Single-Session Counselling in Mental Health Services: Evaluation of a New Program

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Abstract

Organizations offering mental health services are in need of innovative solutions to address a lack of accessibility and availability in service provision. Waitlists for counselling services are long, often forcing those experiencing mental health difficulties to rely on acute care services in the interim. One option, single-session counselling, allows consumers to access services when they need it, as often as they need it. This service model can be integrated into current services to contend with difficulties related to efficiency and accessibility. The current study evaluated a new single-session counselling program offered in an outpatient community mental health clinic in Northwestern Ontario. The majority of participants rated the service favourably, and experienced a decrease in mental health difficulties and associated impairment. Single-session counselling reduced difficulties associated with the presenting problem, and allowed access to services sooner. Continued implementation of this model of care is supported by the current findings. Dissemination of information describing the nature of single-session counselling, as well as outcomes of program evaluations such as the current study, may help to increase acceptance of its integration into ongoing mental health services.

Single-Session Counselling in Mental Health Services:

Evaluation of a New Program

Mental health service providers across Canada are facing an ever-growing client base, with insufficient resources to manage the increasing demand. Seventeen percent of Canadians report a need for mental health care in the past year, with 36% stating that a need for counselling services was only partially met or unmet (Sunderland & Findlay, 2013). Mental health service agencies in Canada have reported wait times of up to two years for counselling, with upwards of 900 individuals waiting, and even temporary closures of intake services due to an inability to meet demands (Mireau & Inch, 2009; Stalker, Horton, & Cait, 2012; Young, Dick, Herring, & Lee, 2008).

When clients first seek counselling, motivation and need are at their highest, particularly for clients presenting in crisis (Bloom, 2001; Brown, Parker, & Godding, 2002). As clients remain on the waitlist to receive services, they become increasingly dissatisfied and lose motivation, resulting in high rates of nonattendance for first appointments (Sherman, Barnum, Nyberg, & Buhman-Wiggs, 2008; Stalker et al., 2012; Taylor, Wright, & Cole, 2010). Missed appointments and drop outs resulting from lengthy wait times further decrease accessibility and efficiency in the provision of services.

Identifying accurate statistics on mental health care in Northwestern Ontario is problematic, as methods used to obtain data on utilization and waitlists for medical care are not validated across mental health services, and the information gathered is excluded from reports due to a lack of confidence (North West Local Health Integration Network [NW LHIN], 2013). One of the recommendations made for Ontario's Mental Health and Addictions Strategy was to monitor wait times for community-based mental health and addiction services, highlighting the

need for reliable waitlist data in these areas (Ministry of Health and Long-Term Care, 2010).

Policy makers in Northwestern Ontario have relied on general opinion surveys to understand

current issues. In 2009, the Mental Health and Addictions Survey asked respondents to identify

ways to improve the design of mental health services in the region. Information on the perception

of mental health services was obtained from consumers, their families, and service providers

(NW LHIN, 2010). Responses focused on reducing barriers to accessing services, shorter

waitlists for services, and making the system easier to navigate by having a single point of

contact that can help consumers indentify and access appropriate services.

The "Shape Your Care, Share Your Story" community engagement initiative also

addressed perceptions of the regional health care system, seeking contributions from residents of

the LHIN and health care professionals (Centre for Rural and Northern Health Research, 2009).

Accessibility and availability were again highlighted as issues. Residents and health care

professionals expressed a lack of awareness of mental health services, as well as gaps in the

services provided, and a lack of integration (Centre for Rural and Northern Health Research,

2009). Services in the NW LHIN are described as having "absurdly long wait times," and health

care professionals emphasise that significantly delayed access to care for those with mental

illness puts these individuals at an increased risk (Centre for Rural and Northern Health

Research, 2009).

Community Mental Health Services at St. Joseph's Care Group in Thunder Bay reviewed

the issues currently faced in the provision of services in a Health System Improvement Pre-

Proposal submitted to the NW LHIN (M. A. Mountain, personal communication, January 14,

2015). The waitlist for individual counselling was over 200 people at the end of November 2014,

and had been steadily increasing from 137 individuals in November 2013. Maximum wait times

during this time period were anywhere from approximately 4 months to 19 months depending on the symptoms presentation and associated level of priority. Those waiting for counselling were described as the most complex and vulnerable of the outpatient group. The pre-proposal also stated that individuals who seek counselling experience increased psychosocial difficulties while not receiving services, and often depend on emergency medical services to meet their needs (M. A. Mountain, personal communication, January 14, 2015).

Data from the acute sector provides further evidence of an inability to meet demands for mental health services in Northwestern Ontario. The number of individuals accessing the emergency department for mental health reasons in 2011-2012 in the NW LHIN was almost twice that for Ontario as a whole, and 4 times the provincial rate for individuals presenting with substance-related difficulties. The Thunder Bay District has the highest rate of emergency department visits for those with mental health conditions per 100,000 in NW LHIN. High rates of acute care utilization demonstrate a need for more immediately accessible services (NW LHIN, 2013).

Many mental health service providers and consumers in Northwestern Ontario contend with unavailable, inaccessible, and inefficient services (NW LHIN, 2010). Due to these issues, individuals seeking mental health care are forced to cope without treatment for an indeterminate period of time, or rely on emergency medical services (NW LHIN, 2013). This is evident in the length of waitlists for services, and the data on acute care utilization by individuals presenting with mental health and addiction concerns (NW LHIN, 2013). When treatment becomes available, drop-outs and missed appointments are common, further contributing to service inefficiency and inaccessibility (Stalker et al., 2012; Taylor et al., 2010). Local mental health service providers and consumers identify accessibility as an area requiring attention in mental

health care, and strategies for increasing accessibility are currently being considered in the provision of ongoing mental health services (NW LHIN 2010).

Single-Session Counselling

Single-session counselling is broadly defined as any therapeutic encounter determined at the onset to be self-contained by both the therapist and the client (Slive & Bobele, 2012). The session is approached as a single encounter, regardless of the client's intention to access the service in the future. This is to be distinguished from a client terminating or dropping out of traditional counselling after one session, as traditional counselling is conducted under different assumptions, and termination may result from factors other than treatment sufficiency (Hymmen, Stalker, & Cait, 2013).

Research into effective psychotherapy duration traditionally suggested a linear relationship between number of counselling sessions and treatment outcomes, where longer durations of counselling result in greater improvements (Howard, Kopta, Krause, & Orlinsky, 1986). Recent research, however, demonstrates that while longer durations of counselling are more effective over all, rapid improvement occurs early in treatment, with each additional session producing less significant results, and the rate of change varying from client to client (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Stulz, Lutz, Kopta, Minami, & Saunders, 2013). In fact, if counselling clients have not experienced functional changes by the 8th session, the likelihood of significant change is greatly diminished (Baldwin et al., 2009). This shift in the understanding of required length of treatment, along with increased demand for services and decreased resources, resulted in a movement towards more brief models of counselling, and the implementation of single-session counselling (Hymmen et al., 2013).

In Ontario, single-session counselling has primarily taken on the form of walk-in counselling programs, providing immediate access to services (Hymmen et al., 2013). Programs that schedule an appointment for single-session counselling for the same day or up to a couple weeks in advance also exist, primarily outside of Ontario (Hymmen et al., 2013). For example, the Access and Early Intervention Program in Red Deer, Alberta adopted pre-scheduled counselling sessions in the provision of intake assessments for community mental health services (Taylor et al., 2010). With most single-session counselling programs, the option to return for future sessions is presented to clients, although this is not considered a "pure" form of single-session counselling, which is, by definition, a single therapeutic encounter (Hymmen et al, 2013). Despite this differentiation, examples of a single-session program that do not allow clients to return for multiple visits are not available in the literature. Clients who access single-session counselling multiple times may or may not meet with the same therapist, as many single-session counselling programs employ a team of therapists with different theoretical approaches, as well as student trainees (Stalker et al., 2012; Young et al., 2008). Examples in the literature suggest that clients with more severe difficulties or specific presenting problems may be screened and treated through different programs. For instances, the walk-in program at K-W Counselling Services in Waterloo, Ontario screens for suicidality, homicidality, addictions, and intimate partner violence (Stalker et al., 2012).

Various approaches are utilized to integrate single-session counselling into currently existing mental health services. For example, Reach Out Centre for Kids in Burlington, Ontario replaced the intake appointment for current mental health services with single-session counselling (Young et al., 2008). Also, the Yorktown West End Walk-In Counselling Centre in York, Ontario provides single-session counselling to clients on the waitlist for future services

(Barwick et al., 2013). Other programs operate as stand-alone services with no direct connection to other programs. Flexibility in the implementation of single-session counselling, and integration into ongoing mental health care, has resulted in an increase in this model of counselling delivery in Ontario.

Integration of single-session counselling into current services has the potential to address many issues faced by mental health service providers including waitlists, accessibility, and inefficiency. There is little to no wait for services with single-session counselling, allowing clients to access services when motivation and need are highest. Clients can access services when it is most convenient for them, with no specific time commitment required beyond the attendance of one session. Drop-outs do not exist in single-session counselling, and missed appointments are greatly reduced in scheduled single-session counselling, and eliminated in walk-in single-session counselling. Treatment sufficiency is no longer an issue, as each session of counselling is considered sufficient, regardless of whether the client returns for future sessions (Bloom, 2001; Hymmen et al., 2013).

Challenges in Implementing Single-Session Counselling

Despite increasing popularity of the single-session counselling model, many therapists and decision makers have reservations about the effectiveness of brief interventions, believing that it does not address the underlying problem, "put[ting] a Band-Aid on a complicated problem" (pp. 20, Taylor et al., 2010; Warner, 1995; Young et al., 2008). Some therapists concede that single-session counselling can be effective, however, view it as ineffective or even ill-advised for clients with more complex or severe presenting problems, limiting its usefulness (Hymmen et al., 2013; Talmon, 2012). Concerns exist that the increased presence of the single-session counselling service model is due to demands placed on health service providers, and is

not in the best interest of clients (Taylor et al., 2010). Evidence is necessary to support the use of single-session counselling and validate its integration into mental health services.

Existing Research on Single-Session Counselling

Research suggests that clients are satisfied with single-session counselling services, with some clients reporting improvement after one session, and reduced need for future services (Bloom, 2001; Hymmen et al., 2013). Single-session counselling is also associated with reduced symptomology and difficulties with the presenting problems (Hymmen et al., 2013). Findings are mixed regarding the relationship between type and severity of the presenting problem and outcomes in single-session counselling (Hymmen et al., 2013). Single-session counselling is associated with reduced waitlists and increased accessibility of services for clients (Taylor et al., 2010).

Limited published research is available for single-session counselling programs in Ontario. In 2009, a meeting between nine walk-in counselling agencies from Ontario occurred and resulted in a report that provides brief descriptions of the services offered and the results of any evaluations (Bhanot-Malhotra, Livingstone, & Stalker, 2010). According to this report, all programs obtained some form of client feedback after the sessions. Responses have been positive with clients reporting satisfaction with services immediately and at follow-up (Bhanot-Malhotra et al., 2010). An informal evaluation of the Thunder Bay Counselling Centre Walk-In Clinic was included in the report, stating that the program reduced symptomology, increased client's knowledge of the problem and available resources, increased their confidence to deal with the problem, and showed high client satisfaction.

Agencies publishing evaluations of walk-in counselling programs in Ontario report client satisfaction with services and increased ability to cope with the presenting problem as main

outcomes (Barwick et al., 2013; Stalker et al., 2012; Young et al., 2008). Stalker et al. (2012) determined that clients who attended K-W Counselling Services, in Kitchener, Ontario, showed significant improvement on scores on the General Health Questionnaire-12, a standardized measure assessing level of psychological distress, at 1-month and 4-month follow-ups, and decreased limitations as a result of their mental health. Moreover, 91% of those attending the K-W Counselling Walk-In service reported requiring no further counselling immediately after the session (Bhanot-Malhotra et al., 2010). Despite promising results, this evaluation had a low response rate and the authors speculated this was related to follow-up responses being returned by mail.

Young et al. (2008) evaluated Reach Out Centre for Kids and found that including an option to access walk-in counselling significantly reduced waitlists from over two years to between two to six months. Of those that accessed the clinic, 45-50% per year did not request further referral services, and 11% returned for another session. Clients reported that the sessions 'somewhat/mostly' or 'very much' helped them deal with the problem (84%), as well as to develop a plan to manage the problem (87%), and that they "somewhat/mostly' or 'very much' intended to carry out that plan (91%).

An exploratory evaluation of the Yorktown West End Counselling Centre completed by Barwick et al. (2013) found that the parents of children who attended the walk-in counselling service were more likely to report having their concerns addressed, more likely to recommend the service to a friend, and saw more of a reduction in symptoms when compared to those accessing treatment through the standard intake process at Yorktown Child and Family Centre. The available research provides preliminary evidence for the utility of single-session counselling

in reducing barriers to services, increasing client satisfaction, and helping clients address their

mental health concerns.

Limitations of the Current Research

While single-session counselling is being implemented throughout Ontario, there is still

insufficient research supporting its use. Moreover, the limited available research on single-

session counselling programs has methodological issues that reduce the ability to draw

conclusions. For example, most services lack ongoing standardized outcome measurement for

analysis, relying mainly on client satisfaction questionnaires, and/or employ self-created

measures which lack psychometric validation (e.g., Young et al., 2008). Another example is the

involvement of the therapists in data collection and analysis, which may bias the results.

Evaluations have also exhibited high attrition rates, potentially related to using mail-in follow-up

evaluations (Stalker et al., 2012). Lastly, restrictions based on presenting problems make

generalisations to a larger client base difficult (Stalker et al., 2012). Existing program evaluations

provide preliminary support for single-session counselling, but additional research is needed to

address common methodological concerns.

Evaluation of a New Program

The current study evaluated a novel single-session counselling service offered at a large

outpatient community mental health clinic in Northwestern Ontario. This service is referred to as

Same-Day Counselling (SDC) and was integrated into existing services in March 2014. SDC is

similar to single-session and walk-in service models, in that each session is considered self-

contained. Clients book an appointment on the day(s) they would like to attend by calling

reception staff and selecting an available time that day. Clients are able to access the service as

often as they would like, and have the option of meeting with the same therapist should they

attend multiple sessions. There are no restrictions on who can access the service in terms of symptom severity or presenting problem. The option for SDC was offered to new clients at intake and made available to those on the waitlist for counselling in an effort to provide immediate access to services for clients and to reduce the lengthy waitlist.

The present study attempted to increase methodological rigor over previous studies, including the use of multiple standardized measures, exclusion of the therapists from data collection and analysis, use of phone calls for follow-up evaluation to reduce attrition rates, and a lack of restrictions on who can access the program. This evaluation examined not only client satisfaction, but also changes in scores on measures of mental health, as well as general health and daily functioning. The results contribute to the evidence surrounding single-session counselling programs, specifically same-day programs, with increased attention to methodology as compared to previous studies.

Objectives

This study determined who accesses the single-session counselling service as well as clients' satisfaction with the service, and whether the service led to improvements in presenting problems and general functioning. The specific objectives were as follows:

1. Characterize the sample of participants who access SDC in terms demographic information, psychiatric history, initial symptom scores, length of time on waitlist for individual therapy, and referral source.

2. Determine the participants' level of satisfaction with the services provided.

3. Compare participant ratings concerning the stress caused by the presenting problem, their understanding of the cause of the problem, their confidence in coping, and their

knowledge of resources and supports before the session, after the session, and at 1-month

follow-up.

4. Compare scores on measures of mental health difficulties and general functioning

before the session and at 1-month follow-up.

Hypotheses

Based on the available literature, the following results were hypothesised:

1. There will be a long average wait time for services, and high symptom severity in

participants accessing SDC.

2. Participants' ratings of satisfaction with services will be high.

3. The stress caused by the presenting problem will be reduced. Their understanding of

the cause of the problem, their confidence in coping, and their knowledge of resources

and supports will increase.

4. Participants' scores on measures of mental health difficulties and related impairment

will decrease.

Method

Participants

Participants were recruited for the SDC program at St. Joseph's Care Group Mental

Health Outpatient Programs in Thunder Bay, Ontario. Services are provided to adults, living in

and around Thunder Bay. Clients seeking outpatient mental health services, who were

subsequently placed on a waitlist for counselling, were provided with information regarding the

SDC program and encouraged to attend. Those accessing the SDC program are those who do not

have an ongoing individual counsellor, although they may be accessing other services such as

groups or medication consultations. Those who pursue SDC were informed of the evaluation and

invited to participate. There were no exclusionary criteria for this study. Participants were

compensated with a $10 gift certificate to a local coffee shop and entered into one of 5 draws for

a $100 grocery gift certificate.

Intervention

SDC sessions were typically 60-90 minutes in length and focused on addressing clients'

immediate mental health concerns. Counsellors were registered social workers with previous

experience providing counselling within the clinic. There were no specific requirements in terms

of how to conduct the SDC session, and no formal training was completed regarding the

provision of SDC. In general, interventions used by the counsellors were informed by evidence-

based practice and included techniques from cognitive-behavioural therapy, dialectical behaviour

therapy, and emotion focused therapies, among others. Counsellors also assisted clients with

functional tasks associated with goal setting, securing safe housing, navigating legal matters, and

promoting health and wellness. Counsellors did not book follow up appointments with clients,

but welcomed clients to attend SDC in the future, as needed.

Measures

The research team reviewed relevant literature and consulted with the counsellors when

choosing the outcome measures. Considerations included breadth and depth, length, clinical

utility, accessibility, as well as the psychometric properties of the measures.

General Questions. Researchers generated four general questions that were used to assess

participants' ability to manage the presenting problem. Participants selected, on a scale from 1 to

10, the amount of stress the main presenting problem is causing, the amount of understanding

they have related to the cause of the problem, the amount of confidence they have to cope with

the problem, and the amount of knowledge, supports or resources they have to manage the problem.

Session Rating Scale. The SRS is a four-item global measure of therapeutic alliance designed to be brief and easily administered to clients in a clinical setting (Miller & Duncan, 2000). The SRS was used as a measure of client satisfaction in the current study, and was modified to include a 10 point Likert-type scale in addition to the visual analogue scale. The SRS, as one component of the Partners for Change Outcome System, is also frequently used in a clinical setting for progress monitoring (Ionita & Fitzpatrick, 2014). Internal consistency for the SRS in the current study was $\alpha = .87$.

Behavior and Symptom Identification Scale-24. The BASIS-24 is a 24-item self-report measure of mental health and functioning, which also asks 12 background, demographic questions, including age, sex, language, ethnicity, education, relationship status, living situation, employment situation (McLean Hospital, 2011). The BASIS-24 assesses six problem domains: depression, interpersonal relationships, psychotic symptoms, alcohol/drug use, emotional lability, and self-harm (Cameron et al., 2007). Participants rated the amount of difficulty associated with the problem and the frequency of the problem on a 5-point scale, from 'no difficulty/none of the time' to 'extreme difficulty/all of the time.' A score between 0 and 4 is calculated for each domain, as well as an overall score. The BASIS-24 has strong internal consistency across the six domains (α greater than .70), and good concurrent validity with other self-report mental health measure, including the Mental Component Summary of the Short-Form Health Survey-12, global ratings of mental health and life satisfaction, and DSM-IV psychiatric diagnoses ($r = .59-.82$; Eisen, Gerena, Ranganathan, Esch, & Idiculla, 2006). The BASIS-24 is currently used in Canada to monitor client progress during routine clinical practice (Ionita &

Fitzpatrick, 2014). A study conducted with a sample of 71 individuals receiving compulsory community treatment in Vancouver, found an overall mean score on the BASIS-24 of 0.72 ($SD =$ 0.44), and good internal consistency of the scale ($\alpha = .81$; Livingston, 2012). For the current study, internal consistency of the overall BASIS-24 scores at baseline was $\alpha = .76$, and at follow-up was $\alpha = .64$. For the BASIS-24 subscales, internal consistency at baseline was $\alpha = .68 - .86$ and at follow-up was $\alpha = .59 - .81$.

World Health Organization Disability Assessment Schedule 2.0 - 12 Item. The WHODAS 2.0 is a 12-item measure of general health and functioning, shortened from the original 36-item version, which also includes three additional items on the frequency of problem occurrence (World Health Organization, 2010). Six domains of functioning are assessed in the original version: cognition, mobility, self-care, getting along, life activities, and participation in society (Üstün et al., 2010), although research indicates a single global disability factor measured by the 12-item version (Andrews, Kemp, Sunderland, Von Korff, & Üstün, 2009). Participants rated the amount of difficulty associated with the problem or the frequency of the problem on a 5-point scale, from 'none' to 'extreme or cannot do.' The average WHODAS 2.0 sum score for all respondents of the Canadian Community Mental Health Survey in 2012 was 6.23 ($SD = 10.24$; Statistics Canada, 2013). For respondents who identified as having experienced a mental disorder during their lifetime the average sum score was 8.7 ($SD= 11.83$; Statistics Canada, 2013). Internal consistency for the WHODAS 2.0 in the current study was $\alpha = .90$, and at follow-up was $\alpha = .88$.

Procedure

Clients attending SDC who provided consent to participate in the evaluation were given a questionnaire package by reception staff in the clinic. Measures completed at pre-session, post-

session, and 1-month follow-up are presented in Table 1. We obtained demographic information and service utilization information after the session via a thorough chart review.

Ethics approval for the study was obtained through the St. Joseph's Care Group and Lakehead University research ethics board. To maintain confidentiality, personal identifying data was stored separately from evaluations and information from the chart reviews. Only researchers were able to access both files. We identified each participant's responses by using a coded participant ID number. Information pertaining to their participation in the evaluation or their scores on the evaluation measures were not included in their clinical chart.

Statistical Analyses

The following statistical analyses were conducted for hypothesis testing using IBM SPSS Statistical Software (IBM Corp, 2012):

1. Descriptive statistics for clients of the SDC program in terms of demographic variables, contact with mental health services and wait times.

2. Descriptive statistics for the SRS after the session.

3. Paired *t*-tests and Cohen's *d* effect sizes were used to compare change from pre-session to post-session and post-session to follow-up on ratings relating to participants' stress relating to the problem, their understanding of the cause, their confidence in coping with the problem, and their knowledge of resources.

4. Generalized mixed linear modeling was used to compare pre-session and follow-up scores for each standardized outcome measure (BASIS-24, WHODAS 2.0).

For the fourth analyses, the therapist-client interaction was included as a random effect and time as a repeated measure, as well as a fixed effect. Fixed or random effects controlling for age, sex, ethnicity and education were included if significantly related to model fit, as appropriate. Initial

severity of mental health difficulties, comorbid physical health condition, referral source, utilization of other services, and number of SDC sessions between initial session and follow-up were also considered as potential fixed or random effects. Including variables as random effects extends the results to levels of the variable that are not included in the sample, whereas including variables as fixed effects limits the analysis to the levels of the variable present in the sample, reducing the generalizability of the results if all levels of the variable are not sampled (West, Welsh, &, Galecki, 2007). A pseudo R^2 was also calculated as an estimate of the proportion of variance accounted for by the model based on the residual variance of the full and null models (Howell, 2007; M. Stones, personal communication, July 4, 2016).

Mixed modelling analyses are more appropriate for repeated measures and missing data in comparison to traditional approaches, such as analysis of variance (ANOVA), as it does not assume independent cases, and is more tolerant of missing data (Gueorguieva & Krystal, 2004; Salim, Mackinnon, Christensen, Griffiths, 2008).

Results

Clients Demographics

One-hundred and ten clients participated in the study. Participants attending multiple SDC sessions were given the opportunity to complete baseline and follow-up measures multiple times in relation to the additional sessions. Twenty-four participants attended multiple sessions and completed multiple baseline measures, for a total of 146 completed baselines (5 individuals consented but did not complete baseline measures). Seventy-nine participants completed measures at 1-month follow-up, with 13 of these participants completing multiple follow-up measures in relation to multiple sessions, for a total of 100 follow-ups (66.2% retention).

Participant characteristics are presented in Table 2, with each participant included only once, regardless of the number of baseline and follow-up measures completed.

The majority of participants had received mental health treatment prior to their intake for the Mental Health Outpatient Programs (87.2%, $n = 82$), with those receiving previous treatment having an average of 2.73 previous treatment providers ($SD = 1.83$). Participants waited an average of 54.20 weeks ($SD = 73.05$) after intake before accessing SDC for the first time. This wait time varied greatly, as many individuals were on the waitlist for counselling services before SDC was available. For those whose intake occurred before the start of SDC, the average time between intake and the first SDC session was 104.43 weeks ($SD = 78.93$). For participants whose intake occurred after SDC had been implemented, the average time spent on the waitlist before accessing SDC for the first time was 7.98 weeks ($SD = 8.68$). The average number of sessions attended between baseline and follow-up was 2.51 ($SD = 2.81$), with 49.5% ($n = 49$) of participants attending only one session. 55.6% ($n = 55$) of participants also accessed other outpatient services in addition to SDC between baseline and follow-up, primarily psychiatric services and groups.

General Questions

Item scores for the general questions at baseline, post-session, and follow-up are displayed in Table 3. Two-tailed, paired t-tests were conducted for the general questions and Cohen's d effect sizes calculated. Stress related to the problem consistently decreased across time points, from baseline to post-session, $t(138) = -6.74$, $p < .001$, and post-session to follow-up, $t(93) = -3.10$, $p = .003$, with effect sizes of 0.57 and 0.32 respectively. Participants' understanding of the cause of the problem increased significantly from baseline to post-session, $t(136) = 4.20$, $p < .001$, with an effect size of 0.36. Change in understanding of the cause from

post-session to follow-up was no longer significant, $t(92) = 0.83$, $p = 0.40$. Participants' confidence in coping with the problem increased significantly from baseline to post-session, $t(137) = 7.30$, $p < .001$, with an effect size of 0.62. Confidence in coping did not change significantly from post-session to follow-up, $t(92) = -0.63$, $p = 0.53$. Knowledge of resources continued to increase across all time points, from baseline to post-session, $t(136) = 3.93$, $p < .001$, and post-session to follow-up, $t(91) = 2.82$, $p = .006$, with effect sizes of 0.34 and 0.29, respectively.

Session Rating by Participants

Participants, on average, reported feeling heard, understood, and respected during the SDC session, with a rating of 9.14 ($SD = 1.59$). Participants also reported working on or talking about the issues that they wanted to talk about, with an average rating of 8.97 ($SD = 1.89$). The therapist's approach was generally considered a good fit, with an average rating of 8.88 ($SD = 1.80$). Overall, participants reported that the session was right for them, with an average rating of 8.72 ($SD = 1.87$). The average sum of ratings across all items was 35.71 ($SD = 5.52$). Responses to the items were variable, with each item receiving the full range of scores, and the sum of the ratings ranging from 9 to 40. Although variability existed, low ratings were rare, with the majority of participants endorsing an item rating of 9 or higher (Item 1: 80.3%, $n = 114$; Item 2: 80.9%, $n = 115$; Item 3: 74.6%, $n = 106$; Item 4: 69.7%, $n = 99$).

Generalized Linear Mixed Modelling Analyses

BASIS-24. Before completing the Generalized Linear Mixed Modelling (GLMM) analysis, the normality of scores was confirmed through visual inspection of the QQ-plots (Ghasemi & Zahediasl, 2012). Overall BASIS-24 scores were examined using a normal distribution with an identity link function, and compound symmetry as a covariance type.

Covariance type, for all analyses, was selected through examination of the null model (i.e., no fixed effects, only the intercept) under different structures to determine which produced the lowest -2 log likelihood (West et al., 2007). Inclusion of the random intercept did not result in a positive Hessian matrix, therefore mean centered age, sex, and intake BASIS-24 were included as fixed effects, increasing model fit and improving predicted values (West et al., 2007). Inclusion of other potential covariates did not result in a significant improvement in the model. The overall model was significant, $F(4, 149) = 30.45$, $p < .001$, as was time, $F(1,149) = 43.33$, $p < .001$ and BASIS-24 at intake $F(1,149) = 77.62$, $p < .001$. Beta coefficients and confidence intervals are displayed in Table 4. Pseudo R^2, calculated as an estimate of the proportion of variance accounted for by the model, was 0.49. Residuals for the analysis were examined using QQ-plots to assess for normality (Grace-Martin, 2011), displaying sufficient normality to support model selection.

GLMM analyses were conducted for each of the BASIS-24 subscales as well, all showing significant reduction in scores over time, $F = 14.00 - 25.60$, $p < .001$, $\beta = -0.20 - -0.49$. Based on the beta coefficients, scores on the relationship subscale showed the greatest effect of time, with the substance abuse subscale showing the least. Intake BASIS-24 overall was significantly associated with all subscales, $F = 18.18 - 70.07$, $p < .001$, with higher intake scores associated with higher scores overall, $\beta = -0.35 - 1.10$. Sex was associated with scores on the relationship subscale, $F(1,149) = 5.54$, $p = .02$, where men had higher scores than women, $\beta = 0.34$. Age was associated with scores on the substance use subscale, $F(1,150) = 15.12$, $p < .001$, where older participants had higher scores than younger participants, $\beta = -0.01$. Age was also associated with the emotional liability subscale, $F(1,150) = 11.55$, $p = .001$, where older participants had higher

scores than younger participants, $\beta = -0.02$. Variation accounted for by the models for the subscales (Pseudo R^2) ranged from 0.07-0.41.

To account for multiple SDC sessions, additional services accessed during baseline and follow-up, and psychiatric medication use, GLMM analyses were conducted for participants who accessed SDC only once, those who only utilized SDC without accessing alternate services, and those that were and were not on psychiatric medication. Participants who attended only one session showed a significant decrease in mental health difficulties over time, $F(1,50) = 28.99$, $p < .001$, $\beta = -0.52$. Participants who did not access any additional services between baseline and follow-up also showed a significant decrease, $F(1,42) = 24.36$, $p < .001$, $\beta = -0.45$. Participants on and off psychiatric medications both showed significant decreases as well, $F(1,107) = 31.60$, $p < .001$, $\beta = -0.43$ and $F(1,29) = 12.68$, $p = .001$, $\beta = -0.43$, respectively.

WHODAS 2.0. Item sum scores on the WHODAS 2.0 were analyzed using a normal distribution with an identity link function, and compound symmetry as a covariance type. A normal distribution was used, as a gamma distribution was less appropriate based on a visual inspection of the QQ-plots (Ghasemi & Zahediasl, 2012). Inclusion of the random intercept did not result in a positive Hessian matrix, therefore mean centered age, sex, and intake BASIS-24 were included as fixed effects, increasing model fit and improving observed vs. predicted values (West et al., 2007). The overall model was significant, $F(4,142) = 19.89$, $p < .001$, time was significant, $F(1, 142) = -6.30$, $p = .013$ and intake BASIS-24 overall was significant, $F(1,142) = 66.40$, $p < .001$. Beta coefficients and confidence intervals are displayed in Table 5. The proportion of variance accounted for by the model (pseudo R^2), was 0.44. Residuals for the analysis were examined using QQ-plots to assess for normality (Grace-Martin, 2011), displaying sufficient normality to support model selection.

In addition to a reduction in the overall sum of scores, the number of days participants experienced functional difficulties decreased significantly, $t(171) = 3.29$, $p = .001$, as well as the number of days where they were unable to engage in activities or had to restrict activities due the health problem, $t(163) = 6.11$, $p < .001$ and $t(161) = 5.38$, $p < .001$ respectively.

Discussion

This study evaluated the outcomes of clients attending a new mental health service, SDC. The service was implemented to help address the accessibility of individual counselling services offered through Mental Health Outpatient Programs at St. Joseph's Care Group. This study aimed to characterise clients accessing the service, determine their level of satisfaction with the service, and compare their ability to manage the presenting problem, mental health difficulties, and related impairment before and after the SDC session.

Confirming the first hypothesis, clients experienced long average wait times for services and reported considerable mental health difficulties and related impairment. The average participant waited over a year before being able to access an individual counsellor through SDC, in line with previously reported wait times for services. For clients whose intake occurred after the implementation of the service, the average wait time was a couple of months, suggesting that the service helped to increase the accessibility of individual counselling services for those accessing SDC. Clients in the current study reported mental health difficulties more than twice as severe as those receiving compulsory community mental health treatment in Vancouver, British Columbia (Livingston, 2012). Compared to respondents of the Canadian Community Mental Health Survey, clients in the current study reported disability 3 times higher than those in the general population, and more than twice as high as respondents who indicated experiencing a mental disorder in their lifetime (Statistics Canada, 2013).

As hypothesised, the majority of participants rated the SDC sessions favourably. Low ratings were present, but they were infrequent, and appear to have been limited to only a few individuals. The reasons for unsatisfactory ratings were not ascertained, but potential explanations include client preferences and therapeutic alliance. Individuals who had a preference for more traditional counselling may have attended SDC because it was the first available option, and therefore rated the service more poorly. Client preference has been shown to impact treatment outcome, likely through its effect on the therapeutic alliance (Lindhiem, Bennett, Trentacosta, & McLear, 2014). Alternately, some individuals may not be happy with the therapist they saw or how the session progressed, indicating that SDC was not perceived as useful by all clients. Dissatisfaction with the therapist or the session may be related to reduced opportunity in single-session counselling to repair any ruptures in the therapeutic alliance, especially given the lack of scheduled follow-up. Greater attention to maintaining alliance may be required when engaging in this type of counselling.

The third hypothesis relating to participants' ability to manage the presenting problem was supported, with perceived abilities improving from baseline to post-session, although change from post-session to follow-up showed some variability. Immediately after attending SDC, participants reported feeling less stress surrounding the problem discussed in session. The benefits of attending the session appeared to continue, with participants reporting experiencing even less stress 1 month after the session when compared to directly following the session. These benefits may be due to positive changes that participants made in their life as a result of the skills obtained during the SDC session. Not only did participants report a reduction in stress caused by the presenting problem, but they also indicated that following the session they had a better understanding of the cause of problem. This improved understanding was maintained 1 month

later. Understanding the cause of the problem has been identified by some clients as one of the most helpful aspects of therapy, allowing clients to more effectively change maladaptive behavioural patterns (Straarup & Poulsen, 2015). Those who accessed SDC also reported feeling more confident in their ability to cope with the presenting problem after the session, and this was maintained 1 month later. Confidence in coping, in the form of self-efficacy, is frequently implicated as a potential mechanism of change in counselling, as clients are more likely to engage (or not engage) in activities that will improve their mental health if they feel capable of doing so (Fentz, Arendt, O'Toole, Hoffart, & Hougaard, 2014; Goldin et al., 2012; Wilhelm, Berman, Keshaviah, Schwartz, & Steketee, 2015). Finally, clients reported that they had more awareness of the resources that were available to help them cope with the issue after the SDC session, and that they continued to increase their knowledge of resources 1 month later.

Those who accessed SDC increased their understanding of the cause of the problem and felt better able to cope with the problem immediately after the session and maintained these increases at 1-month follow-up. Maintenance of improvements in these areas is promising, however stress associated with the presenting problem and knowledge of resources continued to show improvements from pre-session to follow-up. The maintenance rather than continuation of improvement in this area may indicate that clients reached a sufficient level of understanding of the cause and confidence in coping immediately after the session to experience significant benefits. It may also be the case that some participants would have benefitted from additional sessions, although they chose not to return.

The fourth hypothesis relating to SDC contributing to a reduction in mental health difficulties and disability was supported. Participants experienced a decrease in their mental health difficulties overall. Specific mental health difficulties (in addition to overall difficulties)

were also reduced for participants, with the greatest change evident for difficulty in interpersonal relationships and the least change for substance abuse issues.

Participants showed improvements in their reported level of impairment (or disability). Although, the improvements in level of impairment were smaller than the reductions in mental health difficulties. Comparatively lower levels of functional improvement may be due to the relatively short follow-up period, as such improvement generally occurs at a slower rate than symptom reduction (Dunn et al., 2012). For example, an individual coping with depression is unlikely to seek out employment until after they experience a significant reduction in feelings of hopelessness and anhedonia. The item content may have also been a factor, as most participants did not report difficulties such as washing themselves and getting dressed, showing a floor effect on these items. Overall, while not reduced to the same degree as mental health symptoms, impairment, particularly in the areas of learning a new task and taking care of household responsibilities, was significantly reduced, indicating functional improvement in participants attending SDC.

Overall mental health difficulties at intake were significantly related to improvements in mental health difficulties and related impairment 1 month after the SDC session. This indicates that those with more severe mental health difficulties do not experience improvements comparable to those with less severe difficulties. Severity of mental health difficulties is frequently associated with outcomes in traditional counselling (Lindhiem, Kolko, & Cheng, 2012), although previous findings on the relationship between the severity of the presenting problem and outcomes from single-session counselling are mixed (Hymmen et al., 2013). While the present findings indicate that outcomes from SDC are related to intake severity, individuals with scores above the mean still experienced significant reduction in mental health difficulties

(Ewen et al., 2016), although not reduced to the same degree as those who had less difficulties at intake.

Limitations

The primary limitation of the current research is the lack of a control group (waitlist or treatment as usual). Without a control group, it is difficult to rule out the possibility that the results are not simply due to regression to the mean, as individuals were quite symptomatic upon initial presentation (Kantowitz, Roediger, & Elmes, 2015). Findings could also be due to demand characteristics without a control group for comparison (Kantowitz et al., 2015). Only those who elected to access the service participated in the evaluation, therefore there is the possibility of selection bias, as those who felt the service would not be helpful were not required to attend. Inclusion of individuals whose preferred model of care was not SDC could modify the findings regarding client session ratings and outcomes.

Also, outcomes reported are based entirely on self-report measures; no clinician-rated measures were used. This is relevant, as clients and clinicians may have different perspectives on the improvements experienced as a results of counselling. When included, clinician-rated measures tend to indicate greater improvement in mental health difficulties as compared to client self-report (Cuijpers, Li, Hofmann, & Andersson, 2010). Inclusion of clinician-rated measures may show even greater improvements in client mental health difficulties after accessing SDC than those seen in the current study.

While it is not possible to rule out the effect of additional sessions, medication adjustments, or other services accessed resulting in improvement in some cases, these variables were not significantly related to outcomes in the analyses (Ewen et al., 2016). Analyses comparing the various subgroups showed significant reductions for individuals regardless of the

number of sessions they attended, whether they accessed other services, or whether they received psychiatric medication, therefore the impact of these variables is likely minimal.

In terms of statistical analyses, a random intercept is generally included in GLMM to account for individual variation in scores over time, or the differing individual slopes. The lack of convergence of the model with the random intercept indicates there was not sufficient variation in participants' scores over time to require its inclusion (West et al., 2007). As covariates were included as fixed effects, the present results are limited to the ages and intake BASIS-24 scores that exist in the current sample.

Implications

Single-session counselling benefits a number of individuals, who otherwise may go without individualized mental health treatment. The results of this study indicate that single-session counselling is helpful and should be incorporated into ongoing mental health services to help clients access services sooner. It is important to note that there is a great deal of similarity between single-session counselling and more traditional models of counselling (Talmon, 2012). Clinicians should be made aware that clients choose the frequency and number of sessions they attend in traditional counselling through missed appointments and drop outs, despite collaborative session scheduling. The difference between single-session counselling and ongoing traditional therapy, based on this premise, is that single-session counselling is more client-directed, rather than a reduced amount of sessions. This conceptualization may help aid in some of the concerns surrounding the nature of single-session counselling.

As with most mental health services, single-session counselling may not be appropriate for all clients. Ratings of the service were not universally positive, and while all mental health difficulties were significantly reduced, the amount of reduction varied across domains. Although

single-session counselling may or may not be a long-term solution for certain clients, it can help prevent deterioration in the interim while waiting for more appropriate services.

Future Research

As discussed, the key limitation to this study is the lack of a control group. The single-session counselling literature would benefit greatly from a study that includes randomization of participants to a waitlist/treatment as usual control group or single-session counselling to determine if effects are similar to those seen in typical counselling models, or superior to waitlist controls. This would strengthen current findings that support the effectiveness of this type of service. Inclusion of clinician-rated or other types of measures in addition to participant self-report would also help to strengthen the current findings.

Factors associated with single-session outcomes that may indicate who the service is more or less appropriate for should also be studied in more detail. Additional research on single-session counselling including clients with more severe suicidality a wider range of mental health difficulties is required. It is important to examine if other clients also experience significant benefits from single-session counselling programs, and to ensure restrictions on accessing such services is supported by research evidence.

Conclusion

While many clinicians and stakeholders believe that the implementation of single-session counselling is a response to financial constraints in the provision of mental health services, the current findings indicate that this model of care reduces mental health difficulties, results in functional improvements, allows faster access to counselling services, and receives high client satisfaction ratings. Based on this information, the primary difference between single-session counselling and more traditional models is that it is more explicitly client-directed. Although

additional research is required in order to determine who is most appropriate for this service, single-session counselling is beneficial for a number of clients. Results of this study support continued integration of single-session counselling into ongoing community mental health outpatient services.

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Appendix

Table 1

Completion Times for Outcome Measures

Pre-Session	Post-Session	1-Month Follow-Up
General Questions	General Questions	General Questions
	SRS	
BASIS-24		BASIS-24
WHODAS 2.0		WHODAS 2.0

Note. SRS = Session Rating Scale; BASIS-24 = Behaviour and Symptom Identification Scale-24; WHODAS 2.0= World Health Organization Disability Assessment Schedule 2.0.

Table 2

Demographic and Clinical Sample Characteristics

Characteristic	M	SD
Age (*n* = 103)	38.95	13.96
BASIS-24		
Intake (*n* = 68)	1.99	0.58
Pre-session (*n* = 146)	2.08	0.67
Follow-up (*n* = 99)	1.67	0.69
WHODAS 2.0 sum score		
Pre-session (*n* = 146)	18.28	10.51
Follow-up (*n* = 99)	17.54	10.44
	n	%
Sex		
Women	69	63.3
Men	40	36.7
Racial background		
Aboriginal	13	12.9
Asian	2	2.0
African-Canadian	1	1.0
Caucasian	82	81.2
Other	3	3.0
Education		
8th grade or less	2	1.9
Some high school	20	19.4
High school/GED	13	12.6
Some college	40	38.8
4-year college graduate or higher	28	27.2
Marital status		
Married	24	23.1
Separated, widowed, or divorced	31	29.8
Never married	49	47.2
Employed		
No	65	63.1
Yes	38	36.9
Current student		
No	88	85.4
Yes	15	14.6
Referral source		
Professional	92	91.1
Self/family member	5	5.0
Self and professional	4	4.0
Psychiatric medication		
Yes	63	64.3
No	35	35.7

Note. BASIS-24 = Behavior and Symptom Identification Scale-24; WHODAS 2.0= World Health Organization Disability Assessment Schedule 2.0.

Table 3

Ratings of General Questions

	Baseline (n = 146)		Post-Session (n = 142)		Follow-up (n = 100)	
Item	M	SD	M	SD	M	SD
1. Stress	8.68	1.44	7.55	2.30	6.32	2.94
2. Understanding	6.92	2.47	7.61	2.00	7.93	2.08
3. Confidence	5.30	2.66	6.38	2.25	6.27	2.48
4. Resources	6.26	2.59	6.97	2.13	7.93	2.10

Note. Items are shortened; for specific item content see measure.

Table 4

Fixed Coefficients for BASIS-24

					95% CI	
Model Term	β	SE	t	p	Lower	Upper
Intercept	0.12	0.20	0.63	0.53	-0.26	0.51
Time	-0.43	0.07	-6.58	0.00	-0.56	-0.30
Male	-0.02	0.10	-0.15	0.88	-.22	0.19
Female	0[a]	.	.	.	.	.
Age	-0.00	0.00	-1.13	0.26	-0.01	0.00
Intake BASIS-24	0.78	0.09	8.81	0.00	0.60	0.95

Note. BASIS-24 = Behaviour and Symptom Identification Scale-24; SE = Standard Error; CI= Confidence Interval.
[a]This coefficient is set to zero because it is redundant.

Table 5

Fixed Coefficients for WHODAS 2.0 Item Sum Scores

					95% CI	
Model Term	β	SE	t	p	Lower	Upper
Intercept	-6.54	3.26	-2.01	0.05	-12.98	-0.10
Time	-2.12	0.85	-2.51	0.01	-3.79	-0.45
Male	-1.42	1.73	-0.82	0.42	-4.84	2.01
Female	0[a]	.	.	.	.	.
Age	0.13	0.06	2.02	0.05	0.00	0.26
Intake BASIS-24	11.98	1.47	8.15	0.00	9.08	14.89

Note. BASIS-24 = Behaviour and Symptom Identification Scale-24; SE = Standard Error; CI= Confidence Interval.
[a]This coefficient is set to zero because it is redundant.

General Questions

When you first arrived, you listed the main problem that brought you to single-session counselling. Please complete the following questions about that main problem by choosing a number from 1 (none) to 10 (extreme).

	None				A little				A lot	
1. How much stress is the problem causing you?	1	2	3	4	5	6	7	8	9	10
2. How much of an understanding do you have about what is causing the problem?	1	2	3	4	5	6	7	8	9	10
3. How much confidence do you have to fix, reduce, or cope with the problem?	1	2	3	4	5	6	7	8	9	10
4. How much do you know about finding supports or resources to help fix, reduce, or cope with the problem?	1	2	3	4	5	6	7	8	9	10

SRS

Please rate today's session by circling the number on the line that best fits your experience.

1. I did not feel heard, understood, and respected.
    1 2 3 4 5 6 7 8 9 10
    ---I
    I felt heard, understood, and respected.

2. We did *not* work on or talk about what I wanted to work on and talk about.
    1 2 3 4 5 6 7 8 9 10
    ---I
    We worked on and talked about what I wanted to work on and talk about.

3. The therapist's approach is not a good fit for me.
    1 2 3 4 5 6 7 8 9 10
    ---I
    The therapist's approach is a good fit for me.

4.
    There was something missing in the session today.
    1 2 3 4 5 6 7 8 9 10
    ---I
    Overall, today's session was right for me.

BASIS-24

Instructions:
This survey asks about how you are feeling and doing in different areas of life. Please check the appropriate box on the answer sheet that best describes yourself during the *PAST WEEK*.
Please answer every question.
If you are unsure about how to answer, please give the best answer you can.

Example: During the past week, how much difficulty did you have sleeping?
    ☐ No difficulty
    ☐ A little difficulty
    ☑ Moderate difficulty
    ☐ Quite a bit of difficulty
    ☐ Extreme difficulty

During the PAST WEEK, how much difficulty did you have....

1. Managing your day-to-day life?

2. Coping with problems in your life?

3. Concentrating?

During the PAST WEEK, how much time did you....

4. Get along with people in your family?

5. Get along with people outside of your family?

6. Get along well in social situations?

During the PAST WEEK, how much time did you....

7. Feel close to another person?

8. Feel like you had someone to turn to if you needed help?

9. Feel confident in yourself?

During the PAST WEEK, how much of the time did you....

10. Feel sad or depressed?

11. Think of ending your life?

12. Feel nervous?

During the PAST WEEK, how often did you....

13. Have thoughts racing through your head?

14. Think you have special powers?

15. Hear voices or see things?

16. Think people are watching you?

17. Think people are against you?

Please answer on the next page…

Answer Sheet

1. ☐ No difficulty
   ☐ A little difficulty
   ☐ Moderate difficulty
   ☐ Quite a bit of difficulty
   ☐ Extreme difficulty

2. ☐ No difficulty
   ☐ A little difficulty
   ☐ Moderate difficulty
   ☐ Quite a bit of difficulty
   ☐ Extreme difficulty

3. ☐ No difficulty
   ☐ A little difficulty
   ☐ Moderate difficulty
   ☐ Quite a bit of difficulty
   ☐ Extreme difficulty

4. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

5. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

6. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

7. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

8. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

9. ☐ None of the time
   ☐ A little of the time
   ☐ Half of the time
   ☐ Most of the time
   ☐ All of the time

10. ☐ None of the time
    ☐ A little of the time
    ☐ Half of the time
    ☐ Most of the time
    ☐ All of the time

11. ☐ None of the time
    ☐ A little of the time
    ☐ Half of the time
    ☐ Most of the time
    ☐ All of the time

12. ☐ None of the time
    ☐ A little of the time
    ☐ Half of the time
    ☐ Most of the time
    ☐ All of the time

13. ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Often
    ☐ Always

14. ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Often
    ☐ Always

15. ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Often
    ☐ Always

16. ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Often
    ☐ Always

17. ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Often
    ☐ Always

During the PAST WEEK, how often did you....

18. Have mood swings?

19. Feel short-tempered?

20. Think about hurting yourself?

During the PAST WEEK, how often....

21. Did you have an urge to drink alcohol or take street drugs?

22. Did anyone talk to you about your drinking or drug use?

23. Did you try to hide your drinking or drug use?

24. Did you have problems from your drinking or drug use?

ABOUT YOU

25. How old are you? _____

26. What is your sex?

27. What is your primary language?

28. What is your racial background?

29. How much school have you completed?

30. Are you now....

31. Outside of your treatment providers, what is your main source of social support?

32. Where did you sleep in the past 30 days?

33. At any time in the past 30 days, did you work at a paying job?

34. At any time in the past 30 days, did you work at a volunteer job?

35. At any time in the past 30 days, were you a student in a high school, job training or college degree program?

36. Do you now receive disability benefits or other disability insurance (check one or more)?

Please answer on the next page…

18. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

19. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

20. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

21. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

22. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

23. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

24. ☐ Never
    ☐ Rarely
    ☐Sometimes
    ☐ Often
    ☐ Always

ABOUT YOU

25. How old are you? _____

26. What is your sex? ☐ Male
                      ☐ Female

27. ☐ French
    ☐ English

28. ☐ Aboriginal/First Nations
    ☐ Asian
    ☐Black or African-Canadian
    ☐ Caucasian/White
    ☐ East Indian
    ☐ Other (specify)_____

29. ☐ 8th grade or less
    ☐ Some high school
    ☐High school graduate/GED
    ☐ Some college
    ☐ 4-year college graduate or higher

30. ☐ Married
    ☐ Separated
    ☐Divorced
    ☐ Widowed
    ☐ Never married

31. ☐ Wife, husband, or partner
    ☐ Other family (parents, children, relatives)
    ☐Friends/roommates
    ☐ Community/church
    ☐ No one

32. ☐ Apartment or house
    ☐ Halfway house/group home/board and
        Care home/residential centre/supervised
        housing
    ☐School or dormitory
    ☐ Hospital or detox centre
    ☐ Nursing home/assisted living
    ☐ Shelter/street
    ☐ Jail/prison
    ☐ Other (fill in)_____

33. ☐ No
    ☐ Yes, 1-10 hours per week
    ☐Yes, 11-30 hours per week
    ☐ Yes, more than 30 hours per week

34. ☐ No
    ☐ Yes, 1-10 hours per week
    ☐Yes, 11-30 hours per week
    ☐ Yes, more than 30 hours per week

35. ☐ Yes
    ☐ No

36. ☐ No
    ☐ Yes, I receive disability for medical
        reasons
    ☐Yes, I receive disability for psychiatric
        reasons
    ☐ Yes, I receive disability for substance
        abuse

WHODAS 2.0 - 12 Item Version

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, circle one response.

	In the past 30 days, how much difficulty did you have in:					
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

	In the past 30 days, how much difficulty did you have in:					
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	*Record number of days* ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	*Record number of days* ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	*Record number of days* ____