Evaluation of Brief Outpatient Services in a Children's Mental Health Community Clinic

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Abstract

In the past two decades, increased emphasis has been placed on the use of brief treatment services in clinical practice with youth. However, despite the common use of such services, there is a lack of research evaluating the effectiveness of this treatment approach, especially pertaining to brief services that are four sessions or less. The current study addressed this gap in the literature by evaluating the effectiveness of a Brief Service program consisting of four treatment sessions or less. It also investigated how therapeutic alliance, client satisfaction, youth and parent psychopathology, and caregiver strain were related to treatment effectiveness. A pre/post-treatment design was used in order to determine if successful treatment outcomes could be attributed to the Brief Services. Specifically, families with children under 18 years of age who would normally be assigned to Brief Services within a local children's mental health centre were invited to participate. Participants (N = 33) received brief outpatient treatment at the Children's Centre Thunder Bay (CCTB), which involved one to four sessions over a maximum of six weeks. The CCTB Brief Service program was found to be effective in reducing child and parent mental health issues and caregiver strain. Clients were satisfied overall with their experiences at CCTB as well. Client ratings of therapeutic alliance were associated with treatment satisfaction for sessions one and two, and changes in youth mental health for session two. Parent and youth depression, anxiety, and stress were not associated with treatment outcomes in youth or caregiver strain.

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The distribution of limited mental health resources in community-based settings plays an important role in the type and quality of services made available for children and adolescents. While many evidence-based treatments require lengthy involvements of youth and their families in services (i.e., 10 to 20 sessions), the actual attendance for treatment often involves significantly fewer sessions (Mueller & Pekarik, 2000). For instance, Weisz and Weiss (1989) reported that the majority of children and their families attended fewer than 10 sessions before terminating or dropping out. Given the reality of limited treatment attendance and often long waitlist for services, the use of shorter outpatient treatments has become an increasingly popular method of intervention (Girling-Butcher & Ronan, 2009; Mireau & Inch, 2009). However, in comparison to longer treatment services, the effectiveness of these services has received little attention or empirical study.

Defining Brief Services

One of the primary defining characteristics of brief services, also known as time-limited or short-term treatment, is that goals are quickly and mutually defined by both the client and clinician (Dziegeilewski, 2008; see also Searle, Lyon, Young, Wiseman, & Foster-Davis, 2011). Above all, the main goal of brief therapy is to promote positive changes in the client's current functioning and life (Dziegeilewski, 2008). Another characteristic of brief therapy is that homework is given to complement what is taught during the sessions (Dziegeilewski, 2008). The pacing of the therapy is also important due to the limited number of sessions available. Furthermore, paper-and-pencil, self report measures are frequently distributed to the client before the start of treatment to provide a summary of the presenting issues and direct goal development (Dziegeilewski, 2008). Termination is discussed earlier in treatment in comparison to long-term

interventions as well (Dziegeilewski, 2008). For instance, Bloom (2001) posits that brief therapy should be seen as a self-contained unit, with each session providing a plan for intervention so that additional sessions may not be necessary. In this case, termination is taken into consideration at the end of every session. In general, brief service is best suited for clients who are motivated to participate in therapy (Searle et al., 2011; Welfel, 2004). In addition, brief service is typically inappropriate for individuals with severe, chronic problems or co-morbid disorders (Welfel, 2004). Finally, an additional session can be planned one to four months after the last session as a maintenance strategy if needed (Dziegeilewski, 2008).

The current literature on brief therapy in a mental health setting was influenced by early research on the dose-response relationship in the 1980s. For instance, Howard, Kopta, Krause, and Orlinsky (1986) challenged the previous idea of a positive relationship between the amount treatment received and the therapeutic benefit. In their meta-analysis, 15 studies were included from 1951 to 1983. Over 2,400 participants were included and the number of treatment sessions ranged from four to 33 sessions. Over two thirds of the therapeutic benefit was evident in the first 25 sessions. In addition, 29-38% of clients displayed symptom improvement within the first three sessions no matter the total length of treatment. These findings introduced the idea that an important portion of treatment change occurred in the initial sessions of therapy and that clinicians should pay particular attention to what happens early on. Although the studies chosen greatly varied in therapeutic orientation, mental health setting, and outcome measures used, this meta-analysis nevertheless stimulated research aimed at defining brief service as a unique form of treatment. Furthermore, research has recently described a slight variation of brief therapy known as intermittent therapy (Dziegeilewski, 2008). Specifically, both traditional brief therapy and intermittent therapy focus on fast and effective service (Dziegeilewski, 2008). However,

intermittent therapy does not include planning sessions ahead of time and thus sessions occur on an as-needed basis (Dziegeilewski, 2008). Thus, research continues to be conducted on this topic.

In analyzing the literature on brief service interventions, there is much variability in the type of theoretical approaches used within a brief services model. For instance, the majority of literature describes brief services in terms of individual or group brief cognitive-behavioural therapy (CBT; e.g., Clark et al., 2001; Girling-Butcher & Ronan, 2009; March et al., 1998). With brief CBT, the relationship between thoughts and feelings and their influence on behaviours is stressed (Dziegeilewski, 2008). There is also literature describing brief psychodynamic therapy (e.g., Leichsenring et al., 2009; Searle et al., 2011). This type of brief therapy focuses on a client's history and unconscious processes in developing current problem-solving techniques (Dziegeilewski, 2008). Solution-focused brief therapy (SFBT) is also a popular approach in treating mental health issues (e.g., Corcoran, 2006; Lee, 1997). In this type of therapy the client's strengths are identified and used to develop a specific course of action, with minimal emphasis placed on deficits or pathology (Dziegeilewski, 2008).

There is also much discrepancy in the literature in defining the length of brief services, even when comparing similar types of treatment and target populations. For instance, a study conducted by Girling-Butcher and Ronan (2009) described their short term cognitive behavioral therapy (CBT) for youth with anxiety disorders as having eight sessions, whereas March, Amaya-Jackson, Murray, & Schulte (1998) used 18 sessions for the same client group. According to the review article by Dziegeilewski (2008), brief services typically involves six to 10 sessions. However, some studies even consider 15 to 20 treatment sessions to be brief therapy. For instance, one randomized controlled study was interested in the effectiveness of a

brief psychodynamic therapy in adults between the ages of 18 and 60 years with Dysthymic Disorder (Maina, Forner, & Bogetto, 2005). The therapy consisted of a minimum of 15 to 20 sessions, with a maximum of 30 possible sessions, and participants were assigned to either brief psychodynamic therapy, brief supportive therapy, or a control group. Both brief interventions were effective in reducing symptoms on measures of depression, anxiety, and overall functioning, with the psychodynamic therapy being more effective. Likewise, a randomized controlled study of adults with Generalized Anxiety Disorder involved participation in 30 sessions of either brief CBT or short-term psychodynamic psychotherapy (Leichsenring et al., 2009). Both CBT and psychodynamic therapy produced an equivalent reduction in symptoms on the Hamilton Anxiety Rating Scale (Hamilton, 1960), although other outcome measures of anxiety and depression determined that CBT was superior. Overall, these studies were limited by relatively small sample sizes of 30 and 57 respectively. More importantly, the majority of studies in the literature involving therapy greater than 15 sessions include adults as well as a psychodynamic orientation. Thus, these services may have been considered brief due to the fact that regular, long term psychodynamic psychotherapy can take more than six months to complete (Holmes, 1994). However, it may not be considered brief service in comparison with CBT, which is more commonly seen in children's mental health clinics.

In the past two decades, there has been an increased emphasis placed on the use of brief treatment for youth (Girling-Butcher & Ronan, 2009). Several reasons for this include brief services often being cost effective and reducing therapist time, which allows more clients to be taken into therapy (Girling-Butcher & Ronan, 2009). Furthermore, managed care often places a limit on the number of sessions a client is entitled to, which prevents certain manualized types of interventions from being conducted (Girling-Butcher & Ronan, 2009). Shefler (2000) also

supports the use of brief treatment, especially with adolescents, in his clinical opinion paper. This is due to the high attrition rates in adolescent referrals and the fact that certain adolescents may resist long-term attachments with therapists (Shefler, 2000). However, there is an absence of studies evaluating whether such recommended brief service approaches in a community-based setting are effective. In particular, determining the effectiveness of an intervention is not only consistent with the idea of evidence-based practice but will also lead to data that can then, in turn, improve treatment. Due to the lack of literature on child populations, an overview of both child and adult research on the effectiveness of brief services will be described. In addition, for the purpose of this review, the current literature will also be divided according to length of service, namely, between five and 15 sessions, and four sessions or less.

Brief Services Consisting of Five to 15 Sessions

The literature has mainly supported the effectiveness of brief service consisting of five to 15 treatment sessions (a listing of these studies is presented in Appendix A). Specifically, the majority of this research evaluates brief CBT. For instance, a study conducted by Birmaher and colleagues in 2000 studied youth ages 13 to 18 years with Major Depressive Disorder (MDD). The youth were randomly assigned to 12 to 16 sessions of either brief CBT, brief systemic-behavioural family therapy, or brief supportive therapy involving reassurance and an emphasis on strengths. Upon conclusion of treatment, it was found that 80% of the youth in all treatment conditions no longer met criteria for MDD according to several measures of affect, hopelessness, negative cognitions, family relationships, and overall functioning. In addition, no long term differences were seen on the three types of brief therapies after approximately eight months, suggesting that each treatment was comparable in effectiveness.

Another study involving brief CBT was conducted by Stice, Rohde, Seeley, and Gau (2008). A randomized controlled design was implemented and 341 adolescents aged 14 to 19 years with elevated depressive symptoms participated. In particular, inclusion criteria included the adolescent needing a score of 20 or greater on the Center for Epidemiologic Studies-Depression scale (Radloff, 1977) but not having a diagnosis of MDD. The adolescents were assigned to six sessions of either brief group CBT, group supportive therapy, bibliotherapy that included being given a cognitive-behavioural based self-help book, or a control group. Upon completion of the study, the CBT group had the greatest reduction in depressive symptoms and substance use and greatest improvement in social adjustment in comparison to the other groups. However, this difference failed to reach significance at a six month follow up, which again questions the long term effectiveness of brief services. Moreover, it was concluded that all therapies significantly reduced the risk for future MDD onset at a six month follow up versus the control group. This was due to the fact that the authors reported current depressive symptoms being the strongest predictor of future onset of MDD in the literature. One limitation of this study is that only youth self-reports were used as opposed to other sources of information, such as parent or teacher reports. Although both studies (Birmaher et al., 2000; Stice et al., 2008) suggested that brief CBT is effective with youth, the study by Birmaher et al. (2000) did not have a control group and therefore causality cannot be inferred. Likewise, Girling-Butcher & Ronan (2009) conducted a modified case study with children aged eight to 11 years of age with anxiety disorders and found support for brief therapy using a CBT approach. That is, eight sessions of brief CBT led to an increase in overall functioning by comparing pre and post assessment scores on child anxiety, depression, and coping measures. In addition, all participants no longer qualified for diagnosis of anxiety disorders at three and 12 month follow ups. However, one

significant limitation to this study was that only four children and their families participated and that quantitative analyses could not be conducted. A larger and more diverse sample is needed in order to confirm the findings.

Several studies with more rigorous designs have also been conducted. For instance, a study conducted by Wood, Harrington, and Moore (1996) determined that brief CBT consisting of five to eight treatment sessions was more effective in improving overall functioning and depression than a relaxation control group. In particular, 53 youth ages nine to 17 years with MDD were randomly assigned to either condition. Interestingly, there was no difference between CBT and relaxation on co-morbid anxiety and conduct problems. This suggests that brief service may be more effective for certain types of symptoms than others. Furthermore, a high relapse rate caused the CBT and relaxation conditions to become comparable at a six month follow up, which suggests that the benefits of brief service may not be sustained over time. Similarly, a randomized controlled study was conducted with 94 youth ages 13 to 18 years with subdiagnostic levels of depressive symptoms (Clarke et al., 2001). Treatment included either 15 sessions of brief group CBT, or a control condition of treatment as usual. Brief CBT reduced depressive symptoms and frequency of depressive episodes to levels comparable to a nonclinical community sample. In addition, 9% of the CBT group as opposed to 29% of the control group developed MDD at a 15 month follow up. This study suggests that brief CBT does not only target current depressive symptoms but it may also be used as a preventative intervention. However, further research is needed in order to determine if these results extend to individual brief CBT.

Other studies chose to focus on other theoretical orientations when evaluating brief services. For example, a study of seven children ages six to 11 years with Attention-

Deficit/Hyperactivity Disorder (ADHD) was conducted by Cocciarella, Wood, and Low (1995). It was found that a seven session brief behavioural therapy that included the reinforcement of positive behaviours and skills training led to a significant decrease in ADHD symptoms. Several limitations to this study included the fact that a control group was not incorporated and that a sample of only seven children was used. Likewise, Lee (1997) conducted a descriptive qualitative study in a children's mental health facility. A total of 59 children ages four to 17 years and their families participated. Presenting problems included family relationship problems, behavioral problems at home, school-related problems, emotional regulation, self-esteem problems, parents' marital situation, children's coping skills, parenting skills, and problems with the law. Individual or team SFBT was administered in an average of 5.5 therapy sessions. Specifically, exception questions (de Shazer et al., 1986), outcome questions (de Shazer & Molnar, 1984), and coping, scaling, and relationship questions (Berg, 1994) were asked and a coding scheme for the responses was developed by a four member committee in order to measure outcome. Results from telephone interviews completed at six month post treatment showed via self-reports a 64% success rate for an average of 5.5 therapy sessions, defined as attaining positive goals set by the client and finding solutions to the presenting problems. Both variations of SFBT saw improvements in the parent and child, with the most commonly attained goals including an improved family relationship, child's behaviour at home, parenting skills and child's coping. Related to goal attainment, therapist support and educational feedback were reported by the clients as the most important aspects of therapy leading to attainment of goals.

With respect to the effectiveness of community-based brief service for adults, one study compared brief psychodynamic psychotherapy and pharmacotherapy in 87 adults with

Generalized Anxiety Disorder (Ferrero et al., 2007). Between 10 and 15 sessions were involved and participants were randomly assigned to receive either therapy, anti-anxiety medication, or a combination of both. Overall scores of anxiety and depression decreased and social and occupational functioning increased, with this improvement being comparable among all three treatment conditions. However, further research needs to be conducted in order to clarify the relationship between brief service and pharmacotherapy in both adults and childhood populations.

Several meta-analyses targeting specific therapeutic orientations in brief service have also been conducted. For instance, a meta-analysis conducted by Kim (2008) involving studies with both youth and adults found small, positive treatment effect sizes (d = .13 to .26) for SFBT on treating a variety of externalizing and internalizing behaviours as well as family relationship difficulties. Overall, only internalizing behaviour problems reached significance at the .03 level, suggesting that SFBT consisting of an average of eight sessions may be the most effective for issues such as depression, anxiety, and self-esteem. Although less than half of the studies used in this meta-analysis involved youth (45%), it nevertheless supports the effectiveness of SFBT. However, one limitation is that not all of the studies were true experimental designs. Similarly, Abbass, Kinsely, and Kroenke (2009) conducted a meta-analysis of studies involving short-term psychodynamic psychotherapy, consisting of an average of 12 sessions, for adults with somatic symptom disorders. In particular, they included 23 studies in their analysis, with 57% of the studies involving randomized controlled designs. Moderate to large effect sizes were found, ranging from .60 to 1.10. Although this meta-analysis only focused on adults, others studies have shown support for the effectiveness of brief psychodynamic therapy with youth (e.g., Maina et al., 2005).

In summary, the effectiveness of brief service consisting of five to 15 treatment sessions is supported in the literature. Although brief CBT is the most common, other theoretical orientation have been used including brief behavioural therapy, SFBT, and psychodynamic therapy.

Brief Services Consisting of Four Sessions or Less

Within the brief services literature, interventions consisting of four or fewer sessions were the least studied. Out of the studies available, session length typically varied from four sessions, a single session, and a two-plus-one model involving two weekly sessions followed by a follow up session three months later. For example, one study of 35 adults with co-morbid depression and anxiety was conducted by Lang (2003). Individuals were randomly assigned to either brief CBT consisting of four weekly sessions or a waitlist control group. It was found that brief CBT was more effective in reducing symptoms of depression and anxiety as well as improving overall functioning. However, one significant limitation of this study is that no diagnostic information was collected by a mental health professional. Rather, the identification of depression and anxiety was made using self-reports. It nevertheless provides a good starting point for future, more comprehensive empirical studies.

With respect to working with young adults, a study conducted by Searle et al. (2011) investigated a brief psychodynamic-based program consisting of four sessions. Self-referred young adults ages 16 to 30 years with a wide range of mental health issues were targeted. A significant change in scores from a clinical to non-clinical range was seen on measures of internal disorders and overall functioning, suggesting this type of therapy was most effective for clients with internalizing problems. This finding is similar to that reported by Kim (2008) where brief therapy was found to be the most effective with internalizing disorders. However, several

limitations included the small sample size of 24 individuals and a lack of control group for comparison. A related clinical opinion paper by Briggs (2010) describing brief psychodynamic psychotherapy with adolescents and young adults in the United Kingdom suggests that four weekly sessions is a suitable length of time for treatment, although more research needs to be conducted in this area.

Furthermore, single session therapy is frequently associated with a psychodynamic orientation and is commonly termed "very brief dynamic psychotherapy" (Aveline, 2001). According to Bloom (2001), single session therapy can be effective as it takes advantage of the fact that improvement in psychotherapy tends to negatively accelerate, with rapid improvements early on and slowing over time. Single session therapy is different from other forms of brief therapy as the therapist plays more of an active role in directing the client towards possible goals and intervention strategies (Bloom, 2001). Single session therapy also heavily focuses on preparing the client for therapy completion, as most of the therapeutic work takes place with the client during this time (Bloom, 2001). The literature on single session therapy, involving both controlled and uncontrolled studies, concludes that it is effective for medical problems, drug addiction, university counseling issues, and family relationship problems (Bloom, 2001). It is thought to be less appropriate for those with psychoses or suicidal tendencies, ongoing abuse, or family violence (Bloom, 2001). However, there is an absence of research regarding the use of single session therapy with youth. One uncontrolled study that related to youth mental health was conducted by Campbell (1999) and examined 44 parents participating in a single session family mental health service. Outcome measures assessed the severity of the presenting issue, level of coping and confidence in dealing with the problem, family functioning, and family pride. Significant improvements in family functioning and level of parent coping and confidence were

seen for approximately 75% of the sample when assessed pre-treatment and six weeks later. Thus, further research is needed in order to determine if single session therapy is effective with youth with mental health issues in a community-based setting.

Research conducted by Barkham, Shapiro, Hardy, and Rees (1999) expanded on the work by Howard et al. (1986) and initiated the development of a two-plus-one model of brief psychotherapy. In this model, a target issue is addressed and effort is made to facilitate positive client change (Aveline, 2001). Specifically, it was hypothesized that clients receiving time-limited psychotherapy would show significant improvements at the end of three sessions (Barkham et al., 1999). A randomized controlled study was conducted and involved a group of 116 adults with varying degrees of subsyndromal depression, ranging from merely stressed, subclinical depression, or low level clinical depression. Both brief CBT and psychodynamic psychotherapy were effective, with an average symptom improvement rate of 68% seen for all treatment groups. However, CBT was superior to psychodynamic psychotherapy at a one year follow up assessment. This study was limited to participants with relatively mild mood disorders, thus, the effectiveness of the two-plus-one model for more severe disorders has yet to be determined. Although there is a lack of research involving CBT and psychodynamic psychotherapy with the two-plus-one model with respect to youth, there has been a study involving this model with a solution-focused orientation (McGarry et al., 2008). This study involved 60 youth ages three to 16 years and their parents who were randomly assigned to either the brief model or treatment as usual in a community clinic. Of the sample, 48% had an externalizing problem, 33% had an internalizing problem, and 19% had a co-morbid problem. Both groups showed improvement overall on measures of child and parent functioning, although only those in the brief treatment group had sustained benefits at a six month follow up. Although

replication of these results is needed, this study provides preliminary evidence of the effectiveness of a two-plus-one model with youth in a community-based setting.

Despite the fact that the two-plus-one model of psychotherapy has recently been developed, it is thought to be one of several popular and effective brief treatments for young adults (Searle et al., 2011). Aveline (2001) suggests that this model can be used as a stand-alone therapy, which typically involves two sessions once a week and a third session three months later. Alternatively, it can be used as a first stage to a regular, long-term service plan for more complex and severe presenting issues (Aveline, 2001). It may also be applicable to other theoretical orientations other than psychodynamic (Aveline, 2001). In fact, Barkham et al. (1999) suggest that the two-plus-one model can be implemented with any orientation as long as it is highly focused and structured. Its popularity has even led to the development of a three-plus-one model, consisting of three weekly sessions followed by a three month follow up (Searle et al., 2011). However, there has yet to be empirical research published investigating the effectiveness of a three-plus-one model with youth in a community-based setting (Aveline, 2001).

In summary, brief services consisting of four or fewer sessions were found to be effective in the literature, although this length of intervention was the least studied. Further research is needed to investigate the effectiveness of the two-plus-one and three-plus-one models with youth, although current studies with adult populations are promising.

A Comparison of Brief and Long Term Services

Several studies have compared the effectiveness of brief and long-term services, with conflicting results. For instance, a meta-analysis of cognitive and non-cognitive based psychotherapy for youth with depression by Weisz, McCarty, and Valeri (2006) found no

significant correlation between treatment duration (dosage) and outcome, and concluded that brief service may be just as effective as long term service. This meta-analysis was unique in that it used a continuous measure of treatment duration, ranging from four to 32 hours with a mean of 13 hours. Treatment hours included total time spent in parent, family, and youth sessions.

Smyrnios and Kirkby (1993) randomly assigned 30 youth and their families to either a time-unlimited group, 12 session psychodynamic psychotherapy, or a control group, with 10 youth placed in each group. All groups showed significant improvements upon completion of the study, by comparing pre-post scores on a Goal Attainment Scale (Kiresuk & Sherman, 1968) and several measures assessing presenting issues. These findings suggest that the effects of brief and long-term therapy may be similar to improvement merely due to the passage of time. With respect to the adult population, a study of 326 adults with mood and anxiety disorders was conducted by Knekt et al. (2007). In particular, short-term outpatient psychodynamic therapy was found to be effective and produced benefits more quickly than long-term psychodynamic psychotherapy. However, these benefits reduced over time and it was ultimately concluded that long-term psychotherapy may have more long-term effects than brief therapies. Nevertheless, further research must be conducted in order to determine if similar long term effects are seen with youth in a community-based setting.

Moreover, a study conducted by Barkham and colleagues in 1996 found that 36 adults diagnosed with depression and given eight sessions of either psychodynamic-interpersonal or cognitive behavioural psychotherapy displayed a statistically significant advantage over clients given 16 sessions in terms of symptom reduction. This was consistent for both theoretical orientations. Although improvements were seen with both types of brief services, it was suggested that treatment length, less than eight sessions, may be ideal. It was therefore proposed

by the authors that change occurred more rapidly when a shorter time period of treatment was given. In addition, it is important to note that these results need to be replicated with other populations, with youth in particular.

In summary, the majority of published studies suggest that brief interventions are more effective than giving no intervention to adults and youth with mental health issues. However, there are studies indicating that brief services may not be effective and that increasing treatment dosage may not lead to improved outcomes. Given the limited number of studies done in this area and the mix of outcome results, further research is clearly needed to confirm the effectiveness of brief interventions. In addition, investigating the causal mechanisms of brief service interventions would allow for a more comprehensive understanding of why it is or is not effective. According to Hoagwood (2005), there is an absence of literature on many process variables relating to brief treatment for youth and their families in community-based clinics. However, the few studies that are available suggest that several factors that can be used to predict treatment effectiveness include a strong therapeutic alliance, positive client attitudes, and parent mental health issues such as maternal depression being particular important.

Predictors of Treatment Outcome

Therapeutic alliance. There is an abundance of research regarding the importance of the relationship between the client and therapist, namely, the working or therapeutic alliance. In particular, the literature indicates that an increase in therapeutic alliance during treatment leads to improved client symptoms and overall functioning (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003; Meyer et al., 2002; Searle et al., 2011). In addition, it is thought to be one of the most robust predictors of therapeutic improvement regardless of the type of therapy used (Blais, Jacobo, & Smith, 2010). For instance, Klein et al.

(2003) reported that early therapeutic alliance was a significant predictor of subsequent improvement in symptoms, even when prior improvement was statistically controlled. In particular, a sample of 367 depressed patients was used, with each participant being given an average of 16 weekly sessions of CBT either with or without pharmacotherapy. Interestingly, the influence of the therapeutic alliance on outcome was similar for those receiving either combination treatment or CBT alone.

Likewise, two meta-analyses of therapeutic alliance found a moderate positive association between therapeutic alliance and treatment outcomes in adult therapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Mean weighted effect sizes for these studies included $r = .26$ (Horvath & Symonds, 1991) and $r = .21$ (Martin et al., 2000). However, the current research mostly pertains to adult populations.

A child's relationship with their therapist has also been investigated as a possible predictor variable of treatment outcome. Furthermore, one study using hierarchical linear modeling found that the therapeutic alliance played a significant role in influencing youth treatment outcomes, with a positive therapeutic relationship being related to fewer reported mental health symptoms at the end of treatment (Hawley & Weisz, 2005). This study included a sample of 65 youth ages seven to 16 years and their parents who received 23 sessions in a community-based outpatient treatment. The majority of treatment (54%) was based on a psychodynamic theoretical orientation, while 14% involved CBT and 32% involved a combination of orientations. Interestingly, the parent-therapist therapeutic relationship failed to produce similar results. In addition, this study did not pertain to brief services. A review of the literature by Green (2006) found a modest yet consistent correlation between therapeutic alliance between the therapist and child and treatment improvement. Another study examined

therapeutic alliance in a sample of 100 substance abusing adolescents with an average age of 15 years (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006). Adolescents were randomly assigned to receive either CBT or family therapy for an average of 13 sessions. This study was comparable to the one by Klein et al. (2003) in that therapeutic alliance was found to be predictive of outcome. Specifically, those adolescents whose therapeutic alliance increased throughout treatment had a reduction of externalizing symptoms while those who failed to establish a strong alliance showed worsening symptoms at the end of treatment. However, this relationship only pertained to family therapy, with therapeutic alliance failing to be a significant predictor of outcome with CBT. Also, therapeutic alliance was not associated with improved internalizing symptoms upon completion of treatment, suggesting that it may be a significant predictor for only certain childhood disorders.

In the first meta-analysis specific to children's treatment, Shirk and Karver (2003) reviewed 23 studies on therapeutic alliance and treatment outcomes for children and adolescents with a variety of mental health issues. Although the majority of studies (n =14) involved outpatient services, none of the treatments included in this meta-analysis were considered to be brief. It was concluded that the correlation between overall therapeutic relationship and outcome was modest but robust (mean r = .24). This relationship was independent of type of treatment, although it was stronger for children with externalizing (mean r = .30, SD = .18) rather than internalizing (mean r = .10, SD = .08) problems. The authors note that this correlation is also similar to studies of therapeutic alliance with adult populations. However, there is an absence of research regarding therapeutic alliance predicting brief treatment outcomes of youth in brief community-based services. Nevertheless, based on the promising results seen with adult

populations treated with brief therapy and long term therapy with youth, it is suggested that therapeutic alliance may also predict treatment effectiveness with youth in brief service.

Parent psychopathology. There is a large body of research describing the relationship between the parent's and the child's mental health (Kazdin, 1995). In fact, parental psychopathology, particularly maternal depression, is commonly seen in the literature as a significant predictor of youth depression. For instance, a longitudinal study by Weissman et al. (2006) followed children of parents with moderate to severe Major Depressive Disorder for a period of 20 years to an average age of 35 years. Another group of children whose parents lacked any psychiatric disorder were also followed for comparison. Children with depressed parents as opposed to non-depressed parents were three times more likely to develop an anxiety disorder, major depression, or substance dependence. Similarly, a literature review conducted by Gunlicks and Weissman (2008) investigated the relationship between improvement in parental depression and its effects on child mental health. Ten studies were reviewed, with eight studies that focused on mothers. A moderate association existed between improvement of parents' depression due to psychotherapy and medication, and improvement in children's emotional and behavioural problems and psychosocial functioning. Although only 10 studies were taken into consideration, this review contributes to the additional literature supporting the relationship between parent and child mental health issues. Parental psychopathology has also been described as one of the many factors that predict the onset of other mental health issues in youth, such as conduct disorder (Beauchaine, Webster-Stratton, & Reid, 2005).

Moreover, parental psychopathology can also be used to predict how well the youth performs in treatment for mental health issues. For instance, the literature suggests that simultaneous maternal depression can predict poor treatment outcomes in youth, including lack

of homework completion, poor session attendance, and failure to reach treatment goals (Beauchaine et al., 2005; Kazdin, 1995). It is also suggested that the more severe and complex the parent psychopathology is, the more it minimizes the impact of a given treatment on the youth (Kazdin, 1995). One related study was conducted by Berman, Weems, Silverman, and Kurtines (2000) who investigated possible predictors of outcome in youth receiving exposure-based CBT for phobic as well as other types of anxiety disorders. Along with hostility and paranoia, maternal depression was rated as one of the most significant predictors of poor youth treatment outcomes. A related study by Southam-Gerow, Kendall, and Weersing (2001) was also interested in predictors of outcome for youth with anxiety disorders. In particular, 135 youth aged seven to 15 years were assessed on anxiety symptoms and overall functioning upon completion of CBT. Higher levels of maternal depressive symptoms were strongly associated with less success in treatment, as measured by the presence of at least one anxiety disorder at posttreament or one-year follow up. However, replication of this study with a wider range of psychometric measures of child and parent psychopathology was suggested by the authors.

Additional research has also supported parental psychopathology predicting treatment outcomes in youth with other mental health issues. For example, Emslie et al. (2003) attempted to identify characteristics that predicted a child's response to the treatment of mood disorders. The presence of a psychiatric disorder in a parent not only contributed to the development of a mood disorder in their child but also predicted poorer prognosis with the child in cognitive-behavioural therapy. These findings have also been confirmed in a meta-analysis by Reyno and McGrath (2006). This meta-analysis found that maternal mental health had a moderate contribution to child treatment response, with maternal depression being particularly important in predicting poor treatment outcomes in children with externalizing behaviour problems. It was

suggested that the presence of depression may be able to explain why a child's behaviour did not improve, as depression would make it more difficult for the parent to keep up with the demanding behaviour modification techniques needed for successful treatment outcomes. Alternatively, it was suggested that maternal depression may distort perceptions of their child's behavior and this would contribute to a poor response to treatment. A meta-analysis by Connell and Goodman (2002) provided support for maternal depression as a predictor of internalizing problems as well, defined by symptoms of depression, anxiety, or social withdrawal. Studies that were included investigated the association between mothers and fathers and mental health issues in youth ages two to 18 years. Parental depression was a small but significant predictor of child internalizing problems, with maternal depression being a stronger predictor than paternal depression. In general, mental health issues in mothers resulted in an overall small, comparable effect size as paternal mental health issues for children with internalizing problems.

Lastly, one study was found that pertained to parental psychopathology predicting outcome to brief service as defined by the researchers. This study was conducted by Brent et al. (1998) and was interested in identifying predictors of outpatient treatment efficacy for 107 adolescents aged 13 to 18 years with depression. Treatment involved 12 to 16 sessions of brief CBT, brief family-systems therapy, or brief nondirective supportive therapy. Maternal depressive symptoms were related to poor treatment efficacy in the adolescents, as defined by one or more of the following aversive conditions: co-morbid anxiety, high level of cognitive distortion, and hopelessness. Interestingly, this relationship depended on the type of therapy assigned, with brief CBT being the most effective and brief nondirective supportive therapy being the least effective. As a result, it was concluded that treatment of parental psychopathology may improve adolescent outcomes, especially with those receiving brief CBT.

There is an abundance of research on the relationship between parental psychopathology, particularly maternal depression, and youth treatment outcomes. Specifically, it can be suggested that good parental mental health can predict more effective treatment for the youth. However, replications of these studies need to be conducted in order to determine if parental psychopathology better predicts one particular type of youth mental health issue over another. In addition, one limitation to most of the studies involving maternal depression is that only self-reports were used to assess maternal depression. It would also be beneficial to include multi-method assessments. Lastly, although there is some research on parental psychopathology as a predictor of treatment outcomes (e.g., Berman et al., 2000; Southam-Gerow et al., 2001), replication of these studies is needed. Furthermore, only one study pertained solely to brief service (Brent et al., 1998).

Client attitudes and stress. It makes sense that the client's attitudes towards treatment can be used as an outcome measure of treatment change. For instance, such attitudes may include confidence in and knowledge of managing the presenting issue, sense of hope for the future, and subjective stress level. However, there is a paucity of recent literature regarding these attitudes as predictors of treatment outcome for youth and their families. Instead, one can study the literature of the related construct of self-efficacy. In fact, there are numerous articles in the literature that involve parental self-efficacy in predicting youth outcomes and overall functioning. For instance, parental treatment involving positive parenting practices improves parental self-efficacy and in turn, is related to positive child adjustment and overall functioning (Jones & Prinz, 2005). Specifically, parents with high self-efficacy tend to try new, more effective parenting practices, while those with low self-efficacy resist due to a lack of confidence in their abilities. Thus, it is reasonable to assume that a lack of parental self-efficacy can hinder

brief services that require modifications in parenting practices to achieve youth behaviour change. One study conducted by Hoza et al. (2000) investigated various parent variables in predicting treatment outcome in a sample of 105 youth ages seven to 10 years with Attention-Deficit/Hyperactivity Disorder. Interestingly, parenting self-efficacy in fathers rather than mothers was found to significantly predict youth treatment outcomes. That is, high self-efficacy in fathers was associated with positive youth outcomes. However, replication of this study is needed in order to better understand the possible gender differences in parental self-efficacy. A related study also found that self-efficacy predicted treatment outcome, although a sample of 88 adolescents ages 13 to 18 years with substance abuse disorder was used (Burleson & Kaminer, 2005). After nine months of either CBT or psychoeducation therapy, high self-efficacy significantly predicted positive outcomes in the adolescents, as defined by an increase in abstinent behaviours. Thus, it appears that the benefits of high self-efficacy pertain to both parent and youth.

A client's sense of hope in dealing with their problem, much like self-efficacy, is related to treatment change. For instance, much like low parental self-efficacy, hopelessness can lead to low motivation in treatment and in turn, lead to dropout or poor child outcomes (Morissey-Kane & Prinz, 1999). In particular, the importance of hope and its association with positive treatment outcomes was emphasized in the uncontrolled study by Campbell (1999) that examined 44 parents participating in a single session family mental health service. Along with significant improvement in family functioning and level of parent coping, it was found that families with high levels of hopefulness showed large reductions in the presenting issues compared to families with low levels of reported hopefulness based on repeated measures analysis of variance. It was therefore hypothesized by the authors that families with more hope had the energy and

motivation to try new ways of dealing with the presenting issues and maintain these positive coping mechanisms over time. However, due to the lack of literature on this variable, one can also extrapolate its relationship with treatment outcome from the existing literature on optimism. One relevant study of college students found similar results as the study by Campbell (1999), although optimism rather than hope was included (Hatchett & Park, 2004). In particular, 96 college students receiving university counseling were assessed on measures of overall functioning, coping skills, and psychopathology. Although optimism was positively correlated with effective coping skills, optimism was the sole best predictor of student counseling outcomes, defined by therapist ratings of student improvement.

Furthermore, there is an absence of literature on subjective parental stress as being a predictor of youth treatment outcomes. However, reduced parent levels of stress have also been reported, in addition to high self-efficacy, in effective treatments. For example, one study evaluating a behavioural parent training program for families with two year olds was interested in maternal self-efficacy and maternal stress in predicting program effectiveness (Tucker, Gross, Fogg, Delaney, & Lapporte, 1998). A total of 46 mothers participated and measures of self-efficacy and stress were administered one year upon completion of the program. At the end of the program, it was concluded that reported maternal self-efficacy improved, maternal stress decreased, and that these changes would increase the quality of the relationship between the mother and child. Likewise, a randomized controlled study by Kazdin and Whitley (2003) investigated the additional benefit of adding an intervention targeting parent stress to a problem solving skills training program for parents of youth receiving treatment for aggressive and antisocial behaviours. A total of 127 families participated, with children aged 6 to 14 years, and half of the sample received a stress-related intervention. The children whose parents received

the additional stress intervention, as opposed to the parents who did not, displayed less severe antisocial behaviour and fewer overall symptoms. This effect was seen in addition to the intervention leading to a decrease in reported parent depression and stress. Although more research on this topic needs to be conducted, including a comprehensive literature review and the investigation of possible moderating variables such as socioeconomic disadvantage or poor living conditions, it is suggested that parental stress may also predict youth outcomes.

Overall, the above studies taken collectively suggest that client attitudes of confidence, knowledge, and hope as well as reduced feelings of stress, may be predictors of treatment effectiveness. This is especially relevant to parent variables influencing youth treatment outcomes. However, there is a significant need for future studies investigating these variables in a community-based clinic with brief service.

Brief Services Gray Literature in Ontario Children's Mental Health

As a brief service intervention model is not uncommon in Ontario's children's mental health system, a search was conducted for any past studies or program evaluation projects done in this area through the provincially funded Ontario Centre of Excellence for Children and Youth Mental Health. One recent evaluation was conducted on the Short Term Intervention Program at the George Hull Centre in Toronto, Ontario (Bartlett & Vahed, 2010). This brief program targets youth with early onset difficulties and consists of an average of three sessions. After collecting data on all referrals in a nine month period, it was concluded that their services were effective based on a significant increase seen on measures of overall functioning and strength of family relationships. However, change in stress failed to reach significance. In addition, there was a high degree of satisfaction, with 79% of clients reporting that their needs were met by partaking in the service. However, one major limitation of the evaluation included a lack of control group,

which was needed to verify if an effect was truly present or if the improvements were merely due to the passage of time. In addition, this evaluation was limited by a small sample size of 42 individuals from 26 families. It was also limited by the small response rate of 12 families in post assessment measures, thus follow up information was not able to generalize to the rest of the cases seen at the Centre.

A related program evaluation was conducted by St. Clair Child and Youth Services in Sarnia, Ontario, for their Brief Intervention Program (Lavery, 2005). It was based on their one-to-nine-session service for parents and youth. Eighty-two clients were referred to brief service and 69 cases completed treatment. However, completed pre/post data from the Brief Child and Family Phone Interview 3 (BCFPI-3; Cunningham, Pettingill, & Boyle, 2006) was collected from only 53 parents. This organization found that their brief service led to a decrease in symptom severity for all cases, as large effect sizes were seen for all BCFPI-3 subscales following the intervention. The strongest effects were seen in the following areas: internalizing problems, separation anxiety, and overall child functioning. In addition, 93% to 98% of the sample was satisfied with most aspects of service, such as service time of day, location, courtesy, participation, and helpfulness. The St. Clair evaluation is similar to the George Hull evaluation in that a control group was not included for comparison. An additional weakness is that only one measure of functioning was included for analysis.

Gaps in the Literature

The existing literature provides relevant, but very limited, information regarding the identification of brief treatment effectiveness as well as predictors of treatment change. For instance, only a small number of studies have been conducted in community-based settings involving outpatient services for youth. As a result, some of the evidence supporting the

effectiveness of brief service needs to be extrapolated from studies with adult populations. Studies also vary on the general theoretical approach of the intervention, target population, presenting problems, and types of measures used. A more notable inconsistency includes the varying lengths of the interventions, despite the fact that they are all considered brief services. Thus, replication of studies needed to increase confidence in the results is rarely seen. In addition, there is a substantial lack of information of the effectiveness of brief services that are four sessions or less, despite their common use in the children's mental health system in Ontario. More importantly, current studies often have problems in their designs, such as small sample size (e.g., Cocciarella et al., 1995; Girling-Butcher & Ronan, 2009), lack of control group (e.g., Birmaher et al., 2000; Lee, 1997), or restricted to using only self- report measures (e.g., Lang, 2003; Stice et al., 2008). Program evaluations such as the ones at George Hull and St. Clair can also be used to supplement research studies and provide helpful insight into the effectiveness of services for youth in a community-based setting. However, it is important to note that they are typically weak in design and have limited explanatory power. Overall, a more comprehensive evaluation of brief services for youth is needed.

The Current Study

Brief Services at the Children's Centre Thunder Bay (CCTB) were originally implemented to address issues related to a lengthy client waitlist and the fact that an important minority of clients did not want lengthy interventions. As the Brief Service has never been formally evaluated and the existing research regarding brief interventions is weak, it is critical that CCTB gather direct information about the effectiveness of this significant intervention. This study hoped to describe common Brief Service practices in children's mental health in the province of Ontario and identify strengths and weaknesses of the current service at CCTB.

Specifically, this study of Brief Services for youth at CCTB was supported by the Ontario Centre of Excellence in Children and Youth Mental Health and will be disseminated within the service system sector in Ontario.

In general, the aim of the current study was to formally evaluate, for the first time, the effectiveness of the Brief Services conducted at CCTB. In order to do this in a systematic fashion, the following questions were addressed:

1. Based on clinical judgment at Intake, were clients appropriately assigned to Brief as opposed to Long Term Services (i.e. clients with more severe presenting issues are assigned to Long Term Service)?
2. What were the treatment goals and therapeutic strategies used in a typical Brief treatment session? Were the Brief Service strategies used in treatment consistent with the empirically-based intervention techniques identified in research?
3. Were clients satisfied with their Brief Service involvement? Was client satisfaction associated with greater improvement in treatment outcomes?

Lastly, specific hypotheses were developed focusing on the effectiveness of Brief Services. In addition, given the understudied nature of brief service programs, treatment process issues potentially related to treatment outcomes were also investigated.

1. It was hypothesized that the Brief Service program would be effective in improving youth and adult mental health and overall functioning, as well as decreasing caregiver strain.
2. It was hypothesized that therapeutic alliance would be positively associated with treatment outcomes and client satisfaction.

3. It was hypothesized that parent and youth depression, anxiety, and stress would be associated with poorer treatment outcomes in youth mental health functioning and parent caregiver strain.

Method

Participants

Participants included clients who were assigned to a brief outpatient treatment at CCTB. Clients included youth under the age of 18 years and their parent(s). A total of 82 clients were invited to participate. Fifty-one participants (62.2%) agreed to participate in the study and completed the pre-treatment measures. BCFPI-3 scores from clients that chose not to participate in the study were also included in the data set, due to the fact that BCFPI-3 is a provincially mandated intake instrument which must be collected as part of the regular Intake process at CCTB. At the end of the study, 33 participants had all pre- and post measures completed, which is a 64.7% completion rate. Only these participants were included in the statistical analyses below.

Measures

Brief Child and Family Phone Interview 3 (BCFPI-3). The BCFPI-3 (Appendix B) takes 30 to 45 minutes to complete either by telephone interview or self-report measure (Cunningham, Pettingill, & Boyle, 2006). It assesses 19 areas of behavioural and emotional functioning in children between six and 18 years of age as well as an assessment of family functioning (Cunningham et al., 2006). It also provides demographic information and measures a family's readiness for service (Cunningham et al., 2006). The BCFPI-3 has test-retest reliabilities of .71 for ages 6 to 11 years and .67 for ages 12 to 18 years (Cunningham et al., 2006). In addition, it has internal consistency scores ranging from .75 to .83, with the exception

of the *Conduct Problems* subscale (.56; Cunningham et al., 2006). It also possesses sound construct, concurrent, and content validity (Cunningham et al., 2006).

Caregiver Strain Questionnaire (CGSQ). The CGSQ (Appendix C) consists of 21 items involving objective, subjective internal, and subjective external categories of caregiver strain in the past 2 months (Brannan, Heflinger, & Bickman, 1997). It is typically used with families of youth with emotional and behavioural disorders (Brannan et al., 1997). It is also rated on a 5-point Likert-type scale, with 1 representing no problems or situations reflecting caregiver strain and 5 representing a high degree of problems related to caregiver strain (Brannan et al., 1997). This measure has good psychometric properties, including an overall internal consistency alpha of .93 (Brannan et al., 1997).

Client Satisfaction Questionnaire (SQ). The SQ (Appendix D) is a 10 item measure that assesses overall satisfaction with services. Each item is scored on a 6-point Likert-type scale, with 1 representing a low level of service satisfaction and 6 representing a high level of service satisfaction. Questions two and five are reversed scored. It was developed by CCTB and closely resembles the CSQ-8 developed by Attkisson and Zwick (1982). The CSQ-8 has good psychometric properties, including reported internal consistencies between .86 and .94 (Attkisson & Zwick, 1982). It also has good concurrent validity, as it is highly correlated with client reports of symptom improvement and therapist ratings of client progress (Attkisson & Zwick, 1982).

Depression, Anxiety, and Stress Scale 21 (DASS-21). The DASS-21 (Appendix E) is a measure of a variety of symptoms reported in the past week (Lovibond & Lovibond, 1995). It is divided into three subscales, with the Depression subscale measuring dysphoria and hopelessness, the Anxiety scale assessing autonomic arousal and skeletal muscle effects, and the

Stress scale measuring difficulty relaxing and nervous arousal (Lovibond & Lovibond, 1995). The DASS-21 contains 21 items and is based on a 4-point rating scale, where a score of 0 represents "Did not apply to me at all" and a score of 3 represents "Applied to me very much, or most of the time" (Lovibond & Lovibond, 1995). It also takes less than 10 minutes to complete and is available in both paper and computerized formats (Lovibond & Lovibond, 1995). It has good reliability, with internal consistencies including .94 for the Depression subscale, .87 for the Anxiety subscale, and .91 for the Stress subscale (Antony, Bieling, Cox, Enns, & Swinson, 1998). It also exhibits concurrent validity, with moderate correlations seen with the BDI (.69 for the Stress subscale, .79 for the Depression subscale, and .62 for the Anxiety subscale; Antony et al., 1998). Furthermore, there is evidence in the literature that the DASS-21 can be used with youth as well as adults (Barrett, Dadds, & Rapee, 1996; Duffy, Cunningham, & Moore, 2005; Szabo, 2010).

Individual Session Treatment Summary. The Individual Session Treatment Summary for Brief Services (Appendix F) was developed by CCTB for the current study. It is completed by the therapist after each session and provides a short summary of what took place during the session. Along with the client and therapist's names, session number, date, and session length are included. Moreover, types of issues addressed in the session are highlighted and ordered according to priority. Lastly, it provides a comprehensive checklist of intervention strategies used in the session. Although this measure is not a psychometric test, its contents reflect the literature on evidence-based practice elements (Chorpita & Daleiden, 2009). Practice elements include various clinical strategies that are part of more complex interventions and are typically sorted according to client characteristics such as age, sex, ethnicity, or presenting problem (Chorpita & Daleiden, 2009). For example, Chorpita and Daleiden (2009) recently analyzed

treatment elements reported in 322 randomized controlled trials for successful child mental health treatments. This included empirically-based practice elements such as praise, problem solving, exposure, education, and rewards. It was concluded that practice elements can be useful in developing individualized treatment plans for children and that they are most often organized according to the type of presenting issue (Chorpita & Daleidin, 2009). Although they do not describe the efficacy of various components of treatment, an analysis of treatment elements will nevertheless be beneficial for service providers and indicate whether appropriate treatment strategies are being used within usual treatment care.

Intake Assessment Rating Guidelines. The Intake Assessment Rating Guidelines (Appendix G) is an existing risk rating system already in established use at CCTB. It involves rating clients at Intake on five areas of functioning, namely, risk to self or others, behavioural presentation, family functioning, global functioning, and other concerns. Each client is then assigned an overall assessment rating ranked on a scale from 1 to 4, with 1 being 'critical', 2 being "severe", 3 being "urgent", and 4 being "moderate". Lower values indicate more severe presenting issues.

Working Alliance Inventory Short Form (WAI-S). The Working Alliance Inventory-Short Form (Appendix H) is a 12 item self-report measure of the therapeutic relationship (Tracey & Kokotovic, 1989). In addition to an overall score, the WAI-S produces 3 subscale scores (Tracey & Kokotovic, 1989). Specifically, the Goals subscale measures how well the client and therapist agree on the mutually developed goals of treatment (Knaevelsrud & Maercker, 2006). This scale has an internal consistency of .79 (Knaevelsrud & Maercker, 2006). The Tasks subscale assesses the level of agreement on how to reach these treatment goals and has an internal consistency of .70 (Knaevelsrud & Maercker, 2006). Lastly, the Bonds subscale

measures the degree of trust and acceptance between the client and therapist (Knaevelsrud & Maercker, 2006). The internal consistency for this subscale is .75 (Knaevelsrud & Maercker, 2006). Furthermore, separate versions of the WAI-S are given to the therapist and client to complete after each session (Tracey & Kokotovic, 1989). Items are rated on a 7-point Likert-type scale ranging from 1 representing "never", to 7 representing "always" (Tracey & Kokotovic, 1989). The WAI-S is also highly correlated with a longer form of the WAI by Horvath and Greenberg in 1989 (Hatcher & Gillaspy, 2006).

Procedure

In order to determine if successful treatment outcomes could be attributed to Brief Service, the study was conducted utilizing a pre/post research design. Specifically, families with children under the age of 18 years who would normally be assigned to Brief Service at CCTB were invited to participate. Exclusion criteria involved suicide ideation or attempts, sexual abuse or other significant trauma, grief issues, and having a significant co-morbidity (defined as having T scores greater than 65 on multiple BCFPI-3 subscales). This service accepted children and families with a broad range of presenting issues with treatment ranging in length from one to four sessions. Families were referred into this service by the Intake services program if they were determined to have mild to moderate level difficulties or that they could complete treatment within a maximum of four sessions. The types of presenting issues and intervention models used by therapists within this program were one of the topics investigated in the current study.

Data collection for this study began September 1, 2011 and ended June 1, 2012. Prior to completing the study, participants were given a cover letter (Appendix I) and were asked to read and sign a consent form (Appendix J). Therapists were given a transcript to introduce the study (Appendix K) and were provided with a checklist that detailed the process of the study

(Appendix L). Youth 12 years and older who were assigned to Brief Service and consented to participant also required their parent's signature on the consent form in order to ensure that they fully understood what was required of them. Consenting participants received Brief Service at CCTB, which involved one to four treatment sessions over a maximum six week time period. Participants were thanked for completing the study (Appendix M) and were given a $20 honorarium. This study was approved by the Lakehead University Research Ethics Board (Appendix N) as well as Children's Centre Thunder Bay Ethics Committee (Appendix O).

Research questions and hypotheses regarding treatment effectiveness, later described in detail, were tested with client outcome measures (Table 2), with participants completing measures at Intake, after each session, and upon completion of treatment. Specifically, a youth over 12 years of age receiving treatment without their parents completed the outcome measures themselves, including the DASS-21. However, youth did not complete the CGSQ as this questionnaire was a measure of caregiver strain. If a youth was under the age of 12 years, or if they were 12 year or over and were joined by a parent in treatment, the parent completed all of the outcome measures for the child.

In addition to the data collection that began in September, 2011, the Children's Centre completed a pilot project of the Brief Services program using the same outcome measures as in this study. Organization and implementation of this project was conducted by the Brief Service Steering Committee, which included this author. Information collected from clients that participated in the pilot project (running from May 9, 2011 to August 31, 2011) was added to the current dataset. This included 10 participants.

Results

Data Screening

Based on the recommendations by Tabachnick and Fidell (2007), data were screened for outliers, defined as scores that are three standard deviations above or below the mean. In addition, the normality of all measures was investigated using histograms and skewness and kurtosis values. All of the measures had appropriate skewness and kurtosis values (within the range of plus or minus two).

Internal Consistency and Reliability of Measures

The mean, standard deviation, and internal consistency of the study's measures were calculated (Table 3). The reliability of the BCFPI-3 is well known in the literature and therefore was not evaluated in the current study (i.e., the majority of internal consistency scores ranging from .75 to .83; Cunningham et al., 2006). The remaining measures that have been utilized in previous research (i.e., CGSQ, DASS-21, and WAI-S) were subjected to reliability analyses, with these measures having excellent internal consistencies for both pre-treatment and post-treatment. All measures had alpha levels over .90, except for the DASS-21 (pre-treatment α = .82; post-treatment α = .80) and therapist rated WAI-S for session one (α = .89). The SQ was developed by the Committee and was found to have excellent internal consistency. Thus, it was not only appropriate for the current study, but can be used in future program evaluations at CCTB due to its strong psychometric properties.

Selection Bias Analyses

Importantly, an analysis of the 82 Brief Service clients seen over the course of the study at CCTB was conducted to compare the 31 clients who refused to participate in the study and the 51 clients who consented. No significant differences were found between these two groups on

the following factors: severity of presenting issue ($t(80) = -.35$, $p = .727$), BCFPI Total Mental Health ($t(80) = -.71$, $p = .481$), Internalizing Issues ($t(80) = -.23$, $p = .820$), Externalizing Issues ($t(80) = -1.34$, $p = .183$), age ($t(80) = .84$, $p = .402$), and sex (χ^2 (1) = .83, $p = .363$).

An analysis of Brief Service study dropouts indicated that there was a significant difference in the severity of presenting issues, as identified by the intake screening process, between Brief Service completers and dropouts, $t(49) = -2.20$, $p = .033$. Brief Service completers ($M = 3.70$, $SD = .47$) were found to have less severe presenting issues when compared to Brief Service dropouts ($M = 3.40$, $SD = .50$). However, there was no difference between completers and dropouts on the following factors: BCFPI Total Mental Health ($t(49) = -.12$, $p = .908$), Internalizing Issues ($t(49) = 1.01$, $p = .314$), Externalizing Issues ($t(49) = -.77$, $p = .45$), age ($t(49) = -.66$, $p = .510$), and sex (χ^2 (1) = .01, $p = .918$).

When comparing responses by parents and youth who agreed to participate in the study, there were no significant differences on client satisfaction or severity of child functioning (SQ: $t(31) = -.28$, $p = .785$; BCFPI Total Mental Health score: $t(31) = .94$, $p = .355$).

Question 1: Comparison of Brief and Long Term Services

Brief Service clients participating in the study consisted of 19 (57.6%) parents and 14 (42.4%) adolescents (i.e., age 12 or older). Seventeen youth (51.5%) were male and the age of youth ranged from one year seven months to 17 years and 9 months ($M = 11.38$ years, $SD = 3.87$). New referrals made up 54.5% of the sample. The majority of Brief clients had a Moderate level of urgency with respect to their presenting issues (69.7%) and participated in two treatment sessions (36.4%). Seven therapists were involved in the current study, with each therapist seeing approximately 4 clients. See Table 1 for a summary of the demographic characteristics of Brief Service clients.

For the purposes of this study, Long Term Service included individual therapy longer than 4 sessions, as well as the Triple P (Positive Parenting Program) group program. There were a total of 78 long term cases. The mean age of children in Long Term Service (M = 11.78 years, SD = 3.40) was comparable to the mean age of children participating in Brief Service. A total of 47.4% of children in Long Term Service were male. Slightly more Long Term cases were new referrals (58.2%) in comparison to Brief clients. The majority of Long Term clients (60.0%) were rated as having an Urgent level of problem severity.

To address whether clients were appropriately assigned to Brief Services, scores on the pretreatment BCFPI-3 from both Brief and Long Term Service clients were compared. Independent samples t tests were conducted comparing Brief and Long Term cases on each BCFPI-3 scale, and no significant differences were found. Table 4 provides a summary of the BCFPI-3 results.

In order to gain a better understanding of how Brief and Long Term cases compared, both service programs were compared qualitatively in terms of the top five presenting treatment issues identified at the time of Intake. Four of the top five presenting issues were common across Brief and Long Term clients and included the following referral problems: depression, anxiety, parenting issues, and anger/aggression. Unique to Long Term clients was the presenting issue of suicide ideation, while Brief Service clients had high conflict separation/divorce as a top five referral problem.

A logistic regression was performed on several key BCFPI-3 scales and demographic variables to further examine for possible differences between Brief and Long Term treatment cases. These variables included age, sex, urgency level (as rated by the Intake worker), and several BCFPI-3 scales including Internalizing, Externalizing, Managing Mood, Conduct, and

Global Family Functioning. The overall model was significant, indicating that differences between Brief and Long Term cases could be established, χ^2 (8) = 62.95, $p < .001$. Only urgency level significantly predicted entry into either Brief or Long Term Services, ($p < .001$). Specifically, Long Term clients ($M = 2.82$, $SD = .67$) had more urgent or severe presenting issues than Brief clients ($M = 3.57$, $SD = .50$), as assigned by Intake workers at CCTB. Please refer to Table 5 for details of the remaining predictor variables entered into the regression.

Question 2: Treatment Approaches and Therapeutic Strategies Used

Currently, the common treatment techniques used in Brief Services is unknown. To develop a description or profile of services, the Individual Session Treatment Summary was analyzed in order to determine what are the most common activities taking place during Brief Services. In addition, evidence-based practice elements were identified and compared according to children with externalizing issues (such as ADHD, Oppositional Defiant Disorder, and Conduct Disorder) and internalizing issues (such as mood and anxiety disorders). It is important to note that therapists could rate more than one presenting issue or practice element per session. All presenting issues reported were included in the analyses according to frequency.

The average session length was found to be 76.71 minutes ($SD = 13.71$) and the overall session format or modality included: 46% family, 26% individual youth, and 28% parent formats. Moreover, session length was not correlated with BCFPI-3 Total Mental Health change scores ($r = -.02$, $p = .920$), change in caregiver strain ($r = .12$, $p = .520$), change in stress ($r = -.27$, $p = .125$), anxiety ($r = -.05$, $p = .789$), and depression ($r = -.13$, $p = .459$), and satisfaction ($r = -.08$, $p = .642$).

As displayed in Figure 1, parent-child conflict, dealing with high conflict separation/divorce, family relationship issues, and anxiety symptoms were the most common

presenting issues for session one. Session one was the primary focus of analysis as it was the most informative (i.e., consisted of the highest number of practice elements out of all the sessions) and was consistently completed by all clients. The following presenting issues were not endorsed by the clients over any of the treatment sessions and are not included in Figure 1: child protection issues, parenting an adult child, sexual orientation, lack of basic needs, attention difficulties, criminal activity, eating issues, high risk behaviour, hyperactivity/impulsivity, obsessions/compulsions, process addiction (e.g., gambling), sexual offending, substance abuse, suicide attempts, psychosis symptoms, abuse, other domestic violence issues, traumatic events, victim of a crime, Autism Spectrum Disorder, work related issues, learning disability, finances/money issues, and physical health issues.

When analyzing practice elements session by session (Figure 2 and Table 6), it was found that session one had the most practice elements utilized, with relationship/rapport building, family engagement, and supportive listening being the most commonly used. Reframing, emotional coping skills, and problem solving were the most common practice elements used in session two. Emotional coping skills, insight building, and reframing were most utilized in session three, while emotional coping skills, motivational interviewing, reframing, and challenging cognitions were most commonly used in session four. In summary, emotional coping skills and reframing were consistently used across sessions two, three, and four. The following practice elements were endorsed less than 10 percent of the time in any given session and were therefore not included in Figure 2 or Table 6: activity scheduling, tangible rewards, time outs, self reward/praise, assertiveness, self-monitoring, modeling, monitoring youth, educational support, crisis management, social skills, and psychoeducation of the parent.

The practice elements used with particular categories of presenting issues were also identified for sessions one and two for the following treatment problems: externalizing issues (Figure 3), internalizing issues (Figure 4), parent/family issues (Figure 5), parent relationship issues (Figure 6), and "other" issues (Figure 7). The top five presenting issues were compared with respect to the practice elements used. For clients with externalizing issues (e.g., aggression, criminal activity, and antisocial behaviour), relationship and rapport building, emotional coping skills, insight building, problem solving, and challenging cognitions were common among sessions one and two. For internalizing issues (e.g., anxiety and depressive symptoms), emotional coping skills, challenging cognitions, reframing, and problem solving were similar between sessions one and two. For clients with mainly parenting or family issues (e.g., parent-child conflict, child management issues for internalizing or externalizing issues), emotional coping skills, problem solving, and reframing were common. For clients with parent relationship issues (e.g., marriage, or relationship difficulties and high conflict separation or divorce), problem solving and reframing were the practice elements used in the early sessions. Lastly, for clients who identified other issues not previously mentioned (e.g., difficulty meeting basic needs, and addiction), there was no overlap in practice elements between sessions one and two. Despite the similarities seen in practice elements between sessions one and two, differences in practice elements used from sessions one to session two were also noted for all categories of presenting issues. The shift between types of practice elements used for sessions one and two will be discussed later.

Question 3: Satisfaction with Brief Service

To address the third question, responses on the SQ were analyzed according to a descriptive profile of satisfaction levels across all 10 satisfaction questions. It was expected that

clients would be highly satisfied with the Brief Service program and that satisfaction would be strongly correlated with the greatest improvement in youth treatment outcomes (i.e., largest change scores on the BCFPI-3).

Overall, clients were satisfied with Brief Services, with a mean score of 39.76 (*SD* = 10.48) out of a possible score of 54 on the SQ. The mean score per item was 4.97 (*SD* =.97) out of a possible 6. The average rating of the overall quality of Brief Service was "Very Good". "Most Needs Have Been Met" with respect to child needs, while ratings of parent needs fell between "Most Needs Have Been Met" and "Almost All Needs Have Been Met". See Table 7 for average SQ scores.

The correlations between SQ scores and several outcome variables were non-significant. Specifically, no relationship was found between client-rated satisfaction scores and BCFPI-3 change score (r = -.12, p = .505). There was also a lack of correlation between satisfaction and change in caregiver strain (r = -.05, p = .775). Similarly, there was no correlation between satisfaction and change in depression (r = -.20, p = .255), anxiety (r = -.09, p = .610), stress (r = -.07, p =.695) or DASS-21 total scores (r = -.15, p = .400). However, it was found that client ratings of overall alliance were significantly related to client satisfaction (Table 8). Task was significantly related to satisfaction for the first three sessions, Goal was related to satisfaction for session one, and Bond was not correlated with satisfaction. Therapist ratings of alliance were not related to satisfaction for any treatment session.

Hypothesis 1: Effectiveness of Brief Service

Pre/post data from important and relevant outcome measures were analyzed to determine whether significant improvements in youth and parent functioning occurred following involvement in the Brief Service treatment program. In particular, paired sample t tests were

utilized with pre/post scores on the CGSQ, DASS-21, and BCFPI-3 Internalizing, Externalizing, and Total Mental Health scores. When paired samples t-tests were conducted on the above outcome variables, all scales were significant. Table 9 displays the means, standard deviations, t values, and effect sizes for these outcome measures. DASS-21 Depression, Stress, and Anxiety scales, and BCFPI-3 Total Mental Health and Internalizing scales demonstrated moderate effect sizes with respect to change. Changes in the BCFPI-3 Externalizing scale approached a moderate effect size while changes in Caregiver Strain and DASS-21 Total Score had small effect sizes. Effect sizes were calculated using the following formula from Cohen (1988):

$$\text{Effect Size} = \frac{\text{Mean}_1 - \text{Mean}_2}{(SD_1 + SD_2)/\ 2}$$

Hypothesis 2: Therapeutic Alliance

The results of Hypothesis 1 suggest that treatment within the Brief Services program was effective. Thus, it is meaningful to examine possible predictors of treatment outcomes. The WAI-S was used to address the second hypothesis regarding the relationship between therapeutic alliance and treatment outcomes. The WAI-S was broken down into Goal, Task, Bond, and Total Scores and was used to measure therapeutic alliance after the first session as well as measure the level of agreement by therapist and client over time. Correlations were used to determine the strength and direction of the relationship between therapeutic alliance and improvement in various treatment outcomes, including caregiver strain, youth mental health issues, client satisfaction, and depression, stress, and anxiety.

Therapist WAI-S overall ratings of therapeutic alliance for session one were not significantly associated with treatment change on any of the measures, while client WAI-S overall ratings were correlated only with post-treatment satisfaction ($r = .40$, $p = .021$). When

alliance was broken down into the three subscales, it was found that client ratings of Task were significantly correlated with client satisfaction (r = .45, p = .008) and client Goal was correlated with client satisfaction (r = .50, p = .003). Therapist ratings did not correlate with any changes in outcome measures. See Table 10 for all of the correlations investigated for session one.

Therapeutic alliance measured at session two was then investigated to see if results differed from session one. It was found that client WAI-S overall ratings were significantly correlated with post-treatment satisfaction, as seen for session one (r = .38, p = .033). Similarly, when alliance was broken down into the three subscales, client ratings of Task were significantly correlated with satisfaction (r = .41, p = .024) and client Goal was correlated with change in BCFPI Total Mental Health score (r = .48, p = .008). See Table 11 for all of the correlations investigated for session two.

Level of therapist and client agreement with respect to therapeutic alliance over time was also investigated. WAI-S Bond, Goal, Task, and Total Score subscales for both clients and therapists were correlated for sessions 1 and 2. Analyses with sessions 3 and 4 were not conducted due to low sample sizes (n = 20 and n = 10 respectively). It was found that there was a significant correlation between client and therapist ratings of Task (r = .35, p = .050), Goal (r = .05, p = .004), and Total Score (r = .40, p = .024) for session two. Session one correlations failed to reach significance. Please refer to Table 12 for a summary of the level of agreement of therapeutic alliance over time.

Hypothesis 3: Parent and Youth Mental Health

The DASS-21 was utilized to address the third and last hypothesis that parent and youth depression, anxiety, and stress would be associated with poorer treatment outcomes in youth and with caregiver strain. The DASS-21 was completed either by the parent, or the youth if they

participated in treatment on their own. As a significant minority (n =14) of DASS-21 scores were completed by youth, it could not be used as a true measure of parent mental health. As a result, analyses focused on a combined measure of parent and youth depression, anxiety, and stress. Correlations were conducted with pre-treatment mental health scores and treatment change scores on various outcome measures. No significant correlations were identified (Table 13).

Discussion

Question 1: Comparison of Brief and Long Term Services

It was expected that clients with less severe problems (indicated by lower BCFPI-3 scores) would be referred into the Brief Service program in comparison to clients triaged into regular Long Term outpatient treatment. This is the expectation of the CCTB service delivery model and expressed intention of the Intake program. This service delivery approach at CCTB is consistent with the existing literature which suggests that a Brief Service intervention is more appropriate for clients with less severe problems and limited co-morbidity (Welfel, 2004). However, no significant differences were found between Brief and Long Term clients in terms of the severity of child mental health issues. This is inconsistent with the stated expectation by the CCTB service delivery model regarding which clients should be placed into Brief Services.

There was also a lack of significant difference between the two types of cases in terms of type of presenting issues reported, with both types of cases having depression, anxiety, parenting issues, and anger/aggression as the most common presenting issues. A unique referral issue referred into Long Term services included suicide ideation. Given the serious nature and risk associated with this presenting problem, it made intuitive sense to seek more intensive interventions for this presenting problem in order to ensure adequate levels of treatment and

relapse management. Conversely, Brief Service clients reported high conflict separation/divorce as a top five referral problem, reflecting a consultation and mediation model for post-divorce family problems and conflicts.

Despite the relative similarity in child mental health issues between service programs, the majority of Long Term cases were rated as Urgent in terms of severity of presenting issue while the majority of Brief cases were rated as Moderate. This particular assessment of case severity was rated by the Intake worker using clinical judgment, while the BCFPI-3 described level of child behavioural and emotional problems as rated by the parent or youth. It appears that the classification of urgency by intake may be based on additional or different factors than that measured by the BCFPI-3. For example, the BCFPI-3 is child focused and does not capture other important areas of functioning such as family relationships, life stress, poverty, and parent functioning. Alternatively, Intake workers may have different opinions of severity of presenting issues than that described by youth and their parents on self-report paper-and-pencil measures. This finding was reinforced by the logistic regression results that found Urgency level to distinguish between Brief and Long Term cases. Thus, if the presenting issues are relatively less severe, as provided by self-reports, it does not guarantee that they will be directed to Brief Service. It is other unknown factors, based on clinical judgment, which appear to lead to decisions regarding the intensity of services received. It is not clear if this is standardized or applied consistently across the therapists who make up the Intake team. If it is based solely on clinical judgment, there may be a risk of subjectivity and inconsistency in how severity is determined and which treatment program clients will then receive.

These results may also suggest that a drift in Intake screening criteria has occurred. Further clarification of the criteria may be needed to ensure that clients are appropriately

assigned to Brief and Long Term Services. Moreover, multiple screening measures at the Intake level appear to be beneficial when deciding if a client is more appropriate for Brief or Long Term Service. This may aid in determining more standardized screening criteria at Intake and the possible development of a motivation/treatment readiness measure or clearer criteria regarding the severity of presenting problems.

Question 2: Treatment Approaches and Therapeutic Strategies Used

When investigating the characteristics of Brief Service, it was noted that close to 50% of sessions involved the family, which included having at least one parent or caregiver with the child in the therapy sessions. In addition, when presenting issues were investigated during the first session of Brief Service, it was found that parent-child conflict, dealing with high conflict separation/divorce, family relationship issues (e.g., separation, step/blended family, alternative care), and child anxiety symptoms were the most commonly endorsed by clients. Thus, the majority of Brief Service cases involved child internalizing issues and parenting concerns.

When analyzing practice elements or treatment strategies used within each session, it was found that different practice elements were utilized according to the session number and ultimately the client's stage in therapy. It was found that most practice elements were utilized in session one, with relationship/rapport building, family engagement, and supportive listening being the most common. Reframing and emotional coping skills were commonly utilized for sessions two, three, and four. It made sense that relationship and rapport building and supportive listening were implemented the most in the first session, due to the fact that these elements aid in the development of a strong therapeutic alliance, which is associated with improved client outcomes (e.g., Searle et al., 2011). In fact, the development of the therapeutic alliance was evident in the current study from the increased concordance in therapist and client ratings of

alliance from session one to session two. This highlights the fact that the client and therapist are quickly getting "in-synch" with each other early in the therapy process. It also makes sense that family engagement is commonly addressed in the first session, due to the large amount of family-related presenting issues seen in Brief Service.

If the client progressed to further sessions, other concrete tools were implemented to target the client's presenting issues, such as learning emotional coping skills and how to challenge cognitions. Overall, it appeared that emotional coping skills were the most consistently used strategy in the sessions. Specifically, emotion-focused coping can include strategies such as maintaining a sense of humor or being optimistic, where one's perception of a situation changes (Folkman & Lazarus, 1980). Interestingly, there was a lack of maintenance or relapse prevention strategies being implemented in later sessions. This may limit the ability of clients to maintain the treatment gains obtained through intervention. Inclusion of a three or six month follow-up with clients to determine if treatment changes were maintained may be helpful to determine if this is a gap in the service model.

Next, practice elements were compared based on corresponding presenting issues for session one, including externalizing, internalizing, parent/family, parent relationship and "other" issues. It was interesting to find that problem solving skills were one of the top five practice elements utilized for four of the five categories of presenting issues, including Externalizing, Internalizing, Parenting and Family Issues, and Parent Relationship Issues. Reframing was also in the top 5 practice elements for three of the five categories of presenting issues (Internalizing, Parenting and Family Issues, and Parent Relationship Issues). Several differences were also noted between sessions one and two, indicating a change in treatment process. For instance, techniques that fostered the therapeutic relationship were utilized for all categories of presenting

issues for session one, such as relationship and rapport building, supportive listening and family engagement. Across all types of presenting issues, the second session typically involved techniques that engaged the client and challenged their current way of thinking, such as reframing, challenging cognitions, problem solving, and insight building.

Lastly, while therapeutic techniques such as relationship and rapport building, family engagement, and emotional coping skills can be beneficial and promote client change, it was observed that additional techniques commonly seen in the literature were not used. For instance, exposure techniques have been found to be beneficial in treating anxiety-related issues (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008), yet were not utilized by Brief Service therapists in any of the sessions.

In this respect, the results of the current study were compared to a review of practice elements in the literature from the Children and Adolescent Mental Health Division (CAMHD) of the Hawaiian Department of Health Task Force for Empirical Basis to Services (Figures 8-10; Chorpita, Daleiden, & Wise, 2009). This comparison was included in order to determine if Brief Service at CCTB utilized similar evidence-based strategies as other child and adolescent mental health agencies. The presence or absence of practice elements in successful mental health treatments for youth was based on ratings and reviews of three judges at CAMHD. Fifty-five practice elements from a total of 435 studies were included in the CAMHD evaluation, whereas the current study contained a more select number of 38 practice elements. This article provided a unique comparison of commonly used practice elements across varying child mental health agencies according to several common presenting issues. Interestingly, there was less overlap than expected in practice elements between the CAMHD review of effective treatments and CCTB. However, several differences should be taken into consideration and may account for

this discrepancy. First, the studies that were included in the CAMHD review focused on randomized controlled trials that included psychosocial (non-medication) treatments for youth. Second, the CAMHD review evaluated Long Term treatments as opposed to Brief Service. Third, the CAMHD review did not discuss the level of severity of their mental health issues and therefore may not be comparable to the types of clients seen for Brief Service at CCTB. For future program evaluations, it would be beneficial to interview the therapists to better understand why techniques like exposure were not used and how their theoretical orientation relates to empirically based intervention strategies like practice elements. In addition, the therapists' approach at CCTB may not have been comparable to the current literature regarding practice elements, which is largely based on long term individual therapy. Nevertheless, it would be beneficial to consider how evidence-based practice elements could be incorporated into interventions, including Brief Services.

Question 3: Satisfaction with Brief Service

In general, clients were satisfied with Brief Services. Interestingly, it was reported that parents' needs were addressed slightly more than their children's needs. This may be explained by the fact that the majority of presenting issues dealt with parenting concerns (i.e., parent-child conflict, dealing with high conflict separation/divorce, and family relationship issues). Satisfaction was not related to change scores from measures of child mental health, caregiver strain, depression, anxiety, or stress. However, satisfaction was strongly associated with client-rated overall therapeutic alliance, and more specifically, Tasks and Goals. In addition, most WAI-S scales were significantly correlated with overall satisfaction for the first session. This suggests that the effect of the therapeutic alliance in the first session was sustained and related to client satisfaction at the end of treatment. Furthermore, the lowest rated item on the SQ

pertained to whether or not the client received the type of help they wanted from the service. Perhaps this relates to the clients preferring a change in the content of the service and types of practice elements used. Ultimately, qualitative data relating to client satisfaction was not available to clarify SQ responses.

Hypothesis 1: Effectiveness of Brief Service

The results of this study revealed that less severe parent strain, depression, anxiety, and stress and child mental health issues were reported upon completion of the Brief Service program. This is informative as it suggests that Brief Service is effective in targeting both youth and parent related concerns. This result is consistent with the study of SFBT by Lee (1997) who found improvements in child mental health, parenting skills, and family dynamics following a brief treatment service. However, the Lee (1997) study consisted of an average of 5.5 treatment sessions and was qualitative in nature. Although treatment effect sizes were not included in Lee's study, a literature review by Corcoran and Pillai (2009) reported effect sizes for 10 recent studies conducted on SFBT. Session length ranged from five to seven sessions with presenting issues ranging from child mental health issues, orthopedic rehabilitation, marital difficulties, and care-giving for elderly family members (Corcoran & Pillai, 2009). The closest study to the present study (Corcoran, 2006) included five sessions of family-based SFBT for child behaviour problems, and had an overall effect size of .11. This effect size is lower than the effectiveness reported in the current study based on the BCFPI-3. However, the study by Corcoran (2006) had a nonrandomized treatment control group and did not evaluate other types of mental health issues.

Other studies have provided support for the effectiveness of Brief Services in treating internalizing issues in particular. For instance, Birmaher et al. (2001) and Stice et al. (2008)

reported reductions in symptoms for MDD in youth, although their brief interventions did not consist of four sessions or less. Similarly, Lang (2003) investigated the effectiveness of a brief CBT intervention that was four sessions long and found support for the improvement of depression and anxiety symptoms. However, this latter study did not include externalizing behaviour difficulties or parenting issues for comparison. The meta-analysis conducted by Kim (2008) found that brief service was most effective in treating internalizing issues. However, 45% of the studies included pertained to youth and not all of the studies had an experimental design. In comparison, the current study found significant results for the treatment of both internalizing and externalizing issues.

Therefore, the results of the current study support the limited existing literature that brief service is truly effective and provides meaningful improvements in parent and youth functioning. Thus, Brief Service is an eclectic, cost-effective intervention that can successfully treat a variety of presenting issues. However, there is a lack of literature that is directly comparable in terms of presenting issues, session length, and research design.

Hypothesis 2: Therapeutic Alliance

This hypothesis was partially accepted as therapeutic alliance, as assessed in sessions 1 and 2, was associated with better client satisfaction. It was also found that Task and Goal played more of an influential role than Bond with respect to therapeutic alliance in general. However, ratings of depression, anxiety, stress, and caregiver strain were not related to alliance. Alliance was also not related to improvements in youth mental health functioning for session one, but client WAI-S ratings of Goal was related to changes in youth mental health for session two.

More factors were expected to be associated with therapeutic alliance and positive treatment outcomes due to the fact that decreased mental health issues and caregiver strain, as

well as increased therapeutic alliance, are all associated with positive treatment outcomes in the literature (e.g., Gunlicks & Weissman, 2008; Hawley & Weisz, 2005). However, it is important to note that the current literature on the connection between alliance and treatment outcomes pertains to Long Term Service. For instance, the study by Hawley and Weisz (2005) included 23 treatment sessions. Indeed, the current study is unique in that it is the first to examine the development of therapeutic alliance in Brief Service consisting of four sessions or less. Therefore, further investigation is needed to determine the differences in process issues between Brief and Long Term with respect to therapeutic alliance.

It was interesting that therapist ratings did not relate to client outcomes, thereby enforcing the importance of the client's perspective of the therapeutic alliance. This is consistent with the literature. For example, an outpatient treatment study of adolescents found that adolescent, but not therapist, ratings of alliance were associated with better treatment outcomes (Hawley and Garland, 2008). Although this latter study was not a brief service, it emphasizes the importance of both self- and therapist- report measures in the evaluation process. Likewise, evaluations of a manualized group-based parenting program found that parent, but not therapist, ratings of alliance were associated with treatment outcomes (Schmidt, Chomycz, Houlding, Kruse, & Franks, under review; Kazdin, Whitley, & Marciano, 2006).

When determining the level of agreement with respect to therapeutic alliance ratings, client and therapist ratings were not significantly related to each other for session one. However, alliance ratings between clients and therapists were associated for session two for the majority of subscales. The results suggest that therapeutic alliance builds over time and that only one Brief session may not be enough time for a strong therapeutic relationship to form. For instance, the study on the effectiveness of a parenting program at CCTB found that therapeutic alliance was

related to treatment outcomes, although alliance was measured at session three (Schmidt et al., under review). In addition, other literature regarding mental health interventions for youth typically do not assess therapeutic alliance during session one. For instance, a number of articles by Kazdin and colleagues (Kazdin, Marciano, & Whitley, 2005; Kazdin & Whitley, 2006; Kazdin, Whitley, & Marciano, 2006) investigated the role of therapeutic alliance in a 12-week intervention that included problem solving skills for youth and parent management training. In these studies, therapeutic alliance was measured at the fourth and eighth treatment sessions (i.e., the one-third and two-third stages of treatment). These studies support the evaluation of therapeutic alliance at a later stage in the therapy process.

Hypothesis 3: Parent and Youth Mental Health

Ratings of parent and youth levels of depression, stress, and anxiety prior to Brief Service involvement were not related to changes in child treatment outcomes or changes in caregiver strain. This did not align with the existing literature which suggests that such factors as depression and stress play a role in treatment outcomes (e.g., Beauchaine et al., 2005; Brent et al., 1998). However, the current literature on this topic is far from developed. For instance, the study by Beauchaine et al. (2005) did not include brief service or youth over the age of nine years. Similarly, one study pertaining to parent psychopathology predicting brief service outcomes defined brief service as consisting of 12 to 16 treatment sessions and did not include children under the age of 13 years (Brent et al., 1998). In addition, there is a possibility that the lack of significant results may be explained by the low sample size or lower levels of pre-treatment mental health issues. For example, correlations between DASS-21 measures of depression, anxiety, and stress with CSQ change scores were in the expected direction but did not reach significance. In addition, only 13.1% of Brief Service cases reported severe or

extremely severe levels of depressive symptoms prior to receiving service. Likewise, 28.3% reported similar levels of severe anxiety symptoms and 17.4% reported severe stress. This may also suggest that other factors may play a role in predicting treatment change, both prior to and during treatment, such as type of presenting issue.

Additional Limitations and Future Directions

Several limitations of this study must be noted. Primarily, different treatment modalities were used during the Brief Service, thereby providing a treatment confound. There is no specific treatment model or approach used across the therapists who provide Brief Services. In addition, a large focus of the Brief Service program pertains to adult functioning, therefore, additional parenting factors such as knowledge of the presenting issues, confidence in parenting practices, and a sense of hope for the future should be evaluated in future evaluations. Therapists could also rate more than one presenting issue or practice element per session. This made the results more difficult to interpret. For example, one was not able to determine what practice elements were utilized to target specific presenting issues. As a result, it may be beneficial for future program evaluations that therapists rank order the presenting issues and practice elements in order of frequency of use or importance. Another difficulty was that the Brief Service clients varied in the number of sessions. Therefore, the frequency of presenting issues and practice elements may have been overrepresented if a client had more than one session, identified the same presenting issues, and implemented the same practice elements each time. In order to address this issue in the future, therapists could provide an overall summary of presenting issues and practice elements utilized upon completion of therapy, despite the number of sessions taken. Furthermore, each practice element should be clearly operationalized in order to provide the

most accurate results and "other" endorsements should be explained in further detail for additional information.

Moreover, there was no experimental control of service delivery in order to control for the passage of time as a factor in symptom improvements. It would be interesting to include multi-informant (e.g., observer-rated) measures to this study, in order to gain additional information regarding changes in client functioning, such as level of parenting skill and intensity and severity of mental health issues, as well as the observer-reported therapeutic relationship between the therapist and client. This would address social desirability and shared method variance that could have occurred when completing the measures in this study. Specifically, clients may have been influenced by social desirability, due to the fact that the majority of SQs were completed in the presence of the therapist. In addition, SQs contained the client's name and completed SQs were given to the therapist without an envelope. Shared method variance may have contributed to the strong relationship between satisfaction and therapeutic alliance that was found, as both measures were completed by the same informant. A follow-up study should also include a larger sample of participants so that additional and more sophisticated analyses could be completed to better understand the process of treatment change. Likewise, future studies should develop separate parent and adolescent outcome measures to determine if any unique effects are seen. Lastly, although Brief Service completers had less severe presenting issues when compared to Brief Service dropouts, the study's results should only be generalized to future Brief clients with similar presenting issues. It is not clear how the results may have differed if Brief Service clients with more severe presenting issues had been included.

Conclusion

In summary, the CCTB Brief Service program was found to be effective in reducing child and parent mental health issues and caregiver strain. Clients were also satisfied with their overall experiences at CCTB. Thus, Brief Service can be beneficial in community-based clinics for treating a variety of presenting concerns. In addition, the study identified several factors that should therefore be taken into consideration when conducting Brief Services, such the importance of therapeutic alliance and how it develops over time. Moreover, the evaluation of Brief Services for children and adolescents in a community-based setting allowed for the identification of possible areas of improvement of services. For example, developing more explicit criteria for how cases are assigned to either Brief or Long Term Services. This has broader implications for service delivery within all children's mental health clinics. Furthermore, the optimal distribution and utilization of limited mental health resources can be better understood, which will ultimately benefit youth in need of treatment.

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Figure 1

Percentage of Presenting Issues in Session One

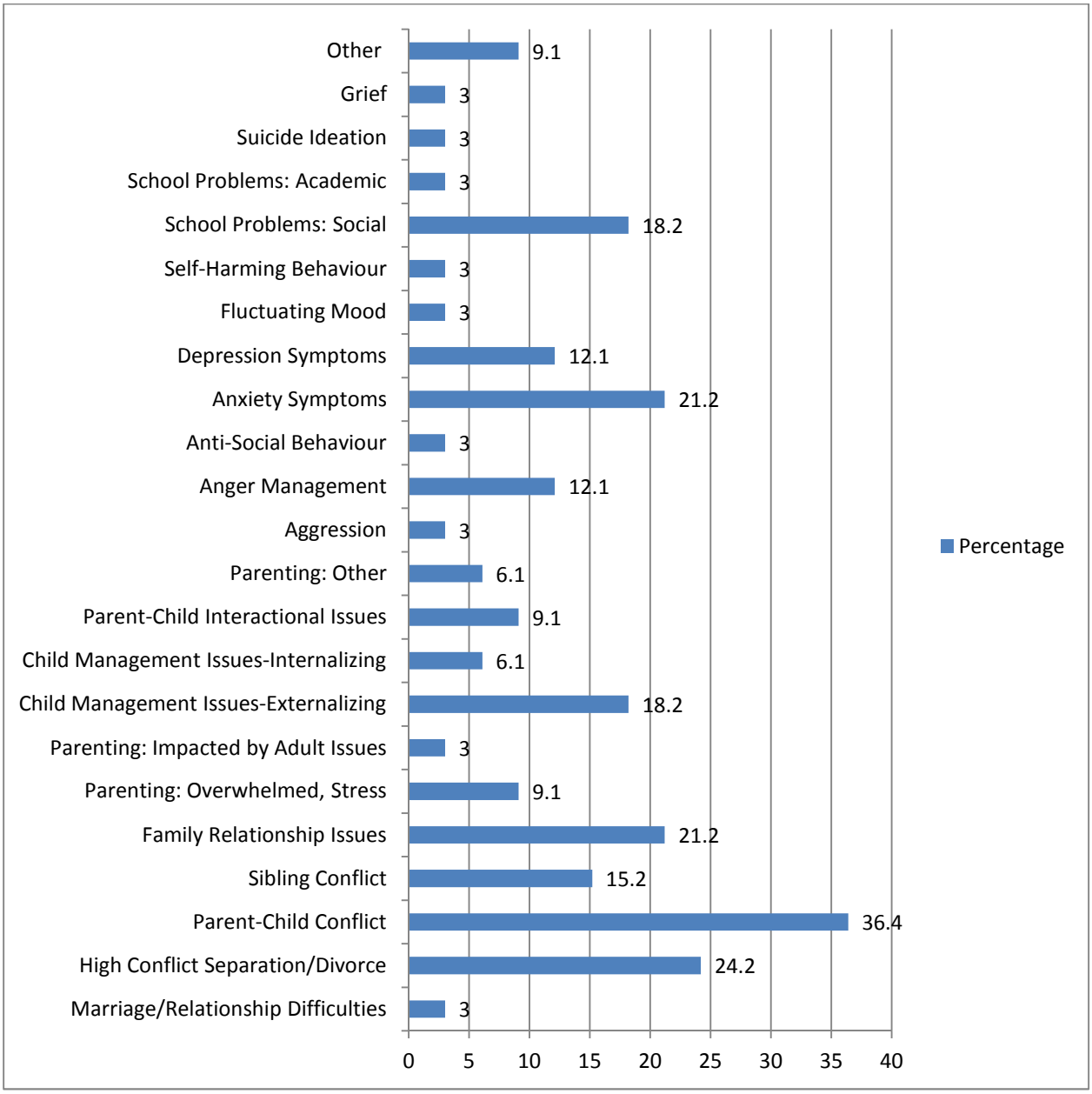
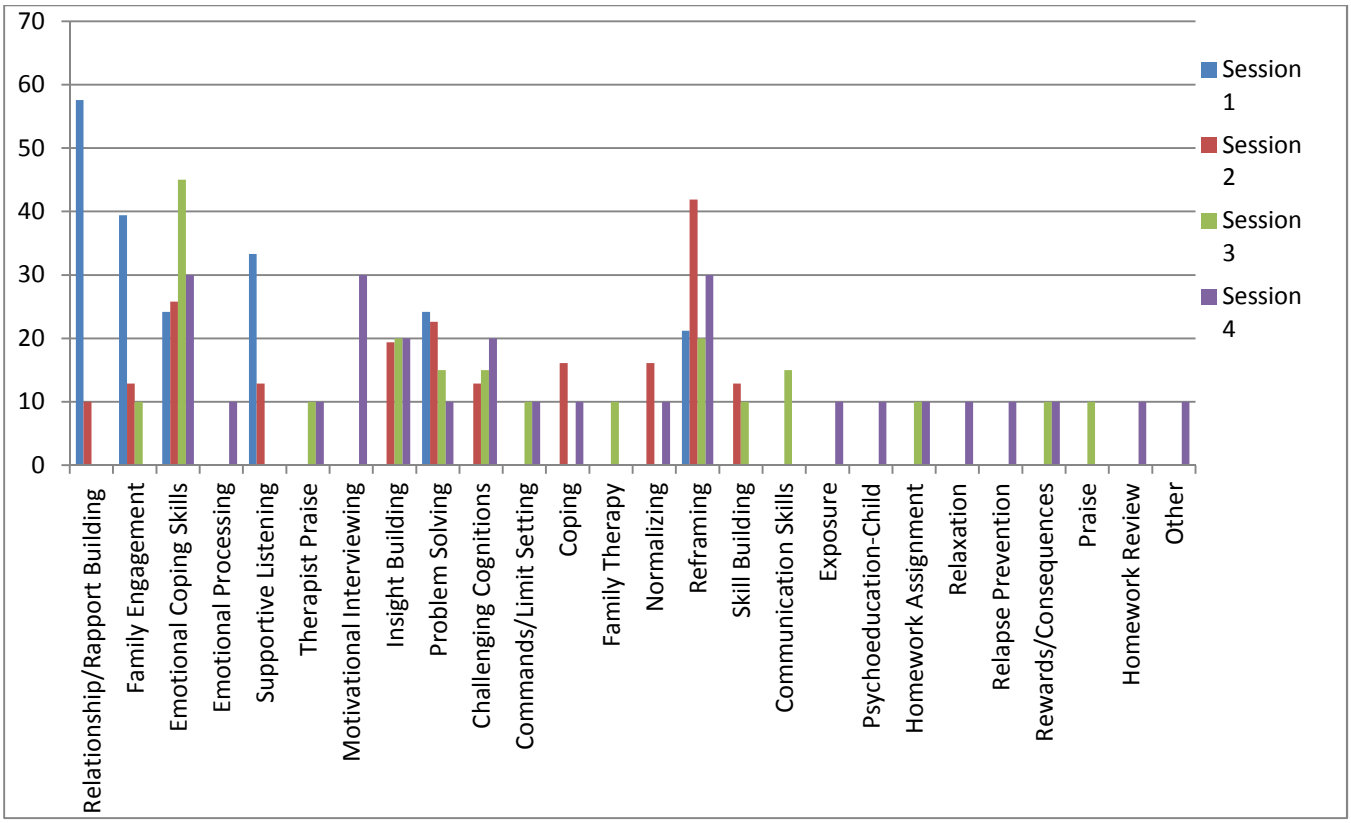


Figure 2

Percent of Practice Elements Used for All Brief Sessions



Note. Only practice elements utilized 10% of the time or more for any session are included in this figure.

Figure 3

Top Practice Elements Used in Sessions One and Two for Clients with Externalizing Issues

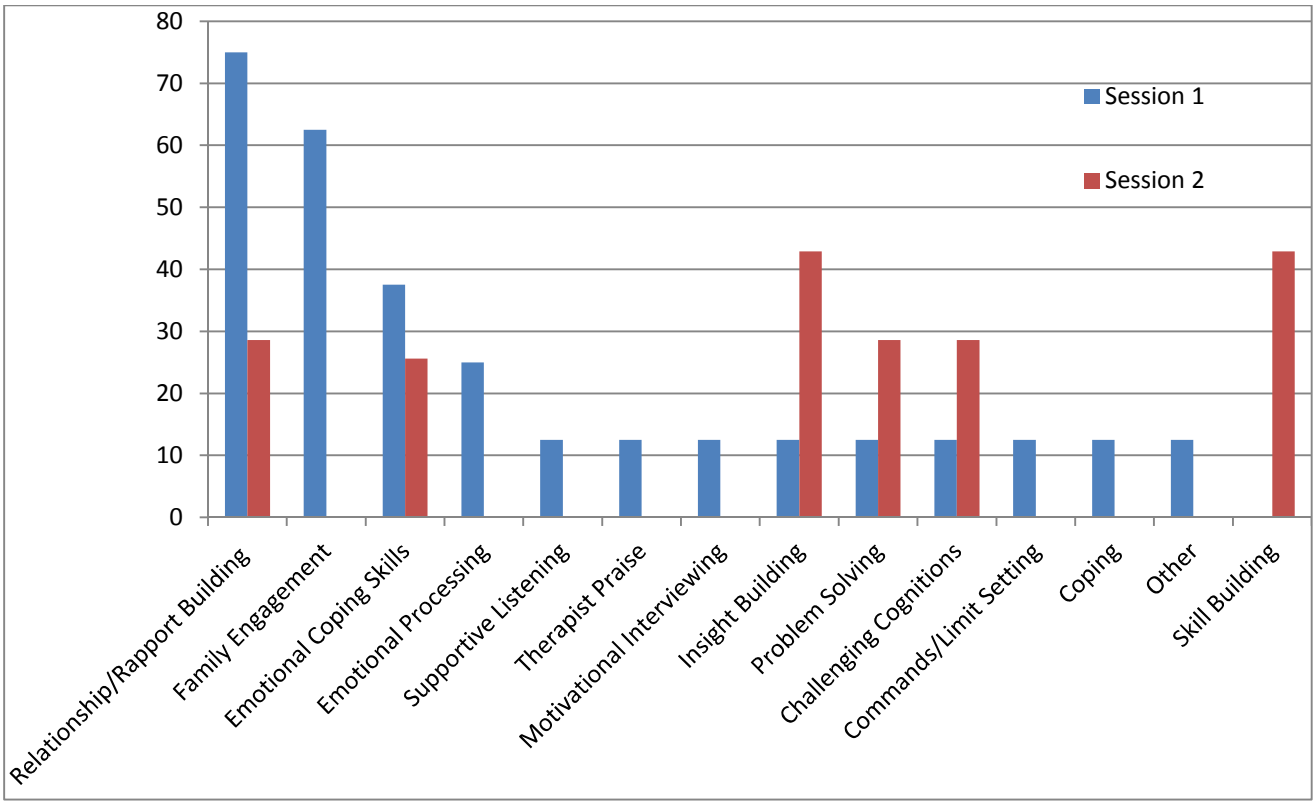


Figure 4

Top Practice Elements Used in Sessions One and Two for Clients with Internalizing Issues

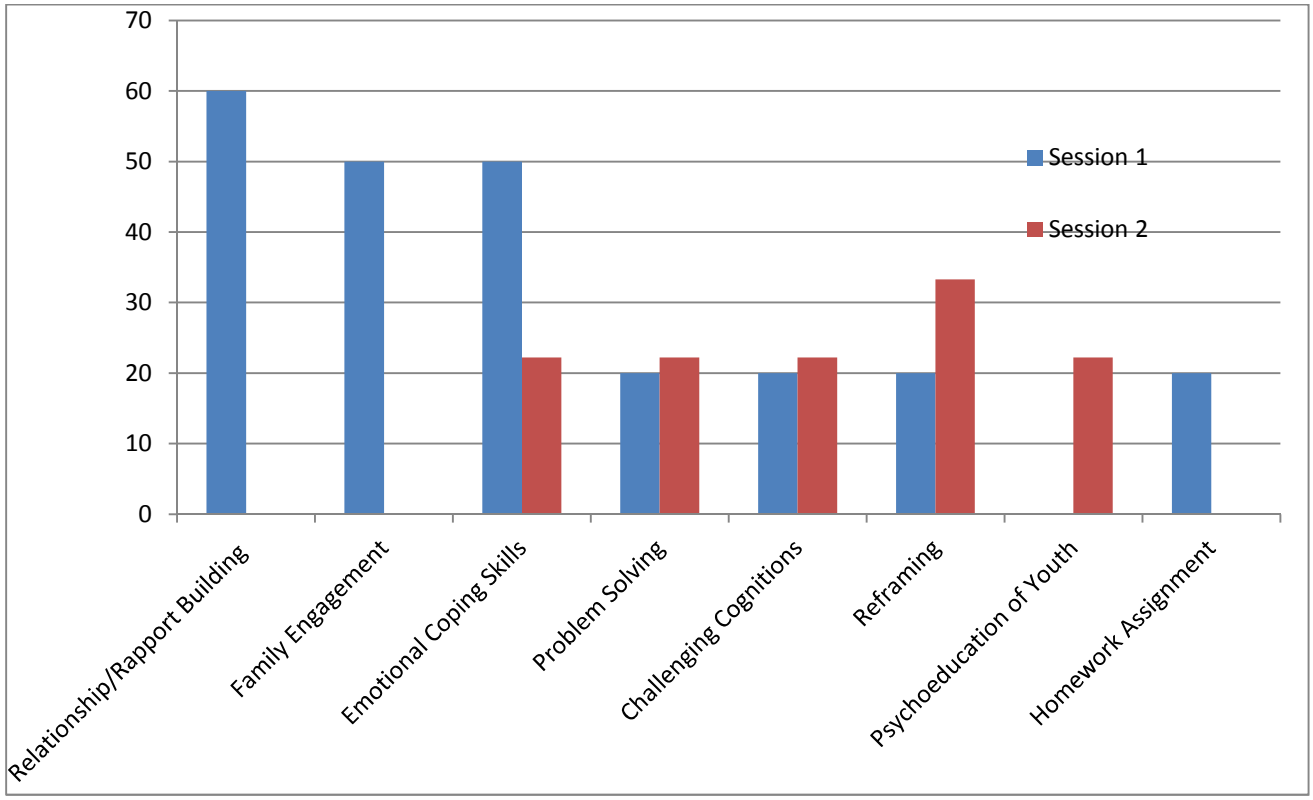


Figure 5

Top Practice Elements Used in Sessions One and Two for Clients with Parenting/Family Issues

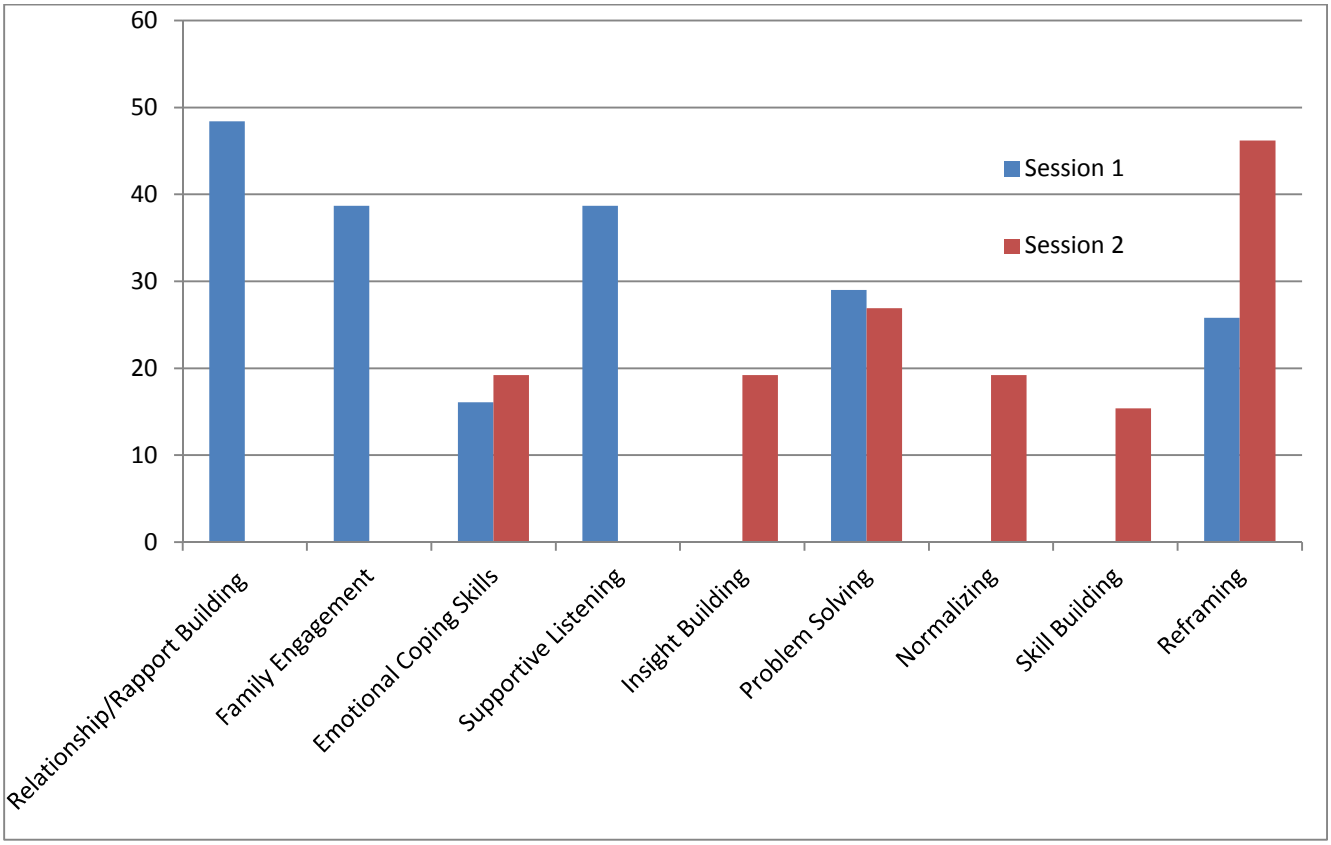


Figure 6

Top Practice Elements Used in Sessions One and Two for Clients with Parent Relationship Issues

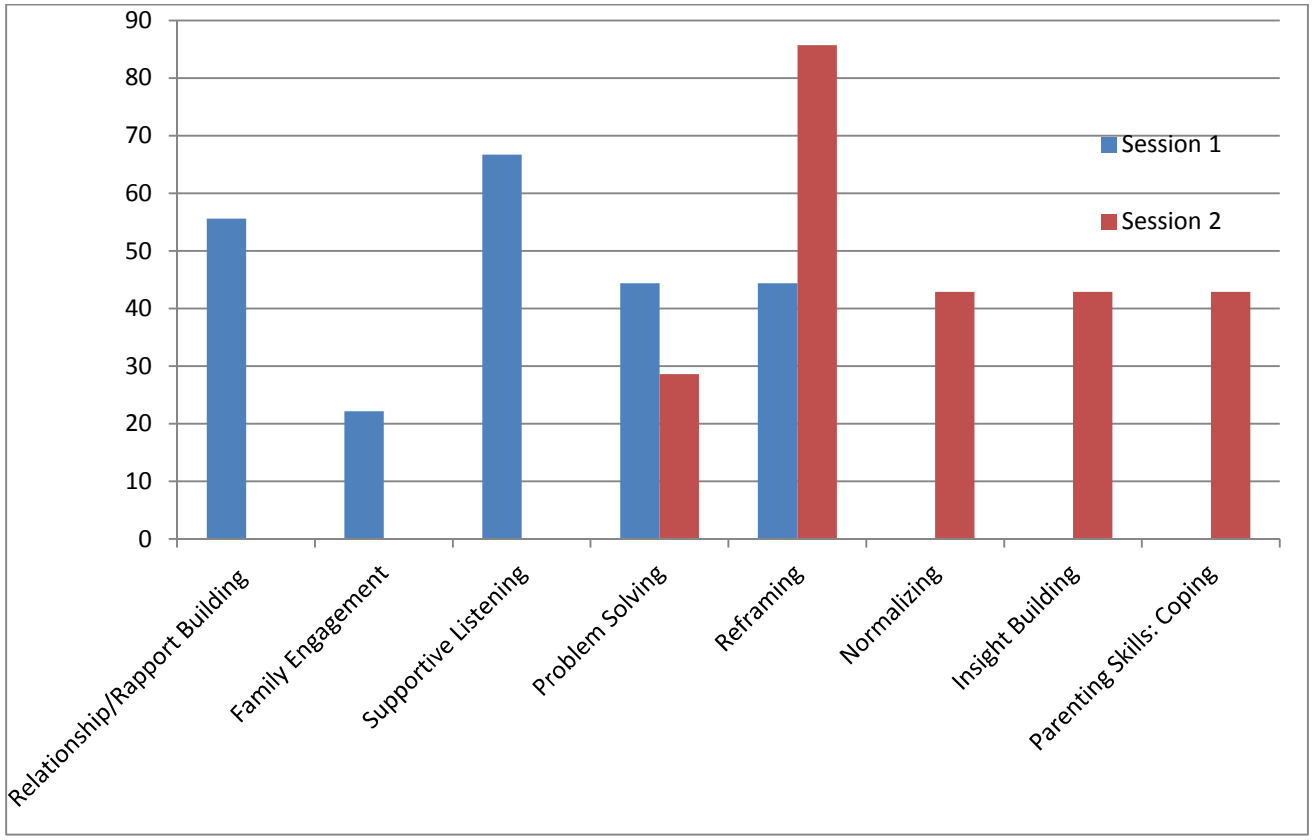


Figure 7

Top Practice Elements Used in Sessions One and Two for Clients with Other Issues

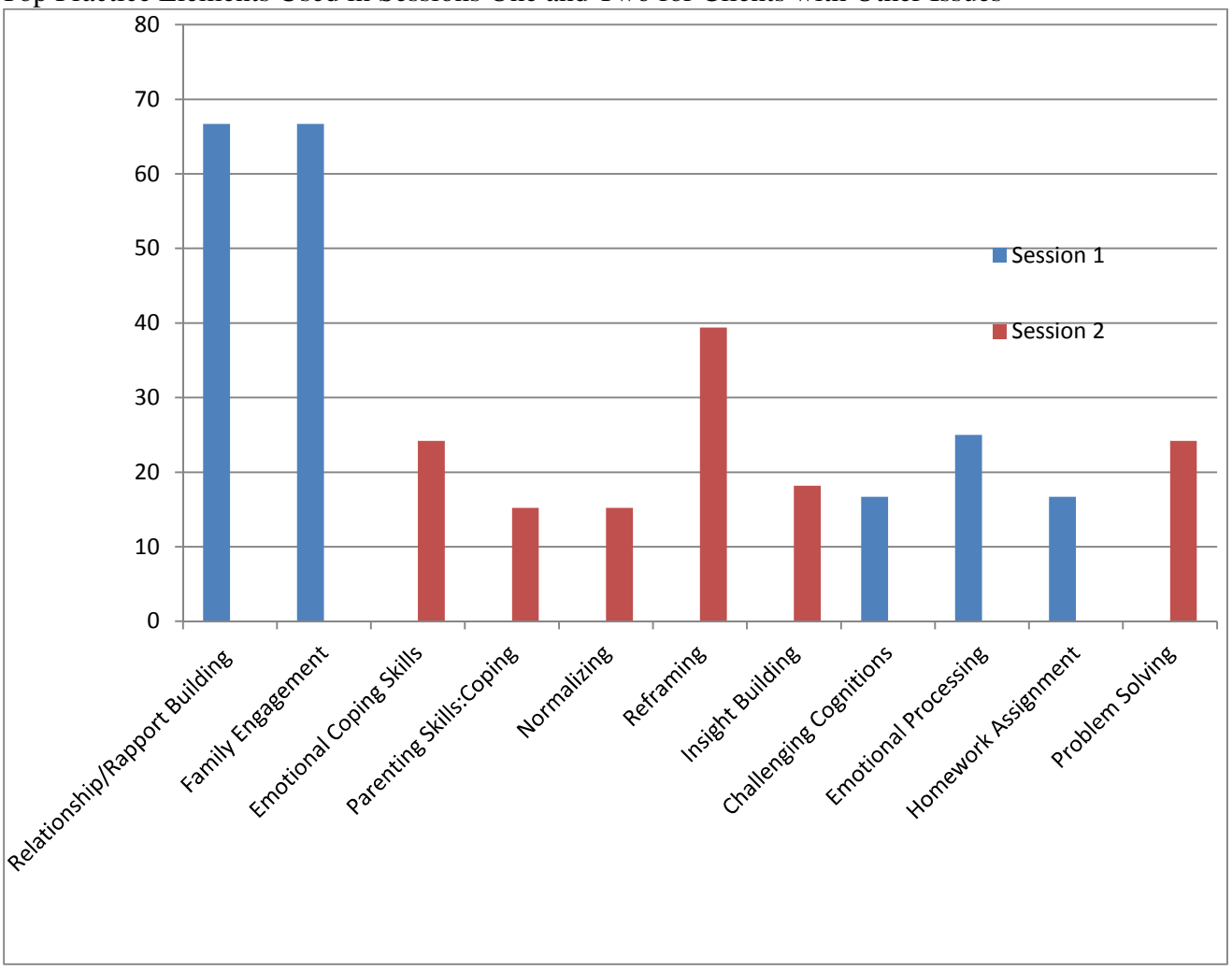


Figure 8

Percentage of Top Five Practice Elements Utilized at Children's Centre Thunder Bay (CCTB) and Children and Adolescent Mental Health Division (CAMHD) for Anxiety

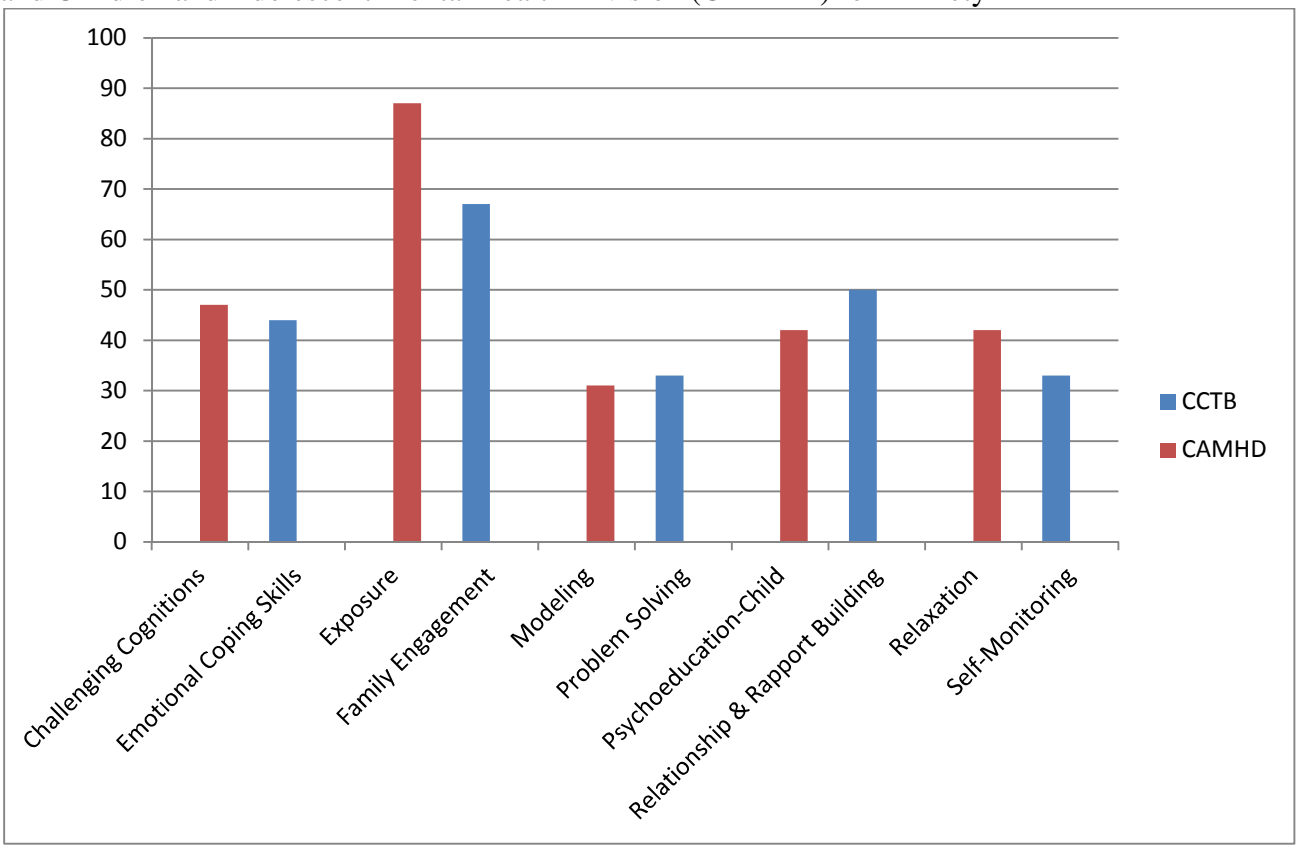


Figure 9

Percentage of Top Five Practice Elements Utilized at Children's Centre Thunder Bay (CCTB) and Children and Adolescent Mental Health Division (CAMHD) for Depression

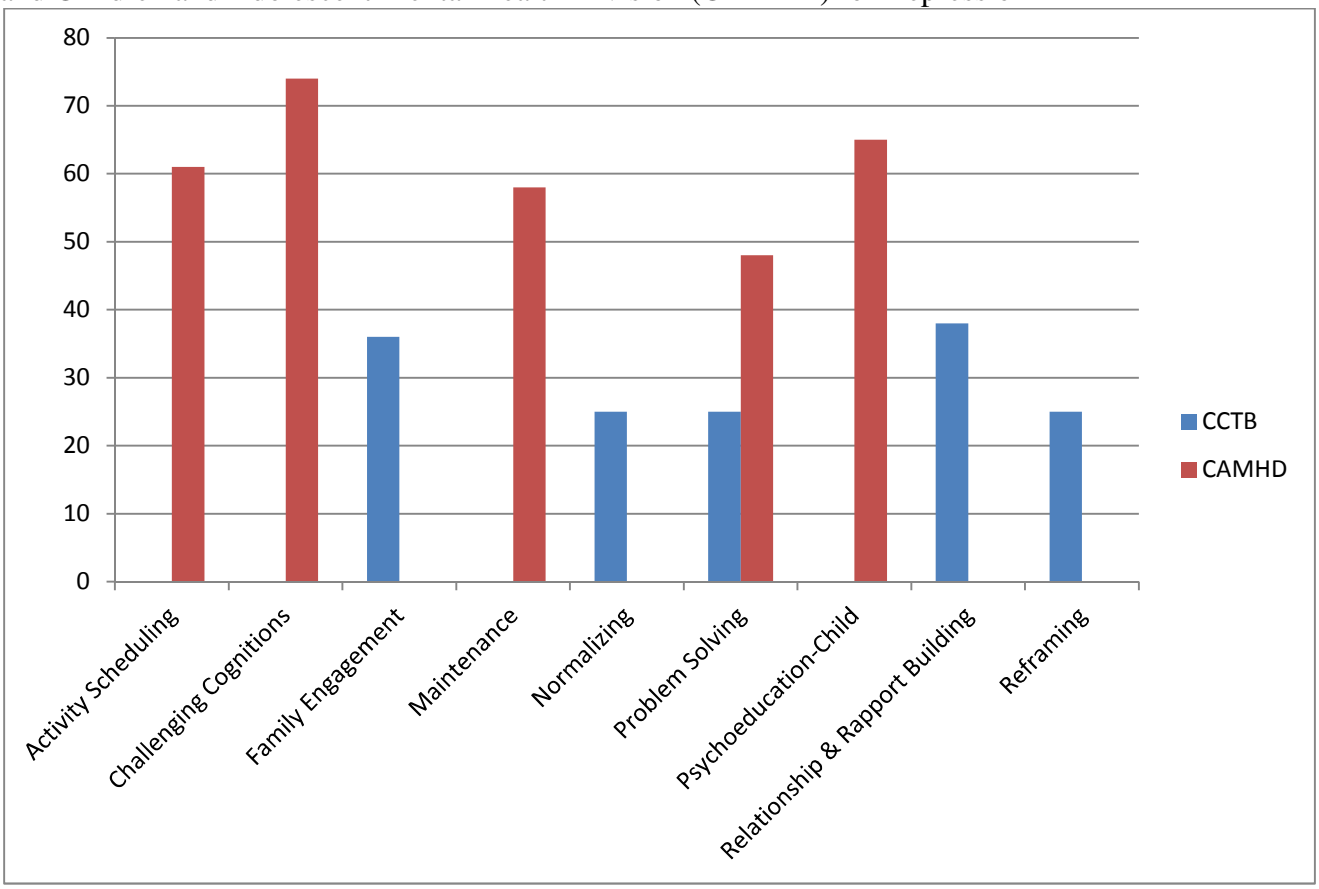
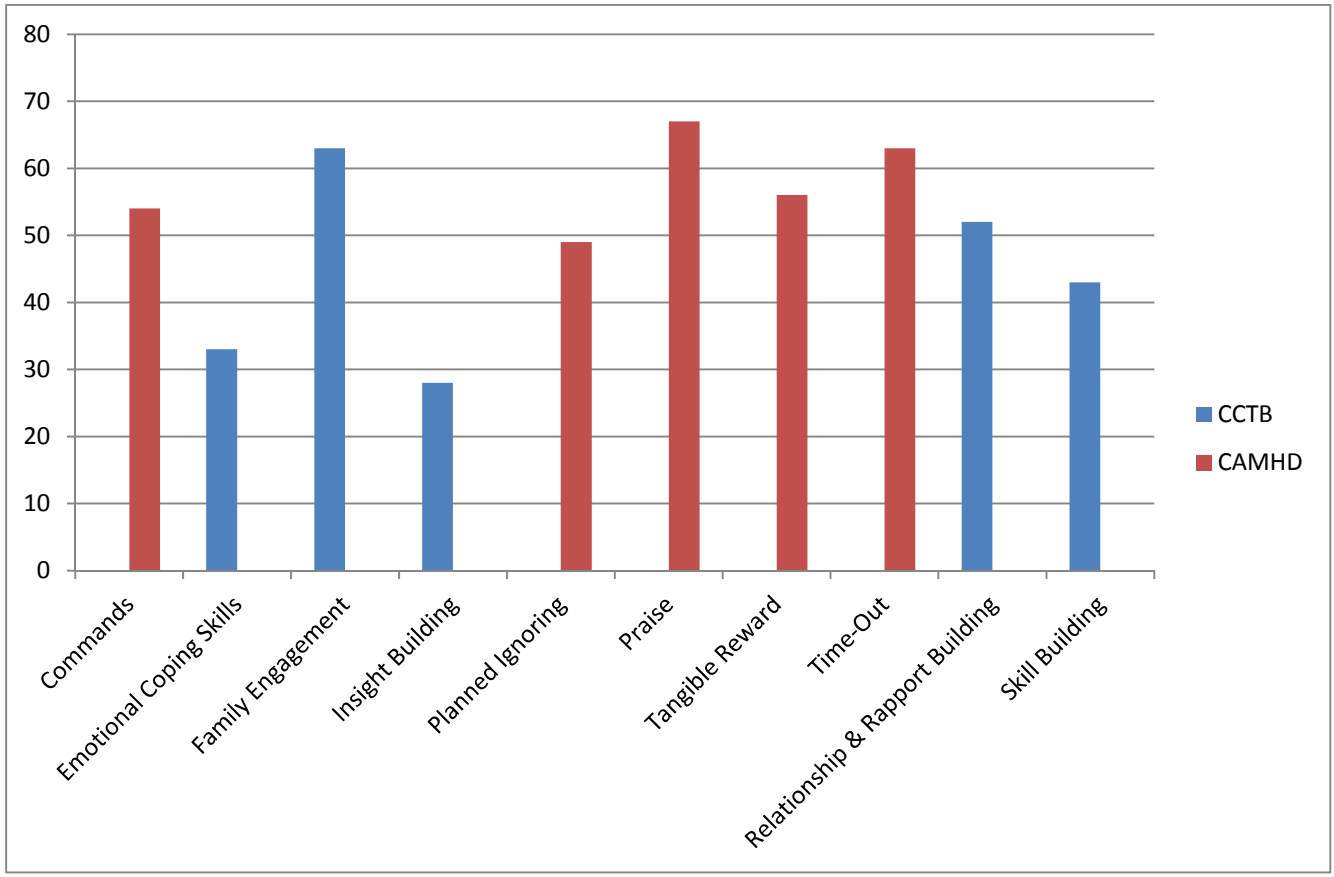


Figure 10

Percentage of Top Five Practice Elements Utilized at Children's Centre Thunder Bay (CCTB) and Children and Adolescent Mental Health Division (CAMHD) for Delinquency and Disruptive Behaviours



Note. Delinquency and disruptive behaviours include the following presenting issues for CCTB: Aggression, anger management, anti-social behaviours, criminal activities, high risk behaviours, self-harm behaviours, sexual offending, and suicide ideation/attempt.

Table 1

Demographic Characteristics of Brief Service Clients (n = 33)

Variable	*n*	%
Referral Type		
New Referral	18	54.5
Re-Referral	15	45.5
Urgency Level		
Moderate	23	69.7
Urgent	10	30.3
Severe	0	0
Critical	0	0
Number of Sessions		
1	1	3.0
2	12	36.4
3	9	27.3
4	11	33.3
Type of Client		
Parent	19	57.6
Adolescent	14	42.4

Table 2

Structure of Data Collection

Intake interview	After each session	End of service
BCFPI-3[1] (Parent or Youth)	Treatment Summary (Therapist)	BCFPI-3 (Parent or Youth)
Intake Assessment Rating Guidelines (Intake)	WAI-S[3] (Therapist and Parent or Youth)	SQ[4] (Parent or Youth)
DASS-21[2] (Parent or Youth)		DASS-21 (Parent or Youth)
Caregiver Strain Questionnaire (Parent)		Caregiver Strain Questionnaire (Parent)

Note. [1] Brief Child and Family Phone Interview; [2] Depression, Anxiety, Stress Scales; [3]Working Alliance Inventory (Short Form); [4] Client Satisfaction Scale.

Table 3

Psychometric Properties of the Scales Used

	Pre-Treatment (n = 33)			Post-Treatment (n = 33)		
Scale	*M*	*SD*	Cronbach's α	*M*	*SD*	Cronbach's α
CGSQ	54.39	17.86	.95	47.50	20.68	.96
SQ	--	--	--	43.12	9.28	.92
DASS-21	33.00	24.71	.82	19.32	14.44	.80
WAI-S						
Session 1	46.38	9.17	.91	59.67	9.54	.89
Session 2	51.26	8.81	.95	63.68	10.36	.92
Session 3	48.82	8.21	.91	61.58	11.47	.93
Session 4	51.89	7.88	.93	62.80	11.55	.95

Note. DASS-21= Depression, Anxiety, Stress Scale; CGSQ= Caregiver Strain Questionnaire; SQ= Client Satisfaction Questionnaire; WAI-S= Working Alliance Inventory. Psychometric properties for the WAI-S reflect client and therapist –rated therapeutic alliance, respectively.

Table 4

Comparison of BCFPI-3 Scores for Clients in Brief and Long Term Services

Scales	Brief (n = 82)		Long Term (n = 78)				
	M	*SD*	*M*	*SD*	*df*	*t*	*p*
RaP	58.33	14.93	58.55	17.04	158	.09	.930
RAIp	51.15	17.45	54.77	16.06	158	1.36	.174
RAIAp	56.74	14.01	58.36	15.41	158	.69	.489
Cop	59.06	15.01	56.99	16.96	158	-.82	.413
CDp	53.32	19.03	52.28	16.31	158	-.37	.713
Exp	56.72	17.94	58.23	15.90	158	.56	.574
SPp	53.54	14.85	55.65	14.65	158	.91	.365
Map	55.45	16.26	55.63	14.64	158	.27	.792
MMp	53.49	15.58	55.04	17.68	158	.59	.557
SHp	52.79	15.92	55.63	17.95	158	1.06	.292
INp	55.32	15.66	56.62	17.86	158	.49	.625
TMHP	57.54	14.95	58.00	17.62	158	.18	.858
PeerP	28.18	28.51	25.83	28.39	158	-.52	.602
AdschP	27.50	27.97	24.10	24.98	158	-.81	.420
SocPartP	25.16	31.44	25.91	30.76	158	.15	.879
QRelP	24.82	26.68	23.31	25.84	158	-.37	.715
SchooP	28.27	29.14	23.25	27.05	158	-1.13	.262
ChFP	53.42	14.24	48.81	16.64	158	-1.88	.061

FActP	26.37	30.40	28.42	34.35	158	.40	.688
FcfP	25.45	28.36	26.81	29.47	158	.30	.767
GfsP	26.40	29021	26.55	32.03	158	.03	.976

Table 5

Summary of Logistic Regression Comparing Brief and Long Term Clients (N = 160)

Variable	*B*	*SE*	Wald statistic	*p*
Sex	-.47	.41	1.35	.246
Age	.09	.09	.99	.319
Urgency Level	2.57	.43	35.16	.000
Internalizing	-.01	.02	.15	.694
Externalizing	-.01	.01	.11	.738
Managing Mood	.01	.02	.08	.781
Conduct	.01	.01	1.04	.307
Global Family Functioning	-.01	.01	1.02	.313

Table 6

Percentage of Practice Elements Utilized in Sessions One Through Four

Practice Element	Session 1 (n = 33)	Session 2 (n = 31)	Session 3 (n = 20)	Session 4 (n = 10)
Relationship/Rapport Building	**57.6**	9.7	0	0
Family Engagement	**39.4**	12.9	10	0
Supportive Listening	**33.3**	12.9	4.8	0
Emotional Coping Skills	**24.2**	**25.8**	**45**	**30**
Problem Solving	**24.2**	**22.6**	**15**	10
Reframing	**21.2**	**41.9**	**20**	**30**
Therapist Praise	6.1	3.2	10	10
Normalizing	9.1	**16.1**	0	10
Homework Assignment	9.1	6.5	10	10
Emotional Processing	9.1	3.2	0	10
Family Therapy	6.3	9.7	10	0
Motivational Interviewing	6.1	0	5	**30**
Insight Building	6.1	**19.4**	**20**	**20**
Challenging Cognitions	6.1	12.9	**15**	**20**
Coping	6.1	**16.1**	5.3	10
Self-Monitoring	6.1	3.2	5	0
Psychoeducation-Child	6.1	9.7	5	10
Other	6.1	3.2	5	10
Commands/Limit Setting	3	3.2	10	10
Skill Building	3	12.9	10	0
Assertiveness Skills	3	0	5	0
Exposure	3	0	5	10
Modeling	3	0	0	0
Monitoring Youth	3	0	0	0
Educational Support	3	0	0	0
Communication Skills	0	6.5	**15**	0
Crisis Management	0	3.2	5	0
Social Skills	0	0	5	0
Relaxation	0	0	0	10
Psychoeducation-Parent	0	6.5	0	0
Relapse Prevention	0	0	5	10
Rewards/Consequences	0	3.2	10	10
Praise	0	0	10	0
Homework Review	0	3.2	0	10

Note. Top practice elements for each session in bold.

Table 7

Average Scores for the Satisfaction Questionnaire (n = 33)

Question	*M*	*SD*
1. How would you rate the overall quality of the service you received?	5.27	1.07
2. Did you receive the type of help you wanted from the service?	3.58	1.66
3. To what extent has the service met your child's needs?	4.31	1.51
4. To what extent has the service met your needs?	4.82	1.18
5. How satisfied were you with the amount of help you received?	3.94	1.39
6. Has the service helped you to deal more effectively with your child's behaviour?	4.92	1.08
7. Has the service helped you to deal more effectively with the problems you came to work on?	4.92	1.12
8. In an overall sense, how satisfied are you with the service you received?	5.08	1.23
9. If you were to seek help again, would you come back to the Children's Centre?	5.27	1.12

Note. Responses range from 1 to 6.

Table 8

Correlations between Satisfaction and Client Ratings of Therapeutic Alliance for All Sessions

WAI-S Scale	Session 1 (n = 33)	Session 2 (n = 31)	Session 3 (n = 20)	Session 4 (n = 10)
Goal	.50**	.29	.28	.21
Task	.45**	.41*	.55*	.31
Bond	.06	.27	.24	.10
Total Score	.40*	.38*	.39*	.82**

*p < .05. **p < .01. ***p < .001.

Table 9

Summary of Effectiveness on Outcome Measures (n= 33)

	Pre-Tx		*Post-Tx*				
Measure	*M*	*SD*	*M*	*SD*	*df*	*t*	*ES (r)*
BCFPI-3							
Total	58.30	12.71	51.03	16.19	32	2.31*	.50
Externalizing	57.06	17.22	47.16	26.08	32	2.07*	.46
Internalizing	57.00	13.61	44.46	23.87	32	2.68*	.67
DASS-21							
Depression	10.00	9.37	5.76	5.56	32	2.94**	.57
Stress	14.24	9.30	8.85	5.80	32	3.92***	.71
Anxiety	8.94	9.19	4.65	5.45	32	3.40**	.59
Total Score	54.56	18.06	47.62	20.38	32	4.10***	.36
Caregiver							
Strain	54.56	18.06	47.62	20.38	18	2.22*	.36

Note. An effect size of .2 is considered small, .5 is moderate, and .8 is large.
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 10

Correlations between Therapeutic Alliance and Outcome Measures for Session One (n = 33)

	Client				Therapist			
Treatment Change	Goal	Task	Bond	Total	Goal	Task	Bond	Total
Caregiver Strain	.18	.10	.17	.23	-.13	-.09	.10	-.09
BCFPI-3 Total	.10	.12	.15	.12	-.17	-.13	-.03	-.08
DASS-21								
Depression	.04	-.15	-.02	-.01	-.08	.00	.02	-.01
Stress	-.03	.00	.12	.04	-.15	-.18	-.15	-.16
Anxiety	-.11	-.18	.07	-.02	-.16	-.19	-.22	-.17
Total	-.04	-.13	.07	.01	-.15	-.13	-.13	-.13
Satisfaction	.50**	.45**	.06	.40*	-.13	-.06	.09	-.01

*$p < .05$. **$p < .01$.

Table 11

Correlations between Therapeutic Alliance and Outcome Measures for Session Two (n = 31)

	Client				Therapist			
Treatment Change	Goal	Task	Bond	Total	Goal	Task	Bond	Total
Caregiver Strain	-.06	.21	.23	.25	-.24	-.21	-.27	-.26
BCFPI-3 Total	.48**	.22	.26	.31	.20	.19	.07	.18
DASS-21								
Depression	-.27	-.09	.03	-.07	.03	.11	.20	.12
Stress	-.22	-.10	-.05	-.10	-.11	-.07	.04	-.06
Anxiety	-.26	-.15	-.05	-.11	.11	.12	.17	.14
Total	-.30	-.13	-.02	-.11	.01	.06	.16	.08
Satisfaction	.29	.41*	.27	.38*	.17	.24	.07	.18

*$p < .05$. **$p < .01$.

Table 12

Correlations between Therapist and Client Ratings of Alliance over Time on the WAI-S

Session	*Subscale*			
	Goal	*Task*	*Bond*	*Total*
1 (n = 33)	-.05	.23	-.03	.02
2 (n = 31)	.50**	.35*	.21	.40*

*$p < .05$. **$p < .01$.

Table 13

Correlations between Pre-Treatment Parent and Youth Mental Health, BCFPI-3 Treatment Change, and Change in Caregiver Strain (n = 33)

Treatment Change	*Depression*	*Anxiety*	*Stress*	*Total*
Caregiver Strain	-.13	-.21	-.23	-.21
BCFPI-3 Total	-.03	.03	.05	.01

Appendix A

Brief Services, 1-15 Sessions

Author(s)	# Sessions	Population: presenting problem, age, N	Theoretical orientation/design	Measures	Outcome	Limitations
Birmaher et al., 2000	12-16	N=107, youth 13-18years with MDD	brief CBT, brief systemic-behavioural family therapy, or brief supportive therapy	Kiddie Schedule for Affective Disorders and Schizophrenia, BDI, Children's Global Assessment Scale, Children's Negative Cognitive Error Questionnaire, Beck Hopelessness Scale, Conflict Behavior Questionnaire, the Areas of Change Questionnaire, FAD	80% of sample no longer met criteria for MDD. No long term differences were seen on the three types of brief therapies after approximately eight months	No control group
Clarke et al., 2001	15	N=94, youth 13-18 years with subdiagnostic levels of depressive symptoms	RCT; brief group CBT or TAU	CBCL, K-SDAS-E, CES-D, HAM-D, GAF	brief CBT reduced depressive symptoms and frequency of depressive episodes to levels comparable to a nonclinical community sample. In addition, 9% of the CBT group as opposed to 29% of the control group developed MDD at a 15 month follow up	Small sample, mostly female
Ferrero et al., 2007	10-15	N=87 adults with GAD	Brief psychodynamic psychotherapy, anti-anxiety medication, or a combination of both; naturalistic	HAM-A, HAM-D, Clinical Global Impression, Social and Occupational Functioning Assessment Scale,	Overall scores of anxiety, depression, and social and occupational functioning increased, and this improvement was comparable among all three treatment conditions	Lack of control group, small sample size, lack of consistent treatment length throughout study

Girling-Butcher & Ronan, 2009	8	8-11 yr old children with anxiety disorders; N=4	Brief CBT; modified single case design; multiple baselines	Anxiety Disorders Interview Schedule For Children, Revised Children's Manifest Anxiety Scale, State-Trait Anxiety Inventory for Children, Children's Depression Inventory, Coping Questionnaire – Child and Parent, Negative Affect Self-Statement Questionnaire, CBCL/4–18 — Parent and Teacher Forms, State-Trait Anxiety Inventory for Children — Modification of Trait Version for Parents	Therapy led to increase in functioning; no longer qualified for diagnosis of anxiety disorder at post-treatment, 3 and 12 month follow ups	Larger & more diverse sample needed
Cocciarella, Wood, & Low (1995)	7	N=7, children ages 6-11 years with ADHD	Behaviour therapy (reinforced positive behaviours, skills training); no control group	Attention Deficit Disorder Evaluation Scale	Significant decreases in impulsivity	Low sample size, no control group
Lee, 1997	M=5.5	N=59; children 4-17 years of age and their families; most common issues included family/school problems, behaviour problems at home, emotion regulation	SFBT; individual or team therapy (one therapist with family and other therapists behind 1 way mirror); uncontrolled study	Exception questions (de Shazer, 1985; ex. "When don't you have this problem?"), outcome questions (de Shazer & Molnar, 1984; ex. "If a miracle happened … and your problem was resolved, what would be the first small sign that tells you that a miracle has happened?"), coping questions (Berg, 1994; ex. "How come things aren't worse?"), scaling questions (Berg, 1994; ex. "Rank progress on scale from 1-10, where 1 is poor and 10 is good")	Improved family relationships, behaviour at home, parenting skills, child coping skills for both individual and team therapies	Lack of control group
Wood, Harrington, & Moore, 1996	5-8	N=53, children ages 9-17 years with depressive disorders	Random assignment to brief CBT or control	Antisocial Behaviour Scale, Clinical Global Improvement	CBT group had better outcome overall and less depressive	Sample not include comorbidity/thos e taking

		according to K-SADS	(relaxation training)	Scale, Global Assessment Scale, K-SADS, Mood and Feelings Questionnaire, Revised Children's Manifest Anxiety Scale, Social Adjustment Inventory for Children and Adolescents, Warr and Jackson Self Esteem Scale	symptoms (short term improvement); no difference between treatments on anxiety or conduct symptoms; at 6 mo. Follow-up, group differences reduced due to high relapse from those in treatment condition and the fact that those in relaxation group continued to recover	antidepressants so may not apply to more severe MDD cases
Stice, Rohde, Seeley & Gau, 2008	6	N=341, high risk teens 14-19 years old with elevated depressive symptoms (28% received treatment for emotional/behavior problems 1 yr before study)	RCT; brief group CB, group supportive-expressive intervention (based on non-directive supportive psychotherapy), bibliotherapy (CB based self-help book), or assessment-only control	K-SADS, BDI, Social Adjustment Scale-Self Report for Youth, Eating Disorder Diagnostic Interview	CB group had greatest reductions in depressive symptoms and greatest improvement in social adjustment; all therapies reduced risk for MDD at 6 month follow-up versus control	Relied on youth self-report (more confidence with multiple informants); did not exclude teens with previous depressive episodes
Searle, Lyon, Young, Wiseman & Foster-Davis, 2011	4	Self-referred youth and young adults ages 16-30 with a wide range of problems, N=24	Brief psychodynamic; not a RCT	Young adult self-report form, youth self-report form	Scale scores reduced significantly in all cases, significant change from clinical to non-clinical range on Internalizing and Total subscales (suggesting this type of therapy most effective for clients with internalizing problems)	Small sample size, not RCT (no comparison to other psychotherapy or control), only self-report measures used
Lang, 2003	4	N=35 adults with depression/anxiety	Brief CBT or waitlist	Brief Symptom Inventory, Beck Anxiety Inventory, CES-D, Short Form-36 Health Survey, Quality of	CBT was more effective in reducing symptoms of depression and anxiety as well	Only self reports used, diagnosis not done by mental health professional

				Life Inventory	as improving overall functioning	
Campbell 1999	1 (90 min)	Low risk cases, adults, broad range of issues, N=38	Involved interview and problem solving with client and family (lack of particular theoretical orientation); pre/post methodology; no control	Problem Evaluation Summary, Self-Report Family Inventory, Family Pride Inventory	Overall, group had significant reduction on the PES and significant increase in reported coping abilities, family pride major factor in having a positive outcome	Small sample size, may not apply to severe psychopathology; not RCT
Barkham, Shapiro, Hardy & Rees,1999	3 (2+1 model)	N=116, adults with various degrees of subsyndromal depression (ranging from stressed, subclinical or low level clinically depressed, based on BDI scores. Excludes dysthymia)	2 sessions, 1 week apart, 3rd session 3 months later; received either CB or Psychodynamic-Interpersonal therapy, either immediately or after a 4 week delay; RCT	BDI; Millon Clinical Multiaxial Inventory, Present State Examination	Immediate/delayed conditions similar; no significant difference between CB and PI, although CB superior at 1 yr follow-up; average of 68% improvement rate overall	May not apply to more severe psychopathology
McGarry et al., 2008	3 (2+1 model)	N=60 youth, 3-16 years and their parents, varying types of mental health issues, both externalizing and internalizing	Solution-focused brief therapy or TAU, RCT	Strengths and Difficulties Questionnaire, Symptom Behaviour Inventory, Parental Stress Index, General Health Questionnaire, Visual Analogue Scale, FAD, Child Health Related Quality of Life Questionnaire, Visual Analogue Scale for Therapists of BCA/Routine Treatment Participants, POSQ, Service Model Preference Questionnaire	Improvement overall on measures of child and parent functioning, although only those in the brief treatment group had sustained benefits at a six month follow up	Small sample, small response in follow-up questionnaires

Appendix B

The Brief Child and Family Phone Interview (BCFPI)

Parent Form

Paper Version

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Externalizing

"I will read you examples of (other types of) problems which children sometimes have. Tell me whether each is NEVER true, SOMETIMES true, or OFTEN true of _____."

REGULATION OF ATTENTION, IMPULSIVITY AND ACTIVITY *"Do you notice that _____ .....?"*	never (1)	some-times (2)	often (3)	comments
Is distractible or has trouble sticking to an activity				
Fails to finish things he/she starts				
Has difficulty following directions or instructions				
Is impulsive or acts without stopping to think				
Jumps from one activity to another				
Fidgets				

COOPERATIVENESS *"Do you notice that _____ .....?"*	never (1)	some-times (2)	often (3)	comments
Is cranky				
Is defiant or talks back to adults				
Blames others for his/her own mistakes				
Is easily annoyed by others				
Argues a lot with adults				
Is angry and resentful				

CONDUCT *"Does _____ .....?"*	never (1)	some-times (2)	often (3)	comments
Steal things at home				
Destroy things belonging to others				
Engage in vandalism				
Has ____ broken into a house, building, or car				
Does ____ physically attack people				
Does ____ use weapons when fighting				

Internalizing

"Now, I will read examples of (other types of) problems which children sometimes have. Tell me whether each is NEVER true, SOMETIMES true or OFTEN true of _____"

SEPARATION FROM PARENTS *"Do you notice that _____ .....?"*	never (1)	some-times (2)	often (3)	comments
Worries that bad things will happen to loved ones				
Worries about being separated from loved ones				
Is scared to sleep without parents nearby				
Is overly upset when leaving loved ones				
Is overly upset while away from loved ones				
Complains of feeling sick before separating				

MANAGING ANXIETY *"Do you notice that ___ .....?"*	never (1)	some-times (2)	often (3)	comments
Worries about doing better at things				
Worries about past behaviour				
Worries about doing the wrong thing				
Worries about things in the future				
Is afraid of making mistakes				
Is overly anxious to please people				

MANAGING MOOD *"Do you notice that _____ .....?"*	never (1)	some-times (2)	often (3)	comments
Has no interest in his/her usual activities				
Gets no pleasure from usual activities				
Has trouble enjoying him/her self				
Is not as happy as other children				
Feels hopeless				
Seems unhappy, sad, or depressed				

ASK THE NEXT 3 QUESTIONS IF THERE IS ANY CONCERN RE: POSSIBLE DEPRESSION OR SELF-HARM. IF ANY OF THE NEXT 3 ITEMS ARE ENDORSED, IMPLEMENT YOUR AGENCY'S RISK MANAGEMENT PROTOCOL.

"Would you say that _____ .....?"	never (1)	some-times (2)	often (3)	comments
Has lost a lot of weight without trying				
Talks about killing himself/herself				
Deliberately harms self or attempts suicide				

"Now I'll ask few questions about _____'s day to day functioning and how all of this may have affected your child. Tell me if it is "NONE", "A LITTLE", or "A LOT". "

Child Functioning	none (1)	a little (2)	a lot (3)	comments
Social Participation How much has _____ withdrawn or isolated him\herself as a result of these problems?				
How much has _____ been doing things less with other kids as a result of these problems?				
How much has _____'s life become less enjoyable as a result of these problems?				
Quality of Relationships How much trouble has ___ had getting along with his/her teachers as a result of these problems?				
How much trouble has ___ had getting along with you or your partner as a result of these problems?				
How much has ____ been irritable or fighting with friends as a result of these problems?				
School Participation & Achievement How much has ____ missed school as a result of these problems?				
How much have _____ 's grades gone down as a result of these problems?				

"Now, I'd like to ask about some family circumstances. Tell me if they apply "NEVER", "SOMETIMES", "OFTEN", or "ALWAYS"."

Impact on Family	never (1)	some-times (2)	often (3)	always (4)	comments
Family Activities How frequently has _____'s behaviour prevented you from taking him/her out shopping or visiting?					
How frequently has _____'s behaviour made you decide not to leave him/her with a babysitter?					
How frequently has _____'s behaviour prevented you from having friends, relatives or neighbours to your home?					
How frequently has _____'s behaviour prevented his/her brothers or sisters from having friends, relatives or neighbours to your home?					
Family Comfort How frequently have you quarreled with your spouse regarding _____'s behaviour?					
How frequently has _____'s behaviour caused you to be anxious or worried about his/her chances for doing well in the future?					
How frequently have neighbours, relatives or friends expressed concerns about _____'s behaviour?					

Other Concerns Checklist

The interviewer may record degree of concern, if any, regarding any of the following items. Items should be selected which seem to be of concern to the informant, or are of routine concern to the provider.

Concern	none	A little	A lot	comments
Bullying: Repeatedly bullies, teases, harasses or excludes other children from social activities				
Cruelty to Animals: Cruel to animals, hurts and/or teases animals repeatedly				
Fire: Inappropriate involvement with fire, matches, etc.				
Substance Use: Recurrent use of alcohol or drugs leading to impaired functioning (e.g., substance-related absences, suspensions, or expulsions from school)				
	none	A little	A lot	comments
Specific Fear: Unusually strong and persistent fear of something specific (e.g. animals, needles, heights)				
Social Phobia: Persistent fear and avoidance of social situations with peers, or social performance demands due to a fear of embarrassment or scrutiny				
Obsessions: Recurrent thoughts or impulses cause distress or impair functioning				
Compulsions: Repetitive behaviours (e.g. hand washing, ordering, or checking) cause distress or impair functioning				
Movement Problems: Recurrent movements (tics) or vocalizations cause stress or impairment				

Concern	none	A little	A lot	comments
Thought Problems: Delusions, hallucinations, paranoia, disorganized speaking or behaviour resulting in significant impairment				
School Refusal: Persistent unwillingness or refusal to regularly attend school due to anxiety or a fear of separation				
Selective Mutism: Consistent failure to speak in some situations (e.g. school) but speaks comfortably in other situations (e.g. home)				

<<<< The following 6 items are 'pilot' screening items re: Selective Mutism. They are optional, under review, and may be dropped or changed in future versions.>>>>	never	some-times	often	comments
In the past 2 months did your child speak to his/her parent at home?				
In the past 2 months did your child speak to his/her brothers or sisters at your home?				
In the past 2 months did your child speak to other children at your home?				
In the past 2 months did your child speak to his/her parent at school?				
In the past 2 months did your child speak to other children at school?				
In the past 2 months did your child speak to the teacher at school?				

Concern	none	A little	A lot	comments
Victimized/Bullied: Is repeatedly bullied, teased, harassed, or excluded from social activities by others				
Trauma: Experienced or witnessed an event(s) that threatened death or serious injury to self or others resulting in intense fear or helplessness. Re-experiences the event, attempts to avoid similar settings and shows increased arousal (sleep difficulties, irritability, etc.)				
	none	A little	A lot	comments
Speech Difficulties: Significant difficulty speaking or understanding speech				
Development Problems: General development significantly below age				
Learning Problems: Academic progress significantly below ability. Record examples in 'comment' section				
	none	A little	A lot	comments
Sleep Difficulties : Persistent difficulty falling asleep, staying asleep, awakening from anxiety-provoking nightmares, or prolonged sleep during the day which causes stress or impairment				
Eating Problems: Not maintaining weight, significant loss of weight, fear of being overweight, disturbed thinking about body shape or weight				
Urination Problem: Urinates in bed or clothing several times per week				
Bowel Movement Problem: Bowel movements in inappropriate places (e.g. clothes, floor) several times over a three-month period				

Concern	none	A little	A lot	comments
Sexual Problems: Problems with sexual behaviour or identity which cause distress or impairment				

Risk Factors

"Some of the following items may help us understand your situation and _____'s overall situation better. Different combinations of these things seem to make life easier or more difficult for many families and children."

"Here I'll ask a couple of health questions."

Health - Mom and Dad	very much	some-what	not at all	n/a	comments
Are you limited, in carrying out normal activities, at home, at a job, or in school, because of a medical condition or health problem?					
Is your spouse or partner limited, in carrying out normal activities, at home, at a job, or in school, because of a medical condition or health problem?					

"Parent's moods are also important. The following statements describe some of the ways people feel at different times. Please tell me how often have you felt or behaved this way during the past week. Was it "less than 1 day", "1-2 days", "3-4 days" or "5-7 days"."

Mood - Informant	less than 1 day	1-2 days	3-4 days	5 or more days	comments
You did not feel like eating; your appetite was poor.					
You had trouble keeping your mind on what you were doing.					
You felt depressed.					
Your sleep was restless.					
You felt sad.					
You could not 'get going'.					

"Now some similar questions regarding your spouse or partner. During the past week, how often has your partner .....?"

Mood - Partner	less than 1 day	1-2 days	3-4 days	5 or more days	Comments
seemed unable to 'get going'?					
seemed to feel sad?					
had crying spells?					

"We'd like to rate whether or not you feel that drinking is a problem in your home. Please say how much you agree or disagree that ....."

Alcohol - Mom & Dad	strongly agree	agree	disagree	strongly disagree	n/a	comments
Your drinking is a source of tension or disagreement in your home.						
Your spouse or partner's drinking is a source of tension or disagreement in your home.						

"The next statements are about families and family relationships. How much do you agree or disagree with the following statements about your family?"

Family Functioning	strongly agree	agree	disagree	strongly disagree	comments
In times of crises we can turn to each other for support.					
Individuals (in the family) are accepted for what they are.					
We express feelings to each other.					
We are able to make decisions about how to solve problems.					
We DON'T get along well together.					
We confide in each other.					

Couple Relationship	excellent	good	fair	poor	n/a	comments
Overall, how would you rate the relationship between you and your spouse or partner?						

"Next, a few questions regarding discipline. When _____is being bad or doing something wrong, how often do you.....?"

Discipline Style	never	some-times	often	always	comments
Reason with ___ or explain to ___?					
Send ____ to his/her room?					
Take away ____'s privileges?					
Spank ____ with your hand?					
Spank ____ with a belt, brush, or something else?					

"We also need to know whether abuse or neglect has been part of _____'s situation."

Abuse	yes	no	don't know	comments
To your knowledge, has _____ ever been physically abused?				
To your knowledge, has _____ ever been sexually abused?				
To your knowledge, has _____ ever been neglected to that extent that seemed to impair his/her emotional or physical well being?				
To your knowledge, has _____ ever witnessed verbal or physical violence amongst the adults who have been involved in parenting him/her?				

Protective Factors

"Next, a few questions regarding some of _____'s activities and talents, and some related family characteristics."

Supervised activities Outside of regular physical education classes, did ___ take part in any sports during the past year which involved adult coaching or instruction? (If 'yes', record number and details in comments for this question). ❑ yes ❑ no ❑ don't know	comments
Outside of regular classes in school, did ___ take any lessons or instruction during the past year in music, dance, or other non-sport activities? (If 'yes', record number and details in comments for this question). ❑ yes ❑ no ❑ don't know	comments
During the past year, did ___ belong to any clubs or groups with adult leadership, such as cubs, scouts, brownies, a church group or community programs? (If 'yes', record number and details in comments for this question). ❑ yes ❑ no ❑ don't know	comments
Family Recreation How often have all or most of the family participated together in any recreational activities, such as walks, games, fishing, etc., in the past 6 months? ❑ once a week or more ❑ 2-3 times per month ❑ once a month ❑ less than once per month ❑ never	comments
Spiritual How often does __ attend religious services or cultural ceremonies? ❑ almost every week ❑ less than weekly, but more often than just on holidays ❑ only on holidays or special occasions ❑ never, almost never	comments
Child - Confidant Does ___ have anyone in particular he/she talks to or confides in? (if answer is 'yes', record relationship of confidant to child and impact of sharing on child's coping in comment section for this question.) ❑ yes ► ❑ no ❑ don't know	relationship _____ impact:

Parent - Confidant Do you have anyone in particular that you can talk to or confide in about yourself or issues you are concerned about? (if 'yes', record relationship of confidant to parent and impact of sharing on parent's coping in this comment section). ❑ yes ► ❑ no ❑ don't know	relationship _____ impact:

Appendix C

Caregiver Strain Questionnaire (CGSQ)

Name:
Date:

Caregiver Strain Questionnaire

Please think back over the <u>past 2 months</u> and try to remember how things have been for <u>your family</u>. We are trying to get a picture of how life has been in your household over that time.

For each question, please tell me which response (which number) fits best.

In the past 2 months, how much of a problem was the following:

		Not at all	A little	Somewhat	Quite a bit	Very much
1.	Interruption of personal time resulting from your child's emotional or behavioral problem?	1	2	3	4	5
2.	You missing work or neglecting other duties because of your child's emotional or behavioral problem?	1	2	3	4	5
3.	Disruption of family routines due to your child's emotional or behavioral problem?	1	2	3	4	5
4.	Any family member having to do without things because of your child's emotional or behavioral problem?	1	2	3	4	5
5.	Any family member suffering negative mental or physical health effects as a result of your child's emotional or behavioral problem?	1	2	3	4	5
6.	Your child getting into trouble with the neighbors, the school, the community, or law enforcement?	1	2	3	4	5
7.	Financial strain for your family as a result of your child's emotional or behavioral problem?	1	2	3	4	5
8.	Less attention paid to other family members because of your child's emotional or behavioral problem?	1	2	3	4	5
9.	Disruption or upset of relationships within the family due to your child's emotional or behavioral problem?	1	2	3	4	5
10.	Disruption of your family's social activities resulting from your child's emotional or behavioral problem?	1	2	3	4	5

Please Turn Over and Complete Back →

In this section, please continue to look back and try to remember how you have felt during the past 2 months.

For each question, please tell me which response (which number) fits best.

In the past 2 months:

		Not at all	A little	Somewhat	Quite a bit	Very much
11.	How isolated did you feel as a result of your child's emotional or behavioral problem?	1	2	3	4	5
12.	How sad or unhappy did you feel as a result of your child's emotional or behavioral problem?	1	2	3	4	5
13.	How embarrassed did you feel about your child's emotional or behavioral problem?	1	2	3	4	5
14.	How well did you relate to your child?	1	2	3	4	5
15.	How angry did you feel toward your child?	1	2	3	4	5
16.	How worried did you feel about your child's future?	1	2	3	4	5
17.	How worried did you feel about your family's future?	1	2	3	4	5
18.	How guilty did you feel about your child's emotional or behavioral problem?	1	2	3	4	5
19.	How resentful did you feel toward your child?	1	2	3	4	5
20.	How tired or strained did you feel as a result of your child's emotional or behavioral problem?	1	2	3	4	5
21.	In general, how much of a toll has your child's emotional or behavioral problem taken on your family?	1	2	3	4	5

Appendix D

The Client Satisfaction Questionnaire (SQ)

CLIENT SATISFACTION QUESTIONNAIRE (CSQ 10)

This questionnaire will help us to evaluate and continually improve the program we offer. We are interested in your *honest opinions* about the services you have received, whether they are positive or negative. Please answer all the questions. Please circle the response that best describes how you honestly feel.

1. How would you rate the overall quality of the service you received?

6	5	4	3	2	1
Excellent	Very good	Good	Average	Fair	Poor

2. Did you receive the type of help you wanted from the service?

6	5	4	3	2	1
No definitely not		No not really	Yes generally		Yes absolutely

3. To what extent has the service met your *child's* needs?

6	5	4	3	2	1
Almost all needs have been met		Most needs have been met	Only a few needs have been met		No needs have been met

4. To what extent has the service met *your* needs?

6	5	4	3	2	1
Almost all needs have been met		Most needs have been met	Only a few needs have been met		No needs have been met

5. How satisfied were you with the amount of *help* you received?

6	5	4	3	2	1
Quite Dissatisfied		Dissatisfied	Satisfied		Very Satisfied

6. Has the service helped you to deal more effectively with your child's behaviour?

6	5	4	3	2	1
Yes, it has helped a great deal		Yes, it has helped somewhat	No, it hasn't helped much		No, It made things worse

7. **Has the service helped you to deal more effectively with the problems you came to work on?**

6	5	4	3	2	1
Yes, it has helped a great deal		Yes, it has helped somewhat	No, it hasn't helped much		No, It made things worse

8. **In an overall sense, how satisfied are you with the service you received?**

6	5	4	3	2	1
Very Satisfied		Satisfied	Dissatisfied		Very Dissatisfied

9. **If you were to seek help again, would you come back to the Children's Centre?**

6	5	4	3	2	1
Yes definitely		Yes, I think so	No, I don't think so		No definitely not

10. **Do you have any other comments about this service or the Centre?**

.....
.....
.....
.....
.....
.....

Appendix E

Depression Anxiety Stress Scale 21 (DASS-21)

DASS21 *Name:* *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Appendix F

Individual Session Treatment Summary for Brief Services

BRIEF SERVICES INDIVIDUAL SESSION TREATMENT SUMMARY

Client/Family Name: _____ _____ Date: _____

Clinician Name: _____ Session Number: _____

Targets Addressed This Session (number in order of priority and emphasis)

Couple, Marriage, Intimate Relationship ☐	High Conflict Separation-Divorce ☐	Parent-Child Conflict ☐	Sibling Conflict ☐	Family Relationship Issues ☐ (separation, step, blended, alternate care, GLBTQ)
Parenting: Overwhelmed, Incapacitated, Stress ☐	Parenting: Impacted by adult issues ☐ (MH or AOD)	Parenting: Child Management Issues - Externalizing ☐	Parenting: Child Management Issues - Internalizing ☐	Parent-Child Interactional Issues ☐ (attachment)
Parenting: Child Protection Issues ☐	Parenting an Adult Child ☐	Parenting: Other ☐	Sexual Orientation ☐ (struggles with identity)	Basic Needs ☐ (shelter, clothing, food)
Aggression ☐ (hitting, tantrums)	Anger Management ☐	Anti-social Behaviour ☐ (stealing, serious lying, bullying)	Anxiety Symptoms ☐ (worrying, preoccupations, sleep, other)	Attention Difficulties ☐ (problems focusing, distracted)
Criminal Activity ☐ (in conflict with law)	Depression Symptoms ☐ (mood, energy, thinking)	Eating Issues ☐ (over eating, anorexia, bulimia, hoarding)	Fire Setting ☐	High Risk Behaviour ☐ (running, sexual acting out)
Hyperactivity/ Impulsivity ☐	Labile/Fluctuating Mood ☐ (Mania, dysthymia)	Obsessions or Compulsions ☐ (thoughts/behaviours)	Process Addiction ☐ (including Gambling, Sex, other)	Self-Harming Behaviour ☐
Sexual Offending ☐ (bhaviours)	School Problems ☐ (peers, social)	School Problems ☐ (academic/learning)	Substance Abuse ☐	Suicidal/Ideation ☐
Suicide Attempt ☐	Psychosis Symptoms ☐ (thought , voices, hallucinations)	Abuse ☐ (social, psych, physical, sexual)	Grief & Loss ☐	Other Domestic Violence Issues ☐ (non VAW)
Traumatic Event ☐ (car accident, witness crime)	Victim of a Crime ☐ (assault, theft, ect)	ASD/PDD ☐	Work Related Issues ☐	Learning Issues ☐ (disabilities)
Finances/Money ☐	Physical Health Issue ☐	Others Not listed ☐	Others Not listed ☐	Others Not listed ☐

1

BRIEF SERVICES INDIVIDUAL SESSION TREATMENT SUMMARY

Intervention Strategies **Addressed This Session** (number in order of priority and emphasis)

Supportive Listening ☐	Therapist Praise and Validation ☐	Family Engagement ☐	Family Therapy ☐	Relationship or Rapport Building ☐
Motivational Interviewing ☐	Emotional Processing ☐	Normalizing ☐	Reframing ☐	Insight Building ☐
Crisis Management ☐	Problem- Solving ☐	Activity Scheduling/ Behavioural Activation ☐	Skill Building ☐	Emotional Coping Skills ☐
Communication Skills ☐	Assertiveness Skills ☐	Social Skills ☐	Exposure ☐	Relaxation ☐
Challenging Cognitions ☐	Self-Monitoring ☐	Psychoeducation Child or Youth ☐	Psychoeducation Parent ☐	Maintenance or Relapse Prevention ☐
Modelling ☐	Parent Skills: Commands/Limit Setting ☐	Parent Skills: Rewards/ Consequences ☐	Parent Skills: Monitoring ☐	Parent Skills: Praise ☐
Parent Skills: Coping ☐	Parent Skills: Tangible Rewards ☐	Parent Skills: Time-Out ☐	Self Reward/ Self Praise ☐	Educational Support Liaising with School ☐
Homework Assignment ☐	Homework Review ☐	Other: ☐	Other: ☐	Other: ☐

Length of Session: _____ **(minutes)**

Session Format: Individual ☐ Group ☐ Parent ☐ Family ☐ Other ☐

Rev. May 2, 2011

Appendix G

Intake Assessment Rating Guidelines

	Risk to self or other	Behavioural presentation	Family Functioning	Global Functioning	Other
1. CRITICAL	**High** - currently or recently suicidal - hospital, health system, police involved	- suicide attempt - dangerous self harm behaviour - out of control - violent - running, sex trade, - sexual offending - extreme distress - severe depression - involvement with weapons, drugs, fire - psychosis	- imminent breakdown - child removed from home - significant adult MH/AOD issues - Child Protection involvement - family violence - severe conflict	- struggling to function across many domains - not coping - impaired functioning - severe drug use - criminal activities - not attending School/suspended - psychological, social, behavioural problems	- recent (<month) Trauma - grief, sexual abuse - multiple service providers involved - limited MH services - requires system response - homeless - no supports
2. SEVERE	**Moderate** - recent suicide ideation/attempt - threats of harm - health system involved	- suicide ideation - repeat self harm - physical, sexual, emotional aggression - significant behavioural difficulties (eating, depression, anxiety, self regulation, other) - marked changes	- potential family breakdown - conflict - Child Protection may be involved - adult MH issues - parenting struggles - multiple children struggling	- impaired functioning & coping - school struggles (suspensions, attendance, academics) - home struggles - substance use - peer problems, serious bullying (victim or bully)	- trauma within last 3-6 months - pressure from other service providers - minimal supports or resources
3. URGENT	**Low** - past suicide ideation and/or threats of harm	- poor self esteem, anger management, self regulation - physical problems related to MH issues - some changes in Behaviour	- family struggling - family conflict - parenting/adult issues - Child Protection history - lack resources - some supports	- poor functioning - emotional regulation problems - parents concerned - school attendance - peer problems or bullying (victim or bully)	- acute, single specific problem - some ability to wait for service - may have some useful supports or resources
4. MODERATE	**None** - no threats of suicide ideation and/or threats of harm	- relationship struggles - social difficulties - fairly stable - minor changes in child's behaviour	- some family support - parenting issues - other children ok - family stress	- single issue - able to wait - some distress	- single issue - some supports or resources

Appendix H

Working Alliance Inventory Short Form (WAI-S)

Client Form

Working Alliance Inventory – Short Form – Revised

Instructions: Below is a series of statements about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____in the text. For each statement, please take your time to consider your own experience and then fill in the appropriate bubble.

Important: The rating scale is not the same for all the statements. **PLEASE READ CAREFULLY!**

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

3. I believe_____likes me.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

4. _____and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. _____and I respect each other.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

6. _____and I are working towards mutually agreed upon goals.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that_____appreciates me.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

8. _____and I agree on what is important for me to work on.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

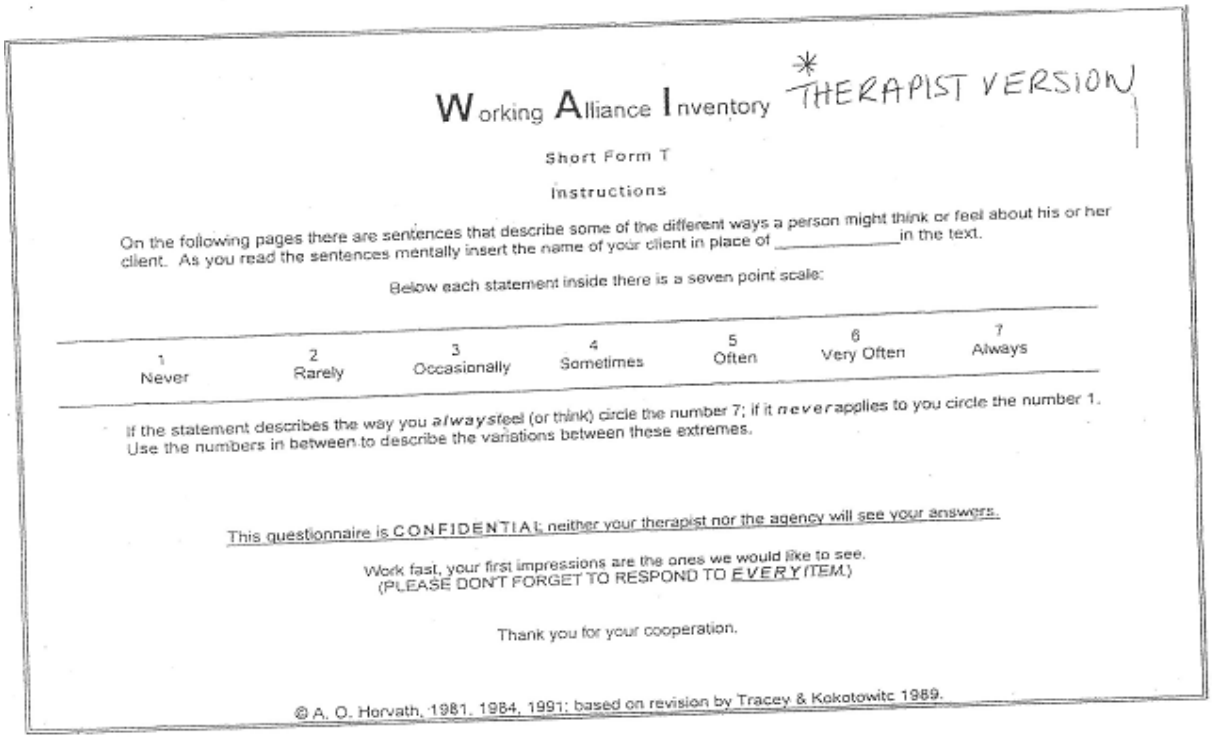
11. _____ and I have established a good understanding of the kind of changes that would be good for me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Always	Very Often	Fairly Often	Sometimes	Seldom

Therapist Form



Working Alliance Inventory * THERAPIST VERSION

Short Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____ in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it *never* applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO *EVERY* ITEM.)

Thank you for your cooperation.

Therapist Forn Continued

1. _____ and I agree about the steps to be taken to improve his/her situation.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
2. My client and I both feel confident about the usefulness of our current activity in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
3. I believe _____ likes me.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
4. I have doubts about what we are trying to accomplish in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
5. I am confident in my ability to help _____	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
6. We are working towards mutually agreed upon goals.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
7. I appreciate _____ as a person.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
8. We agree on what is important for _____ to work on.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
9. _____ and I have built a mutual trust.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
10. _____ and I have different ideas on what his/her real problems are.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
11. We have established a good understanding between us of the kind of changes that would be good for _____	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
12. _____ believes the way we are working with his/his problem is correct.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always

Appendix I

Cover Letter

Dear potential participant,

Thank you for your interest in our study assessing the effectiveness of the Brief Service Treatment Program at the Children's Centre Thunder Bay (CCTB), entitled "Evaluation of Brief Outpatient Services in a Children's Mental Health Community Clinic". This study is being conducted by the Program Evaluation Committee at CCTB, with the assistance of Suzanne Chomycz, a graduate student in the Department of Psychology at Lakehead University.

Participation in this study involves taking part in brief service consisting of 1-4 treatment sessions at CCTB, over a maximum six week time period. Participants will be asked to complete several short questionnaires at intake (approx. 20 minutes), after each session (approx. 5 minutes) and upon completion of service (approx. 30 minutes), regarding their overall functioning, presenting issues/concerns, treatment satisfaction, and relationship with their counselor.

A $20 honorarium will be awarded to participants upon completion of the aforementioned questionnaires.

You may refuse to participate, refuse to answer any question, or withdraw from the study at any time without explanation or penalty. The information obtained will be securely stored at CCTB for seven years and only persons directly involved with the research will have access to the questionnaires. All records of your participation will be kept in confidence and there will be no identifying information in any subsequent reports.

There is no expected risk for harm to yourself or your child by participating in this study. Minimal risk may occur that is associated with discussing presenting issues. This study has been approved by the Children's Centre Thunder Bay Ethics Committee and you may contact Tom Walters (343-5066) if you have any questions or concerns about the approval of the study. It has also been approved by Lakehead University's Research Ethics Board, who can be contacted for questions or concerns as well (343-8283).

If you would like a summary of the results of this study, please fill out your contact information on the Consent Form attached.

Any questions about the study can be directed to Joanie Nelson, Project Lead, at 343-5088, or Dr. Fred Schmidt at 343-5016, or fschmidt@childrenscentre.ca**.**

Thank you,

Program Evaluation Committee
Children's Centre Thunder Bay

Appendix J

Consent Form

My signature on this form indicates that I agree to participate in the study assessing the effectiveness of the Brief Service Treatment Program at the Children's Centre Thunder Bay, entitled "Evaluation of Brief Outpatient Services in a Children's Mental Health Community Clinic".

I understand that my participation in this study is conditional on the following:

1. I have read the cover letter and have had the study explained to me.
2. Participation in this study involves taking part in brief service consisting of 1-4 treatment sessions at CCTB, over a maximum six week time period, and completing several short questionnaires at intake (approx. 20 minutes), after each session (approx. 5 minutes) and upon completion of service (approx. 30 minutes), regarding overall functioning, presenting issues/concerns, treatment satisfaction, and relationship with the counselor.
3. I fully understand what I will be required to do as a participant in the study.
4. I am a volunteer participant and may refuse to answer any question or withdraw from the study at any time. My treatment will not be affected by dropping out of the study.
5. The risks associated with participation in this study are minimal.
6. My data will be securely stored at the Children's Centre for a period of seven years.
7. Only persons directly involved with the research will have access to the questionnaires, and they will be required to uphold confidentiality.
8. There will be no identifying information in any subsequent reports.
9. A $20 honorarium will be awarded to participants upon completion of the study.
10. I will receive a summary of the study, upon request, following its completion.

I _____agree to participate in the study.

_____ _____
Signature of Participant Date

_____ _____
Signature of Parent (if applicable) Date

_____ _____
Assent of Child (Under 12 Years) Date

I wish to obtain a summary of the findings: Yes No
Address: _____

_____ _____
Signature of Witness Date

Appendix K

Therapist Transcript

The Children's Centre Thunder Bay is interested in evaluating their Brief Service Program. The quality and effectiveness of the program is very important to us, as is the satisfaction of the clients we serve. Ongoing evaluation is vital in ensuring that the needs of our clients are being met and we hope that you are open to participate, but want to make sure that you know participation is voluntary. Deciding not to participate will not affect your service from Children's Centre Thunder Bay.

We will use this information to improve our services for future clients. Could I take a few minutes to explain the evaluation to you? I would like to review the following forms with you (Cover Letter and Consent Form).

Please feel free to ask questions at any time during this process.

As a thank you, you will be given an honorarium of a $20 value for Wal-Mart upon completion of the study.

Client agreed/disagreed to participate in project:

- ☐ Agree
- ☐ Disagree

Project, Cover Letter, and Consent Form reviewed on the telephone or in person:

- ☐ Telephone
- ☐ In person

Appendix L

Therapist Checklist

1. Referral to CCTB – refer to Brief Services if appropriate

2. INTAKE Appointment – standard forms to be completed:
   - ☐ CIMS (presenting issues)
   - ☐ Pre-BCFPI (parent or youth version)
   - ☐ Intake Assessment Rating Guidelines
   - ☐ If client agrees to participate–continue with the following steps:
   - ☐ Read TRANSCRIPT, followed by a review and of the following forms:
     - ☐ Cover Letter
     - ☐ Consent Form (client must sign, and counselor must witness) – *make photocopy for clients if desired.*
     - ☐ **Be sure to "check off" on the transcript if the project was reviewed in person or on the phone*
   - ☐ Pre-DASS (parent or youth)
   - ☐ Pre-Caregiver Strain (parent)

3. **Session 1 :** Client to complete the following forms:
   - ☐ Session Treatment Summary
   - ☐ Working Alliance Inventory

4. **Session 2:** Client to complete the following forms:
   - ☐ Session Treatment Summary
   - ☐ Working Alliance Inventory

5. **Session 3:** Client to complete the following forms:
   - ☐ Session Treatment Summary
   - ☐ Working Alliance Inventory

6. **Session 4** (or final session): Client to complete the following forms:
   - ☐ Session Treatment Summary
   - ☐ Working Alliance Inventory
   - ☐ Post-BCFPI (parent or youth version)
   - ☐ Post – Caregiver Strain (parent)
   - ☐ Post -DASS (parent or youth)
   - ☐ Client Satisfaction Questionnaire

7. **Follow up:**
   - ☐ Post package collected from family
   - ☐ Gift card given to client

Appendix M

Thank You Letter

Dear Client,

Thank you for your participation in the program evaluation study of the Brief Service Program at the Children's Centre Thunder Bay. The information we collect as part of this study will help us to improve our program and services. Included in this envelope is a $20 Wal-Mart gift card as our way of saying thank you for participating. If previously requested, the results of this study will be mailed to you upon its completion in the summer of 2012.

Thank you again,

Suzanne Chomycz

Appendix N

Lakehead University Ethics Approval

Lakehead
UNIVERSITY

Office of Research

Tel 807-343-8934
Fax 807-346-7749

September 02, 2011

Principal Investigator: Dr. Fred Schmidt
Co-Investigator: Dr. Dwight Mazmanian
Student Investigator: Suzanne Chomycz
Department of Psychology
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Researchers:

Re: REB Project #: 042 11-12 / Romeo File No: 1462084
Granting Agency: N/A
Granting Agency Project #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project entitled, "Evaluation of Brief Outpatient Services in a Children's Mental Health Community Clinic".

Ethics approval is valid until September 2, 2012. Please submit a Request for Renewal form to the Office of Research by August 2, 2012 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available at:

http://research.lakeheadu.ca/ethics_resources.html

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Completed reports and correspondence may be directed to:

Research Ethics Board
c/o Office of Research
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1
Fax: (807) 346-7749

Best wishes for a successful research project.

Sincerely,

Dr. Chander Shahi
Chair, Research Ethics Board

/scw

Appendix O

Children's Centre Thunder Bay Ethics Approval

May 1, 2011

Dr. Fred Schmidt
Psychologist
CCTB

Dear Dr. Schmidt and Suzanne Chomycz:

RE: Research Ethics Approval

The Ethics Review Committee of the Children's Centre Thunder Bay has reviewed your study, on the "Brief Services Program Evaluation". It has been found to comply with the ethical requirements and policies of the Children's Centre Thunder Bay. You have been given approval to proceed with the research study pending approval from Lakehead University. Please submit the University's approval to use once you have received it.

In conducting the research, you are required to report to the agency any significant change in the procedures described in your research proposal before putting such change into effect.

Thank you.

Sincerely,

Tom Walters, MSW, RSW, MHA, CHE
Executive Director