Guidelines for practice at ROCK’s Walk-in Clinic:
Karen Young, M.S.W., R.S.W.
Director Windz Institute
May 2015

Walk-In Clinics:

The walk-in therapy clinic is a unique way of offering therapeutic conversation opportunities to people that is truly client centred as it is there for them to use when they choose, with no more required than to walk in. There is no pre-screening, intake or phone call needed, just show up! When service delivery occurs at a walk-in clinic, there are no missed appointments or cancellations. Clinics maximize staff time, are easy to find and access, and professionals are immediately available to clients. People can walk in with no appointment required and are seen for a single session of competency-based therapy at their chosen moment of need. Clients are provided with reassurance that immediate help will be available if needed in the future as they can re-access the walk-in clinic if needed in the future.

In summary the benefits a walk-in clinic offers are:

• quick & easy access to a therapy session without complex referral processes
• creates an accessible service for population groups that might not otherwise seek services
• diverts people away from hospital emergency rooms, reducing pressure on health care systems
• counseling with trained brief therapists/counselors
• an opportunity for a competency-focused therapeutic conversation
• may include an intake/referral function
• may often be a single session
• helps people with immediate concerns while keeping many people off waitlists
• can be accessed as needed over time
• efficient, effective service with good clinical outcomes
In 2001 Reach Out Centre for Kids opened the door to the second walk-in clinic in Ontario. By 2009, there were nine operating clinics in Ontario, and by 2014 this phenomena has grown to at least 36 clinics in the province! ROCK has consulted to many of these walk-in clinics to support organizations to re-vision their service delivery pathway.

**Summary of the evidence:**

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

It is important to influence change when it counts the most—at the start. The first meeting with the family is critical in engaging clients as primary agents of change, and in determining the need for further services. A 2001 review of the literature on single-session therapy reported “consistent evidence that planned short-term psychotherapies often as short as a single interview, generally appear to be as effective as time-unlimited psychotherapies…this seems to be true regardless of client characteristics [and] regardless of diagnosis or problem severity” (Bloom, 2001). Studies on change have consistently found that it occurs earlier rather than later in the treatment process (Duncan & Miller, 2000).

In 1999 Hampson and colleagues surveyed caregivers who attended a single session and found at 3 months post session that 88% of the clients reported the session was helpful and 96% were satisfied with the single session. In another study, Price (1994) found even after one year that 78% of the clients reported a single session was helpful. In 1999, Campbell administered three different standardized measures to 44 subjects prior to a
booked single session and then 6 weeks later. He found that SST is effective in significantly reducing problem severity and increasing coping across all family types. A 2006 study (Perkins) with clients that were 5-15 years of age was conducted at an outpatient child and adolescent mental-health clinic. The treatment group was provided with a single-session within two weeks of intake and the comparison group was wait-listed for six weeks after intake. The problems across both groups were the same including parent/child relationship problems and a range of mental health diagnoses. There was improvement in the severity of the problem in 74% of clients in the treatment group, and client satisfaction ratings averaged 95%. This study indicates that a single-session of therapy “is therapeutically effective in the treatment of children and adolescents with mental health problems” (pp. 225). In terms of durability of improvement, treatment effectiveness of the single-session was found at an 18-month follow-up (Perkins & Scarlett, 2008).

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

Ontario 2008-2009:

Research was undertaken in order to evaluate the effectiveness of the Reach Out Centre for Kids (ROCK) walk-in clinic in 2008-2009 by Dr. Surbhi Bhanot-Malhotra and Karen Young (Young, 2011). The primary purpose of this research was to conduct an outcomes-based program evaluation of ROCK’s walk-in clinic. In particular, the effectiveness of the walk-in clinic was assessed by determining the extent to which walk-in sessions were producing the desired goals/outcomes.

Procedure:
Clients attending the walk-in clinic were asked to complete a series of general questions prior to seeing the therapist. A pre-test questionnaire was added to these questions.
Clients subsequently proceeded to their walk-in session. Upon completion of this session, the therapist asked clients to complete a post-test questionnaire. This post-test questionnaire was similar to the pre-test questionnaire except that clients were informed of the two-month follow-up and asked if they would participate in this.

**Results:**

*Does the walk-in clinic produce the desired outcomes for clients?*

The results suggested that a walk-in session produces a number of desired outcomes in clients. In particular, the results of the paired-samples t test indicated that clients were significantly: 1) less worried post-session, 2) more competent about their skills as a parent post-session, 3) more confident in their ability to resolve/manage the problem post-session, 4) more knowledgeable about available resources post-session, and 5) had more ideas about how to resolve/manage their mental health problem post-session.

*What do clients learn during a walk-in session?*

The themes from the data were: 1) increased self-awareness (e.g., “I learned that I have a lot of tension from the past and that it will be dealt with very soon”), 2) awareness of the impact of the problem, 3) increased awareness of resources, 4) more general knowledge about the nature of problem, 5) knowledge of general strategies to help deal with the problem, 6) knowledge of specific techniques to manage mental health issue, 7) better communication skills, and 8) knowledge that children were willing to get help.

*Are these outcomes maintained at 2 months?*

Some of the desired outcomes were maintained for those 74 clients for whom the problem was still a concern. Clients were still: 1) significantly less worried 2 months post walk-in session, 2) more knowledgeable about resources 2 month post session ,and 3) had more ideas about how to resolve and/or manage the problem 2 months post session. Clients’ responses suggest that they use fewer negative coping strategies and more positive coping strategies at 2 months post-test.

Since 26 clients reported that the problem was no longer a concern for them at the two-month follow-up, the post-test questions were modified somewhat to increase their applicability. In this case clients were asked to specify the extent to which the walk-in
session helped to reduce or increase various outcomes. The findings suggested that the walk-in session had a significant and positive impact on a number of outcomes.

Multi-agency Brief Services Evaluation 2014:
With funding from the Ontario Centre of Excellence, Reach Out Centre for Kids and the Hincks Dellcrest Centre, worked together with 5 partner organizations to design the very first in Ontario comprehensive look at the effects of brief therapy/walk-in therapy for clients. ROCK provided the lead project management for this evaluation. The evaluation partnership spanned multiple organizations, multiple ways to deliver brief services, and multiple therapeutic approaches for brief therapy, across a client age-range from 0 to 24 years.

This evaluation examined outcomes from a sample of Ontario's brief service delivery mechanisms: walk-in clinics at Reach Out Centre for Kids, the collaboratively run What's Up Clinic based in Toronto (East Metro, Oolagen, Yorktown, and Hincks-Dellcrest), Point in Time brief services in Haliburton, and Youth Services Bureau walk-in clinic in Ottawa. All serve children and youth 0-18 (some to age 24) and their families.

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

The methodology included a pre-test immediately prior to the brief therapy session, a post-test immediately after the session, and then a three-month post-test. The surveys used include one designed by the research team, one previously designed and published questionnaire, and one standardized measure that has been widely used.

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

Findings:
We have results for 494 clients (191 youth, 303 caregivers)
352 clients completed both pre-session and post-session measures
The most common reason for clients coming to the walk in clinic were Anxiety (22.1% of clients), Other Problems (23% of clients), General Behavioral Issues (13.7%) and Family Conflict (8%).

Analysis:
Overall, results suggest that clients’ experience a number of positive outcomes as a result of participating in brief services.
• Biggest areas of improvement were: clients’ awareness of their own skills, ideas about how to solve the problem/issue and awareness of community resources
• The majority of clients (about 80%) reported having “aha moments/realizations from the session
• The average 3-month post-session scores were higher than the pre-session scores for every outcome that was measured.
• 86% of clients reported that they had used ideas стрategies from the session.
• Clients reported improvements in coping
• The results of our 3 month follow up suggest that clients perceive that the problem is less severe/less frequent and that they have more control over the problem
• The findings of our evaluation further suggest that strong therapeutic alliance is possible during brief services

Informing practice:

The literature on single session and walk-in therapy identifies the common factors to successful implementation as: utilization of client/system resources, attending to client
motivation, focusing on client motivation, focusing on client wants, linking hope with expectations for improvement from the therapeutic process, and seeking continuous feedback from the client regarding fit between the procedures used by the therapist and the client’s own ideas about what will work (Slive, NeElheran & Lawson, 2008). The literature strongly supports ongoing, specific training and consultation for clinicians working with single session and walk-in models, and mostly supports models that minimally pair therapists or employ teams working along with clinicians behind two-way mirrors (Duvall, Young, Kays-Burden; Young, 2008; Slive, NeElheran, & Lawson, 2008; Slive, MacLaurin, Oakander & Amundson, 1995).

*Best practices at walk-in clinic* are described as: an orientation to the notion the clients can solve their problems, and that all client have resources that can be directed toward new possibilities. The job of the therapist is to facilitate the conversation in such a way that resources that could be utilized are *mutually discovered*. It is important that the overarching approach is one that is “competency-focused”, where the therapist listens for and highlights client’s knowledge, strengths, and abilities whether the particular model is Solution-Focused, Narrative, or an overarching Competency-based practice (Duvall, Young, Kays-Burden, 2013; Slive, et al 2008). The literature of course supports that risk of harm to self/and/or others is always addressed and action is taken by the therapist if indicated. Therapists must be capable of identifying serious mental health issues and to know how to connect the client to the appropriate level of service (Harper-Jacques, McElheran, Slive, & Leahey, 2008).

Brief therapy is collaborative, highly respectful and taps into client preferences, skills and abilities. As a result of working this way, people tend to require a briefer amount of involvement and are more prone to embrace their own resources. They become the primary agents of change, which results in better clinical outcomes (Duvall & Beres, 2011). A brief therapy approach is not about providing traditional services faster, but about providing services differently, which results in a briefer duration of involvement. It is not rush therapy, but adopts a different set of assumptions, principles and practices about how people change (Duvall, Young, Kays-Burden, 2013).
To implement brief therapy effectively we need to significantly shift the way we view the children, youth and families who come to us for help. In much of current practice, the professional is positioned hierarchically as the expert in the therapeutic process and seldom are children, youth and families regarded as the principal agents of change (Bohart & Tallman, 1999; Bohart & Tallman, 1996). Yet research shows that expert professional knowledge, treatment modalities and assessment protocols contribute a mere 15% effect toward positive therapeutic outcome. Clearly, it is the client, and what the client brings to the process, that is the most potent contributor to outcome in psychotherapy. “...it is the ‘engine’ that makes therapy work” (Bohart & Tallman, 1999; Bohart & Tallman, 1996).

Studies have shown that engaging with families through genuine collaboration, listening to and consulting them about what services they want and how they want them delivered, results in greater participation in the therapeutic process and better outcomes (Orlinsky, Grawe & Parks, 1994; Clemente et al., 2006; Lambert & Bergin, 1994). “As therapists have depended more on client’s resources, more change seems to occur” (Bergin & Garfield, 1994). The brief therapy philosophy embraces engagement. Clinicians partner with their clients in every way possible, including using collaborative documentation, where case notes are completed with the clients during the therapeutic session and include the client’s perspective.

Working briefly requires a philosophy that assumes a relationship of co-responsibility with the children, youth and families served, rather than a dependent relationship, in which long-term service provision is viewed as an indication of engagement and success (Duvall, Young & Kays-Burden). Practice must be transformed to reflect the philosophy that clients are capable and have the strengths and resources necessary to solve their problems (Watzlawick, 1987). Numerous studies (Salovey et al., 2000; Taylor et al., 2000) illustrate the advantage of focusing on clients’ abilities and strengths (Franklin, Moore, Hopson, 2008; Franklin, Streeter, Kim, Tripodi, 2007).
The policy-ready paper *Access and Wait Times in Child and Youth Mental Health: A Background Paper* (2010) raises the issue of waiting times for assessments versus waiting for appropriate interventions. The authors state that, “although families benefit from diagnostic clarity, they are also in need of active interventional help for their children and youth” (p. 17).

The evidence indicates that there is minimal correlation between deficit-focused protocols and predictors of positive change (Orlinsky, Runnestad, & Willutzki, 2004). When people first approach organizations for help, they are not at their best and may be at their worst. This is not a realistic time to implement a deficit-focused intake protocol that may well obtain a distorted representation of the child, youth and family, and at worst exacerbate the situation leaving them to experience further blame and shame (Duvall, Young & Kays-Burden).

There is a need to shift our philosophy from a focus on problems to a focus on strengths, and to adopt the use of strengths-based assessments (Franklin et al, 2012). A brief therapy philosophy shifts the focus of every visit to a *therapeutic encounter* and places uncompromised priority on a competency-based approach.

**Guidelines for Practices at walk-in:**

*Arrival, Questionnaires, and Pre-session:*

When people arrive at the walk-in clinic a receptionist greets them. The receptionist’s job is to welcome them and provide information about the process that will be happening at the clinic. She/he provides them with questionnaires that are designed in ways that reflect important brief competency-based therapy concepts. These pre-session questionnaires set the stage for conversations where the counselor strives to understand the problem and to find hope, new ideas and knowledge about how to proceed. The questionnaires help people to shift into paying attention to their abilities, skills and accomplishments even before the session begins. This will provide important initial information for the counsellor that will assist in preparing for the session. The multiple
focus that includes both why the client is here and what more there is to know about them reassures clients that they will be respected and seen as people who both have competencies and have a current problem or struggle that they are here to talk about (Young, Dick, Herring & Lee, 2008).

After the questionnaires are completed the receptionist brings them to the clinic manager, who takes the file to an available counselor who then sees the person/family for a session. It is useful for the counselor to take time ahead of the session to notice important information about the concerns and the strengths and competencies of the client reflected on the questionnaire. Supervisors should meet briefly with the counselor(s) prior to the session to assist in preparing for the session with this competency-lens. The supervisor and/or the counselor will need to have skills to look at the questionnaire with ‘eyes’ for both the problem story and the other stories that reflect the knowledge and skills of the client(s).

On occasions where it is not possible to provide clients with a session due to volume and unavailability of counselors, the receptionist will consult with the clinic manager and plans will be made to support the client (e.g. contacting crisis counselor if needed, booking an appointment for them at the next clinic, providing questionnaires to complete in advance).

The Session:
Given the challenges of achieving and maintaining a competency-focus in the session, it is very useful to have at least two counselors; one can be more ‘in the lead’ of the session, while the other can focus on offering reflections that highlight knowledge, skills and possibilities. This could follow an Outsider Witnessing tradition as in narrative therapy (White, 2007). The pair might be a therapist or counselor paired with an intern or student. A best practice is for the counselor(s) to take a break and consult with a supervisor, colleague or a small team part way through the session (Slive & Bobele, 2011). This is a useful practice that helps to maintain a focused session, and is particularly important for times when counselors working in the session alone.
Sessions usually last between one hour and up to one and one half hours maximum. The most common therapeutic approaches utilized at walk-in clinics across Ontario are narrative therapy and solution-focused brief therapy (Duvall, Young, Kays-Burden, 2013) due to the uncompromising competency-lens of these approaches. The overarching practice ‘attitude’ for any counselor working at the walk-in clinic is guided by a collaborative, competency-based, or strength-focused way of engaging with people. The focus is to provide a conversation that is useful and meaningful—an experience that is more than just gathering information, intake practices, or triaging. Clients should expect more than a ‘checklist’ oriented meeting, more than just a lens of assessment and then placement ‘in line’ for help down the road. The session should provide a therapeutic encounter (Duvall, Young, Kays-Burden, 2013).

Overarching attitudinal stance or posture of the walk-in counselor:

It is important to reflect on and identify the therapeutic posture that we occupy in a brief competency-based therapy, as this guides and creates the foundation for our actions throughout our engagement with clients in brief services. You might think of this as an “attitudinal stance” (Pare, 2014, p. 101) or your intentional, deliberate use of self throughout the process and approach.

Key aspects of therapist posture in a brief competency-based approach include:

- Respect
- Seeing problems and people as separate
- Collaboration
- Transparency
- Guiding
- Listening for values, commitments and preferences
- Listening for skills and abilities
- A competency-focused curiosity
- Not knowing yet/non-expert stance
- Keeping the pace slow

(Duvall & Beres, 2011; Freedman & Combs, 1996; Slive & Bobele, 2011; White, 2007; Young, 2008, 2011)
Documentation practices:
Transparency and collaboration is maintained throughout the session from the beginning explanations and information about the process, to the concurrent and open in-session note taking. The counselor takes notes during the session in an open and transparent way onto a summary report form that is photocopied and given to the client at the end.

It is useful to create documents during every session. This sides with transparency and collaboration, and is often very engaging of people, especially children. These notes, lists, quotes, statements, drawings, diagrams and so on are sent home with people so these documents are available to them between meetings. This assists with “stickability” of what was talked about in the meeting (Duvall & Young, 2009).

A Guideline for Session Structure:

1) **Pre-session preparation**: a brief discussion to focus on possible strengths that are apparent on the questionnaire, to consider possible questions, and to speculate on the focus for the session.

2) **Beginning the Session**: Explain the process, forms, consents, risks and benefits to the clients. Explain everyone’s role: for example, the lead therapist, the intern or student who may offer competency-focused reflections and may assist with documentation, or may share the lead in the session. Explanation of the session break part way through. Explanation of Outsider Witnessing if using this.

3) **Setting the agenda**: Find out what the client(s) wants to focus on for this conversation today.

   We might start with something like: “I am prepared to work hard with you for the next hour or so in relation to what it is that brought you here. What should we focus on in our conversation so that you leave feeling it was useful?” Whatever words the therapist uses to set the agenda should convey messages of
collaboration, respect for what they want to talk about, the importance of having a focus, and especially that they can leave with something useful today.

4) **Discover Strengths:** Explore strengths, skills, abilities, knowledge, values, commitments, and preferences. Get to know the person away from the problem.

5) **Exploring the problem:** Develop an understanding of what this problem is like for this client, and how they understand it. Ask questions that create novel understandings of the problem (Siegel, 2011) that expand or shift the client’s understanding of the problem. Practices such as “externalizing problems” are highly effective in brief therapies (Combs & Freedman, 2012; White, 2007, Young, 2011).

6) **Develop details of knowledge/skill/values and preferences:** Explore the actions/initiatives/responses the clients have taken to try to reduce the problem, and their skills/strengths/abilities they drew on to do this. Work hard to get the details of their competencies and how these can be useful in relation to the problem or concern.
   Explore the preferences the client has for their life/relationship and why and how they want to move toward these, and any ways that they already do this. Stay away from trying to talk the client into change. Instead elicit from them their reasons for change.

7) **Review and expand what was useful:** Discuss what stood out from the conversation and why this stood out to them. Generate this together (this is collaborative, it is not simply the counsellor giving advice or teaching).

8) **Co-develop next steps:** Explore how any new ideas or understandings might help, and specifically how to use these new understandings or ideas. This
conversation should be collaborative, and generative—together with the client planning for any next steps. Discuss about how to keep the ideas/plans/next steps going; what supports are needed to do this?

9) **Wrap up:** Provide client with the summary report and any documents developed together in the session (lists, pictures). Give the client the evaluation to complete privately. The counsellor then finishes administrative/data base paper work and returns the file to admin.

**References:**


Bhanot, Livingstone, & Stalker, 2010; Walk-in Inventory, on the web


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