



Ontario Centre of Excellence
for Child and Youth
Mental Health

Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents

Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.

No more, no less:

Brief mental health services for children and youth

November 2012

P r e p a r e d b y :

Jim Duvall,

Director of Training, Hincks-Dellcrest Centre/Gail Appel Institute

Karen Young

Manager of Clinical Services, ROCK (Reach Out Centre for Kids)

Angela Kays-Burden

Director of Innovative Practice, ROCK

Consulting team members:

Donna Duncan

President and CEO, Hincks-Dellcrest Centre

Dr. Nancy Cohen

Director of Research, Hincks-Dellcrest Centre/Gail Appel Institute

Research assistant:

Heidi Kiefer

Psychological Intern, ROCK

www.excellenceforchildand youth.ca • www.excellencepourenfantsados.ca

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
EXECUTIVE SUMMARY	4
POLICY RECOMMENDATIONS FOR BRIEF SERVICES	6
PROBLEM STATEMENT/NEED	7
PURPOSE AND SCOPE OF THIS PAPER	10
UNDERSTANDING THE EVIDENCE BASE	12
BRIEF SERVICES DEFINED	15
A.	The
philosophy of brief therapy	15
B.	Bri
ef therapy approaches and clinical outcomes	18
Solution-focused and narrative therapy	18
Duration of therapy	19
C.	Bri
ef services in the Ontario context	21
Case study: Brief services at the Hincks-Dellcrest Centre	22
<i>Intake as first session</i>	22
<i>Extended intake</i>	22
<i>Focused consultation</i>	22
Walk-in clinics.....	23
Brief service via technology.....	26
ENVIRONMENTAL SCAN	27
CONSIDERATIONS FOR IMPLEMENTING BRIEF SERVICES	29
LIMITATIONS OF BRIEF SERVICES	29

NOT ALL COMMUNITIES ARE ALIKE: PLANNING FOR UNIQUE ISSUES 30
IMPLICATIONS FOR ALL CHILD AND YOUTH-SERVING SECTORS 31
POLICY RECOMMENDATIONS FOR BRIEF SERVICES 33
REFERENCES 38
APPENDIX A 56

ACKNOWLEDGEMENTS

This policy-ready paper was initiated by the Ontario Centre of Excellence for Child and Youth Mental Health. It was developed in collaboration by a team of practitioners and policy researchers to identify current models and theories of brief service, and to provide a link between the research evidence and a policy landscape that demands the efficient delivery of effective services.

Our team would like to acknowledge the work of Research Assistant Heidi Keifer, who was instrumental in compiling the literature review. We would like to thank staff at the Ontario Centre of Excellence for Child and Youth Mental Health, particularly Ian Manion, Charles Carter, and Purnima Sundar, for their guidance with conceptualizing the paper and their invaluable editing work. We also want to thank the child and youth mental health agencies in Ontario and the front-line workers who contributed their practice experiences and information on the brief services they provide to inform our scan of the cutting-edge therapies already available to children, youth and families.

I. EXECUTIVE SUMMARY

Ontario's child and youth mental health sector is comprised of a fragmented array of services and supports. Various reports speak to the need to address the problems of a "patchwork" of child and youth mental health services, service gaps, increasing demand for services, long wait lists and the impact of these issues on children and families. Progress in these areas is hampered, at least in part, by a failure to adapt services to meet the evolving needs of children, youth and families, and fundamental gaps in research and evidence about what treatment approaches are most effective, and for whom. Through its recent and highly-anticipated mental health strategy and corresponding investments across ministries to meet the mental health needs of our children, youth and their families, the Government of Ontario has made a commitment to tackling these barriers to treatment and service.

The provision of brief services in child and youth mental health presents a significant opportunity for Ontario. Research demonstrates that child and youth mental health agencies are not the primary point of entry into mental health services for Ontario's children and youth. Instead, family health teams, pediatric clinics, schools and post-secondary campuses are emerging as critical settings to provide timely, effective care. The Ministries of Education, Health and Long-Term Care, and Training, Colleges and Universities have joined the Ministry of Children and Youth Services as partners in efforts to decrease wait times and improve access to quality child and youth mental health services. As all ministries grapple with finding ways to marry impact with efficiency, sectors are working separately and together to ask hard questions about how to maximize resources, provide better service and improve access for Ontario's children and youth.

All brief service therapies and delivery mechanisms offer therapeutic encounter, instead of assessment, at the first session and then provide a variety of brief service options based on families' needs. Brief service delivery mechanisms offer therapeutic help from the first contact and make the most of the time with young people and their families. Such services address immediate needs, divert people from waitlists whenever possible and operate on the premise that "all the time you have is now."

Brief services can be conceptualized as having three components: the overarching philosophy that guides efforts to provide timely, high quality, accessible, and consumer-driven services; the specific therapeutic approach; and the service delivery mechanism through which organizations provide

access to therapy. 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. The brief service philosophy embraces a service ethic that ensures children, youth and families receive exactly the amount of service they need – no more, no less. It assumes that some children, youth and families can and should be involved in services for a shorter period of time. Recognized brief therapy approaches include collaborative, client-centred models used by skilled clinicians such as narrative therapy and solution-focused therapy.

Rather than viewing brief services as “the best we can do” in light of fiscal pressures and wait lists, the research indicates that brief modalities show promise for strong clinical outcomes in ways that are economically sound. Innovative research is currently underway, and evaluations of specific interventions indicate that brief services can positively impact wait times, clinical outcomes, and client satisfaction in an efficient and convenient manner. Research shows that for most people, therapy is typically brief. Therefore, therapists and systems must organize their work to optimize therapeutic outcomes within a few sessions (Lambert, 1992; Talmon, 1990), with allowance for more intensive, longer-term services as required. By providing brief but effective interventions, precious system resources are freed up to provide adequate care for children and youth who have more intensive needs.

Brief mental health services have already been implemented in family health teams, family services agencies, and child and youth mental health agencies across Ontario. Current models include walk-in clinics, re-envisioned intake processes and other quick access service delivery methods. Studies on brief services are still emerging, and the field would benefit greatly from innovative research and systematic evaluation on relevant models and approaches and the role of brief interventions in system integration, implementation and related long-term outcomes.

POLICY RECOMMENDATIONS FOR BRIEF SERVICES

Implementing a brief therapy approach requires a significant paradigm [attitudinal] shift among organization leaders and practitioners. To maximize the therapeutic potential of every moment, brief, collaborative, strength-focused services should be available to children, youth and families throughout a transformed service system, regardless of where they live.

We present the following recommendations pertaining to sectors, training, funding, collaboration and evaluation:

1. Establish brief collaborative, strength-focused approaches to service delivery in every community in Ontario.
2. Provide comprehensive and mandatory training in brief service delivery and brief therapy models to the existing and emerging workforce, across all sectors that serve children and youth (e.g. health, education, youth justice, training, colleges and universities, and child and youth mental health agencies.)
3. Restructure the funding framework to ensure providers meet with success as they develop brief services within an appropriate continuum of care.
4. Support formal and informal collaboration in and between sectors to ensure that brief services planning and implementation efforts are successful and consistent.
5. Assess pathways to service to ensure that intake, assessment and therapeutic procedures are designed based on the needs of the children, youth and families who we serve and that needs are addressed from the first contact. Revise policies and protocols to reflect a collaborative, strength-focused approach.
6. Support the ongoing research and program evaluation of Ontario's brief service delivery mechanisms, including cost-benefit analysis.

II. PROBLEM STATEMENT/NEED

The child and youth mental health system in Ontario is presently struggling and in a state of disarray. A patchwork of services prevails instead of a comprehensive, well-designed continuum of care. The availability of services and supports for children, youth and their families varies greatly across communities and the problem of access has reached serious proportion. Barriers to access can include daunting waitlists, difficult to navigate service pathways, poor system integration, fragmentation within and across sectors, ineffective services based on questionable evidence and lack of coordination among providers. In some cases, young people have waited as long as four years to finally gain access to service (The National Infant, Child, and Youth Mental Health Consortium, 2010; Reid & Brown, 2008).

Wait-times can have devastating effects on children and families (Boyhan, 1996; Rosenbaum, Hoyt, & Talmon, 1990). Not only are clients being deprived of much-needed services while waiting, but the longer they wait, the less likely it is that they will connect with the services when they are finally available (Reid & Brown, 2008; Sherman et al., 2009). The report, *Access and Wait Times in Child and Youth Mental Health: A Background Paper* (The National Infant, Child, and Youth Mental Health Consortium, 2010), cites research that indicates “the time elapsed between initial contact and intake appointment is a significant predictor of appointment attendance...the longer a person or family waits, the less likely they are to seek treatment” (p 18). Poor access to mental health services is not simply the result of insufficient resources and increasing demand, but underscores the practices of a failing system. In 2008, the Auditor General of Ontario’s report stated that our current capacity in mental health treatment “... is largely determined by the amount and allocation of ministry funding available rather than need of the consumers” (p. 12).

As the government progresses with implementing its 10-year strategy, the provision of brief services in child and youth mental health presents an opportunity for Ontario’s child-serving sectors. Research demonstrates that family health teams, pediatric clinics, schools and post-secondary campuses are key settings to locate timely and effective care. The Ministries of Education, Health and Long-Term Care, and Training, Colleges and Universities, have joined the Ministry of Children and Youth Services in efforts to decrease wait times and improve access to quality child and youth mental health services. As all

ministries grapple with effective ways to do more with less, sectors are working separately and together to ask hard questions about how to maximize resources, provide better service and improve access for Ontario's children and youth.

Issues with access and wait times are impacted by knowledge gaps around what treatment approaches are most effective and the mental health sector's traditional approaches to treatment that often assume the need for complex, deficit-focused assessments at the front end of services and elaborate longer-term involvement once children and youth finally do engage with services. Seen through the lens of familiar paradigms, providers can begin to equate success with the length of time a client has been enrolled in therapy. As organizations find themselves caught within this system at the same time that they face significant economic pressures, they can become more rigid, falling back on traditional ways of working instead of responding to challenges with innovation and flexibility.

Similar paradigms are apparent in the training of developing professionals. Even where schools provide some introduction to brief therapy approaches, trainees are mostly taught about discrete theoretical schools of therapy (e.g., the 'solution-focused therapy' or 'brief therapy' approaches) rather than applied or practical skills. Rarely are professionals taught how to work within a critically reflective philosophy that is client centered and more likely to result in a brief duration of involvement with beneficial results.

The current provincial funding framework operates as an incentive to *have* waiting lists, since many providers receive funding based on the demand for services, as evidenced by waiting lists. Decreased waiting lists create a dilemma for organizations, since funders could use this as a rationale to reduce funding. Since annualized funding is not tied to any measure of the length of time clients spend on waiting lists, there is no incentive to decrease wait times and the funding formula remains process driven rather than outcome driven.

These problems are exacerbated by a substantial lack of coordination among service providers, both within and across sectors. Ministry mandates impose divisions between children/youth and adult, between health and mental health, and between school and community. These rules and eligibility restrictions are not helpful for families who are trying to lead whole lives. Reforms and financial cutbacks have unintentionally led to a disconnected system with gaps, redundancy and tensions among providers, and changes to

one system can have significant impacts on other systems. The lack of unified policy and protocol, collaborative dialogue and integrated funding places our children, youth and their families at increased risk.

The mental health needs of children and youth demand unique focus. In the present organization of Ontario's mental health services, there is significant possibility that the needs of children and youth will be eclipsed by those of the larger adult population. "It is a simple fact that children and youth are still growing and have mental and physical health requirements that set them apart from adults", says the Office for the Provincial Advocate for Children and Youth in Ontario in a Statement on Child and Youth Mental Health in Ontario (p.2). Access to child and youth mental health services must remain at the forefront of decision making to ensure that the unique needs and unlimited potential of children and youth are not lost within a complex policy landscape.

The existing service delivery system, across all sectors that serve our children and youth, and the mindsets of those who work within it, must be transformed. Emerging research and promising practice indicate that brief services, if well-implemented, can provide one solution within a system that faces significant demand and access challenges.

III. PURPOSE AND SCOPE OF THIS PAPER

This paper is meant to spark a dialogue for the role of brief services within a transformed child and youth mental health system for Ontario. System transformation in Ontario is already in motion and it is clear that a significant paradigm shift in how we work with children, youth and families – how we do business – is critical and inevitable.

This report has four principal objectives:

1. Provide a common understanding of what we mean by brief services in child and youth mental health, with a focus on modality and structure.
2. Present an overview of current knowledge of brief services, including their use and limitations, and current use within Ontario.
3. Engage policy leaders and key stakeholders in a thoughtful dialogue regarding the implementation of brief services within and across sectors.
4. Collate information from the literature and policy perspectives and make recommendations for the use of brief services in system transformation.

We highlight the groundswell of transformative brief service responses that are emerging across the province. These new programs and services provide quick access and facilitate clinical work with children and families that is highly accountable, collaborative and client-focused. As we will demonstrate through the summary of research, brief services provide significant opportunity for children and families to experience a shorter duration of involvement with the system, a higher degree of satisfaction and better service outcomes.

This paper presents the case for brief services within a transformed child and youth mental health system, describing the economic and mental health benefits and impact on wait lists and access to services. We argue that brief services have potential for a strong return on investment, can help to reach excellent outcomes for children and youth, and can foster resiliency in families rather than dependence on professional services. This paper will outline current brief services knowledge and literature, including current known practice within the Ontario context. We include a section on the limitations of brief services and

their appropriate use within the continuum of care. Finally, we summarize our findings and offer recommendations for change, proposing brief approaches and service delivery mechanisms that are feasible, reliable and valid across sectors.

Historically, there has been a divide between those with decision-making authority at policy levels, and those on the ground who are doing the work. We present this paper with an invitation for ongoing dialogue and a thoughtful exchange of ideas and sometimes opposing realities in order to move forward with concrete solutions that will improve the way we work together to provide mental health services to children, youth and their families.

IV. UNDERSTANDING THE EVIDENCE BASE

We conducted a literature review of published studies related to brief services in child and youth mental health via a search of the following databases: PubMed, PsycINFO and ERIC on ProQuest as well as online internet searches of international child and youth mental health organizations providing educational resources (e.g., Children's Mental Health Ontario). Searches were performed using keywords (mental health, brief services, service delivery mechanisms, access, brief narrative therapy, brief solution-focused therapy, etc.). In addition, we conducted a literature review of books to find publications that address the history and effectiveness of narrative and brief solution-focused approaches and modalities. The consultant team members also identified key documents for review, as well as unpublished studies.

A short survey was developed and delivered to 80 agencies to gather information about current brief service practice and delivery mechanisms through the Children's Mental Health Ontario (CMHO) e-mail lists of clinical directors and Fast Reports. It was not feasible within time constraints to survey beyond the CMHO stakeholders, but a comprehensive provincial environmental scan would be important, as would surveying other stakeholder groups such as education and the Ontario Medical Association.

The environmental scan was expanded through the practice knowledge of the authors, which has been gained through the last several decades as they have conducted extensive training in brief services throughout the province, Canada, the United States, Australia, and Asia and have built significant informal networks of practitioners and sector leaders practicing brief services in child and youth mental health. Additional phone calls and e-mails were made to agencies known to operate brief service models, in order to add practical context to this paper.

The consultant team met with inter-ministerial policy directors during the course of the initial literature review to understand key issues facing sectors and to ensure those issues are addressed here. This dialogue occurred with representatives from the Ministries of Health and Long-term Care, Education, Training, Colleges and Universities, and Children and Youth Services. Our team attended a subsequent meeting to present initial recommendations and receive feedback on the multi-sectoral relevance of the policy paper while it was in development.

While there is substantial support for the use of brief therapy approaches, gaps in research exist for identifying and evaluating brief service delivery mechanisms and the connection to the underlying philosophy of a child and youth mental health system that supports the successful implementation of brief services. Research on approaches and service delivery mechanisms only follows clients for a maximum of 18 months, and long-term clinical outcomes and longer-term studies are warranted. Research and evaluation specific to cost-benefit/return on investment are also critical to building the body of evidence.

The efficacy of brief narrative and brief solution-focused therapies are embedded in a broad body of research surrounding solution-focused and narrative approaches, and these have been summarized in the paper. The literature on brief interventions and therapies has at its core that feedback from the client and family to the therapist is crucial and is considered a form of evidence that informs treatment success, that helps to achieve good clinical outcomes, and that fits into an evidence-informed perspective that puts an equal weighting on evidence from rigorous research, therapist expertise, and client and family perspective.

Resistance to briefer approaches to therapy and services are often based on beliefs such as:

- One session can never be enough
- A thorough assessment is always needed first
- Most people need long-term therapy
- Brief therapy only works with simple problems
- Brief therapy really is only for clients dropping out prematurely from therapy, and most people attend multiple therapy sessions
- Since problems have taken a long time to develop, they take a long time to solve

These myths exist in contrast with research evidence that supports the effectiveness of brief therapy approaches. For example, research by Perarik (1992) showed that the assumption that clients who drop out of therapy are dissatisfied with the service does not hold true. In addition, clinical outcomes demonstrate that people receiving a brief therapy intervention can have equally complex presenting problems as a control group, and achieve good clinical outcomes (Perkins, 2006). Research conducted at the Yorktown Child and



Ontario Centre of Excellence
for Child and Youth
Mental Health

Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents

Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.

November 2012

No more, no less

Family Centre in Ontario supports this finding by demonstrating that children and youth who attended the walk-in clinic had higher BCFPI (Brief Child and Family Phone Interview) scores prior to the single session at the walk-in than clients in the regular service stream had at intake (Bhanot, Livingstone, & Stalker, 2010).

V. BRIEF SERVICES DEFINED

All brief service therapies and delivery mechanisms offer therapeutic encounter, instead of assessment, at the first session and then provide a variety of brief service options based on families' needs. Brief service delivery mechanisms offer therapeutic help from the first contact and make the most of the time with young people and their families. Such services address immediate needs, divert people from waitlists whenever possible and operate on the premise that "all the time you have is now."

Brief services can be conceptualized as having three components: the overarching philosophy that guides efforts to provide timely, high quality, accessible, and consumer-driven services; the specific therapeutic approach; and the service delivery mechanism through which organizations provide access to therapy.

A. The philosophy of brief therapy

Brief services succeed in an environment where individual practice, service pathways and community-level planning enable a paradigm of service provision that is client-oriented and focused on providing only as much service as is needed. A brief services philosophy takes the position that more is not better; better is better. Therapy should not extend one session longer than necessary and should not stop one session short of what people need.

"It is redundant to say brief therapy, when therapy should always be as brief as possible." (Lazarus & Fay, 1990)

The provision of mental health services is not a one-size-fits-all model. By providing less service to some people who only require that much, precious system resources can be freed up to provide adequate care for children and youth who have more intensive needs. However, when a longer duration of service is required, the approach should remain time-sensitive, focused and accountable to the children and youth seeking help.

Brief service can be framed within principles of effective care that are relevant to all mental health interventions, for instance youth and family engagement. It is collaborative, highly respectful and taps into client preferences, skills and abilities. As a result of working this

way, people tend to require a briefer amount of involvement and are more prone to embrace their own resources. They become the primary agents of change, which results in better clinical outcomes (Duvall & Beres, 2011). A brief therapy approach is not about providing traditional services faster, but about providing services differently, which results in a briefer duration of involvement. It is not rush therapy, but adopts a different set of assumptions, principles and practices about how people change.

To implement brief services as an effective component in system transformation, we need to significantly shift the way we view the children, youth and families who come to us for help. In much current practice, the professional is positioned hierarchically as the expert in the therapeutic process and seldom are children, youth and families regarded as the principal agents of change (Bohart & Tallman, 1999; Bohart & Tallman, 1996). Yet research shows that expert professional knowledge, treatment modalities and assessment protocols contribute a mere 15% effect toward positive therapeutic outcome. Clearly, it is the client, and what the client brings to the process, that is the most potent contributor to outcome in psychotherapy. *"...it is the 'engine' that makes therapy work..."* (Bohart & Tallman, 1999; Bohart & Tallman, 1996)

Studies have shown that engaging with families through genuine collaboration, listening to and consulting them about what services they want and how they want them delivered, results in greater participation in the therapeutic process and better outcomes (Orlinsky, Grawe & Parks, 1994; Clemente et al., 2006; Lambert & Bergin, 1994). *"As therapists have depended more on client's resources, more change seems to occur"* (Bergin & Garfield, 1994). The brief service philosophy embraces engagement. Clinicians partner with their clients in every way possible, including using collaborative documentation, where case notes are completed with the clients during the therapeutic session and include the client's perspective. Not only does this increase clinician efficiency, as notes are finished when the session is finished, but the process increases client satisfaction with therapy. In a study of concurrent documentation practices, 84% of the 927 respondents reported that the practice was helpful and staff at these agencies reported increased time efficiency and job satisfaction (Lloyd, 2002).

Working briefly requires a philosophy that assumes a relationship of co-responsibility with the children, youth and families served, rather than a dependent relationship, in which long-term service provision is viewed as an indication of engagement and success. Practice

and policy – and the mindset working within our systems – must be transformed to reflect the philosophy that clients are capable and have the strengths and resources necessary to solve their problems (Watzlawick, 1987). Numerous studies (Salovey et al., 2000; Taylor et al., 2000) illustrate the advantage of focusing on clients' abilities and strengths (Franklin et al., 2012).

The policy-ready paper *Access and Wait Times in Child and Youth Mental Health: A Background Paper* (2010) raises the issue of waiting times for assessments versus waiting for appropriate interventions. The authors state that “although families benefit from diagnostic clarity, they are also in need of active interventional help for their children and youth” (p. 17). As a strategy for waitlist management, the report cites work by McGarry and colleagues (2008) that involved a brief consultation service that was found to lead to improved clinical outcomes for children and increased satisfaction with wait times for parents (p.38).

The evidence indicates that there is minimal correlation between deficit-focused protocols and predictors of positive change (Orlinsky, Runnestad, & Willutzki, 2004). When people first approach organizations for help, they are not at their best and may be at their worst. This is not a realistic time to implement a deficit-focused intake protocol that may well obtain a distorted representation of the child, youth and family, and at worst exacerbate the situation leaving them to experience further blame and shame. The mental health system today is front-end loaded with standardized assessment tools and intake protocols that are deficit focused instead of strengths based. While these instruments and protocols may be rigorously developed, they are in conflict with a competency-based approach and the research that emphasizes the importance of the first two sessions in predicting positive change in the therapeutic process.

There is a need to shift our philosophy from a focus on problems to a focus on strengths, and to adopt the use of strengths-based assessments (Franklin et al, 2012). A brief services philosophy shifts the focus of every visit to a therapeutic encounter and places uncompromised priority on strengths-based tools. Epstein and Sharma (1998) define strengths-based assessment as “the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationship with family members, peers, and adults; enhance one’s ability to deal with adversity and stress; and promote one’s personal, social, and academic

development” (Franklin et al., 2012, p. 57). A thorough search for strengths-based instruments used in clinical and research settings by these authors found 41 reliable and/or valid measures. These included measures used with adults, children, adolescents, and families.

Brief, client-centred approaches are situated within a philosophical backdrop of critically reflective practices, which assist mental health professionals in managing ambiguity and understanding the effects of context. “...professionals currently work in a social environment that is preoccupied with uncertainty, risk and complexity” (Fook & Gardner, 2007). Mental health professionals have to constantly adapt to changing conditions, developing knowledge that is seen as useful and relevant, making and remaking themselves in response to uncertainty (Giddens, 1991; Ferguson, 2001)

Brief therapy is not just about technique, but also about using critically reflective practices to understand people’s distress as a response to the effects of social context on their lives. When taught fully, the principles and methodology of brief therapy approaches contain the critical thinking frameworks that enable professionals to manage the complexity of their work more effectively (Fook & Gardner, 2007). In recent years, encouraging developments are occurring in some university settings that are now incorporating teaching modules and courses in these more collaborative and critically reflective approaches to working.

B. Brief therapy approaches and clinical outcomes

As demonstrated through our environmental scan, two of the most-used brief approaches in Ontario are solution-focused brief therapy (SFBT) and narrative therapy, and multiple agencies provide walk-in clinics and single-session therapy.

Solution-focused and narrative therapy

In their book *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice* (Franklin et al, 2012), the authors assert that SFBT has been successfully implemented at different levels of school programs and with diverse groups within the school environment. It has been used to “help at risk students in individual, group, and family interventions (Franklin et al., 2001; Murphy, 2008) and change school outcomes with students at risk for dropout (Harris & Franklin, 2008)” (p. 231). More generally, “...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” (p. 107).

A 2008 study (Franklin et al.) showed that SFBT improved the outcomes of children who had classroom and behavioural problems that could not be resolved by teachers, principals, or school counsellors. These findings need to be replicated in larger studies. A 2009 study (Violeta Enea) showed a 61% reduction in truancy among adolescents after group counselling using a solution-focused approach. In 1995 Littrell and colleagues demonstrated the efficiency and effectiveness of a single session of Solution-focused counselling for struggling students in a high school.

A 1989 paper regarding the use of a brief intervention of narrative therapy with children who were stealing tracked the outcomes for a six-12 month follow-up period, and found that 80% of the children had not been stealing at all or had substantially reduced rates of stealing (Seymour & Epston).

Duration of therapy

Historically, therapy has focused on assessment in the early sessions, leaving treatment and problem resolution until later (Perkins 2006). However, by 1990 the evidence gathered on clients' length of involvement in services had shown that “the most common number of sessions attended by clients is one” (Talmon, 1990), demonstrating that therapists need to maximize the impact of the first, and possibly only, session with clients. Clearly, our sectors must offer more than assessment and information gathering at the first encounter, as it may be the only opportunity to provide service.

Constructive change ramps up most significantly in the first two to three sessions (Hubble, Duncan, & Miller, 1999; Lambert, 1992). Therefore, it is important to influence change when it counts the most—at the start. The first meeting with the family during an intake process is critical in engaging family members as primary agents of change, and in determining the need for further services. A 2001 review of the literature on single-session therapy reported “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” (Bloom, 2001). The age groups included in these studies were adults, young adults (college students) and adolescents, demonstrating single-session

therapy to be “useful for the treatment of...adolescents as well as adults” (Bloom, 2001, p. 80).

Studies on change have consistently found that it occurs earlier rather than later in the treatment process (Duncan & Miller, 2000). Research by Howard and colleagues (1986) on the dose-effect relationship found that 30% of clients improved by the second session and 60% to 65% of clients experienced significant symptomatic relief within the first two sessions and even more so by the seventh visit, which increased to 70% to 75% after six months and to 85% at one year (Bohart & Tallman, 2010; Miller, Duncan & Hubble, 1999). Substantial improvements in the early stages of therapy are followed by ever-decreasing improvements as therapy continues (Baldwin et al., 2009; Feaster, Newman, & Rice, 2003; Harnett, O’Donovan, & Lambert 2010; Lambert & Forman 2003; Wolgast, et. al., 2003). McGarry and colleagues demonstrated that a brief (one-to-three session) intervention was as effective, and in some cases more effective, than longer term treatment as usual that was not itself evidence-informed (2008). Conversely, therapies in which little or no change (or a worsening of symptoms) occurs early in the treatment process are at significant risk for a null or even negative outcome (Lebow, 1997).

A 2006 study (Perkins) with clients that were 5-15 years of age was conducted at an outpatient child and adolescent mental-health clinic. The treatment group was provided with a single-session within two weeks of intake and the comparison group was wait-listed for six weeks after intake. The problems across both groups were the same including parent/child relationship problems and a range of mental health diagnoses. There was improvement in the severity of the problem in 74% of clients in the treatment group, and client satisfaction ratings averaged 95%. This study indicates that a single-session of therapy “is therapeutically effective in the treatment of children and adolescents with mental health problems” (pp. 225). In terms of durability of improvement, treatment effectiveness of the single-session was found at an 18 month follow-up (Perkins & Scarlett, 2008).

A 2007 study of parents who attended a single-session to assist them in making changes to how they respond to their child’s behaviour reported a high degree of satisfaction with the brief consultation. They reported feeling less stressed in ways that had been adversely affecting their parenting, less dislike for how they were responding to their child and less overwhelmed by their child’s needs or behaviour (Sommers-Flanagan, J., 2007).

In the Ontario context, an evaluation of brief services conducted at the Hincks-Dellcrest Centre/Gail Appel Institute from 1996 through 2008 showed that more than 42% of families attended one session and 34% of families attended three-to-four sessions. All clients in the study completed session rating scales and post-session interviews indicating that they had accomplished enough through their involvement to confidently address their concerns. As well, their feedback indicated that they experienced the process as highly collaborative and that they were generally satisfied with the service.

Brief therapy approaches are being implemented in other provinces and countries, with associated evaluation findings, including British Columbia, Australia, and the United States. Dalmar Child and Family Care, in New South Wales, implemented an “open day” in 1992 where all clients who were on waiting lists were invited to attend a single session of therapy. In their evaluation of this service the results indicated that 78% of families found the session helpful and 45% chose to attend only one session (Price, 1994).

Also in Australia, the ACT Child and Adolescent Mental Health Service offered single-session family counselling to more than 1,000 families (Hampson et al., 1999). Telephone follow-ups of 100 families in 1994 and 70 families in 1996 found that single-session family interviews were well accepted by the large majority of families seen. Clinicians saw the program as reducing pressure from clients for early attention, enhancing client motivation when seen at crisis times, providing readily available consultation support from peers, increasing learning opportunities and building inter-disciplinary team work.

The Bouverie Centre La Trobe University (Victoria, Australia) evaluated the experiences of the first 50 clients who attended their single-session therapy program. The results showed that 45% to 53% of clients were satisfied with receiving a single session of therapy with the option of an ‘open door’ to return to if needed. 63% to 78% of families reported moderate to high improvement after a single session of therapy, and 78% to 81% of clients found the session ‘very helpful’ to ‘somewhat helpful’ (Boyhan, 1996).

C. BRIEF SERVICES IN THE ONTARIO CONTEXT

Effective brief service delivery models place highly trained, experienced staff at the front door of the systems to work in the moment with each client and avoid over-servicing and the bottleneck effect. Such service delivery models are implemented with the

understanding that increased accountability and close supervision is required during training as staff learn how to operate in a quick-access environment.

To be effective in a system with daunting waitlists, a brief therapy approach must be provided via a brief service delivery mechanism that ensures quick access and timely help. A scan of brief service delivery mechanisms in Ontario illustrates that they differ in design and specific therapy approach, but all provide a therapeutic encounter at the first contact. Model mechanisms include walk-in clinics, single-session therapy, intake as first session, extended intake and focused consultation, and direct response service.

Case study: Brief services at the Hincks-Dellcrest Centre

To illustrate intake as first session, extended intake and focused consultation, we outline the client pathway for the model delivered at the Hincks-Dellcrest Centre where senior staff worked in intake teams with students in a brief therapy approach. The service offered therapeutic encounter, instead of assessment, at the first session (intake as first session), and then provided a variety of brief service options based on families' needs (extended intake, focused consultation).

Intake as first session: Families are satisfied with the therapeutic service they receive in the first session and gain enough knowledge, skills, confidence, and hope to continue to manage the problem on their own. All families were told that that if they chose to return, they could do so without having to return to the waiting list.

Extended intake: Families who made gains in the first session but indicated that an additional session or two would help to sustain the changes were provided an opportunity to receive another session or two from the intake team. The families could then take the changes into their lives and return to discuss their experiences with the intake team to further refine their efforts (trial and error), while increasing their confidence and competence to manage the problem on their own. Instead of referring the families to other services within the agency, many of which have their own lengthy waiting periods, the intake process was extended by one or two sessions, resulting in a timely and effective delivery of service.

Focused consultation: For some families, the problem may require additional therapeutic involvement. The therapist and family agreed to work in a focused approach for two

sessions and at the completion of the two sessions they were asked to reflect back on the process and note what worked well and contributed to preferred change. The family was also asked to notice anything in the process that did not work as well as they would have liked and how they could benefit from adjustment to certain elements of the process. This “check in” process is congruent with existing research that most useful change occurs in the first two or three sessions (Hubble, Duncan & Miller, 1999; Lambert, 1992).

After the focused consultation, the family was offered three choices. Most families decided they achieved enough gains to manage their situation on their own and choose to end involvement, but it is made clear that they can return for service in the future. Some families chose to continue with brief therapy services which typically last three to five sessions, including the first intake session. This number corresponds with the overall average number of sessions that people attend psychotherapy (Lambert, 1992). A small number of families preferred a different type of service (e.g., play therapy, assessment, individual therapy, etc.) and were referred on to that service within the agency. In those cases a well-informed referral was made as a result of the focused consultation process.

In the Hincks-Dellcrest set of mechanisms, all of the families receiving services through the focused consultation process completed a Session Rating Scale (Miller, Duncan, & Hubble, 1997) following each counselling session. A significant number of people indicated a measurable increase in their sense of hopefulness as a result of a collaborative, strength focused approach to bringing forth their knowledge, abilities, preferences, values and commitments (Duvall & Beres, 2011).

Walk-in clinics

When service delivery occurs at a walk-in clinic, there are no missed appointments or cancellations. Clinics maximize staff time, are easy to find and access, and professionals are immediately available to clients (Bhanot, Livingstone, & Stalker, 2010; McElheran, & Lawson, 2008; Miller, 2008; Slive, & Bobele, 2011; Slive, McElheran, & Lawson, 2008; Young, 2011; Young et al., 2008). Children and families can walk in with no appointment required and are seen for a single session of brief, collaborative, strength-focused therapy at their chosen moment of need. All children, youth and families are provided with reassurance that immediate help will be available if needed in the future and they can re-access the walk-in clinic as needed after their initial session, or while waiting for further services.

In 2009 nine walk-in clinics operating in Ontario (five at child and youth mental health centres, three at family service agencies, and one combined) came together to share information and produced a document that outlined history, description, staff training and evaluation and research data (Bhanot, Livingstone, & Stalker, 2010). Highlights of this shared practice-based evidence include positive clinical outcomes and reductions in agency waitlists. After attending a single session at a walk-in clinic:

- 93% of clients reported that “the consultation was helpful”
- 91% reported that they “felt hopeful after the session”
- At least 50% of clients attending walk-in clinics required no further services
- 68% of clients reported improvement in their presenting concerns

The Thunder Bay Walk-in Therapy Clinic conducted a program evaluation on three separate occasions from 2007-2009. The results from all three of the evaluation efforts support the outcomes for clients attending the walk-in clinic session (Bhanot, Livingstone, & Salkers, 2010), with:

- reductions in stress
- reduced negative physical symptoms related to the identified problem
- reduced negative coping
- increased knowledge of the cause of the identified problem
- increased confidence to address the identified problem
- increased knowledge of resources
- increased positive coping as a result of a single session

Haldimand-Norfolk REACH evaluated their walk-in clinic over two years. They used the Session Rating Scale (Miller, Duncan, & Hubble, 1997) to gather information from 337 clients who attended walk-in single sessions. Ninety-three percent of these clients reported that “the consultation was helpful”, and 91% reported that they “felt hopeful after the session” (Bhanot, Livingstone, & Stalker, 2010).

Reach Out Centre for Kids (ROCK) opened its walk-in clinic in 2001, when the agency's waitlist for children, youth and their families was longer than two years. A short telephone call was the sole contact with families before they were placed on a waiting list. Ten years of statistics have shown that 50% of families coming to ROCK's walk-in clinic find a single session useful and do not require or request a referral for additional services. ROCK's walk-in clinic served 1,600 families in 2010 and only 50% of those families went onto waiting lists (Young, Dick, Herring, & Lee, 2008). A process evaluation with 408 clients who accessed the walk-in clinic found that the most common presenting problems were anxiety and depression, and clients reported increased coping strategies and increased confidence to solve the problem they came for as a result of the single session at the walk-in clinic.

An evaluation of the walk-in clinic at Yorktown Child and Family Centre in Toronto was implemented in the fall of 2006 in partnership with the Hospital for Sick Children and the University of Western Ontario. The study compared the characteristics, mental health symptoms, psychosocial adjustment and service use of children and adolescents using the walk-in clinic with those accessing usual care. It found that walk-in clients presented with behavioural problems and impaired self/family functioning. Walk-in clients tended to have higher scores on the Brief Child and Family Phone Interview (BCFPI), a provincially mandated assessment and screening tool for child and youth mental health centres, compared to the group waiting for usual care. This refutes some perceptions that clients that attend walk-in and benefit from the session are "not as difficult" as clients in more traditional services. These same walk-in clients (n=112) showed significant improvement in all areas of psychosocial functioning over a three-month period of time, using a standardized measure of adjustment (BCFPI), and were largely satisfied with the structure of walk-in service.

Research conducted in the longest running walk-in therapy clinic in Canada, the Eastside Clinic in Calgary, Alberta, has shown that clients attending the clinic achieve significant lower post-session distress levels. In samples of these clients, 68% reported improvement in their presenting concerns following the walk-in session and 45% considered the one session to be sufficient in addressing their concerns (Harper-Jacques et al., 2008). Another study involving the Eastside Clinic (Miller, 2008) found that 82% of adult clients attending reported high satisfaction or satisfaction with the walk-in service. Ratings were categorized in relation to presenting problems that demonstrate satisfaction with family related issues as follows:

- child behavioural problems (10.8% of respondents): 93.1% general satisfaction
- family breakdown (7.1% of respondents): 89.5% general satisfaction
- defiant/noncompliant child (6.3 of respondents): 82.4% general satisfaction
- parent/adolescent & parent/child conflict (4.1% of respondents):
81.8% general satisfaction
- custody/co-parenting issues (3% of respondents): 87.5% general satisfaction

Brief service via technology

Kid's Help Phone integrates a brief therapy approach with technology such as telephone counselling, e-mail and web chat lines to support children, youth and families throughout the province. This makes it possible to provide service to people who are isolated in remote areas and would not otherwise have access to service

VI. ENVIRONMENTAL SCAN

Therapists and caseworkers increasingly practice in settings where they are required to offer time-limited and time-sensitive therapy. 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 therapy service to clients.

With the help of Children's Mental Health Ontario (CMHO), CMHO member agencies were surveyed for their current practice in brief services. Respondents answered questions related to brief therapeutic approaches currently used by their clinicians and their use of brief service delivery mechanisms. 80 member agencies were invited to participate in the survey. Sixteen centres from across the province responded to the survey. Four primary methods of offering brief services emerged from the data:

- 50% of the centres offer walk-in clinics
- 31% of the centres provide the option for a booked single session
- 31% of the centres offer crisis services
- 50% offer six sessions or less of brief counselling

These same agencies reported employing the following brief therapeutic models within the above-mentioned services:

- 94% use solution-focused brief therapy
- 56% use brief narrative therapy
- 31% use cognitive behavioural approaches

Both narrative and solution-focused brief therapies are located within collaborative, client-centred, strength focused schools of thought and are clearly the preferred orientation of these agencies in their efforts to implement brief service delivery.

There are currently at least 23 walk-in clinics in operation in the province, with the majority (17) in child and youth mental health centres. Five are at family service agencies, and one is part of a family health team. For instance, Point in Time Centre for Children, Youth and

Parents in Halliburton operates a walk-in clinic located in a school, which potentially reduces the stigma of receiving mental health services in a rural community. All staff at Point in Time also use a general brief collaborative approach.

New Path Youth and Family Services of Simcoe County and Northeastern Family and Children's Services provide an example of single-session family consultations that families can access after intake, while waiting for ongoing service. This sometimes results in families receiving all the service that is necessary at the time without the need to remain on a waiting list. New Path also streamlines clients into brief services following intake, with a wait that is shorter than for other services. New Path Youth and Family Services of Simcoe County also have the COMPASS program which takes direct referrals from school personnel to child and youth mental health workers in the schools who provide brief service in an individual, family or small-group format depending on the need. If longer-term service is required they are referred internally to another of New Path's programs.

This data is a beginning and does not represent an exhaustive search or complete picture of provincial practice and current realities. Even during the writing of this paper, we assume that the practice landscape has changed, as organizations look to new ways of providing child and youth mental health services in increasingly stringent fiscal times.

VII. CONSIDERATIONS FOR IMPLEMENTING BRIEF SERVICES

A. LIMITATIONS OF BRIEF SERVICES

As with any approach to mental health, brief services are not a “one-size-fits-all” model of care. The practice of brief services needs to be negotiated to fit within the aggregate of services of a transformed service delivery system. Brief services must exist within, rather than replace, a continuum of care. While we make the assertion that all children and youth can benefit from the competency-based characteristics of brief collaborative services, we are not proposing that brevity of service is appropriate for every child, youth and family. A review of the practice, as well as research on short-term work reveals a number of potential indications and contraindications (Steenbarger 1994; 2002; Steenbarger and Budman, 1998). Some of these include:

- *Duration of the presenting problem* – When a problem pattern is chronic, it has been overlearned and often will require more extensive intervention than a pattern that is recent and situational.
- *Interpersonal history* – For therapy to proceed in an efficient way, a rapid alliance between therapist and patient is necessary. If the client’s interpersonal history includes significant incidents of abuse, neglect or violence, it may take many sessions before adequate trust and disclosure can develop.
- *Severity of the presenting problem* – A severe disorder is one that interferes with many aspects of the client’s life. Such severity often also interferes with the individual’s ability to actively employ therapeutic strategies between sessions, a key element in accelerating change.
- *Complexity* – A highly complex presenting concern, one that has many symptomatic manifestations, often requires more extensive intervention than highly focal problem patterns. For instance, a client who presents with an eating disorder may be abusing drugs and alcohol and experiencing symptoms of depression. Sometimes such complex presentations require a combination of helping approaches—psychotherapeutic and psychopharmacological—to address each of the problem components, extending the duration of treatment.
- *Understanding* – Brief therapy tends to be most helpful for patients who have a clear understanding of their problems and a strong motivation to address these.

In situations where people's readiness to change is low (Prochaska et al, 1994), they enter therapy denying the need for change, unclear about the changes they need to make, or ambivalent over the need for change. As a result, they may require many weeks of exploratory therapy and self-discovery before they are ready to make a commitment to more action-oriented, short-term approaches.

- *Social support* – Many clients enter therapy not only to make changes in their personal and interpersonal lives, but for ongoing social support. This is particularly true of individuals who are socially isolated because of a lack of social skills and/or fears of rejection and abandonment. While social support is a necessary and legitimate end of psychotherapy, situations requiring extensive support will necessarily preclude highly abbreviated courses of treatment. Indeed, clients who are particularly sensitive to interpersonal loss may find it impossible to tolerate a therapy in which a working bond is quickly dissolved. (Steenbeger, 2004)

The assumptions and principles of brief collaborative therapy still apply to these special populations of children and youth who require longer or more intricate services in order to function well in their communities. Brief services remain suitable when implemented as an immediate access to help when needed, service to those requiring a limited number of sessions, triage and support while waiting for other services. By serving many children and families efficiently with less duration of service, we are able to re-invest and divert resources to children with the most complex needs.

B. NOT ALL COMMUNITIES ARE ALIKE: PLANNING FOR UNIQUE ISSUES

Implementing brief services throughout Ontario will require thoughtful planning for unique issues in diverse communities. Considerations for rural communities include culture, geographic isolation, dispersed poverty, lack of public transportation, privacy and confidentiality concerns and, on a system level, consolidation of services, and relocation of services further away from families. All of these conditions contribute to an overall social isolation, infrequent contacts with children youth and families, and unpredictable service delivery, and must be considered when attempting to establish services that are accessible and immediate.

VIII. IMPLICATIONS FOR ALL CHILD AND YOUTH-SERVING SECTORS

In a successful system transformation, all sectors must continually challenge traditionally held assumptions regarding child and youth mental health. For example, given that the majority of children and youth enter our mental health system through education and health-care portals, child and youth mental health agencies must make room for new service delivery models that do not place them at their centre. We are obliged to think differently about who is best suited to provide mental health services, where services are best located and what they look like. The needs of children, youth and families must trump turf and territory, and remain at the forefront of the change process.

The location of services in informal, familiar and readily accessible settings such as schools improves access to services in urban communities (York, Roy, James., 1989). Research on school-based models for urban child and youth mental health has showed dramatically greater involvement of parents in school-based services relative to clinic-based services in some urban communities (Atkins et al., 2003). Reports have demonstrated the importance of capitalizing on the unique and natural opportunities at schools to promote mental and social health (Adelman, 2005). By locating mental health services in natural and comfortable non-stigmatizing settings such as schools and community health clinics, providers meet the clients where they are, reducing stigma that can present an additional barrier to brief service access.

The Ministry of Training, Colleges and Universities has identified mental health as the current number one priority on campuses of higher education. This has the potential to evolve university health clinics into drop-in counselling centres, and counsellors into brief therapy practitioners. Professionals working in the Ministry of Education do not have the luxury of waitlists; children and youth with needs show up at the door of the school guidance counsellor, social worker, or nurse, and become the priority of the current hour. Increasingly, the Ministry of Health and Long-Term Care is helping to add responsive mental health professionals to family health teams in primary care settings. Clearly, child and youth mental health has become a shared responsibility.

Cross-sector collaboration can streamline intake procedures and reduce the barriers to service at the front end of our systems, helping to serve the young person as a whole person and improving the coordination between mental, physical and educational care.

The Drummond Report (Commission on the Reform of Ontario's Public Services, 2012) recommends greater integration of services for children and youth and co-operation across ministries to improve service delivery (recommendations 8-13 and 8-14). In the 2010 report, *Access and Wait Times in Child and Youth Mental Health: A Background Paper*, the authors cite numerous research reports that clearly demonstrate that, "Bridges must be forged, as child and youth mental health needs cross many sectors and disciplines" as this integration and collaboration is shown to create the best outcomes for children, youth and families (pp. 34-35).

We are witnessing in Ontario the beginnings of community-level conversations between sectors about how to combine resources in order to provide expanded access to brief services. Increasingly, health care, education, addictions, adult services and child and youth mental health are at the same table. Collaborative cross-sectoral models represent one possibility when considering the next innovation in brief services, helping under-resourced sectors to establish a collective response that would not be possible by an individual agency.

IX. POLICY RECOMMENDATIONS FOR BRIEF SERVICES

Implementing a brief therapy approach will require significant paradigm and attitudinal shifts among organization leaders and practitioners. The entire system needs to evolve to one that is competency based, privileging the client as the primary agent of change and maximizing the therapeutic potential of every moment. Brief, collaborative and strength-focused services should be available to children, youth and families throughout a transformed service system, regardless of where they live.

We present the following recommendations pertaining to sectors, training, funding, collaboration and evaluation:

- 1. Establish brief collaborative, strength-focused approaches to service delivery in every community in Ontario:**
 - i. Develop accessible and visible walk-in clinics that are based on the emotional and mental health needs of families, are culturally relevant and address unique community issues.
 - ii. Establish a range of service delivery models that include *intake as first session*, *extended intake*, *focused consultation*, and *brief therapy* services in order to provide immediate access to children, youth and families and provide therapeutic help at first contact.
 - iii. Ensure that highly skilled and experienced staff manage the gate of services by placing them at the front end of our systems.
 - iv. Locate services in natural, drop-in and community settings that are accessible and reduce the stigma barrier (e.g., schools, probation attendance centres, youth mental health courts, primary health care, pediatric clinics, higher-education campuses).
 - v. Given that child and youth counsellors, mental health nurses and social workers are already placed within schools, ensure that these positions are providing a single session of therapy as opposed to only gathering information and referring on to longer term services, for which there are waitlists.

- vi. Social workers and counsellors that currently staff student services offices at universities and colleges should be trained to provide brief therapy to students who come into these on-campus sites for counselling. These roles should function as more than only information gathering and referral.
- 2. Provide comprehensive and mandatory training in brief service delivery and brief therapy models to the existing and emerging workforce, across all sectors that serve children and youth (e.g. health, education, youth justice, training, colleges and universities, and child and youth mental health agencies.)**
- i. Training should help professionals to adopt a collaborative consumer-driven approach to service delivery, including collaborative documentation processes.
 - ii. Focus on training and education for staff who are positioned in early contact positions such as intake workers, crisis, walk-in, receptionists, school social workers and child and youth workers. Youth justice probation staff can be trained to provide competency-based counselling to assist clients reporting to them to problem solve with a focus on strengths and skills.
 - iii. Establish professional practice leads in each organization or institution who receive intensive training in brief, collaborative approaches and in program design, consultation skills and presentation skills.
 - iv. Include education and training in brief services in graduate and professional curricula, to shift attitudes and build skills of the emerging workforce across sectors (youth justice, nurses, psychologists, pediatricians, social workers, psychiatrists, etc.).
- 3. Restructure the funding framework to ensure providers meet with success as they develop brief services within an appropriate continuum of care.**
- i. Provide incentives for organizations to eliminate waiting lists, reduce wait times and provide immediate access to children and youth waiting for services. Ensure that such formulas fully support our most complex and vulnerable children, for whom greater numbers served is not the benchmark of success that we want to embrace.

- ii. Fund the infrastructure required to support the transformation to brief services (e.g., technology, support staff, supervision, and physical space). Funding will be required for knowledge transfer to train and educate staff and students, for staff retention, to involve young people and their families and to support client-driven evaluation of services.
- iii. Fund innovation to ensure that communities work together and across sectors to design, implement and evaluate initiatives that maximize resources and positive outcomes for children, youth and families.

4. Support formal and informal collaboration in and between sectors, to ensure that brief services planning and implementation efforts are successful.

- i. Coordinate funding allocations and planning efforts across ministries ensuring consultation with those responsible for local service delivery before decisions are finalized and implemented. Incorporate multiple local perspectives that encourage collaboration and thinking outside of traditional silos.
- ii. Encourage and provide incentives for cross-sectoral collaboration, co-locating services and cross-training staff to improve communication and eliminate barriers.
- iii. Provide flexibility and incentives for communities to pool resources, and blend and braid funding for collaborative, cross-sector initiatives that hold potential for greater benefit to families, improved clinical outcomes and cost savings.
- iv. Integrate treatment, training and research and establish living laboratories to evaluate and improve upon brief service innovation. Bring together professionals such as social workers, child and youth workers and nurses from various sectors to join together in brief services provision at walk-in clinics and other forms of brief service. This provides the opportunity to work together side-by-side and share knowledge and skills to break through barriers that impede communication and collaboration across sectors.
- v. Engage in multi-sectoral efforts to eliminate wait lists. Determine who is waiting for service and their level of need to ensure that the continuum of care has the full array of necessary services and programs, and availability of appropriate amounts of each service to meet the needs.

- 5. Assess pathways to service to ensure that intake, assessment and therapeutic procedures are sensitive, respectful and responsive to the needs of the children, youth and families who we serve. Revise policies and protocols to reflect a collaborative, strengths-focused approach.**
 - i. Review mandated instruments and data collection practices to streamline and eliminate unnecessary paperwork, allowing professionals more time to work with children and families, and the ability to provide therapeutic help at the first contact.
 - ii. Evaluate the appropriateness, relevance and usefulness of assessment and screening tools, and the timing of their use within the intake process. Replace deficit-focused tools with alternative, strength-based and family-friendly solutions. Instruments should be used in combination with, rather than substitute for, family expertise and professional judgment.
 - iii. Work collaboratively to develop common, strengths-based instruments and tools that can be implemented within and across sectors, and which measure client outcomes and family strengths and skills.
 - iv. Establish common language and standardize definitions that facilitate communication across sectors.

- 6. Support evaluation and research of Ontario's brief service delivery mechanisms.**
 - i. Support a thorough environmental scan of Ontario's brief service delivery mechanisms in the education and primary health care systems.
 - ii. Provide funding for evaluation and research of Ontario's walk-in clinics and other brief service delivery mechanisms. This should include mixed methods outcome research of the services as well as research that identifies and evaluates outcomes of the brief service approach being utilized, including immediate, short-term and long-term outcomes that follow clients for 18 months or longer.
 - iii. Fund research and evaluation within and across sectors to increase our ability to identify best practices located at the early stages of services. This will include examining front-end services through both strong practice based evidence and



Ontario Centre of Excellence
for Child and Youth
Mental Health

Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents

Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.

November 2012

No more, no less

evidence based practice, and qualitative and quantitative research. This integration of research and practice involves reflective practices that include clients' feedback every step of the way.

REFERENCES

- Adelman, H., Taylor, L. (2005). Mental health in urban schools. National Institute of Urban School Improvement. University of California and University of Los Angeles.
- Anderson, L., Vostanis, P., O'Reilly, M. (2005). Three-year follow-up of a family support service cohort of children with behavioural problems and their parents. *Child: Care, Health and Development* 31, 4, 469-477.
- Antle, B.F., Barbee, A.P., Christensen, D.N., Martin, M.H. (2008). Solution-based casework in child welfare: preliminary evaluation research. *Journal of Public Health Child Welfare*, 2,2,197-227.
- Anker, M., Duncan, B., Sparks, J. (2009). Using client feedback to improve couple outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, 77, 693-704.
- Atkins, M.S., Graczyk, P.A., Frazier, S.L, Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services. *Psychology Review*, 32,4, 503-514.
- Barbopoulos, A., Clark, J. (2003). Practicing psychology in rural settings: Issues and guidelines. *Canadian Psychology*, 44, 410-424.
- Barkham, M., Connell, J., Stiles, W., Miles, J., Margison, F., Evans, C., Mellor-Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology*, 74, 1, 160-167.
- Berger, P., Berger, D., Kelner, H. (1974). *The homeless mind: Modernization and consciousness*. New York, NY: Vintage Books.
- Beyeback, M., Rodriguez Sanchez, M.S., Arribas de Miguel, J., Herrero de Vega, M., Hernandez, C., Rodriguez-Morejon, A., (2000) Outcome of solution-focused therapy at a university family therapy center. *Journal of Systemic Therapies*, 19, 116-28.

Bhanot, S., Livingstone, S., Stalker, C. (2010). An inventory of walk-in therapy clinics in Southern Ontario. Unpublished paper.

Black, M., Krishnakumar, A. (1998). Children in low-income, urban settings: Interventions to promote mental health and well-being. *American Psychologist*, 53, 635-646.

Bloom, B.L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief Treatment and Crisis Intervention*, 1, 75-86.

Bloom, B. L. (1981). Focused single-session therapy: Initial development and evaluation. In S. H. Budman (Ed.), *Forms of brief therapy*, pp. 167-216. New York: Guilford Press.

Bohart, A.C., Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In *The Heart and Soul of Change: Delivering what works in therapy: Second Edition*. American Psychological Association. Miller, Duncan, Hubble & Wampold, (eds) Washington, D.C

Bostandzhiev, V.I., Bozhkova, E. (2011). A comparative study in a Mental Health Day Center 2002-2005. In Macdonald A.J. (Ed), *Solution Focused Therapy: Theory, Research and Practice*. Sage Publications: London.

Boydell, K.M., Bullock, H., Goering, P.N. (2009). Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health. *Getting our acts together: Interagency collaboration in child and youth mental health*. The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

Boyhan, P.A. (1996). Client's perceptions of single session consultations as an option to waiting for family therapy. *Australian and New Zealand Journal of Family Therapy*, 17, 85-96.

Bringhurst, D., Watson, C., Miller, S, & Duncan, B. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure: *Journal of Brief Therapy*, 5, 1, 23-30.

National Infant, Child, and Youth Mental Health Consortium Advisory. The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. (2010). *Access and Wait Times in Child and Youth Mental Health: A Background Paper*. Canadian Institutes of Health Research.

Caudill, M. H. (1993). School social work services in rural Appalachian systems: Identifying and closing the gaps. *Social Work in Education, 15*, 179–185.

Cepukiene, V., Pakrošnis, R. (2010). The outcome of Solution-Focused Brief Therapy among foster care adolescents: The changes of behavior and perceived somatic and cognitive difficulties. *Children and Youth Services Review, 33*, 6, 791-797.

Eakes, G., Walsh, S., Markowski, M., Cain, H., Swanson, M. (1997). Family-centred brief solution focused therapy with chronic schizophrenia: a pilot study. *Journal of Family Therapy, 19*, 145-158.

Forrester, D., Copello, A., Waissbein, C., Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review, 17*, 6, 410 – 426.

Franklin, C., Moore, K., Hopson, L. (2008). Effectiveness of Solution-Focused Brief Therapy in a School Setting. *Children and Schools, 30*, 1, 15-26.

Franklin, C., Streeter, C.L., Kim, J.S., Tripodi, S.J. (2007). The Effectiveness of a Solution-Focused, Public Alternative School for Dropout Prevention and Retrieval. *Children and Schools, 29*, 3, 133-144.

Charman, D., Barkham, M. (2005). Psychological treatments: Evidence-based practice and practice-based evidence. In Psych. ISSN 1441-8754. Retrieved June 20, 2012 from <http://www.psychology.org.au/publications/inpsych/treatments>

Charon, R. (2006). *Narrative medicine. Honoring the stories of illness*. New York: Oxford University press.

Children's Mental Health Ontario. Position Statement. Funding Principles for Child and Youth Mental Health. www.kidsmentalhealth.ca. Downloaded on April 7, 2012.

Chung, S.A., Yang, S. (2004). The effects of solution-focused group counseling program for the families with schizophrenic patients. *Taehan Kanho Hakhoe Chi (Journal of the Korean Academy of Nursing), 34*, 1155-63

Clemente, C., McGrath, R., Stevenson, C., Barnes, J. (2006). Evaluation of a waiting list initiative in a child and adolescent mental health service. *Child and Adolescent Mental Health, 11, 2, 98-103.*

Cockburn, J.T., Thomas, F.N., Cockburn, O.J. (1997). Solution-focused therapy and psychosocial adjustment to orthopedic rehabilitation in a work hardening program. *Journal of Occupational Rehabilitation, 7, 97-106.*

Corcoran, J., Pillai, V. (2007). A review of the research on solution-focused therapy. *British Journal of Social Work, 10, 1-9*

Corcoran, J.A. (2006). A comparison group study of solution-focused therapy versus “treatment-as usual” for behaviour problems in children. *Journal of Social Service Research, 33, 69-81.*

Czinca, J. Romano, E. (2009). Examining how the mental health needs of children who have experienced maltreatment are addressed within Ontario Children’s Aid Societies. *Canadian Journal of Family and Youth, 2, 25-51.*

Daki, J., Savage, R.S. (2010). Solution-Focused Brief Therapy: Impacts on Academic and Emotional Difficulties. *Journal of Education Research, 103, 309-326.*

Daley, M. R., Avant, F. L. (2004). Rural social work: Reconceptualizing the framework for practice. In T. L. Scales, C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets*. Belmont, CA: Thomson/Brooks/Cole. 34–42.

deShazer, S.(1984). The death of resistance. *Family Process, 23, 30-40.*

deShazer, S. (1985). *Keys to Solutions in Brief Therapy*. New York, NY, Norton.

deShazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*, New York, NY. Norton.

deShazer, S. (1991). *Putting difference to Work*. New York: NY Norton.

deShazer, S.(1994). *Words Were Originally Magic*. New York, NY, Norton.

- Dunbar, E. R. (1999). Strengthening services in rural communities through blended funding. In I. B. Carlton-LaNey, R. L. Edwards, & P. N. Reid (Eds.), *Preserving and strengthening small towns and rural communities* (pp. 15–26). Washington, DC: NASW Press.
- Duncan, B.L., Miller, S.D., Wampold, B.E., Hubble, M.A. (2010). *The heart & soul of change: Second edition. Delivering what works in therapy.* American Psychological Association, Washington, DC.
- Duncan, B., Miller, S. (2000). *The heroic client: Doing client-directed, outcome informed therapy.* Jossey Bass Inc. Publishers. San Francisco, CA.
- Duvall, J., Beres, L. (2011). *Innovations in narrative therapy: Connecting practice, training, and research.* New York, N.Y.: W.W. Norton & Company.
- Duvall, J., Beres, L. (2007) Movement of identities: A map for therapeutic conversations about trauma. In C. Brown, T. Augusta-Scot (Eds.). *Narrative therapy: Making meaning Making lives.* 229-250. Thousand Oaks, CA: Sage
- Epstein, M.H., & Sharma, J.M. (1998). Behavioral and Emotional Rating Scale: A strength-based assessment in transition planning. Austin, TX: PRO-ED.
- Everitt, A. Hardiker, P, Littlewood, J., Mullender, A. (1992). *Applied research for better practice.* Basingstoke, UK: Macmillan Education.
- Ferguson, H. (2001). Social work, individualization and life politics. *British Journal of Social Work*, 31, 41-55.
- Fitchen, J. M. (1998). *Rural poverty and rural social work.* In L. H. Ginsberg (Ed.), *Social work in rural communities.* 115–134. Alexandria, VA: Council on Social Work Education.
- Fook, J., Gardner, F. (2007). *Practising critical reflection: A resource handbook.* McGraw-Hill Education, Berkshire, England.
- Forrester, D., Copello, A., Waissbein, C., Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review*, 17, 6, 410-426.

Franklin, C., Moore, K., Hopson, L. (2008). Effectiveness of solution-focused brief therapy in a school setting. *Children and Schools, 30*, 15-26.

Franklin, C., Biever, J.L., Moore, K.C., Clemons, D., Scamardo, M. (2001.) Effectiveness of solution-focused therapy with children in a school setting. *Research on Social Work Practice, 11*, 411-434.

Franklin, C., Moore, K., Hopson, L. (2008). Effectiveness of Solution-Focused Brief Therapy in a School Setting. *Children and Schools, 30*, 1, 15-26.

Franklin, C., Streeter, C.L., Kim, J.S., Tripodi, S.J. (2007). The Effectiveness of a Solution-Focused, Public Alternative School for Dropout Prevention and Retrieval. *Children and Schools, 29*, 3, 133-144.

Franklin, C., Trepper, T.S., Gingerich, W.J., & McCollum, E.E. (2012). *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice*. New York, NY: Oxford University Press.

Gostautas, A., Cepukiene, V., Pakrosnis, R., Fleming, J.S. (2005). The outcome of solution-focused brief therapy for adolescents in foster care and health institutions. *Baltic Journal of Psychology, 6*, 5-14.

Grant, A.M., Green, L.S., Rynsaardt, J. (2010). Developmental Coaching for High School Teachers: Executive Coaching Goes to School. *Consulting Psychology Journal: Practice and Research, 62*, 151-168.

Grant, A.M., Curtayne, L., Burton, G. (2009). Executive coaching enhances goal attainment, resilience and workplace well-being: a randomised controlled study. *Journal of Positive Psychology, 4*, 5, 396-40

Hampson, R., O'Hanlon, J., Franklin, A., Petony, M., Fridgant, L., Heins, T. (1999). The Place of Single Session Family Consultations: Five Years' Experience in Canberra. *Australian and New Zealand Journal of Family Therapy, 20*, 4, 195-200

Froeschle, J.G., Smith, R.L., Ricard, R. (2007). The Efficacy of a Systematic Substance Abuse Program for Adolescent Females. *Professional School Counselling, 10*, 498-505

Garfield, S.L., Bergin, A.E. (Eds.) (1978, 1986) *Handbook of psychotherapy and behaviour change*. 2nd & 3rd eds. New York: Wiley.

Giddens, A. (1991) *Modernity and Self-Identity*. Cambridge: Polity.

Gingerich, W.J. and Eisengart, S. (2000) Solution-focused brief therapy: a review of the outcome research, *Family Process*, 39: 477-98.

Green LS, Grant AM, Rynsaardt J (2007) Evidence-based life coaching for senior high school students: building hardiness and hope.' *International Coaching Psychology Review*, 2: 24-32

Harris, M.B., & Franklin, C. (2008). *Taking charge: A school based life skills program for adolescent mothers*. New York: Oxford University Press.

Harper-Jacques, S., McElheran, N., Slive, A., Leahey, M. (2008). A comparison of two approaches to the delivery of walk-in single session mental health therapy. *Journal of Systemic Therapies*, 27, 40-53.

Harris, M.B., Franklin, C. (2009). Helping Adolescent Mothers to Achieve in School: An Evaluation of the Taking Charge Group Intervention. *Children and Schools*, 31, 1, 27-34.

Howard, K., Moras, K., Brill, P.L. Martinovich, Z., Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness and patient progress. *American Psychologist*, 51, 1059-1064

Hubble, M., Duncan, B., & Miller, S. (1999). *The heart and soul of change: What works in therapy*. American Psychological Association. Washington, DC

Jensen, G. M., Royeen, C. B. (2002). Improved rural access to care: Dimensions of best practice. *Journal of Interprofessional Care*, 16, 117–128.

Kim, J.S., Franklin, C. (2009). Solution-focused brief therapy in schools: A review of the outcome literature. *Children and Youth Services Review*, 31, 4, 464-470

Kim, J.S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice*, 18, 107-116.

Knekt, P.I., Lindfors, O., Harkanen, T., Valikoski, M.I., Virtala, E., Laaksonen, M.A., Marttunen, M., Kaipainen, M., Renlund, C., Helsinki Psychotherapy Study Group. (2008). Randomized trial on the

effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine*, 38, 689-703.

Knekt, P., Lindfors, O. (2004) A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders: design, methods and results on the effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy during a one-year follow-up, *Studies in Social Security and Health*, No. 77. The Social Insurance Institution.

Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Laaksonen, M.A. Martunen, M. Kaipainen, M., Renlund, C., the Helsinki Psychotherapy Study Group (2008). Randomized trial on the effectiveness of long and short term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up, *Psychological Medicine*, 38, 689-703

Ko M.J., Yu S.J., Kim Y.G. (2003). The effects of solution-focused group counselling on the stress response and coping strategies in the delinquent juveniles. *Taehan Kanho Hakhoe Chi (Journal of Korean Academy of Nursing; Korean)*, 33, 3, 440-450.

Koob, J.J., Love, S.M. (2010). The implementation of solution-focused therapy to increase foster care placement stability. *Children and Youth Services Review*, 32, 10, 1346-1350

Kvarme, L.G., Helseth, S., Sørnum, R., Luth-Hansen, V., Haugland, S., Natvig, G.K. (2010). The effect of a solution-focused approach to improve self-efficacy in socially withdrawn school children: A non-randomized controlled trial. *International Journal of Nursing Studies*, doi:10.1016/j.ijnurstu.2010.05.001

LaFountain, R.M., Garner, N.E. (1996). Solution-focused counselling groups: the results are in. *Journal for Specialists in Group Work*, 21, 128-143

Lambert, M.,J. (2005). Enhancing psychotherapy outcome through feedback. *Journal of Clinical Psychology*, 61, 141-217.

Lambert, M.J., Okiishi, J.C., Finch, A.E., Johnson, L.D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research & Practice*, 29, 63-70.

Lamprecht, H., Laydon, C., McQuillan, C., Wiseman, S., Williams, L., Gash, A., Reilly, J. (2007). Single-session solution-focused brief therapy and self-harm: a pilot study. *Journal of Psychiatric and Mental Health Nursing*, 14, 601-602.

Lazarus, A., Fay, A., (1990). Brief psychotherapy: Tautology or oxymoron? In Zeig, J.K. & Gilligan, S.G., Eds. *Brief therapy: Myths, Methods and Metaphors* (pp. 26-51). CITY: Brunner, Mazel.

Lebow, J. (1997). New science for psychotherapy: Can we predict how therapy will progress? *Family Therapy Networker*, 21, 2, 85-91

Lloyd, D. (2002). *How to deliver accountable care*. Rockville, MD: National Council for Community Behavioral Healthcare.

Lindfors, L., Magnusson, D. (1997) Solution-focused therapy in prison. *Contemporary Family Therapy*, 19, 89-104

Lipman, E.L., Boyle, M.H. (2003). Barriers to services promoting child emotional, behavioral, and social health. Chedoke Child and Family Centre, Canada. Published online.

Littrell, J.M., Malia, J.A., Vanderwood M. (1995). Single sessions brief counselling in a high school. *Journal of Counselling and Development*, 73, 451-8

Macdonald, A.J. (2011). *Solution-focused therapy: Theory, research and practice*. Sage Publications. Los Angeles, CA.

Madsen, W. (1999) *Collaborative therapy with multi-stressed families: From old problems to new futures*. New York: The Guilford Press.

McAllister, M., Zimmer-Gimbeck, M., Moyle, W. Billet, S. (2008). Working effectively with clients who self-injure using a solution-focused approach, *International Emergency Nursing*, 16, 272-279.

McGarry, J., McNicholas, F., Buckley, H.I., Kelly B.D., Ross, N. (2008). The clinical effectiveness of a brief consultation and advisory approach compared to treatment as usual in child and adolescent mental health services. *Clinical Child Psychology and Psychiatry*, 13, 365-376.

McKay, M.M. & Bannon, W.M. (2004). Engaging families in child mental health services. *Child Adolescent Psychiatric Clinics of North America*, 13, 4, 905-921.

McKeel, A.J. (1996). A clinician's guide to research on solution-focused therapy, in Miller, S.D., Hubble, M.A. and Duncan, B.L. (eds) *Handbook of Solution Focused Brief Therapy*. San Francisco, CA; Jossey-Bass. 251-271.

Midgeley, N. (2009). Editorial: Improvers, adapters and rejecters—the link between “evidence-based practice” and “evidence-based practitioners.” *Clinical Child Psychology and Psychiatry*, 14, 3, 323-327.

Miller, J.K. (2008). Walk-in single-session team therapy: A study of client satisfaction. *Journal of Systemic Therapies*, 27, 78-94.

Miller, S.D. (2009). Practice-Based Evidence Goes Mainstream. Retrieved June 20, 2012 from <http://www.scottmiller.com/?q=node/27>.

Miller, S.D., Duncan, B.L. Brown, J., Sorrell, R., Chalk, B. (2006) Using outcome to perform and improve treatment outcome. *Journal of Brief Therapy*, 5, 5-22

Miller, S. Duncan, B., Hubble, M., (1997). *Escape from Babel: Toward a unifying language for psychotherapy*. New York: WW Norton.

Mintoft, B., Bellringer, M.E., Orme, C. (2005). Improved client outcome services project: an intervention with clients of problem gambling treatment. *ECOMMUNITY: International journal of mental health and addiction*, 3, 30-40

Murphy, J.J. (2008). *Solution-focused Counselling in Schools*. Alexandria, Virginia: American Counselling Association.

Newsome, W.S. (2004). Solution-Focused Brief Therapy Groupwork with At-Risk Junior High School Students: Enhancing the Bottom Line. *Research on Social Work Practice*, 14, 5, 336–343.

Nowicka, P., Haglund, P., Pietrobelli, A., Lissau, I., Flodmark, C.E. (2008). Family Weight School treatment: 1-year results in obese adolescents. *International Journal of Pediatric Obesity*, 3, 3, 141-147.

Nystuen, P., Hagen, K.B. (2006). Solution-focused intervention for sick-listed employees with psychological problems or muscle skeletal pain: a randomised controlled trial. *BMC Public Health*, 6, 69-77.

Ontario College of Family Physicians. (2005) Report on Public Health and Urban Sprawl in Ontario. www.ocfp.on.ca

Orlinsky, D.E. (2006). Comments on the state of psychotherapy research (as I see it). *Psychotherapy Bulletin*, 41, 37-41

Orlinsky, D.E., Runnestad M.H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*. New York: Wiley.

Pakrosnis, R., Cepukiene, V. (2011). Outcomes of solution-focused brief therapy for adolescents in foster care and health care settings. In Franklin, C., Trepper, T., Gingerich, W.J., McCollum, E. (Eds) *Solution-focused Brief Therapy: A Handbook of Evidence- Based Practice*. Oxford University Press: New York.

Panayotov, P., Anichkina, A., Strahilov, B. (2011). Solution-focused brief therapy and long-term medical treatment compliance / adherence with patients suffering from schizophrenia: a pilot naturalistic clinical observation. In Franklin, C., Trepper, T., Gingerich, W.J., McCollum, E. (Eds) *Solution-focused Brief Therapy: A Handbook of Evidence-Based Practice*. Oxford University Press: New York.

Pekarik, G. (1992). Relationship of client's reasons for dropping out of treatment to outcome and satisfaction. *Journal of Clinical Psychology*, 48, 91-98.

Perkins, R. (2006). The effectiveness of one session of therapy using a single-session therapy approach for children and adolescents with mental health problems. *Psychology and psychotherapy: Theory, Research and Practice*, 79, 215-227.

Perkins, R. Scarlett, G. (2008). The effectiveness of single session therapy in child and adolescent mental health. Part 2: An 18-month follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 143-156.

Price, C. (1994). Open days: Making family therapy accessible in working class suburbs. *Australian and New Zealand Journal of Family Therapy*, 15, 4, 191-196.

Rhee, W.K., Merbaum, M., Strube, M.J. (2005). Efficacy of brief telephone psychotherapy with callers to a suicide hotline. *Suicide and Life-Threatening Behaviour*, 35, 317-328.

Rothwell, N. (2005). How brief is solution focused brief therapy? A comparative study. *Clinical Psychology and Psychotherapy*, 12, 402-405.

Reibschleger, J. (2007). Social workers' suggestions for effective rural practice. *Families in Society: The Journal of Contemporary Social Services*, 88, 203-213.

Reid, G.J., Brown, J.B. (2008). Money, case complexity, and wait lists: perspectives on problems and solutions at children's mental health centers in Ontario. *Journal of Behavioral and Health Services Research*, 35, pp. 334-346.

Roberts, G.A., (2000). Narrative and severe mental illness: What place do stories have in an evidence-based world. *Advances in Psychiatric Treatment*, 6, 432-441.

Roberts, A. R., Yeager, K. (2004). Systematic reviews of evidence-based studies and practice-based research: How to search for, develop. In A. R. Roberts & K. Yeager (Eds.), *Evidence-based practice manual: research and outcome measures in health and human services* (pp. 3–14). Oxford: Oxford University Press.

Rothwell, N. (2005) How brief is solution-focused brief therapy? A comparative study. *Clinical Psychology and Psychotherapy*, 12, 402-5

Rosenbaum, R., Hoyt, M.F., & Talmon, M. (1990) The challenge of single-session therapies: Creating pivotal moments. In R.A. Wells & V.J. Giannetti (Eds.), *Handbook of brief psychotherapies*. New York: Plenum Press.

Salovey, P., Rothman, A.J., Detweiler, J.B., Steward, W. T. (2000). Emotional states and physical health. *American Psychologist*, 55, 110-121.

Schade, N., Torres, P. Beyebach, M. (2011). Cost-efficiency of a brief family intervention for somatoform patients in primary care. *Families, Systems, & Health, 29, 3, 197-205.*

Seidel, A., Hedley, D. (2008). The Use of Solution-Focused Brief Therapy With Older Adults in Mexico: A Preliminary Study. *American Journal of Family Therapy, 36, 3, 242-252.*

Seymour, F., Epston, D. (1989). An approach to childhood stealing with evaluation of 45 cases. *Australian & New Zealand Journal of Family Therapy, 10, 3, 137-143.*

Shanley, D.C., Reid, G.J., Evans, B. (2008). How parents seek help for children with mental health problems. *Journal of Administrative Policy of Mental Health, 35, 135-146.*

Sherman, M.L., Barnum, D.D., Buhman-Wiggs, A., Nyberg, E. (2009). Clinical intake of child and adolescent consumers in a rural community mental health center: does wait-time predict attendance? *Community Mental Health Journal, 45,78-84.*

Shin, S.K. (2009). Effects of a Solution-Focused Program on the Reduction of Aggressiveness and the Improvement of Social Readjustment for Korean Youth Probationers. *Journal of Social Service Research 35, 3, 274-284*

Shon, D.A. (1983). *The Reflective Practitioner: How Professionals Think in Action.* USA: Basic Books.

Shon, D.A. (1987) *Educating the Critically Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions.* Wiley & Sons, Inc. N.J, USA.

Shon, D.A. (1995) *Reflective inquiry in social work practice,* P.M. Hess and E.J. Mullen (eds.) *Practitioner-Researcher Relationships.* Washington, DC: NASW Press.

Short, E., Kinman, G., Baker, S. (2010). Evaluating the impact of a peer coaching intervention on well-being amongst psychology undergraduate students. *International Coaching Psychology Review, 5, 1, 27-35.*

Silver, E., Williams, A., Worthington, F., Phillips N. (1998). Family therapy and soiling: An audit of externalizing and other approaches. *Journal of Family Therapy, 20, 413-422.*

Silverman, W.H., Beech, R.P. (1984). Length of intervention and client assessed outcome. *Journal of Clinical Psychology, 40*, 475-480.

Slive, A., Bobele, M. (2011). *When one hour is all you have: Effective therapy for walk-in clients*. Phoenix, AZ: Zeif, Tucker & Theisen, Inc.

Slive, A., McElheran, N., Lawson, A. (2008) How brief does it get? Walk-in single session therapy. *Journal of Systemic therapies, 27*, 5-22.

Smock, S.A., Trepper, T.S., Wetchler, J.L., McCollum, E.E., Ray, R., Pierce, K. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy, 34*, 1, 107–120.

Sommers-Flanagan, J. (2007). Single-session consultation for parents: A preliminary investigation. *The Family Journal: Counselling and Therapy for Couples and Families, 15*, 24-29.

Spence, G.B., Grant, A.M. (2007). Professional and peer life coaching and the enhancement of goal striving and well-being: An exploratory study. *Journal of Positive Psychology, 2*, 3, 185–194

Springer, D.W., Lynch, C., Rubin, A. (2000) Effects of a solution-focused mutual aid group for Hispanic children of incarcerated parents. *Child and Adolescent Social Work, 17*, 431-442.

Stams, G.J., Dekovic, M., Buist, K. and de Vries, L. (2006). Efficacy of solution-focused brief therapy: a meta-analysis, *Gedragstherapie (Dutch Journal of Behavioral Therapy), 39*, 2, 81-95.

Tallman, K., Janisse, T., Franel, R.,M., Sung, S.H., Krupat, E., &Hsu, J.T. (2007) Communication patterns of physicians with high patient satisfaction ratings. *The Permanente Journal, 11*, 19-29.

Stith, S.M., Rosen, K.H., McCollum, E.E., Thomsen, C.J. (2004). Treating intimate partner violence within intact couple relationships: outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30*, 305-318

Stoddart, K.P., McDonnell, J., Temple, V., Mustate, A. (2001). Is brief better? A modified brief solution-focused therapy approach for adults with a developmental delay. *Journal of Systemic Therapies, 20*, 24-41.

Sundmann, P. (1997). Solution-focused ideas in social work. *Journal of Family Therapy*, 19, 159- 172.

Steenburger, B. (2004). *The Art and Science of the Brief Psychotherapies*. American Psychiatric Press, Inc. 2004.

Szatmari, P. (1999). Evidence-based child psychiatry and the two solitudes. *Evidence-Based Mental Health*, 2, 6–7.

Talmon, M. (1990). *Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter*. San Francisco: Jossey-Bass.

Taylor, S.E., Kemeny, M.E., Reed, G.M., Bower, J.E., Gruenewald, T.L. (2000). Psychological resources, positive illusions, and health. *American Psychologist*, 55, 99-109.

Templeton, S. B., Mitchell, L. (2004). Utilizing an asset-based framework to improve policies for rural communities: One size does not fit all families. In T. L. Scales & C. L. Streeter (Eds.). *Rural social work: Building and sustaining community assets* (pp. 196–205). Belmont, CA: Brooks/Cole.

Thorslund, K.W. (2007). Solution-focused group therapy for patients on long-term sick leave: a comparative outcome study. *Journal of Family Psychotherapy*, 18, 3, 11-24.

Triantafillou, N. (1997). A solution-focused approach to mental health supervision. *Journal of Systemic Therapies*, 16, 305-328.

Viner, R.M., Christie, D., Taylor, V., Hey, S. (2003). Motivational/solution-focused intervention improves HbA1c in adolescents with Type 1 diabetes: a pilot study. *Diabetic Medicine*, 20, 9, 739-742.

Violeta Enea, I.D. (2009). Motivational/solution-focused intervention for reducing school truancy among adolescents. *Journal of Cognitive & Behavioural Therapies* 9, 2, 185-198.

Vogelaar, L., van't Spijker, A., Vogelaar, T., van Busschbach, J.J., Visser, M.S., Kuipers, E.J., van der Woude, C.J. (2011). Solution focused therapy: A promising new tool in the management of fatigue in Crohn's disease patients: Psychological interventions for the management of fatigue in Crohn's disease. *Journal of Crohn's and Colitis*. doi:10.1016/j.crohns.2011.06.

Vostanis, P., Anderson, L., Window, S. (2006). Evaluation of a family support service: short-term outcome. *Clinical Child Psychology and Psychiatry*, 11, 4, 513-528. doi: 10.1177/1359104506067874.

Vromans, L. Schweitzer, R. (2010). Narrative therapy for adults with a major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research*. doi: 10.1080/10503301003591792

Vromans, L. (2008). Process and outcome of narrative therapy for major depressive disorder in adults: Narrative reflexivity, working alliance and improved symptom and inter-personal outcomes. PhD thesis, Queensland University of Technology, AU.

Wake, M., Baur, L.A., Gerner, B., Gibbons, K., Gold, L., Gunn, J., Levickis, P., McCallum, Z., Naughton, G., Sanci, L., Ukoumunne, O.C. (2009). Outcomes and costs of primary care surveillance and intervention for overweight or obese children: the LEAP 2 randomised controlled trial. *British Medical Journal*, 339, doi: <http://dx.doi.org/10.1136/bmj.b3308>

Wake, M., Gold, L., McCallum, Z., Gerner, B., Waters, E. (2008). Economic evaluation of a primary care trial to reduce weight gain in overweight/obese children: the LEAP trial. *Ambulatory Pediatrics*, 8, 336-341.

Walker, L., Hayashi, L. (2009). Pono Kaulike: reducing violence with restorative justice and solution-focused approaches. *Federal Probation* 73, 1.

Waltman, G. H. (1986). Main street revisited: Social work practice in rural areas. *Social Casework*, 67, 466-474.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, N.J.: Erlbaum.

Weber, M., Davis, K., McPhie, L. (2006). Narrative therapy, eating disorders and groups: Enhancing outcomes in rural NSW. *Australian Social Work*, 59, 4, 391-405.

Wells, A., Devonald, M., Graham, V., Molyneux, R. (2010). Can solution focused techniques help improve mental health and employment outcomes? *Journal of Occupational Psychology, Employment and Disability*, 12, 1, 3-15.

Wideman, G. Strengthening rural social work practice: The relevance of intermediate resources in a Newfoundland community. Retrieved on April 3, 2012 from www.nlcahr.mun.ca/research/affinity.

Wheeler, J. (1995). Believing in miracles: the implications and possibilities of using solution focused therapy in a child mental health setting. *ACPP Reviews & Newsletter*, 17, 255-261.

Wilmshurst, L.A. (2002). Treatment programs for youth with emotional and behavioural disorders: an outcome study of two alternate approaches. *Mental Health Services Research*, 4, 85-96.

Wiseman, S. (2003). Brief intervention: reducing the repetition of deliberate self-harm. *Nursing Times*, 99, 34-36.

Wolgast, B. M., Lambert, M. J., Puschner, B. (2003). The Dose-Response Relationship at a College Counselling Centre: Implications for Setting Session Limits. *Journal of College Student Psychotherapy*, 18, 2, 15-29.

Yang, F.R., Zhu, S.L., Luo, W.F. (2005). Comparative study of solution-focused brief therapy (SFBT) combined with paroxetine in the treatment of obsessive-compulsive disorder. *Chinese Mental Health Journal*, 19, 4, 288-290.

Young, K. (2011). When All the time you have Is Now: Re-visiting practices and narrative therapy in a walk-in clinic. In Duvall, J. & Beres, L., *Innovations in Narrative Therapy: Connecting Practice, Training, and Research (147-166)*. New York: W.W. Norton & Company.

Young, K. Cooper, S. (2008). Toward co-composing an evidence base: The narrative therapy re-visiting project. *Journal of Systemic Therapies*, 27, 67-83.

Young, K., Dick, M., Herring, K., Lee, J. (2008). From waiting lists to walk-in: Stories from a walk-in therapy clinic. *Journal of Systemic Therapies*, 27, 23-39.

Zhang, H.Y., Wu, W-E., Wen, W-J and Zheng, YM. (2010) Application of solution-focused approach in schizophrenia patients of convalescent period, *Medical Journal of Chinese Peoples' Health*, 18, 2410-12.



Ontario Centre of Excellence
for Child and Youth
Mental Health

Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents

Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.

November 2012

No more, no less

Zhang, W.J., Xu, G., Guo, H., Luo, P., Yu, I. (2011). Application of solution-focused approach in follow-up management among patients with type 2 diabetes complicated by non-alcohol fatty liver disease. *Chinese Journal of Nursing*, 3. DOI CNKI:SUN:ZHHL.0.2011-03-006.

Zimmerman, T.S., Jacobsen, R.B., MacIntyre, M., Watson, C. (1996). Solution-focused parenting groups: an empirical study. *Journal of Systemic Therapies*, 15, 12-25.

Zimmerman, T.S., Prest, L.A., Wetzel, B.E. (1997). Solution-focused couples therapy groups: an empirical study. *Journal of Family Therapy*, 19, 125-144.

APPENDIX A

The state of the research: Author's note

Research suggests that a promptly delivered, brief, collaborative, client-centered single therapy session has the potential to be highly cost effective and to meet the needs of clients. During the late 1970's and early 1980's the information regarding brief therapies came from clinical researchers such as Beck, Rush, Shaw and Emery (1979) and Klerman, Rounsaville, Chevron and Weissman (1984), as well as large meta-analysis studies (Smith, Glass, & Miller, 1980). With 97 relevant studies, two meta-analyses, 17 randomized controlled trials, 42 comparison studies, and effectiveness data from some 4,000 cases with success ratings exceeding 60 percent, the literature in support of the clinical effectiveness of brief services is now quite extensive (Macdonald, 2011).

The research on brief collaborative therapies continues to grow and has taken root in many different countries. The total amount of available research knowledge compares favorably with that of many other psychological therapies (Macdonald, 2011). This is fortunate because the most frequent number of therapy sessions attended by clients is one.

A traditional research lens will often demonstrate a preference for evidence-based practice, sometimes at the expense of other information that is as valuable, if not more valuable, when considering impact and client outcomes. Historically, measures such as consumer satisfaction have a reputation as insufficient, and have been glossed over in favour of empirical data. Because of this, we stress that research and evaluation must incorporate both evidence-based practice and practice-based evidence.

Effective evaluation of brief services in children's mental health requires an appreciation for outcomes and process. Within the profession, researchers are already shifting towards incorporating *practice-based evidence* into the evaluation of brief services (Anker, Duncan, & Sparks, 2009; Barkham et al., 2001; Duncan & Hubble, 2004). In practical terms, this means not only gathering data on how treatment is working for a particular client and therapist pairing but also then providing feedback to the therapist about the client's improvement (Howard, Moras, Brill, Matinovich, & Lutz, 1996). The results are impressive (Anker et al., 2009; Lambert, 2005; Miller, Duncan, Brown, Sorrel and Chalk, 2006). The combination of measuring progress (i.e., monitoring) and providing feedback consistently yields clinically significant change, with treatment effects

outstripping the empirically supported psychotherapy literature. Rates of deterioration are cut in half (Hubble, Duncan, Miller & Wampold, 2010).

The research that supports brief collaborative therapy and which is fitting with a client-centred approach is not just research that focuses on outcomes, but which also incorporates information about the process of delivering services and in particular the role of the therapeutic alliance. Although evidence based practices are tested in randomized clinical trials in order to be considered empirically validated, meta-analyses of over forty years of outcomes research reveals that it is what clients bring to the therapy process, in partnership with the therapist, that accounts for over 40% toward positive outcome (Bohart & Tallman 2010).

Practice-based evidence is “clinicians' use of real-time feedback to develop, guide, and evaluate services (Miller, S.D., Ph.D., 2009). Practice-based evidence incorporates the knowledge and clinical experience gained by individual practitioners from various contexts, including their interactions with clients, and contributes actionable information to a ‘toolbox’ of practice-based strategies (Roberts & Yeager, 2004). This evidence is crucial to innovation, development and forward motion in all therapeutic practice, including brief therapy approaches, for the following reasons:

- An evidence base rooted in practice can complement data from controlled research settings and yield a more robust knowledge base (Charman & Barkham, 2005).
- Evidence arising from practice in real-world settings is important for practitioners working in real-world settings (Midgeley, 2009).
- Research findings also have to be judged by the standards of values and utility (Weick, 2000), and data generated by researching what practitioners are actually doing can help to produce usable practices.
- It has been shown that ongoing outcome feedback from clients to clinicians doubled the overall effectiveness of therapy in a sample of over 6000 clients (Bringinghurst et al., 2006).
- The proximity of the research to practice enables practice to be responsive to the data, creating a continuous feedback loop between practice and research (deShazer, 1991).
- Developing “research-mindedness” as practitioners encourages a reflective and critical stance toward taken-for-granted ways of doing things (Everitt et al., 1992).
- As the purpose of research is to enhance practice in the light of results, being constantly alive to one’s effectiveness is conducive to a developmental approach to practice.