FROM WAITING LISTS TO WALK-IN: 
STORIES FROM A WALK-IN THERAPY CLINIC

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At Reach Out Centre for Kids (ROCK) we receive many requests from other agencies all over Ontario for information about the details of how we created and set up our walk-in therapy clinics. In response to this we have written this article that describes our concept of a walk-in clinic, the preparatory steps we took to open the clinics, details of the process and the paperwork, as well as a summary of the evaluations we receive back from clients who have attended our clinics. We describe the foundational philosophy and assumptions that inform the therapy conversations at the clinics and how these unifying beliefs connect our work but also create the possibility for a diversity of therapeutic practices. There are many ways of working present at our clinics: narrative, solution focused, and cognitive behavioral therapies to name a few. The stories included in this article are guided by these three different therapy approaches and “bring to life” the range of ways of working illustrating the possibilities for useful conversations with people who attend the clinic. Therefore further aims of this article are to show that when people “walk-in,” with some very minimal information gathered by brief questionnaires that a therapy session is both possible and useful, and that a range of therapy approaches can guide the therapy sessions.
Children’s mental health services in Ontario have long struggled with the problem of a lack of timely access to services for children and families. Research shows that approximately 1 in every 5 children in Ontario are in need of mental health services and many end up waiting on long lists before any help can begin (Offord Centre for Child Studies, 2008). By 2001, with population growth and demand for services growing, our agency\(^1\) developed an over two-year waiting list for family therapy services. There were times when intake was temporarily closed in an attempt to focus on assisting those waiting and to prevent wait lists from growing even longer.

A new Executive Director arrived in 2001 with a vision and commitment to implement a walk-in therapy clinic. Inspired by writings from Wood’s Homes in Calgary (Miller & Slive, 2004) and the Executive Director’s prior experience of beginning a walk-in service in northern Ontario, the management team began to shape what this clinic is today.

This article is our story of moving from waiting lists to walk-in. For over six years ROCK (Reach Out Centre for Kids) has opened the doors of our three walk-in clinic sites. Each site has one 8-hour day a week designated to walk-in thereby offering communities an opportunity for immediate access to a single session of therapy at times when they are most in need. In the early days of the clinic, a woman with three young children walked in. After completing a questionnaire she then asked our receptionist how many months it was going to be before someone would call. When it was explained that they would see a therapist now, she began to cry tears of relief, saying, “Someone is going to talk to me now and help me now?” This is why we created our walk-in clinics.

**STEPS FROM WAIT LISTS TO WALK-IN**

There were many steps to prepare for opening our walk-in clinics. First the vision: we wanted to create clinics in three small cities within our catchment area. The clinics would function as the “front door” to our services, eliminating the traditional telephone intake and instead inviting people to attend the clinics—no appointments, an actual walk-in. For those unable to come to our clinics, we would “walk-out” to people in their homes or other locations. Although people could use this service more than once, we believed that many people could benefit from a single session of therapy and that some would not need any further services. This would provide children and families with help when needed and reduce referrals into further services, thereby reducing waiting lists. Since a therapeutic single session intervention is our primary task at walk-in, information gathering and intake are secondary. Our main purpose is to have a conversation that results in some immediate assistance.

\(^1\)Then Children’s Assessment and Treatment Centre, becoming Halton Child and Youth Services in 2001 and Reach Out Centre for Kids in May 2007.
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We set the opening target date for the start of July 2001. Our next step began in January when the therapists were provided with readings (Friedman, 1994; Furman & Ahola, 1988; Miller & Slive, 2004; Rosenbaum, Hoyt, & Talmon, 1990; Walter & Peller, 1994; White, 1991, 1995) and training in brief, narrative, and solution focused therapies. This was of key importance in our preparation for opening the walk-in clinics. It created a required “shift in thinking” about therapy being possible in a single session and assisted the therapists to develop skill in single session therapy. The reading, discussion groups, and training were frequent and ongoing for six months prior to start-up of the clinics and have continued since with less frequency.

Over these six months therapists were encouraged to work hard and creatively with families they were currently seeing and try to complete the work by the end of May. Therapists needed to open one day a week of “space” in their workweek for the clinics and the agency needed to try to create more space for people who had been waiting to be served after June. This was very successful. In May 2001 therapists had a day a week “freed up” plus many spaces for new families.

In May of 2001 there were about 150 children and families waiting on lists for family therapy. Many had been waiting for up to two years. The next step was to invite these families to attend a scheduled single session of therapy to offer assistance and determine if more sessions were required. This was done in our three geographic sites over the month of June. A small percentage of the people waiting declined and indicated the problem had been resolved in other ways (unfortunately we did not keep information on the exact percentage, but it was certainly under 5%). About 20% who did attend found the single session sufficient and knowing that they could access the walk-in clinics at any time, decided to not pursue any further services. Our waiting lists were now shorter. Therapy was initiated with many of the people who had been waiting, again with a focus on keeping the therapy both effective and as brief as possible. We were now ready to open the walk-ins knowing that summer would be a time of less activity so therapists could keep focused on moving through the waiting list. By October there were no clients waiting for therapy services. This “no waiting list” situation did not continue for very long, but our waiting lists have continued to be significantly reduced since the implementation of the walk-in clinics.

STAFFING

In each geographic site there are a range of three to five staff working at the walk-in clinics each week. Some of the sites are consistently busier than others hence the range. The staff qualifications are a mix of masters level trained therapists, with some B.S.W.s, and a few Child and Youth/Social Service Worker certificate trained crisis staff. There is a supervisor available for consultation and a receptionist in each site trained in administration and “people” skills.
The receptionist’s vital role is to be welcoming and to treat each person as a host would a guest reassuring that, “you have come to the right place.” The receptionist is observant of what is happening in the waiting room, offering assistance with paperwork, information, or coffee. She sets the stage for optimism and hope. Our receptionist has said that she does this work because it provides her with “opportunities for acts of kindness.” A therapist at the clinic reported this story: “As the meeting I was participating in drew to a close, the person I was meeting with asked me to thank the woman who greeted her at reception. I heard that in the past the client had experienced a sense of being unwelcome when seeking out services for her family and that the way in which our receptionist had greeted her was so welcoming that she felt at ease and became hopeful that something good could happen here. In talking with our reception staff about this later, I heard that she sensed some nervousness on the part of this person and felt it would be helpful to go out into the waiting room, give her the forms directly and explain a bit about the process at the walk-in clinic. It is my sense that this initial interaction had a profound impact on the session that followed.”

**PROCESS AND PAPERWORK**

When people arrive at our clinics they are given an information letter and a questionnaire. We designed the questionnaires in ways that reflect important brief therapy concepts (see Appendix A for questionnaires). These pre-session questionnaires set the stage for conversations that strive to understand the problem and to find hope, new ideas, and knowledge about how to proceed. They help people to shift into paying attention to their abilities, skills, and accomplishments, and how to use these in relation to the current problem they are experiencing (Epston, 2003; Young, 2006).

Two of the questions in particular are shaped by the idea that these “abilities” stories are often only barely present but are meaningful and useful if brought forward. These questions were designed not to seek out “lists” but to find detailed and therefore more useful “stories.” For example, a question such as “What are your strengths?” will likely result in a list, whereas the question: “What would someone else come to admire and respect most about you if they had months or years to get to know you? It’s OK to guess,” will bring forward more specific detail. The question “Remember a problem that happened any time in your life that you resolved in such a way that left you feeling proud of yourself. What did you do that you felt proud of?” brings forward rich stories of people’s lives that otherwise would not have been told (Epston, 2003). Most people are quite willing to spend some time answering these and other questions on the questionnaire, which then provides some information to further explore in the session.

After the questionnaires are completed the receptionist brings them to an available therapist who then sees the person/family for a session that usually lasts about
one and one half hour. Therapists work on their own some of the time, but more often have a co-therapist or sometimes an outsider witness group (White, 2000).

During the session the therapist takes notes in an open and transparent way onto a Summary Report form that is photocopied and given to the family at the end (see Appendix B). People are given an evaluation form and asked to complete it in about one month’s time and then return it by mail so they have a chance to live with and experience the effects of the session (see Appendix C).

OUTCOMES/EVALUATION

For the past six years approximately 1000 families per year are seen at the walk-in clinics. About 11% use the clinics more than once (average over 4 years, 2004–7). Each year 45 to 50% of the people do not ask for or require referral into further services at the agency as they report the one session to have been sufficient to assist them. This has had major impact on our waiting lists, which have reduced from over two years to usually fluctuating between two and six months.

We have summarized information from the evaluation forms for over six years. We recognize that this information is only a beginning to gathering evaluation/outcome data. We are attempting to pursue support for researching the clinic’s outcomes. Overall, across all three sites, the walk-in was reported to be a very positive resource for families. A majority indicated the session assisted them with dealing with the problem. Also many parents/caregivers reported that a plan had been developed during the walk-in session and that they were carrying out the plan. The following summary of one year of evaluations provides a picture of how people experience the clinics.

By percentages that responded: (A) “somewhat,” and (B) “mostly, very much”

<table>
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<tr>
<th></th>
<th>A</th>
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<tbody>
<tr>
<td>Did the session assist you in dealing with the problem?</td>
<td>35%</td>
<td>49%</td>
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<tr>
<td>Did it help you to develop a plan to address the problem?</td>
<td>24%</td>
<td>63%</td>
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<tr>
<td>If so, are you carrying out the plan?</td>
<td>13%</td>
<td>78%</td>
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Almost all the evaluations indicated that they would return to the agency if needed. Specific comments indicated that people found the sessions were “informative, reassuring, gave hope, support, helped make the issues clear, provided new viewpoints, strategies and ways of thinking, positive outlook, and as giving them good direction.”

PHILOSOPHY AND ASSUMPTIONS

The therapists who work at the walk-in clinics bring many diverse backgrounds, training, and preferences for how to create therapeutic conversation. Therapists
are informed by narrative therapy, solution focused therapy, cognitive behavioral therapy, and a range of other ideas and practices. We have discovered through discussion in teams and small groups that we share many foundational philosophical ideas about people, problems, and how to be useful to those people who come to consult with us. The following points are a short list of some of these beliefs and assumptions that we generated in these discussions.

- People know when they need help
- It’s best to offer therapy when people are ready and asking for it rather than when wait lists allow for it
- Many people can benefit from a single session and may not need more
- Many people will use sporadic single sessions when they want help
- Many people will need referral in for more services
- Everyone is multi-storied, with many versions of problem and solution events
- When people come for therapy they are unable to resolve a current problem/dilemma because they are limited by their current knowledge and understandings of their situation
- People have knowledge, abilities, skills that can be discovered and developed in ways that can assist them to resolve current struggles

We strive to be respectful of people’s preferences and values for how to live their lives. We are interested in joining with people around their agenda and concerns in ways that step away from the usual conversations they have been having about the situation and create an unusual enough conversation that can bring forward new possibilities. It is important to find opportunities to assist people to question what they routinely think and do (White, 2007b). We are interested in asking questions that create the possibility for learning new ideas, knowledge, and skills. Our focus is on people’s strengths, on finding their resilience, generating hope, and facilitating learning.

We like to begin the meeting by saying something like: “We are ready to work hard with you for the next hour or so to help with the concerns that brought you here. Many people find that they benefit from one session here. If you do need more therapy we can provide that” (Rosenbaum, Hoyt, & Talmon, 1990). These words create optimism and hope that this conversation can make a difference.

**STORIES**

We would like to include some stories that illustrate the therapeutic conversations that are possible at the walk-in clinic. We are not suggesting that these therapy approaches are novel, but we are suggesting that immediate “engagement” in therapeutic conversations on a “walk-in” basis is novel. In “traditional” first sessions, the therapist would enter into sessions with an “information gathering” and “as-
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assessment” perspective, which not only would result in very different conversations, but also would likely have resulted in a referral into further therapy services at the agency in each situation. In walk-in sessions, we enter the sessions assuming that one session may be all that is necessary. Only one of these families was referred in for further therapy.

All the therapists at our walk-in clinic share the philosophy and assumptions outlined above. Within these ideas there are a range of practices that include narrative, cognitive behavioral, and solution focused therapies. We share these stories here, to attempt to “bring to life” the work we do at our walk-in clinic. The individuals in these stories and transcripts have given permission to include them in this article. Their names have been changed to maintain confidentiality.

Narrative Practice at the Walk-in Clinic

Our lives are shaped by stories (White & Epston, 1990). People develop and are influenced by dominant narratives in their lives, some of which are experienced as liberating while others can be constraining of broader meanings and of action. Often, when people attend therapy, they are under the strong influence of dominant stories that relate to the problem they are experiencing and the meaning about the world and themselves that has been developed around the problem. However, dominant stories that become constraining are not the total story, as people are living multi-storied lives (White, 2004). There are other stories, which have not yet been “detailed” or well developed that may be more inspiring and liberating for people. Therefore the role of therapy as described by White is to bring alternative or subordinate stories that are less constraining into a place of more prominence in a person’s life (Nicholson, 1995).

At the walk-in clinic I (KH) have found it helpful to utilize the concept of subordinate storyline development (White, 2005). Subordinate stories are found in thin traces, in the shadows of the dominant stories of people’s lives (White, 2005). That is, the stories are present but not well known and lack detail or richness. Within these storylines are the actions or initiatives that people have already taken, or considered taking, their responses to the struggles and dilemmas they are experiencing (White, 2005). The purpose of subordinate storyline development in therapeutic conversations is to aid in rich development of these stories, connecting the person to their skills and abilities and the values and beliefs that are reflected by them (White, 2005). This reconnection may assist people to better manage the challenges in their lives.

Gail, mother of two children ages 14 and 9 arrived at the walk-in clinic. In our meeting, I had the opportunity to talk with Gail about a very powerful dominant story in her life. I heard immediately from Gail that she came to the clinic because she “has no parenting skills.” This was clearly a powerful dominant discourse. She had been told many times that she did not have any parenting skills and in some ways she had come to believe this about herself. Gail did not experience
knowing what to do “in the moment” with her children. She could see that her children were struggling with the impact of trauma they had experienced, which included the death of an immediate family member and a history of significant verbal abuse from her partner.

During our conversation I strove to maintain a “narrative posture” and a position of post-structuralist curiosity (Young, 2006), which is described as a curiosity that is in search of people’s interpretations, meanings, and conscious purposes (White, 2007b). In paying attention to what is hidden within what is being said, and rendering meaningful the hopes and wishes that are implicit within the words, we can contribute to the development of new perspectives (White, 2000).

This position of post-structuralist curiosity allowed for the development of a conversation about ways in which Gail had been parenting that she was pleased about, specifically that she was listening to and trying to understand the meaning of her children’s actions instead of reacting to the actions themselves isolated from meaning. We then had a conversation about the values that are reflected in these parenting decisions such as a value for the health and well-being of her children, which is different from a focus on obedience, and value for connection, closeness, and understanding. By paying attention to these values informed choices, we were able to develop the subordinate storyline of Gail as a “thoughtful parent.” As we talked together about this “thoughtful parent” subordinate storyline, it is my sense that the dominant story Gail initially presented began to loosen its hold on her.

As Gail talked about her experiences it became clear that she had already taken many steps to educate herself about the challenges she was facing and to improve the situation she and her children were in. Some of these steps involved seeking out books to read to educate herself about abuse and its effects, speaking out to others about the abuse instead of being silent, making plans for ways to leave. It is my understanding that these were very difficult steps to take, which required a lot of courage. I asked Gail what she felt had guided her in making these changes. I heard from her that the changes she had made are related to her values and what she called her “path to enlightenment.” This “path to enlightenment” included being positive and forward thinking, such as seeking information, planning, and then taking steps that included coming to our walk-in.

One of the ways a subordinate storyline can be “thickened” is to trace the development of values, beliefs, and commitments throughout one’s life (White, 2007a). This concept informed the question, “Who in your life would not be surprised about the changes you have made for yourself and for your children?” Gail responded that her stepfather would know and that he had always been like a compass for her because he treated her and her mother with love and respect. Throughout her life she has referred back to her experiences with him as a reference point regarding how one is treated in a loving family relationship. “What would it be like for your stepfather to hear about the impact he has had on her life?” I then heard from Gail that on a past father’s day she wrote him a letter let-
ting him know and that this had been a very important step in the movement she has made in her life.

As our conversation continued, I heard about the many ways in which Gail was parenting her children with great skill. I believe that this conversation, which created space for the discovery of skills, commitments, and values that were already present in Gail’s life contributed to an increased sense of agency and hope for the future. She was experiencing a renewed energy, sense of her own abilities, and future possible initiatives. She wished to pursue a parent education group regarding effects of trauma for example. She expressed a confidence in being able to continue taking steps guided by “thoughtful parenting” and speculated on ways in which this style of parenting might show up in the day-to-day moments with her children. Gail indicated that she did not feel a need for any further therapy at that time and would come back to the clinic in the future if needed.

Solution Focused Therapy at the Walk-in Clinic

In solution focused therapy, the therapist engages in less talk about the problem, and attends more to developing ideas around a solution and discovering what solutions the client is already attempting. This is called solution building and was key in guiding the therapy session described below. It moved the conversation from a focus on the problem to a focus on building on exceptions. The task of the therapist is to find out what the client’s hopes are from the session, what would be different when this is achieved, and what they are already doing to contribute to this goal (Iveson, 2002).

In solution building, we look to the clients to be the experts and trust that they can know their own successes, strengths, and resources that have been used in the past to face these problems (Berg & De Jong, 1996). Keeping in mind the posture of “client as expert,” the therapist acts as a collaborative partner to help the persons explore their own successes and their meanings. By identifying the client’s perceptions of these meanings, we assist them to develop a sense of control and empowerment. They can then use this awareness to make differences and changes in their lives.

Courtney, age 13, Chloe, age 10, and their mother Sharon, attended a session at our walk-in clinic to seek help around the sisters getting along better. Chloe reported to me (JL) that her sister hates her and on the initial intake questionnaire wrote that she wanted to know “why my sister is always mean to me.” Chloe described how it is challenging to take space as the sisters share a bedroom. They both described how they feel that they are in each other’s way, and lots of negative interactions seem to happen. According to everyone, name-calling, bossiness, pointing out of flaws, and swearing are getting in the way of the sisters getting along. This creates resentment and anger between them. Anger shows itself through the girls taking each other’s things and destroying them or hiding them. The sisters describe that they fight “all the time,” and what they would like is “less fighting to happen” and “to get along better.”
In order to better understand their hopes, and assuming a posture that places the “client as expert,” I invited the clients to clarify their meanings (De Jong & Berg, 2001). In this case, Courtney and Chloe were invited to describe what “less fighting” and “getting along” looked like. Less fighting and getting along would happen when they were not annoying each other, have more to talk about, more opportunities to talk, and they started to be nice to each other.

We then moved on to exploring exceptions, working from the assumption that there were times when the problem was not happening or was happening less than they reported.

Therapist: So then, can you tell me about a time when you are able to get along, or when you are being nice to each other, even a little bit?

Chloe: Ummm . . . like this one time I went to my friend’s house for a birthday party, and Courtney was there too because she is friends with my friend’s sister. She like cut me a piece of cake. And we didn’t get into any fights that day.

Therapist: OK, so you were at a party and she cut you a piece of cake. What was it like for you to have her do that?

Chloe: It was really nice, and it sort of made me feel . . . like umm . . . she liked me that day, and I didn’t have to worry that she was going to be mean to me.

Therapist: So what was it about that experience that made you feel like you didn’t have to worry?

Chloe: Well, she didn’t say anything mean to me, like she always does, and she did something nice, like give me cake. She was nice, it made me feel happy that she was my sister.

Therapist: Wow! So what was it like to hear Chloe describe a time when things are different and she was happy you are her sister? (turned to Courtney)

Courtney: It felt good.

Therapist: What was good about it?

Courtney: It felt good . . . like we have more of a connection or something like that.

Therapist: So what helped you do that? What helped you do something different at the birthday party?

Courtney: Well . . . because she didn’t know anyone there, and I wanted her to have a good time.

Therapist: Hmmm . . . what you just said makes me wonder . . . what do you think this might say about how you would want your relationship with Chloe to be?

Courtney: That I’d like us to get along more, be friends, and I’d like to be a good big sister.

Therapist: To get along more, to be friends, be a good sister . . . (writing it down). What does “a good big sister” look like?
Courtney: Maybe she would look up to me as a big sister . . .
Therapist: What would make her look up to you?
Courtney: I don’t know.
Therapist: OK, tell me about times when you think she might look up to you now?
Courtney: Well . . . maybe the times when I am not acting all mad and I try to include her in stuff.
Therapist: What makes you do that?
Courtney: Well I want her to be able to come to me with stuff, and if I was mad all the time then she probably won’t do that.

As the sisters continued to explore how they wanted their relationship to be, they started to talk more about how it is sometimes like that now. They described times when they were able to do things together, went out with common friends, and times they have babysat together. What was surprising to each sister was that they both wanted to spend time with each other, and that they do currently enjoy some times together now. Bringing these exceptions to their attention presented future possibilities for the relationship to be more how they both wanted. Once they began to identify exceptions, the girls got better at it as we continued.

As Courtney and Chloe continued to uncover exceptions and talk about what helped them be able to spend time together, Chloe spontaneously made a suggestion about what they could do together. She suggested that they put together a social gathering that the sisters and common friends can enjoy. Both sisters were excited about the idea and wanted to pursue it. They began to explore more common things they both enjoyed doing, such as cooking, movies, and the desire to explore more outdoor activities. We continued to build on these ideas and they made plans about how to do some of these things.

When clients are given the opportunity to talk about what they are already doing “right,” it helps the clients see the possibility of a better future and feel encouraged as they have been able to do some of it already (De Jong & Insoo, 1998). This is solution building. With these strengths and past successes identified the client can then build upon them to make desired differences and changes happen (Berg & De Jong, 1996).

This story illustrates how client perceptions can shift during a solution focused conversation. The sister’s initial perception was that they were “always fighting.” Early in the session it took many respectful re-directs from problem talk to talking about strengths and exceptions to help them explore times when the problem was not happening. Once the clients were able to see their strengths and achievements they were able to expand on these. By the end of the session, Courtney and Chloe were sharing specific ideas on what they could do next. They were seeing themselves doing things differently in the future. They all wanted to come back for one more meeting some time in the future to check in on the progress regarding “getting along.”
Cognitive Behavior Therapy Influence at the Walk-in Clinic

Cognitive behavioral counselling theory provides a rationale, structure, and theory of change that is relevant to the intervention practices and goals of a walk-in therapy clinic. Essentially, cognitive counselling theory asserts that, ultimately, effective and lasting change is achieved through a fundamental shift in the cognitive pattern that characterizes emotional problems, whether addressed through cognitive or through behavioral change strategies (Fall, Holden, & Marquis, 2004; Greenberger & Padesky 1995; Kendall, 2000; Persons, Davidson, & Tompkins, 2001). Cognitive theorists, Beck and Weishaar, note that therapy clients “have many serious social, financial, or health problems as well as functional deficits. In addition to real problems, however, they have biased views of themselves, their situations, and their resources that limit their range of responses and prevent them from generating effective solutions” (Fall et al., 2004, p. 314). Cognitive behavior therapy aims to modify distorted belief systems that perpetuate unnecessarily distressing emotions and nonadaptive behavior, and build lasting cognitive and behavioral skills for navigating current and future distress. It helps to make sense of overwhelming problems by breaking them down into smaller parts and understanding the connections between thoughts, feelings, and actions (The Royal College of Psychiatrists, 2005). The therapist works from a collaborative stance that respects the client as the expert on her own experiences and utilizes a purposeful question-answer dialogue to support insight and skill development. While the long-term intention is to make enduring shifts in cognitive patterns and core beliefs, this process also has the potential to facilitate more immediate experiences of change, symptom relief, strategy development, and hopefulness.

The following is a description of a walk-in session within which a cognitive behavioral approach was used to assist Ava, a 16-year-old girl, move toward the goals she identified. Both Ava and her mother, Carol, attended the clinic due to struggles that Ava was having with anxiety. They reported to me (MD) that these difficulties started a few years earlier when Carol was diagnosed with a serious illness. However, more recently, the intensity and frequency of anxiety attacks seemed to be increasing. Of particular concern on the day of this session was the fact that Ava was preparing to leave for a weeklong trip to participate in a special university program for high school students. She reported feeling particularly anxious about this trip. The session goals as identified by Ava on the walk-in questionnaire were to “walk out with a minor solution to what [was] happening to her,” and to “find out what’s wrong.”

At first, conversation was focused on developing a detailed account of a recent anxiety attack. This provided a context within which to begin to explore and understand Ava’s actions and thoughts as related to her experience of overwhelming anxiety. Questions involving when, where, who was involved, and what led up to the situation, as well as mood rating questions helped to draw out the details. During this process, specific attention was given to noting how a good understanding of
this recent event could help us better understand Ava’s anxiety and give us clues about what to start working on to help accomplish her goals. It was important for Ava to feel that our conversation would assist her in moving toward her goals.

A continued question-answer dialogue helped to bring automatic and spontaneous thoughts into awareness, again providing us with clues for understanding Ava’s emotional experience and reactions. In addition to bringing spontaneous cognitions into awareness, the questions asked at this point in the conversation were constructed to help discover the personal meaning that this situation and the cognitions carried for Ava. For example, the first thoughts Ava identified were, “we have a quiz,” “I forgot my ruler and pencil.” From here questions regarding what she was worried would happen, what her worst fears were, and what this said about her, helped to draw out more information and a better understanding of how Ava’s cognitions were connected to her anxiety and her behavioral reactions. Through this process, Ava was able to articulate more emotionally charged thoughts and worries including, “mom will be disappointed, I upset mom, mom will get sick,” and “I will be alone.” The identification of these cognitions also enabled us to make a connection between Ava’s current emotional reactions and her past experience and reaction to her mother’s illness.

Through this conversation some attention was also given to noting Ava’s behavioral reactions and exploring how these were connected to her thoughts and feelings. Ava was able to acknowledge behaviors that involved protecting mom from negative emotion, pushing feelings down, and keeping her eyes open for what to expect. Given the time constraints of this single session we did not explore these behaviors in detail. However, an awareness of them allowed us to make connections between Ava’s reactions, past stress, and current thoughts and feelings, and to consider briefly the benefits and drawbacks of this coping behavior.

With this information the focus of conversation was turned to looking for evidence that might support or disconfirm the emotionally charged automatic thoughts that Ava had identified. To assist in this task, we were able to consult directly with Ava’s mother, and the feedback she gave helped determine the degree to which Ava’s thoughts might be realistic, or biased and unhelpful. Ava’s mother provided important additional information. For example, she clarified that she would feel disappointed with Ava at about a 1 out of 10, as opposed to the 10 out of 10 suggested by Ava.

This additional information allowed for an expanded view of the situation and helped us reconsider the accuracy of Ava’s automatic thoughts. In view of this information Ava was able to articulate more balanced ways of thinking that reflected both realistic concerns, as well as the new and less alarming information provided by her mother. After establishing that these new thoughts were in fact meaningful to Ava, attention was given to developing a plan to use these balanced thoughts to cope with the upcoming trip as well as future anxiety provoking situations. Following this Ava expressed interest in further therapy, and later she shared that her trip was successful.
SUMMARY

It is our hope that this article has provided the reader with clear understandings about the processes that lead up to the opening of the walk-in clinic at Reach Out Centre for Kids and the details of “how it looks.” It is exciting for us to share our enthusiasm and our belief in the usefulness and importance of offering people help when they need it. Our deep respect for a diversity of ways of working with people and our shared foundation of philosophy and assumptions that unites our ways of constructing conversations has created a rich environment in which to work. We hope that the stories included in the article have both illustrated this and provided the reader with a glimpse into the rich and useful conversations that are possible at a walk-in clinic.

REFERENCES

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APPENDIX A

WALK-IN THERAPY CLINIC
PARENT/GUARDIAN QUESTIONNAIRE

Initial questions gather data about names, addresses, and so on. Then the questions that follow are below. The forms have spaces for answers below each question.

1. What concerns have brought you here today?

2. If 10 is the best and 1 is the worst, how are things in your life today?
   Worst 1 2 3 4 5 6 7 8 9 10 Best

3. How does this concern affect:
   (a) you?
   (b) your children?
4. What would be important for us to know about the background of this concern?
5. What would be most helpful to talk about in this meeting today?
6. Remember a problem that happened any time in your life that you resolved in such a way that left you feeling proud of yourself. What did you do that you felt proud of?
7. (a) What would someone else come to admire and respect most about you if they had months or years to get to know you? It’s OK to guess.
7. (b) What would someone else come to admire and respect most about your child if they had months or years to get to know them? It’s OK to guess.

**WALK-IN THERAPY CLINIC**

**CHILD/YOUTH QUESTIONNAIRE**

After initial information is gathered the form proceeds with the following questions:

1. Why have you come today?
2. If 10 is the best and 1 is the worst, how are things in your life today?
   Worst 1 2 3 4 5 6 7 8 9 10 Best
3. What would be the best thing that could happen in this meeting today?
4. What is the one problem that seems most important to work on now?
5. What is it like when this problem is around?
6. What would someone else like and respect most about you if they had a lot of time to get to know you?

**APPENDIX B**

**WALK-IN CLINIC SUMMARY FORM**

The headings on the form are as follows:

1. Family Constellation
2. Present in the Session
3. What the Clients Want from Today’s Session
4. Relevant Current or Past Information
5. Issues Addressed in the Meeting
6. Next Steps and Recommendations
APPENDIX C

WALK-IN CLINIC EVALUATION FORM

The questions on the evaluation are as follows:

1. Did the session assist you in dealing with the problem(s)?
   Not at all  a little  somewhat  mostly  very much

2. Did it help you to develop a plan to address the problem(s)?
   Not at all  a little  somewhat  mostly  very much

3. If so, are you carrying out the plan?
   Not at all  a little  somewhat  mostly  very much

4. Was the session helpful in any other way? Yes ___ No ___ If yes, in what ways?

5. Was the service disappointing in any way? Yes ___ No ___ If yes, in what way?

6. How would you rate the situation today?
   Much worse  a little worse  no change  a little better  much better

7. Have you sought or will you be seeking further service for the difficulties that brought you to ROCK? Yes ___ No ___

8. If yes, will you come back to ROCK? Yes ___ No ___

9. Do you have any suggestions that would help us to improve the walk-in therapy clinic?