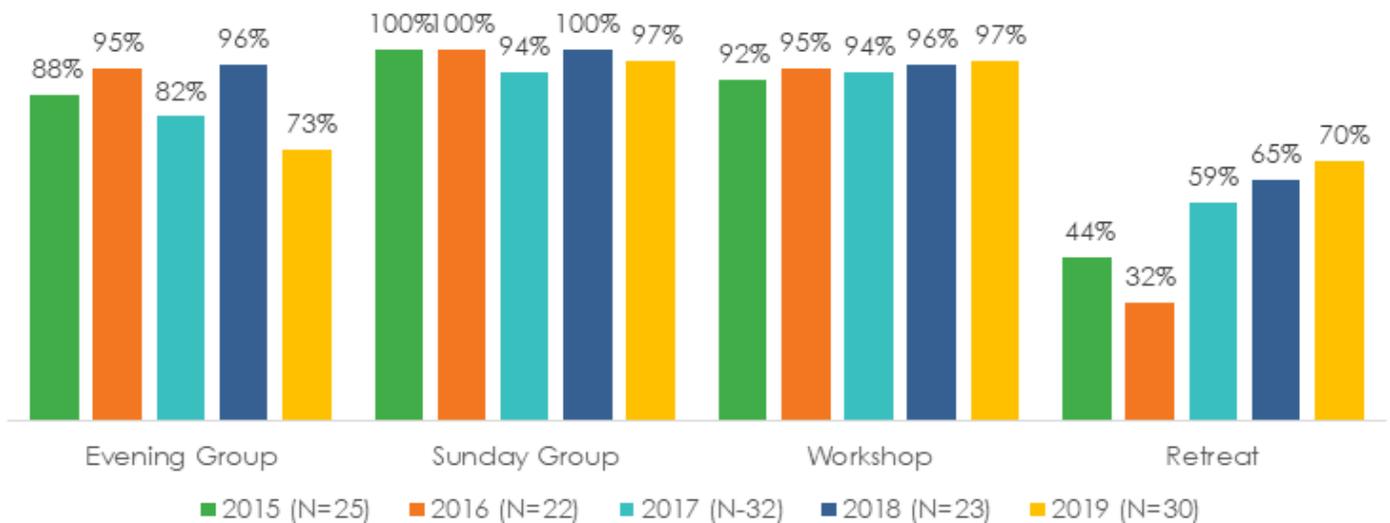
When youths complete transition they are encouraged to participate in Aftercare, a fee-for-service option (a grant from RBC partially funds this program). In 2019, 16 of the 20 youths who completed transition participated in Aftercare. Similarly, across the last five years, 80% - 100% of our treatment 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 1.7 family members is involved at each opportunity.

Figure 3. Parent Attendance at Parent Opportunities by Year of Departure (2015 – 2019)



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 2019, there were **59**, in 2018, there were **98** reported incidents; in 2017, there were **89**. 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 (widely tested to ensure they are valid and reliable), and there are 'normed' clinical functioning benchmarks. This will result in increasingly robust results and evaluation-informed program decisions. At this point, we do not always use standardized measures. Each measurement in the report has a 'robustness rating' based on the strength of measurement, as follows:

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, we cannot generalize our outcomes to other youths.

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, we 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

Before PRI, **parents** indicated that PRI youths started using substances at an average age of 13.4. Before coming to PRI, most youths had tried several types of drugs and were poly-substance users. About two-thirds of parents (62%) reported that their child used substances daily, only 11% indicated no recent substance use. The most common youth drug of choice as reported by parents over the last three years was marijuana (72%), then alcohol (12%).



To measure substance use, we now use the standardized and widely-used measure called the Drug History Questionnaire (DHQ)⁸. Since it is 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	3M Post-PRI		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	N=321	C (N=36)	NC (N=13)	C (N=36)	NC (N=12)	C (N=38)	NC (N=11)	C (N=31)	NC (N=5)
Daily Use	62%	0%	15%	11%	17%	16%	27%	19%	40%
1-6 Days per Week	23%	25%	15%	33%	33%	42%	0%	51%	60%
1x Per Month or Less	3%	28%	15%	22%	16%	24%	18%	22%	0%
None in Last 3 Months	11%	48%	54%	33%	33%	18%	36%	23%	0%

Before PRI, **youths** reported having started to use substances at an average age of 13.0; most were using daily or several times per week, and most indicated that marijuana was their primary drug of choice. After PRI, youths reported significantly reduced substance use – often socially a few times per month.

1y Post-PRI, Clinician:

'...Is graduating high school this spring and has been accepted with scholarship to University of Guelph in the fall. Works full-time at Starbucks and is on good terms with family. Continues to struggle with mood and peer relationships. Nothing extreme, mom just mentioned he is sometimes lonely and doesn't have too many friends.'



ACADEMICS

SCHOOL ENGAGEMENT



Most inquiries to PRI are for secondary-school-aged-youth. Often, however, their academic careers are sporadic, stalled, or were abandoned. For example, **before PRI**, parents reported that their child missed an average of 27 (at application) to 31 (at assessment) school days in the three months before taking the survey. Many students who should be in school are not. 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 ⁹		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	APPLY (N=114)	ASSESS (N=282)	C (N=62)	NC (N=25)	C (N=55)	NC (N=18)	C (N=44)	NC (N=18)	C (N=36)	NC (N=11)
% in School Who Should Be in School	61%	59%	79%	67%	85%	55%	62%	45%	76%	67%
	(N=167)	(N=103)	(N=44)	(N=16)	(N=34)	(N=14)	(N=35)	(N=11)	(N=24)	(N=4)
Average Days Missed in 3 Months (60 school days)	27	31	2	10	5	7	6	14	1	8

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, 46% of PRI Completers (26% for Non-Completers) are in or have completed University or College (N = 207), 39% Cs (44% NCs) have graduated high school, and 14% Cs (30% 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, hospitality, sales, 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 reported that they were attending school most days and earning As and Bs.

PRI Mom:

'At Queen's University and probably not living up to his potential but he secured all of his credits and maintains a B average. Wouldn't have dreamed this possible a few years ago!'

PRI Mom:

'Amazing! Has a job at a florist that she loves and is doing very well at. She will continue this job throughout the school year.'

ACADEMIC ACHIEVEMENT



Achievement. Table 5 shows the historical achievement for PRI clients. About 80% of PRI youths earned As and Bs in early grades, which is higher than Ontario trends of 60%-75% of students earning As and Bs. PRI applicants' marks deteriorated during later grades, with up to one third of parents reporting that their child was failing academically in later secondary school. Only 21% of parents indicated that their child's most recent mark was successful for that child.

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

	A	B	C	D	FAIL
Grade 3 (N=196)	31%	54%	8%	2%	0%
Grade 6 (N=197)	24%	55%	17%	2%	1%
Grade 7 (N=197)	21%	48%	26%	4%	2%
Grade 8 (N=196)	18%	41%	30%	9%	2%
Grade 9 (N=199)	12%	25%	31%	20%	12%
Grade 10 (N=152)	5%	22%	32%	22%	19%
Grade 11 (N=81)	5%	15%	20%	34%	26%
Grade 12 (N=29)	14%	14%	21%	17%	34%



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

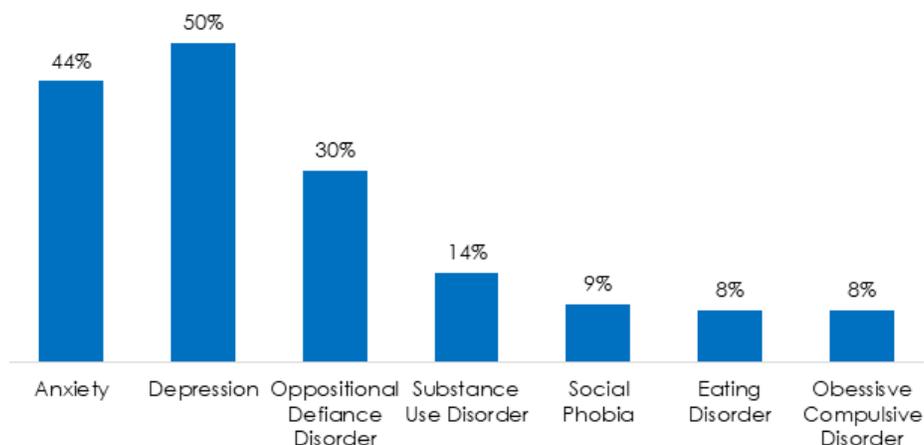
	A		B		C		D		Fail	
Pre-PRI (N=224)	4%		14%		26%		27%		30%	
	Cs	NCs	Cs	NCs	Cs	NCs	Cs	NCs	Cs	NCs
3M Post-PRI (N=70) ^{10*}	36%	10%	27%	7%	6%	11%	1%	1%	0%	0%
6M Post-PRI (N=52)	46%	23%	29%	54%	15%	8%	5%	8%	5%	8%
1Y Post-PRI (N=51)	29%	23%	47%	46%	21%	15%	3%	0%	0%	15%
2Y Post-PRI (N=36)	33%	17%	40%	17%	17%	33%	10%	33%	0%	0%

MENTAL HEALTH & LEARNING ISSUES

Understanding mental health and learning issues among PRI youths is challenging. Parents may note that symptoms clearly suggest a mental health disorder that has not been formally diagnosed, others indicate that testing is in process or results have been withheld. In several cases, a medical professional suggests a specific disorder but will not give a formal diagnosis until substance use is not a complicating factor. A significant number of parents indicate their child is on psychotropic medication without a formal diagnosis. In general, we can understand that the landscape of mental health and learning issues among applicants is complex and importantly, underestimated in responses to questions about formal diagnoses, which are the focus of the analyses below.

Between 2010 and 2019, **parent** reports indicated that 72% of admitted youths (N=214) had at least one formally diagnosed mental health disorder (not including ADD/ADHD)¹¹. Of those with a diagnosis, 22% were diagnosed with one disorder, 20% were diagnosed with two, 14% with three and 15% with four or more, to a maximum of seven diagnoses (Figure 4).

Figure 4. Parent-Reported Youth Mental Health Diagnoses at Application (2010 – 2019)



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: 5% or less of parents report their youth as having had a diagnosis of: Bipolar Disorder, Panic Disorder, PTSD, and Schizophrenia.

About half (47%) of PRI parents indicate their child has a learning disability, some of which specify only ADD or ADHD, but a significant number also note their child's processing or communication difficulties. Yet more indicate that their child has been given accommodations such as extra time for tasks or special seating to reduce anxiety without a formal diagnosis of a learning disorder.



We utilize a suite of tools developed by the Achenbach System of Empirically Based Assessment (ASEBA). The parent report tools are called the Child Behaviour Checklist (CBCL) and the Adult Behaviour Checklist (ABCL). Scores indicate whether youths have Clinically Problematic, Borderline Problematic, or Non-Problematic¹² 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. After PRI, most parents report that youth problems were in the non-problematic range, 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* ¹³		6M Post-PRI* ¹⁴		1Y Post-PRI* ¹⁵		2Y Post-PRI ¹⁶		3Y Post-PRI* ¹⁷	
	N=160	C (N=89)	NC (N=37)	C (N=83)	NC (N=34)	C (N=90)	NC (N=35)	C (N=76)	NC (N=32)	C (N=56)	NC (N=32)
Anxious / Depressed	58%	5%	22%	7%	35%	13%	23%	13%	16%	5%	34%
Withdrawn/Depressed	61%	5%	24%	6%	27%	10%	14%	14%	16%	9%	34%
Somatic Complaints	36%	7%	10%	5%	24%	7%	15%	13%	25%	4%	38%
INTERNALIZING	89%	19%	43%	19%	52%	29%	54%	29%	25%	18%	62%
Social Problems	27%	0%	4%	2%	14%	0%	12%	7%	4%	0%	8%
Thought Problems	49%	3%	19%	7%	23%	12%	29%	9%	19%	4%	28%
Attention Problems	49%	7%	16%	8%	24%	8%	6%	5%	7%	0%	13%
Rule-Breaking	78%	4%	25%	7%	21%	8%	20%	9%	16%	11%	27%
Aggression	48%	0%	8%	0%	21%	1%	9%	5%	3%	4%	9%
EXTERNALIZING	88%	8%	29%	12%	42%	14%	34%	14%	34%	14%	44%

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

To give context to our findings on mental and behavioural health, we explored the literature. There is no 'exact comparison' group for PRI; the closest was in a study that explored youth health at private residential centres in the U.S.¹⁸. The sample is similar to PRI clients: average age about a year younger than PRI youths; predominantly Caucasian; and, most were from affluent families whose parents were the catalysts for treatment entry. Most (70%) had been prescribed psychotropic medication, and 31% had experienced a psychiatric hospitalization. The U.S. sample included 54% Completers (average for PRI over the last three years was 62%), who had a length of stay of 10.5 months (PRI average is 17 months) and seven months for Non-Completers (at PRI, 5-6 months).

Table 8. CBCL Scores for PRI and U.S. Sample at Admit, 6 Months, and 1 Year Post-Treatment

	ADMIT		6M POST		1Y POST	
	PRI	U.S. SAMPLE	PRI	U.S. SAMPLE	PRI	U.S. SAMPLE
Anxious Depressed	11.1	8.5	6.7	3.5	5.1	3.4
Withdrawn Depressed	8.5	7.0	3.2	2.9	3.5	2.9
Somatic Complaints	5.7	3.6	2.7	1.4	2.1	1.7
Internalizing Disorder	25.2	19.1	11.0	7.9	10.3	8.0
Social Problems	6.1	5.2	3.0	2.0	2.4	2.1
Thought Problems	7.6	5.5	3.0	2.0	3.5	2.1
Attention Problems	12.1	10.1	6.0	5.2	5.8	5.3
Rule-Breaking	16.8	13.8	5.9	5.2	5.2	5.3
Aggression	16.7	14.4	5.2	5.3	4.4	5.3
Externalizing Disorder	33.5	28.2	11.1	14.2	9.6	11.1

On the Internalizing Disorder scores, PRI clients start with more problematic scores but both groups have a similar amount of change from admit to post-treatment (Figure 5a). On Externalizing scores, PRI clients at admission have higher scores and there is a different initial improvement but similar maintenance of treatment gains (Figure 5b). The discrepant pre-treatment scores might be a function of myriad factors: for example, many clients at private programs in the U.S. previously attended Wilderness Therapy and thus might be healthier at entry to residential care; the one year age difference may factor into symptom severity; and, PRI's waiting list is a time during which clients tend to decline – waiting lists are often not a part of the treatment journey in Private U.S. care.

Figure 5a. Internalizing Disorder Scores for PRI & U.S. Sample Pre- and Post-Tx

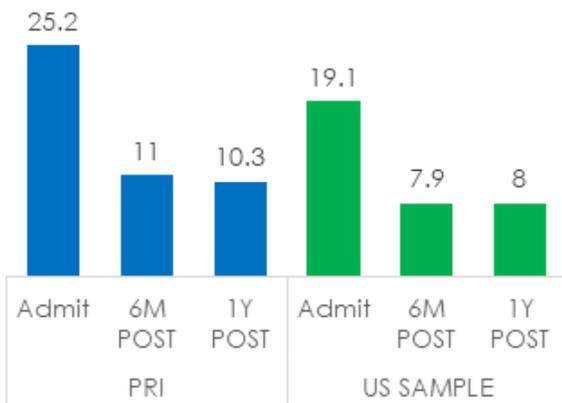
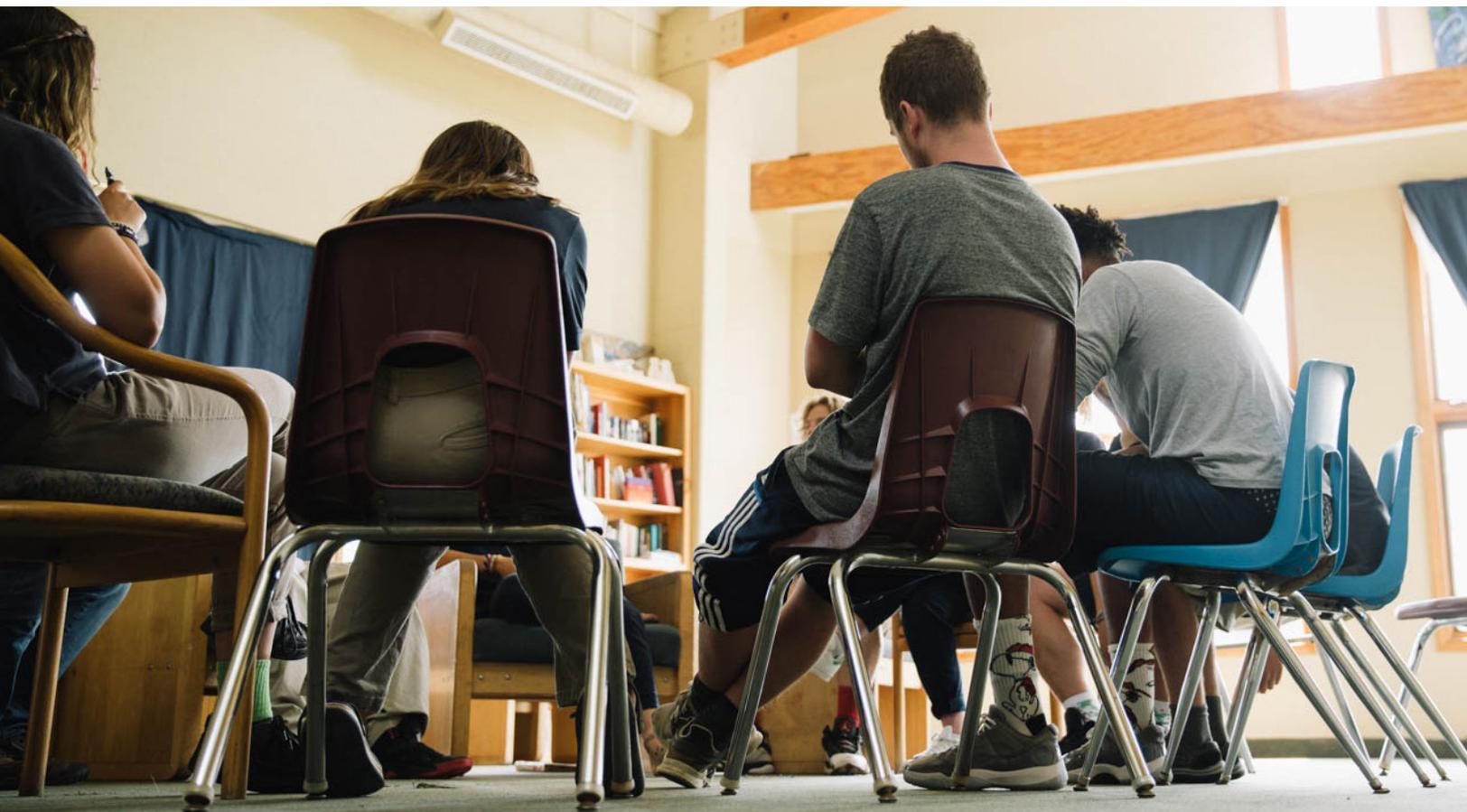
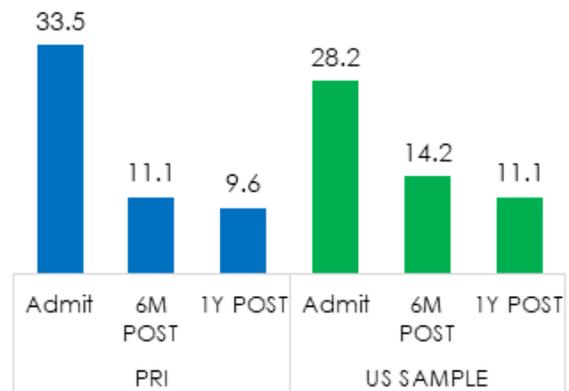


Figure 5b. Externalizing Disorder Scores for PRI & U.S. Sample Pre- and Post-Tx



SUICIDALITY & SELF-HARM

Statistics Canada states that in 2009, 18 (males) and 6 (females) of every 100,000 people aged 15 - 24 had committed suicide, with an estimated 20 attempts for every completed event. 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 41% of youth had suicidal thoughts in the recent 3 months (74% at some time in the child's life), 12% had made a recent suicidal plan (54% at some point in life), and 10% had recently (29% at some point in life) made an attempt to end his or her life. The frequency of suicidality is reduced after PRI (Table 9).

Non-suicidal self-harm is also common among PRI applicants. One third of parents report recent self-harm behaviour (only one third reported no self harm ever in the youth's lifetime). Self-harm is reported by parents as less common after PRI.

Table 9. Parent-Reported Recent Suicidality by Time and PRI Completion¹⁹

	PRE-PRI	3M Post-PRI*		6M Post-PRI*		1Y Post-PRI	
	(N=108)	C (N=39)	NC (N=17)	C (N=43)	NC (N=14)	C (N=39)	NC (N=13)
Suicidal Thoughts	26%	5%	24%	2%	7%	3%	0%
Suicidal Plan	12%	5%	7%	2%	7%	3%	0%
Suicidal Attempt	10%	5%	0%	0%	0%	3%	8%
	(N=101)	(N=41)	(N=13)	(N=44)	(N=13)	(N=42)	(N=13)
Non-Suicidal Self-Harm	24%	5%	27%	2%	21%	7%	9%

6M Post-PRI, Clinician:

'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 father's family that lives there.'

3M post-PRI, Clinician:

'She has been working at a marina. She seems to be living an appropriate life for a 16-year-old. She is in good spirits and has been getting along well with family.'

3M post-PRI, Clinician:

'...Has integrated back into her family and has applied to school for the fall. She is spending a lot of time with her boyfriend which is bordering on enmeshed. Working hard and connecting with friends. Overall very satisfied.'

PHYSICAL HEALTH



Body Mass Index. About 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 10).

Table 10. Parent-Reported Youth BMI by Time and PRI Completion²⁰

	Pre-PRI	3M Post-PRI		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	N=266	C (N=70)	NC (N=31)	C (N=66)	NC (N=26)	C (N=72)	NC (N=27)	C (N=46)	NC (N=14)
Underweight	20%	3%	6%	9%	15%	6%	11%	9%	14%
Healthy	64%	76%	52%	68%	50%	69%	63%	72%	71%
Overweight	11%	21%	35%	18%	27%	21%	19%	17%	14%
Obese	5%	0%	6%	9%	8%	4%	7%	2%	0%



CRISIS & BEHAVIOURAL INDICATORS

HOSPITAL VISITS



Before PRI, visits to a hospital²¹ were common for PRI youths. Table 11 displays parent-reported hospitalization in the three months before taking a survey. When asked about lifetime history of visits to the hospital, parents report 38% for substance use, 62% for mental health reasons, and 34% for other reasons. **After PRI**, the proportions of hospital visits were comparatively low (Table 11), particularly for treatment completers within the first year²².

Table 11. Parent-Reported Most Recent 3 Months' Hospitalizations by Time and PRI Completion

	PRE-PRI	3M Post-PRI		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	N=141	C (N=41)	NC (N=16)	C (N=47)	NC (N=14)	C (N=44)	NC (N=19)	C (N=33)	NC (N=7)
Substance Use	13%	0%	19%	4%	13%	7%	0%	0%	0%
Mental Health	17%	3%	39%	7%	24%	6%	5%	0%	0%
Other	7%	3%	6%	6%	14%	9%	8%	12%	20%

Post-PRI, Clinician:

'...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.'

Post-PRI, Clinician:

'...Is engaged in Aftercare and fully participates on group calls, often pushing others to grow. He has demonstrated mature decision making with regard to his future goals.'

POLICE INVOLVEMENT & CRIMINALITY



Pre-PRI, parents reported that about two-thirds of youths had police involvement in the three months before applying to PRI. Another 28% reported police involvement or illegal behaviour over the life of their child. Reasons for police contact included mischief, property damage, arson, theft, intoxication, possession / dealing, probation, and parole. **Post-PRI**, police involvement decreased (Table 12)²³ particularly among treatment completers.

Table 12. Parent-Reported Recent Contact with Police Post-PRI by Time and PRI Completion

	PRE-PRI	3M Post-PRI		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)
Criminality / Police Contact	62%	8%	37%	12%	36%	11%	19%	6%	10%

Note: 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.

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**, over one half of youths had run away in their lives, a third in the three months before parents completed their survey. **Post-PRI**, the percentage of parents who reported that their child had recently run away was lower than the North American average if they completed the program (Table 13).

Table 13. Running Away Pre- to Post-PRI, Parent-Report, by Time and PRI Completion²⁴

	PRE-PRI	3M Post-PRI		6M Post-PRI		1Y Post-PRI		2Y Post-PRI	
	N=151	C (N=48)	NC (N=17)	C (N=50)	NC (N=18)	C (N=51)	NC (N=17)	C (N=35)	NC (N=7)
Last 3 Months	32%	8%	12%	2%	17%	6%	6%	0%	0%
4-12 Months Ago	15%	0%	6%	4%	11%	4%	12%	3%	0%
Over a Year Ago	10%	38%	29%	40%	33%	37%	59%	51%	71%
Never	43%	54%	53%	54%	39%	53%	24%	46%	29%

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

3M post-PRI, Clinician:

'Is working full time and reports good relationships with family and S.O. He reflects that peer relationships are more difficult while avoiding substance use. He was accepted to a college program for September.'

3M post-PRI, Clinician:

'He is working regularly and attends NA weekly. He is engaged in extra curricular activities and has been accepted to the college program of his choice for September.'

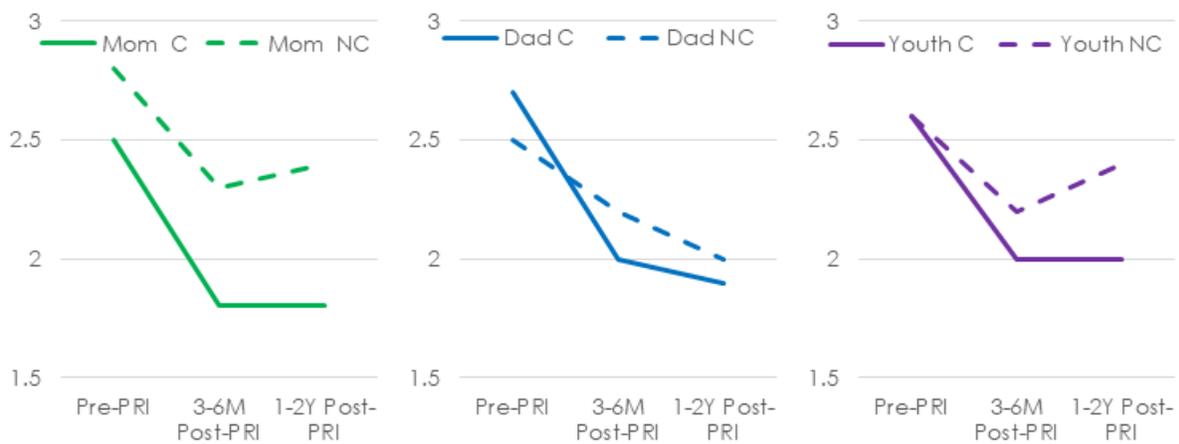
FAMILY

FAMILY FUNCTIONING



Family functioning is measured with the McMaster Family Assessment Device (FAD)²⁵, scored from 4 (most unhealthy) to 1 (healthiest); scores **of 2 or lower are considered non-clinically problematic**. On the FAD, we can report matched pre-post-follow-up data for moms, dads, and youths. **Pre-PRI**, scores were 2.5 or higher – about a standard deviation or more above ‘healthy’. The interaction between time, relationship, and respondent was not statistically significant²⁶ but clinically relevant; among Cs, scores improve to healthy levels or better **after PRI** and are maintained. NCs show less improvement and gains are not as well maintained.

Figure 6a,b,c. Family Functioning by Time & Completion for Moms, Dads and Youths



Parents Missing Work to Support Child. In the three months before applying to PRI, there are about 60 work days. Parents are missing significant work due to their child’s issues. **After PRI**, fewer days of work were missed for both parents at all time points (Table 14).

Table 14. Number of Days Work Missed for Parents Post-PRI by Time and PRI Completion

N(moms)/(dads)	PRE-PRI	3M Post-PRI*27		6M Post-PRI		1Y Post-PRI	
	194 / 173	C 62 / 46	NC 22 / 18	C 60 / 45	NC 20 / 19	C 58 / 50	NC 22 / 17
Moms Avg Missed Work	9.8	.3	1.1	0.4	0.6	.3	1.4
Dads Avg Missed Work	5.4	1.5	2.1	0.2	0.8	0.4	0.9

1Year Post-PRI, Clinician:

'She was in residence yesterday to participate in our high school graduation. She has been well since her graduation from Pine River's Aftercare. She is on good terms with her family and is not having mental health or substance abuse issues. She drinks occasionally. Is planning to move in with BF and his father in Toronto as she starts school.'



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 ²⁸		6M Post-PRI ²⁹		1Y Post-PRI ³⁰		2Y Post-PRI ³¹	
	C	NC	C	NC	C	NC	C	NC
OLE	4.8	4.5	4.7	4.6	4.8	4.6	4.8	4.7
Individual Therapy	4.7	4.0*	4.6	3.9*	4.6	4.1*	4.6	4.1*
Front Line Staff	4.7	4.4*	4.7	4.3	4.7	4.2*	4.8	4.3*
Groups	4.4	3.6*	4.2	3.4*	4.4	3.3*	4.4	3.7*
Family Therapy	4.3	2.9*	4.1	4.1	4.2	3.4*	4.4	3.8*
Mentor	3.2	2.5	3.5	2.3*	3.7	2.9*	3.7	1.9*
Academics	4.4	3.9*	4.4	3.7	4.4	3.9*	4.6	3.4*
Transition	4.0		3.7		3.7		3.6	
Aftercare	3.4		2.9		3.2		3.2	

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

Among youths, satisfaction on all elements of PRI were between 3.2 and 4.3 (slightly lower than parent scores); front line staff had the highest ratings, followed by OLE and Academics; Cs consistently rated PRI higher than NCs.

NOTES

1. Wait times were not different based on year of entry ($F(4,141) = .98, p = .42, \eta^2 = .03$.)
2. Private Pay clients wait fewer days than MOH clients ($F(144) = 47.6, p < .001, \eta^2 = .25$).
3. Adopted does not include youths adopted by a step-parent.
4. Please note that the data regarding such personal experience as suicidality and self-harm 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, when respondents may not feel comfortable disclosing such information.
5. 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.
6. Completers stay longer than Non-Completers across all five years ($F(1) = 78.02, p < .001, \eta^2 = .35$)
7. 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 was longer for Completers than Non-Completers ($F(1) = 63.4, p < .001, \eta^2 = .32$).
8. Sobell, L. C., Kwan, E., & Sobell, M. B. (1995). Reliability of a Drug History Questionnaire (DHQ). *Addictive Behaviors*, 20, 233-241.
9. Cell proportions not different for C/NC and Attend/No Attend among youths for whom parents indicated they 'should' be in school at no Post-PRI timepoint & no difference in days missed b/w NCs & Cs at any Post-PRI timepoint (all $p > .05$).
10. C/NC by Achievement proportions were diff at 3M Post-PRI ($\chi^2(5) = 14.6, p = .01; \phi = .32$) but not different at other timepoints ($p > .05$).
11. Note that even though we specify 'physician diagnoses', some parents might report a disorder without formal diagnosis.
12. 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.
13. 3M-Post PRI (C/NC by Non-Clin/Bord/Clin) proportions were diff for Anx/Dep ($\chi^2(2) = 11.4, p = .003; \phi = .3$); WD/Dep ($\chi^2(2) = 10.9, p = .004; \phi = .29$); Internalizing ($\chi^2(2) = 7.9, p = .02; \phi = .25$); Tht ($\chi^2(2) = 11.2, p = .004; \phi = .3$); Agra ($\chi^2(2) = 7.9, p = .02; \phi = .02$); Rule ($\chi^2(2) = 11.6, p = .003; \phi = .3$), and Externalizing ($\chi^2(2) = 11.0, p = .004; \phi = .30$) (all other $p > .05$).
14. Significant diffs at 6M-Post (NC/C and Norm/Bord/Clin) on Anx/Dep ($\chi^2(2) = 15.6, p < .001; \phi = .36$), WD/Dep ($\chi^2(2) = 11.9, p = .003; \phi = .32$), Somatic ($\chi^2(2) = 9.2, p = .01; \phi = .28$), Internalizing ($\chi^2(2) = 14.1, p = .001; \phi = .35$); Thought ($\chi^2(2) = 10/0, p < .007; \phi = .29$), Rule Break ($\chi^2(2) = 6.9, p = .03; \phi = .24$), Aggression ($\chi^2(2) = 19.7, p < .001; \phi = .41$), and Externalizing ($\chi^2(2) = 14.4, p = .001; \phi = .35$). (all others $p < .05$).
15. Significant proportional differences at 1Y-Post PRI (NCs / C and Norm/Borderline/Clinical) on Anx/Dep ($\chi^2(2) = 8.2, p = .02; \phi = .26$), With/Dep ($\chi^2(2) = 12.2, p = .002; \phi = .31$), Internalizing ($\chi^2(2) = 9.6, p = .008; \phi = .28$); Thought ($\chi^2(2) = 7.7, p = .02; \phi = .25$), Attention ($\chi^2(2) = 7.9, p = .02; \phi = .30$), Social Problems ($\chi^2(2) = 6.04, p = .04; \phi = .29$), and Externalizing ($\chi^2(2) = 16.6, p = .04; \phi = .23$). (all others $p < .05$).
16. Differences in 2Y-Post PRI proportions (NCs / Cs by Norm/Borderline/Clinical) were not significant (all $p < .05$) with the exception of Externalizing ($\chi^2(2) = 7.3, p = .03; \phi = .26$).
17. Significant proportional differences at 3Y-Post PRI (NCs/Cs and Norm/Bord/Clinical) on Anx/Dep ($\chi^2(2) = 13.3, p = .001; \phi = .39$), With/Dep ($\chi^2(2) = 14.7, p = .001; \phi = .41$), Somatic ($\chi^2(2) = 17.9, p < .001; \phi = .45$), Internalizing ($\chi^2(2) = 20.0, p < .001; \phi = .48$); Thought Problems ($\chi^2(2) = 11.2, p = .004; \phi = .36$), Rule Breaking ($\chi^2(2) = 6.5, p = .04; \phi = .28$), and Aggression ($\chi^2(2) = 7.8, p = .02; \phi = .30$) (all others $p < .05$), and Externalizing ($\chi^2(2) = 16.4, p < .001; \phi = .43$)
18. Behrens, E., Satterfield, K. (2011). A multi-center study of private residential treatment outcomes. *Journal of Therapeutic Schools & Programs*, 2017, 20-45.
19. Cell proportions different for C/NC and Never/>1Year Ago/4-12M Ago/Past 3 Months 3M Post-PRI for Thoughts ($\chi^2(4) = 15.4, p = .004; \phi = .46$), Plan ($\chi^2(4) = 14.3, p = .006; \phi = .44$), and Attempt ($\chi^2(4) = 11.0, p = .01; \phi = .40$), and Self-Harm ($\chi^2(4) = 11.9, p = .02; \phi = .42$); at 6M Post-PRI for Attempt ($\chi^2(4) = 7.4, p = .02; \phi = .34$), but no differences at any other timepoint for any indicator ($p < .05$)

20. Proportions are not for Cs and NCs by BMI category at 3M ($\chi^2(3) = 8.7, p = .03; \phi = .29$), 6M, or 1Y (all $p > .05$; n.s.).
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 C/NC -cell proportions were different for Substance Use at 3M ($\chi^2(3) = 15.9, p = .001; \phi = .5$), 1Y ($\chi^2(3) = 7.7, p = .05; \phi = .36$); but no other timepoints (all $p > .05$); for Mental Health at 3M ($\chi^2(4) = 25.5, p < .001; \phi = .67$), 6M ($\chi^2(3) = 12.5, p = .006; \phi = .46$), 1Y ($\chi^2(4) = 11.4, p = .02; \phi = .45$); and for Other at 3M ($\chi^2(4) = 9.3, p = .05; \phi = .4$), 1Y ($\chi^2(4) = 9.4, p = .05; \phi = .42$)
23. C v NC by Time proportions were different at 3M ($\chi^2(4) = 11.3, p = .02; \phi = .41$) and 6M ($\chi^2(4) = 16.9, p = .002; \phi = .49$); numbers for 2Y post-PRI are too few.
24. Proportions between Cs and NCs and all response options were different at 6M Post-PRI ($\chi^2(4) = 10.6, p = .03; \phi = .37$), 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. Three way interaction time/respondent/completion was not significant and nor was main effect of relationship, but main effect of Cs / NCs almost reached significance ($F(5,77) = 3.05, p = .09, \eta^2 = .04$).
27. Moms of C's missed fewer days than moms of NCs at 3M Post-PRI ($F(82) = 11.9, p = .001, \eta^2 = .13$). Dads of Cs missed less work than those of NCs at 6M Post-PRI ($F(62) = 14.3, p = .04, \eta^2 = .06$). Moms of Cs missed less than moms of NCs ($F(78) = 8.5, p = .005, \eta^2 = .10$) No other differences were significant
28. 3M Post-PRI Satisfaction higher for Cs than NCs on Ind Ther ($F(136) = 13.6, p < .001, \eta^2 = .09$); Front Line ($F(137) = 4.4, p = .04, \eta^2 = .03$); Groups ($F(135) = 15.3, p < .001, \eta^2 = .1$) Fam ($F(132) = 34.8, p < .01, \eta^2 = .2$); Academics ($F(132) = 13.9, p < .001, \eta^2 = .10$); (all other $p > .05$).
29. 6M Post-PRI Satisfaction was higher among Cs than NCs for Ind Ther: ($F(65) = 6.8, p = .01, \eta^2 = .1$); : Groups ($F(67) = 3.8, p = .05, \eta^2 = .05$); Mentor ($F(62) = 4.3, p = .04, \eta^2 = .06$) (all other $p > .05$).
30. 1Y Post-PRI Satisfaction was higher among Cs than NCs for: Ind Ther ($F(144) = 7.8, p < .01, \eta^2 = .05$); Frt Line ($F(159) = 16.0, p < .001, \eta^2 = .09$); Groups ($F(159) = 25.7, p < .001, \eta^2 = .14$); Fam ($F(152) = 15.4, p < .001, \eta^2 = .09$); Mentor ($F(134) = 8.7, p = .004, \eta^2 = .06$); Academics ($F(141) = 5.2, p = .02, \eta^2 = .04$); (OLE $p > .05$)
31. 2Y Post-PRI Satisfaction higher among Cs than NCs for: Ind Ther ($F(114) = 7.5, p = .007, \eta^2 = .06$); Front Line ($F(115) = 21.2, p < .001, \eta^2 = .16$); Groups ($F(113) = 7.8, p = .006, \eta^2 = .06$); Fam ($F(111) = 6.0, p = .02, \eta^2 = .05$); Mentor ($F(107) = 6.5, p = .01, \eta^2 = .06$); Academics ($F(110) = 12.8, p = .001, \eta^2 = .10$); (all other $p > .05$)



If you have any questions or comments regarding this report, please contact Dr. Laura Mills, Director of Research & Evaluation at laura.m@pineriverinstitute.com. Pine River Institute acknowledges funding support provided by the Toronto Central LHIN.

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