Evaluation of tykeTALK: Phase2

Family Satisfaction Survey Report

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Executive Summary

Purpose of the Survey

The purpose of the survey was to determine the extent to which parents/caregivers perceive the tykeTALK system is achieving the following intended outcomes:

- Provision of services at convenient times and locations
- High family satisfaction with the intake process
- High family satisfaction with the assessment process
- High family satisfaction with interventions
- High parental/caregiver involvement in interventions

Method

A questionnaire was developed collaboratively by members of an evaluation committee made up of representatives from tykeTALK system administration, front-line Speech and Language Pathologists, and evaluation researchers from Middlesex-London Health Unit. A stratified random sampling procedure was conducted, in order to select a representative sample of clients from each of the five service-providing agencies in the system. Questionnaires were mailed to respondents with a postage-paid return envelope provided. Two follow-up mailings were conducted. The data were collected between April 5th and July 20th, 2004. Based on an adjusted sample of 1153 clients, 609 questionnaires were returned with usable data, yielding a return rate of 52.8%. Preliminary analysis of data was conducted by the MLHU Program Evaluator, and presented to members of the evaluation committee for discussion and feedback in order to inform further analysis. A preliminary report was written and presentations made to front-line service providers and members of the tykeTALK Alliance Steering Committee in order to obtain further feedback before completing this report.

Profile of Respondents

There was a fairly even representation in the sample from four of the five agencies, which each represented from 19% to 21% of the respondents. The exception was Strathroy-Middlesex General Hospital whose clients made up 12.5% of the sample. About 38% of the respondents were currently receiving service at the time of the survey. The average duration of service received by clients was 14.2 months, with approximately two thirds of the respondents receiving between 4 and 25 months of service.

The great majority of respondents (93%) were the mothers of the children receiving service. The majority of the children receiving service (68%) were male. In terms of marital status, 86% of the respondents were married, 4% were single and 4% were divorced or legally separated.

The majority of respondents (50%) indicated that they had completed trade school, college or university. Relatively few (5%) had less than a high school education. A relatively high percentage of respondents (17%) had at least some post-graduate university education. There were significantly fewer people with less than high school diploma in the tykeTALK sample (5%) compared with the general population in Elgin, Middlesex and Oxford counties (21%). The percentage that had completed high school and/or had some post-secondary education was almost identical at 28% to 29%. A significantly greater percentage of tykeTALK survey respondents (68%) had completed trade school, college or university, compared with 51% among the general population in Elgin, Middlesex and Oxford.

In terms of citizenship status, 87% indicated they were Canadian by birth and 9% indicated they were landed immigrants. Of those not Canadian by birth (a total of 71 of 609 respondents) 16% had lived in Canada for 5 years or less. Ninety seven per cent (97%) of all respondents rated their ability read and write in English or French good or very good.

Almost 68% of the respondents indicated they were currently employed in a job for which they receive a salary or fee-for-service. Of those employed, 41% were employed part-time. More than 80% of those not employed were full-time homemakers. The median before-tax annual family income level of our sample was in the $60,000 to $70,000 range. Compared to the general population in the Elgin, Middlesex and Oxford counties, our sample had proportionally fewer persons in the lower income groups (less than $50,000) and more in the higher income groups (greater than $50,000).

Respondents' Overall Assessment of Change Due to tykeTALK Services

When asked to make a global assessment of what difference tykeTALK services as a whole made in their child's speech and language ability, more than 60%

of respondents indicated that it *improved a lot*, while almost a third (32%) indicated *it improved a little*. Respondents were also asked whether they had observed a number of possible changes in certain communication behaviours and communication-related social behaviours since their child started receiving tykeTALK services. A strong majority of respondents (from 57% to 80%) identified positive changes in various communication behaviours per se, while fewer though substantial numbers of respondents identified improvements in social behaviours including *getting along better with others* (47%) and having *fewer behaviour problems* (34%) since starting tykeTALK.

Convenience of tykeTALK Services

To what extent do tykeTALK clients at the various sites perceive that services are provided at convenient times and locations? At least two thirds of respondents indicated that *time of appointments, parking, and location of services* were convenient or very convenient. A notable minority (about 10-13%) however, did find services inconvenient or very inconvenient in terms of these three dimensions. Parking was identified as more of a problem at one agency in particular. Very few respondents indicated that physical or literacy barriers were problems. Thus we conclude that a substantial majority of respondents, tykeTALK services were provided at convenient times and locations.

Satisfaction with the Intake Process

In order to assess satisfaction with the intake process respondents were asked to indicate how they first heard about tykeTALK, whether their first call was answered by a person or by a voice mail system, and to rate their intake experience according to several dimensions of satisfaction.

Most tykeTALK clients first found out about tykeTALK from a physician. Other common ways to find out about tykeTALK include community agencies and health units. Though more than three-quarters of the respondents agreed that it was easy to find out about tykeTALK, more than 15% were neutral and 5% disagreed. Thus, there may be some room to increase public awareness about tykeTALK. About 25% of respondents indicated that they encountered a voice mail system the first time they called tykeTALK. A notable percentage of those encountering voice mail (about 25%) disagreed that it was easy to make person-to-person contact with tykeTALK. Some consideration by tykeTALK system administrators may be in order, as to whether this finding warrants putting more resources into improving this aspect of the intake process. The great majority of respondents were satisfied with the aspects of the intake process we measured.

Experience with the Assessment Process

How satisfied were clients with the assessment process? The great majority of respondents were satisfied with respect to the aspects of the assessment we measured: 93% indicated that their *concerns were listened to carefully,* 91% indicated they were given *suggestions of things to do to help their child*, 87% indicated that the Speech and Language Pathologist *helped them understand their child's speech and language needs*, 85% indicated they *understood what to expect* over the next few months, and 73% felt they *had a say in what happened next*.

Based on the foregoing, there may be some room for improvement with respect to conveying to clients "what to expect" in the months subsequent to the assessment process, particularly in one agency. Administrators may also consider exploring whether steps need to be take to either a) give clients more of "a say in what happens next," or b) clarify with clients the constraints the program operates under so that they understand the legitimate limits on how much say they can expect to have in their child's service.

Respondents' Evaluations of Five Specific tykeTALK Interventions

We asked a series of questions designed to measure the extent of respondents' experience with each of five specific interventions, as well as their perceptions about the impact of those interventions.

Extent of Experience with Interventions

Most clients received some combination of the five interventions. In our sample, about 26% of respondents participated in a parent group, 83% received individual therapy, 37% received group therapy, 43% undertook a home program, and 15% had suggestions given by a speech and language therapist to their childcare provider. In terms of the two primary interventions offered, the median number of individual therapy sessions received among those in our sample was 14, while the median number of group therapy sessions received was 8.

Perceptions of Impact of Interventions

Respondents were asked to indicate the extent to which they agreed with statements about the impact of each intervention on their child's speech and language abilities. At least three-quarters of the

respondents gave favourable "improvement ratings" to each of the interventions (i.e., they agreed or strongly agreed that the intervention improved their child's speech and language skills) with the exception of group therapy, which received a favourable rating from 59% of the respondents. Individual therapy received a favourable rating from 85% of the respondents.

Group versus Individual Therapy

We considered whether a respondent had only individual therapy, only group therapy, or both interventions made a difference in the extent to which they agreed the intervention caused an improvement. The mean improvement rating[1] of group therapy among those who had both interventions was 3.6, while for those who had only group therapy it was 3.7. The mean improvement rating of individual therapy among those who had both interventions was 4.1, while for those who had only individual therapy it was 4.3. Thus we found that regardless what combination of group and/or individual therapy received, respondents gave more favourable improvement ratings to individual therapy than to group therapy. There were no statistically significant differences found between different agencies in these analyses.

Effect of Number of Sessions on Perception of Impact

Given that on average, respondents received more units of individual therapy than group therapy, we considered whether the total number of sessions received might account for the more favourable improvement ratings for individual therapy. We found that the total number of sessions received did have a positive impact on improvement ratings for those who had individual therapy only, and for those who had both interventions, but only *up to a point* (somewhere around 20 to 30 sessions) after which diminishing returns set in. For those who had group therapy only, improvement ratings actually appear to decrease as the total number of sessions received increased up until around 10 sessions, at which point improvement ratings increased. (The result of this analysis must be taken as tentative, given limitations in our data.)

Despite the fact that individual therapy received comparably more favourable improvement ratings, there was nothing in our findings, which suggests that group therapy is not an effective intervention, especially in combination with individual therapy. Because those who had only group therapy perceived it as having less positive impact, efforts may be in order to enrich or enhance the experience of clients who are receiving only group therapy for a period of time, by adding some individual components. While parents may prefer individual therapy for readily apparent reasons related to receiving individual attention, a combination of group and individual therapy actually received marginally *more positive* ratings on global measures of satisfaction, than individual therapy alone.

In sum, a substantial majority of parents agreed that each of the five interventions had a positive impact on their child's speech and language skills, were very to completely satisfied with the services they received, felt that almost all or most of their needs were met, and would recommend tykeTALK to others in need of such services.

Parental Involvement in Child's Care

Does the tykeTALK system foster meaningful involvement of parents/caretakers in their child's care? In order to determine this we adapted and incorporated into our questionnaire a pre-existing, well-validated tool—the MPOC-20—designed to assess the degree of family-centredness of services as experienced by families.

MPOC stands for *measures of processes of care*. The MPOC-20 consists of twenty indicators or questionnaire items clustered into five distinct scales, measuring five distinct processes of care. We used 11 of the 20 items which constitute three of the five scales: *Enabling and Partnership*, *Providing Specific Information about the Child*, and *Respectful and Supportive Care*. Respondents rated each item on a scale from 1 = Not at All to 7 = To a Very Great Extent. Each scale could thus receive a scale score ranging from 1.00 to 7.00.

The mean score on the *Enabling Partnership Scale* was 5.54. The score on the *Providing Specific Information about Child Scale* was 5.82. The score on the *Respectful and Supportive Care Scale* was 5.91. In other words, on average, tykeTALK clients rate three key dimensions of family-centredness of care in the "Fairly Great Extent" to "Great Extent" range. The highest scores were given on the *Respectful and Supportive Care* scale. There may be some room for improvement on dimensions of care measured by the *Enabling and Partnership* scale.

[1] Based on a five point scale where 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree and 5 = Strongly Agree.

Comparing the MPOC scores received by the tykeTALK program with a recent Ontario-wide survey of similar agencies reveals that the tykeTALK program scored higher on all three dimensions measured. We conclude that tykeTALK program delivers service in a manner consistent with principles of "family-centred service".

Conclusion and Recommendations

We set out to determine how parents/caregivers view the tykeTALK system in terms of several indicators of effectiveness of and satisfaction with services. On virtually every indicator, most survey respondents gave the tykeTALK service very favourable ratings. The great majority of respondents felt that services were convenient, were satisfied with the intake and assessment processes, agreed that the interventions received had a positive impact on their child's speech and language abilities, and felt appropriately and meaningfully involved in their child's treatment.

Though the overall ratings of tykeTALK services were very favourable, some indicators received relatively lower ratings. Perhaps most noteworthy among these was the finding that respondents tended to perceive individual therapy more favourably than group therapy, in terms of its impact on their child's speech and language abilities.

In terms of findings that may call for some change or adjustment in the system based on comparisons among ratings on various indicators, the following recommendations are offered for the consideration of tykeTALK decision-makers.

- Consider whether putting additional resources into the warm-line system in order to increase clients' sense of "ease of making personal contact" is warranted.
- Consider whether putting additional resources into increasing public awareness in order to increase ease of finding out about tykeTALK is warranted.
- Consider together with front-line service providers whether there is room for improvement with respect to conveying to clients "what to expect" in the months subsequent to the assessment process.
- Explore with front-line service providers whether steps need to be take to either a) give clients more of "a say in what happens next" after assessment, or b) clarify with clients the constraints the program operates under so that they understand the legitimate limits on how much say they can expect to have in their child's service.
- Efforts may be in order to enrich or enhance the experience of clients who are receiving group therapy, by adding some individualized component to the group therapy service.
- Explore further with front-line service providers and parents/caretakers what steps can be taken to enhance parents'/caretakers' sense of involvement in terms of choosing when to receive and type of information, providing written information about their child's progress, and providing opportunities for parents to make decisions about their child's therapy.

Introduction

This document reports the results of the tykeTALK *Family Satisfaction Survey*. The survey was administered to parents or guardians of children who, at the time the survey was undertaken, were using, or had recently used tykeTALK services.

Purpose of Phase 2

The purpose of the survey was to determine the extent to which parents/caregivers perceive the tykeTALK system is achieving the following intended outcomes related to family satisfaction:

- Provision of services at convenient times and locations
- High satisfaction with the intake process
- High satisfaction with the assessment process
- High satisfaction with interventions
- High parental/caregiver involvement in interventions

Prior Steps and Products in the Evaluation Process

Program Logic Model

The first preliminary step was the review and revision of the program logic model for the tykeTALK system. This was undertaken collaboratively between the MLHU Program Evaluator, the MLHU Research Associate and the tykeTALK System Facilitator. The program logic model describes key components, activities, and intended outcomes of the tykeTALK program. The program logic model is included as Appendix A to this report. From this ground work an evaluation plan was developed. The initial evaluation plan is presented in Table 1.

Phase 1: SLP Focus Groups

Phase 1 involved a series of focus groups conducted with Speech and Language Pathologists (SLPs) employed by tykeTALK, and was carried out in May and June of 2003. The results of Phase 1 are reported in a separate document entitled *Evaluation of tykeTALK, Phase 1: View From the Front Line.*

Table 1: Evaluation Plan

	Phase 1: SLP/CA Focus Groups and Interviews	**Phase 2: Family Satisfaction Survey**
Target Group	Speech and Language Pathologists and Communications Assistants providing service through 5 tykeTALK affiliated community agencies	Parents or guardians of children who have receive tykeTALK service within the year prior to the survey
Outcomes to Be Evaluated	• SLPs/CAs feel competent & supported in providing all interventions • Partners & service providers kept up-to-date on program performance • Belief in tykeTALK vision, planning principles and objectives • Staff satisfaction with system (operationalization of mission and objectives)	• Services available at convenient locations and times • High family satisfaction with intake process • Increase parent/caregiver involvement in interventions • High family satisfaction with assessment process • High family satisfaction with interventions
Method	Qualitative study to elicit in-depth perceptions and experiences of front line staff around key aspects of tykeTALK	Quantitative study of a representative sample of tykeTALK families, the findings from which will be generalizable to the population of tykeTALK families.

Let's Grow Survey

Another element of the tykeTALK evaluation not described in Table 1 was the inclusion of indicators that would provide information useful to the tykeTALK system on a survey of subscribers to the Tri-county *Let's Grow* parent information mail out program. The *Let's Grow* Program, though not formally a component of the tykeTALK program, has administrative links and objectives that dovetail with the tykeTALK program, in terms of promoting earlier identification and intervention of children with health risks, including speech and language delays. *Let's Grow* reaches more than 80% of families experiencing new births in the Thames Valley. Among the purposes of the Let's Grow survey was to determine the extent to which the *Let's Grow* program achieves the following outcomes that are shared with the tykeTALK program.

- Parents' ability to recognize potential speech & language problems
- Awareness of how to access speech & language services through tykeTALK
- Parent/childcare provider knowledge of how to stimulate speech & language development
- Knowledge of community professionals and families regarding speech and language developmental milestones
- Knowledge on how to refer
- Parent/childcare provider identification of related developmental concerns (e.g. hearing)

The *Let's Grow* survey was conducted in April and May of 2003. The full results of the survey are reported in a separate document (Middlesex-London Health Unit, 2003*).* An excerpt from the *Let's Grow* survey report that pertains to these outcomes is included as Appendix B to this report.

Overview and Organization of this Report

The next two sections of this report provide additional background information. The *Methods* section provides information on sample selection, return rate and procedures followed in carrying out the study. The *Profile of Respondents* section presents a demographic and other descriptive information of those that responded to the survey. Following these two sections, survey findings are presented in detail. *Section A: Respondent's Overall Assessment of Change Due to tykeTALK Services* presents respondents' global assessments of the impact of tykeTALK Services on their child's speech and language skills. The subsequent sections of the report (Sections B through F) is organized to correspond to the structure of the questionnaire, which was designed to measure the intended outcomes outlined at the beginning of this introduction.

Methods

Survey Design

Key principles and guidelines as presented by Dillman (2000) in his *tailored design method* were closely followed in designing the survey. The survey was designed primarily to measure five key outcomes that had been identified in the process of developing a program logic model for the tykeTALK program, as discussed in the introduction to this report.

Questionnaire Development

The questionnaire was developed collaboratively by the MLHU Program Evaluator, Research Associate, and the tykeTALK evaluation subcommittee, which consisted of the tykeTALK System Facilitator, and three Speech and Language Pathologists, one of whom also served in the role of agency manager.

In addition to developing a set of original indicators to measure intended outcomes stipulated in the program logic model, we adapted the brief version of a pre-existing, validated instrument developed by researchers at McMaster University known as the *MPOC-20*, which stands for *Measure of Processes of Care,*[2] to measure an intended outcome related to parent involvement in interventions. (See Appendix C for a copy of the questionnaire.)

Pilot

The questionnaire was pilot tested with a sample of 103 tykeTALK clients. Revisions were made based on feedback elicited through the pilot version of the questionnaire.

Sampling Procedures

The stratified random sampling strategy described below was developed by the MLHU Program Evaluator. The sampling plan was reviewed with and endorsed by a consultant with the Biostatistical Support Unit at the University of Western Ontario.

Inclusion/Exclusion Criteria

Eligibility for inclusion in the survey was established by the evaluation subcommittee, with the intention of assuring that respondents 1) would have had *sufficient* experience with the service to have a well informed perspective, and 2) would have had services *recently enough* to be able to recall their experiences clearly.

In order to be included tykeTALK families had to have been in the system at least 5 months since their date of initial assessment at the time of the survey, and had to have been discharged no longer than 12 months prior to the survey date.

Sampling Frame

The Ministry of Health and Long-term Care requires that official administrative and clinical tracking data for a variety of children's services be entered in a database called ISCIS (Integrated Services for Children Information System). Controls on that system are very strict, and it was unavailable for use as a sampling frame for the survey.

The sampling frame for the survey was a "shadow" database (set up in MS Excel) which was maintained by tykeTALK Administrative Assistant. This database includes much of same data entered into ISCIS, such as client contact information, service provider, date of assessment, dates of interventions, and date of discharge.

Drawing the Sampling

At the time of sampling, the shadow database had a total of 5761 records. After those who did not meet the inclusion criteria and those with missing address were excluded, 2584 records remained. Those selected for the pilot phase of questionnaire development were also excluded from the final sampling frame. The 2481 remaining records constituted the sampling frame from which a random sample was drawn.

A stratified sampling procedure was conducted, whereby a separate sample was drawn for each service-providing agency. Calculations were made in order to determine how many questionnaires would need to be sent out in order to obtain a sufficient number of completed questionnaires needed to make estimates within a ± 5% margin of error, assuming a 60% return rate. A separate random sample was drawn for each agency using SPSS. A sample of 1686 records was drawn.

[2] See the following website for details about research with and related to the development of the MPOC: http://www.fhs.mcmaster.ca/canchild/

Questionnaire Distribution, Return Procedures and Return Rate

A Research Assistant was hired to carry out all procedures associated with mailing out, tracking returns, and data entry.

The questionnaires were distributed and returned through Canada Post. Distribution procedures included up to four separate mailings, including: 1) a pre-survey letter; 2) an initial mail out of the questionnaire with cover letter, small token gift and postage-paid return envelop; 3) a follow-up reminder postcard; and for those who did not respond within three weeks of the first follow-up, 4) a second copy of the questionnaire with postage-paid return envelop.

The first three mailings were conducted in-house under the supervision of the research assistant. The final mailing was contracted out to an external service.

Questionnaires were received from April 5th through July 20th, 2005. After adjusting for questionnaires that were returned undeliverable and other adjustments as described in Table 1, the overall return rate for the survey was 52.8%.

Data Entry

A database was prepared by the MLHU REED Services Data Analyst using MS Access software program. The program allows strict definition of data that will be accepted by the system for each variable, thereby minimizing data entry errors.

The majority of data was entered by the Research Assistant. Two other data entry clerks assisted with data entry, under the supervision of the research assistant. Data cleaning was performed by the Program Evaluator.

Data Analysis

The data were analyzed using SPSS for Windows, Version 13.0. Preliminary data analysis was conducted by the Program Evaluator. The Program Evaluator consulted the PHRED Community Researcher/Educator on interpretation of the findings reported in Sections E and F. The PHRED Community Researcher/ Educator conducted additional analysis for Section E of this report.

Report Writing

Preliminary results were vetted to REED Services colleagues and through the tykeTALK System Facilitator. Presentations were made and draft reports circulated to front-line Speech and Language Pathologists at one of their "System Days" (regular professional development sessions) and to members of the tykeTALK Alliance Steering Committee in order to gain perspective and insight in preparation for finalizing this report.

Table 1: Return Rate Information

Agency Name	Original Sample Size	# returned undeliverable	# returned by client, but indicated received service more than 3 years ago	# returned by client, but indicated received assessment only (no interventions)	Adjusted sample size (# in sample assumed delivered and eligible)	# completed and eligible questionnaires received	Return rate
UWO	333	63	4	26	240	131	54.6%
St. Thomas	330	61	3	9	257	148	57.6%
Thames Valley Children's Centre	499	176	15	14	294	115	39.1%
Strathroy	157	32	4	4	117	79	67.5%
Woodstock	367	104	10	8	245	136	55.5%
TOTAL	1686	436	36	61	1153	609	52.8%

Profile of Respondents

Agency Providing Service

Respondents were asked to indicate which of the five agencies in the tykeTALK system provided service to their child. If they received service from more than one agency, they were asked to indicate which provided the *most* service. Respondents whose answer did not agree with the service-providing agency with which they were identified in the sampling frame were coded "uncertain".[3]

As indicated in the table below, there was a fairly even representation in the sample from four of the five agencies, which each represented from approximately 19% to 21% of the respondents. The exception was Strathroy-Middlesex General Hospital, which had a much smaller client population from which to sample. (See Methods section for detailed explanation of sampling procedure and return rate.)

Table 2. Agency Providing Service

	N	%
Thames Valley Children's Centre	113	18.6%
Woodstock General Hospital	121	19.9%
University of Western Ontario	116	19.0%
Elgin-St. Thomas	128	21.0%
Strathroy-Middlesex General Hospital	76	12.5%
Uncertain	55	9.0%
Total	609	100.0%

Is Child Currently Receiving Services?

Respondents were asked to indicate whether their child was currently receiving services. As indicated in Table 2, nearly 38% of the respondents were receiving services at the time they completed the questionnaire.

[3] Respondents' answers to this question were compared with service provider information in the original database from which the sample was drawn (see Methods section). Reasons for lack of agreement may include, for example: more than one agency provided service, the respondent may have confused a community *location* where they received service with the service provider, or they may have indicated they *referring agency* rather than the service provider. In order that any analysis which compares respondents' satisfaction based on which agency provided service be as robust as possible, any instance in which the agency identified in the original data base did not agree with the respondents' indication on this question were coded "uncertain".

Table 3. Is Child Currently Receiving Service?

	N	%
Yes	231	37.9%
No	377	61.9%
Unknown	1	0.2%
Total	609	100.0%

Reason No Longer or Not Currently Receiving Service

Those who were not receiving service at the time of the survey (377, or 62% of respondents) were asked to indicate from a list of four options why they were not receiving services, or to write in an "other" reason.

As presented in Table 3, of those not receiving services at the time of the survey, the great majority indicated either their child was discharged because they had met their goals (45%), or had transferred to school services (31%). Only a handful of respondents indicated they stopped because they were not satisfied with service, or because they had moved.

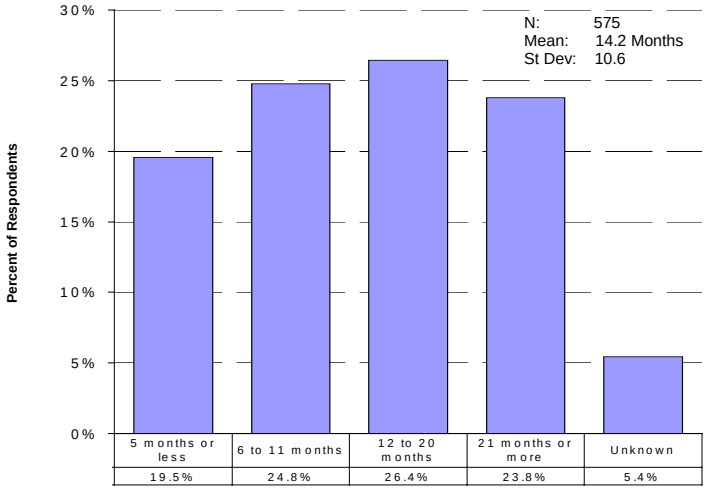
A notable subset of those not currently receiving service (79 or 21%) volunteered reasons other than the four possible reasons listed in the questionnaire. Those open-ended responses were analyzed and categorized into one of five additional categories as follows. Nearly 10% gave reasons such *as waiting for reassessment or on a temporary break from service*. Almost 6% wrote in reasons having to do *with no longer being eligible for service*, such as child being too old, being in-between finishing with tykeTALK and starting school-based services, or being given a limit on the amount of service available by tykeTALK. About 3% stated reasons such as they had *had an assessment, and that service was deemed unnecessary*, or that the child had improved on his or her own without service. Less than two percent of respondents gave reasons such as their *child had transferred to another service* such as a special service for autistic children, or *because of other barriers or problems* such as an illness or parents being too busy.

Table 4 If Not Currently Receiving Service		
	N	**%**
Discharged because child reached goals	175	46.3%
Transferred to services at school	118	31.2%
Waiting for Reassessment, Temporary Break	37	9.8%
No Longer Eligible (age, waiting for school services, tykeTALK judged child had sufficient services)	21	5.6%
Assessed, Service Not Needed or Child Improved on Own	10	2.6%
Transferred to Specialized or Other Service	6	1.6%
Problems/Barriers (e.g., illness, parent too busy, behaviour)	5	1.3%
Stopped because not satisfied with service	3	0.8%
Moved	2	0.5%
Total	377	100.0%

Duration of Service (in Months)

Based on 575 valid responses, the average duration of service received by clients was 14.2 months. As indicated by the standard deviation statistic, approximately two thirds of the respondents had between 4 months and 25 months of service.

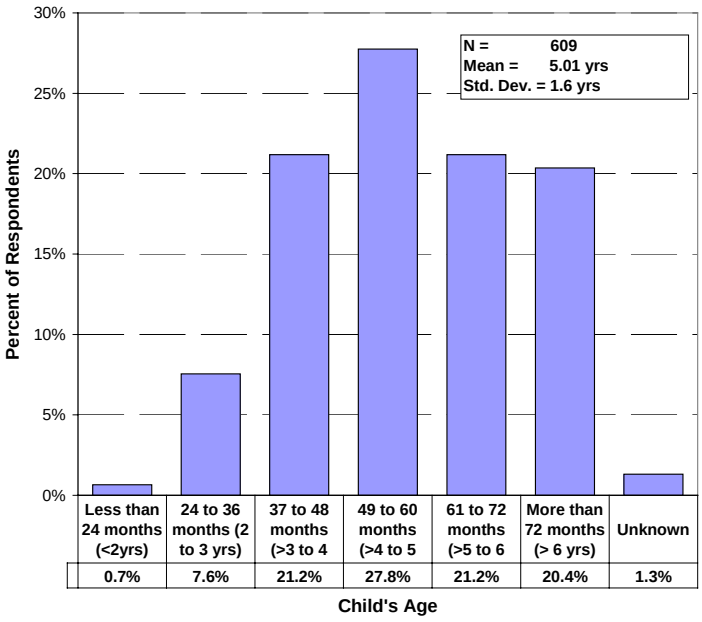
Chart 1: Months of Service Received



Age of Child at Time of Survey

The average age of children at the time of survey (April 1, 2004) was 5 years old. The age distribution of children receiving service is presented in the Chart 2.

Chart 2: Child's Age at Time of Survey



Sex of Child Receiving Service

More than two thirds (67.7%) of respondents indicated that the child receiving service was male.

Respondents' Sex

The great majority of survey respondents (94%) indicated they were female, as shown in Table 5.

Table 5. Respondents' Sex		
	N	**%**
Female	572	93.9%
Male	25	4.1%
Unknown	12	2.0%
Total	609	100.0%

Respondents' Relationship to Child Receiving Service

As displayed in Table 6, nearly all respondents identified themselves as the parent of the child receiving service. Nearly 2% indicated an "other" relationship. Analysis of written in comments indicates that most of these identified themselves as foster mothers or grandmothers.

Table 6. Respondent's Relationship to Child Receiving Service

	N	%
Parent	587	96.4%
Legal Guardian	4	0.7%
Other	11	1.8%
Unknown	7	1.1%
Total	609	100.0%

Respondents' Age

Respondents were between the age of 22 and 65 years of age, with average age of the respondents being about 36 years. Approximately two thirds of the respondents were between 30 and 41 years of age.

Respondents' Marital Status

As indicated in the following table, the great majority (86.2%) of respondents indicated they were married. About 4% were single, common law or divorced/legally separated, respectively.

Table 7. Respondents' Marital Status

	N	%
Single	22	3.6%
Married	525	86.2%
Common Law	26	4.3%
Divorced or Legally Separated	24	3.9%
Widowed	2	0.3%
Unknown	10	1.6%
Total	609	100.0%

Number of Children (<19-Years-Old) Living at Home

On average, families in our sample had 2.4 children less than 19 years of age living at home. While the range of the number of children living at home was between one and twelve, 90% of the sample reported three or fewer children living at home.

Table 8. Number of Children (<19yrs old) Living at Home

	N	%
One	81	13.3%
Two	304	49.9%
Three	150	24.6%
Four	45	7.4%
Five	10	1.6%
Six	3	0.5%
Seven	1	0.2%
Twelve	1	0.2%
Unknown	14	2.3%
Total	609	100.0%

Highest Level of Education Completed

The majority of respondents (50%) indicated that they had completed trade school, college or university. Relatively few (4.7%) had less than a high school education. The following table also indicates that a relatively high percentage of respondents (17.1%) had at least some post-graduate university education.

Table 9. Highest Level of Education Completed

	N	%
Some elementary school	2	0.3%
Completed elementary school	3	0.5%
Some high school	24	3.9%
Completed high school	86	14.1%
Some trade school, college or university	80	13.1%
Completed trade school, college or university	305	50.1%
Some post-graduate university education	57	9.4%
Completed masters or doctorate	47	7.7%
Unknown	5	0.8%
Total	609	100.0%

Comparison of tykeTALK Sample with General Population

How does the education level of tykeTALK respondents compare with the general population? In order to estimate this, the tykeTALK sample was compared with 2001 census data for females age 20-64 residing in the Thames Valley region,[4] which is the catchment area served by the tykeTALK program.

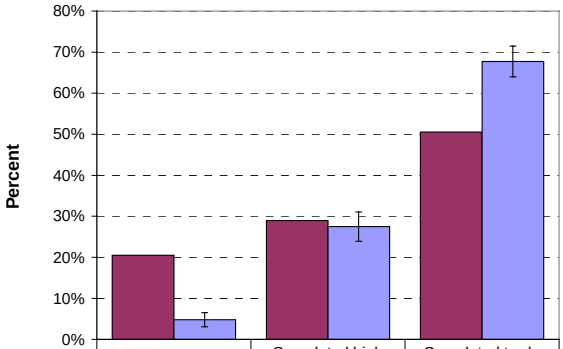
As illustrated in Chart 3, there were significantly fewer people with lower levels of education (less than

[4] Middlesex, Elgin and Oxford counties.

high school diploma) in the tykeTALK sample compared with the general population in Thames Valley. The percentage that had completed high school and/or had some post-secondary education was almost identical. A significantly greater percentage of tykeTALK survey respondents had completed trade school, college or university, compared with the general population in Thames Valley.

From this data we are not able to determine the extent to which people with less than a high school education are not utilizing tykeTALK services, or fewer among this segment of the population responded to the questionnaire.

Chart 3: Comparison of Highest Level of Education tykeTALK Sample with Thames Valley*

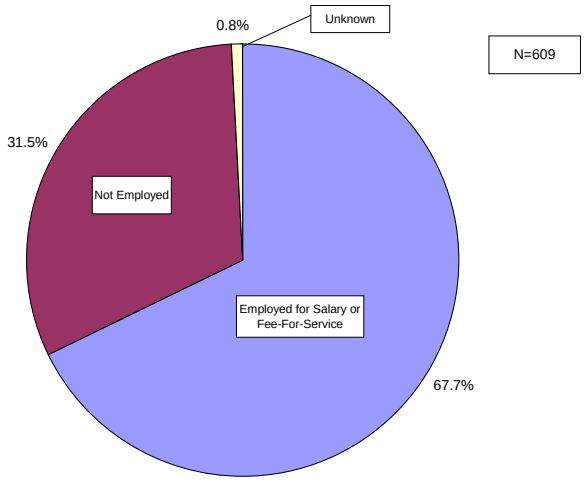


*Elgin, Middlesex and Oxford Counties. Source: Statistics Canada, 2001 Community Profile

Employment Status

Almost 68% of the respondents indicated they were currently employed in a job for which they receive a salary of fee-for-service.

Chart 4: Respondents' Employment Status



Status of Those Not Employed

The status of those respondents not currently employed is displayed in Table 10. As indicated, more than 80% of those not employed were full-time homemakers. Notably, more than 10% identified themselves as disabled.

Table 10. If Not Currently Employed, What is Status?

	N	%
A full-time homemaker	152	80.4%
Unemployed	13	6.9%
Retired	1	0.5%
Student	3	1.6%
Disabled	20	10.6%
Total	189	100.0%

Part-time versus Full-time Workers

Of those respondents that indicated they were employed, 59% indicated they were employed full-time, and 41% indicated they worked part-time.

Table 11. If Currently Employed, Full or Part Time?

	N	%
Full-time	241	59.4%
Part-time	165	40.6%
Total	406	100.0%

Job Classification of Those Employed

As shown in Table 12, almost 50% of those respondents who were employed classified themselves as *professional or technical workers*. The categories of *sales or clerical worker* and *manager or proprietor* were also indicated by a substantial numbers of respondents (19% and 16% respectively).

Table 12. Classification of Respondents' Primary Paid Employment

	N	%
Semi-skilled worker or apprentice trades person	26	6.5%
Sales worker or clerical	76	19.1%
Skilled worker, trades person or foreman	35	8.8%
Manager or proprietor	63	15.8%
Professional or technical worker	198	49.7%
Total	398	100.0%

Language and Citizenship Status

Respondents' First Language

Just over 90% of the respondents indicated that English was the language they first learned to speak and still understand. Only one respondent indicated French as their first language. A notable minority of respondents indicated "other" as a first language.

Table 13. First Language (Still Understood)

	N	%
English	549	90.1%
French	1	0.2%
Other	50	8.2%
Unknown	9	1.5%
Total	609	100.0%

Table 14 displays the first language learned and still understood for the 50 respondents (about 8% of the sample) who indicated their first language was other than English or French.

Table 14. Other First Language Still Understood

	N
German	10
Portuguese	5
Arabic	4
Croatian	3
Dutch	3
Polish	3
Vietnamese	2
Gujarati	2
Russian	2
Spanish	2
Chinese	1
Chinese and Vietnamese	1
Albanian	1
Belgium	1
Hebrew	1
Hungarian	1
Indonesian	1
Japanese	1
Low German	1
Pennsylvania Dutch	1
Punjabi	1
Slovak	1
Somalian	1
Tayang	1
Total	50

Language Spoken at Home

More than 96% of the respondents indicated that English was the language spoken at home most often.

Table 15. Language Spoken at Home Most Often

	N	%
English	585	96.1%
Other	19	3.1%
Unknown	5	0.8%
Total	609	100.0%

Three percent (3%) of our sample indicated an "other" language was spoken at home most often, as presented in Table 16.

Table 16. Other Language Most Often Spoken at Home	
	N
German	2
Polish	2
Vietnamese	2
Albanian	1
Arabic	1
Chinese	1
Dutch and English	1
Hebrew	1
Indonesian	1
Japanese	1
Pennslvyania Dutch	1
Portuguese	1
Serbian	1
Somalian	1
Spanish	1
Total	18

Respondents' Ability to Read and Write English or French

The vast majority of respondents rated their ability to read and write English or French as *very good* (87%) or *good* (10%). Less than 2% of respondents rated their proficiency with at least one of the official languages as *fair* or *poor*.

Table 17. Respondent's Ability to Read and Write English or French		
	N	%
Poor	5	0.8%
Fair	5	0.8%
Good	60	9.9%
Very Good	532	87.4%
Unknown	7	1.1%
Total	609	100.0%

Respondents' Citizenship Status

We asked respondents about their citizenship status because recent newcomers to Canada may be considered "vulnerable" depending upon other socioeconomic variables, such as social support, income, education and employment status. As part of its strategic planning for 2004 and 2005, the Middlesex-London Health Unit has identified that segment of our population that has resided in Canada for five years or less as being a potentially "vulnerable population" warranting special attention.

While a substantial majority of the respondents (87%) indicated they were Canadian by birth, a notable minority of respondents (11.5%) indicated they had come to Canada as an immigrant or refugee.

Table 18. Respondent's Citizenship Status		
	N	%
Canadian by birth	530	87.0%
Landed immigrant	53	8.7%
Refugee	1	0.2%
Other	16	2.6%
Unknown	9	1.5%
Total	609	100.0%

Years Living in Canada

Those who responded that they were not Canadian by birth were asked to indicate what year they arrived in Canada. The length of residence of those respondents in our sample that make up the 12% who were not Canadian born, ranged from 2 to 45 years. The average length of residence in Canada was 20.3 years.

As indicated in Table 19, eleven individuals in our sample indicated they have lived in Canada less than five years. This figure amounts to almost 16% of those in our sample who were not Canadian by birth, but only 1.8% of the entire sample.

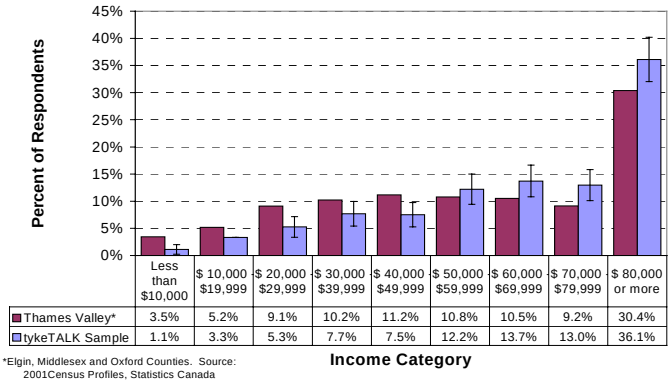
Table 19. Years in Canada (Not Canadian by Birth)		
	N	%
5 years or less	11	15.5%
More than 5 years	60	84.5%
Total	71	100.0%

Income

Table 20 displays income data for our sample. Examination of the column headed "cumulative percent" reveals that three quarters of the respondents indicated their total household income (before taxes) was more than $50,000. More than a third of those who responded to this question (36.1%) indicated that their total household income exceeded $80,000.

Table 20. Respondent's Total Household Income Before Taxes				
	N	**Percent including unknown**	**Percent excluding unknown**	**Cumulative Percent**
Less than $10,000	6	1.0%	1.1%	1.1%
$10,000 to $14,999	10	1.6%	1.9%	3.0%
$15,000 to $19,999	8	1.3%	1.5%	4.5%
$20,000 to $29,999	28	4.6%	5.3%	9.8%
$30,000 to $39,999	41	6.7%	7.7%	17.5%
$40,000 to $49,999	40	6.6%	7.5%	25.0%
$50,000 to $59,999	65	10.7%	12.2%	37.2%
$60,000 to $69,999	73	12.0%	13.7%	50.9%
$70,000 to $79,999	69	11.3%	13.0%	63.9%
$80,000 or more	192	31.5%	36.1%	100.0%
Total (excluding unknown)	532	87.4%	100.0%	
Unknown	77	12.6%		
Total	609	100.0%		

Chart 5: Comparison of Total Household Income tykeTALK Sample with Thames Valley*



*Elgin, Middlesex and Oxford Counties. Source: 2001Census Profiles, Statistics Canada

How does the income level of our respondents compare to the general population in Thames Valley? Chart 5 displays the before-tax income distribution of our sample, in comparison with household income data taken from the 2001 census.[5] Our sample had proportionally fewer persons in the lower income groups (less than $50,000) and more in the higher income groups (greater than $50,000).

[5] Household income in 2000 of two or more person private households, 2001Census Profiles, Statistics Canada.

Section A: Respondents' Overall Assessment of Change Due to tykeTALK Services

Purpose of the Section

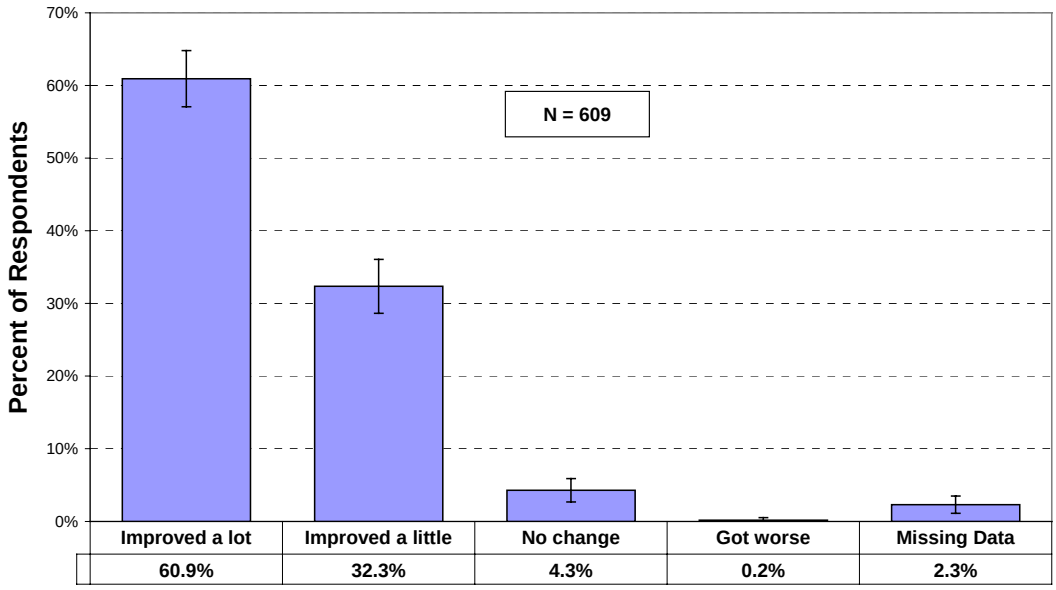
The main purpose of this section of the questionnaire was to get respondents to begin to critically reflect on their experience of tykeTALK services. The idea here was to ask respondents to assess the service from a rather global perspective. Once having stimulated critical thinking about the program in general, the questionnaire would then move into questions about specific aspects of the program.

Findings

The very first question asked in the questionnaire was *"What difference has tykeTALK made in your child's speech and language ability?"* Respondents' perceptions of the impact of specific interventions are treated in more depth in Section E of this report.

As shown in the Figure A.1, more than 60% of the respondents indicated that they thought there child's speech and language ability had *improved a lot* as a result of tykeTALK services, and another third of the respondents indicated their child had *improved a little*.

Figure A.1: Respondents' Assessment of Difference tykeTALK Made for Child's Speech & Language



No statistically significant differences were found between agencies.

Next, respondents were presented with a list of eight possible changes they may have observed in their child's communication ability and behaviour since starting tykeTALK, and asked to indicate the extent to which they agreed that their child has exhibited that change.

The possible changes are presented in Table A.1 in rank order, based on the percentage of respondents that agreed or strongly agreed the change applied to their child. No statistically significant differences were found between agencies.

As indicated, respondents were more likely to agree with the statements directly describing improvements in communication abilities per se, than with statements pertaining to behaviour and/or attitude changes that may be indirectly related to improvement in communication abilities. Fewer though substantial numbers (at least one third) of the respondents agreed they observed improvement in various communication-related behaviours and attitudes.

Conclusions About Respondents Overall Assessment of Change Due to tykeTALK

The great majority of respondents noted positive changes in their child's speech and language ability since receiving tykeTALK services. Most often respondents identified changes in communication abilities per se. Substantial numbers of respondents also noted improvement in other social behaviours related to speech and language skill.

Table A.1: Possible Changes Observed in Child Since Starting tykeTALK

	N	Strongly Disagree or Disagree	Neutral	Agree or Strongly Agree	Missing Data
Understood Better	609	4.6%	13.6%	79.5%	2.3%
Communicates Wants Better	609	3.9%	15.4%	78.5%	2.1%
Seems Less Frustrated When Trying to Communicate	609	8.0%	19.4%	68.5%	4.1%
Talks with Family More	609	8.2%	27.4%	61.6%	2.8%
More Self Confident	609	6.2%	31.2%	57.5%	5.1%
Talks More With Other Children	609	9.0%	31.5%	57.0%	2.5%
Gets Along Better With Others	609	10.2%	39.9%	46.5%	3.4%
Has Fewer Behaviour Problems	609	17.9%	43.5%	33.7%	4.9%

Section B: Convenience of tykeTALK Services

Purpose of this Section

The purpose of this section was to measure the extent to which the tykeTALK system is successful in achieving the objective of *provision of service at convenient times and locations*. The inclusion of this outcome in the evaluation plan reflects the importance of one of the perceived advantages of creating an integrated system of speech and language services for the Thames Valley region—to make services convenient across the system.

To assess convenience of tykeTALK services, respondents were asked to rate the three dimensions of service listed in Table B.1 on a scale from *Very Inconvenient to Very Convenient*. (Respondents had the option of indicating "Doesn't Apply to Me" with respect to parking.)

Findings

At least two thirds of the respondents rated each of the three specified dimensions of service *convenient or very convenient*. Between 10% and 13% rated these dimensions *very inconvenient or inconvenient*, with parking being rated inconvenient most frequently.

Cross tabulation analysis of the three items reported in Table B.1 revealed a statistically significant difference with respect to respondents' ratings of the convenience of parking at different agencies. Table B.2 presents the results of analyzing convenience of parking by agency.

Those who are familiar with the physical settings of each of the agencies may not be surprised to find that parking at the Thames Valley Children Centre—which is located in the midst of a very congested hospital complex—was more frequently rated inconvenient compared to the other sites.

Table B.1: Respondent Ratings of Convenience of Service (N=609)

	Very Inconvenient or Inconvenient	Neutral	Convenient or Very Convenient	Doesn't Apply	Missing Data
Time of Appointments	9.9%	6.2%	79.8%	-	4.1%
Parking	12.6%	7.6%	68.1%	8.2%	3.4%
Location	10.2%	5.4%	74.5%	-	9.9%

Table B.2: Convenience of Parking by Agency (N=560)

	Thames Valley Children's Centre	Woodstock General Hospital	University of Western Ontario	St. Thomas-Elgin (Hospital or OEYC)	Strathroy Middlesex General Hospital	Total
Very Inconvenient	11.0%	6.6%	5.4%	5.6%	6.6%	7.1%
Inconvenient	14.2%	5.0%	2.7%	5.6%	1.3%	6.3%
Neutral	15.0%	7.4%	5.4%	6.4%	2.6%	7.9%
Convenient	25.2%	42.1%	36.0%	24.8%	40.8%	33.0%
Very Convenient	13.4%	35.5%	45.0%	53.6%	46.1%	37.9%
Doesn't Apply	21.3%	3.3%	5.4%	4.0%	2.6%	7.9%

Table B.3: Other Possible Convenience Related Problems (N=609)					
	Very Serious Problem	**Serious Problem**	**Small Problem**	**Not a Problem**	**Missing**
Physical Barriers	0.3%	0.2%	1.8%	92.6%	5.1%
Reading English or French	0.7%	0.7%	2.6%	89.3%	6.7%

We also asked respondents to indicate whether they experienced any physical barriers such as stairs or literacy barriers (i.e., "reading or understanding English or French") when accessing services. Respondents could also list any other convenience-related problem they may have had when accessing services. As reported in Table B.3, very few respondents indicated they had problems with physical barriers or reading English or French.

Respondents were given an option of writing in other convenience-related problems they may have experienced. Twenty respondents (3%) gave relevant responses. Other problems mentioned included building problems (5) such as elevators out of order, some problems with scheduling or rescheduling of appointments (7), and transportation problems (4).

Conclusions About Convenience of tykeTALK Services

A substantial majority of respondents indicated that *time of appointments, parking, and location of services* were convenient or very convenient. A notable minority (about 10-13%) however, did find services inconvenient or very inconvenient in terms of these three dimensions. Very few respondents indicated that physical or literacy barriers were problems.

We can conclude that for a substantial majority of respondents, tykeTALK services were provided at convenient times and locations. Only about 10% of respondents reported any convenience-related problems. Parking was identified as more of a problem at one agency in particular.

Section C: Getting Connected to tykeTALK

Purpose of this Section

Section C was designed to determine the degree of satisfaction with the intake process. Respondents were asked how they first found out about tykeTALK, and whether they reached a live person or answering machine at their first inquiry. They were then asked to rate the intake process according to a number of indicators.

Findings

Respondents were asked to indicate how they first found out about tykeTALK by selecting one among a list of nine options. One of the options respondents could select was "other" which, if selected, asked respondents to further specify how they heard. Those responses were further analyzed and categorized. The results of this two-step analysis are presented in Table C.1. Results are presented in descending order from the most to least frequently indicated.

Most respondents (about 37%) first found out about tykeTALK through a physician. Other common ways included a community agency, the health unit, a family member or friend, and advertisements.

Satisfaction with the Warmline

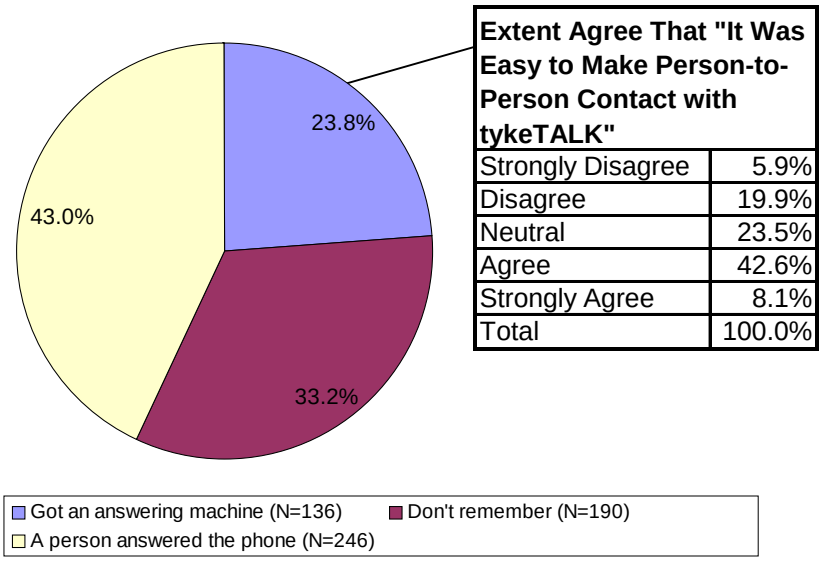
A question that had been raised during planning of the evaluation was the degree of satisfaction clients have with the "warm-line". The program has a centralized intake procedure. All inquiries are directed to one phone line that is staffed during regular business hours by an administrative assistant whose role includes intake and other duties. If the staff member is otherwise engaged, or if a call comes in after regular business hours, a caller will encounter a voice mail system. Calls are followed up at the earliest opportunity. The question is "Does encountering a voice mail system affect satisfaction with the intake process?"

The analysis presented in Figure C.1 provides some insight into this question. We found that just less than one-quarter of the respondents reported encountering a voice mail system the first time they called tykeTALK. Of those that indicated they encountered voice mail, about one-quarter disagreed or strongly disagreed with the statement that "it was easy to make person-to-person contact with tykeTALK." If ease of making person-to-person contact with tykeTALK is taken as an indirect indicator of satisfaction with the warmline, we might infer that about one-eighth of the respondents were less than satisfied due to having encountered an answering machine when they first called tykeTALK.

Table C.1: How Respondent Found Out About tykeTALK

	N	%
Doctor	226	37.1%
Another community agency	83	13.6%
Health Unit	62	10.2%
Family member or friend	55	9.0%
Advertisement	50	8.2%
Let's Grow newsletter	26	4.3%
Daycare	20	3.3%
School	19	3.1%
Already known speech and language professional or other closely related health professional	17	2.8%
Other	8	1.3%
tykeTALK internet web site	7	1.1%
Hospital	4	0.7%
Phone book	2	0.3%
Don't remember	17	2.8%
Missing	13	2.1%
Total	609	100.0%

Figure C.1: What Happened First Time Called tykeTALK?



Extent Agree That "It Was Easy to Make Person-to-Person Contact with tykeTALK"	
Strongly Disagree	5.9%
Disagree	19.9%
Neutral	23.5%
Agree	42.6%
Strongly Agree	8.1%
Total	100.0%

Table C.2: Respondents' Assessment of the Intake Process (N=609)

	Strongly Disagree or Disagree	Neutral	Agree or Strongly Agree	Missing Data
	%	%	%	%
Intake Worker was Polite and Friendly	0.7%	3.6%	92.8%	3.0%
Felt Concerns Were Taken Seriously	1.0%	3.9%	90.8%	4.3%
Understood What Would Happen Next	2.6%	7.6%	84.7%	5.1%
Easy to Find Out	5.4%	15.6%	75.4%	3.6%
Easy to Make Personal Contact	7.6%	18.2%	70.4%	3.8%

Table C.2 presents respondents' ratings of several dimensions of the intake process. A very large majority (at least 85%) of respondents agreed or strongly agreed that the intake worker was polite and friendly, that their concerns were taken seriously, and that they understood what would happen next. Two other items received only slightly less favourable ratings. About 75% of all respondents agreed or strongly agreed that it was easy to find out about tykeTALK, and about 70% agreed or strongly agreed it was easy to make person-to-person contact. Respondents were more likely give neutral rather than negative ratings on these items compared to the three previously mentioned items.

Conclusions About the Intake Process

Most tykeTALK clients first find out about tykeTALK from a physician. Other relatively common ways to find out about tykeTALK include community agencies and health units. Though more than three-quarters of the respondents agreed that it was easy to find out about tykeTALK, more than 15% were neutral and 5% disagreed, indicating there may be some room to increase public awareness about tykeTALK.

About 25% of first calls inquiring about tykeTALK encountered a voice mail system. A notable percentage (about 25%) of those encountering voice mail disagreed that it was easy to make person-to-person contact with tykeTALK. Some consideration by tykeTALK system administrators may be in order, as to whether or not this finding warrants putting more resources into improving this aspect of the intake process.

The great majority of respondents were satisfied with the intake process based on the dimensions of this process we measured.

Section D: Experience with the Assessment Process

Purpose of this Section

In order to measure the outcome *high family satisfaction with the assessment process*, respondents were asked the extent to which they disagreed or agreed with five statements about the assessment process. They were also asked to indicate their overall level of satisfaction with the assessment process, and given an opportunity to suggest how the assessment process could be improved.

Findings

Respondents' ratings of five aspects of the assessment process are presented in Table D.1. These statements were developed in collaboration with the tykeTALK evaluation committee as indicators of an effective assessment process. As shown, more than 85% of respondents gave favourable ratings on all but one aspect of the assessment process. Based on this comparison, it might be argued that there is some room for improvement in giving clients "a say in what happens next" in their treatment. If there are factors that limit the discretion over how much say a client can have in what happens after the assessment process, steps should be taken to help clients understand what those limits are.

Were there differences in ratings of the assessment process depending on which agency the respondent received services from? Each aspect of the assessment process listed in Table D.1 was cross-tabulated by agency. As displayed in Table D.2, a statistically significant difference was found for the item "I understood what to expect over the next few months."

Table D.1: Respondents' Ratings of Aspects of Assessment Process

	N	Strongly Disagree or Disagree	Neutral	Agree or Strongly Agree	Missing
Concerns Were Listened to Carefully	609	1.0%	3.9%	92.8%	2.3%
Was Given Suggestions to Help Child	609	0.7%	2.6%	91.0%	5.7%
SLP Helped Me Understand Child's S&L Needs	609	2.5%	8.0%	87.0%	2.5%
Understood What to Expect	609	2.3%	9.0%	85.2%	3.4%
Had a Say in What Happened Next	609	3.6%	20.0%	73.1%	3.3%

Table D.2: Understood What to Expect After Assessment by Agency (N=537)

Understood What to Expect Over Next Few Months	Agency					
	A	B	C	D	E	Total
Strongly Disagree or Disagree	1.8%	6.8%	0.0%	0.8%	4.2%	2.4%
Neutral	9.6%	4.1%	11.2%	8.9%	12.6%	9.7%
Agree or Strongly Agree	88.6%	89.2%	88.8%	90.2%	83.2%	87.9%
Column Totals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
p=.048						

Anova analysis revealed that the statistically significant difference found in Table D.2 is attributable to differences between agency "D" and "E". Anova is based on an analysis of mean scores. The mean rating on the five-point scale[6] for Agency D was 4.34, and for Agency E was 4.08. Substantively, these differences may not be of great significance. For all five agencies, the mean rating on this item was between "Agree" and "Strongly Agree."

In sum, though clients' ratings on "knowing what to expect" from the tykeTALK program after assessment were generally very good across all five agencies, there is a high probability of a real difference between agency D and E. More Agency D clients agreed they "know what to expect" compared to E.

How did respondents rate their overall level of satisfaction with the assessment process? As shown in Table D.3, more than 75% of the respondents were "Completely" or "Very Satisfied" with the assessment process. There were no statistically significant differences found between agencies.

Table D.3: Overall Satisfaction Rating for Assessment Process

	N	%
Completely Dissatisfied	5	0.8%
Very Dissatisfied	7	1.1%
Somewhat Dissatisfied	15	2.5%
Neutral	23	3.8%
Somewhat Satisfied	73	12.0%
Very Satisfied	257	42.2%
Completely Satisfied	213	35.0%
Missing	16	2.6%
Total	609	100.0%

Conclusions about the Assessment Process

The great majority of respondents were satisfied with respect to the five aspects of the assessment process we measured. There may be some room for improvement with respect to:

- Conveying to clients "what to expect" in the next few months after the assessment process, particularly in one agency.
- Exploring whether steps need to be take to either a) give clients more of "a say in what happens next," or b) clarify with clients the constraints the program operates under so that they understand the legitimate limits on how much say they can expect to have in their child's service.

The great majority of clients were very satisfied with the assessment process overall.

[6] 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5 = Strongly Agree

Section E: Respondents' Evaluations of Five Interventions

Purpose of the Section

Section E of the questionnaire was designed to measure the extent of respondents' experience with each of five specific interventions, as well as their perceptions about the impact of those interventions. The following interventions were evaluated:

- Parent Group
- Individual Therapy
- Group Therapy
- Home Program
- Support for Child Care Providers

The following kinds of information were collected:

- Descriptive information:
  - Proportion of respondents that received each type of intervention.
  - Number of sessions received, for parent group, individual therapy and group therapy.
- Measures of respondents' perception of impact of each intervention.
- Respondents' overall satisfaction with tykeTALK services.

Percentage of Respondents that Received Each Type of Interventions

Table E.1 reports the number of respondents that received each intervention, and the percentage of the entire sample of 609 respondents that is represented by that number.

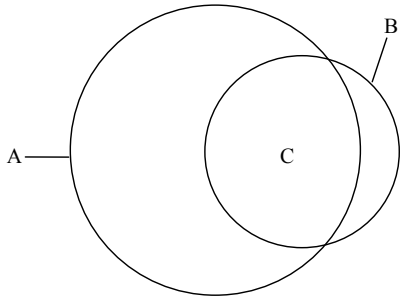
Clients may have received any combination of interventions. In much of the analysis presented in this section of the report, we will be especially interested in how various combinations of group and/or individual therapy affected respondents' evaluations of the respective interventions. These two interventions seem to be the two key interventions offered in the tykeTALK program. We are interested in determining whether there are important differences in respondents' evaluations of these two interventions, depending upon whether they received either one or the other, or both of these interventions.

Figure E.1 uses a "venn diagram" to portray the relationship in our sample among those that received individual and/or group therapy. The percentages reported in Figure E.1 are based on 552 cases. The size of each circle and the degree of overlap is drawn in proportion to accurately portray the relative size of each group to the whole sample. This diagram will be referred to in subsequent analysis.

Table E.1: Percentage of Respondents That Received Each Type of Intervention

	N	% of All Respondents
Participated in Parent Group	157	25.8%
Child Received Individual Therapy	503	82.6%
Child Participated in Group Therapy	225	36.9%
Asked to Do a Home Program	304	49.9%
Did a Home Program	264	43.3%
Child Attended a Childcare Centre	231	37.9%
SLP Gave Suggestions to Childcare Provider	94	15.4%

Figure E.1: Proportion of Sample Receiving Individual and/or Group Therapy



Segment of Diagram	Portion of Sample	N	% of Cases
Circle A	Individual Therapy	499	81.3%
Circle B	Group Therapy	222	40.2%
Segment C	Both Individual and Group Therapy	169	30.6%
Circle A minus Segment C	Individual Therapy Only	330	59.8%
Circle B minus Segment C	Group Therapy Only	53	9.6%
A+B+C	Total	552	100%

Table E2: Number of Sessions Attended

	N	Min	Max	Median	Mean	Std. Dev.
How Many Parent Group Sessions Attended?	156	1	20	3.0	3.9	3.0
How Many Individual Therapy Sessions Attended?	483	1	100	14.0	19.2	16.6
How many Group Sessions Attended?	216	1	84	8.0	10.9	9.2

Number of Sessions Attended (Parent Group, Individual and Group Therapy)

As reported in Table E.2, respondents reported attending up to 20 parent group sessions, with a median[7] value of 3 sessions; up to 100 individual therapy sessions, with a median value of 14 sessions; and up to 84 group therapy sessions, with a median value of 8 sessions.

Comparative Ratings of Each of Five Types of Intervention

Respondents were asked to evaluate each of the five interventions by indicating the extent to which they agreed with statements about the impact of the intervention, as summarized in Table E.3. In general we observe quite favourable ratings for each of the interventions. More than three-quarters of the respondents gave favourable ratings to the interventions with the exception of group therapy.

[7] Because each of the three distributions being reported here is positively skewed, the median value is a better indication of central tendency than the mean.

Table E.3: Ratings of Extent to Which Various Interventions Had a Positive Impact						
	N	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
		%	**%**	**%**	**%**	**%**
Parent Group						
Parent Learned Skills to Help Child Improve?	154	0.6%	5.2%	9.7%	48.7%	35.7%
Parent Learned Skills to Communicate Better with Child?	151	0.7%	3.3%	13.2%	47.7%	35.1%
Individual Therapy						
Extent Agree Individual Therapy Improved Child's S&L	496	3.6%	2.0%	9.7%	36.7%	48.0%
Group Therapy						
Extent Agree Group Therapy Improved Child's S&L	222	5.9%	10.4%	25.2%	42.8%	15.8%
Home Program						
Extent Agree Home Program Clear and Easy to Do	267	0.4%	0.7%	9.7%	56.9%	32.2%
Extent Agree Home Program Improved Child's S&L	262	0.4%	3.4%	21.4%	52.7%	22.1%
Support to Child Care						
Extent Agree Support to Childcare Centre Helped	103	1.9%	6.8%	16.5%	47.6%	27.2%

If we collapse "Agree" and "Strongly Agree" into one category in order to simplify the analysis, we find that 84.7 % respondents receiving individual therapy agreed or strongly agreed that that intervention improved their child's speech an language skills, compared with 58.6% of those receiving group therapy--a difference of 26.1%. In the following sections, we further explore the implications of this finding.

Perception of Impact of Individual versus Group Therapy

Figure E.2 is a graphic representation of the data on evaluation of the impact of group and individual therapy that was presented in Table E.3. It compares the perceptions of the impact—or respondents' *improvement ratings*—of individual therapy with their improvement ratings of group therapy. Included in the analysis were all those who had individual therapy and all those who had group therapy, regardless of whether they had only individual therapy, only group therapy, or both interventions. [8]

[8] The venn diagram in the upper left corner of figures E2 & E4 illustrates which portions of the sample were included in the analysis. The "I" shaped line at the top of each bar represents the 95% confidence interval around the estimate, or the range within which there is a 95% probability the actual population value lies.

Figure E.2: Comparison of Improvement Ratings of Individual vs. Group Therapy

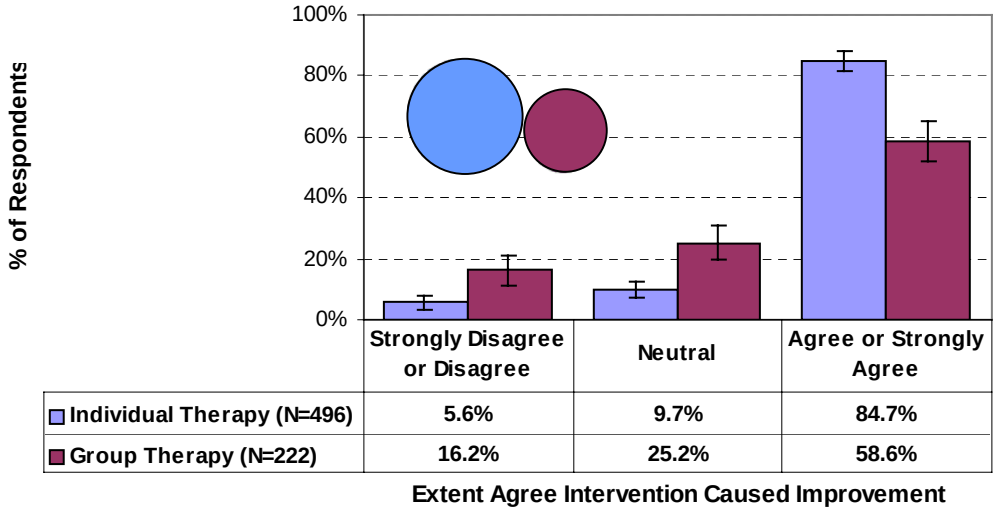
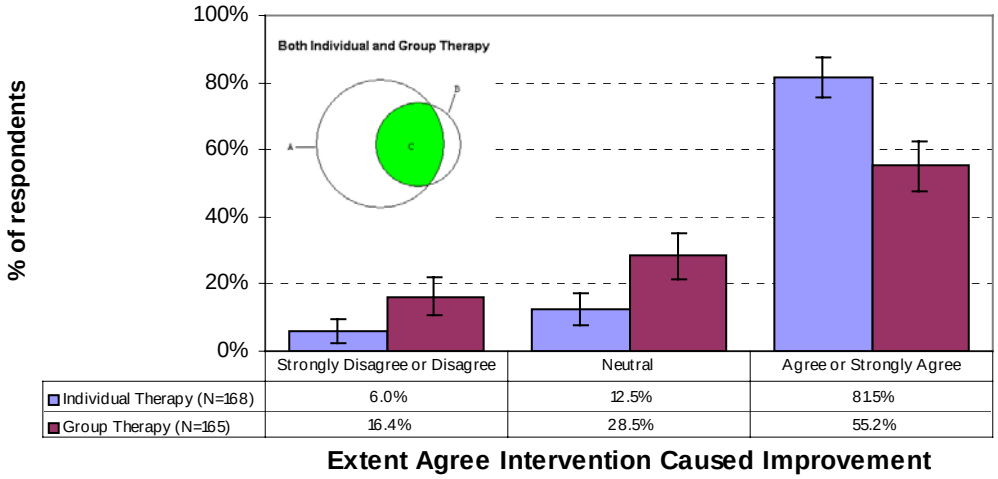


Figure E.3: Improvement Ratings on *BOTH* Individual *AND* Group Therapy

Those Who Had Both Individual and Group Therapy

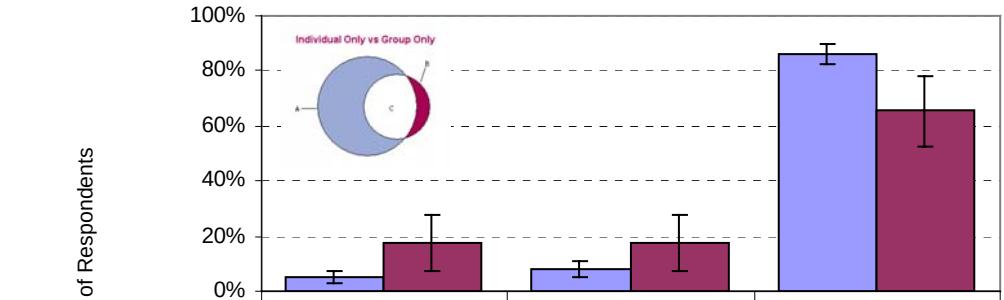


Thus, while the majority of those received the interventions agreed or strongly agreed that both interventions improved their child's speech language skills, a substantially greater percentage (the difference was more than 25%) gave a positive improvement rating to individual as compared with group therapy.

We hypothesized that whether a client had only individual therapy or only group therapy or both interventions may have influenced their perception of the impact on a given intervention. In order to test this hypothesis, we took the analysis several more steps. Figure E.3 compares the improvement ratings of those who had *both* individual and group therapy, on *both* interventions. (Those that had only group or only individual therapy were excluded from this analysis.) The pattern in Figure E.3 is essentially the same as in the previous analysis.

Figure E.4: Improvement Ratings on Individual OR Group Therapy

Those Who Had Individual Therapy Only With Those Who Had Group Therapy Only



	Strongly Disagree or Disagree	Neutral	Agree or Strongly Agree
Individual Only (N=324)	5.2%	8.3%	86.4%
Group Only (N=52)	17.3%	17.3%	65.4%

Extent Agree Intervention Caused Improvement

Figure E.4 depicts the results of an analysis in which the improvement ratings of those who received *only* individual therapy is compared with the improvement ratings of those who received *only* group therapy (those who received both interventions were excluded from the analysis.) Again, a similar pattern as found in Figures E.2 and E.3 is repeated, however the difference in the improvement ratings between group and individual therapy is smaller (21%).

There were no statistically significant differences in improvement ratings between any of the agencies in any of these analyses.

Comparison of Means Analysis

A different analysis strategy was employed to further investigate this relationship. The following analysis is based on a *comparison of means* instead of the percentage of respondents that fell into various categories. Recall that the data being reported here are based on responses to the question "To what extent do you agree or disagree…" with the statement that the intervention--either individual or group therapy-- "improved my child's speech and language abilities"? Respondents were asked to select from a set of five response options ranging from strongly disagree to strongly agree, with a neutral category in the middle.[9] In this analysis, the response options were given a value ranging from strongly disagree=1 to strongly agree=5. A mean value was calculated for each subgroup in the sample.

There are a couple of advantages in this approach. First, treating the data as *interval-ratio* level data (as opposed to *ordinal* level data) allows us to use more sensitive statistical techniques, such as Analysis of Variance (ANOVA), which was used in this analysis.

Second, this analysis allows us to directly compare the improvement ratings of each of the sample subgroups. This is a way of controlling for the possible effect of the various combinations of interventions (i.e., individual only, group only, or both) may have had on the improvement ratings. In other words, we can get a sense for example, of whether having had individual therapy *as well as* group therapy effects improvement ratings of group therapy.

Like the analysis presented in Figure E.2 this analysis includes all cases that had either or both interventions. The difference with this analysis is that improvement ratings of those who had both interventions (segment C in Figure E.1) are separated out from those had only one of the interventions.

Figure E.5 shows the relationship between each of the sample subgroups (those that received individual therapy only, those that received group therapy only, and those that received both) and the units of analysis, that is, improvement ratings on individual therapy and improvement ratings on group therapy.

[9] See questions E4 and E5 on pages 8 and 9 of the questionnaire.

Figure E.5: Relationship Between Sample Subgroups and Unit of Analysis for Comparison of Means Analysis

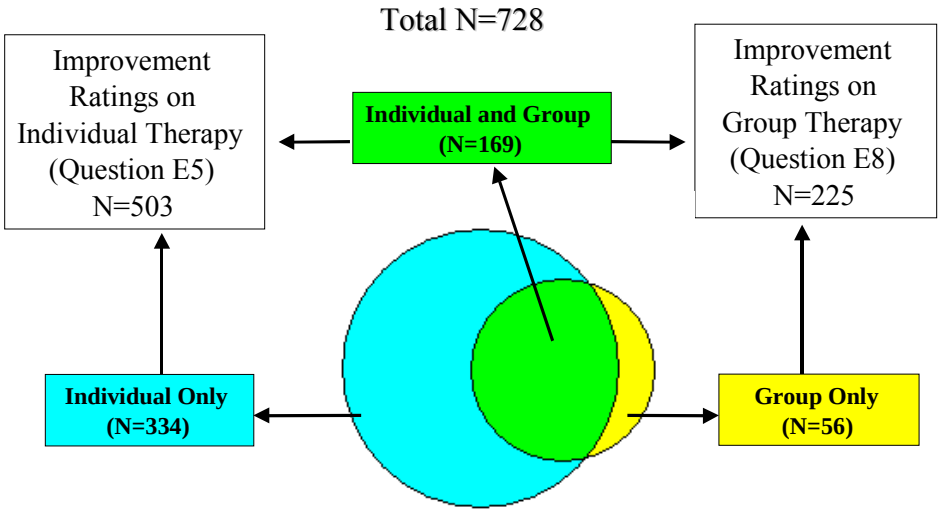


Figure E.6: Comparison of Mean "Improvement Rating" Scores for Group and Individual Therapy Between Sample Subgroups With 95% Confidence Intervals

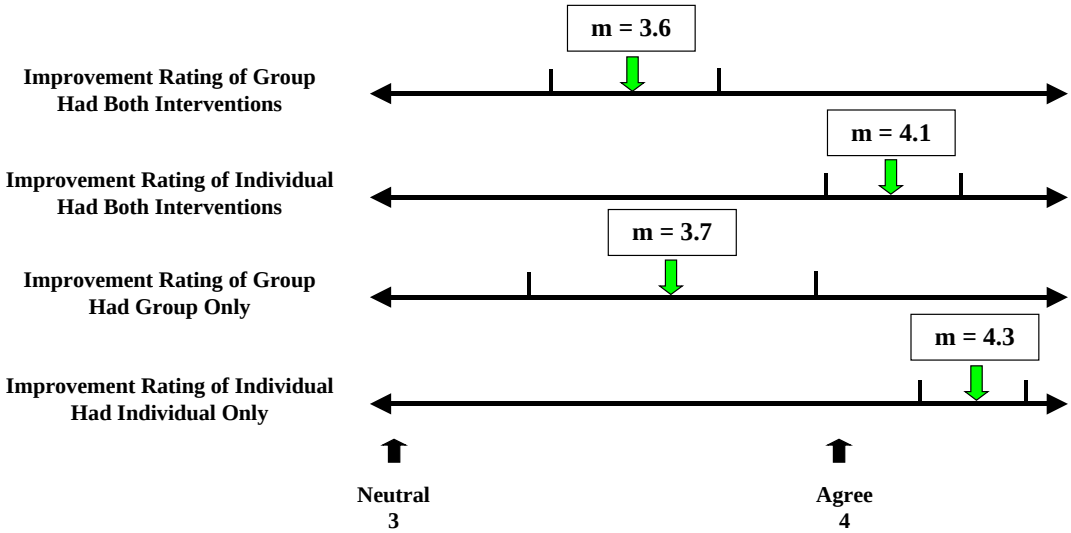


Figure E.6 presents the results of the comparisons of means analysis. Recall again that the response options (1=strongly disagree to 5=strongly agree) were treated as a scale. Each horizontal line represents the portion of the scale that ranges from *neutral* (with a value of 3) to just above *agree* (with a value of 4). This is the portion of the scale within which the vast majority of the responses fell. The arrow pointing down indicates where on the scale the mean value for each subgroup lies. The two vertical lines on either

side of the arrow define the 95% confidence interval around the estimate.

This analysis indicates that regardless of which combination of interventions received, respondents more strongly agreed that individual therapy improved their child's speech and language skills, as compared with group therapy.

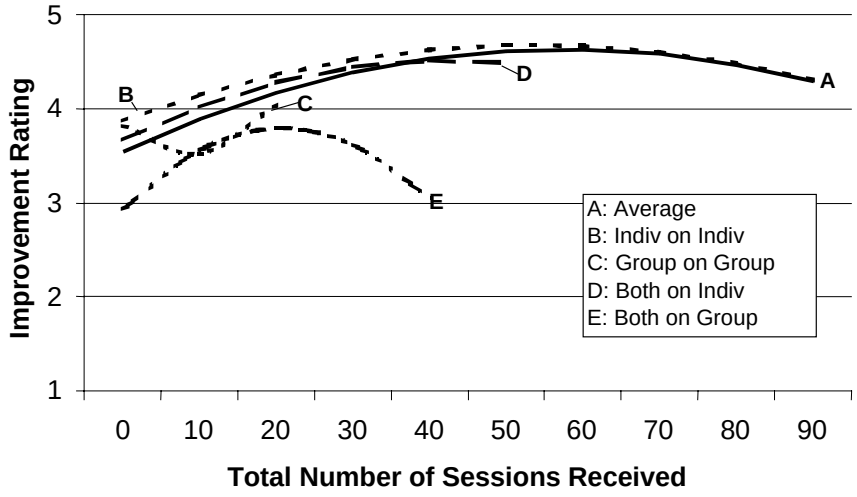
Impact of the Number of Sessions on Improvement Ratings

After reviewing the results reported above during the preliminary analysis stage, members of the evaluation subcommittee raised the following question. Does the finding of higher improvement ratings for individual therapy have something to do with the number of sessions received? In other words, does the finding have more to do with the fact that on average, people who received individual therapy received more sessions? Perhaps their more favourable assessment is due to having received more sessions.

In order to answer this question a regression analysis was performed. The improvement ratings on individual and group therapy were treated as the dependent variable. The independent variable was "number of sessions". Preliminary cross-tabulation analysis indicated that the relationship between these two variables is non-linear. That is, the effect of the number of sessions on improvement ratings diminishes at some point. The type of analysis performed took this into account.[10]

The result of this analysis is presented in Figure E.7. An interpretation of this chart follows.

Figure E.7: Effect of Total Number of Sessions on Improvement Ratings



[10] The independent variable was entered into the model as a quadratic function of the dependent variable ($Y = a + X + X^2$). The primary characteristic of this function is that it allows the line to take the form of a line with a single curve. Many thanks to Mr. Piotr Wilk, Community Health Researcher/Educator, REED Services, who performed this sub-analysis and was of great help in much of the analysis reported in this section of the report.

First consider the average improvement rating for both individual and group therapy for all subgroups combined, as represented by the solid line A. The total number of sessions received has a positive effect on the respondents' evaluation of the impact of the interventions up to a point. Somewhere around 20 to 40 sessions, the rate of improvement in evaluation ratings with additional sessions levels off and begins to diminish. In other words, you don't see as great an improvement in evaluation ratings for each quantum of additional sessions.

Next consider the various subgroups, and their ratings of individual and group therapy respectively.

The ratings of individual therapy by those who had *only* individual therapy (dotted line B) and the ratings of individual therapy by those who had *both* individual and group therapy (dashed line D) are very similar, although those who had individual only gave slightly more favourable evaluations to individual therapy than those who had both interventions.

It gets interesting when we examine ratings of group therapy by both subgroups.

The ratings of group therapy by those who had both group and individual therapy (line E), is similar to the pattern for evaluations of individual therapy, although the leveling off or diminishing return happens after about only 15 to 20 sessions.

By contrast, when we examine the ratings of group therapy by those who had only group therapy (line C), the *evaluation rating* actually *decreases* as the level of the *total number of sessions received increases* up to a point (about 10 sessions), whereupon the evaluation rating begins to increase. It is important to note that this particular finding must be treated with caution, because it is based on relatively few cases. Based on this we may hypothesize for future investigation, that clients who only have access to group therapy may be disgruntled or dissatisfied in the earliest phases of the services. Perhaps those in our sample who had less than 10 sessions terminated because they didn't want or like group therapy. But those who stayed with service until at least 10 sessions or so began to see some benefit, or concluded it was better than no service, and their evaluations reflect that.

Conclusion About Impact of Number of Sessions on Improvement Ratings

This sub-analysis should be seen as exploratory and suggestive. The survey was not designed to answer the question we posed here. We have labeled the outcome indicator (dependent variable) in this and the previous analysis "improvement rating." It is important to keep in mind that this label is shorthand for the extent to which parents (or caretakers) disagreed or agreed that the intervention improved their child's speech and language skills. It is an indicator of parents'/caretakers' *perceptions* of whether intervention "improved child's speech and language skills," rather than an objective, formally validated measure of improvement in speech and language ability.

This data suggests that it is not a simple matter of more individual therapy equals more favourable ratings. More sessions do seem to translate into more favourable improvement ratings for those who received only individual therapy or both individual and group therapy up to some point at which there appears to be diminishing returns. It may be the case that those who only had access to group therapy may be dissatisfied in the earliest phases of the services.

There is nothing in these results that would justify eliminating group therapy as a viable mode of intervention. Particularly considered in terms of optimal allocation of resources, some combination of group and individual therapy seems to be warranted.

Assessment of Overall Impact and Overall Satisfaction with Service

To conclude this section of the report, we return to a more global assessment of the impact of and satisfaction of tykeTALK services by the respondents.

Table E.4 presents a cross-tabulation analysis based on the first question we asked in the questionnaire, by type of intervention received. Keeping in mind that the respondents had not yet been taken through the process of being asked progressively more specific questions about their experience with tykeTALK, it may be taken as their global assessment of the overall impact of the tykeTALK program on their child's speech and language ability. In general, this table shows that the vast majority of respondents thought tykeTALK improved their child's speech and language ability. There appears to be a slightly less favourable assessment among those who received group therapy only, although this difference was not statistically significant (p= .49)

Table E.4: Assessment of Overall Impact by Type of Intervention				
What Difference Did tykeTALK Make in Your Child's Speech and Language Ability?	**Type of Intervention**			
	Individual only (N=324)	**Group only (N=50)**	**Both Group and Individual (N=167)**	**Total (N=541)**
Improved a lot	64.8%	60.0%	64.7%	64.3%
Improved a little	31.5%	32.0%	33.5%	32.2%
No change	3.4%	8.0%	1.8%	3.3%
Got worse	0.3%	0.0%	0.0%	0.2%
Total	100.0%	100.0%	100.0%	100.0%

Table E.5: Overall Satisfaction with Services by Type of Intervention				
Degree of Satisfaction with Services Received	**Type of Intervention Received**			
	Individual only (N=325)	**Group only (N=52)**	**Both Group and Individual (N=169)**	**Total (N=546)**
Completely or Very Dissatisfied	6.5%	7.7%	5.9%	6.4%
Somewhat Dissatisfied to Somewhat Satisfied	19.1%	34.6%	17.8%	20.1%
Very to Completely Satisfied	74.5%	57.7%	76.3%	73.4%
Total	100.0%	100.0%	100.0%	100.0%

In order to assess overall satisfaction with tykeTALK services, respondents were asked "Overall, how dissatisfied or satisfied are you with the services you and your child received?" (See question E17 on page 12 of the questionnaire.) Respondents were given seven response options ranging from *completely dissatisfied* to *completely satisfied*, with a *neutral* category in the middle. This question was also cross-tabulated by type of intervention. Depending on how the categories are combined, there appears to be a slight difference in overall satisfaction ratings depending on type of intervention. The nearly statistically significant result ($p = .082$) [11] is presented in Table E.5.

Results presented in Tables E.4 and E.5 reinforce the conclusion that a substantial majority of respondents were very satisfied overall with tykeTALK services, and thought that the service improved their child's speech and language skills a lot. While this conclusion applies regardless of what type of intervention respondents received, those who received group therapy only were somewhat less satisfied, and perceived somewhat less of an impact on their child's speech and language ability.

The final two sets of results to be discussed in this section are two indirect measures of satisfaction. We asked respondents to what extent tykeTALK met their needs (question E16), and whether they would recommend tykeTALK to a friend if their child needed similar help (question E18).

As shown in Table E.6, the great majority of respondents indicated that almost all or most of their needs were met by the program. Cross-tabulation analysis revealed however that those who received group therapy only were significantly more likely to indicate that only a few of their needs were met.[12] The result was statistically significant ($p < .01$).

[11] By convention, one determines in advance what probability level one will accept as statistically significant. The usual level is predetermined at $p < .05$, which means there is a 95% probability that the result is not due to chance. In some cases, a 90% probability level ($p < .1$) may be considered statistically significant. In practical terms the finding reported here means that there is about an 8% chance that the result reported in the table is due to chance rather than a real difference in the population from which the sample of tykeTALK clients was drawn.

[12] In terms of original response categories, of those who received group therapy only, 23.1% indicated that "only a few of their needs were met," and 3.8% indicated that "none of our needs were met."

Table E.6: Extent to Which Needs Were Met by Type of Intervention				
	Type of Intervention Received			
To What Extent Did tykeTALK Meet Your Needs?	Individual only (N=321)	Group only (N=52)	Both Group and Individual (N=169)	Total (N=542)
Almost All or Most Needs Met	87.9%	69.2%	91.1%	87.1%
Only a Few or No Needs Met	9.7%	26.9%	8.3%	10.9%
No Opinion	2.5%	3.8%	0.6%	2.0%
Total	100%	100%	100%	100%

Table E.7: Whether Would Recommend tykeTALK by Type of Intervention				
	Type of Intervention Received			
Would You Recommend tykeTALK?	Individual only (N=325)	Group only (N=52)	Both Group and Individual (N=169)	Total (N=546)
Definitely or Probably Not	0.6%	3.8%	0.6%	0.9%
Maybe	7.4%	19.2%	4.1%	7.5%
Yes, Definitely	92.0%	76.9%	95.3%	91.6%
Total	100%	100%	100%	100%

Table E.7 shows that the great majority of respondents would definitely recommend tykeTALK services to a friend whose child needed speech and language services. Less than one percent said they would definitely or probably not recommend tykeTALK. Consistent with the general pattern we have found, the response of those who had group therapy only was somewhat less favourable. The result presented in Table E.7 was statistically significant ($p < .01$).

Conclusions about Respondents' Perceptions of Impact of tykeTALK Interventions

At least three-quarters of the respondents receiving any given intervention agreed or strongly agreed that intervention had a positive impact, with one exception. A somewhat smaller percentage (about 60%) gave group therapy a positive "improvement rating."

Most respondents received a combination of various interventions. Further analysis of the two primary interventions, i.e., individual therapy and group therapy, confirmed that respondents more frequently perceived individual therapy as having a positive impact on their child's speech and language abilities, regardless of whether they had only individual therapy, only group therapy, or a combination of both.

The most commonly received intervention was individual therapy. We found that the more positive improvement ratings for individual therapy appears to have some relationship to the greater number of sessions on average for those that received individual therapy. However, we found the relationship was not a simple matter of more sessions equals better improvement ratings. More sessions, whether in the case of group or individual therapy appears to produce more positive improvement ratings up to a point, after which diminishing returns sets in.

There was nothing in our findings, which suggests that group therapy is not an effective intervention, especially in combination with individual therapy. Group therapy alone was clearly perceived as having less positive impact by parents. Efforts may be in order to enrich or enhance the experience of clients who are receiving group therapy only for a period of time, while they wait for individual therapy. While parents may prefer individual therapy for readily apparent reasons related to receiving individual attention, a combination of group and individual therapy received marginally more positive ratings on global measures of satisfaction, than individual therapy alone.

In sum, a substantial majority of parents agreed that each of the five interventions had a positive impact on their child's speech and language skills, were very to completely satisfied with the services they received, felt that almost all or most of their needs were met, and would recommend tykeTALK to others in need of such services.

Section F: Parental Involvement in Child's Care

Purpose

The goal of fostering meaningful involvement of parents/caretakers in their child's therapy is reflected in the values and planning principles adopted by the tykeTALK system. Section F of the questionnaire was designed to assess the quality of parents'/caretakers' involvement in their child's service. Section F is an adaptation of a 20-item questionnaire called the MPOC-20.

Measure of Processes of Care

MPOC stands for *Measures of Processes of Care*. The MPOC-20, which was identified through background research during the survey development process, is a pre-existing, well-validated instrument designed to assess the extent of "family-centredness" of services as experienced by families. The MPOC-20 is a refinement of an earlier, longer version of the tool called the MPOC-56. The MPOC was developed by a small group of scholars affiliated with the CanChild Centre for Childhood Disability Research at McMaster University in Hamilton, Ontario.

The MPOC-20 consists 20 questionnaire items that are grouped conceptually and statistically into five independent scales. The items measure "aspects of care that parents had identified in earlier studies to be behaviours of providers that they felt were important to decrease parental stress and reduce worries" (CanChild Centre for Childhood Disability Research, 2000, p. 18).

The five scales are:

- **Enabling and Partnership**
- Providing General Information
- **Providing Specific Information about the Child**
- Coordinated and Comprehensive Care of the Child and Family
- **Respectful and Supportive Care**

Based on the purpose and needs for the present evaluation as identified by the evaluation steering committee, the first, third and fifth scales mentioned in the preceding list (those highlighted in bold text) were incorporated into Section F of the questionnaire.

Scores on the Individual Items

For each of the 20 items in Section F, respondents were asked to indicate the extent to which their service providers exhibited the behaviour in question, according to a seven-point scale ranging from *To a Very Great Extent* to *Not at All*. In Table F.1, displays the percentage of respondents that fell into each category for each item. The items are grouped according to the three MPOC scales.

A great deal of information is displayed in Table F.1. In order to make all this data more intelligible, and in keeping with the method intended by the creators of the MPOC, this data is further processed by computing scale scores.

Table F.1: Frequency Distribution for 11 Parental Involvement Indicators, Grouped by MPOC Scale

	N	Not at All	To a Very Small Extent	To a Small Extent	To a Moderate Extent	To a Fairly Great Extent	To a Great Extent	To a Very Great Extent
		%	%	%	%	%	%	%
Enabling and Partnership Scale								
Let You Choose When to Receive and Type of Info?	537	4.8%	1.7%	4.3%	10.4%	16.0%	37.1%	25.7%
Fully Explain Treatment Choices?	571	2.6%	2.8%	4.9%	8.9%	15.4%	31.7%	33.6%
Provide Opportunities to Make Decisions About Therapy?	567	3.0%	3.0%	5.1%	10.8%	16.2%	32.1%	29.8%
Providing Specific Information About Child Scale								
Provide Info About What Child is Doing in Therapy?	570	0.4%	1.4%	1.2%	5.8%	13.5%	34.7%	43.0%
Provide You with Written Info About Child's Progress?	565	6.2%	2.7%	3.5%	9.6%	14.2%	29.2%	34.7%
Tell You About Results From Assessments?	576	1.6%	2.1%	2.6%	7.6%	12.5%	33.9%	39.8%
Respectful and Supportive Care Scale								
Help you feel competent as a parent?	560	1.8%	0.9%	4.1%	8.4%	16.1%	38.0%	30.7%
Provide a Caring Atmosphere, Not Just Information?	589	0.8%	0.5%	1.9%	5.8%	14.6%	33.6%	42.8%
Provide Enough Time to Talk So You Don't Feel Rushed?	588	1.0%	1.5%	3.6%	7.8%	18.2%	31.0%	36.9%
Treat You as An Equal, Not Just a Parent?	577	0.9%	1.7%	2.8%	8.8%	14.6%	36.0%	35.2%
Treat You as An Individual, Rather Than a "Typical" Parent?	570	1.2%	1.6%	2.5%	7.4%	14.2%	35.6%	37.5%

To compute a scale score, each item is first assigned a score for each respondent of from 1 (Not at All) to 7 (To a Very Great Extent). Based on individual scores, a mean value is computed for each item. Table F.2 presents the mean score and standard deviation[13] for each individual item. Also presented is a "grand mean and standard deviation" which allows comparison of each individual item with an overall mean and standard deviation for all 20 items.

Those items with the lowest scores which are presented in Table F.2 may be seen as areas where is room for improvement. The three items with the lowest scores and which scale they are associated with are presented in Table F.3.

Table F.2: Mean Scores 11 Parental Involvement Indicators, Grouped by MPOC Scales

	N	Mean	SD
Enabling and Partnership Scale			
Let You Choose When to Receive and Type of Info?	537	5.45	1.55
Fully Explain Treatment Choices?	571	5.61	1.50
Provide Opportunities for You to Make Decisions About Child's Therapy?	567	5.50	1.53
Providing Specific Information About Child Scale			
Provide Info About What Child is Doing in Therapy?	570	6.07	1.10
Provide You with Written Info About Child's Progress?	565	5.49	1.71
Tell You About Results From Assessments?	576	5.88	1.33
Respectful and Supportive Care Scale			
Help you feel competent as a parent?	560	5.73	1.30
Provide a Caring Atmosphere, Not Just Information?	589	6.05	1.13
Provide Enough Time to Talk So You Don't Feel Rushed?	588	5.81	1.29
Treat You as An Equal, Not Just a Parent?	577	5.83	1.25
Treat You as An Individual, Rather Than a "Typical" Parent?	570	5.89	1.26
Grand Mean and Standard Deviation		5.76	1.36

Table F.3: Items with Lowest Scores

Scale	Item	Score
Enabling and Partnership	Let You Choose When to Receive and Type of Info?	5.45
Providing Specific Information About Child	Provide You with Written Info About Child's Progress?	5.49
Enabling and Partnership	Provide Opportunities for You to Make Decisions About Child's Therapy?	5.50

[13] The standard deviation statistic is a measure of dispersion of scores around the mean. It gives a picture of how much spread or variation there is in a distribution of scores. Approximately two thirds of all scores fall within ± 1 standard deviation of the mean.

MPOC Scale Scores

An overall *scale score* is computed for each of the three MPOC scales. Scale scores are computed as the average of the ratings of all the items belonging to the scale. A scale score can range from 1.00 to 7.00. Figure F.1 displays the scale scores for each of the three MPOC scales, as well as a picture of the relative position of those scores on a graphic representation of the response scale.

So far we can make the following observations:

- On average, tykeTALK clients rate key dimensions of "family-centredness" of care in the "Fairly Great Extent" to "Great Extent" range.
- The highest scores were given on the *Respectful and Supportive Care* scale.

Based on the analysis of individual items presented in Table F.2, as well as the scale scores (including standard deviations) reported in Figure F.1, there may be room for improvement on dimensions of care measured by the *Enabling and Partnership* scale.

Differences between Agencies in MPOC Scale Scores

Were there any differences between agencies on their MPOC scale scores? As presented in Table F.4 there was a statistically significant difference between agency A and D on the *Enabling and Partnership* scale.

Differences in MPOC Scale Scores Based on Type of Intervention

The only statistically significant difference found in MPOC scale scores in terms of type of intervention was also found with respect to the *Enabling and Partnership* scale. The statistically significant difference in the findings displayed in Table F.5 is between the scores for individual only and group only.

Figure F.1: Comparison of Findings on 3 MPOC Scales

	N	Mean	Std. Deviation
Enabling and Partnership Scale	518	5.54	1.43
Providing Specific Information About Child Scale	533	5.82	1.14
Respectful and Supportive Care Scale	534	5.91	1.04

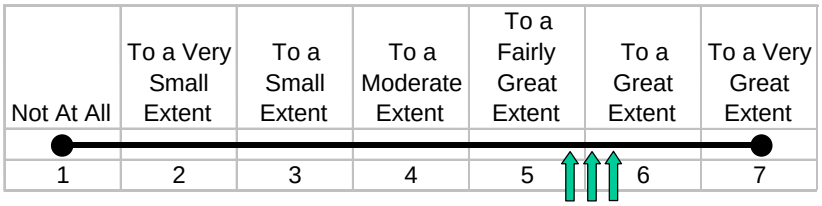


Table F.4: Differences Between Agencies on Enabling and Partnership Scale

	Mean	SD
Agency A	5.27	1.57
Agency B	5.46	1.38
Agency C	5.70	1.26
Agency D	5.83	1.39
Agency E	5.53	1.30
p = .05		

Table F.5: Differences in Enabling and Partnership Scale by Type of Intervention			
Type of Intervention	**N**	**Mean**	**SD**
Individual only	281	5.65	1.39
Group only	44	5.03	1.72
Both Group and Individual	151	5.55	1.30
Total	476	5.56	1.40
p = 0.25			

Table F.6: Comparison of tykeTALK Respondents' Scores on MPOC Scales with an Ontario-Wide Sample						
	tykeTALK Survey			**CanChild Survey**		
	N	**Mean**	**SD**	**N**	**Mean**	**SD**
Enabling and Partnership Scale	518	5.54	1.43	453	5.11	1.55
Providing Specific Information About Child Scale	533	5.82	1.14	458	5.23	1.48
Respectful and Supportive Care Scale	534	5.91	1.04	465	5.40	1.29

Comparison of tykeTALK MPOC Scale Scores with Ontario-Wide Scores

To help put the findings reported above into some perspective, we compared the MPOC-20 scores from the tykeTALK survey to MPOC-20 scores from an Ontario-wide survey of clients from 16 different agencies providing similar services, conducted by CanChild Centre for Childhood Disability Research (CCCDR, 2000). The agencies included ten from the Ontario Association of Children's Rehabilitation Services (OACRS) and six Community Care Access Centres. Services provided by the agencies included speech and language related services.[14] Parents were randomly selected from among current clients of each agency. Data were collected from February through September 1999.

The findings from the tykeTALK and CanChild surveys are reported in Table F.6. The tykeTALK service providers were rated more favourably than the comparison group on each of the three MPOC scales.

Conclusions About Parental Involvement

Based on findings generated through the use of the MPOC-20, we can conclude that tykeTALK program delivers service in a manner consistent with principles of "family-centred service". On average, tykeTALK clients rate three key dimensions of family-centredness of care in the "Fairly Great Extent" to "Great Extent" range. The highest scores were given on the *Respectful and Supportive Care* scale. There appears to be room for improvement on dimensions of care measured by the *Enabling and Partnership* scale.

Comparing the MPOC scores received by the tykeTALK program with a recent Ontario-wide survey of similar agencies reveals that the tykeTALK program scored higher on all three dimensions measured.

[14]The types of services provided by participating agencies included: audiology, augmentative communication, developmental pediatrics/pediatrician, early childhood education, nursing nutrition, occupational therapy, orthotics/prosthetics, physiotherapy, psychology/psychometry, recreational therapy, rehabilitation engineering, service coordination/case management, social work, speech-language pathology, technology access, and transition services.

Conclusion and Recommendations

We set out to determine how parents/caregivers view the tykeTALK system in terms of several indicators of effectiveness of and satisfaction with services. On virtually every indicator, most survey respondents gave the tykeTALK service very favourable ratings. The great majority of respondents felt that services were convenient, were satisfied with the intake and assessment processes, agreed that the interventions received had a positive impact on their child's speech and language abilities, and felt appropriately and meaningfully involved in their child's treatment.

Though the overall ratings of tykeTALK services were very favourable, some indicators received relatively lower ratings. Perhaps most noteworthy among these was the finding that respondents tended to perceive individual therapy more favourably than group therapy, in terms of its impact on their child's speech and language abilities.

In terms of findings that may call for some change or adjustment in the system based on comparisons among ratings on various indicators, the following recommendations are offered for the consideration of tykeTALK decision-makers.

- Consider whether putting additional resources into the warm-line system in order to increase clients' sense of "ease of making personal contact" is warranted.
- Consider whether putting additional resources into increasing public awareness in order to increase ease of finding out about tykeTALK is warranted.
- Consider together with front-line service providers whether there is room for improvement with respect to conveying to clients "what to expect" in the months subsequent to the assessment process.
- Explore with front-line service providers whether steps need to be take to either a) give clients more of "a say in what happens next" after assessment, or b) clarify with clients the constraints the program operates under so that they understand the legitimate limits on how much say they can expect to have in their child's service.
- Efforts may be in order to enrich or enhance the experience of clients who are receiving group therapy, by adding some individualized component to the group therapy service.
- Explore further with front-line service providers and parents/caretakers what steps can be taken to enhance parents'/caretakers' sense of involvement in terms of choosing when to receive and type of information, providing written information about their child's progress, and providing opportunities for parents to make decisions about their child's therapy.

References

CanChild Centre for Childhood Disability Research (2000). Children with disabilities in Ontario: A profile of children's services, Part 2: Perceptions about family-centred service deliver for children with disabilities. Hamilton, Ontario: McMaster University.

Dillman, D. (2000). Mail and Internet surveys: The tailored design method (2nd ed). John Wiley & Sons.

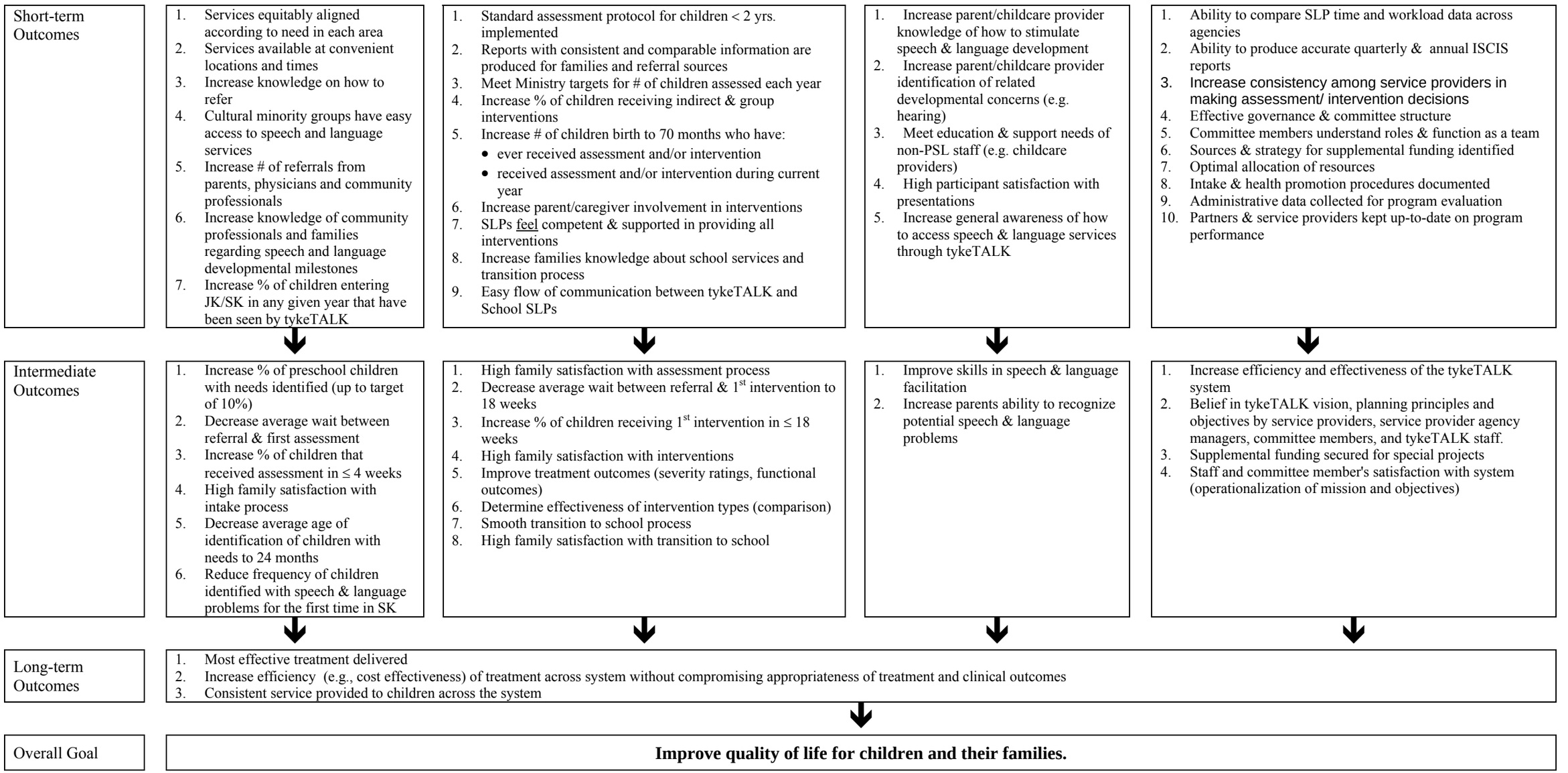
Middlesex-London Health Unit (2003). Evaluation of the Tri-County Let's Grow Program Phase 3 Summary Report. London, Ontario: Author.

Appendix A – Program Logic Model

Updated January 28, 2003

Components	Referral/Intake		Intervention			Community Awareness Support and Education		Program Management		
	Simplified Access	Early Identification	Assessment	Range of Intervention	Transition to School	Parent/ Childcare Provider Education	Social Marketing	Consistency of Service Delivery	Governance	Admin/Office Management
Main Activities	• Provide central intake line • Provide service at various locations and convenient times • Assess and overcome cultural barriers to service and and provide culturally sensitive services	• Disseminate information on when and how to refer • Link with schools, HBHC and community Early Years Initiative	• Develop and use standard assessment protocol for children < 2 yrs. • Standard report format used • Agencies follow guidelines for 1st level assessment	• Provide full range of interventions across system • Provide intervention in French when requested • Provide supports and professional development to service providers for various types of interventions • Provide parents/ caregivers with education and opportunities to be involved in child's treatment	• Provide families with information about school services • Facilitate communication between tykeTALK and school SLPs • Follow protocol for transitioning children to school SLPs	• Offer and conduct education sessions to families and childcare providers • Develop and/or purchase educational resources for families and childcare providers • Provide information to families through info line	• Use mass media and community events to promote general awareness of tykeTALK and developmental milestones • Maintain a tykeTALK website • Ongoing production, revision and distribution of tykeTALK info resources	• Track and analyze SLP time and workload data • Each SLP completes required client data collection forms monthly to be entered into ISCIS database • Develop, revise and update policy and procedure guidelines as necessary • Ensure that service provider agencies are following tykeTALK policy and procedure guidelines	• Review, update and evaluate system plan • Explore supplemental sources of funding for special projects • Ensure optimal allocation of resources among system goals and objectives • Develop and conduct activities for identifying, recruiting, training and supporting members of Steering Committee	• Create manual for health promotion and intake process • Maintain ISCIS database and generate statistical reports • Issue an annual report and a quarterly System Facilitator's update • Distribute meeting minutes in a timely manner

Please see next page


Short-term Outcomes
1. Services equitably aligned according to need in each area
2. Services available at convenient locations and times
3. Increase knowledge on how to refer
4. Cultural minority groups have easy access to speech and language services
5. Increase # of referrals from parents, physicians and community professionals
6. Increase knowledge of community professionals and families regarding speech and language developmental milestones
7. Increase % of children entering JK/SK in any given year that have been seen by tykeTALK
1. Standard assessment protocol for children < 2 yrs. implemented
2. Reports with consistent and comparable information are produced for families and referral sources
3. Meet Ministry targets for # of children assessed each year
4. Increase % of children receiving indirect & group interventions
5. Increase # of children birth to 70 months who have:
• ever received assessment and/or intervention
• received assessment and/or intervention during current year
6. Increase parent/caregiver involvement in interventions
7. SLPs feel competent & supported in providing all interventions
8. Increase families knowledge about school services and transition process
9. Easy flow of communication between tykeTALK and School SLPs
1. Increase parent/childcare provider knowledge of how to stimulate speech & language development
2. Increase parent/childcare provider identification of related developmental concerns (e.g. hearing)
3. Meet education & support needs of non-PSL staff (e.g. childcare providers)
4. High participant satisfaction with presentations
5. Increase general awareness of how to access speech & language services through tykeTALK
1. Ability to compare SLP time and workload data across agencies
2. Ability to produce accurate quarterly & annual ISCIS reports
3. Increase consistency among service providers in making assessment/ intervention decisions
4. Effective governance & committee structure
5. Committee members understand roles & function as a team
6. Sources & strategy for supplemental funding identified
7. Optimal allocation of resources
8. Intake & health promotion procedures documented
9. Administrative data collected for program evaluation
10. Partners & service providers kept up-to-date on program performance
Intermediate Outcomes
1. Increase % of preschool children with needs identified (up to target of 10%)
2. Decrease average wait between referral & first assessment
3. Increase % of children that received assessment in ≤ 4 weeks
4. High family satisfaction with intake process
5. Decrease average age of identification of children with needs to 24 months
6. Reduce frequency of children identified with speech & language problems for the first time in SK
1. High family satisfaction with assessment process
2. Decrease average wait between referral & 1st intervention to 18 weeks
3. Increase % of children receiving 1st intervention in ≤ 18 weeks
4. High family satisfaction with interventions
5. Improve treatment outcomes (severity ratings, functional outcomes)
6. Determine effectiveness of intervention types (comparison)
7. Smooth transition to school process
8. High family satisfaction with transition to school
1. Improve skills in speech & language facilitation
2. Increase parents ability to recognize potential speech & language problems
1. Increase efficiency and effectiveness of the tykeTALK system
2. Belief in tykeTALK vision, planning principles and objectives by service providers, service provider agency managers, committee members, and tykeTALK staff.
3. Supplemental funding secured for special projects
4. Staff and committee member's satisfaction with system (operationalization of mission and objectives)
Long-term Outcomes
1. Most effective treatment delivered
2. Increase efficiency (e.g., cost effectiveness) of treatment across system without compromising appropriateness of treatment and clinical outcomes
3. Consistent service provided to children across the system
Overall Goal
Improve quality of life for children and their families.

Appendix B: Excerpt from Evaluation of the Tri-County Let's Grow Program, Phase 3, Summary Report

Use of the Nipissing District Developmental Screen and Influences on Health Promoting Behaviour

Fully 96% of respondents indicated they were familiar with the Nipissing District Developmental Screen, and 91% indicated they usually complete the checklist that comes with each issue. Almost 94% indicated they thought the tool is a good measure of their child's progress.

About 22% of respondents indicated they contacted a health professional to discuss a concern raised by completing the checklist. Of these, about half expressed concerns about speech, language and hearing. More than 75% indicated they use the activities listed on the screening tool, which are designed to stimulate their child's growth and development. On a scale of 0 (not helpful) to 10 (very helpful), the mean helpfulness rating of the NDDS for the entire sample of respondents was 8.25. (No one rated the screening tool lower than five. Almost 74% of respondents gave the screening tool a helpfulness rating of eight or higher.)

Respondents were invited to make an open-ended comment after indicating whether they thought the NDDS was a good measure of their child's progress. More than half (240) commented. They were also invited to make an open-ended comment after indicating whether they ever contacted a health professional because of a concern raised by completing the NDDS. Seventeen percent (76) respondents made comments. A few key themes emerged in the analysis of these comments. Most respondents seemed to be reassured, as the NDDS is designed to track the normal pace of child development. Many respondents expressed general praise or appreciation for the value and usefulness of the NDDS, in terms of making sure their child is progressing satisfactorily and giving them helpful exercises to encourage development.

Two themes raised concerns among members of the evaluation committee. First, a substantial number of respondents indicated that they only do a quick scan or mental review of the NDDS to make sure their child is on track, rather than going through the checklist systematically. The most prevalent theme among all these open-ended comments was the notion that each child is unique, progresses through developmental stages differently, and therefore the checklist should be taken as a general guideline only. This later theme often seemed to be expressed by those who found that their child was not "on track" with respect to a developmental norm. For example, one respondent said, "I do the screen informally, mentally. It is a guideline. It used to worry me at first because of the wording—you are supposed to go to the doctor if the child misses one—but that seemed too drastic because my daughter wasn't doing things but then would do it one week later. So at first I would get all worked up but now I am more relaxed with it."[15]

In many cases respondents commented that they had contacted their physician and were told not to worry. For example, one respondent said, "I talked to my doctor about my child's rolling because she was behind according to the checklist, but the doctor said she was fine and that all babies develop at different stages and that the checklist is just a guideline."[16]

Regarding Speech and Language Concerns and Awareness of tykeTALK

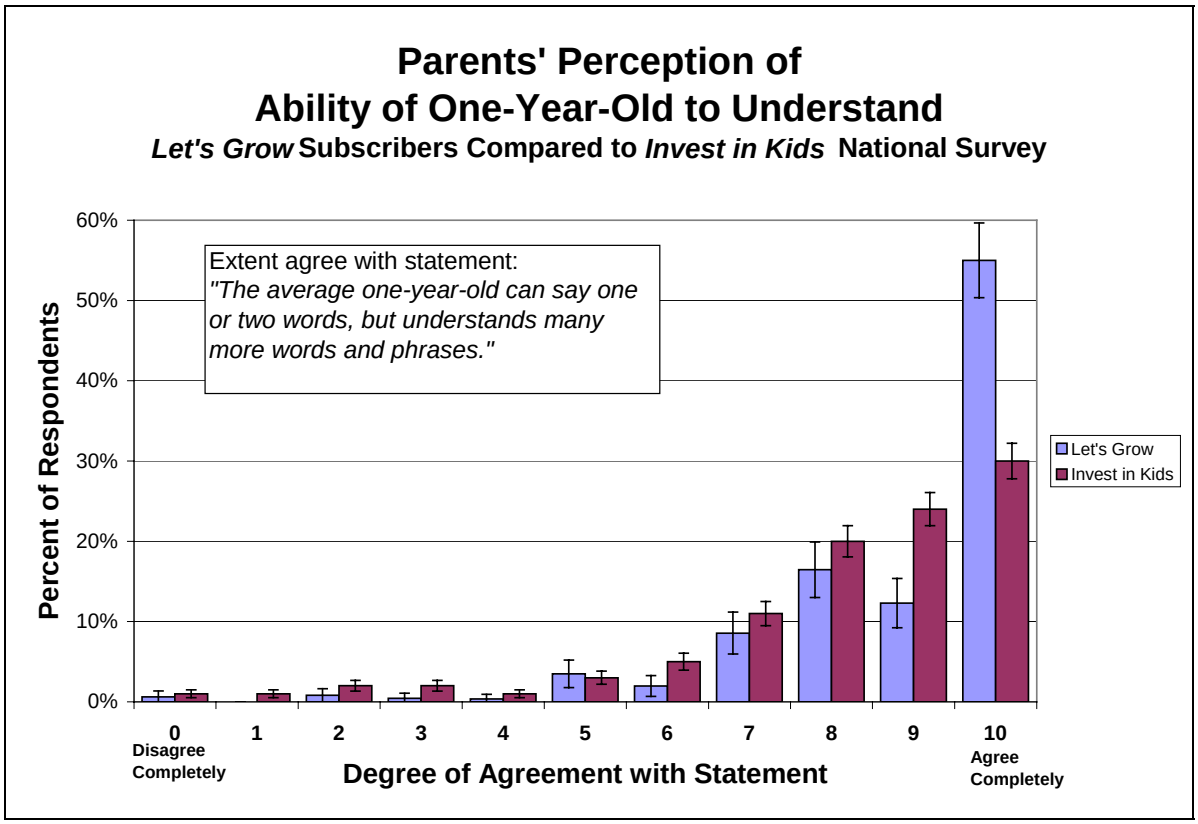
Almost 30% (131 out of 440) of the respondents indicated they had at some point a concern about their child's speech and language development. These 131 respondents were asked to indicate what action they took with respect to their concerns. About 34% said they consulted their doctor; about 28% said they contacted tykeTALK or other speech specialist; about 28% said they decided to wait for the time being to see if the child progressed. Other actions taken included contacting a Public Health Nurse, spending more time working with child on language development, and contacting their own mother or grandmother.

[15] Respondent I.D. X35638. Quotes represent comments as transcribed by telephone interviewer.
[16] Respondent I.D. E87396.

Those 309 respondents (about 70%) who indicated they did not have a concern about their child's speech and language development were asked what they would do if such a concern were to emerge. Of the 309, 70% said they would consult a doctor; 11% said they would contact tykeTALK or a speech specialist; 10% said they would contact a Public Health Nurse; 5% said they would contact their mother, grandmother, or a friend.

Just over half of all respondents (57%) indicated they had heard of tykeTALK. However, when comparing awareness of tykeTALK between those who had a concern about their child's speech and language development with those who did not indicate such a concern, the picture changes. Among those who had no concern about their child's language development, there was about a 50/50 split between those who were aware of tykeTALK and those who were not. Among those who did have a concern, almost 72% were aware of tykeTALK.

A recent national random sample survey[17] of 1,643 parents of young children included a question in order to understand parents' ideas about one-year-olds' language production and comprehension. Respondents were asked to indicate on a scale of 0 (disagree completely) to 10 (agree completely) the extent to which they agree with the following statement: "The average one-year-old can say one or two words, but understands many more words and phrases." According to the report authors, "Child development studies show that sometime after their first birthday, children are able to understand a large number of words and phrases—many more than they can actually say. Parents who understand this fact will be more likely to talk to their toddlers using a wider variety of words and sentences, thereby helping to expand their child's vocabulary and foster language development" (Invest in Kids, 2002, page 46). We posed the exact same question to our sample of Let's Grow subscribers. As displayed in the following graph, readers of Let's Grow were much more likely to agree completely with the statement than respondents to the national survey.[18]



[17] Invest in Kids Foundation. June 2002. *A National Survey of Parents of Young Children*.

[18] The "I" shaped lines at the top of each data bar on the graph indicates 95% confidence intervals. If confidence intervals for any pair of bars do not overlap, the difference is considered statistically significant.

Appendix C - Questionnaire

Family Satisfaction Survey

Please return your completed questionnaire in the enclosed envelope to:

Research, Education, Evaluation and Development Services
Middlesex-London Health Unit
50 King Street, London, Ontario N6A 5L7

Your participation in this survey is voluntary. You may decline to participate at any time. The data is being used for program evaluation purposes. Findings may be presented to public health professionals. Neither your name nor any identifying information will ever be connected to any report or presentation of findings. Call Jim Madden, MLHU Program Evaluator at 663-5317, ext. 2480, if you have any questions.

A) CHANGES IN YOUR CHILD BECAUSE OF tykeTALK?

First, we would like to get a sense of the whether or not tykeTALK services have improved your child's speech and language skills.

1. What difference has tykeTALK made in your child's speech and language ability?

☐ Improved a lot
☐ Improved a little
☐ No change
☐ Got worse

Check ONE box

To what extent do you disagree or agree with the following statements about possible changes in your child's communication ability and behaviour because of tykeTALK?

CHECK ONE BOX FOR EACH ITEM

POSSIBLE CHANGES SINCE STARTING tykeTALK	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
2. Since starting tykeTALK, my child is understood better by others……	☐	☐	☐	☐	☐
3. Since starting tykeTALK, my child communicates what s/he wants and needs better……	☐	☐	☐	☐	☐
4. Since starting tykeTALK, my child talks more with other children ……..	☐	☐	☐	☐	☐
5. Since starting tykeTALK, my child talks more with family members……	☐	☐	☐	☐	☐
6. Since starting tykeTALK, my child gets along better with other children and family members…….	☐	☐	☐	☐	☐

POSSIBLE CHANGES SINCE STARTING tykeTALK

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Since starting tykeTALK, my child seems less frustrated when trying to communicate with others……	☐	☐	☐	☐	☐
8. Since starting tykeTALK, my child has fewer behaviour problems (such as temper tantrums or withdrawing)……	☐	☐	☐	☐	☐
9. Since starting tykeTALK, my child is more self confident……	☐	☐	☐	☐	☐

10. Please write in any <u>other changes</u> you have noticed in your child's communication ability and/or behaviour since s/he started tykeTALK

_____

_____

_____

B) CONVENIENCE OF tykeTALK SERVICES

To what extent were the following convenient when you went for tykeTALK services?

CHECK ONE BOX FOR EACH ITEM

	Very Inconvenient	Inconvenient	Neutral	Convenient	Very Convenient	Doesn't Apply to Me
11. Time of appointments…….	☐	☐	☐	☐	☐	
12. Parking……	☐	☐	☐	☐	☐	☐
13. Location where you usually went for services	☐	☐	☐	☐	☐	

If location was inconvenient, please explain why.

To what extent were the following problems when you went for tykeTALK services?

CHECK ONE BOX FOR EACH ITEM

	Very Serious Problem	Serious Problem	Small Problem	Not a Problem
14. Physical barriers (such as stairs)……	☐	☐	☐	☐
15. Reading or understanding English or French….	☐	☐	☐	☐
16. Other problem related to convenience:				
_____ (please write in problem and then check box):	☐	☐	☐	☐

C) GETTING CONNECTED TO tykeTALK

1. How did you <u>first</u> find out about tykeTALK?

Check one box only

- ☐ Doctor
- ☐ *Let's Grow* newsletter
- ☐ Family member or friend
- ☐ Health Unit
- ☐ Advertisement
- ☐ Another community or social service agency (Write in name of agency)

_____

- ☐ Other (Write in how you found out)

_____

- ☐ Don't remember

THE FIRST TIME YOU TALKED WITH tykeTALK INTAKE WORKER

2. Which of the following best describes what happened the first time you called tykeTALK?

☐ A person answered the phone
☐ I got an answering machine
☐ Don't remember

Check one box only

To what extent do you disagree or agree with the following statements?

CHECK ONE BOX FOR EACH ITEM

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
3. It was easy to find out about tykeTALK…….	☐	☐	☐	☐	☐
4. It was easy to make person-to-person phone contact with the tykeTALK intake worker……	☐	☐	☐	☐	☐
5. The intake worker was polite and friendly…	☐	☐	☐	☐	☐
6. I felt my questions or concerns were taken seriously..	☐	☐	☐	☐	☐
7. At the end of the intake phone call I understood clearly what would happen next…	☐	☐	☐	☐	☐

8. How could we improve the intake process?

_____

_____

_____

_____

D) EXPERIENCE WITH ASSESSMENT PROCESS

"The assessment process" is what happened the first time your child was seen in person by a tykeTALK **Speech and Language Pathologist (SLP).**

To what extent do you disagree or agree with the following statements?

CHECK ONE BOX FOR EACH ITEM

WHEN MY CHILD WAS ASSESSED…	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My concerns about my child's speech and language development were listened to carefully……	☐	☐	☐	☐	☐
2. The SLP helped me get a better understanding of my child's speech and language needs……	☐	☐	☐	☐	☐
3. I had a say about what would happen next……..	☐	☐	☐	☐	☐
4. I understood what to expect over the next few months	☐	☐	☐	☐	☐
5. I was given suggestions of things I could do to help my child……	☐	☐	☐	☐	☐

6. Which of the following comes closest to describing your overall dissatisfaction or satisfaction with the assessment process?

- ☐ Completely Dissatisfied
- ☐ Very Dissatisfied
- ☐ Somewhat Dissatisfied
- ☐ Neutral
- ☐ Somewhat Satisfied
- ☐ Very Satisfied
- ☐ Completely Satisfied

Check one box only

7. How could we improve the assessment process?

_____

E) tykeTALK SERVICES

Next we want to find out your satisfaction with the tykeTALK services you and your child received.

There are five types of services we want to ask you about: parent group, individual therapy, group therapy, home program, and support for children in childcare.

About the PARENT GROUP:

"Parent Group" means one or more group sessions for family members only, where the SLP provides information about speech and language and what you can do to help your child at home. The child is NOT present during these sessions.

1. Did you participate in a parent group?

- ☐ No → please skip to # 4 on page 8
- ☐ Not sure → please skip to # 4 on page 8
- ☐ Yes

How many sessions did you attend? _____ (best estimate is OK)

To what extent do you disagree or agree with the following statements?

CHECK ONE BOX FOR EACH ITEM

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
2. "I learned ideas and skills to help my child improve his or her speech and language abilities."	☐	☐	☐	☐	☐
3. "I learned skills to help me communicate better with my child."	☐	☐	☐	☐	☐

About INDIVIDUAL THERAPY:

"Individual Therapy" means a series of therapy sessions where the SLP or Assistant works individually with you and/or your child on speech and/or language goals. These sessions may take place at a variety of sites, such as a clinic or agency, a childcare centre, your home, and so on.

4. Did your child receive <u>individual therapy</u>?

☐ No
☐ Not sure → please skip to # 7 on page 9
☐ Yes

How many sessions did your child attend? _____ (best estimate is OK)

5. To what extent do you disagree or agree with the following statement?

"Individual therapy improved my child's speech and language abilities."

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree

6. Were you given suggestions of things to do at home as part of your child's individual therapy?

☐ No
☐ Not Sure → please skip to # 7 on page 9
☐ Yes

Did you usually do what was suggested?

☐ Yes
☐ No

please go to # 7 on page 9

How helpful were the suggestions?

☐ Not At All Helpful
☐ A Little Helpful
☐ Moderately Helpful
☐ Very Helpful

CHECK ONE BOX

About GROUP THERAPY:

"Group Therapy" means a series of therapy sessions where the SLP or Assistant works with two or more children on speech and/or language goals. Family members may be present during these sessions. These sessions may take place at a variety of sites, such as a clinic or agency, a childcare centre, your home, and so on.

7. Did your child participate in group therapy?

☐ No
☐ Not sure → please skip to # 10 on page 10
☐ Yes

How many sessions did your child attend? _____ (best estimate is OK)

8. To what extent do you disagree or agree with the following statement?

"Group therapy improved my child's speech and language abilities."

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree

9. Were you given suggestions of things to do at home as part of your child's group therapy?

☐ No
☐ Not Sure → please skip to # 10 on page 10
☐ Yes

Did you usually do what was suggested?

☐ Yes → How helpful were the suggestions?
☐ No

- ☐ Not At All Helpful
- ☐ A Little Helpful
- ☐ Moderately Helpful
- ☐ Very Helpful

CHECK ONE BOX

please go to # 10 on page 10

About the HOME PROGRAM:

"Home Program" refers to speech and/or language goals and activities given to you to practice at home with your child over a period of several months. During this time, your child is not being seen on a regular basis by the SLP.

10. Were you asked to do a <u>home program</u> with your child?

☐ No
☐ Not sure → please skip to # 13 on page 11
☐ Yes

Did you do the home program?

☐ No → If no, explain why not, then go to # 13 on page 11

_____

_____

_____.

☐ Yes

To what extent do you agree or disagree with the following statements?

CHECK ONE BOX FOR EACH ITEM

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
11. The steps in the home program were clear and easy to do……..	☐	☐	☐	☐	☐
12. The home program improved my child's speech and language abilities …….	☐	☐	☐	☐	☐

About SUPPORT FOR YOUR CHILD'S COMMUNICATION AT A CHILD CARE CENTRE:

This refers to speech and/or language goals and activities given to staff at your child's childcare centre to practice with your child over a period of several months.

13. Did your child's Speech and Language Pathologist give suggestions to your child's childcare provider?

☐ Child not in Childcare
☐ No → please skip to # 15 on page 12
☐ Not sure → please skip to # 15 on page 12
☐ Yes

14. To what extent do you disagree or agree with the following statement?

"Support provided by tykeTALK to my child's childcare provider helped improve my child's ability to communicate at the childcare centre."

☐ Strongly Disagree
☐ Disagree

- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

About your OVERALL SATISFACTION WITH tykeTALK SERVICES

15. To what extent has tykeTALK met your and your child's needs?

- ☐ Almost all needs were met
- ☐ Most needs were met
- ☐ Only a few needs were met
- ☐ None of our needs were met
- ☐ No opinion

16. Overall, how satisfied or dissatisfied are you with the services you and your child received?

- ☐ Completely Satisfied
- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Neutral
- ☐ Somewhat Dissatisfied
- ☐ Very Dissatisfied
- ☐ Completely Dissatisfied

17. If the child of a friend needed similar help, would you recommend tykeTALK?

- ☐ No, definitely not
- ☐ Probably not
- ☐ Maybe
- ☐ Yes, definitely

F) INVOLVEMENT IN YOUR CHILD'S TREATMENT

The next few questions ask about your involvement in your child's treatment.

CHECK ONE BOX FOR EACH ITEM

TO WHAT EXTENT DO tykeTALK STAFF:

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not At All	Doesn't Apply to Me
17. Help you to feel competent as a parent?	☐	☐	☐	☐	☐	☐	☐	☐
18. Provide you with information about what your child is doing in therapy? ……	☐	☐	☐	☐	☐	☐	☐	☐
19. Provide a caring atmosphere rather than just give you information? …….	☐	☐	☐	☐	☐	☐	☐	☐
20. Let you choose when to receive information and the type of information you want? ……..	☐	☐	☐	☐	☐	☐	☐	☐
21. Fully explain treatment choices to you?	☐	☐	☐	☐	☐	☐	☐	☐
22. Provide opportunities for you to make decisions about your child's speech and language therapy? ……...	☐	☐	☐	☐	☐	☐	☐	☐
23. Provide enough time to talk so you don't feel rushed? ……	☐	☐	☐	☐	☐	☐	☐	☐
24. Treat you as an <u>equal</u> rather than just as a parent (for example, by not referring to you as "Mom" or "Dad")? ……..…….	☐	☐	☐	☐	☐	☐	☐	☐
25. Treat you as an individual rather than as a "typical" parent of a child with a speech and language difficulty? ……	☐	☐	☐	☐	☐	☐	☐	☐
26. Provide you with written about your child's progress? ……..……	☐	☐	☐	☐	☐	☐	☐	☐
27. Tell you about the results from assessments?……	☐	☐	☐	☐	☐	☐	☐	☐

G) BACKGROUND INFORMATION

Finally we have some questions to ask about your background. The reason we ask these is to help us make more sense of all the other questions.

Please remember, your name will not be connected with these or any other questions.

1. Is your child currently receiving tykeTALK services?

☐ Yes → If yes, when was your child first assessed? (first time seen by tykeTALK SLP)

_____ _____ → (go to # 2)
MONTH **YEAR**
(Best estimate is OK)

☐ No

If no, why not?

- ☐ Discharged because child reached goals
- ☐ Transferred to services at school
- ☐ Moved
- ☐ Stopped because not satisfied with service
- ☐ Other (please specify) _____

How long did your child receive tykeTALK services (starting from time first seen by tykeTALK SLP)?

_____ or _____ (Best estimate is OK)
(months) (years)

2. Through which agency did your child receive tykeTALK services? (If more than one, indicate which agency provided the most service.)

Check ONE box

- ☐ Thames Valley Children's Centre
- ☐ Woodstock General Hospital
- ☐ University of Western Ontario
- ☐ St. Thomas Elgin General Hospital or Ontario Early Years Centre on West Ave. in St. Thomas
- ☐ Strathroy Middlesex General Hospital
- ☐ Other (please specify) _____

3. What is the birth date of the child receiving tykeTALK service?

_____ _____ _____
day month year

4. What is the sex of the child receiving tykeTALK service?

☐ Female
☐ Male

5. What is your sex?

☐ Female
☐ Male

6. What is your relationship to the child receiving tykeTALK services?

☐ Parent
☐ Legal guardian
☐ Other (please specify) _____

7. What is your age?

_____ years

8. What is your marital status?

☐ Single
☐ Married
☐ Common law
☐ Divorced or legally separated
☐ Widowed

Check ONE box only

9. How many children do you have living at home under the age of 19 years old?

_____ children living at home

10. What is the highest level of school you have completed?

- ☐ Some elementary school
- ☐ Completed elementary school
- ☐ Some high school
- ☐ Completed high school
- ☐ Some trade school, college, or university
- ☐ Completed trade school, college, or university
- ☐ Some post-graduate university education
- ☐ Completed post-graduate university degree (masters or doctorate)

Check ONE box only

11. Are you <u>currently</u> employed in a job for which you receive a salary or fee-for-service?

☐ No → Which ONE below best fits your current situation?

- ☐ A full-time homemaker
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ Other (please specify) _____

Check ONE box and go to #13

☐ Yes

Are you employed full-time or part-time?

- ☐ Full-time
- ☐ Part-time

12. How would you classify your primary paid job?

- ☐ Semi-skilled worker or apprentice trades person
- ☐ Sales worker or clerical
- ☐ Skilled worker, trades person or foreman
- ☐ Manager or proprietor
- ☐ Professional or technical worker

Check ONE box only

13. To which ethnic or cultural group(s) do you belong?

_____

14. What is the language you first learned to speak and still understand?

- ☐ English
- ☐ French
- ☐ Other (please specify) _____

15. What language do you speak most often at home?

- ☐ English
- ☐ French
- ☐ Other (please specify) _____

16. How would you rate <u>your ability to read and write</u> the language your child received services in (either English or French)?

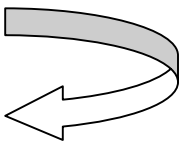
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

17. What is your <u>best estimate of the total income</u> of all members of our household from all sources <u>before taxes</u> and deductions for the past year (2003)?

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $29,999
- ☐ $30,000 to $39,999
- ☐ $40,000 to $49,999
- ☐ $50,000 to $59,999
- ☐ $60,000 to $69,999
- ☐ $70,000 to $79,000
- ☐ $80,000 or more

Check ONE box only

Please turn over



Thank you very much for taking the time to complete this questionnaire. Your responses will help us improve our services.

If there is anything you would like to tell us about this survey or tykeTALK services and programs, please do so in the space provided below.

This space is for any comments you may have about this survey or tykeTALK.