Maintaining the Gains: What Worked in the Year after Brief Family Therapy

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Brief family therapy, including single session therapy, is widely used to provide a timely and responsive service for children with emotional and behavioural problems. However, there is surprisingly little information about how these children and families fare in the longer term. The brief family therapy program described here was directed toward children with problems of moderate severity. Child Behaviour Checklists (CBCL) were completed by parents before, three months after, and twelve months after therapy; 110 parents also participated in semi-structured telephone interviews twelve months after therapy. Parents' CBCL ratings showed a significant decrease in children's problems after therapy, which were maintained over the subsequent year, although some children continued to experience difficulties. Parents generally found brief therapy a helpful experience. Ways to strengthen the preventive possibilities of brief therapy work will be identified at both a practical and conceptual level.

Childhood emotional and behavioural problems are widespread in Australia; Sawyer et al. (2000) recently reported a 14% national prevalence rate of mental health problems for children and adolescents. Only 25% of these young people attended a service to address their issues and a much smaller percentage (~8%) reached a child and adolescent mental health service. Of this smaller group, over 75% reported severe problems. Therefore, therapists in such services are usually seeing those young people with the highest needs.

Despite being only a small percentage of the overall population in need, thousands of Australian parents seek help from child and adolescent mental health professionals in public and private practice each year. To provide early intervention and avoid lengthy waiting lists, single session therapy (e.g. Boyhan, 1996; Campbell, 1999; Hampson, O'Hanlon, Franklin, Pentony, Fridgant & Heins, 1999; Hoyt, Rosenbaum & Talmon, 1992; Price, 1994; Talmon, 1990) and brief therapy (e.g. Nichols & Schwartz, 1995; Smith, Sayger & Szykula, 1999; Smyrnios & Kirkby, 1993) have been developed.

Although brief therapy presents an economical and convenient alternative to longer and more intensive treatments, there have been few extended follow-up studies of families who have received brief family therapy in either public or private practice. This is of concern, given reports of frequent relapse or setbacks after brief therapy (Pinsof & Wynne, 1995). It is also important given the need for services indicated by the above figures (Sawyer et al., 2000) and the spotlight this places on finding a range of early intervention, prevention and mental health promotion responses (Raphael, 2000), of which brief family therapy may be one.

Our current study aimed to provide more information about how parents cope with children's problems in the year following brief family intervention. Families received either single session or brief therapy and had no further contact with the service (with the occasional exception). The twelve-month follow-up study combined quantitative and qualitative methods to examine whether children's emotional and behavioural problems recurred in the year after therapy, and to explore parents' descriptions of what worked for them and how they applied what they gained.

Previous Studies of Brief Family Therapy

There is little agreement on definitions of brief family therapy in the literature (Nichols & Schwartz, 1995; Pinsof & Wynne, 1995; Smyrnios & Kirkby, 1992). A British audit of a child and family centre over a fifteen-month period found each therapy case received an average of six hours consultation, with the exception of 'complex' cases, which were referred to their Adolescent or Child Protection Programs (Carr, McDonnell & Owen, 1994). In the current study, brief family therapy typically involved up to six 1.5-hour sessions, with follow-up work and documentation occurring between sessions.

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Most studies reported have done short-term follow-up (e.g., Nicholson, 1989; Hampson & Beavers, 1996). Nicholson (1989) found that adolescents and their families attending six or fewer sessions were as likely to report improvement as those attending more sessions (improvement was reported by 82%). At three-month follow-up, she found no link between number of sessions and therapy outcomes (*except* for one-session attenders, who reported slightly less improvement). It is unknown whether gains were maintained over time. However, she did identify that some problems required more therapist time, such as sexual abuse, grief and strange behaviour/thoughts, whereas problems with discipline, sleeping, school or running away required less time. Reasons for this were not discussed.

Hampson and Beaver's (1996) work on family therapy outcomes has shown that

> ... six sessions seems to be a breakpoint in increasing the probability of good results from family intervention ... there is not a dramatically increasing improvement in results with family visits in excess of six (359).

They cautioned that this was an average figure and would not always be applicable to any specific family. Once again, this was based on a short follow-up, that is, two months.

Smith, Sayger and Szykula (1999) outlined the immediate outcomes of brief family therapy interventions, involving nine sessions on average, by comparing parents' ratings of children's problems pre-therapy and two weeks after therapy completion for children at an outpatient hospital clinic. Changes were statistically significant, with 77% of the group reporting improvement. Further follow-up was not conducted.

Using pre- and post-therapy measures, Campbell (1999) provided statistically significant evidence for the effectiveness of single session intervention in reducing the strength and negative effects of presenting problems, and increasing families' sense of coping. This was on the basis of a six-week follow-up. Hampson et al.'s (1999) review of their single session work with families over several years indicated that over 70% reported improvement, with reports of high levels of satisfaction and helpfulness (i.e. over 80%). Again, most of this follow-up enquiry occurred within three months.

Boyhan (1996) examined clients' perceptions of single-session therapy and compared her outcomes with Australian and international studies (Talmon, 1990). Between 63% and 88% of participants in these studies reported improvement at two month follow-up, with the Australian groups rating 78–81% of sessions as helpful. Boyhan (1996) also noted that longer-term follow-up information was needed to explore whether and how clients sustain immediate post-session gains and use their experience to facilitate ongoing constructive change. This echoes other concerns that 'many of the positive changes evident at termination do not last for significant periods of time (beyond two years)' (Pinsof & Wynne, 1995: 608). As a one-year follow-up, the current study takes a step in the direction of responding to these concerns.

The Research Context

Southern CAMHS is a community-based child and adolescent mental health service operating with an 'open door' policy. This direct referral system gives it the capacity to respond to parents' concerns in a timely way. It provides therapy, prevention and mental health promotion services across the southern metropolitan and country areas of South Australia. In its clinical work, CAMHS has a family therapy and systemic orientation. Approximately two-thirds of children receive brief therapy, with half of these attending for one session only — the remaining third have severe or complex problems and receive extended therapy. The present study includes only families receiving brief therapy.

Methods

Our previous studies have reported on the short-term follow up (three months) of families receiving single session therapy (Allison, Roeger, Dadds, Wood & Martin, 1999), and brief therapy in a rural team (Allison et al., 2000). The current study reports on the long-term follow-up (twelve months) of families who participated in the short-term studies of single session and brief therapy at three CAMHS centres. Parents completed the Child Behaviour Checklist questionnaires at Time 1, just prior to attending their first session. Questionnaires were again completed at Time 2, three months after consumers' last contact with CAMHS, and Time 3, twelve months later. The telephone interviews were the main qualitative component and occurred at Time 3, 12–15 months after therapy had ended. Forty percent of the participants from the short-term follow-up studies responded to the request to be involved in the phone interviews. This is comparable to response rates in other consumer satisfaction studies, which range from 30–55% (Kotsopoulos, Elwood & Ole, 1989).

In line with qualitative inquiry in family related research (e.g., Daly, 1992; Gilgun, 1992), the phone interviews sought to gain a richer account of people's experiences than was available through quantitative methods. The interviews were based on structured questions, with some questions being determined by whether participants judged their situation to be better, unchanged or worse. Interviews were organised around the following themes:[1]

- What did parents do differently in response to brief therapy?
- What did parents find helpful about brief therapy?
- What resources did parents utilise, in addition to CAMHS, to address their concerns?
- What did parents gain from brief therapy that assisted in preventing setbacks?
- What factors negatively shaped parents' experiences?

The interviewer was a Research Officer who was not a clinician and had had no prior personal contact with the families. The interviewer recorded detailed notes, including verbatim comments which were then transcribed in full. A Senior Research Officer, who was a clinician but had no personal knowledge of the families, identified themes to capture common and significant experiences and conducted a detailed content analysis to explore the particularities of people's experiences.

The quantitative data was gained from the CBCL (Achenbach, 1991), a frequently used questionnaire for parents, with 112 questions about children's emotional and behavioural problems used to derive a total problem score. This provides a general severity index of children's mental health problems for which national and international comparisons are available (e.g. Alfons, Crijnen, Achenbach & Verhulst, 1997; Sawyer et al., 2000).

Participants and Therapy Offered

There were 110 parents in the phone interviews. Of these, 94 (85%) completed the CBCL. All had therapeutic contact with CAMHS during 1996 and 1997, either in a metropolitan or a rural team in South Australia. Fifty-two percent were female and 48% male. Ages ranged from five to eighteen years, with the mean being ten years, eight months, over 52% being in the seven to eleven year age range.

All CAMHS therapists are trained in family therapy, with knowledge of the most common approaches. The strongest influences on our therapy practice, particularly in the brief therapy program, are solution-focused therapy (Berg, 1994; de Shazer, 1988; 1991) and narrative therapy (White & Epston, 1990, Freedman & Combs, 1996). All therapists are expected to engage in the following practices (Southern CAMHS, 1998):

- Clarification of the therapy process and service options, including whether a single session is sufficient or whether families will go on to brief or longer-term therapy
- Clear identification of the problems or issues and their effects on the family, as well as on school and social settings
- Identification of, and attention to, the historical and contextual issues that impact on the problems experienced (including family, developmental and health history, and history of the problem)
- A risk assessment (i.e. self-harm, harm to others, safety concerns, abuse or neglect, family breakdown)
- Gaining agreement around the focus of the session(s)
- Facilitating improved understandings of the issues being faced and developing strategies for addressing them (solution-focused and narrative approaches are most commonly used in the development of these strategies)
- Identification of additional resources previously or currently accessed, as well as those needed now, and support in accessing them
- Clarification of a follow-up plan after completion of the session(s)

Results

The CBCL results (n = 94) will be presented first, followed by parents' responses to the research questions in the phone interview. In the phone interviews, research questions 1 and 2 (on what parents did differently or found helpful) were asked of the improved group only (n = 80). Questions 3 and 4 regarding other resources utilised and what skills parents gained for preventing setbacks were put to all groups (n = 110). Question 5 on negative factors was addressed through analysing all stories.

CBCL Results

Before brief therapy, parents rated their children as having moderately severe emotional and behavioural problems. The mean CBCL total problem scores were 49.0 for males and 43.4 for females (see Table 1). Parents rated their children again at Time 2 (three months after therapy). At this point, the CBCL total problem scores were significantly lower, indicating fewer emotional and behavioural problems. These mean scores showed non-significant changes over the next twelve months to Time 3. Parents rated both girls and boys as having slightly fewer problems than they showed the year before (see Table 1).

1. What did Parents do Differently?

Four frequent themes were identified. The majority (61%)[2] identified *changes in their own parenting behaviour*. These ranged from having more patience, learning how to remain calm and not yelling, to learning how to communicate by listening and talking more with their child, and by recognising and expressing feelings. Parents also followed or agreed with counsellor suggestions, became firmer in their parenting decisions with children and allowed children to take responsibility for change. For example:

> 'It was good knowing that I had somewhere to go to find help as a parent. Despite [the fact] that it was difficult getting her to come, they were able to give me advice on some strategies to use without needing to see her. They educated me on how to deal with my kids when there was nowhere else to turn.'

TABLE 1

Child Behaviour Checklist Total Problem Scores Before Brief Therapy (Time 1), at 3-Month Follow-up (Time 2) and 12-Month Follow-up (Time 3)

	Mean	*SD*	Number	*t*	*p*
Males					
Time 1	49.0	26.4	46		
Time 2	38.5	33.0	46	3.5	0.01
Time 3	34.4	30.6	46	1.2	0.23
Females					
Time 1	43.4	21.6	48		
Time 2	33.2	23.3	48	3.5	0.01
Time 3	29.4	20.8	48	1.6	0.11

'Counselling made us change too, particularly in the discipline side of things. We learnt strategies and the counsellor supported the things that we were concerned about.'

'I understood a lot more, particularly that it was not all my fault, and didn't blame myself as much. Counselling helped me the most because the problem was that I wasn't coping with my daughter. It is difficult to get things out of her until she is ready, so I learnt to be more patient and picked up skills in communication. I always knew that communication was important but realised I wasn't as good at communicating as I thought.'

Looking at things differently (45%) involved changes in thinking, expectation or understanding of the child's perspective. Others reported seeing the problem rather than the child or themselves as the problem. Some believed they had been provided with new options and referrals to consider or that the child had developed new self-perceptions. For example:

'Counselling helped me to deal with it by bringing it back to ground level and looking more objectively at things. I was stressed out and being too emotional about it because everything I tried hadn't worked. As a result my peace of mind improved, I felt better about things and got some things off my chest. This helped us to be able to get together to look at resolving and stabilising things.'

'It helped me to see that it was not my fault and to be more confident of the way I was parenting. This was very encouraging.'

'It changed my whole attitude towards a lot of things, including how I approached the children.'

In describing how they were able to *connect with their own needs and strengthen coping abilities* (18%), parents commented on how important it was to be listened to and have the stress they experienced acknowledged, on being supported in doing things for their own self-care and in addressing their own issues. Some also commented on how they experienced personal growth, strengthened their self-belief and stopped feeling so alone in their struggles. For example,

'It made me take up more interests for myself. I get out more and have joined a gym. I came to realise my resources were low and that doing this would help me to cope. I began to handle it better, which helped things to get better.'

'I have grown with the situation.'

Some people (10%) reported *feeling reassured they were on the right track and supported in their own parenting strategies* — this was reported more frequently by people attending single sessions. For example, *'They gave me encouragement to keep persevering on strategies already being attempted. We decided to see how things went and come back if they didn't really work.'* Fifteen percent reported they did not do anything differently; however, these people often found aspects of the sessions helpful.

2. What did Parents Find Helpful?

Almost all participants reported helpful aspects. The *counsellor's qualities* were frequently noted (31%). Those identified as important included: level of skill, understanding, approachability, supportiveness, balanced approach, exploration of different avenues, ability to make children feel welcome and gain their confidence, and ability to listen well to children.

When describing how therapy was an *opportunity to talk as a parent to someone* (reported by 25%), parents identified the effects of this as: a reduced sense of isolation, less worry, support for their self-worth through having problems 'normalised', knowing help was available and having the perspective of someone who was not involved. For example:

'Just talking to somebody who understood the way she was behaving was helpful. It made me realise that my problems with this child were not perhaps as bad as the problems of others and that I was not the only one with these problems.'

'Being able to talk about things helped. The child looked forward to being able to speak to someone. Counselling gave her a sense of normalcy.'

'Mainly talking to someone else for support and coming to realise I'm not the only one in this type of situation. The child is very stubborn and fixed so he didn't actually change much himself.'

Several people (20%) believed that *someone for the child to talk to other than the parent* was helpful, with others (20%) reporting their *child began talking more openly* either at or since the session(s). Also appreciated (by 11%) was *being given strategies to try.*

3. What Resources did Parents Utilise in Addition to Brief Therapy?

Regardless of whether people's situation was improved, unchanged or worse, many participants chose to use other services in addition, or as an alternative, to CAMHS. Those receiving one session were only slightly more likely to do this than those receiving more than one session: 66% compared with 56%. The sources of other help fell into four main categories: public services (48%), personal networks and/or personal changes (40%), community services (7%) and private services (6%).

4. What did Parents Gain from Brief Therapy that Assisted in Prevention?

All participants were asked whether their experience with CAMHS would influence how they would deal with *other* child-related problems in the future. Although some people stated it would have no influence (4%), that they had gained nothing for other specific problems (3%), or that they were discouraged from returning to CAMHS (5%), the majority (88%) indicated there were ways in which they would be influenced.

A large percentage of people (65%) stated that they would return to CAMHS to assist them with other problems, e.g. *'I would go back to CAMHS if I needed to. However, I am a lot stronger now and don't feel as alone so I am more likely to be able to cope with problems. I really appre-*

ciate what the service did for me — it turned my life around for good.' There was a strong sense that a number of people would return to CAMHS if they *'felt there was no other option'* or *'if needed'*. The *'if needed'* group were those more likely to feel more confident in their own capacity to manage the situation, at least at first. The *'felt there was no other option'* group did hint at having increased confidence; however, they tinged their answer with admissions that CAMHS was a *'last resort'* when all other things had been tried and *'nothing else was working.'*

> "I really appreciate what the service did for me — it turned my life around for good."

In contrast, quite a few people (16%) considered that although they would *use their own strategies to address the issue first*, if the problem was a new one, they would need to get guidance straight away rather than draw on their existing range of skills or on skills developed during their contact with CAMHS. Others (24%) better identified their transferable skills, reporting they would use *information and strategies gained at CAMHS*, including *talking more openly with their child, listening and understanding more* and being more *aware of noticing child's difficulties and how to respond.*

Some families (15%) had already experienced other emotional or behavioural problems with their child, (with a higher rate of problems among those receiving a single session). When asked how CAMHS influenced the management of these problems, parents reported being able to develop and implement a range of strategies, some of which involved gaining other services or returning to CAMHS, although a minority of parents nominated the last option. Several reported changes in their expectation of or communication with their child, increased confidence in their own parenting, and/or in their ability to identify early warning signs, or other options for action and gaining information.

Participants whose situations had *improved* and who attributed this to CAMHS were asked what they had gained that they would use if the problem *recurred.* Several themes emerged, the most frequently reported being: *ideas/strategies to use specific to the issue of concern* (34%); *reassurance that CAMHS is available in the future if needed* (24%); *the child's acquisition of useful realisations and how to deal with feelings/situations* (14%); *opportunity to work on how to talk and help child open up* (11%); *acknowledging the need and learning how to address issues from the child's perspective and listen to child* (8%), *signs to look for in picking up problems early and taking them seriously* (8%). (Only 8% reported that there was nothing else gained.)

> 'We definitely gained a lot we could use. There were a few problems again early in the year, but she was able to stand up for herself and could probably use what she learnt for this the rest of her life. She is now able to think about how she can approach and deal with certain situations since CAMHS counselling.'
>
> 'I felt I could go back at any time if I needed help. From counselling I also got a lot stronger and more able to stand up for myself.'
>
> 'I would just sit down and talk to her to ask why. CAMHS helped with this as I am able to do this now and hold her attention more.'
>
> 'I learnt to take it seriously earlier and to be aware of warning signals so I can do something about it earlier and stop the problem arising to the point it did.'

5. What Factors Negatively Shaped Parents' Experiences?

Results of this question will only be briefly reported, as satisfaction issues are addressed in more detail in a forthcoming companion paper in this journal (Stacey, Allison, Dadds , Roeger, & Wood, 2002). It was apparent from the interviews that certain service practices could have minimised negative experiences — follow-up, initiating or supporting involvement with other services, maintaining positive changes and prevention, support and flexibility, and transferability of skills to other situations. All of these matters have key implications for prevention and will be discussed below. Examples of negative or ambiguous comments included:

> 'I've brought him back because I feel he needs more help as he didn't get enough last time.'
>
> 'We would bring her back except that the waiting times tend to put me off, this is why we haven't sought further follow up and we're not doing really well.'
>
> 'We were disillusioned about CAMHS counselling so stopped. We had some help to start off with through a special needs program run by Anglican services. It became a matter of constantly doing behavioural management. We also saw an ADD specialist paediatrician and the medication prescribed from this has toned down the child's behaviour problems.'
>
> 'We didn't get any feedback or strategies from CAMHS the last time. We came to the first session but then they did not suggest we come to further sessions. We've asked for feedback a couple of times and were disappointed we still didn't receive help. We found it was painful and difficult to divulge information in the first session and it's hard to do that again if you don't feel it's a two-way thing.'
>
> 'How I would deal with other problems would depend on the particular problem. If it was a similar problem I would treat it the same way and if not I would probably come back to CAMHS to find out how to deal with it.'
>
> 'If there were other issues which arose I would probably have to come back as some of what I learnt may not necessarily be applicable any more.'

Discussion

Most parents (73%) reported positive changes after brief family therapy and these gains were maintained over twelve-month follow-up, that is, there was sustained

improvement. These parents described their changes as: *viewing things differently, changing their behaviours as a parent* and *connecting with their own personal needs.* It appeared that parents became more child-centred and empathic, as well as gaining more clarity, definition, consistency and calmness in their parenting behaviour. Importantly, some parents found that brief therapy enabled them to consider their own personal needs, and find ways of strengthening personal coping abilities or resilience. Many parents felt more in charge of the situation and believed they and their child had gained useful skills and strategies, increased their confidence and capacity in addressing issues and improved their communication.

Parents described brief therapy as helpful due to *the counsellor's qualities, the opportunity to talk to someone as a parent; having someone for the child to talk to other than the parent; the child beginning to talk more openly,* and *being given strategies to try.* Many of these factors are desirable experiences in a therapeutic process and also contribute positively to good outcomes (e.g. see Miller, Duncan & Hubble, 1997).

For outcomes to be sustained, people need to develop skills that are *transferable* across situations. Strengthening these skills enables early action to be taken by parents, minimises the impact on the child and family, and builds resilience, as well as preventing the need for further therapy. As Boyhan (1996) has noted,

> Timely interventions can facilitate transformation at moments when individuals or family members are demonstrating readiness for change, which is signified by their request for therapy. Even if these changes are small, it is suggested that through the process, many clients may discover their own capacity for self-healing and problem solving (93).

To further strengthen efforts regarding prevention, attention needs to be paid to the following five areas:

1. Follow-up. Follow-up has not been emphasised as a component of brief therapy. In this study, therapist follow-up of families seemed to occur on an *ad hoc* basis rather than being standard practice. Although a variety of reasons may explain this, the effect on families was clearly evident, with a considerable number of parents stating they would have appreciated follow-up. Those who were offered or received follow-up valued this highly. Further, such follow-up would have assisted the identification of early warning signs of a new problem or the recurrence of the old one, before the situation reached serious proportions. Follow-up also strengthens families' capacity and sense of support, as people often feel isolated and can lose perspective on the progress they have achieved.

2. Supporting or Initiating Involvement with Other Services. Therapists know that mental health issues are not solely dealt with by dedicated mental health services. Other agencies or workers commonly and jointly involved in child–adolescent mental health issues are schools, GPs and welfare or child protection services. Brief therapy is but one piece of the picture for families — even when things improved, families often enlisted other services or people to assist them. This is not always specifically acknowledged in outcome studies, but clearly, personal and professional networks both contributed to the short-term improvement in children's mental health and the maintenance of this positive change over the subsequent twelve months.

This involvement occurred both with and without therapist recommendations and was not always the result of therapists' actively engaging in collaborative practice. When therapists initiated and supported collaborative practice, families almost always appreciated this, whether as an adjunct or alternative service. It was important that families saw this as identifying additional or a more appropriate services, rather than being 'handballed'. Ensuring additional and sufficient external supports is also a way of bolstering and maximising the benefits of brief therapy, thereby preventing problems recurring after therapy ends.

3. Maintaining Positive Changes and Prevention. A substantial number saw returning to therapy as a more 'end of the line' choice. This can be understood in at least two ways. The preventive intentions of brief therapy work are effective to the extent that people leave believing they can manage situations themselves, returning to therapy when options have been exhausted or they need additional support. This requires therapists to address proactively with families how to maintain gains made in therapy. In contrast, parents' comments could be seen to endorse a negative image of mental health services as places where you do not go unless you must. This means the opportunity for education on maintaining positive changes and prevention may be missed, and problems may become more entrenched and complex before services are sought.

4. Support and Flexibility. Some people felt they had been short-changed by brief therapy, terminating before they or their children were confident about managing the situation. Some felt they were not taken seriously enough, were blamed, or their situation minimised. It appeared that their right to negotiate how conversations could be held, the amount of therapy, or in some instances, therapist gender, might not have been made explicit by therapists, even if the policy of brief therapy had been explained. If therapists were more proactive in opening up these matters for discussion, better negotiations about support and flexibility might ensue. This is also related to point 1 above and more closely approximates 'user-friendly therapy' as advocated by Reimers and colleagues (Reimers, 2001; Reimers & Treacher, 1995).

5. Transferability of Skills. Over 55% of parents could not identify skills they had developed or further enhanced that would be useful for preventing the development of other emotional or behavioural problems. This is important if brief therapy is to be more successful in fostering *resilience* in children and families, a hallmark of prevention and mental health promotion work. Building these concepts into discussions with families would seem commendable, particularly when bringing therapy to a close. This relates to the issues discussed in point 3 above. *Both* therapists and families need

to be explicitly aware that brief therapy work is an investment in the family's future positive mental health.

Limitations

One limitation in this study is the lack of a specific 'treatment protocol'. These are useful for studies about the efficacy of particular treatment approaches. However, Miller, Duncan and Hubble (1997) discuss how such efficacy research does not address the realities of providing therapy to families in community-based services. Protocols promote rigidity and a single focus rather than emphasising flexibly responding to families. In relation to single-session therapy work, Boyhan (1996) concurs that despite guidelines put forward by some proponents 'there needs to be a lack of rigidity in practice, and a commitment to respond to the individual needs of clients' (92).

Another limitation of this study is the absence of a control group. The improvements in children's emotional and behavioural status could have occurred for a wide variety of reasons other than therapy. Some of these were identified by the qualitative interview, including family resilience and other support networks. (However, in the phone interviews, parents were specific about what improvements they attributed to CAMHS.) It is also possible that parents may not be giving accurate reports and that the quantitative measures may simply show 'regression to the mean'. Future studies should consider randomised controlled trials to estimate the effects of brief therapy (provided ethical issues involved in this can be appropriately resolved) and include reports from more people in the system (e.g. the child, teachers, both parents).

What Does the Study Tell Us?

Parents' responses seem to concur with previous findings that

> ... clients tend to emphasise the reassurance and problem-solving aspects of therapy as being most valuable, while therapists tend to emphasise the cognitive and affective insights that they assume clients gain during therapy (Macran, Ross, Hardy & Shapiro, 1999: 329).

Although parents reported they did *look at things differently* and considered this valuable, parents seemed to place a higher priority on learning how to *change their behaviour,* identifying and responding to *personal needs, reassurance* (including the opportunity to *talk to someone else* for either the parent or the child), and having *new strategies* to try. This suggests that it is not useful to adopt an 'either/or' response to what clients value, but rather a 'both/and' position that enables us to listen more closely to what consumers tell us.

In summary, this study indicates that brief family therapy is a positive experience for a significant number of people and has early intervention and prevention effects in two respects. Firstly, providing rapid response and timely support prevents problems from escalating to a point of crisis or chronicity, which would have more extensive and invasive effects on people's lives and require higher level and longer-term involvement with mental health services. Secondly, brief therapy can equip children and families with a range of skills, and bolster their resilience and existing coping strategies for dealing with future difficulties. Finally, proactive attention to certain service practices is likely to enhance these effects.

Implications for Brief Therapy Theory and Practice

The active provision of follow-up services by therapists, and transferability of skills to other or future situations — both factors influencing prevention of setbacks —is not emphasised in many brief approaches to therapy. Brief therapy places the responsibility for change with consumers, thus does not advocate *active* follow-up (Campbell, 1999; Hampson et al., 1999). In fact, it anticipates a revolving door phenomenon, with people returning for further sessions when faced with another issue. For example, in this study, some parents reported that if dealing with another issue they would need to return, as they perceived that what they learned was specific to the original issue rather than being transferable.

This raises a key implication for child and adolescent mental health services in general within the context of the current National Mental Health Strategy (Australian Health Ministers, 1998). Given the increased emphasis being placed on early intervention, prevention and mental health promotion (Raphael, 2000), services have begun appreciating that their role extends beyond therapy to involve community-based work. As this transition occurs, it is important to identify how brief therapy can play an important role in secondary prevention or early intervention, that is, action taken once a problem has been identified but before it is fully established (Davis, Stacey, Jackson & Martin, 1999). It must be made clear to clients that brief therapy intends to:

- stop difficulties progressing to the level of illness or disorder, particularly those that become more entrenched and severe
- assist people in maintaining positive mental health, and
- develop skills in responding to future difficulties that may arise

Brief therapy was not developed within a contemporary public health context, therefore, it places less emphasis on identifying how skills gained or strengthened by consumers are transferable across contexts or to building coping strategies, thus enabling preventive effects. Despite this, it is possible to discuss skill development and transferability with consumers, as well as build in active follow-up practices (e.g. Wright & Martin, 1999). Our results indicate that when this occurs, it is highly valued by consumers.

If we accept the charge to educate our clients about the transferability of their new skills, and to be active in follow-up, we may offer some hope in transforming the image of child and adolescent mental health services, which is still tarred with negativity and seen as a 'last resort'. A key step in making stronger contributions to prevention is to highlight a service's capacity for this work through therapeutic

as well as community-based work. Taking up this challenge is a task that CAMHS is stepping into and we invite fellow travellers on the journey.

Endnotes

1 The question guide is available from the authors upon request.

2 Percentages do not add up to 100% as participants' response may have related to one or more themes.

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