Program Evaluation: Bipolar Clinic

A Final Report Submitted to the
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Goals and Objectives

Pediatric Bipolar Disorder is a severe psychiatric illness that yields symptoms of mania and depression that significantly hinder psycho-social functioning, and can chronically impede normal child development across several domains (Geller, Bolhofner, Craney, Williams, DelBellow & Gundersen, 2000). Children/youth with Bipolar disorder represent a relatively new area of clinical and research focus. As a result, many health care providers are at a loss when treating children/youth with this specific disorder. Despite the use of psychotropic medication and treatment regimens, symptoms of the illness are debilitating to the child/youth and distressing to caregivers, family members and teachers (Kowatch & DelBello, 2006). Bipolar children/youth, compared to those with Attention Deficit Hyperactivity Disorder and community controls, are more likely to be retained in the same grade level, terminate educational opportunities, experience life long adjustment problems, have more impaired parent-child relations, thereby increasing the use of social, hospital and correctional services (Fristad, Goldberg-Arnold & Gavazzi, 2002; Geller et. al., 2000; Tillman, Geller, Craney, Bolhofner, Williams, Zimerman, Frazier & Beringer, 2003). Evidence regarding psychological treatment and family support is scarce (Mansell, Colom & Scott, 2005). Pediatric bipolar disorder is associated with significant morbidity and mortality, and yet, effective treatment strategies have remained underdeveloped and understudied (Fristad, Gavazzi & Mackinaw-Koons, 2003). Thus far, evaluation studies examining treatment effectiveness among children/youth with Bipolar Disorder highlight the need for further development, evaluation, research and dissemination of effective treatments for this disorder (Lam & Wong 2005). Hence, evaluating current treatment utilized within the Bipolar Clinic at the Child and Parent Resource Institute can assist in providing evidence of treatment success and gains in specific developmental domains. The results of this investigation will provide further data regarding evidenced-based treatment in an applied setting. Additionally, this evaluation moves beyond simply assessing symptom reduction as an indicator of decreased impairment but also assesses changes in adaptive functioning in the community, home and school. As such, this work is highly relevant to Children’s Mental Health initiatives and the service delivery for children/youth with high, complex and multiple needs. It is hoped that the end result will be an enhanced capacity to identify and treat high-risk children/youth and to increase our understanding of mental health issues in Bipolar children/youth. Long-term program evaluation efforts will also, inevitably, lead to improved services and informed policy decisions for high risk children/youth and their families.

The Bipolar Clinic at CPRI

The Bipolar Clinic is a highly specialized, tertiary care outpatient clinic at the Child & Parent Resource Institute (CPRI) in London, Ontario. Children/youth can receive a number of services including: 1) Assessment; 2) Treatment; 3) Consultation; and 4) Education for their families, schools and community partners within a 17-county catchment across South Western Ontario. Standard treatment for children/youth in the Bipolar Clinic was 8 weeks, and a cognitive-behavioural therapeutic group treatment approach was used. This model was based on Goldberg-Arnold & Fristad’s evidence-based intervention program for children/youth with Bipolar Disorder (Goldemberg-Arnold & Fristad, 2003).
The Goals of the Clinic

1. To confirm the diagnosis of Early Onset/Paediatric Bipolar Disorder after a thorough assessment of the child/youth;
2. To reduce the symptomatology and suffering of the client and his/her family;
3. To improve client/family understanding of the disorder and its impact on overall functioning;
4. To reduce the negative impact of relapse on the client and his/her family;
5. To educate communities on the impact the disorder has on the client's overall functioning;
6. To consult to communities on best practices to meet the client's long term needs;
7. To consult to physicians who maintain these children/youth in the community.

The Bipolar Clinic accepted referrals for children/youth between the ages of 6-18 with a possible mood disorder. With respect to the assessment phase of the clinic, all children/youth referred to the clinic functioned within the normal range of intellect. (If intellectual functioning was in question, a psychological assessment was completed prior to the Bipolar assessment within the Clinic).

For entry into the clinic, a semi-structured interview (WASH-U-KSADS; Geller, Williams, Zimerman & Frazier, 1996), along with a psychiatric assessment / consultation was provided to determine diagnosis. This standardized interview is a validated evidence-based tool used in assessing Early Onset Bipolar Disorder. Clients who were not diagnosed with Bipolar Disorder received a comprehensive assessment summary. The clinic team members were involved in a consultation process with the case manager to assist in the provision of other services within CPRI, and community services outside of CPRI, for those children/youth who did not meet Bipolar diagnostic criteria.

Treatment within the Bipolar Clinic

Treatment began with a group-based psycho-educational program for parents and children/youth concurrently. A sibling sessions also took place. Once completed, the group treatment client also received a 3-month period of in-home supports if required. Booster sessions were offered at 6 and 12 months. Given the significant chronicity of symptomatology associated with Pediatric Bipolar Disorder, outcome measures focused on various domains including: child functioning, symptom reduction, factors associated with quality of life, family functioning, family stress and relationship factors. Clients also received medication consultations and psychotropic treatment via psychiatry. A case manager was also assigned to each child/youth to support the families through difficult transitions, (e.g., school difficulties/demissions), and to assist in accessing community resources. (For an outline of the sessions, please refer to Appendix 1).

Treatment involved an 8 session bi-weekly group consisting of 3-5 children/youths, chosen by age and intellect. Detective thinking exercises were provided and completed at home. Children/youths were encouraged to discuss the problem if this “work” was not completed. They were encouraged to share these ideas with their group.
A co-joint parent group was provided at the same time as the child/youth’s group. A brief overview of the child/youth’s group and new skills were introduced weekly. The parents were encouraged to use this as a support as well as attending the parent support group in the evening.

**Session #1** – The child/youth met the other participants for the first time. Staff gleaned a quick view of the child/youth’s social skills, ability to join in discussion, willingness to participate, etc. The child/youth was introduced to the disorder. The “Storm in my Brain” book was given for educational purposes. The child/youth was asked to read with their family, parent, friends, etc. Some consideration was given to children/youth who denied the disorder; support about acceptance was given.

**Session #2** – Discussions about each child/youth’s medications, side effects (positive and negative) were conducted. Connections between symptoms, strengths and abilities were drawn. Discussion about the daily struggles ensued, including how their routines were affected and how to reduce impact.

**Session #3** – The children/youth began to build on their tool kit. Anger management styles were examined (e.g., what works, what does not) and specific triggers were identified.

**Session #4** – Taking responsibility for choices about their moods/symptoms was the focus. The exercises completed pressed the child to consider how their thinking – feelings – action are all co-related. Cognitive thinking distortions and negative mood states were questioned as well as ways in which they could turn positives into negatives.

**Session #5** – This session used the stop-think-plan approach with exercises that introduced ways that questioned their thinking (Session 4 material). Their ability to attack problems was rated.

**Session #6** – Non-verbal communication was stressed (e.g., how subtle cues are missed). New ways to show their feelings were discussed. A charade activity to practice these skills or ascertain their understanding of the material was conducted.

**Session #7** – Verbal communication, missed messages, long-winded lectures and unhelpful communication styles were discussed. The children/youth were encouraged to name and list the people in their lives that have been helpful. The co-joint group for this session was for siblings.

**Session #8** – A game format was presented to review materials, talk about school issues, friendships, community, etc. The children/youth were given their toolbox to fill with their choice of coping materials/strategies that have worked for them. Phone numbers, etc. were shared as appropriate and a small celebration occurred. The children/youth were asked to share any changes they thought the group had made for them. A booster session occurred within 6 months as a check-in (For more specific details about treatment groups, please see Appendix 1).
Transition Planning

Once clients completed the clinic treatment, the clinic staff partnered with the clients’ community support providers (e.g., community mental health centre, school, therapist, youth worker, youth group, wraparound teams & physician) to develop a long term transition plan to support clients in their community. This included review of clinic sessions, staff training, implementation of management strategies for school and home and an educational workshop to the community. Transition planning provided support for the child/youth within the home community. Clients also received individual cognitive-behavioural therapy if needed after completion of the group-based intervention. Booster sessions were offered to children/youth and their guardians at intervals after clinic treatment ended. Parents were invited to attend a staff-facilitated parent support group which occurred monthly. Parents could access the group via videoconference or teleconference from the home community if requested. “Clinic staff” also assisted communities/families to organize groups in their community to enhance capacity.

Methodology

Participants: 189 children/youth were referred to the Bipolar Clinic. Of the 189 children/youth referred, 65 children/youth received services from the Bipolar Clinic for assessment and treatment. Of those children/youth, 33 (19 males; 14 females) received assessment only and/or did not meet criteria for Bipolar disorder and were referred to alternative services. The age range for assessment clients was 6 years, 8 months to 17 years, 9 months at the time of assessment. Of the other children/youth referred, 27 children/youth were assessed and met criteria as having Bipolar and were placed into the Mood Matters Treatment Group. Two children/youth did not wish to participate in group treatment once a Bipolar diagnosis was received. Additionally, 5 children/youth were assessed and received only individualized treatment. None of the children/youth dropped out of treatment. Hence, 33 children/youth (22 males; 11 females) received treatment. Clients and their parents/guardians were assured that failure to participate in the evaluation would not affect future service at CPRI.

Measures

As part of the assessment process, all children/youth referred to the Bipolar Clinic were required to complete measures prior to their assessment (See Appendix 2 for a detailed description of the measures; see Appendix 3 for a chart of pre- and post-treatment/assessment measures collected). The measures included:

Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS)
Conners’ Parent Rating Scale – Revised (L)
Conners’ Teacher Rating Scale – Revised (L)
Parenting Stress Inventory (PSI)
Hassles and Uplifts Scales (HSUP)
Swanson, Nolan and Pelham (SNAP-IV-C) Rating Scale
Child Behaviour Checklist (ages 6-18)
Teacher Report Form (ages 6-18)
Parent-Child Relationship Inventory (PCRI)
Parent Young Mania Rating Scale (P-YMRS)
Brief Child and Family Phone Interview (BCFPI)
Child and Adolescent Functional Assessment Scale (CAFAS)
Satisfaction Questionnaire (treatment only families)
As a follow-up to evaluate the services for the Bipolar Clinic, families that took part in either the assessment or treatment services were mailed follow-up questionnaires (including the PCRI, P-YMRS, PSI, CBCL and Satisfaction Questionnaire). Of those packages mailed, only 14 were returned. Research assistants contacted the families that had not returned their packages. Questionnaires were competed by telephone for 14 additional families (See Appendix 3 for Telephone Script). In addition, 43 families had BCFPI scores prior to assessment and/or treatment and 24 families were contacted by telephone to complete the BCFPI for follow-up. A satisfaction questionnaire was also administered at the end of the treatment group with 17 families. Of those, 14 families were contacted at follow-up to complete this measure again to assess change.

**Results of Assessment Services**

*Child Behaviour Checklist*

To determine the impact of assessment services on the clientele and the families, a number of pair-wise t-tests were completed on the specific measures collected at both pre- and post-assessment. Results from the CBCL indicated that Rule Breaking Behaviour (e.g., does not show guilt, breaks rules at home/school, chooses to be friends with the wrong crowd, lies/cheats) reduced after assessment, $t(5) = 2.74, p<.05$. (See Figure 1).

*Brief Child and Family Phone Interview*

With respect to the BCFPI, no significant differences were found (See Figure 2).

*Child and Adolescent Functional Assessment Scale (CAFAS)*

On the CAFAS, a significant improvement was found from pre- to post-assessment on the Total Problem scale (combined sub-scales including School, Home, Community, Behaviour, Moods, Self-Harm, Substance Use, Thinking), $t(12) = 3.06, p<.01$. With respect to specific sub-scales, School Impairment, $t(12) = 2.94, p<.05$, Behaviour Toward Others, $t(12) = 2.64, p<.05$, and Moods, $t(12) = 3.33, p<.01$, all reduced from moderate to minimal levels. With respect to Self-Harm, the severity of incidents reduced significantly, $t(12) = 2.54, p<.05$. Specifically, children/youth who were initially referred to the Bipolar Clinic for assessment were rated from moderately impaired to mildly impaired at follow-up (See Figure 3).

*Parent-Young Mania Rating Scale*

Pair-wise t-tests were completed on sub-scales of the Young Mania Rating Scale. Results revealed no significant effect (See Figure 4).
Results of Treatment Services

Child Behaviour Checklist

To determine the effectiveness of the treatment services within the Bipolar Clinic, a number of paired t-tests were completed on the specific measures collected. Results obtained from the CBCL indicated that Total Problems, $t(12)=3.44$, $p<.01$ and Externalizing Problems, $t(12)=4.00$, $p<.01$, significantly reduced after treatment. With respect to specific sub-scales, Thought Problems, $t(12)=3.01$, $p<.01$, Attention Problems, $t(12)=2.15$, $p<.05$, Rule Breaking Behaviour, $t(12)=2.72$, $p<.05$, and Aggressive Behaviour, $t(12)=4.15$, $p<.01$, also declined after treatment (See Figure 5).

Brief Child and Family Phone Interview

With respect to the BCFPI, a significant difference was found on the following sub-scales: Social Participation, $t(13)=2.60$, $p<.05$ and Global Functioning, $t(13)=2.24$, $p<.05$, suggesting improvement (See Figure 6).

Child and Adolescent Functional Assessment Scale (CAFAS)

On the CAFAS, a significant improvement was found on the pre- to post-treatment comparison score for Behaviour Toward Others, $t(21)=3.48$, $p<.01$ only, which indicated that the children/youth were moderately impaired at the beginning of treatment became mildly impaired at the completion of treatment (See Figure 7).

Parent-Young Mania Rating Scale

Pair-wise $t$-tests were completed on sub-scales of the Young Mania Rating Scale. Results revealed a significant difference only with respect to Disruptive Behaviour, $t(9)=2.33$, $p<.05$ (See Figure 8).

Parent Child Relationship Inventory

With respect to the parent-child relationship, Parental Support, $t(9)=2.48$, $p<.05$ and Limit Setting, $t(9)=2.99$, $p<.05$ improved when comparing pre- to post- treatment scores (See Figure 9). With regard to Parental Support, a profile that included a low score indicated a client who perceived parenting responsibilities as a burden from which there was little relief. With regard to Limit Setting, relatively high scores suggested a situation in the home that was fairly harmonious and controlled.

Satisfaction Questionnaire

With respect to parental/guardian satisfaction with Bipolar treatment services, parents/guardians felt they had a better understanding of their child’s needs, $t(15)=2.42$, $p<.05$ and utilized more educational resources (e.g., books, web-sites), $t(14)=2.17$, $p<.05$, after treatment. Parents/guardians also felt that the major problems that led them to seek services were addressed, $t(14)=3.50$, $p<.01$. Satisfaction was sustained at follow-up (See Figure 10).
Discussion

Children/youth with Bipolar illness present with a severe psychiatric illness that yields symptoms of mania and depression that significantly hinder psychosocial functioning and can chronically impede normal development. Children/youth with Bipolar Disorder are viewed as requiring long-term mental health services (Geller, et al., 2000).

Assessment Results

With respect to “assessment” results, outcome data indicated that children/youth were better adjusted following assessment compared to prior assessment on critical factors including overall adaptive functioning and symptom severity. On the CBCL, rule breaking behaviours (such as lying/cheating, choosing inappropriate peers, breaking rules at home and school, displaying no guilt) reduced after the assessment. No differences were found on the BCFPI or the Parent-Young Mania Rating Scale. However, on the CAFAS, children/youth who received assessment services at CPRI were described as having less impaired Total problems after treatment. At school, they displayed reduced impairment (from moderate to mild) in areas such as non-complaint behaviours, repeated disruptiveness with classroom routine, school absences, poor attentiveness, failing grades and truancy. Moreover, these children/youth were described as having significant improvements in their behaviour, mood, substance use and thinking. These children/youth displayed reduced: 1) temper tantrums; 2) angry outbursts; 3) difficulties relating to peers from pre – to – post assessment. Moods were less intense and abrupt. Fears, worries, and anxieties were reduced, and emotional responses became more appropriate, when comparing pre- to post-assessment. Endangering themselves or others (e.g., traffic violations, truancy), and using drugs/alcohol were less apparent after assessment follow-up. As such, children/youth who were initially referred to the Bipolar Clinic for assessment were rated from moderately impaired prior to assessment to mildly impaired at follow-up. With respect to self-harm, improvement reduced from mild impairment (e.g., repeated non-accidental behaviours suggesting self-harm that is non-life threatening) to minimal or no impairment (no self-harm present).

Treatment Results

With respect to treatment results, outcome data indicated that children/youth were better adjusted following treatment than they had been before, especially on critical variables such as overall adaptive functioning and total symptom severity. Specifically, on the CBCL, Total and Externalizing problems were significantly reduced as a result of treatment. Furthermore, thought problems (e.g., harming self, strange thoughts and behaviours, repeating acts over again, sexualized Behaviours), attention problems (e.g., distractibility, inattentiveness, hyperactivity), rule breaking behaviours (e.g., stealing, swearing, lack of guilt, cheating, lying, truancy), and aggressive behaviours (e.g., argumentative, mean, destroying property, fighting, threatening, attacking) all declined as a result of treatment at follow-up. A reduction of disruptive behaviour was also found on the YMRS. On the CAFAS, significant improvement was found on the children/youth’s behaviours toward other individuals. Essentially, the children/youth’s inappropriate, bizarre, and socially problematic behaviours significantly declined.

With respect to the parent-child relationship, improvements in limit setting were found. As such, parents reported less problems disciplining their child/youth, reported better
consistency in their disciplinary practices, and reported less high powered, intrusive strategies to deal with their child/youth’s behaviours (e.g., threatening, losing temper). Improved parental support was also reported. Specifically, parents reported: 1) reduced stress; 2) fewer burdens in relation to their responsibilities; and 3) less overall frustration with their child/youth. Additionally, parents reported greater enjoyment from aspects of their life, rated their relationship with their spouse/significant other as more supportive and were generally more satisfied with their quality of life. As such, intervention decreased negative family interaction and led to an improvement in family climate following treatment. On the BCFPI, social participation and global functioning improved with treatment, suggesting reduced anxiety, isolation and withdrawal in children/youth and youth, improved social involvement with peers and improved quality of life. On the Global Functioning scale of the BCFPI there was a reduction in behaviours that would prevent the family from visiting others, going out in the community or having friends, relatives and neighbours in their home.

With respect to satisfaction after treatment, parents/guardians felt they had a better understanding of the needs of their child/youth and that the major problems that led to seeking mental health services for their children/youth were addressed. Additionally, families were more likely to utilize mental health educational resources after treatment, compared to pre-treatment. Hence, results indicated that parent’s understanding of Bipolar Disorder increased significantly with intervention. Results also suggested consumer satisfaction was sustained at 6-month follow-up.

A major limitation of this evaluation was the low number of participants with complete sets of pre- and post- assessment and treatment data. Missing data (lack of consistent data at pre- and post) reduced the number of children/youth that could be involved in the analyses. Once these participants were further sub-divided into clientele who received assessment and treatment services, the number of participants for analyses further reduced the power of the analyses. Additionally, there was no control group and it, therefore, cannot be firmly concluded that these improvements were not due to maturation issues. However, given the severity of our clientele, spontaneous improvement is not likely.

**Long-Term Program Evaluation Efforts**

As a result of this program evaluation award, we had the opportunity to train 3 undergraduate students and a CPRI staff member. Areas of training included: 1) understanding the operation of various databases; (CAFAS, BCFPI, and Client Information System, SPSS); 2) instruction on the administration of the BCFPI, Conners’, P-YMRS, PSI, CBCL, PCRI and Satisfaction Questionnaire over the telephone; 3) instruction on how to score and code various measures; 4) creating a database on Excel; 5) entering data in SPSS, CIS and BCFPI; and 6) running analyses through the use of SPSS software packages.

Funds also assisted in the long-term development of future evaluation plans across specialized clinics. We developed a program evaluation database for our outpatient clinics to allow the opportunity to compare and contrast the service needs, symptomatology, and treatment success of several diagnostic groups. This will allow us the opportunity to investigate and evaluate particular treatments for children/youth with different psychiatric illnesses through the use of standardized measures.
Program evaluation data collection has historically been a difficult process for the clinics given that collection has been completed by existing staff whose priority was service delivery. This meant very little time could be devoted to reminding clients to complete questionnaires, track missing data or obtain follow-up information. In the future, we plan to allocate and identify a specific individual responsible for providing support for program evaluation efforts (including assessment, treatment, consultation and education) across the clinics at CPRI (e.g., scoring, collecting, tracking, collating and entering data). This will assist in more consistent data collection and follow-up for the clients and families we serve. Data analyses could then be run approximately once every three months to assess initial progress and implement improvements as needed. Subsequently, program evaluation could be examined and disseminated on a yearly basis.

In the future, we plan to develop a collaborative process with the Information Technology department to develop an electronic database housed on our current Client Information System. This database will be used to track questionnaires that have been mailed out and returned to CPRI, identify data collection for the BCFPI and CAFAS, as well as track start and end dates for assessment, treatment, consultation and education services.

Given the fact that the Province of Ontario is adopting the provision of effective and efficient care and accountability, program evaluation of these specialized clinics will shed further light on identifying Best-Practice and evidence-based approaches to reduce the pain and suffering of these complex, high need children/youth. Benefits for managers and clinicians involved in program evaluation include the development of research knowledge with practice knowledge -- an integration that improves clinical decision-making (Buysse, Sparkman & Wesley, 2003). We also plan on tracking results to provide evidence of its impact and to evaluate the strengths and weaknesses of the Bipolar Clinic in an ongoing way.

Knowledge Exchange Activities

Knowledge generation, sharing and dissemination have been conducted through information sessions and in-services to encourage awareness, critical evaluation and the use of the findings generated through this evaluation. We have utilized different communication methods and formats (e.g., intranet, paper reports, executive summaries) as tools for the dissemination of program evaluation results. The program evaluation results of this clinic were also presented to Peter Steckenreiter, CPRI Senior Management Team and the Assistant Deputy Minister, Alexander Bezzina, on April 10, 2006. We also plan to distribute our results in newsletters, and “easy to read” summaries locally, regionally and nationally to a mailing list of over 500 people interested in intervention and service delivery for children/youth with mental health needs. We will provide updated results of the program evaluation on the intranet and to other mental health agencies. Information will also be provided to the Research and Ontario Measurement Board (ROMB) of the Ministry of Children and Youth Services (MCYS). We also plan to distribute findings to other agencies and mental health facilities, and present results at conferences, lunch and learns, and the Journal Club. We hope to eventually utilize traditional indicators of research outputs as well (e.g., publications). Information regarding the results will also be disseminated to our families. We will seize opportunities to consult with other mental health agencies regarding the effective approaches of our clinic to enhance capacity within the community (e.g., provide educational resources, consultations in the community, presentation slides, protocols, assessment approach, co-facilitation of groups).
Appendix 1

Treatment Regime

MOOD MATTERS (Children/Youth’s Group)

OUTLINE – SESSION #1

MEET AND GREET (A) CHILDREN/YOUTH’S MOOD MATTERS GROUP

1. Introduce ourselves. (Where are we from, something we like to do, siblings, pets.)

2. House rules, rules of group (write on flipchart), how many sessions, how much time, etc.

3. Purpose of the group, what would the children/youth like to accomplish by the end? Bi-weekly “detective thinking” expectations weekly.

4. Point system, reinforcements!

5. What do you know about the disorder?

Provide copies of Storm in my Brain and quickly review. Have a discussion about moods, other problems that come with it. Ask the child to review this with their parents at home. Discuss how they might share this information with others.

6. Other names for bipolar, how can we make it friendlier? How else can they describe their symptoms? (e.g., I feel like my nerves are always on edge, feel like I have a motor running out of control).

INCLUDE: snack, points earned, and an activity.

Points earned for: coming to group, having detective thinking assignments done, staying and/or returning from difficulties, participating, trying to follow the rules of the group, being a leader/role model. They should earn at least 5 points bi-weekly to save or cash in, but could earn more as bonuses.
OUTLINE – SESSION #1

MEET AND GREET
(B - Pre Adolescents)
MOOD MATTERS GROUP

1. Introduce ourselves. Where are we from, what are our favorite free time activities, best subjects in school, siblings.

   House rules, rules of the group (write on flipchart), how many sessions, how much time, missed sessions, what the homework will look like, etc.

3. Purpose of the group. What would they like to have learned or changed by the end of the group? What has been the hardest part/or what they dislike most about the disorder? Make a list and keep for the end of the 8 sessions.

4. Discuss what they can earn for coming and participating. Talk about the points. Enlist their suggestions.

   What is their knowledge of the disorder? Provide some paperwork, discuss. Discuss moods, symptoms, how they affect their functioning. Discuss alternate ways to describe these feelings. What words do they use to describe it now?

   INCLUDE: snack, points earned.

   DON’T FORGET: supplies, pencils, markers, flip chart

   Points for: coming to group, having homework done, staying and/or returning from difficulties, participating, trying to follow the rules of being in a group, being a leader. They should each earn 5 points bi-weekly to cash in, but can earn more for bonuses.

OUTLINE – SESSION #1

MEET AND GREET
PARENT (A)
MOOD MATTERS GROUP

1. Introductions. What brought them to the group? Include family makeup, history, etc.

2. What are your expectations of this group? (e.g., understand their child’s needs better, their medications, understand the raging behaviours; have better skills). What do you hope will be changed or look different? Make a flipchart list to refer back to at the end of the sessions. Review the 8 session sheet handout explaining the emphasis on psycho educational and cognitive Behaviour strategies.

3. What do they already know about bipolar and how it has affected their child? (Use handout “Is your child bipolar?”). Provide handout “What exactly is bipolar?” Review to section on medication, if time.
OUTLINE – SESSION #2

WHAT I LIKE ABOUT ME!

(A)

MOOD MATTERS GROUP

1. Review discussions that occurred at home over the last 2 weeks, any questions that arose from the group. What did their child think of the book?

2. Have each child cut out a large paper hand or use one already drawn. Have them title it “All about me”. Generate sample ideas on the flip chart of any positive descriptions they can come up with to describe themselves or others. Have them start working on their hands, assign to finish next week if needed.

3. Ask the children/youth what medications they are taking, if they know their dosages, why they are taking them, symptoms, etc. Direct them to talk to their parents about questions. (Parent group leaders will hand out the child’s guide to medications.)

OUTLINE – SESSION #2

DIVIDE AND CONQUER

(B)

MOOD MATTERS GROUP

1. Discuss their routine; how many target times do they reach in a day? (See adult Social Rhythm Metric). What’s so important about being on a schedule, what are ways in which they could break up things into smaller tasks? Divide and conquer! (Discuss ways in which they can do this with schoolwork too, who could help them, what are the steps involved in that)?

2. Discuss strength/symptom chart.

3. Review some common symptoms of the disorder with the children/youth (use their own words). Provide them with some descriptions from the bipolar child questionnaire.

4. Using the symptoms they have come up with, shift to a discussion about their medications. Provide them with printouts of Medication Information for Youth. Discuss medications they are on, what reason, why they must follow them as ordered, etc. Encourage them to follow up this discussion with their parents.

INCLUDE: snacks, points earned.
OUTLINE – SESSION #2

WHAT I LIKE ABOUT ME
PARENT (A)
MOOD MATTERS GROUP

1. Review any discussions from the past week/s. Were there questions from the material given? What comments did the child have about the first session? Did the book start any discussions?

2. Discuss routines of their children/youth, daily rhythms. How often are these disrupted? What are the worse times of the day? How are they reinforcing and keeping a schedule? (If one is not established, reasons why). Discuss adult social rhythm metric.

3. Discuss strengths/symptoms exercise with the parents for each of their children/youth. Their homework will be to work with their child on the things I like about me hand exercise. Review common symptoms of the disorder (pre-screening questionnaire).

4. Review second half of handout from the first session on medications.

5. Provide medication sheets for parents. Review the purpose of the meds, dosages. Talk about side effects and warning signs of toxicity. Direct them to the pharmacist if they are concerned about immediate contraindications. Refer them to discuss any concerns with Dr. Andreychuk or family physician.

OUTLINE – SESSION #2

DIVIDE AND CONQUER
PARENT (B)
MOOD MATTERS GROUP

1. Review any questions from the last 2 weeks. Were they any questions that came up about bipolar that feel they need more information on? Was there any feedback from their children/youth on the first group? How did they utilize the book?

2. Discuss the child’s routines, daily rhythms (sleeping, waking, exercise, etc). What works for each family, parent? What are the most challenging times of day? How do they maintain them?

3. Present example of strength/symptom chart. Ask them to complete this as homework with their child. Generate some discussion of their child’s symptoms; suggest some that they may have in common. (Can use the Bipolar Child Questionnaire for ideas).

4. Provide Medication Information sheets for Parents. Discuss what each child is on, dosages and reason. Refer them back to Dr. Andreychuk for any concerns.
OUTLINE - SESSION #3

BUILDING MY TOOL KIT
(A)
MOOD MATTERS GROUP

1. Review detective thinking exercise from previous week. “About me” hand – things I like about me (Naming the Enemy Exercise).

2. Do activity for triggers (what sets you off) and anger signals (signs of building anger) to help develop coping skills. Draw out body on large paper. Identify for each child. To facilitate a STOP before you ACT plan, create examples on the flip chart (in the circles). Discuss the importance of knowing what makes them angry as well as taking responsibility for it. Ask for any things that have happened to them lately that have not turned out well. Inform the children/youth that they will be building a tool kit to use when they have difficulties. Encourage the children/youth to give you ideas. During this discussion, practice any physical ideas presented (e.g. counting to ten). Have the children/youth start to fill in their own circles. Help with fine motor problems, or write in for them as necessary.

3. Introduce the second part of the “taking charge of the bad, mad feelings” exercise. Enlist the children/youth to give ideas that can be written up on the flip chart as well as on their own sheet. Try to provide as many strategies as possible.

4. Ask the children/youth to come up with an example over the next week of an anger provoking situation, how they used their tools, how it went, etc (provided on worksheet).

INCLUDE: snack, points, activity

OUTLINE – SESSION #3

BUILDING MY TOOL KIT
(B - Preadolescents)
MOOD MATTERS GROUP

1. Review of homework sheet, things I like about me and symptoms. (Naming the Enemy Exercise).

2. Give a copy of the Rainbow Concept. Review and discuss.

3. In group discussion, look at My Tool Kit handout. Generate ideas for each circle. Ask the children/youth to list any key adults or friends who might be part of their support network. Review ideas.

INCLUDE: snacks, points
OUTLINE – SESSION #3
BUILDING MY TOOL KIT
PARENT
MOOD MATTERS GROUP

1. Review any discussion the children/youth had about their strengths, things they liked about themselves, what gets in their way.

2. Give parents a copy of the Rainbow Concept. Review. Discuss it’s impact and how it is being used.

3. Make flip board chart of possible antecedents leading to their child’s anger. Also, discuss consequences, what they do, etc. and list as ABC’s.

4. List possible ways in which the parents can be coaches to their children/youth.

5. Provide paperwork on time out from stress, self talk, etc.

6. Explore their support systems, who is more user-friendly, are there community people they have or could contact?

7. The children/youth will be working on a negative case scenario (one of their triggers). Encourage them to change this to a positive experience.

OUTLINE – SESSION #4
THINKING – FEELING- DOING
(A)
MOOD MATTERS GROUP

1. Review detective thinking, how did they handle a problem? Generate some shared discussion about any ideas that people came up with that were unusual.

2. Having responsibility means thinking about how we think, feel and then react. Draw a matching picture of the modified figure 13.5, on the flipchart.

3. Place cards on table. Match negative examples of thoughts, feelings and actions. Then match positive ones. (Use approximately 3 matching sets for each participant). Fill some of these into the stickman figure.

4. Complete Lost in the Woods exercise, if time.

5. Present one case scenario of a thought – feeling – action that was positive. (T - This is a huge project to get done. F – I’m thinking that I can probably get started tonight. A - I will break it down into a whole bunch of steps. My mom can help me. F - That wasn’t so bad. I feel pretty good.)
6. Help the children/youth to come up with one that would be negative. (e.g: T – My teacher is mad at me for not listening. F – I feel bad. A – I will get kicked out of gym class, so I can’t get in trouble there.)

7. Assign the children/youth to come up with a major scenario at home – based in negative mood. Use How do you feel? handout to suggest ideas for feelings.

INCLUDE: snacks, points and an activity if there’s time.

OUTLINE – SESSION #4

THINKING-FEELING-DOING

(B)

MOOD MATTERS GROUP

1. Review completion of tool kit circles. Discuss one anger provoking situation and how it worked out. What would they have done differently?

2. Introduce the idea that we are responsible for ourselves. First we think, then we have a feeling about it and then we react. This can be a positive or negative outcome and comes from our experiences. Using the stick man figure, ask the group to think of both sides for each area. Two way arrows are emphasized. Fill in the examples on the flip chart. Give copy of An Outburst in many Words.

3. Using board game, have each child turn over a card, say if it’s a thought, action or feeling. Spin the wheel to see how many chips they get. Generate discussion about positive versus negative examples. Discuss positive self talk, logical thinking, best realistic case scenario thinking. How difficult it is to will yourself away from negative thinking, focus on positive thoughts and change moods? Use the Magnify sheet as a tool for discussion of worse case scenario thinking.

4. Encourage examples of negative moods and times they have experienced positive or negative outcomes. For example:

   Your favorite toy is missing.
   You don’t get picked for the team, you thought they were your friends.
   Your forget your assignment for school.
   Your mother yells at you for forgetting your chore.

   How did they feel? Did someone help them with their reaction? What happened?
OUTLINE – SESSION #4

THINKING – FEELING - DOING
PARENT
MOOD MATTERS GROUP

1. Discuss the previous week’s idea, what was the anger provoking incident? Did their child use their tools? Did they use old coping strategies of coping?

2. Discuss “I” messages. Give examples: use handout.

3. Start a flip chart on thoughts, feelings, actions including negative mood states such as angry, anxious, irritated (neg.) vs content, accepted (pos). Discuss as many examples of negative mood states and what might help or hurt the situation for the child. Use a line in the middle of each of the bubbles to indicate positive versus negative responses. Emphasize the cycle of interaction between T-A-F.

OUTLINE – SESSION #5

CHILDREN/YOUTH’S MOOD MATTERS GROUP
STOP—THINK—PLAN—CHECK

1. Housekeeping, hand out names tags and snacks, review group rules, complete mood charts, review reward system.

2. 5 minutes of relaxation/calming techniques.

3. Finish up “Thinking, Feeling, Doing” worksheet.

4. Coping statement game: members get a point for each negative statement that they can turn into a positive statement.

5. Introduce problem solving model: Stop, Think, Plan, and Check. Given STPC overview handout.

6. Role Plays: members pick scenario and act out how the problem solving model.

7. Homework: handout copy of STPC worksheet to explore solutions to a problem during the coming week as a family project.

8. 5 minutes of relaxation/calming techniques.


10. Freetime—crafts, board games, etc.

OUTLINE – SESSION #5

STOP-THINK-PLAN-CHECK
PARENT GROUP

1. Welcome. Talk about THINKING - FEELING - DOING Did it help you in talking with your child and refocusing them on the problem? Did it help with the problem solving process? Are there other incidents where you might use it?

2. Discuss the depressive cycle. Review handout (Controlling upsetting thoughts).
   A. What does it look like for each of their children/youth?
   B. How long does it last? Does it ebb and wane, daily, etc.?
   C. Are there ways in which you get through the cycle/handle the Behaviours?
3. Handout the chapter on Self-Talk and Thermometer (Feelings - Self Talk).
   Discuss how parents can become down, how they protect themselves from loss of hope.

4. Topic of the Day: Stop
   Think
   Plan
   Check worksheet for their child.

Role play situations: e.g: Mom tells you to turn off the computer and come eat dinner, now!
Brother/sister tells you to “get lost” when they are playing on the computer.

* How could your child start using their tool box, if they’re not already? *Some children/youth will talk about what they did that day in group at bedtime.

OUTLINE – SESSION #6

COMMUNICATION SKILLS AND WHY DID THEY END UP RAGING
PARENT GROUP
MOOD MATTERS GROUP

1. Welcome
2. Snack
3. Review homework: Stop-Think-Plan- Check.
4. Topic of the day = Non-Verbal Communication Skills
   - discuss whey their children/youth often demonstrate poor social skills
   - what happens when you tried to figure out what your child is
     requesting and the frustration sets in and your child is in a rage?
   - What does a rage look like?
   - Do’s and Don’ts of dealing with a rage.

If time allows, how to problem solve school refusals and other non-compliant behaviours.

5. Homework – Explain homework and give out chart.
1. Review non-verbal assignment. Was it more difficult when you couldn’t use words? Have children/youth role play any interesting feelings that they did.

2. Facilitator will introduce an item to draw. Ask that they not give the object away if they guess it early. Discuss what was hard about the exercise; what would have made it easier.

3. If time, children/youth can take turns at giving instructions of a drawing and can be coached if needed. A non-verbal activity could be used instead; pair children/youth, time them and have them build a car from Lego blocks without talking.

4. Start a chart of helpful and not-helpful ways their parents/siblings communicate to them. What good listening skills do they use? Have the children/youth give their own examples for the top half of the “Lets Talk” worksheet. Ask them to think about what their parents might put in the bottom half.

Snack, points, activity.

1. Review non-verbal assignment. If not completed, ask for examples of faces/mannerisms their parents/teachers have that they misinterpret or ones that they now understand.

2. Introduce an item to draw. Ask that they not give away the item if they guess it early, but finish the drawing quietly. Discuss what made the activity hard, what would have made it easier. What cues would have helped.

3. Pair the children/youth and ask them to complete a timed puzzle without talking to the other person.

4. Ask them to relate examples from their daily lives when the communication wasn’t clear, to the point, etc. (Example: Hurry up, we’re late VERSUS We have 5 minutes to be in the car OR your room is always a mess VERSUS if you would pick up the clothes on the floor, it would help out when I do laundry). Discuss ways in which it could be more helpful or things that their parents are already doing that help.
5. Ask them to generate at least 3 ideas on their Lets Talk sheet.
   Snack, points, activity, Let's Talk sheet.

**OUTLINE – SESSION #7**

**NON-VERBAL/VERBAL COMMUNICATION**

**PARENT/SIBLING (A & B)**

**MOOD MATTERS GROUP**

1. Introduce ourselves to each other. Facilitators explain the plan, purpose of the day and give a brief overview of what’s been covered over the past sessions to the siblings.

2. Review homework: receiving each others feeling cues/non-verbal communication.

3. Do the exercise on ALL ABOUT ME!

4. Invite anyone to share their information with the group if they like.

5. Complete activities related to verbal and non-verbal messages. (Verbal – Draw object with only verbal instructions. Review what did or didn’t work)
   (Non-verbal- ?)

6. Provide some written case scenarios on examples of the impact of bipolar siblings. Review information and ideas about rage response. What would they want others to do if they were in each others shoes? Invite siblings to discuss how they respond when this occurs. What would help them more? Who would be involved in that, are there ways in which they could get those needs met? Verbal communication skills. (List on easel.)

7. Inform parents that there was a verbal communication worksheet and the purpose.

**OUTLINE – SESSION #8**

**REVIEW, GROUP WRAP-UP & PARTY**

**MOOD MATTERS GROUP**

1. Tool Kit Assembly – allow participants to choose the relaxation cards that best suit them.


3. Points and rewards.


5. Party – snack and make cookies.
OUTLINE – SESSION #8

PARENT GROUP
MOOD MATTERS GROUP

1. Review Lets Talk Exercise.
2. Discuss any routines that are working/not working with their child. Suggestions or ideas to improve on these skills.
3. Are there tools their children/youth are using that are different than before/tool kit?
4. Issues with food intake. Ideas for lower carbohydrates and high energy snacks, etc.
5. School issues, supports, IPRC process, School website (SEAC).
6. Were goals realistic? Have parents complete the questionnaire.
7. Share phone numbers/emails.
Appendix 2

**Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS)**

The WASH-U-KSADS (Geller, Williams, Zimerman, & Frazier, 1996) was modified from the K-SADS-1986 to include items specific to prepubertal mania and rapid cycling, attention-deficit hyperactivity disorder (ADHD) and all other DSM-IV diagnoses, and items for the onset and offset of each symptom and syndrome for both current and lifetime diagnoses. The WASH-U-KSADS, continues to be administered to mothers about their children/youth and to children/youth / adolescents about themselves by highly trained clinicians (Geller, Warner, Williams & Zimerman, 1998).

**Conners’ Parent Rating Scale – Revised (L)**

The Conners’ Parent Rating Scale – Revised (Conners, 1997) has been widely used in children/youth’s mental health clinical and research endeavours over the past thirty years (Gianarris, et al., 2001). A Canadian and U.S. based norming sample allows parent and teacher ratings to reliably depict their view of a child’s behaviour across settings. The subscales found on the Conners’ Parent include: Oppositional, Cognitive Problems/Inattention; Hyperactivity; Anxious/Shy; Perfectionism; Social Problems; Psychosomatic; ADHD Index; Restless/Impulsiveness; Emotional Lability; Conners’ Global Index total; DSM-IV: Inattentive; DSM-IV: Hyperactive-Impulsive; DSM-IV: Total.

**Conners’ Teacher Rating Scale – Revised (L)**

The Conners’ Teacher Rating Scale – Revised (Conners, 1997) is a rating scale completed by the child’s teacher which includes scales Oppositional, Cognitive Problems/Inattention; Hyperactivity; Anxious/Shy; Perfectionism; Social Problems; ADHD Index; Restless/Impulsiveness; Emotional Lability; Conners’ Global Index Total; DSM-IV: Inattentive; DSM-IV: Hyperactive-Impulsive; DSM-IV: Total for Conduct Problems, Hyperactivity and Inattention. It is used to characterize the Behaviours of a child and compare them to levels of appropriate normative groups.

**Parenting Stress Index – Short Form (PSI/SF)**

The PSI: S (Abidin, 1995) is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children/youth, children/youth with behavioural and emotional problems, and parents who are at-risk for dysfunctional parenting. In the development of the PSI, it was posited that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations which are directly related to the role of being a parent. This measure consists of 36 items derived from the full length PSI and contains three scales: Parental Distress, Difficult Child Characteristics, and Dysfunctional Parent-Child Interaction.
Hassles and Uplifts Scales (HSUP)

The HSUP (Lazarus & Folkman, 2005) measures attitudes about daily situations defined as "hassles". The HSUP provides a way of evaluating positive and negative events that occur in a person's daily life. The Daily Hassles Scale consists of 117 items that measure the frequency and severity of a parent/caregiver(s) stress with day-to-day life events (ex. work, household responsibilities, future security, time pressures, health, inner concerns, financial responsibilities and neighborhood/environmental). The current study only made use of the hassles portion of this questionnaire.

Swanson, Nolan and Pelham (SNAP-IV-C) Rating Scale

The SNAP-IV Rating Scale (Swanson, 2003) is a 90-item measure. Its subscales consist of DSM-IV criteria for Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder and items from the Conners’ Index Questionnaire. The SNAP-IV is based on a 0 to 3 rating scale.

Child Behaviour Checklist (CBCL ages 6-18) & Teacher Report Form (TRF ages 6-18)

The CBCL (Achenbach, 2001) and the TRF (Achenbach, 2001) are checklists of behavioural and emotional problems. Parents/care-givers were asked to respond to each item as not true, sometimes true, or very true as it pertains to the child during the past 2 months. Responses yield a narrow-band and two broad-band scores: The Internalizing broad-band scale consists of the Anxious + Social Withdrawal subscales, and the Externalizing broad-band scale consists of the Inattentive + Aggressive + Delinquent subscales.

Parent-Child Relationship Inventory

This unique self-report inventory tells you how parents view the task of parenting and how they feel about their children/youth. Designed for use with mothers or fathers of 3- to 15-year-old children/youth, the PCRI gives a clear, quantified description of the parent-child relationship as well as identifies specific areas in which problems may occur. The PCRI includes 78 items covering seven distinct scales: Parental Support, Satisfaction With Parenting, Involvement, Communication, Limit Setting, Autonomy and Role Orientation. In addition, two validity scales alert you to the possibility that the parent is responding inconsistently or portraying the parent-child relationship in an unrealistically positive light. Because many fathers now take an active role in parenting, PCRI items are appropriate for either parent—and separate norms are provided for mothers and fathers. Given its specific focus on parenting attitudes, the PCRI is highly useful in child custody evaluation, family therapy, parent training, and child abuse assessment (Gerard, 1994).

Parent Young Mania Rating Scale (P-YMRS)

The P-YMRS (Gracious, Youngstrom, Findling & Calabrese 2002) consists of eleven questions that parents are asked about their child's present state. The original rating scale (Young Mania Rating Scale) was developed to assess severity of symptoms in adults hospitalized for mania. It has been revised in an effort to help clinicians determine when children/youth should be referred for further evaluation by a mental health professional.
health professional (such as a child psychiatrist), and also to help assess whether a child's symptoms are responding to treatment. The scale is NOT intended to diagnose bipolar disorder in children/youth. The child's total score is determined by adding up the highest number circled on each question. Scores range from 0-60. Even a high score is unlikely to indicate a Bipolar diagnosis. The P-YMRS is similar to the screening test for prostate cancer, where it will identify most cases of Bipolar, but with an extremely high false positive rate (Parent Version of the P-YMRS).

**The Brief Child and Family Phone Interview (BCFPI)**

The BCFPI (Cunningham, Pettingill, Boyle, 2004) provides a measure of the type and severity of children/youth’s problems. The BCFPI is a standardized interview consisting of 81 forced-choice questions. It is the mandated intake measure used by all Children’s Mental Health Centres in the Province of Ontario. This consists of subscales measuring the following areas: Regulation of Attention/Impulsivity/Activity; Cooperativeness; Conduct; Externalizing; Separation from Parents; Managing Anxiety and Mood; Internalizing; Social Participation; Quality of Relationships; Social Participation and Achievement; Global Functioning and Global Family Situation; Family Activities; and Family Comfort.

**The Child & Adolescent Functional Assessment Scale (CAFAS)**

The CAFAS (Hodges, 2000) is a multidimensional rating of level of functioning, originally developed to use in the large Fort Bragg Evaluation Project of children/youth’s mental health treatments. It was created to replace the standard use of DSM Axis V ratings or other unidimensional global assessments of functioning which have shown questionable reliability (Bates, 2001). This consists of subscales measuring functional impairment in eight domains: School/Work, Home, Community, Behaviour Toward Others, Moods and Emotions, Self-Harm, Substance Abuse, and Thinking. Each is rated in ten-point increments on a scale from 0 (no impairment) to 30 (severe impairment), the total score used here is the eight-subscale total, with a range of 0-240.

**Satisfaction Questionnaire (families who received treatment)**

A 5-point Likert scale of 8 items focusing on satisfaction with CPRI services within the clinics. Additionally, there were open-ended questions addressing strengths and weaknesses of the service delivery.
## Appendix 3

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<thead>
<tr>
<th>TI Pre-Service</th>
<th>T2 Post-Service</th>
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<td>Parenting Stress Inventory</td>
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<tr>
<td>Child Behaviour Checklist (ages 6-18)</td>
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</tr>
<tr>
<td>Brief Child and Family Phone Interview (BCFPI)</td>
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<tr>
<td>Parent-Child Relationship Inventory</td>
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<td>Child and Adolescent Functional Assessment Scale (CAFAS)</td>
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<td>Satisfaction Questionnaire</td>
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<td>(Treatment only families)</td>
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References


 Append 3  
Telephone Script  
Hello, this is _____ calling from CPRI in London  
How are you today?  

At this time we are conducting a follow-up evaluation of our Bipolar Clinic services. We are interested in understanding how your family found the services at CPRI and would like to find out how (child’s name) is doing. In order to do this, we are asking that you complete several questionnaires. Have you received the package that CPRI mailed out to your family a few weeks ago in regards to (child’s name) assessment/treatment at CPRI?  

1. **NO** – would it be ok of I had you complete these questionnaires over the phone with me now? It will only take about half an hour of your time and any information we can collect is greatly appreciated. **IF NO** – would there be a better time I could call you back to complete these questionnaires?  

2. **IF YES** – We are hoping you may have some time to complete these questionnaires and either mail them to us. However, if this isn’t possible, would you be willing to complete the questionnaires over the phone with me now? It will only take about half an hour of your time and any information we can collect is greatly appreciated. **IF NO TO BOTH** – is there a better time for someone to call and do the questionnaires with you over the phone?
Figures: Pre and Post Measures for Bipolar Assessment Clients

*Figure 1.* Child Behaviour Checklist Pre-Assessment vs. Post-Assessment

*Figure 2.* Brief Child and Family Phone Interview: Pre-Assessment vs. Post-Assessment

*Figure 3.* Child & Adolescent Functional Assessment Scale: Pre-Assessment vs. Post-Assessment

*Figure 4.* Young Mania Rating Scale: Pre-Assessment vs. Post-Assessment
Figure 1. Child Behaviour Checklist: Pre-Assessment vs. Post-Assessment

n=6

** p<.01
* p<.05
Figure 2. Brief Child and Family Phone Interview: Pre-Assessment vs. Post-Assessment

The graph shows the comparison of t-scores for various BCFPI subscales between Pre and Post assessments. The categories include:

- Regulation of Attention
- Regulation of Impulsivity & Activity
- Cooperativeness
- Conduct
- Externalizing
- Separation from Parents
- Managing Anxiety
- Managing Mood
- Internalizing
- 6 mood + 3 self-harm
- 6 mental health domains
- Social Participation
- Quality of Relationships
- School Participation
- Global Functioning
- Family Activities
- Family Comfort
- Global Family Situation

The data is presented for n=10 participants.
Figure 3. Child & Adolescent Functional Assessment Scale: Pre-Assessment vs. Post-Assessment

CAFAS Subscales

n=13

** p<.01
*  p<.05
Figure 4. Young Mania Rating Scale: Pre-Assessment vs. Post-Assessment

n=13
Figures: Pre and Post Measures for Bipolar Treatment Clients

*Figure 5.* Child Behaviour Checklist Pre-Treatment vs. Post-Treatment

*Figure 6.* Brief Child and Family Phone Interview: Pre-Treatment vs. Post-Treatment

*Figure 7.* Child & Adolescent Functional Assessment Scale: Pre-Treatment vs. Post-Treatment

*Figure 8.* Young Mania Rating Scale: Pre-Treatment vs. Post-Treatment

*Figure 9.* Parent-Child Relationship Inventory: Pre-Treatment vs. Post-Treatment

*Figure 10.* Satisfaction Questionnaire: Immediately Following Treatment vs. 6-Month Follow-up
Figure 5. Child Behaviour Checklist Pre-Treatment vs. Post-Treatment

CBCL subscales

PRE  POST

n=13

** p<.01
* p<.05
Figure 6. Brief Child and Family Phone Interview: Pre-Treatment vs. Post-Treatment

- **n=14**
- **p<.01**
- **p<.05**

BCFPI Subscales
Figure 7. Child & Adolescent Functional Assessment Scale: Pre-Treatment vs. Post-Treatment

n=22

** p<.01
* p<.05
Figure 8. Young Mania Rating Scale: Pre-Treatment vs. Post-Treatment

YMRS scales

n=10

** p<.01
* p<.05
Figure 9. Parent-Child Relationship Inventory: Pre-Treatment vs. Post-Treatment

n=10

** p<.01
* p<.05
Figure 10. Satisfaction Questionnaire: Immediately Following Treatment vs. 6-Month Follow-up

Satisfaction: At end of Bipolar Treatment VS. follow-up

<table>
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<tr>
<th>Satisfaction Questions</th>
<th>Immediately Aft. Treatment</th>
<th>6-Mo. Follow-up</th>
</tr>
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<tbody>
<tr>
<td>I felt comfortable speaking with CPRI staff</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Staff were respectful, helpful and supportive</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>I feel that I now have a better understanding of my child's needs</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>The major problems that led me to seek services were addressed</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>In an overall sense, I was satisfied with the services received</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>My confidence as a parent has improved</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>I would recommend the CPRI Bipolar Program to other families</td>
<td>1.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

n=15

** p<.01
* p<.05