Getting Services Right: An Ontario Multi-agency Evaluation Study

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Reach Out Centre for Kids
&
Hincks-Dellcrest Centre-Gail Appel Institute
Partner Organizations in the project:

- Reach Out Centre for Kids (Burlington)
- Hincks-Dellcrest Centre (Toronto)
- East Metro Youth Services (Toronto)
- Oolagen (Toronto)
- Yorktown Child and Family Centre (Toronto)
- Point In Time Centre for Children, Youth and Parents (Haliburton)
- Youth Services Bureau (Ottawa)

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Project Summary

Reach Out Centre for Kids and the Hincks Dellcrest Centre, are working together with five partner organizations to design the first in Ontario comprehensive look at the effects of brief therapy/walk-in therapy. The evaluation lead is Karen Young, Reach Out Centre for Kids, with the partnership including multiple organizations, multiple ways to deliver brief services, and multiple therapeutic approaches for brief therapy. This evaluation is examining outcomes from a sample of Ontario's brief service delivery mechanisms: walk-in clinics at Reach Out Centre for Kids, Brief Services at the Hincks-Dellcrest Centre, the collaboratively run What's Up Clinic based in Toronto (East Metro, Oolagen, and Yorktown), Point in Time brief services in Haliburton, and Youth Services Bureau walk-in clinic in Ottawa.

Executive Summary:

The Program

With funding from the Ontario Centre of Excellence, Reach Out Centre for Kids and the Hincks Dellcrest Centre worked together with 5 partner organizations to design the very first in Ontario comprehensive look at the effects of brief therapy/walk-in therapy for clients. The evaluation partnership spans multiple organizations, multiple ways to deliver brief services, and multiple therapeutic approaches for brief therapy, across a client age-range from 0 to 24 years. This evaluation is examining outcomes from a sample of Ontario's brief service delivery mechanisms: walk-in clinics at Reach Out Centre for Kids, Brief Services at the Hincks-Dellcrest Centre, the collaboratively run What's Up Clinic based in Toronto (East Metro, Oolagen, and Yorktown), Point in Time brief services in Haliburton, and Youth Services Bureau walk-in clinic in Ottawa. All serve children and youth 0-18 (some to age 24) and their families.
The Plan

The evaluation has addressed the following questions:

1) Do clients benefit from participating in a single therapy session? If so, what positive outcomes are achieved?

2) Are the benefit(s) from a single session maintained after 3 months?

3) What kinds of presenting problems are the clients experiencing who access these services?

Our methodology includes a pre-test immediately prior to the brief therapy session, a post-test immediately after the session, and a three-month post-test. The surveys used include one designed by the research team, one previously designed and published questionnaire, and one standardized measure that has been widely used. As well, key informant interviews are being conducted with 3 therapists from each partner organization to determine how their thinking about brief services may have changed from their work at a walk-in clinic or brief service.

Questionnaire items are designed to measure:

- The issues that brought a client to walk-in
- Clients’ understanding of the issue that brought them to walk-in,
- Clients’ perceptions of their own skills, strengths, and problem-solving abilities,
- Clients’ knowledge of their social supports and community resources,
- The severity of the problem/issues
- Clients’ coping skills

Data was collected from 494 clients at the partner sites’ walk-in clinics or booked brief therapy sessions during April 2014 to November 2014. Data of 352 completed pairs of in-house pre- and post-session Brief Services Questionnaires were analyzed to determine if there were shifts in clients’ understanding of their problem/issue, clients’ perceived awareness of their skills and strengths, ideas as to how to deal with the problem/issue, and knowledge of both social supports and community
resources. Seventy clients completed the pre-session and three month post-session Brief Services Questionnaires and Problem Evaluation Summary measures. These data were analyzed to measure if behavioral shifts were maintained three months post-session, and also if clients perceptions of their problem and their coping skills had changed. The Session Rating Scale was also used as a post-session measure of therapeutic alliance.

**The Product**

Clients reported a variety of presenting problems that had brought them to the session. Results of statistical analysis of in-house measures indicated that statistically significant shifts occurred in all measured dimensions from pre- to immediately post-session, suggesting that change may be possible after a single session of therapy. Biggest areas of improvement were: clients’ awareness of their own skills, ideas about how to solve the problem/issue and awareness of community resources.

Data from the Session Rating Scale suggested that therapeutic alliance might also be possible after a single session. The majority of clients agreed that they had “aha” realizations during the session. The shifts were also maintained after three months with 86% of clients reported that they had used ideas/strategies from the session. Analysis also showed that clients’ perceptions of their problem and coping skills improved over time.

The findings suggest that not only is change possible after one session of therapy, but that those effects may be maintained over time and therefore have long term benefits. The results of the evaluation have already been presented at the CMHO Conference in November 2014. Further plans include submitting the findings to a journal for publication.

**Final Report submitted: December 31st, 2014**

Region: MCYS-Central
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Introduction and Literature Review

Program Overview:

An overview of the Brief Services programs that are the focus of this evaluation is presented in the logic model (refer to Appendix A.) Note that since this project is a multi-site evaluation involving seven partner organizations, we had to create one overarching logic model that incorporated the commonalities between all seven Brief Service programs. The two primary goals of these programs are to: 1) provide immediate barrier free service and 2) to provide a diverse group of clients with a relevant and useful therapeutic encounter. The programs are designed for a wide range of clients (i.e., different age groups, different presenting issues, etc.). However, common presenting issues include anxiety, depression, and family conflict. The average number of clients seen at each partner organization also varies. Clients are referred to the programs through different sources (e.g., school boards, hospitals, CAS, etc.). Clients are also able to self-refer.

The Brief Services programs at each partner organization provide clients with the opportunity to access a single session of therapy. Once a client/family arrives at the clinic, they are asked to fill out some paperwork by the receptionist (i.e., questions about demographics, the presenting issue, client’s perceived strengths, their hopes for the session, etc.). The completed paperwork is given to a supervisor or receptionist and she/he gives this information to the clinician who will provide the therapy session. The clinician reviews the paperwork and subsequently starts the therapy session with the client/family. One or more clinicians conduct the session depending upon the site (some sites have students/volunteers/community partners). The modality of therapy used is narrative, solution-focused, with some modified Cognitive Behavioral Therapy (CBT) or mixed approach. On average, sessions last about 1 hour. At some sites there is a consultation break during which the clinician may consult with a supervisor/team/colleague. At the end of the session, clients are provided with any necessary paperwork (e.g., photocopy of session summary, safety plan, etc.). They are also asked to complete an evaluation questionnaire at most sites.
Purpose of Evaluation

Due to an increased awareness of mental health issues, economic necessity, wait list pressures, and the need for demonstrably improved client outcomes, brief service approaches, new brief service delivery models, and walk-in clinics are being developed across Ontario as a way to offer immediate and effective therapy service to many clients. While there is emerging program evaluation data from these innovative service delivery mechanisms, studies on brief services are at an early stage. The field would benefit greatly from a systematic evaluation on relevant models and approaches and the role of brief interventions in system integration, implementation and related long-term outcomes. Consequently, the purpose of this project was to conduct a multi-site outcomes-focused evaluation of Brief Services programs across Ontario. We hoped to address several evaluation questions through this project. The questions are as follows:

Process Evaluation Questions:

1) What sorts of problems/issues lead clients to access service at Brief Service programs?

2) Are high levels of therapeutic alliance possible during a single session?

Outcome Evaluation Questions – Clients:

1) Do clients have an increased understanding of the issue that brought them to the session after participating in the brief service?

2) Are clients more aware of their strengths after participating in the brief service?

3) Are clients more aware of their skills after participating in the brief service?

4) Do clients have an increased awareness of community resources after participating in the brief service?

5) Do clients have an increased awareness of social supports after participating in the brief service?
6) Do clients learn new ideas/strategies to address the problem after participating in the brief service?

7) Do clients experience realizations/aha moments during the session?

8) Are the benefits that clients experience (i.e., short-term outcomes) maintained 3 months after the counseling session?

9) Do clients utilize the ‘moving forward’ ideas that were identified during the session?

10) Has the problem/issue improved to some extent 3 months after the session?

11) Do clients’ have better coping skills 3 months after the session?

Outcome Evaluation Questions – Therapists:

1) Do therapists experience shifts in their thinking about what is possible in a single session as a result of working in the Brief Service program?

2) Does working in the Brief Service program influence therapists’ work in other areas?

3) Do therapists have realizations/aha moments during their work in the Brief Service program?

Relevant Stakeholders:

There are many internal and external stakeholders involved in the Brief Services program at each partner site. The internal stakeholders are clients who access the service, their caregivers, and staff/therapists/student interns/volunteers who help run the program. The external stakeholders are various funders and other organizations that refer in to the program (e.g., school boards, hospitals, CAS, etc.).

Literature Review

Talmon (1990) stated that “the most common number of session attended by clients is one” (p. 10,) while studies on change during the course of brief therapy suggest that behavioral changes are most likely to occur earlier in the course of treatment (Duncan & Miller, 2000; Hubble, Duncan, & Miller, 1999; Lambert, 1992,) emphasizing the importance of influencing change at the start of treatment.
Bloom (2001) states in a review of the literature on single session therapy that “consistent evidence that planned short-term psychotherapies, often as short as a single interview, generally appear to be as effective as time-unlimited psychotherapies...this seems to be true regardless of client characteristics [and] regardless of diagnosis or problem severity (p. 76.) Slive (2008) notes that walk-in single session therapy can have the unique advantages of convenience for clients, reduced wait times, prevention of the need for long-term service, and a solution-focused, strengths-driven approach. There is much compelling evidence in the literature about the benefits of brief services that supports these assertions.

Researchers have examined types of outcomes that can occur during the course of, or as a result of, brief therapy or single session therapy. It is also of interest whether any changes that can occur during a session can be maintained over time. Perkins (2006) found that the severity of clients’ presenting problems decreased in 74% of clients aged 5-15 who had single session therapy at a child and adolescent mental health outpatient clinic. The data also suggested that this benefit of the session was immediate and could be maintained over time on a short-term basis (one month) (Perkins, 2006.) Perkins and Scarlett (2008) found that benefits of single session therapy could be maintained as long as 18 months in a small sample of children and adolescents from the same child and adolescent mental health outpatient clinic. Clients’ reported severity and frequency of the presenting problem did not significantly increase 18 months after the initial therapy session, nor did evidence of clients’ mental or behavioral disorders (Perkins & Scarlett, 2008.) In an outcomes-based evaluation of ROCK’s walk-in clinic, described by Young (2011), it was found that walk-in sessions had a number of favorable outcomes, including decreased worry, increased feelings of confidence and competence, greater knowledge of community resources and more ideas regarding how to address or manage their issue. McGarry et al (2008) found that child clients who had single session therapy sustained the benefits of that therapy for a longer time than patients who received usual treatment after being placed on a waitlist.
More recently, Barwick et al (2013) examined the outcomes of clients aged 4 to 18 who received single session therapy at Yorktown Child and Family Centre’s West End Walk-In Counseling Centre. When compared to clients who had accessed the usual intake process, the walk-in clients showed significantly greater rates of improvement in a number of areas of functioning, and sustained that improvement at a three-month post assessment. Similarly, Stalker et al (2012) found that adults accessing walk-in services at KW Counseling Services in Kitchener-Waterloo experienced a decrease in stress and improved general functioning.

Despite these promising results, Bond et al (2013) note that single session research thus far has been prone to methodological weaknesses. Small sample sizes, lack of randomization and control groups, an emphasis on case studies, low response rates, and a focus on the therapeutic process rather than outcomes characterize much of the research that has been done thus far on brief therapy (Bond et al, 2013.) In their literature review, Hymmen, Stalker and Cait (2013) noted that the majority of clients find booked single session or walk-in therapy helpful, but that future research should increase its rigor by using standardized measures, control groups and larger sample sizes.

Research has also focused heavily on client satisfaction with these services, rather than their outcomes. Perkins (2006) found that 95% of sample was satisfied with service immediately after service, and 88% satisfied after one month. Miller (2008) reported that 82% of a sample of 403 clients reported overall high satisfaction with Eastside Family Centre’s walk-in program in Calgary, with the greatest perceived strengths of the service being immediate accessibility and therapist attitude. Barwick et al (2012) found walk-in clients had significantly higher levels of satisfaction than “usual service” clients on varying dimensions of client satisfaction. Other researchers have found that, overall, the large majority of clients of brief services tend to be highly satisfied with that service (Hair and Shortall, 2013; Harper-Jaques, McElheran, Slive, & Leahey, 2008; Petrakis & Joubert, 2013; Taylor, Wright and Cole, 2010.) While these results are encouraging, satisfaction is not a direct change as a result of brief
therapy but rather a part of process evaluation, and should be examined as such.

With regard to research that has focused on outcomes, researchers have used a variety of instruments to measure a variety including changes in psychological distress (Perkins, 2006; Stalker et al., 2012,) or behavioral and emotional adjustment (Berwick et al, 2013.) Researchers have also written their own “in-house” measures to capture the specific dimension of interest, for example, frequency and severity of the presenting problem or client satisfaction, (Barwick et al. 2013; Hair & Shortall, 2013; Perkins, 2006; Stalker, Horton, & Cait, 2012.) Campbell (1999) noted that there was no specific measure used to assess the presenting problem in brief services, and thus “it is impossible to evaluate whether clients’ reports of change [were] just reflections of satisfaction with the service” (p. 184.) He used his locally developed Problem Evaluation Summary (PES) instrument to assess both severity and frequency of the presenting problem (“Problem Scale”), and clients perceived coping skills (Coping Scale”). Campbell found that the PES had a high degree of both content and construct validity.

Numerous studies show that therapeutic alliance is a reliable predictor of outcome in psychotherapy in general (Orlinsky, Rønnestad, & Willutzki, 2004.) Building on these results, Duncan et al (2003) describe the development and validation of the Session Rating Scale (SRS), a very brief “everyday use” clinical measure designed to measure therapeutic alliance (p. 9.) The SRS was shown to be a valid and feasible measure of therapeutic alliance and client functioning, and these results have been shown in further research (Hafkenscheid et al, 2010; Janse et al, 2014.) There is limited research indicating that the SRS may be predictive with regard to client outcomes (Sourouri & Olsson, 2011.) It is of interest to determine how therapeutic outcomes may be related to therapeutic alliance.

Program evaluation models have been used to evaluate different brief therapy or walk-in programs. Bhanot-Malhotra, Livingstone and Stalker (2009-2010) used Patton’s (2002) utilization-based framework of evaluation and a goals-based model of program evaluation to conduct an overview of
walk-in counseling centres in Ontario. These frameworks allowed for an outcomes-focused study whose findings would allow investigators to determine the specific outcomes of walk-in clinics, and whether the programs in questions met the desired goals. This approach seemed appropriate with regard to the current investigation, where determining outcomes of brief therapy is imperative.

Methodology
Please note that a copy of the Evaluation Framework is presented in Appendix B.

Evaluation Overview: Evaluation Design

The evaluation was conducted using a pre-test, post-test and 3-month post-test design. Data was collected from clients at three points in time: 1) immediately before they started a counseling session, 2) immediately after they completed a counseling session and 3) three months after they had completed the counseling session.

Timing/Setting of Data Collection

The data were collected between April 2014 and November 2014. Since this project was a multi-site program evaluation, data was collected at 7 different partner sites: Reach Out Centre for Kids, the Hincks-Dellcrest Institute and Gail Appel Institute, East Metro Youth Services, Oolagen, Point in Time Centre for Children, Youth, and Parents, Yorktown Family Services and Youth Services Bureau of Ottawa. Note that the evaluation measures/methodology was the same at each site.

Intervention Type

The focus of this evaluation was on Brief Services programs (single session therapy and booked single session therapy). Please refer to the attached Program Logic Model for a detailed overview of the program (refer to Appendix A).
**Sample Size/Characteristics**

A total of 494 clients from six partner sites participated in the Brief Services Evaluation Project. However, the number of clients who completed both pre and post session measures was 352. Please note that the data analysis focuses on those who completed both pre-test and post-test measures.

Caregivers accounted for 303 (61.3%) of the total sample, while youth were the remaining 191 (38.7%). Females comprised 67.8% of the sample while males comprised 19%; in 13% of cases it was not possible to determine client gender based on client name.

**Data Collection Methods:**

**Instruments**

1) Brief Services Evaluation Pre-Session Questionnaire

The Brief Services Evaluation Pre-Session Questionnaire is an internally developed survey designed to assess various outcomes that may result from a single session of therapy (refer to Appendix C for a copy of the questionnaire). The outcomes that are assessed include: understanding of the problem/issue, awareness of strengths/skills, awareness of community resources/social supports and the development of new ideas/strategies to address the problem/issue. The questionnaire was used as a pre-session measure during this evaluation project (i.e., clients completed it before they went into the session).

The Brief Services Evaluation Pre-Session Questionnaire consists of 7 items. The first question is an open-ended question asking respondents to identify the problem/issue that brought them to the walk in clinic. The remaining 6 questions follow a Likert type format with responses ranging from Strongly Disagree (1) to Strongly Agree (6). Sample items from the questionnaire include “I have a good understanding of the problem/issue that brought me to the counseling session.” and “I have the skills that I need to help me solve the problem/issue.”
2) Brief Services Evaluation Post-Session Questionnaire

The Brief Services Evaluation Post-Session Questionnaire is also an internally developed survey designed to assess various outcomes that may result from a single session of therapy (refer to Appendix C for a copy of the scale). It was administered to clients after they completed their therapy session. The questions/format of the scale are the same as the Brief Services Evaluation Pre-Session Questionnaire. However, an additional two questions were added to the scale in order to assess whether clients had important realizations/aha moments during the counseling session.

3) Brief Services Evaluation 3 Month Post-Session Questionnaire

The Brief Services Evaluation 3 Month Post-Session Questionnaire is an internally developed survey designed to assess some longer-term outcomes that may result from a single session of therapy (refer to Appendix C for a copy of the scale). It was administered to clients 3 months after they had completed their therapy session. The questions/format of the scale are similar to the other Brief Services Evaluation Questionnaires. However, additional questions were added to assess whether 1) the problem/issue had improved, 2) whether clients had used the ideas,strategies they had learned about during the session and 3) whether the realizations/aha moments had continued to be helpful to them. Additional questions were also included to assess whether clients had been to the clinic on more than one occasion, whether they had seen the same therapist (if they had been to the clinic more than once) and whether they had accessed counseling services at another organization.

4) Problem Evaluation Summary

The Problem Evaluation Summary (PES) (Campbell et al, 1999) is a standardized measure of clients’ perceived problems and coping abilities. A copy of the scale is included in Appendix C. The seven-item questionnaire’s first four items measure the client’s perceived frequency, severity and level of interference of the issue, as well as client level of upset. These values are summed to reflect the Problem Scale score. Similarly, the other three items on the PES measure clients’ perceived control,
confidence, and understanding of the issue to comprise the Coping Scale score. Higher scores on the Problem and Coping Scales reflect a more severe problem and greater coping skills, respectively. The Cronbach’s Alphas for both subscales of the PES in this evaluation suggest that the scale has adequate reliability (Problem Scale = .69, Coping Scale = .63).

5) Session Rating Scale

The Session Rating Scale (SRS) (Miller, Duncan, Johnson, 2002) measures four dimensions of therapeutic alliance: a relational bond between the therapist and client; agreement on the goals of therapy; agreement on the tasks of therapy, and overall client perceptions of the session. Please refer to Appendix C for a copy of the scale. Each scale has a range of values from 0-10, which are summed to compute the overall SRS score, with a maximum score of 40 indicating high therapeutic alliance. Overall scores below 36 or below 9 in an individual scale are considered indicative of a source of concern, as in general clients tend to rate therapeutic alliance very highly (Duncan et al., 2003). The SRS had adequate reliability in the current study, with a Cronbach’s alpha scale reliability of .871 for the four items on the scale.

6) Interview Guide for Key Informant Interviews

We conducted key informant interviews with therapists as part of this project. The therapist interviews were guided by the following three questions:

1) Has your thinking about what is possible in a single session of therapy changed? If so, how?

2) Have you experienced personal realizations/“aha” moments in therapy sessions? If so, what were they?

3) Has working in the Brief Services Program influenced the rest of your work? If so, how?

Procedure

1) Before Session (Pre-test)
After a client/family arrived at the clinic, they were asked to fill out some paperwork by the receptionist (e.g., questions about demographics, the presenting issue, perceived strengths, their hopes for the session, etc.). In addition to this usual paperwork, clients were given a consent form for the Brief Services evaluation. This consent form provided them with an overview of the study as well as any additional information required for informed consent. If clients agreed to participate in the evaluation, then they were asked to complete two surveys prior to the session. The first survey was the Brief Services Evaluation Pre-Session Questionnaire. The second survey was the Problem Evaluation Summary. Clients were given as much time as they needed to complete both surveys. Clients handed the completed paperwork to the relevant staff (e.g., receptionist, supervisor) prior to starting their therapy session. Note that for confidentiality reasons, completed surveys were handed back in envelopes.

2) After Session (Post-test)

Clients were asked to complete two evaluation questionnaires at the end of their session. The first survey was the Brief Services Evaluation Post-Session Questionnaire. The second survey was the Session Ratings Scale. The therapist discussed how to complete the measures and gave the client copies of the surveys along with an envelope. The therapist then left the room so that the client could complete these measures. It took clients approximately 5 minutes to complete both surveys. After completing the surveys, the client placed them in an envelope, sealed it, and then placed the envelope in a locked drop box.

3) Three Months After Session (Three month Post-test)

Three months after the date of the session, clients were emailed two surveys to complete. The first survey was the Brief Services Evaluation 3 month Post Session Questionnaire and the second survey was the Problem Evaluation Summary. Both surveys were administered online via Survey Monkey. The completed online surveys were stored on a secure server until accessed for data analysis.
4) Key Informant Interviews

The Research Assistant for the project conducted key informant interviews with 3 therapists at each partner site (21 interviews in total.) Contacts at partner organizations decided which therapists should be interviewed. Therapists were asked three questions related to how their thinking about brief services may have changed. The interviews were conducted over the phone and they took place in October 2014. Therapists had as much time as they need to respond to each question. However, the interviews generally did not last longer than 20 minutes.

Ethical Considerations:

The evaluation project went through an ethics review process at each partner site prior to starting data collection. Several ethical considerations were reviewed during this process (e.g., informed consent, confidentiality of data, etc.). A copy of the Ethics Application is presented in Appendix D. Copies of the consent forms are presented in Appendix E. Note that there were no significant ethical concerns about the project and any minor concerns identified by ethics committees were resolved prior to data collection.

Data Analysis Plan:

The data analyses were conducted using the Statistical Software Package for the Social Sciences (SPSS). Both outcome-focused and process-focused evaluation questions were addressed in these analyses. Since we were utilizing a pre-test, post-test and 3 month post-test design for our evaluation, we conducted Paired Samples t-tests and Wilcoxon Signed Rank tests on the data.

Evaluation Limitations:

Limitation 1: Self-Report Design
One of the limitations of our evaluation was the use of a self-report design. As part of our evaluation, youth/caregivers were asked to report on various outcomes (e.g., understanding of problem/issue, awareness of strengths/skills, etc.). This could have introduced a bias in the results. For example, youth/caregivers may have rated their understanding of the problem/issue as being better than it actually was as this pre-session perspective was shaped by their current understandings prior to the session. We tried to address this challenge by reiterating that there were no right or wrong answers to the survey questions and that their responses would have no impact on the quality of care they received at our agency.

Limitation 2: Small Sample Size for 3 Month Follow Up

A second limitation was that the sample size for our 3-month follow up was relatively small (n=70). This could introduce various biases in the results. For example, it is possible that only those respondents who had a strong interest in the service responded to the follow up survey (e.g., those who had more complex mental health needs, those who were on waiting lists for further services, etc.). In addition, a small sample size leads to lower statistical power. Thus, it is more difficult to show that there was a significant effect (i.e., it is harder to show that there were improvements in outcomes with statistical tests).

Results, Discussion and Interpretation:

Process Evaluation Questions:

*What sorts of problems/issues lead clients to access service at Brief Service programs?*

Clients were asked to identify the problem/issue that brought them to the counseling session on the pre-session questionnaire. Specifically, they were asked to respond to the question “What is the main problem/issue that has brought you to the counseling session today?” Client responses were analyzed and coded according to the presenting problem.
Clients came to the counseling session for a variety of reasons. The most frequently reported were “other problem” (20.4%), anxiety (14.4%), general behavioral issues (12.3%), family conflict (8.7%), anger/aggression (6.7%), anxiety and depression ((3.4%), self-harm/suicidality (3.2%), and school problems (3.2%). Note that 22% of clients did not report the presenting problem.

*Are high levels of therapeutic alliance possible in a single session of therapy?*

In order to answer this evaluation question, we administered the Session Rating Scale to clients. Clients’ were asked to complete the Session Rating Scale (SRS) immediately following their session. The SRS measures four dimensions of therapeutic alliance: a relational bond between the therapist and client; agreement on the goals of therapy; agreement on the tasks of therapy, and overall client perceptions of the session. Each scale has a range of values from 0-10, which are then summed to compute the overall SRS score, with a maximum score of 40 indicating high therapeutic alliance. Overall scores below 36 or below 9 in an individual scale are considered indicative of a source of concern, as in general clients tend to rate therapeutic alliance very highly (Duncan et al., 2003.)

A total of 344 clients completed the SRS; the average score on the scale was 35.14 (out of a maximum score of 40). Approximately 20% of the clients reported a score of 40. The average scores on the individual scales were: 8.98 (relational bond between the therapist and client,) 8.67 (agreement on the goals of therapy,) 8.89 (agreement on the tasks of therapy,) and 8.59 (overall client perceptions of the session.). Overall, these findings suggest that it is possible to have a high level of therapeutic alliance during a single session of therapy.

**Outcome Evaluation Questions – Clients:**

In order to answer the client outcome-related evaluation questions, we compared clients’ scores on different outcome measures before and after the session. The specific outcomes that we looked at included: understanding of the problem/issue, awareness of skills and strengths, ideas about
how to solve the problem/issue, and knowledge about social supports and community resources. Paired samples t-tests were conducted on the data to determine whether there was a statistically significant change in the outcomes as a result of the therapy session. The results of our evaluation suggest that clients do experience a number of positive outcomes as a result of participating in a single session of therapy (refer to Table 1 on next page for an overview of results).

*Do clients have an increased understanding of the issue that brought them to the session after participating in the brief service?*

The results suggest that clients do appear to have a better understanding of the problem/issue after participating in a therapy session. The average pre-session score on this item was 4.69 and increased to 5.10 after the session. Note that this was a statistically significant increase (t(342) = -6.75, p<.001).

*Are clients more aware of their strengths after participating in the brief service? Are they more aware of their skills after participating in the brief service?*

According to the results, clients are more aware of their strengths and skills after participating in a counseling session. The average score on the strengths-related item was 3.99 before the session and 4.51 after the session (t (342) = -8.93, p<.001). There was also a similar increase in the skills-related question (average score pre-session = 3.47, average score post-session = 4.41, t(342) = -13.84, p<.001).

*Do clients have an increased awareness of community resources after participating in the brief service? Do they also have an increased awareness of social supports?*

Clients also appear to be more aware of community resources and social supports after participating in a single session of therapy. The average score on the community resources item was

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1 Note that all of the t values that are reported are statistically significant. In other words, there was a statistically significant increase in all outcomes that were measured.
3.76 before the session and it increased to 4.64 after the session (t(342) = -14.87, p<.001). The average score on the social supports-related question was 4.18 pre-session and 4.77 post-session (t(342) = -9.63, p<.001).

**Do clients learn new ideas/strategies to address the problem after participating in the brief service?**

Finally, the results of our statistical analyses indicate that clients' have more ideas about how to solve the problem/issue after completing a counseling session. The average score on this item increased from 3.66 (pre-session) to 4.62 (post-session) (t(342) = -13.64, p<.001).

**Table 1: Average Scores on Outcome Measures Before and Immediately After Counseling Session (n = 352)**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Average pre-session score (out of 6)</th>
<th>Average post–session score (out of 6)</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of the problem/issue</td>
<td>4.69</td>
<td>5.10</td>
<td>.000*</td>
</tr>
<tr>
<td>Awareness of skills</td>
<td>3.47</td>
<td>4.41</td>
<td>.000*</td>
</tr>
<tr>
<td>Awareness of strengths</td>
<td>3.99</td>
<td>4.51</td>
<td>.000*</td>
</tr>
<tr>
<td>Ideas about how to solve the problem/issue</td>
<td>3.66</td>
<td>4.62</td>
<td>.000*</td>
</tr>
<tr>
<td>Knowledge of social supports</td>
<td>4.18</td>
<td>4.77</td>
<td>.000*</td>
</tr>
<tr>
<td>Knowledge of community resources</td>
<td>3.76</td>
<td>4.64</td>
<td>.000*</td>
</tr>
</tbody>
</table>

Do clients experience realizations/aha moments during the session?

To further explore how clients may benefit from a single session, we included an open-ended question about whether they had experienced a realization or ‘aha’ moment during the session. This
question was part of the Brief Services Evaluation Post-Session Questionnaire (“If you thought that you had important realizations/‘aha’ moments during the session, then please provide us with more details.”). In total, 261 clients provided a response to the “aha” moment question. We analyzed clients’ responses in order to identify major themes. The major themes that emerged in clients’ responses were:

1) Clients perceived that they had an increased understanding of the presenting issue.

2) Clients perceived that they had increased their knowledge of coping strategies.

3) Clients felt reaffirmed by their therapists (e.g., more aware of what they were doing right).

4) Clients had personal realizations/new insights about the problem/issue that brought them to the session.

The following are some examples of responses provided by clients. Note that these responses reflect some of the themes that were identified in the data.

- “Better understanding of some of the “whys” of why [child] sometimes behaves the way he does. Also some of the supports that may be available to him at school that I was previously unaware of.”

- “Counselor provided insight into how to approach communications and how communications may be going wrong that I had not thought of. Once pointed out, these insights made sense to me completely.”

- “During the session, I realized that stress shouldn’t be as large of an issue as it is/was and ways to overcome it.”

- “Given directions/options to deal with situations; realize bigger picture.”

- “I had a few moments that allowed me to see a different perspective and to change focus.”

- “I realize I have a lot more strengths than I thought I had, I also found me strategies to help me”
“I realized that I am on the right track towards helping my son. I also learned that I can trust my parental instincts as they seem to be guiding me to the right conclusions.”

“I realized that anxiety can also be a component of grief; and it is all normal and ok.”

“Our talk helped me see some strengths in a difficult situation.”

“That I am actually using many tools to help myself and realizing why I get anxious.”

“We now understand what stresses and pressures our kids have and ways to deal with the situation.”

Are the benefits that clients experience from a counseling session (i.e., short-term outcomes) maintained 3 months after the session?

We were interested in examining whether the benefits of a single session of therapy are maintained over a longer period of time. In order to answer this evaluation question, we asked clients to complete the same evaluation questionnaires 3 months after they had completed a counseling session (the questionnaires were e-mailed to them via Survey Monkey). We then compared clients’ scores on the 3 months post questionnaire to their scores on the pre-session questionnaire to see if improvements in outcomes had been maintained (e.g., whether they still had a better understanding of the problem/issue 3 months after the session, whether they were still aware of their skills/strengths 3 months after the session, etc.). Since the sample size was small (70 clients completed the 3 month questionnaire), we were not able to conduct Paired Samples t tests on the data, but rather used the Wilcoxon Signed Rank Test instead.

The average pre-session and 3-month post-session scores for each outcome in the Brief Services Pre-Session and Brief Services 3-Month Post-Session Questionnaires are summarized in Table 2. As evident in Table 2, the average 3-month post-session scores were higher than the pre-session scores for
every outcome that was measured. Results of the Wilcoxon Signed Rank Test also indicate that the differences in means were statistically significant for every outcome. Although it is difficult to make definitive conclusions due to the small size of the sample, the preliminary trends do suggest that some of the benefits of a single session of therapy may be maintained in the long-term.
Table 2 Average Pre-Session and 3-month Post-Session Scores for Outcomes (n = 70)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Average Score on Brief Services Pre-Session Questionnaire</th>
<th>Average Score on Brief Services 3-Month Questionnaire</th>
<th>Z Value</th>
<th>Statistical Significance of Wilcoxon Signed Rank Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of the problem/issue</td>
<td>4.73</td>
<td>5.10</td>
<td>-2.817</td>
<td>.005*</td>
</tr>
<tr>
<td>Client awareness of skills</td>
<td>3.18</td>
<td>4.05</td>
<td>-4.473</td>
<td>.000*</td>
</tr>
<tr>
<td>Client awareness of strengths</td>
<td>3.83</td>
<td>4.18</td>
<td>-2.142</td>
<td>.032*</td>
</tr>
<tr>
<td>Ideas about how to solve the problem/issue</td>
<td>3.65</td>
<td>4.12</td>
<td>-2.912</td>
<td>.004*</td>
</tr>
<tr>
<td>Knowledge of social supports</td>
<td>3.95</td>
<td>4.67</td>
<td>-3.753</td>
<td>.000*</td>
</tr>
<tr>
<td>Knowledge of community resources</td>
<td>3.67</td>
<td>4.27</td>
<td>-2.818</td>
<td>.005*</td>
</tr>
</tbody>
</table>

*p<.05

We decided to conduct a further analysis with the subset of clients who did show improvement on their outcome scores between pre-session and 3 months post-session (i.e., those clients whose scores increased from pre-session to 3 months post-session). Table 3 summarizes the differences in these scores and whether they were significant. Again, there was a statistically significant increase in all outcomes between pre-session and 3 months post-session. These findings suggest that clients who did show improvements at 3 months post-session had statistically significant improvements. In other words, clients who were doing better 3 months after completing the counseling session, were doing significantly better than they were before they came in for counseling.
Table 3 Average Pre-Session and 3-month Post-Session Outcome Scores for Clients Who Experienced Improvements (n=41)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Average Score on Brief Services Pre-Session Questionnaire</th>
<th>Average Score on Brief Services 3-Month Questionnaire</th>
<th>Z value</th>
<th>Statistical Significance of Wilcoxon Signed Rank Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of the problem/issue</td>
<td>4.54</td>
<td>5.17</td>
<td>-3.626</td>
<td>.000*</td>
</tr>
<tr>
<td>Client awareness of skills</td>
<td>2.95</td>
<td>4.20</td>
<td>-4.727</td>
<td>.000*</td>
</tr>
<tr>
<td>Client awareness of strengths</td>
<td>3.61</td>
<td>4.29</td>
<td>-3.175</td>
<td>.002*</td>
</tr>
<tr>
<td>Ideas about how to solve the problem/issue</td>
<td>3.42</td>
<td>4.29</td>
<td>-4.184</td>
<td>.000*</td>
</tr>
<tr>
<td>Knowledge of social supports</td>
<td>3.61</td>
<td>4.73</td>
<td>-4.397</td>
<td>.000*</td>
</tr>
<tr>
<td>Knowledge of community resources</td>
<td>3.27</td>
<td>4.51</td>
<td>-4.625</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*p<.05

Do clients utilize the ‘moving forward’ ideas that were identified during the session?

In order to answer this evaluation question, we included a question on the Brief Services Evaluation 3 month Questionnaire related to the utilization of ideas/strategies (“I have used the ideas/strategies that I learned about during the counseling session.”). The results suggest that the majority of clients did utilize the ideas/strategies that they learned about during the session. Specifically, 84% of clients reported that they had used ideas/strategies from the session.

Has the problem/issue improved to some extent 3 months after the session?

We also included an additional question on the Brief Services Evaluation 3 month Questionnaire to assess whether clients perceived that the problem/issue that they came in for had improved (“The
A number of clients reported that the problem/issue had improved (42% somewhat agreed with this statement, 18.8% agreed, 7.2% strongly agreed).

To further explore this evaluation question, we analyzed clients’ responses on the Problem Evaluation Summary (PES) (Campbell et al, 1999). The PES is a standardized measure of problem severity. The seven-item questionnaire’s first four items measure the perceived frequency, severity and level of interference of the problem, as well as client level of upset. These values are summed to reflect the Problem Scale score.

Since the sample size was small, we used a Wilcoxon Signed Rank test to analyze the data instead of a Paired Samples t test. The results of the Wilcoxon test suggest that clients’ problems were less severe after the 3-month period. Clients’ scores on the Problem Subscale at the 3 Month post-test were significantly lower than they were before they attended the single session (Z = -4.266, p = .000). This suggests that the problem occurred less frequently, was less severe, created less interference and upset clients less 3 months after the counseling session.

Table 4: Average Pre-Session and 3-Month Post-Session Scores on Problem-related items and Problem Subscale (n = 55)

<table>
<thead>
<tr>
<th>Problem Evaluation Summary Items</th>
<th>Pre-Session Average Score</th>
<th>3 Month Post-Session Average Score</th>
<th>Z value</th>
<th>Statistical Significance of Wilcoxon Signed Ranks test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of problem</td>
<td>2.74</td>
<td>2.11</td>
<td>-3.355</td>
<td>.001*</td>
</tr>
<tr>
<td>Severity of problem</td>
<td>3.88</td>
<td>3.24</td>
<td>-3.622</td>
<td>.000*</td>
</tr>
<tr>
<td>Level of interference of problem</td>
<td>2.91</td>
<td>2.46</td>
<td>-2.983</td>
<td>.003*</td>
</tr>
<tr>
<td>Level of upset at problem</td>
<td>3.61</td>
<td>3.25</td>
<td>-2.539</td>
<td>.011*</td>
</tr>
<tr>
<td>Problem Subscale Score</td>
<td>12.81</td>
<td>10.72</td>
<td>-4.266</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*p<.05
Do clients’ have better coping skills 3 months after the session?

The Problem Evaluation Summary was also used as a measure of client coping. The questionnaire includes a Coping Subscale that is comprised of three items that measure clients’ perceived control, confidence, and understanding of the issue. Higher scores on the Coping Subscale are indicative of greater coping skills.

Table 5 summarizes the average pre-session and three-month post session scores for the coping-related items as well as the Coping Subscale. Due to the smaller sample size, we used a Wilcoxon Signed Ranks test for the analysis instead of a Paired Samples t-test. The total sample size for the analysis was 35. The results of our analyses indicate that clients experienced improvements in all measured dimensions of coping, with two of these increases (control and confidence) being statistically significant. Clients’ scores on the Coping Scale at the 3-month mark were significantly higher than they were before they participated in the counseling session (Z = -3.769, p = .000).

Table 5: Average Pre-Session and 3-Month Post-Session Scores on Coping-related items and Coping Subscale (n = 55)

<table>
<thead>
<tr>
<th>Problem Evaluation Summary Items</th>
<th>Pre-session Average Score</th>
<th>3 Month Post-Session Average Score</th>
<th>Z value</th>
<th>Statistical Significance of Wilcoxon Signed Ranks test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of problem</td>
<td>1.44</td>
<td>2.00</td>
<td>-3.228</td>
<td>.001*</td>
</tr>
<tr>
<td>Confidence in dealing with problem</td>
<td>1.53</td>
<td>2.13</td>
<td>-4.057</td>
<td>.000*</td>
</tr>
<tr>
<td>Understanding of problem</td>
<td>2.64</td>
<td>2.90</td>
<td>-1.770</td>
<td>.077</td>
</tr>
<tr>
<td>Coping Subscale Score</td>
<td>5.62</td>
<td>7.02</td>
<td>-3.769</td>
<td>..000*</td>
</tr>
</tbody>
</table>

*p<.05
**Outcome Evaluation Questions – Therapists:**

Key informant interviews were conducted with therapists at each partner site to ask them about their thoughts and opinions regarding the Brief Service or single session program they were involved with at their agency. The Research Assistant for the project conducted these interviews over the phone. In total, 21 therapists were interviewed (3 therapists from 7 partner sites). Each therapist responded to three standard questions, and their responses were analyzed to identify common themes in their responses.

*Do therapists experience shifts in their thinking about what is possible in a single session as a result of working in the Brief Service program?*

Therapists consistently answered that their thinking about what is possible in a single session of therapy had changed as a result of working in their respective programs. Some of the themes that emerged in their responses were:

1. The idea that something can be accomplished in a single session of therapy - in other words, change is possible in a single session.

2. The usefulness and utility of the competency-focused approach - clients recognize that they already have strengths and skills to deal with a problem/issue.

3. The benefits of identifying a goal and developing a plan to reach that goal.

The following are examples of responses that reflect these themes:

- “It is possible to support clients within the [single session therapy] framework...it is amazing that clients have felt like they have accomplished something.

- “The single session framework challenges the notion of what therapy is, and changed the idea of what can be accomplished.”

- “One session can have a long-lasting impact on clients and families.”

- “One session can be enough.”
**Does working in the Brief Service program influence therapists’ work in other areas?**

Therapists reported that there were certain aspects of the single session approach that could be brought into other work that they did at their agency. The themes that emerged in their responses included:

1. Focusing on/prioritizing a goal for clients
2. Applying a competency-focused and strengths-based approach with clients rather than a problem-focused approach
3. Being mindful/focused in their work

The following are examples of comments from therapists that reflect the above themes:

- “The single session model increases mindfulness of purpose of session, structure of session, and information gathered in session” [that can be brought into other work]
- “The single session therapy approach helps clients with their own solutions based on what’s already there”
- “It is possible to take the [single session] format and style and apply it elsewhere”
- “Being more purposeful in a longer term session with activities that focus on goals is important”

**Do therapists have realizations/aha moments during their work in the Brief Service program?**

Therapists did report having a variety of personal “aha” moments. These related to a variety of issues, but some of the more common themes included:

1. Being mindful during the session.
2. Identifying a priority problem to work on.
3. The possibilities of change within a single session
4. The importance of identifying a goal-focused plan

Some quotations from therapists that reflect these themes include:

- “The change is almost visible [in clients]...they take with them a new awareness of their skills and resources”
- “Clients recognize that they are not the problem, the problem is the problem”
- “You have to have faith in the process and trust the process” [of single session therapy]
- “One session may be all that a client needs at that moment in time to learn new things about themselves”
- “Small things can make a big difference...you can prioritize and deal with things client sees as important”

Implications of Results
The results of this program evaluation support specific findings noted in the literature review, namely those of Barwick et al (2013,) Perkins (2006,) and Perkins and Scarlett (2008,) which suggest that favorable outcomes of single session therapy can be maintained over time. Significantly, these results continue to build on the foundation of a prior program evaluation conducted at ROCK in 2008-09 as described by Young (2011), which found similar favorable outcomes of single session therapy can include an increased number of ideas about dealing with a problem/issue, increased knowledge of community resources, and increased confidence in dealing with the issue.

There were certain challenges in implementing this program evaluation. Coordinating in-person meetings of the entire team proved logistically complicated, and it was necessary to keep all team members informed of progress via individual and team conference telephone calls. It was particularly challenging to find a measure that was succinct enough to allow for timely completion by clients, which led to the development of in-house measures. A steady flow of information between site contacts and the project leads was imperative to deal with any questions regarding recruitment, questionnaire
administration, transportation of completed instruments, and so on. Site-specific updates and results were periodically presented to each site as well to keep them team members apprised of their contributions to the project.

The process evaluation questions of this investigation showed that there is a variety of presenting problems across multiple sites which first bring clients to the therapy session. The data gathered by use of the Session Rating Scale indicated that a high degree of therapeutic alliance seems possible in a single session of therapy. With regard to outcome evaluation questions, the data from the in-house measures suggest that a significant amount of change can occur after a single session of therapy, and that these effects can be maintained after three months. Specifically, after initial conversations among the research team members, it was collaboratively decided that the outcomes of “skills” and “strengths” would be measured with two separate questionnaire items. Statistically different scores for these items at pre-session, post-session, and three-month post-session times suggests that clients may perceive strengths and skills as two unique concepts. It would appear that the team’s decision to measure these outcomes separately was appropriate.

Findings also demonstrate that a single session of therapy can have a significant impact on clients, as indicated by favorable changes in outcome measures. This lends support to the continuing of single session therapy programs at the participating organizations, and to expanding the service at other mental health organizations. Results also lend support to the idea of mandating Brief Services programs as a core service throughout Ontario, as proposed by the Ontario Ministry of Child and Youth Services.

**Stakeholder Involvement and Knowledge Exchange**

**Stakeholder Involvement**

Stakeholders were involved in different ways throughout the evaluation project. First, we had teleconferences with all partner organizations in order to collectively decide on the purpose and scope of the evaluation. Second, phone interviews were conducted with each partner organization in
order to develop the overarching program logic model for the project. Third, we had an in-person meeting in January 2014 to finalize the logic model and evaluation framework for the evaluation. Thus, partner organizations were part of a collaborative decision-making process for the duration of this project. Furthermore, staff members at each partner site were also involved in the data collection process (i.e., therapists/administrative staff were responsible for administering and collecting all survey data). Although external stakeholders were not directly involved in the evaluation process, they were given updates about the project through informal discussions.

**Knowledge Exchange Activities to Date**

We created summary reports of the preliminary evaluation findings for each partner organization. These reports were distributed to all seven organizations so that the preliminary findings could be shared with staff and other stakeholders. The primary contacts at each partner site have also formally and informally provided updates/information about the evaluation project at their respective agencies.

Karen Young (lead investigator) and Carolyn Scholz (research assistant) also presented the results of the Brief Services Evaluation project at the Children’s Mental Health Ontario conference in November 2014.

**Future Knowledge Exchange Activities:**

We plan to post the final report for the Brief Services Evaluation on the websites of each partner agency. We have presented the project and findings at the CMHO conference in Toronto on November 24, 2014. A summary of the evaluation will also appear in the CMHA E-learning module on Brief Services. We also hope to eventually publish the findings from our project.
Conclusions and Next Steps

The program evaluation allowed for insight regarding not only the impact of single session therapy, but also the best strategies about how to co-ordinate a multi-site evaluation. In a collaborative project such as this it was necessary to have team leads that were responsible for gaining input from site contacts about developing an overarching logic model, research instruments, and other aspects of project administration. Regular communication among the team members was imperative to ensure that data was collected in a timely and correct manner.

With regard to evaluation questions, the main insight would be that change is possible after a single session of therapy. Although many different issues bring clients to therapy, it is still possible to see shifts in outcomes after one session, including an increase in ideas as to how to cope with an issue, clients’ knowledge of their own coping skills, and an increased knowledge of community resources where they can seek additional help. Another significant insight would be that this change could be maintained over time, with clients’ perceptions of their problem/issue decreasing as their coping skills increased. The majority of clients also reported after three months that they had actually used some of the coping strategies that had been developed during a single session of therapy. Overall, the implication is that a single session of therapy can have long-term benefits.

There are a number of next steps that can be taken to build on the knowledge that has been gained during this evaluation. As previously stated, it is the intent of the team to submit the results to a journal for publication. Some partners are involved in training of post-graduate students in conducting Brief Therapy, which will provide further knowledge dissemination. As well, the ROCK partners plan to search for opportunities to use the in-house questionnaires to further assess their validity and reliability as instruments. It would be of interest to use the in-house measures at other organizations to achieve this.
Next steps in Ensuring Sustainability:

Reach Out Centre for Kids is an accredited children’s mental health centre providing services for over 35 years. As Halton’s largest and only regional children’s mental health agency, ROCK offers more than 30 programs and services for children and youth aged birth through 17. ROCK currently operates out of 13 sites, including three main offices in Burlington, Oakville and Milton. The agency’s current array of multi-disciplinary services includes a walk-in clinic that has been in existence for 13 years. The Hincks-Dellcrest Centre - Gail Appel Institute was established in 1986 to improve mental health care for children, by providing advanced training, research and community consultation in the area of children’s mental health. In 1993 the Institute created Brief Therapy Training Centres-International as to address the delivery of brief services through training, research and clinical practices. Research is an essential activity of the Institute. In tandem with The Hincks-Dellcrest Centre, the Research department’s studies help build and expand the knowledge base for the field of children’s mental health.

ROCK has historically invested in evaluation capacity, currently employing several staff with graduate level training in research methodology and analysis. Residents and students are involved in research-related placements entering survey data and conducting preliminary analyses. We have developed the fiscal and technological supports required to support evaluation work including a part-time PhD research associate whose primary role is to oversee program evaluations. We have developed an overall evaluation plan for the agency, conduct evaluations of some of our programs and have an Evaluation Review Committee (ERC). The role of this committee is to review client satisfaction and program outcome data to ensure that programs are producing the desired outcomes. We are currently working with community partners, within Halton, and in other regions, from education, public health and other child and youth mental health agencies, to provide assistance and consultation on evaluation tasks and activities.
The Hincks-Dellcrest Centre has both an Evaluation Department and a Research Department. All of the Hincks-Dellcrest programs are evaluated on a rotating basis in collaboration with clinical managers and clinicians in the respective programs. Following evaluation results are discussed with program clinicians. The Research Department evaluates innovative programs and provides feedback to staff, makes presentations at academic and community meetings and prepares both academic manuscripts and user-friendly brochures that translate findings into lay language for a broad audience. The Centre also has a computerized database and technical staff that support this and can offer consultation. Statistical expertise is also available both within the Evaluation and the Research Departments.

This project assisted ROCK to gain experience in coordination of a large evaluation project that spanned multiple organizations. ROCK’s PhD research associate and the research assistant hired specifically for this project were instrumental in the design and implementation phases of the project at ROCK and across all the organizations. They developed skills and knowledge in project management, and communication. They worked toward finding the common ground between the organization’s brief services in order to design the research. The project assisted in the development of the job description and tasks for the newly created Manager of the Centre of Learning position at ROCK as this position was identified as the Project Lead position. This project lead team completed the analysis of the data, and reports, including the presentation at the CMHO conference and the project final report. This experience will assist us to explore possibilities for future research at our own organization and has inspired us to look toward finding ways to continue gathering data from our own and the partner organizations regarding the effectiveness of Brief Services.
References


Hair, H. J., Shortall, R., & Oldford, J. (2013). Where’s help when we need it? Developing
responsive and effective brief counseling services for children, adolescents, and their families. *Social Work in Mental Health, 11*(1), 16-33.


Appendix A: Program logic model for brief services evaluation

**NEED IN THE COMMUNITY:**
1. Need to reduce wait times for service
2. Need to provide quick access to therapy
3. Need clearer and simpler pathways to access services

**PROGRAM GOAL(S):**
1. Immediate barrier free service
2. To provide a diverse group of clients with a relevant and useful therapeutic encounter

**RATIONALE:** Literature and training on brief therapy approaches

**DESCRIPTION OF SERVICE COMPONENTS:**

**Target population:** Wide range of clients access brief services at different sites. Age range varies from site to site. Common presenting issues are anxiety, depression, and family conflict.

**Required Resources:** Clinicians who conduct the sessions are from varying educational backgrounds (social workers, psychologists, family support workers, MH workers, Child and Youth workers, etc.). Student interns, volunteers and staff from community partners may assist with sessions at some of the sites.

**Referral Process:** Major sources of referral are school boards, hospitals and CAS. Clients are also able to self-refer. Clients may learn about the service in a variety of ways (e.g., community outreach, word of mouth, website, school groups, parents nights, etc.). Two of the sites have a formal intake process after which clients are booked for a session. Other sites utilize a walk in format.

**Session:** A client/family arrives at the clinic. They are asked to fill out some paperwork by the receptionist. Paperwork may include questions about demographics, the presenting issue, client’s perceived strengths as well as their hopes for the session (as well as other information). The completed paperwork is given to a supervisor or receptionist and she/he gives this information to the clinician who will provide the therapy session. The clinician reviews the paperwork and subsequently starts the therapy session with the client/family. One or more clinicians conduct the session depending upon the site (some sites have students/volunteers/community partners). The modality of therapy used is narrative, solution-focused, modified CBT or mixed approach. On average, sessions last about 1 hour. At some sites there is a consultation break during which the clinician may consult with a supervisor/team/colleague. At the end of the session, clients are provided with any necessary paperwork (e.g., photocopy of session summary, safety plan, etc.). They are also asked to complete an evaluation questionnaire at most sites.

1. Clients have an increased understanding of the problem/issue that brought them to the service. (CLIENT OUTCOME)
2. Clients have an increased awareness of the strengths that they have to help them address the problem/issue.
### Appendix B: Process Evaluation Framework

<table>
<thead>
<tr>
<th>Evaluation Questions (What do we want to know about this program?)</th>
<th>Link to activities or target population in logic model</th>
<th>Indicator(s) (What is one possible measurable approximation of the outcome?)</th>
<th>Data Collection Method(s) (What data collection method will be used to measure the indicator? e.g., Survey, focus group, interview, document review, etc.)</th>
<th>Data Collection Tool(s) (What specific tool will be used? Specify the name and whether it is a standardized tool or internally-developed)</th>
<th>Respondent(s) (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)</th>
<th>Person(s) Responsible for Data Collection (Who is responsible for ensuring the data are collected?)</th>
<th>Timing of Data Collection (When will the data be collected?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What sorts of problems/issues lead clients to access service at Brief Service programs?</td>
<td>Target population</td>
<td>Client response on open-ended question specify problems/issues that led clients to seek service</td>
<td>Survey</td>
<td>Brief Services Evaluation Pre-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of August 2014</td>
</tr>
<tr>
<td>Are high levels of therapeutic alliance possible during a single session?</td>
<td>Session</td>
<td>High level of therapeutic alliance (as measured by SRS)</td>
<td>Survey</td>
<td>Session Rating Scale (Miller, Duncan, Johnson, 2002) (standardized tool)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of August 2014</td>
</tr>
<tr>
<td>Evaluation Questions</td>
<td>Link to activities or target population in logic model</td>
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<tr>
<td>Do clients have an increased understanding of the issue that brought them to the session after participating in the brief service?</td>
<td>Increased understanding of problem/issue</td>
<td>Increased score on the understanding-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of November 2014</td>
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</table>

Note that two measures are listed in cases where we needed to make comparisons between pre-test and post-test measures for our data analysis.
<table>
<thead>
<tr>
<th><strong>Evaluation Questions</strong></th>
<th><strong>Link to activities or target population in logic model</strong></th>
<th><strong>Indicator(s)</strong></th>
<th><strong>Data Collection Method(s)</strong></th>
<th><strong>Data Collection Tool(s)</strong></th>
<th><strong>Respondent(s)</strong></th>
<th><strong>Person(s) Responsible for Data Collection</strong></th>
<th><strong>Timing of Data Collection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are clients more aware of their strengths after participating in the brief service?</td>
<td>Increased awareness of strengths</td>
<td>Increased score on the strengths-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of November 2014</td>
</tr>
<tr>
<td>Are clients more aware of their skills after participating in the brief service?</td>
<td>Increased awareness of skills</td>
<td>Increased score on the skills-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
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<tr>
<td>Do clients have an increased awareness of community resources after participating in the brief service?</td>
<td>Increased awareness of community resources</td>
<td>Increased score on the community resources-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation Post-Session Questionnaire</td>
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<td>Increased awareness of social supports</td>
<td>Increased score on the social supports-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
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<tr>
<td>Do clients learn new ideas/strategies to address the problem after participating in the brief service?</td>
<td>Development of new ideas/strategies to address problem/issue</td>
<td>Increased score on the ideas-related item on the Brief Services Post-Session Questionnaire</td>
<td>Survey</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of November 2014</td>
</tr>
<tr>
<td>Do clients experience realizations/aha moments during the session?</td>
<td>Realizations/aha moments</td>
<td>Clients’ responses to open-ended question on Brief Services Evaluation Post-Session Questionnaire indicates that they had aha moments</td>
<td>Survey</td>
<td>Brief Services Evaluation Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of April 2014 to end of November 2014</td>
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<tr>
<td>(What do we want to know about this program?)</td>
<td>(What is one possible measurable approximation of the outcome?)</td>
<td>(What is one possible measurable approximation of the outcome?)</td>
<td>(What data collection method will be used to measure the indicator? e.g., Survey, focus group, interview, document review, etc.)</td>
<td>(What specific tool will be used? Specify the name and whether it is a standardized tool or internally-developed)</td>
<td>(Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)</td>
<td>(Who is responsible for ensuring the data are collected?)</td>
<td>(When will the data be collected?)</td>
</tr>
<tr>
<td>Are the benefits that clients experience (i.e., short-term outcomes) maintained 3 months after the counseling session?</td>
<td>Benefits of session maintained over longer period of time</td>
<td>Scores on all short term outcome items on Brief Services 3 Month Post-session Questionnaire are higher than what they were at baseline/pre-session</td>
<td>Online Survey (administered 3 months after session)</td>
<td>1) Brief Services Evaluation Pre-Session Questionnaire (internally developed) 2) Brief Services Evaluation 3 Month Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of July 2014 to end of November 2014</td>
</tr>
<tr>
<td>Do clients utilize the ‘moving forward’ ideas that were identified during the session?</td>
<td>Utilization of ideas/strategies</td>
<td>Clients’ rating on 3 Month Post-Session Questionnaire indicates that they have used ideas from session.</td>
<td>Online Survey (administered 3 months after session)</td>
<td>Brief Services Evaluation 3 Month Post-Session Questionnaire (internally developed)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
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<tr>
<td>Has the problem/issue improved to some extent 3 months after the session?</td>
<td>Problem/Issue relieved</td>
<td>1) Clients’ rating on 3 Month Post-Session Questionnaire indicates that problem has improved. 2) Score on Problem Subscale of Problem Evaluation Summary is lower than baseline value</td>
<td>Online Survey (administered 3 months after session)</td>
<td>1) Brief Services Evaluation 3 Month Post-Session Questionnaire (internally developed) 2) Problem Evaluation Summary (Campbell et al, 1999) – Problem Subscale (standardized tool)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
<td>End of July 2014 to end of November 2014</td>
</tr>
<tr>
<td>Do clients’ have better coping skills 3 months after the session?</td>
<td>Better coping skills</td>
<td>Score on Coping Subscale of Problem Evaluation Summary is higher than baseline value</td>
<td>Online Survey (administered 3 months after session)</td>
<td>Problem Evaluation Summary (Campbell et al, 1999) – Coping Subscale (standardized tool)</td>
<td>Caregiver and/or Youth over 12</td>
<td>Primary contact at each partner site</td>
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<tr>
<td>Evaluation Questions</td>
<td>Link to activities or target population in logic model (What do we want to know about this program?)</td>
<td>Indicator(s)</td>
<td>Data Collection Method(s) (What data collection method will be used to measure the indicator? e.g., Survey, focus group, interview, document review, etc.)</td>
<td>Data Collection Tool(s) (What specific tool will be used? Specify the name and whether it is a standardized tool or internally-developed)</td>
<td>Respondent(s) (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)</td>
<td>Person(s) Responsible for Data Collection (Who is responsible for ensuring the data are collected?)</td>
<td>Timing of Data Collection (When will the data be collected?)</td>
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<tr>
<td>Do therapists experience shifts in their thinking about what is possible in a single session as a result of working in the Brief Service program?</td>
<td>Therapists shifts in thinking</td>
<td>Themes from therapist interviews indicate that therapists’ thoughts about what is possible in a single session has changed</td>
<td>Key informant interview</td>
<td>Interview guide (internally developed)</td>
<td>3 therapists at each partner site (21 interviews total)</td>
<td>Primary contact at each partner site Research Assistant who conducted interviews</td>
<td>October 2014</td>
</tr>
<tr>
<td>Does working in the Brief Service program influence therapists’ work in other areas?</td>
<td>Influence on therapists other work</td>
<td>Themes from therapist interviews indicate that Brief Service program has influenced therapist practice in other areas of work</td>
<td>Key informant interview</td>
<td>Interview guide (internally developed)</td>
<td>3 therapists at each partner site (21 interviews total)</td>
<td>Primary contact at each partner site Research Assistant who conducted interviews</td>
<td>October 2014</td>
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<td>Evaluation Questions</td>
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<tr>
<th>Link to activities or target population in logic model</th>
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<td>(What is one possible measurable approximation of the outcome?)</td>
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<th>Indicator(s)</th>
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<td>(What is one possible measurable approximation of the outcome?)</td>
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<th>Data Collection Method(s)</th>
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<td>(What data collection method will be used to measure the indicator? e.g., Survey, focus group, interview, document review, etc.)</td>
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<th>Data Collection Tool(s)</th>
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<td>(What specific tool will be used? Specify the name and whether it is a standardized tool or internally-developed)</td>
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<th>Respondent(s)</th>
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<td>(Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)</td>
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<th>Person(s) Responsible for Data Collection</th>
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<td>(Who is responsible for ensuring the data are collected?)</td>
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<th>Timing of Data Collection</th>
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<tr>
<td>(When will the data be collected?)</td>
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<tr>
<th>Do therapists have realizations/aha moments during their work in the Brief Service program?</th>
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<tr>
<th>Therapist realizations/aha moments</th>
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<tr>
<th>Themes from therapist interviews indicate that therapists have experienced realizations/aha moments during their work in the Brief Service program</th>
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<th>Key informant interview</th>
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<th>Interview guide (internally developed)</th>
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<th>3 therapists at each partner site (21 interviews total)</th>
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<th>Primary contact at each partner site</th>
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<th>Research Assistant who conducted interviews</th>
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Appendix C: Questionnaires

Brief Services Evaluation Pre-session Questionnaire

Name: ___________________________________________ Date: ____________________________

What is the main problem/issue that has brought you to the counseling session today?

Please read each statement carefully and circle the number (1-6) that best tells us how much you agree with each statement at this time. There are no right or wrong answers, just your opinions. It's ok to guess.

1. I have a good understanding of the problem/issue that brought me to the counseling session.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |

2. I have the skills that I need to help me solve the problem/issue.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |

3. I am aware of the strengths that I have to help me solve the problem/issue.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |

4. I have some ideas about how to solve the problem/issue.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |

5. I know about the social supports (e.g., family, friends, coaches, etc.) that are available to help me with this problem/issue.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |

6. I know about the community resources that are available to help me with this problem/issue.

| 1 Strongly Disagree | 2 | 3 Somewhat Disagree | 4 Somewhat Agree | 5 Agree | 6 Strongly Agree |
Brief Services Evaluation 3-Month Post Session Questionnaire

Name: ___________________________________________  Date: __________________________

Please read each statement carefully and circle the number (1-6) that best tells us how much you agree with each statement at this time. There are no right or wrong answers, just your opinions. It’s ok to guess.

1. I have a good understanding of the problem/issue that brought me to the counseling session.

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<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Strongly Disagree</td>
<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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2. I have the skills that I need to help me solve the problem/issue.

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<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Strongly Disagree</td>
<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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3. I am aware of the strengths that I have to help me solve the problem/issue.

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<td>Strongly Disagree</td>
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<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
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4. I have some ideas about how to solve the problem/issue.

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<td>Strongly Disagree</td>
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<td>Somewhat Disagree</td>
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<td>Agree</td>
<td>Strongly Agree</td>
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5. I know about the social supports (e.g., family, friends, coaches, etc.) that are available to help me with this problem/issue.

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<td>Strongly Disagree</td>
<td>Strongly Disagree</td>
<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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6. I know about the community resources that are available to help me with this problem/issue.

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<td>Strongly Disagree</td>
<td>Strongly Disagree</td>
<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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Disagree | Disagree | Agree | Agree
--- | --- | --- | ---
7. I had important realizations/’aha’ moments during the counseling session.

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<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Somewhat Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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If you thought that you had important realizations/’aha’ moments during the session, then please provide us with more details: ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

We would like to contact you in a few weeks to ask you some follow up questions. If you consent to this, then please provide your e-mail address and/or phone number below.

Name: ____________________________________________
E-mail address: _____________________________________
Mailing address: _____________________________________

Thanks for your help!
**Brief Services Evaluation 3-Month Post Session Questionnaire**

Please read each statement carefully and circle the number (1-6) that best tells us how much you agree with each statement at this time. There are no right or wrong answers, just your opinions. It’s ok to guess.

1. I have a good understanding of the problem/issue that brought me to the counseling session.

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<tr>
<td></td>
<td>Strongly Disagree</td>
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<td>Somewhat Disagree</td>
<td>3</td>
<td>Somewhat Agree</td>
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2. I have the skills that I need to help me solve the problem/issue.

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<tr>
<td></td>
<td>Strongly Disagree</td>
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<td>Somewhat Disagree</td>
<td>3</td>
<td>Somewhat Agree</td>
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</table>

3. I am aware of the strengths that I have to help me solve the problem/issue.

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<tr>
<td></td>
<td>Strongly Disagree</td>
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<td>Somewhat Disagree</td>
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<td>Somewhat Agree</td>
<td>4</td>
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4. I have some ideas about how to solve the problem/issue.

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<td>Somewhat Disagree</td>
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5. I know about the social supports (e.g., family, friends, coaches, etc.) that are available to help me with this problem/issue.

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6. I know about the community resources that are available to help me with this problem/issue.

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7. I have used the ideas/strategies that I learned about during the counseling session.

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8. The problem/issue that I came in for has improved.

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9. I had important realizations/’aha’ moments during the counseling session.

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10. The realizations/’aha’ moments that I had during the session have continued to be helpful to me.

X

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Have you used our counseling service more than once? YES NO

What was the date of your last visit? (INSERT DATE) _________________________________

If you have been to our clinic more than once, did you see the same therapist each time? YES NO NOT APPLICABLE

Have you used any other counseling service since you came to our clinic? YES NO

Do you have any other comments for us?
_____________________________________________________________________________________________
**Problem Evaluation Summary**

Name: ___________________________________________  Date: ________________

Keeping in mind the main problem that brings you to see us, please complete the following ratings of the problem. Circle the response that best represents what you think.

Over the past seven (7) days:

1. Did the problem happen:
   - Not at all
   - A few days
   - About half the time
   - Nearly every day
   - Every day

2. When the problem happened, was it:
   - Not at all
   - Very weak
   - Pretty weak
   - Quite strong
   - Pretty strong
   - Very strong

3. How much has the problem interfered in your family's life:
   - Not at all
   - Not a lot
   - In the way
   - In the way, sometimes
   - In the way, a lot
   - Constantly in the way

4. How upset/worried have you been by the problem:
   - Not at all
   - Not much
   - A bit
   - Somewhat
   - Extremely

5. How much control do you feel you have over the problem:
   - None at all
   - Not a lot
   - A bit
   - Some
   - Quite a lot

6. How confident have you felt in dealing with the problem:
   - Not at all
   - Not a lot
   - A bit
   - Somewhat
   - Very

7. How much understanding of the problem have you had:
   - None at all
   - Not a lot
   - A bit
   - Some
   - A lot
Session Rating Scale (SRS V.3.0)

Name ____________________ Age (Yrs): ___
ID# ______________________ Sex: M / F
Session # ___ Date: _______________

Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.

We did not work on or talk about what I wanted to work on and talk.

The therapist's approach is not a good fit for me.

Goals and Topics

I felt heard, understood, and respected.

We worked on and talked about what I wanted to work on and talk.

The therapist's approach is a good fit for me.

Approach or Method

There was something missing in the session today.

Overall

I--------------------------

Overall, today's session was right for me.

Institute for the Study of Therapeutic Change

www.talkingcure.com
© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson
Questions for Key Informant Interviews with Therapists

1. Has your thinking about what is possible in a single session of therapy changed? If so, how?
2. Have you experienced personal realizations/“aha” moments in therapy sessions? If so, what were they?
3. Has working in the Brief Services Program influenced the rest of your work? If so, how?
### 1. TITLE OF RESEARCH PROJECT

Brief Services Planning Evaluation Project

### 2. INVESTIGATOR INFORMATION

#### Lead Investigators:

| Title: Ms. | Name: Karen Young, Manager Centre of Learning |
| Organization: ROCK (Reach Out Centre for Kids) |
| Mailing address: 471 Pearl Street, Burlington ON L7R 4M4 |
| Phone: 905-634-2347 ext. 227 | Institutional e-mail: kareny@rockonline.ca |

| Title: Dr. | Name: Surbhi Bhanot-Malhotra, Research Associate |
| Organization: Reach Out Centre for Kids |
| Mailing address: 471 Pearl Street, Burlington ON L7R 4M4 |
| Phone: 905-634-2347 | Institutional e-mail: surbhibm@rockonline.ca |

| Title: Dr. | Name: Nancy Cohen, Director of Research |
| Organization: The Hincks-Dellcrest Institute and Gail Appel Institute |
| Mailing address: 114 Maitland Street, Toronto, Ontario, M4Y 1E1 |
| Phone: 416-924-1164 ext. 3312 | Institutional e-mail: ncohen@hincksdellcrest.org |

| Title: Mr. | Name: Jim Duvall |
| Organization: The Hincks-Dellcrest Institute and Gail Appel Institute |
| Mailing address: 114 Maitland Street, Toronto, Ontario M4Y 1E1 |
| Phone: 416-924-1164 ext. 3342 | Institutional e-mail: jduvall@hincksdellcrest.org |

#### Program Evaluation Team:

| Title: Mr. | Name: David O'Brien, Supervisor |
| Organization: East Metro Youth Services |
| Mailing address: 1200 Markham Road, Scarborough ON M1H 3C3 |
| Phone: 416-438-3697 ext. 360 | Institutional e-mail: dobrien@emys.on.ca |

| Title: Ms. | Name: Marilyn Vasilkioti, Supervisor of Community Services |
| Organization: Oolagen |
| Mailing address: 75 Wellesley Street East, Suite 500,Toronto, ON M4Y 1G7 |
| Phone: 416-395-0660 | Institutional e-mail: marilynvasilkioti@oolagen.org |

| Title: Ms. | Name: Joan Wilson |
| Organization: Point in Time Centre for Children, Youth, and Parents |
| Mailing address: 69 Eastern Avenue, Box 1306, Haliburton, ON K0M 1BO |
|-----------------------------|----------------------|-----------------|
| Phone: 705-457-5345         | Institutional e-mail: joanw@pointintime.ca |
| Title: Ms. Katina Watson, Director of Service |
| Organization: Yorktown Family Services |

| Mailing address: 2010 Eglinton Avenue West, Suite 300, Toronto, ON M6E 2K3 |
|-----------------------------|----------------------|-----------------|
| Phone: 416-394-2424         | Institutional e-mail: katinaw@yorktonfamilyservices.com |
| Title: Ms. Mary Rella, Manager of Clinical Services |
| Organization: Yorktown Family Services |

| Mailing address: 2675 Queensview Drive, Ottawa, ON K2B 8K2 |
|-----------------------------|----------------------|-----------------|
| Phone: 613-562-3004 ext. 235 | Institutional e-mail: mdavidson@ysb.on.ca |
| Title: Ms. Maureen Davidson, Coordinator of Youth and Family Counseling |
| Organization: Youth Services Bureau of Ottawa |

3. **LOCATION(S) WHERE THE RESEARCH WILL BE CONDUCTED:**

This program evaluation will be conducted at the following agencies:

1. ROCK
2. Hincks-Dellcrest and Gail Appel Institute
3. East Metro Youth Services
4. Oolagen
5. Point in Time Centre for Children, Youth, and Parents
6. Yorktown Family Services
7. Youth Services Bureau of Ottawa

4. **OTHER RESEARCH ETHICS BOARD APPROVAL(S)**

Not all sites have a formal Research Ethics Board; however, all partner sites will submit approval from their specific ethics review committees.

5. **FUNDING OF THIS PROJECT**

<table>
<thead>
<tr>
<th>Funding Status</th>
<th>Source and Type</th>
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<tr>
<td>Funded</td>
<td>Ontario Centre of Excellence for Child and Youth Mental Health, Planning Evaluation Grant</td>
<td>Fund #: EPG-1714</td>
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6. **CONTRACTS**

Is this research to be carried out as a contract? Yes X No □

Yes this program evaluation will be carried out as a contract/grant.
Is there any aspect of the contract that could put any member of the research team in a potential conflict of interest? Yes ☐  No ☒

7. PROJECT START AND END DATES

Estimated start date for the component of this project that involves human participants or data: April, 2014
Estimated completion date of involvement of human participants or data for this project: October, 2014

8. LITERATURE REVIEW:

The lead investigators have reviewed the literature and made research-informed decisions regarding the use of the Problem Evaluation Summary and the Session Rating Scale measures. Many different measures such as the Outcomes rating Scale, Parenting Sense of Competence Scale, the Tool to Measure Parenting Self Efficacy (TOPSE,) the Parental Locus of Control Scale, and the Children's Locus of Control Scale were reviewed. The literature shows that the Session Rating Scale is a valid and reliable measure of therapeutic alliance. The Problem Evaluation Summary is also considered to be a reliable measure of various aspects of the problem/issue that clients seek mental health services for (e.g., frequency/intensity of problem, level of disruption that it causes, etc.).

9. CONFLICTS OF INTEREST

(a) Will the researcher(s), members of the research team, and/or their partners or immediate family members:
   (i) Receive any personal benefits (e.g., financial benefit such as remuneration, intellectual property rights, rights of employment, consultancies, board membership, share ownership, stock options, etc.) as a result of or in connection with this study? Yes ☐ No ☒
   (ii) If yes, please describe the benefits below. (Do not include conference and travel expense coverage, or other benefits which are considered standard for the conduct of research.)

(b) Describe any restrictions regarding access to or disclosure of information (during or at the end of the study) that have been placed on the investigator(s). These restrictions include controls placed by the sponsor, funding body, advisory or steering committee.

   No restrictions have been placed on the investigators.

(c) Where relevant, please explain any pre-existing relationship between the researcher(s) and the researched (e.g., instructor-student; manager-employee; clinician-patient; minister-congregant). Please pay special attention to relationships in which there may be a power differential – actual or perceived.

   In certain instances, there may be a pre-existing clinician-patient relationship between participants and therapists. However, since most clients participating in the evaluation will be coming in for a single session, in most cases there will be no long-term relationship.

(d) Please describe the decision-making processes for collaborative research studies. If Terms of Reference exist, attach them. Collaborative research studies include those where a number of sites (e.g. other universities, non-TAHSN hospitals, etc.) are involved, as well as those that involve community agencies.
The Advisory Committee is comprised of representatives from all partner sites on the project. Committee members have all been involved in every stage of the program evaluation. There has been joint decision-making on outcomes to be measured, research instruments, research processes, and the scope of the evaluation.

SECTION B – SUMMARY OF THE PROPOSED RESEARCH

10. RATIONALE

Describe the purpose and scholarly rationale for the proposed project. State the hypotheses/research questions to be examined. The rationale for doing the study must be clear. Please include references in this section.

All brief service therapies and delivery mechanisms offer a therapeutic encounter at the first session and then provide a variety of brief service options based on needs. Such services address immediate needs, divert people from waitlists and operate on the premise that “all the time you have is now.” Brief services can be conceptualized in three ways: the therapeutic approach, the service delivery mechanism and the overarching philosophy that services should be timely, high quality, accessible and consumer-driven. Brief service delivery mechanisms that provide immediate access at the front door of our systems include walk-in clinics, intake as first session, extended intake and focused consultation. We are interested in evaluating a sample group of Ontario's brief service delivery mechanisms: walk-in clinics at Reach Out Centre for Kids (2001, served 1600 clients in 2012), the Hincks-Dellcrest Focused consultation/brief services (2004) and In Person Intake-IPI (423 clients), the collaboratively run What's Up clinic based in Toronto (began 2011), the Point in Time brief services project in Haliburton (began 2010), and Youth Services Bureau (2010) in Ottawa. All serve children 0-18 and their families.

The evidence on clients' length of involvement in services had shown that “the most common number of sessions attended by clients is one” (Talmon, 1990), for clients who continue, constructive change ramps up most in the first 2 to 3 sessions (Hubble, Duncan, & Miller, 1999; Lambert, 1992). Studies on change have found that it occurs earlier rather than later in the treatment process (Duncan & Miller, 2000). Therefore, it is important to influence change when it counts the most—at the start. Brief Service delivery mechanisms are a key response to these findings and shift from a focus on problems to a focus on strengths (Franklin et al, 2012). When SFBT has been compared with established treatments in recent, well-designed studies, it has been shown to be equivalent to other evidence-based approaches, sometimes producing results in substantially less time and at less cost” (Franklin, et al, 2012, p. 107). A 2006 study (Perkins) of single session therapy with clients that were 5-15 years of age was conducted at an outpatient child and adolescent mental health clinic. There was improvement in the severity of the problem in 74% of clients, and client satisfaction ratings averaged 95%. This indicates that a single-session of therapy “is therapeutically effective in the treatment of children and adolescents with mental health problems” (p. 225). In terms of durability of improvement, treatment effectiveness of the single-session was found at an 18 month follow-up (Perkins & Scarlett, 2008). As a strategy for waitlist management, work by McGarry and colleagues (2008) that involved a brief consultation service was found to lead to improved clinical outcomes for children and increased satisfaction with wait times for parents (p.38). An evaluation of the walk-in clinic at Yorktown Child and Family Centre in Toronto was implemented in the Fall of 2006 using the BCFPI. Walk-in clients (n=112) showed significant improvement in all areas of functioning over a three-month period of time, and were largely satisfied with the structure of walk-In service. For more evidence see the policy paper, No more, no less: Brief Mental Health Services for Children and Youth (Duvall, Young, Kays-Burden, 2012).

There are currently at least 28 walk-in clinics and many other quick access to therapy delivery mechanisms operating in Ontario. Some (19) of the clinics serve children 0-18 and their
families, while some (9) serve mainly adults. Due to an increased awareness of mental health issues, economic necessity, wait list pressures, and the need for demonstrably improved client outcomes, brief service approaches, new brief service delivery models, and walk-in clinics are being developed across Ontario as a way to offer immediate and effective therapy service to many clients. While there is emerging program evaluation data from these innovative service delivery mechanisms, studies on brief services are at an early stage. The field would benefit greatly from a systematic evaluation on relevant models and approaches and the role of brief interventions in system integration, implementation and related long-term outcomes.

This evaluation will address the following questions:

1) Do clients benefit from participating in a single therapy session? If so, what positive outcomes are achieved?
2) Are the benefit(s) from a single session maintained after 3 months?
3) What kinds of presenting problems are the clients experiencing who access these services?

11. METHODS

(a) Please describe all formal and informal procedures to be used. Describe the data to be collected, where and how they will be obtained and how they will be analyzed.

Please refer to Appendix A for a diagram/overview of the evaluation methodology.

(b) Attach a copy of all questionnaires, interview guides and/or any other instruments.

Please refer to Appendix B for copies of all questionnaires.

(c) Include a list of appendices here for all additional materials submitted (e.g., Appendix A – Informed Consent; Appendix B – Interview Guide, etc.):

Appendix C - Consent Forms

12. PARTICIPANTS AND/OR DATA

(a) Describe the participants to be recruited, or the individuals about whom personally identifiable information will be collected. List the inclusion and exclusion criteria. Where the research involves extraction or collection of personally identifiable information, please describe from whom the information will be obtained, what it will include, and how permission to access the data is being sought. (Strategies for recruitment are to be described in section #15.) Where applicable, justify the sample size.

There are no formal screening process or inclusion/exclusion criteria per se; all clients who access walk-in services or booked brief therapy services at the partner sites are potential participants. Every client who accesses these services will receive a consent form with the client “package” provided to them upon their arrival. If a client chooses to participate, personal data such as name and email address will be collected from them. This is necessary due to the pre-test post-test design of the program evaluation; we need to compare participants responses at three points in time in order to perform the statistical analyses. We cannot do this without matching the surveys by participant name.

(b) Is there any group or individual-level vulnerability related to the research that needs to be mitigated (for example, difficulties understanding informed consent, history of exploitation by researchers, power differential between the researcher and the potential participant)?
In certain instances there may be pre-existing clinician-patient relationships between participants and the therapists. To control for any perceived power differential, the therapists will reassure participants that their participation is voluntary, and that they are free to withdraw their consent to participate at any time without affecting the quality of the service they receive. This will also be made clear on the informed consent form. Furthermore, although therapists will give participants the post-session measure, they will not be aware of how participants’ responded (it is a self-report measure).

13. EXPERIENCE OF INVESTIGATORS WITH THIS TYPE OF RESEARCH

(a) Please provide a brief description of previous experience with this type of research by (i) the principal investigator.supervisor or sponsor, (ii) the research team and (iii) the people who will have direct contact with the participants. If there has not been previous experience, please describe how the principal investigator/research team will be prepared.

The lead investigators have a substantial amount of experience conducting program evaluations as well as research. Karen Young has assisted in designing the evaluation of ROCK’s walk-in therapy clinic in 2008 and she has designed an evaluation for another walk-in clinic in Northern Ontario in 2012. Her position as Manager of Centre of Learning allows her some dedicated time to facilitate and support evaluation projects and the development of practice based evidence. Surbhi Bhanot-Malhotra has over 10 years experiencing community-based research. She has been involved in a number of program evaluations. In her role as Research Associate, she oversees all program evaluations taking place at ROCK. She has also been involved in the peer review process for program evaluation-related grants. Jim Duvall has served as co-investigator on a large descriptive adoption study, a family attachment study, and various smaller projects inquiring into the efficacy of brief, client-centered therapies. Jim Duvall and Nancy Cohen have over 30 years of experience collaborating together on various research projects. ROCK and Hincks-Dellcrest have a history of collaboration on projects such as the Brief Services policy ready paper. Members of the program evaluation team also have previous experience conducting program evaluations and/or research at their own organizations.

14. RECRUITMENT OF PARTICIPANTS

- Where there is recruitment, please describe how, by whom, and from where the participants will be recruited
  - Where participant observation is to be used, please explain the form of insertion of the researcher into the research setting (e.g., living in a community, visiting on a bi-weekly basis, attending organized functions)
  - If relevant, describe any translation of recruitment materials, how this will occur and whether or not those people responsible for recruitment will speak the language of the participants.
- Attach a copy of all posters, advertisements, flyers, letters, e-mail text, or telephone scripts to be used for recruitment.

There is no formal recruitment process. All clients who attend the walk-in clinics/booked sessions at each partner site will serve as potential participants. There will be no participant observation or recruitment materials distributed.

15. COMPENSATION

(a) Will participants receive compensation for participation? No
(b) If yes, please provide details and justification for the amount or the value of the compensation offered.

Not applicable.

(c) If No, please explain why compensation is not possible or appropriate.

Participants will not be compensated for their participation in this program evaluation. According to the grant guidelines, the funding cannot be used towards incentives for participants.

(d) Where there is a withdrawal clause in the research procedure, if participants choose to withdraw, how will compensation be affected?

Not applicable.

SECTION C –DESCRIPTION OF THE RISKS AND BENEFITS OF THE PROPOSED RESEARCH

16. POSSIBLE RISKS

(a) Please indicate all potential risks to participants as individuals or as members of a community that may arise from this research:

(i) Physical risks (e.g., any bodily contact or administration of any substance): Yes ☐ No X

(ii) Psychological/emotional risks (e.g., feeling uncomfortable, embarrassed, or upset): Yes X No ☐

(iii) Social risks (e.g., loss of status, privacy and/or reputation): Yes ☐ No X

(iv) Legal risks (e.g., apprehension or arrest, subpoena): Yes ☐ No X

(b) Please briefly describe each of the risks noted above and outline the steps that will be taken to manage and/or minimize them.

The psychological/emotional risk for this evaluation is minimal since we have carefully selected ‘strengths-focused’ measures. However, it is possible that some of the questions on the surveys may make participants feel uncomfortable if they have not previously disclosed information about their personal issues. In order to minimize this risk, participants will be informed that they do not have to answer any questions that they do not want to and that their participation is entirely voluntary. This information is included on the consent form for the evaluation.

17. POSSIBLE BENEFITS

- Describe any potential direct benefits to participants from their involvement in the project
- Describe any potential direct benefits to the community (e.g., capacity building)
• Comment on the potential benefits to the scientific/scholarly community or society that would justify involvement of participants in this study

Participants may feel a sense of well being from participating in the project. This is because they will be informed that results of the study could help services be improved for all clients in the future.

From a community standpoint, the ability to demonstrate positive outcomes from brief services is essential for agencies that are looking to provide quick access to mental health therapy. This multi-site collaborative evaluation will provide us with the opportunity to identify a set of indicators and outcomes that can inform the development of an evolving service model for child and youth mental health.

New brief service approaches, delivery models, and walk-in clinics are being developed across Ontario as a way to offer immediate and effective therapy service to many clients. While the emerging program evaluation data from these brief service approaches is promising, studies on brief services are at an early stage. The scholarly community would benefit greatly from a systematic evaluation on relevant models and approaches and the role of brief interventions in system integration, implementation and related long-term outcomes.

SECTION D – INFORMED CONSENT

18. CONSENT PROCESS

(a) Describe the process that will be used to obtain informed consent and explain how it will be recorded. Please note that it is the quality of the consent, not the form that is important. The goal is to ensure that potential participants understand to what they are consenting.

(b) If the research involves extraction or collection of personally identifiable information from or about a research participant, please describe how consent from the individuals or authorization from the data custodian (e.g., medical records department, district school board) will be obtained.

When clients arrive for walk-in or brief services, they will be provided with a consent form telling them about the scope of the project, what their voluntary participation entails, and other information they need to know to make an informed consent. This document will clearly explain that participation is voluntary and that they may withdraw at any time (or not consent at all) without affecting their quality of service. It will also explain that all data will be treated as confidential, and why certain items of personal information will be collected. If they wish to participate they will sign the form, thereby acknowledging that they understand the scope of their involvement in the research and authorizing the collection of pertinent personal information from them.

19. CONSENT DOCUMENTS

(a) Attach a copy of the Information Letter/Consent Form.

Please refer to Appendix C for copies of the consent form.

(b) If any of the information collected in the screening process - prior to full informed consent to participate in the study - is to be retained from those who are later excluded or refuse to participate in the study, please state how potential participants will be informed of this course of action and whether they will have the right to refuse to allow this information to be kept.


20. COMMUNITY AND/OR ORGANIZATIONAL CONSENT, OR CONSENT BY AN AUTHORIZED PARTY

(a) If the research is taking place within a community or an organization that requires that formal consent be sought prior to the involvement of individual participants, describe how consent will be obtained and attach any relevant documentation. If consent will not be sought, please provide a justification and describe any alternative forms of consultation that may take place.

All community partners have provided their consent to be part of the evaluation project as part of the grant application.

(b) If any or all of the participants are children and/or others who are not competent to consent, describe the process by which capacity/competency will be assessed, and the proposed alternate source of consent.

There is a separate consent form for youth who participate in this evaluation project (refer to Appendix C). Youth who are age 16 and over will provide consent for themselves. If participants are younger than 16, then their parents/caregivers will provide consent and we will obtain their assent (i.e., parents/caregivers will provide consent and the child/youth is willing to participate).

21. DEBRIEFING and DISSEMINATION

(a) If deception or intentional non-disclosure will be used in the study, provide justification.

Not applicable - we are not using deception in our program evaluation.

(b) Please provide a copy of the written debriefing form, if applicable.

Not applicable.

(c) If participants and/or communities will be given the option of withdrawing their data following the debriefing, please describe this process.

Not applicable.

(d) Please describe what information/feedback will be provided to participants and/or communities after their participation in the project is complete (e.g., report, poster presentation, pamphlet, etc.) and note how participants will be able to access this information.

We will create a summary report of the results of the program evaluation after the project is finished. We will ask all partner organizations to post this summary on their website so that participants can access this information.

22. PARTICIPANT WITHDRAWAL

(a) Where applicable, please describe how participants will be informed of their right to withdraw from the project and outline the procedures that will be followed to allow them to exercise this right.
The consent form will inform participants that their participation is voluntary and that they may withdraw from the project at any time without their quality of service being affected. To exercise this right, they may tell the therapist, administrative staff, or contact the principal investigator.

(b) Indicate what will be done with the participant’s data and any consequences which withdrawal may have on the participant.

If a participant chooses to withdraw from the evaluation, then any data that has been collected from them will be destroyed. There will no negative consequences for the participant (i.e., it will not impact the service that they receive in any way).

(c) If participants will not have the right to withdraw from the project at all, or beyond a certain point, please explain. Ensure this information is included in the consent process and consent form.

Not applicable.

SECTION E – CONFIDENTIALITY AND PRIVACY

23. CONFIDENTIALITY

(a) Will the data be treated as confidential? Yes X No □

(b) Describe the procedures to be used to protect the confidentiality of participants or informants, where applicable

Completed post-session measures will be placed in sealed envelopes and deposited by participants in a drop-box, rather than being handed back to the therapist. Although participant names will be collected for the purposes of pre-test and post-test comparison, when the data are entered and analyzed in SPSS, participant identification numbers will be used rather than names to ensure anonymity within the database. The 3 months post-test data will be collected via the online tool SurveyMonkey that is protected by SSL encryption. Members of the advisory committee will have access to completed surveys from their own site in order to flag any potential issues with data collection; otherwise access to the data will be limited to the principal investigator, her research associate and research assistant.

(c) Describe any limitations to protecting the confidentiality of participants whether due to the law, the methods used, or other reasons (e.g., a duty to report)

The limitations to protecting the confidentiality of participants are overviewed in the clinical consent form that clients must complete before receiving services. Thus, clients are aware of the limitations prior to starting their service.

24. DATA SECURITY, RETENTION AND ACCESS

(a) Describe how data (including written records, video/audio recordings, artifacts and questionnaires) will be protected during the conduct of the research and dissemination of results.
Completed paper copies of the surveys will be stored in a locked cabinet at ROCK other than for the purposes of data entry. The SPSS electronic database and Survey Monkey account will be password protected. Access to all data stored at ROCK will be limited to the lead investigators (Karen Young and Surbhi Bhanot-Malhotra) and the research assistant (Carolyn Scholz).

(b) Explain how long data will be retained. (If applicable, referring to the standard data retention practice for your discipline) Provide details of their final disposal or storage. Provide a justification if you intend to store your data for an indefinite length of time. If the data may have archival value, discuss how participants will be informed of this possibility during the consent process.

The data will be stored for 10 years. After this point, the surveys will be shred and destroyed.

(c) If participant anonymity or confidentiality is not appropriate to this research project, please explain.

The data will not be anonymous – surveys must include participants’ names in order to conduct the pre-test and post-test analysis (i.e., to compare their scores at 3 different points in time). However, the SPSS database in which the survey data will be entered will not include participant names (they will have participant ID numbers instead). Furthermore, all data will be treated as completely confidential.

(d) If data will be shared with other researchers or users, please describe how and where the data will be stored and any restrictions that will be made regarding access.

The data will only be shared with the seven partner organizations that are involved in this project. The surveys will be stored at ROCK. Only the lead investigators and research assistant will have access to the surveys. The surveys will be stored in a locked and secured area.
Appendix E: ROCK Brief Services Evaluation Consent Forms
Youth Version

Description of the evaluation and your participation:

We are conducting an evaluation of our walk-in clinic. The purpose of this evaluation is to see if the walk-in is meeting the needs of the community. We would like to invite you to participate in this evaluation. If you volunteer to participate, then you will be asked to complete two short surveys before and after the counseling session. We will also e-mail you short online surveys to complete after 3 months. Each of these surveys should take you about five minutes to complete.

Confidentiality

All of the information that we collect during this evaluation will be kept confidential and will not be shared with anyone outside the evaluation team unless required by law. We will need to collect personally identifying information (i.e., your name) for our statistical analyses. However, your name or any other identifying information will not be used on any publications or reports. We will store the completed surveys in a locked and secure area as required by provincial law.

Voluntary Participation

Your participation in this evaluation is voluntary. You can choose whether to be in this evaluation study or not. You may also refuse to answer any questions you do not want to answer. Your choice of whether or not to participate will not influence your ability to get services at our organization in any way. You may withdraw from the study at any time without consequence.

Potential Benefits and Risks

The information that you provide us will help us better understand how our service can be improved for others. However, there are no direct benefits that would result from your participation.

Since the questions will ask you about the problem/issue that you came here for, you may feel some discomfort answering them. If you do not wish to answer a question, you may skip it and go to the next question.

Contact information

If you have any questions or concerns about this evaluation, please contact Dr. Surbhi Bhanot-Malhotra at (905) 634-2347 or surbhbm@rockonline.ca.

Consent

I understand the procedures described above, including the possible results of agreeing to participate or if I choose not to. I also understand I can withdraw my consent at any time. My questions have been answered to my satisfaction, and I agree to participate in this evaluation. I have been given a copy of this form.

________________________________________
Name (please print)

____________________________
Signature

____________________________
Date
ROCK Brief Services Evaluation Consent Form
Caregiver Version

Description of the evaluation and your participation:

We are conducting an evaluation of our walk-in clinic. The purpose of this evaluation is to see if the walk-in is meeting the needs of the community. We would like to invite you and your child to participate in this evaluation. If you volunteer to participate, then you and your child will be asked to complete two short surveys before and after the counseling session. We will also e-mail you short online surveys to complete after 3 months. Each of these surveys should take you about five minutes to complete.

Confidentiality

All of the information that we collect during this evaluation will be kept confidential and will not be shared with anyone outside the evaluation team unless required by law. We will need to collect personally identifying information (i.e., your name) for our statistical analyses. However, your name or any other identifying information will not be used on any publications or reports. We will store the completed surveys in a locked and secure area as required by provincial law.

Voluntary Participation

Your participation in this evaluation is voluntary. You can choose whether to be in this evaluation study or not. You may also refuse to answer any questions you do not want to answer. Your choice of whether or not to participate will not influence your ability to get services at our organization in any way. You may withdraw from the study at any time without consequence.

Potential Benefits and Risks

The information that you provide us will help us better understand how our service can be improved for others. However, there are no direct benefits that would result from your participation.

Since the questions will ask you about the problem/issue that you came here for, you may feel some discomfort answering them. If you do not wish to answer a question, you may skip it and go to the next question.

Contact information

If you have any questions or concerns about this evaluation, please contact Dr. Surbhi Bhanot-Malhotra at (905) 634-2347 or surbhibm@rockonlive.ca.

Consent

I understand the procedures described above, including the possible results of agreeing to participate or if I choose not to. I also understand I can withdraw my consent at any time. I also give consent for my child to participate in this evaluation if she/he would like to participate. I have been given a copy of this form.

_______________________________________________
Name of Child (please print)

_______________________________________________
Parent/caregiver signature

________________________________________________________________________
Date