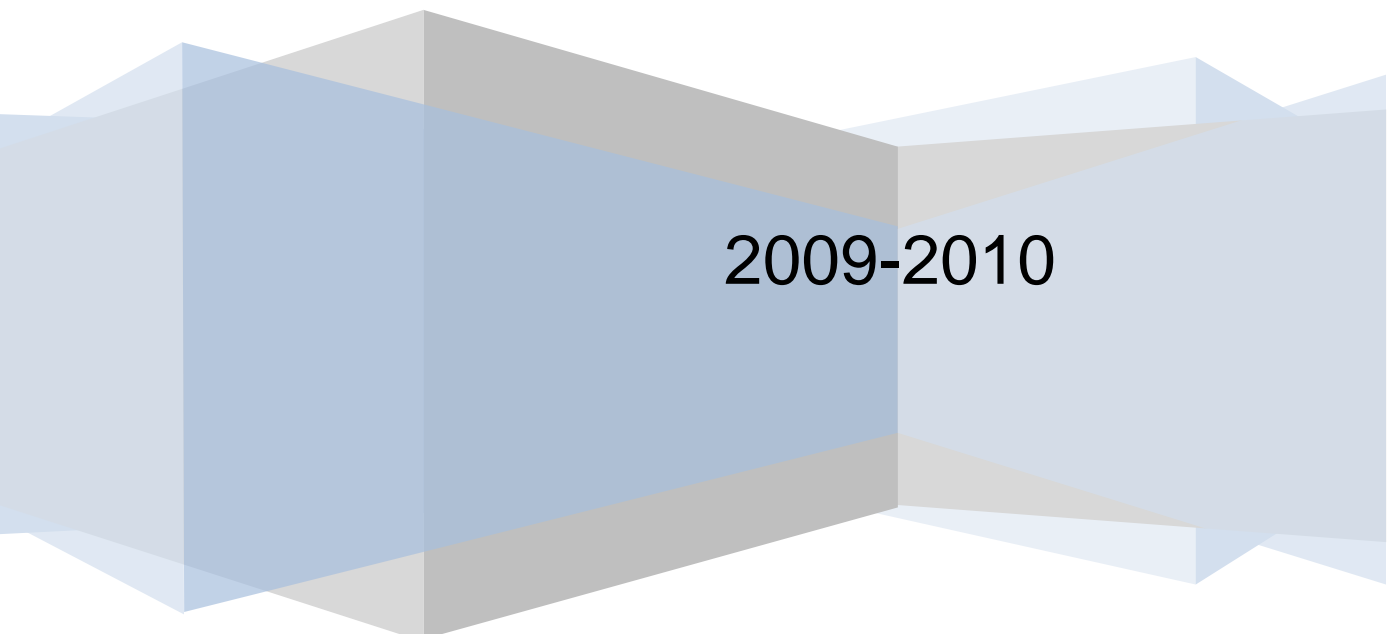


An Inventory of Walk-in Counselling Clinics in Ontario

Compiled by:

Surbhi Bhanot-Malhotra
Sharon Livingstone
Carol Stalker



2009-2010

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Introduction

Mental health services are currently in a state of crisis. The need for these services continues to grow while the funding levels are continually depleted. For example, it is estimated that 7,000 children and families were on waiting lists for children's mental health services in Ontario in 2008. According to Children's Mental Health Ontario (2008), this number has tripled in the last ten years.

These increasing service pressures coupled with the ineffectiveness of the current system have led service providers to develop innovative models of service delivery. One such model is the Walk-In Counselling Clinic. This model, much like the medical model of Walk-In Clinics, increases the accessibility of services. Clients are provided with immediate access to a single session of brief therapy during the hours of the clinic. Through these sessions, therapists help clients develop knowledge and skills, which will assist them in better managing and/or coping with their mental-health related problem.

Context

As of 2008, several mental health agencies throughout Ontario had developed Walk-In Counselling Clinics. However, at that point, there had been little dialogue between them. This changed through an informal meeting that took place in December of that year. Organized by members of Family Service Ontario, the following agencies were represented: Catholic Family Services of Hamilton-Wentworth, Catholic Family Services of Peel-Dufferin, kidsLINK/ Lutherwood Front Door (Kitchener), K-W Counselling Services (Kitchener), Reach Out Centre for Kids in Halton (ROCK), Haldimand-Norfolk Resource Education and Counselling Help (HN-REACH), Yorktown Child and Family Centre (Toronto), Hospital for Sick Children (Toronto), Thunder Bay Children's Centre and social work faculty from Wilfrid Laurier University.

From this meeting, decisions were made to pursue further research into best practices, the impact on clients and families, staff and students, and different approaches and processes around Walk-In Counselling Clinics. Those present agreed that a more formal meeting of agencies to share experiences and think about relevant research would be helpful. Karen Young invited everyone to a meeting at ROCK on April 1, 2009 for the Walk-In Counselling Clinic Symposium.

The organizations represented at the meeting on April 1st included Haldimand-Norfolk Resource Education and Counselling Help (REACH), K-W Counselling Services, Oolagen Community Services, Catholic Family Services Peel-Dufferin, Reach Out Centre for Kids (ROCK), Wilfrid Laurier University, KidsLINK/Lutherwood Front Door Kitchener, Windsor Regional Children's Centre, Hands the Family Help Network, Hospital for Sick Children, and Yorktown Child and Family Centre. Much information was shared throughout the day. Participants talked about the history behind their Walk-In Counselling Clinics, the structure of the clinics as well as the challenges that they had faced in developing and implementing this type of service. Those who had conducted research at their clinics also shared some of the preliminary findings from this research. As the day progressed, participants realized the benefits of this type of knowledge exchange. Scot Cooper (Haldimand-Norfolk) suggested that

it might be a good idea to summarize what was learned during the day in a collaborative document. He envisioned that the document could serve as a snapshot of what we know about Walk-In Counselling Clinics in Ontario – how they evolved, how they are run, and the ways in which they are effective. The group agreed that there was value in creating this type of document.

Purpose

The current document was created in response to and has evolved from the ideas generated at the April 1st Walk-In Counselling Clinic gathering. Its purpose is three fold. First, it is intended to be a resource for those who are interested in developing Walk-In Counselling Clinics at their own agencies. The document reviews Walk-In Counselling Clinics that provide services to a wide range of clients in a variety of settings. It provides the history behind these clinics, a description of the clinics and reviews the research that has been conducted. Since Walk-In Counselling Clinics are a relatively new and innovative method of service delivery, most individuals who developed these first clinics did so with little knowledge about what to expect. By creating this document, we hope to address this gap and provide readers with this type of information.

In addition, we hope that this document can serve as a resource for those advocating for funding for these clinics. Most, if not all, Walk-In Counselling Clinics are currently being operated without additional funding from the government. Staff members volunteer a substantial portion of their time to run these clinics so that clients can receive the care that they need in a timely manner. The research summarized in this document clearly suggests that Walk-In Counselling Clinic sessions can benefit clients in a number of ways. Perhaps this information can serve as the impetus for more resource investment into these clinics.

Finally, from a research standpoint, this document provides the reader with a synopsis of the research that has been conducted on these Ontario Walk-In Counselling Clinics to date. Given the dearth of literature in this area, this is a significant contribution. Much of the research summarized in this document is in its inception stages and is applied in nature. However, it does provide the reader with a snapshot of what has been done and where we need to go from here.

Organization of the Document

In the following pages, the descriptions of the walk-in counselling clinics and research are included as they were received from the agencies with some minor editing. At the end of the document, the editors have summarized the descriptions and noted the similarities and differences among them. The research reported by the agencies has also been summarized with significant findings noted, and some questions that could be addressed by future research identified.

Catholic Family Services (CFS) of Hamilton

Contact Information

447 Main St East, Suite 201
Hamilton, ON L8N 1K1
Phone: 905-527-3823
Fax: 905-546-5779
www.cfshw.com

Walk-In launched in 2004

History of the Walk-in Counselling Clinic

The Walk-In Counselling Clinic was established in 2004 as a response to barriers that clients were encountering when attempting to access counselling services. The identified barriers included limited service hours that restricted clients who needed appointments in the late afternoon or evening, as well as long wait lists for all clients, including those requiring immediate service. Staff had identified that clients had been waiting for services for up to a year.

Description of the Walk-In Counselling Clinic

Catholic Family Services (CFS) of Hamilton operates two Walk-In Counselling Clinics, which serve individuals, couples and families. The main clinic is held every Tuesday from 12:00 pm until 7:30 pm at the main office at 447 Main Street East. An additional clinic is held every Monday from 1:00 pm until 4:30 pm at a satellite location at Wesley Neighbourhood Centre, 93 Delena Avenue North.

The establishment of the clinic enables clients to immediately address their issues and work towards solving problems and dealing with concerns before they turned into a crisis. Appointments are not necessary – people drop in and are booked with the next available counsellor to discuss what type of support would be most beneficial. People can return to the clinic as often as they feel it is necessary. There are no restrictions to accessing counselling services through these clinics based on age, race, culture, gender, sexual orientation or religious affiliation, and clients are not turned away based on inability to pay for services.

The second clinic in the East End of the city opened in 2008 after CFS was approached by Wesley Urban Ministries – a well-known, well-established and well-respected community service provider who identified the lack of services in this area of the city.

By providing services on an immediate, drop-in basis, CFS Hamilton have seen an increase in the number of men accessing counselling services, as they do not have to book an appointment. Staff members also see families during the Walk-In Clinic's evening hours that may not otherwise access services, because they do not have to miss school or work to attend this form of counselling.

All of the counselling programs are confidential. Clients are asked to read and sign a Professional Disclosure Statement, which outlines the confidentiality policy and the instances when the counsellors must break confidentiality (i.e. a child is in need of protection, a disclosure that someone is planning to harm themselves or others, or a medical emergency).

The main funding source for this program is through the United Way of Burlington and Hamilton. To supplement this funding, there is a fee per session, which is based on a sliding scale (based on income and household composition). The minimum fee is five dollars, but people are not turned away based on inability to pay.

CFS Hamilton Walk-In Clinics strive to break down barriers to service for all individuals, couples and families regardless of faith or background who live in the greater Hamilton area. The clinics also serve people from outside of the Hamilton area (a fee for service applies). Culturally sensitive interpreting services can be arranged for clients who require counselling services in a language other than English or French.

Walk-In Specific Training

Clinical training in solution-focused and narrative therapies was offered to all counselling staff when the clinic was initially established. An expert in these therapeutic modalities performed the formal training and annual team-based, peer-lead refresher trainings are provided to all counselling staff involved with the clinics. The Family Counselling staff members service the clinics. A counsellor from the Domestic Violence program is available to assist in the main office clinic. All of the agency's placement students take part in the delivery of services for the main office Walk-In Counselling Clinic. The counsellors are trained professionals with a Masters degree in a counselling-related discipline; they utilize approaches including short-term, solution-focused therapy and narrative therapy.

Research

Not applicable

Catholic Family Services Peel-Dufferin

Contact Information

Main office: 10 Gillingham Drive, Suite 201, Brampton ON L6X 5A5
905-450-1608 x112 (central intake line)

Branch office: 10 Kingsbridge Garden Circle, Unit 400, Mississauga ON L5R 3K6
905- 450-1608 x112 (central intake line)

www.cfspd.com

Primary contact: Sharon Ramsay (sramsay@cfspd.com)

Walk-in launched June 2007

History of the Walk-In Counselling Clinic

Catholic Family Services Peel-Dufferin (CFS Peel-Dufferin) had noticed a 186% increase in the number of persons served through their individual, couple and family therapy program since 1996. The organization was also aware that the population of Peel was anticipated to increase by 27,000 people per year. With that kind of growth, they were not able to keep up, and waiting lists had grown in response. The clinic was established as a means of accomplishing two goals: improve access to quality therapy services to those who live and/or work in the Region of Peel and Dufferin County and reduce waitlists for individual, couple and family therapy services. In order to launch this idea, a proposal was sent to the Region of Peel in 2006 outlining the nature of the organization's services, CFS Peel-Dufferin's sense of the needs of the people in the region and an assessment of how the introduction of walk-in clinics could increase the accessibility of these services.

Description of the Walk-In Counselling Clinic

At the time of the walk-in application in 2005/2006, CFS Peel-Dufferin had served 4,715 men, women and children through their counselling programs; they projected that 1,875 individuals, couples and families would be served through the clinic in 2007-2008. The organization projected that the clinic would serve 2,500 people in 2008/2009. The client base is predominantly urban/suburban, with about 50% of clients reporting their religious affiliation to be other than Catholic. The ethno cultural base of the clients is varied. Most report English to be their mother tongue; however, CFS Peel-Dufferin has made it a priority to hire counsellors who come from the following communities: South Asian (Hindi, Urdu and Punjabi-speaking), Chinese (Mandarin and Cantonese-speaking), Polish, Spanish, Portuguese (currently decreasing demand) and French.

CFS Peel-Dufferin initially launched three sites for their walk-in clinics – Bolton, Brampton and Mississauga. However, due to the different ways in which clients from the north used the Bolton location, they decided to reduce the walk-in sites to two (Brampton and Mississauga) and expand the Bolton office to provide ongoing counselling. CFS Peel-Dufferin did not introduce walk-in services in their Orangeville site.

The walk-in clinics operate one day a week on Tuesdays (Mississauga) and Thursdays (Brampton) from 12:30-7:30pm. For times when the walk-in experiences a high level of demand, scheduled single-sessions are provided to clients throughout the week.

CFS Peel-Dufferin currently does not receive any funding from a government source that directly supports individual, couple family counselling services. The organization does receive funding from the United Way of Peel Region and Catholic Charities for these services. The proposal for the Walk-In Counselling Clinic initiative involved asking those current funders for the permission to divert some of the allocated money to walk-in. In addition, the organization asked the Ministry of Community and Social Services to allow them to redirect some of the Violence Against Women funds to the walk-in because they anticipated that clients who were survivors of intimate partner abuse and/or adult survivors of childhood abuse might seek immediate access to services through walk-in. The final appeal was to the Region of Peel directly, so that the organization could continue to provide this service without unduly impacting the ongoing counselling programs. Also included in the proposal to the Region of Peel was to provide onsite childcare in Mississauga and Brampton as one more way to increase the accessibility of this service to clients. CFS Peel-Dufferin received approval from everyone in time to launch the walk-in clinics in June of 2007.

One supervisor, a senior counsellor, core counselling staff, intake and reception staff and interns from the practicum-training program in couple and family therapy staff the walk-in clinics. It is expected that regular clients of the agency are not seen during walk-in hours; that day is referred to as "All hands on deck." Counsellors/interns ensure that their workday is clear of all other appointments so that the supervisor may assign clients as they move through the intake process. Clients are informed that they will fill out some initial paperwork and a survey and then have a brief conversation with the intake staff to ensure that the situation to be discussed is clear and to set and collect the fee. If there are children present who will not be attending the session, parents complete the childcare form that is given to the childcare provider. Clients then meet with a counsellor/intern for about 50 minutes after which the client completes the post-evaluation.

The clinicians work primarily from a solution-focused theoretical base, helping the client to not only identify what is currently working to limit the influence of the problem, but also to identify other resources that could provide additional support. When the identified issue is trauma-related, this lens comes into focus and the clinicians work towards securing the client's emotional and physical safety and ensuring that she/he is aware of the crisis, legal and transitional housing support that is also available in the region.

Walk-In Specific Training

CFS Peel-Dufferin has used in-house training to familiarize staff with the ideas and practices related to brief/solution-focused therapy through clinical meetings; staff members have also been sent to external trainings to further their knowledge. They have visited more established walk-in clinics in Burlington and Hamilton and consulted with those colleagues about their successes and innovations. The organization is now moving to a biyearly training format (Fall and Spring) to continually improve the use of solution-focused ideas and to provide a platform

to incorporate other aspects of clinical thinking into the walk-in clinics. Individual/dyadic supervision (live and through case consult) has also been an important training tool for intake staff, clinicians and interns.

Walk-In Specific Standardized Assessment

No

Research

Methods

In general, for evaluations, CFS Peel-Dufferin uses the State of Hope scales (Scot Cooper, 1996) pre-session and consumer satisfaction scales with Likert type ratings post-session. In 2007-8, University of Guelph PhD student, Linda Yuval, conducted an evaluation of Client's Experience of Hopefulness. Paired samples t-tests were conducted on the means of each of the six survey items at pre-test and post-test on a sample size ranging from 492 to 504 responses. All six items were significantly higher at post-test than at pre-test at the $p < .01$ significance level. The results of this analysis revealed that all aspects of Hopefulness significantly improved after clients completed their Walk-in session. This was true regardless of location (Brampton, Mississauga or Bolton) or whether the clients had received an individual, couple or family session.

Results/Tellings

The program outcome identified for 2008/2009 was: "In addition to offering immediate access to counselling services within one week, the waiting list for ongoing counselling will reduce from its current level that ranges from 14 weeks to 24 weeks to less than 14 weeks".

This program outcome of offering immediate access to counselling within one week was achieved when the Walk-in Counselling Clinics opened in June 2007. The impact on accessibility continues to be exceptional and throughout 2008 this outcome was maintained. During 2007, the length of wait times for ongoing counselling beyond the initial Walk-in session was dramatically reduced in both Brampton and Mississauga to one week for ongoing daytime sessions and four weeks for evening. However, during 2008 the wait times for ongoing services, particularly in the Brampton Office, gradually began to increase. Due to the continued population growth in Peel Region, the lack of corresponding funding increases and the ever-growing demand for counselling services, CFS Peel-Dufferin is unable to keep up. Currently the wait list times for ongoing services in Brampton are back to 14 weeks for daytime and 18 weeks for evening.

Learnings and Observations

Brampton and Mississauga Walk-in Counselling Clinics continue to be extremely successful. There is a positive impact on staff morale. The pace is fast during Walk-In, staff members are

kept busy and they experience this as a team endeavour. The Office Supervisor is on hand to offer immediate support and consultation. The Walk-in session is held, the file opened and closed and all required paperwork completed during the time that the clinic is open. This results in a sense of having everything tied up, which staff enjoy.

All new clients to the organization are streamed through Walk-in. If a family is unable to attend at the Walk-in times, they are offered what the agency calls a scheduled Walk-In Counselling session. In practice, the majority of clients are able to make themselves available for the clinic hours. This practice has created more efficiency for the use of scarce counsellor resources. Prior to Walk-In the rate of clients not showing for first sessions was approximately 20-25%. The streaming of all new clients through Walk-In has eliminated this costly waste of counsellor time.

Walk-In has been a useful training modality for student interns. They are able to observe and be observed during clinical sessions, participate in the documentation process in order to become familiar with the work in general and the practices and policies of CFS Peel-Dufferin.

CFS Peel-Dufferin continues to serve more men through the clinic than they ever have through traditional counselling programs. This allows for the organization to continue to review programs to ensure that they are responsive to the experience of men and allow CFS Peel-Dufferin to consider new service initiatives.

kidsLINK/Lutherwood Front Door

Contact Information

1770 King St. East Kitchener, ON N2G 2P1

www.lutherwood.ca

www.ares.com

519-749-2932 (phone)

519-749-2920 (fax)

Front Door Manager: Lesley Barraball

Walk-in launched December 5, 2007

History of the Walk-In Counselling Clinic

The Ministry of Children and Youth Services announced new funding through the Community Priorities Fund. A community committee prioritized a Walk-in Service and the funding went to kidsLINK and Lutherwood Joint Initiatives to develop and establish this service through Front Door. The goal was twofold: 1) to increase access to immediate counselling services for children, youth and families and 2) to divert young people and their parents from hospital emergency rooms/crisis clinics who were not in need of emergency services.

Description of the Walk-In Counselling Clinic

Number of Clients Served (as of December 2009):

In the first 3 months of service (December 5/07 to March 31/08), 20 families were served

In the first full year of operation (April/08 to March 31/09), 74 families were served

In the second full year of operation, it is projected that 102 families will be served, which is a 34% increase from the previous year

Presenting Concerns:

The largest groups of clients seeking Walk-in Counselling Services present with child/youth acting out behaviour (15%), parent-child conflict (14%) and school difficulties (13%)

A very small number of clients (2%) present with suicidal ideation

Acting-out behaviour	15%
Parent-child conflict	14%
School difficulties	13%
Aggressive behaviour	9%
Family breakdown/high conflict	8%
Poor social skills/child relationships	5%
ADHD	5%
Anxiety	4.5%
Suicidal ideation	2%

Age of Clients:

Families with children and youth between the ages of 7 and 15 are the most frequent Walk-In clients, comprising 79% of all clients seen. Of the 12-15 year olds, close to half the clients include parents and youth together, while the remaining sessions with this age group are almost equally divided between youth-only and parent-only sessions. The smallest age groups seen at Walk-In are 0-3 year-olds (2%) and 16-18 (7%) year olds

2-3 years	3 (2%)
4-6 yrs	22 (12%)
7-11 yrs	75 (41%)
12-15 yrs	69 (38%)
16-18 yrs	12 (7%)

Age of client	Seen alone	Parent(s) seen alone	Youth and parent(s) seen together
12-15 years (69)	16 (23%)	17 (25%)	31 (45%)
16-18 years (12)	6 (50%)	1 (8%)	4 (33%)

Primary Referral Sources:

The majority of Walk-In counselling referrals come from school personnel (26%) and kidsLINK and Lutherwood staff (26%). While referrals from a broad spectrum of community agencies exist, they are not plentiful. Referrals from the hospitals are lower than expected.

School personnel	26%
kidsLINK/Lutherwood program staff	26%
Local community agencies	22%
Hospital	8%
Self-referral	7%

The Walk-In Service currently operates out of one central location in Kitchener on Wednesdays, 12-8 p.m. Plans are in place to open a second location in Cambridge on a different day of the week. Walk-In is staffed by three staff per Walk-In, consisting of social workers, crisis workers and MSW interns. The service is funded by Ministry of Children and Youth Services. Treatment modalities include narrative therapy; brief solution-focused therapy and crisis intervention strategies.

Walk-In Specific Training

Training in narrative single-session therapy was offered in the first year of operation and at the one-year point; single session therapy training was also offered prior to start-up; Brief, solution-focused therapy training is planned for 2010.

Walk-In Specific Standardized Assessment

None. KidsLINK/Lutherwood Front Door initially used the Session Rating Scale but this is no longer the practice.

Research

Plans are underway for a research project the details of which are as follows:

Estimated start date for this project April 26, 2010.

Estimated completion of involvement of participants for this project:

Approx. N =312 (6 surveys /wk for 52 weeks)

Estimated final research project completion date: April 29, 2011.

Researcher: Sara White, KidsLINK Researcher

Methods

The Front Door Walk-in Service Client Satisfaction Research Project (Phase I) utilizes a longitudinal survey design with data collected across three intervals: pre-service, immediate post-service and three months post-service. Data collection methods per data collection interval are outlined below.

Client satisfaction surveys will be completed in hardcopy format. Respondents include all parent/guardians, collaterals and youth (aged 12 and older) participating in a Front Door Walk-in Service session. All session participants over the age of 12 will be provided with a survey package regardless of previous Walk-in Services attendance and subsequent survey completion. Each survey completion is designed to capture individualized experiences related to the respective walk-in service session (i.e. not in relation to other service provisions nor by respondents as spokesperson for other session participants).

Pre-service Interval: At the time of introduction into the Front Door Walk-in Service, clients aged 12 years old and older will be informed about the Front Door Client Satisfaction Research Project and will be provided with a survey package. Each survey package will contain a consent form, study information and a pre-service questionnaire. Each session participant 12 years and older will be asked, by the Administrative Assistant, to complete a pre-service questionnaire prior to their walk-in session. Each participant meeting the inclusion criteria will be asked to return the survey in a sealed envelope and will be advised to feel free to seek support from the Administrative Assistant as needed in order to complete the survey. Before entering their walk-in session, each consenting session participant will return their completed survey and consent form in a sealed envelope.

Immediate Post-service Interval: Immediately following their Front Door Walk-in Service session, each consenting participant aged 12 and older will complete an Immediate Post-session Client Satisfaction Survey. The Administrative Assistant immediately following each walk-in session will distribute these surveys. Participants will place their completed survey and consent form in an envelope and return their sealed envelopes to the Administrative Assistant.

3 Months Post-service Interval: Three months following their Front Door Walk-in Services session, people who have consented to participate in the research project will be mailed a Front Door Walk-in Services Three-months Post Client Satisfaction Survey package to their home address. Each survey package will include a consent form, a client satisfaction survey and a self-addressed, postage paid, envelope to forward the completed survey back to Front Door.

Results/Tellings

Research not yet completed.

Haldimand- Norfolk Resource Education and Counselling Help (HN REACH)

Contact Information

101 Nanticoke Creek Parkway, Townsend ON, N0A 1S0

519-587-2441 x 263

info@hnreach.on.ca

www.hnreach.on.ca

Walk-In Supervisor: Scot Cooper

Walk-In launched October 4, 2006

History of Walk-In Counselling Clinic

HN REACH Walk-in Counselling Clinic opened in October 2006 as a means to provide a more diverse service menu to the community, to provide more immediate access to counselling services for youth and their families, and to assist with addressing a growing wait list for services. They serve approximately 160 children and youth a year through the Walk-In.

Description of the Walk-In Counselling Clinic

HN REACH Walk-In provides counselling services to children and youth up to and including the age of 18 and their families throughout the counties of Haldimand, Norfolk, and the New Credit Reserve. Our catchment area is described as a rural area approximately the size of Prince Edward Island. The clinic operates out of one site in Townsend (the geographic centre of the area), every Tuesday from noon until 8:00 with the last appointments starting at 6:30 p.m. There is no public bus transportation. Volunteer drive services are offered by our agency to those who need transportation to the clinic. Services are funded through the Ministry of Children and Youth Services. The clinic is free to the community.

Six clinical therapists who are on a bi-weekly rotational schedule staff the Walk-In Counselling Clinic. A minimum of three therapists work the clinic each week as well as a supervisor. Staff members from other teams such as Crisis/In Home Intervention Services also rotate through the schedule. They always try to work in teams of at least two at the walk-in with one staff as the lead therapist while the other participates as an outsider witness (White, 2004.). Volunteers and students are trained and utilized as outsider witnesses when possible. The clinicians practice a variety of competency-based modalities.

Walk-In Specific Training

Primarily, staff members have been trained in specific single session therapeutic practice, brief narrative therapy, as well as some solution focused brief therapy. Training events occur at regular intervals yearly. Supervision specific to single session practice occurs with the frontline staff and is provided by the Walk-in Clinic Supervisor. Videotape micro skill review is a part of the supervision process.

Walk-In Specific Standardized Assessment

No. HN REACH uses a modified version of the Session Rating Scale (Duncan & Miller, 2000, p. 239).

Research

Timeframe and who conducted the research

The Walk-In Counselling Clinic Supervisor collected information annually starting October 2006 to the end of September 2007, and again October 2007 to the end of September 2008.

Methods

1. The walk-in clinic uses a Participant Feedback Questionnaire to assess the usefulness of the service in addressing the presented concerns. These forms are sent home with participants and mailed back to the agency for review.
2. All participants over 11 years old are asked to complete the modified Session Rating Scale immediately after the session. These completed forms are then given to the receptionist.

Results/Tellings

Modified Session Rating Scales

All participants in the walk-in session 11 years old and older are asked to complete a modified version of a Session Rating Scale following the session. This is a shortened version of the scale seeking to elicit a sense of whether the participant felt understood, whether they agreed with what was discussed, whether the session was helpful/useful, and whether they felt hopeful after the session. These items are rated on a scale 0 through 4 with 4 indicating the most positive agreement.

With 157 Session Rating Scales completed from October 2006 through to September 2007 the average rating across the questions was 3.7/4.

Oct 2006- Sept 2007 157 Completed		
	Question	Average Rating out of 4
1.	My consultant understood me?	3.8/4
2.	We discussed what was important to me?	3.7/4
3.	I found the consultation helpful/useful?	3.7/4
4.	I felt hopeful after the session.	3.6/4

Similar results were found between October 2007 and September 2008

Oct 2007- Sept 2008 180 completed		
	Question	Average Rating out of 4
1.	My consultant understood me?	3.81/4
2.	We discussed what was important to me?	3.77/4
3.	I found the consultation helpful/useful?	3.76/4
4.	I felt hopeful after the session.	3.67/4

Summary of Walk-In Participants Feedback Questionnaire

Parent or caregivers were given a Participant Feedback Questionnaire to take home with them after the session. Questionnaires were completed and mailed back to HN REACH by the parents or surrogate caregivers (guardian, grandparents, etc.).

October 2006 to September 2007

A total of 142 clients were seen between October 2006 and September 2007. Twenty-six feedback forms were returned for a response rate of 18%.

<i>n</i> =26	Not at All	A little	Somewhat	Mostly	Very Much
1. Did the session assist you in dealing with the problem(s)?	0	12%	19%	38%	31%
2. Did it help you develop a plan to address the problem?	4%	8%	15%	42%	27%
3. If so, are you carrying out the plan?	0	0	15%	23%	50%

October 2007 to September 2008

A total of 160 clients were seen between October 2007 and September 2008. Thirteen evaluation forms were returned for a response rate of 8%.

Distribution of number and percentage of responses

<i>n</i> =13	Not at All	A little	Somewhat	Mostly	Very Much
1. Did the session assist you in dealing with the problem(s)?	0	0	(23%)	(38%)	(38%)
2. Did it help you develop a plan to address the problem?	0	0	0	(62%)	(38%)
3. If so, are you carrying out the plan?	0	0	(8%)	(38%)	(54%)

Recommendations

From the above information HN REACH has the following understandings:

- The clinic is a well-received service option providing quick access to counselling services and contributes a valuable component to a diverse service menu for children, youth and their families.
- Participants most often want to leave with a plan that they can act upon that may assist to address their concerns. With training, staff members have better developed the skill of co-developing plans and next steps with families that are contextually and culturally relevant to them. This appears to be reflected in the improved ratings of the helpful/usefulness of the Walk-In Counselling Clinic experience.
- In general the majority of people are satisfied with their walk-in experience and indicate that it was useful to some degree.

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K-W Counselling Services

Contact Information

Leslie Josling, Executive Director leslie@kwcounselling.com
www.kwcounselling.com

Walk-in Counselling Clinic launched in July 2007

History of Walk-in Counselling Clinic

In 2006, a new Executive Director was hired and the board and staff began a process of strategic planning. One of the strategic objectives identified was: "Accessibility and Responsiveness". In 2005, K-W Counselling had moved to a new, highly visible and accessible location. This location and other factors resulted in increased referrals by 30%, with a projected future increase of 50% over the next 20 years. Over 900 clients were waiting for counselling services. A goal was set to make counselling available within 7 days via a Walk-In Counselling Clinic and to have less than an 8-week wait for ongoing therapeutic counselling. It was believed that this would:

- Meet individuals' needs for quick and immediate service
- Provide clients with a plan in their moment of need
- Eliminate costly no shows (that accounted for approximately 20% of all first sessions)
- Provide many clients with all the service needed. K-W Counselling Services knew that many clients only came for one session
- Provide a "Cadillac" 1.5-2 hour intervention

Description of the Walk-in Counselling Clinic

- Population served: Ages 0-100 years; location (rural/urban) serves Waterloo Region- 73% were from Kitchener.
- Size: One site. About 1035 people were seen from July 2007-July 2008; 9% had attended more than once.
- How is it funded? United Way for low income clients; also Violence Against Women (VAW); Ontario Works (OW), Ontario Disability Support Program (ODSP), Employee Assistance Plan, or company benefits. Sliding fee scale for others.
- Modalities practiced? Strength based, brief narrative, solution-focused, cognitive behavioural therapy and other modalities.
- How does it work for staff, students, and volunteers?
 1. Staff are assigned and pagers are used to ensure staff response from anywhere in the building.
 2. Students (about 60 per year) are assigned to the Walk-In Counselling Clinic as part of their placement.
 3. Volunteers are assigned to help in the reception area; occasionally, trained volunteer therapists are also involved in the counselling.
- When does it operate? Every Thursdays 12 noon to 6:00 p.m. The final client leaves the building by approximately 8:30pm.

- Intake requires approximately 20 minutes (this includes screening for suicidal ideation, domestic violence and addictions).

Walk-In Specific Training

Scot Cooper provided training prior to the opening of the Walk-In Counselling Clinic. He introduced the agency to the brief narrative model and the use of "good questions". A year later, the agency brought in Karen Young for more training using her brief narrative model and "instilling hope". She met with the entire agency for a day.

Walk-In Specific Standardized Assessment

Yes. At intake, completion of the OQ45 or the Youth OQ 45 is requested. On exit, clients complete a client satisfaction rating scale. Couples complete the Conflict Tactics Scale to assess for domestic violence.

Research

An outcome evaluation was conducted by Sharon Livingstone MSc. (Consultant) between July 2008-November 2008.

Methods

- Mixed methods:
- Literature review and web based review; focus groups with staff and students, key informant interviews with staff and stakeholders, electronic survey of clients, staff, and students, telephone interviews with clients, mailed survey to key stakeholders.

Results/Tellings

The impact on clients:

Single session counselling that is strength based and solution focused maximizes the time and resources of the agency, building on client strengths and motivation to create change. It offers a clinical delivery system that provides immediate accessibility at a time determined by the client. Ninety-one percent of the 1685 clients surveyed required no further counselling; sixty-seven percent felt it was an excellent experience and a good fit and that their issues were being heard, understood and respected; nine percent returned more than once. In a follow up telephone interview of 92 individuals, 75% stated that "things were better, that they were struggling, but doing better" and 23% had returned for more counselling.

The Walk-In Counselling Clinic has generated a more integrated approach to service delivery and reduced wait times for counselling. Eighty-five percent of clients responded that "counsellors were extremely helpful, provided new strategies, treated me with respect and compassion, gave alternatives to try, and helped to find a compromise". Twenty percent felt that the immediate access was the most useful part of the Walk-In Counselling Clinic.

The impact on staff and students: Therapists and students require frequent training to maximize their skills. Therapists who think something important can be accomplished in a single session can have deeply meaningful conversations and provide valuable focus and referrals to help clients' effect change. It is interesting to note that staff also felt that their perceptions of the Walk-In Counselling Clinic had changed (usually in a positive direction) over time. Students felt that the Walk-In Counselling Clinic was easily accessible for clients from both a physical and financial standpoint, and it provided an opportunity for them to be involved in co-counselling with different therapists. Challenges for students included the need for ongoing training and learning to manage a more unstructured day.

Community impact: Doctors and teachers/school counsellors were the top referral sources; 11% of clients identified themselves as involved with other agencies, for example, Canadian Mental Health Association; Violence Against Women, Family and Children's Services; Probation and Parole, Ontario Works, Ontario Disability Support Program. The community is confident that the people will receive good care by qualified professionals; it is an effective way to provide service to people in crisis and provides immediate access. There are issues of concern around geography (difficult for rural and Cambridge clients to access), and lack of weekend availability.

Recommendations stemming from research:

- Staff and students require frequent training, supervision and debriefing.
- Future research should ask whether clients experience changes in levels of stress, coping style, and use of community resources after a single session.
- Establish success indicators for clients, staff, students and community based on short, mid and long term outcomes.
- Establish evidence based best practices for Walk-In Counselling Clinic.

Oolagen Community Services

Contact Information

Contact person: Marilyn Vasilkioti,
Supervisor of Community Services, www.oolagen.org
Walk-in launched 2003

History of the Walk-In Counselling Clinic

The walk-in counselling clinic began in approximately 1997, as a partnership between four children's mental health agencies: Yorktown Child and Family Centre, Hincks-Dellcrest, Youthdale and Oolagen. Oolagen began its own walk service in 2003 (12 – 4 p.m. on Mondays). It was then modified with extended hours of operation, starting in November 2008, one day per week (Tuesdays 12 noon – 8 p.m.) to increase access to service. The primary reason for initiating the Walk-In Counselling Clinic was to address the long waiting for service and to be more responsive to clients by providing help when it is needed.

Description of the Walk-In Counselling Clinic

The Walk-In Counselling Clinic is available to anyone between the ages of 13 and their 19th birthday and their families/caregivers. The Walk-In Counselling Clinic is the 'gateway' to accessing other services offered by Oolagen. Internal and external referrals occur during the Walk-In Counselling session. The agency is located in a central location in downtown Toronto and this is the only location where the Walk-In Counselling Clinic is offered. There are five staff, four who rotate between two shifts and one supervisor who covers both shifts: 12 – 4 p.m. and 4 – 8 p.m. Currently, no students or volunteers are working in the Walk-In Counselling Clinic but the agency is exploring this possibility for the future. The Walk-In Counselling Clinic is funded by a combination of sources including Winners and the Ministry of Child and Youth Services as a component of the agency's counselling services.

Walk-In Specific Training

The Walk-In team of therapists and receptionists have received formal training by Karen Young on two occasions in the Walk-In Counselling Clinic model, which she developed using narrative methods. The team meets monthly to discuss various issues that arise in the context of the Walk-In Counselling Clinic. The small team makes it conducive to consult with one another informally on a regular basis.

Walk-In Specific Standardized Assessments

Oolagen uses questionnaires based on Karen Young's model; they are slightly altered to meet the specific needs of Oolagen. These are given to parents, youth and collaterals upon their arrival at the Walk-In Counselling Clinic, for completion prior to the start of the session. Written evaluation questionnaires are also given to each person at the end of the interview. These may not be considered 'standardized' for the purpose of research. The intake worker conducts the the Brief Child and Family Phone Interview (BCFPI) following walk-in service, if a client is

requesting additional service from the agency such as brief or ongoing counselling or intensive services.

Research

No formal research conducted. Client feedback forms are used for program evaluation and planning.

Reach Out Centre for Kids (ROCK)

Contact Information

Karen Young (kareny@rockonline.ca)
471 Pearl Street
Burlington, Ontario
L7R 4M4
905-634-2347 x227
www.rockonline.ca

Walk-in launched July 2001

For more details of our clinic please see: Young, K.(2008) From Waiting Lists to Walk-in: Stories from a Walk-in Therapy Clinic. *Journal of Systemic Therapies*, (26 pages).

History of the Walk-in Counselling Clinic

By 2001, with population growth and demand for services growing in Halton region, the agency had developed an over two-year waiting list for family therapy services. A new Executive Director arrived with a vision to implement a walk-in therapy clinic, and the management team began to shape what this clinic is today. The goal was to create a service that provided therapy services to people in a way that reduced barriers to service as much as possible, being available without a wait and easy to access. They hoped it would reduce the waiting lists for therapy. The agency opened the doors of three walk-in clinic sites in July 2001 to families in Halton Region. This was achieved with no new funding from the Ministry of Child & Youth Services, which is ROCK's primary funder. The existing staffing resources were re-organized in order to accommodate the walk-in clinic.

Description of the Walk-In Counselling Clinic

The ROCK clinics are located in three small cities within the service area (Burlington, Oakville, Milton). Each site has one eight hour day a week designated to walk-in thereby offering the communities an opportunity for immediate access to a single session of therapy at times when they are most in need. The clinics function as the 'front door' to the agency's services, eliminating the traditional telephone intake and instead inviting families with children/youth between 0 and 18 years of age to attend the clinics. For those unable to come to the clinics, the staff 'walk-out' to people in their homes or other locations. Although people can use this service more than once, many people (about 50%) benefit from a single session of therapy and do not need any further services. This provides children and families with help when they need it and reduces referrals into further services, thereby reducing waiting lists. Since a therapeutic single session intervention is the primary task at walk-in, information gathering and intake are secondary. The main purpose is to have a conversation that results in some immediate assistance.

In each geographic site there are a range of three to six 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 are also mental health nurses staffing two of the clinics. There are usually students from universities and training therapists present to join sessions with staff. There is a supervisor available for consultation and a receptionist in each site.

Walk-In Specific Training

The therapists were provided with readings and training in brief, narrative, and solution focused therapies. This was of key importance in the 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 skills 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 (usually about twice a year).

When people arrive at the walk-in counselling clinics they are given an information letter and a questionnaire. The questionnaires are designed in ways that reflect important brief therapy concepts. 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.

Walk-In Specific Standardized Assessment

No standardized assessments are used at the walk-in clinic.

Research

Introduction (timeframe, who conducted the research)

The focus of ROCK's research has been on evaluating the effectiveness of the Walk-In Counselling Clinic. Although the clinic has provided brief therapeutic intervention for numerous clients, and anecdotal evidence suggests that these interventions have been quite successful, an empirical outcomes-based evaluation of the Walk-In Counselling Clinic has not been conducted. Thus, the current exploratory study was conducted as a first step in this direction. This research took place between September 2008 and April 2009 and Surbhi Bhanot-Malhotra and Karen Young conducted it.

The research drew upon two theoretical frameworks: Patton's (2002) Utilization-Based Framework of Evaluation and the goals-based framework of evaluation. Patton (2002) contends that evaluation research should be judged on its utility and actual use. Consequently, this approach places emphasis on intended use by intended users. Researchers largely take on the role of facilitators. They facilitate the research process by working with intended users in

order to help them determine their needs – for example they may help users select the most appropriate content, model, theory, methods, for their particular program and situation.

In contrast, the goals-based model of evaluation places emphasis on results or outcomes rather than process. According to this framework, the effectiveness of a program can be measured by determining the extent to which it met the predetermined goals (Harris Jones, 2004). The role of the researcher is to: 1) determine the goals of the program, 2) decide how to measure these goals, 3) collect information/data about the goals, 4) to assess the effects, and 5) analyze and interpret the data in order to determine whether the programs stated goals have been met. A program is deemed successful if it has attained most of its specified goals.

The purpose of this research was two-fold. Since a utilization-focused framework was adopted and the intended users (ROCK) thought that an outcomes focused study would be most useful, 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 Counselling Clinic was assessed by determining the extent to which walk-in sessions were producing the desired goals/outcomes. In addition, since staff at ROCK wanted to gain a better understanding of the types of clients who came to the walk-in clinic, their reasons for coming as well as what clients learned during the sessions, a secondary purpose was to gather and analyze information related to these areas.

Methods

Design. The study was conducted using a pre-test, post-test and two-month post-test design.

Participants. 408 clients who accessed ROCK's Burlington, Oakville, and Milton walk-in clinics between October 2008 and April 2009 participated in this study.

Procedure. When clients enter the walk-in clinic, they are asked to complete a series of general questions prior to seeing the therapist. The pre-test questionnaire was added to these questions (see Appendix 1 for copy of questionnaire). Clients subsequently proceeded to their walk-in session. Upon completion of this session, the therapist asked clients to complete the post-test questionnaire (see Appendix 1 for questionnaire). This post-test questionnaire was similar to the pre-test questionnaire except that clients were informed of the two-month follow-up. If clients consented to being part of the two month follow-up, the investigator contacted them via e-mail or phone depending upon their stated preference.

If clients chose to complete the two-month follow up via the Internet, the investigator e-mailed the client the link for the online version of the two-month post-test questionnaire. Once clients accessed this link, they were presented with the online version of the two- month follow-up survey (see Appendix 1 for questionnaire). If clients preferred to complete the two-month post-test questionnaire over the phone, the investigator contacted them via phone. The investigator subsequently administered the questionnaire orally over the phone. Note that this version of the survey was identical to the one administered over the internet.

Results/Tellings

Who are our clients?

The findings suggest that clients with a wide range of mental health-related concerns access ROCK's Walk-In Counselling Clinic (e.g., anger management, anxiety, and depression). On average, clients had endured these problems for a year before they accessed services at the clinic.

Why do they come to our walk-in clinic?

Clients' responses suggest that the most popular reason for coming to ROCK's Walk-In Counselling Clinic was the recommendation of others (e.g., school recommendation, doctor recommendation, friends, etc.). The second most popular reason was quick access to therapy - 33% of clients reported that this was the reason they came to the walk-in clinic. Finally, the third most popular reason was to access further services (e.g., individual counselling, family therapy, etc.).

Does the Walk-In Counselling Clinic produce the desired outcomes for clients?

The results suggest 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 about the problem post-session ($M_{pre} = 7.67$, $SD = 2.31$; $M_{post} = 6.31$, $SD = 2.41$, $t(407) = 12.10$, $p < .001$);
- 2) More competent about their skills as a parent post-session ($M_{pre} = 6.78$, $SD = 1.88$; $M_{post} = 7.28$, $SD = 1.65$, $t(308) = -7.73$, $p < .001$);
- 3) More confident in their ability to resolve/manage the problem post-session ($M_{pre} = 6.23$, $SD = 2.47$; $M_{post} = 7.02$, $SD = 2.15$, $t(406) = -7.34$, $p < .001$);
- 4) More knowledgeable about available resources post-session ($M_{pre} = 4.47$, $SD = 2.74$; $M_{post} = 5.97$, $SD = 2.55$, $t(407) = -11.63$, $p < .001$);
- 5) Had more ideas about how to resolve/manage their mental health problem post-session ($M_{pre} = 5.02$, $SD = 2.27$; $M_{post} = 6.66$, $SD = 2.13$, $t(407) = -14.71$, $p < .001$).

What do clients learn during a walk-in session?

Clients were also asked what they had learned during the session. When clients' responses to this open-ended question were analyzed, eight different themes emerged. These themes 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 (e.g., "Worry still has an impact on my son's life")
- 3) Increased awareness of resources (e.g., Youth Aiding Youth)
- 4) More general knowledge about the nature of problem (e.g., "Rebellious behaviour is because of possible anger and it is not one person responsible but family dynamics"),
- 5) Knowledge of general strategies to help deal with the problem (e.g., "I learned how to control/express my feelings")
- 6) Knowledge of specific techniques to manage mental health issue (e.g., "New strategies for anger management and identification of contributors to anger",
- 7) Better communication skills (e.g., "Learned to communicate with my ex in some way other than our children")

- 8) Knowledge that children are willing to get help (e.g., “I’ve learned that my son is willing to receive help which has helped me to calm down”).

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 ($M_{pre} = 8.45$, $SD = 1.71$; $M_{post} = 7.24$, $SD = 2.19$, $t(73) = 4.45$, $p < .001$), 2) more knowledgeable about resources 2 month post session ($M_{pre} = 4.61$, $SD = 2.69$; $M_{post} = 6.36$, $SD = 2.68$, $t(72) = -5.12$, $p < .001$) and 3) had more ideas about how to resolve and/or manage the problem 2 months post session ($M_{pre} = 5.19$, $SD = 2.26$; $M_{post} = 6.22$, $SD = 1.95$, $t(71) = -4.13$, $p < .001$). Clients’ responses suggest that they use fewer negative coping strategies ($M_{pre} = 5.13$, $SD = 2.45$; $M_{post} = 4.28$, $SD = 2.61$, $t(71) = 2.66$, $p = .01$) and more positive coping strategies ($M_{pre} = 6.36$, $SD = 2.56$; $M_{post} = 6.96$, $SD = 2.02$, $t(69) = -2.06$, $p = .04$) at 2 months post-test.

Recommendations

The research findings suggest that walk-in sessions appear to have the most impact on client’s awareness of resources as well as their ideas about how to solve the problem. Thus, in order to gain a more nuanced/comprehensive understanding of the different ways that a walk-in session may impact clients awareness of resources and their knowledge of how to solve the problem, it is recommended that future research endeavours be focused on these areas

When the researchers constructed the questionnaire, they decided to primarily use closed-ended Likert type questions because they were concerned that clients would likely not have the time to answer more open-ended questions. However, they found that a significant proportion of clients did respond to the few open-ended questions that were included in the survey (e.g., the question where clients were asked what they had learned). Since they gained a lot of valuable information from these responses, they recommend including more open-ended questions in future studies.

When the researchers examined clients’ responses to the open-ended learning question, the responses suggested that they were more aware (e.g., of own behaviour, impact of problem, etc.) and more knowledgeable (e.g., about the nature of problem, specific techniques to manage the problem, etc.) post-session. Thus, it is recommended that researchers explore these areas in more detail in future studies (e.g., study how a walk-in session impacts clients self-awareness, how it impacts clients’ understanding of the nature of the problem, etc.).

Since this was an exploratory evaluation study, the researchers opted to measure as many outcomes as possible using single item measures (i.e., they opted to ask clients one question about their confidence level, one question about their awareness of resources versus asking clients several questions about one outcome). In order to increase the reliability of the findings, the researchers recommend including a number of items to measure each outcome in future research (e.g., asking three questions which relate to clients awareness of resources, three questions related to their level of worry about the problem, etc.).

Thunder Bay Walk-in Counselling Clinic

Contact information

Children's Centre – Diane Walker, Director Programs & Clinical Services, 807 343-5006

Counselling Centre – Nancy Chamberlain, Executive Director, 807-684-1881

Web-site: <http://www.tbaycounselling.com/>

Walk-In launched July 2007

History of the Walk-in Counselling Clinic

The Walk-in Counselling Clinic in Thunder Bay started as a way of providing immediate access to professional counselling without having to go through intake. In September 2003, managers and staff from both partners visited a walk-in service at Halton Youth Services (ROCK) and developed the clinic based upon the model there. Training and program development proceeded with Karen Young coming to Thunder Bay to provide training and consultation to the program. On July 4, 2007 the clinic opened and has operated ever since.

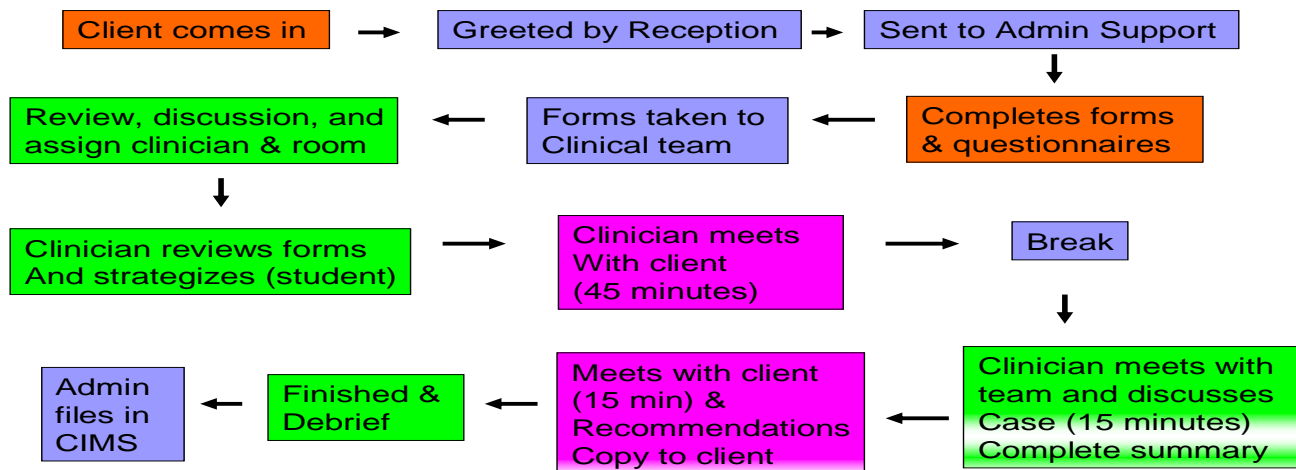
Description of the Walk-In Counselling Clinic

In July 2007, the Children's Centre Thunder Bay (CCTB) and Thunder Bay Counselling Centre (TBCC) together opened up the Walk-in Counselling Clinic in Thunder Bay, Ontario. The focus of this clinic was to provide a barrier free, immediate single session counselling to people in Thunder Bay and the surrounding area.

- The Clinic operates every Wednesday from 12 to 8 pm with the last session at 6:30.
- We alternate sites with the 1st & 3rd Wed at TBCC and 2nd & 4th Wed at CCTB
- The Clinic provides single session intervention for a variety of psycho-social issues including anxiety, depression, anger, parenting, relationship issues, grief and loss, substance use, and financial issues. Services are available for any age, and any constellation of people (individuals, couples, families, parents etc)
- The Clinic is staffed by a variety of professionals including social work, psychology, marriage and family therapists, and child and youth work etc.
- Opportunities to a variety of students are available – primarily social work, but medical students have also participated
- The Clinic is funded by number of sources including United Way, MCYS and MCSS
- Practice is from a Single Session model using a variety of treatment approaches including solution-focused, strength-based and narrative.
- The Clinic is overseen by a cross agency management team and each site has assigned a manager who oversees the operation of the clinic on any given day.
- In terms of files and client information –the Children's Centre client information system is used. A file is opened at reception and then all completed paperwork is scanned into the system.

- Clients complete pre and post questionnaires to measure outcomes and level of satisfaction. Each year we do a second post test one month following attendance at the clinic.
- The therapist generates a summary report with recommendations during the session and the client is given a copy of that report when they leave the clinic.

Process



Walk-In Specific Training

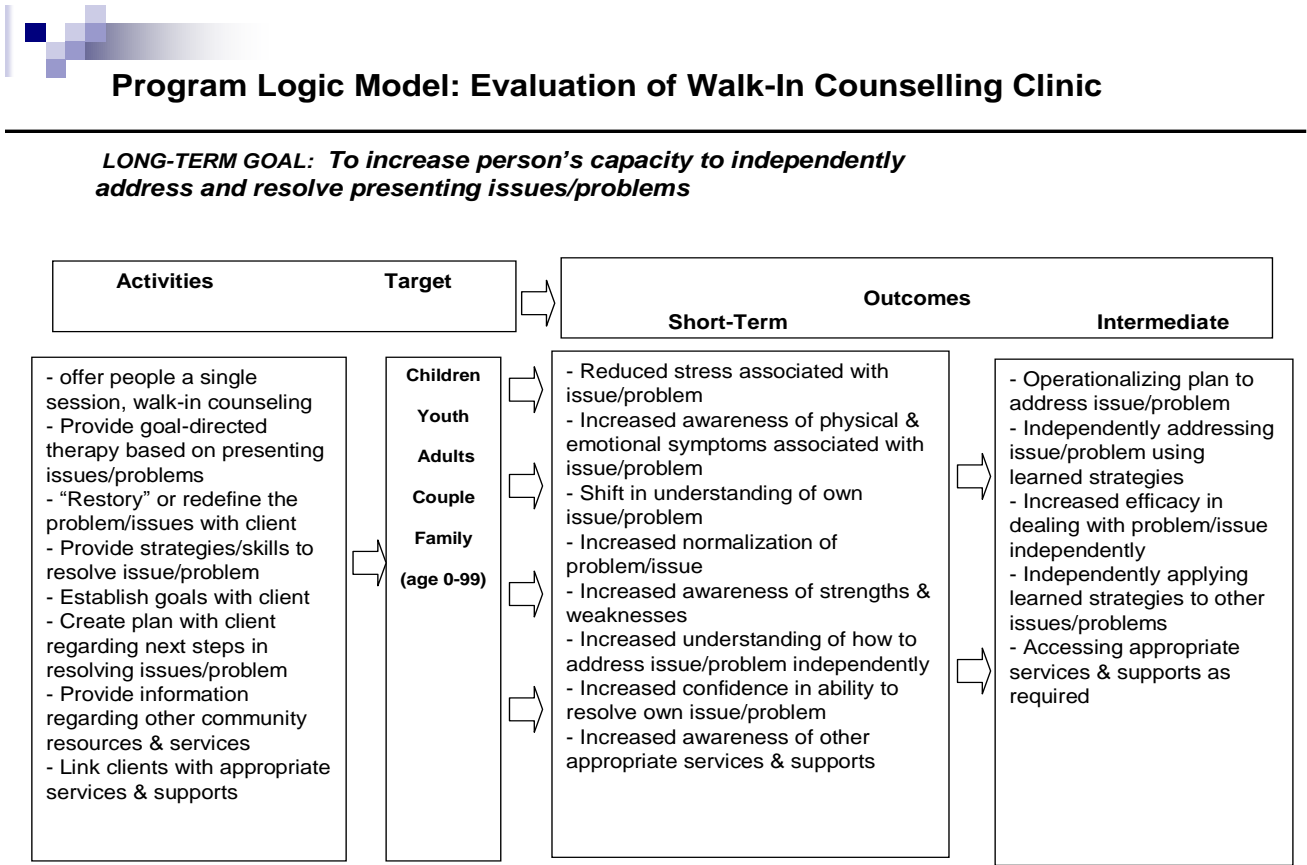
- Review and training is done twice a year when clinic falls on the 5th Wednesday of the month
- Training to date has included:
 - Single Session Model – Dr. Jo Ann Vis
 - Program Evaluation – Diane Walker
 - Therapy in a Single Session – Dave Vilella & Sheila Arding
 - Program Review – Abi Sprakes & Diane Walker

Walk-In Specific Standardized Assessment

- Clients complete a pre evaluation questionnaire prior to the session, which has both clinical, and evaluation utility.
- After the session clients are asked to complete a post-session questionnaire to evaluate outcomes and satisfaction with the services.
- Once each year, a second post evaluation is completed one month after service.

Research

Prior to starting the program, the partners developed a program logic model.



Program evaluation, not formal research, has been completed by the agency on three separate occasions. The last evaluation involved an MSW student completing a review of Single Session Treatment and she used the program evaluation data as a case study. The results from all three of the evaluation efforts support the outcomes the partners are working to achieve including:

- Reduced stress
- Reduced negative physical symptoms related to identified problem
- Reduced negative coping
- Increased knowledge of cause of identified problem
- Increased level of confidence to address identified problem
- Increased knowledge of resources
- Increased positive coping



Outcomes Evaluated

Pre test	Post Test 1	Post Test 2
Stress	Stress	Stress
Physical Symptoms		Physical Symptoms
Negative Coping		Negative Coping
		Positive Coping
Family Relationships		Family Relationships
Knowledge of cause	Knowledge of Cause	Knowledge of Cause
Confidence	Confidence	Confidence
Knowledge of resources	Knowledge of resources	
		Access of resources

Results/Tellings

The most interesting learning is that the Walk-in Counselling Clinic is achieving the outcomes the partners set out to achieve. It was never intended to replace any form of treatment but rather to expand the treatment options for the community.

From a “research perspective, the most interesting learning has to do with the level of confidence a client has to fix or address their problem. The evaluation efforts indicate that the level of confidence to fix the problem is significantly higher immediately following the session (T2) when compared to the start of the session (T1), however, it does go back down one to two months later (T3) but not to T1 levels. We wonder if this is about the effect of the session “wearing off”; however, we are relieved to see that confidence is still a little higher than when clients first come to the clinic.

Also the client satisfaction data shows that people attending the clinic are very satisfied with the experience; however, it is interesting to note that people who were less satisfied indicated in their comments that they thought the clinic would provide something different (i.e. an intake or assessment) than what they received.

Yorktown Child and Family Centre – West End Walk-in Counselling Centre

Contact Information

Liisa Kuuter, liisa.kuuter@yorktownfamilyservices.com; 416-394-2424, ext. 250
Suzette Arruda-Santos (Director of Service), suzette@yorktownfamilyservices.com; 416-394-2424, ext. 223
Website: www.yorktownfamilyservices.com

Walk-In Launched March 27, 2000

History of the Walk-in Counselling Centre

The West End Walk-in Counselling Centre (WWCC) began as a partnership of four children's mental health centres: Yorktown Child & Family Centre, Oolagen Community Services, Hincks-Dellcrest Centre and Youthdale Treatment Centre in response to the continuing problem of long waiting lists and delayed access to high-quality mental health services to children, youth, families and adult individuals. A proposal for a walk-in counselling centre, based on the model of an effective walk-in counselling service at the Family Centre in Calgary, was submitted to the Trillium Foundation and funding was received for three years. Yorktown was the lead agency in the partnership. Currently, Yorktown Family Services operates the Walk-In Counselling Centre without partners.

Description of the Walk-In Counselling Clinic

Population served: Most recently the Walk-in has been serving children, youth, parents and families living primarily in the former City of York and Etobicoke. In the past, the clinic also served adults but is not currently providing service to this group.

Location (rural/urban): The WWCC is located at Yorktown Child and Family Centre in a multi-cultural urban setting in mid-west Toronto, which has very high needs (former City of York has the second highest level of poverty, 32%, in all of Ontario) and is very under-resourced.

Size: One site.

Funding: Currently funded by United Way and Ministry of Child and Youth Services.

Modalities practiced: The treatment model is systemic, competency-based, client-responsive, collaborative, pragmatic, culturally sensitive and draws from Narrative Therapy, Solution-Focused Therapy, and Cognitive Behaviour Therapy approaches.

How it works for staff, students, volunteers: The counselling sessions are conducted by Yorktown social workers, a Walk-in counsellor, and several community volunteer therapists with post graduate training. To date, 92 volunteers have participated and contributed approximately 6,000 hours. Counselling is offered in English, Spanish and American Sign Language. A shift coordinator, who is an experienced clinician, is also on site each evening. Case consultation with the shift coordinator (and a team, if staffing and client consent permits) or a reflecting team process (if staffing and client consent permits) occurs part way through each session to ensure accountability and a broad and thorough perspective.

Operation dates/times: Service is currently offered on Wednesday evenings from 4 -8 p.m.

Walk-in Specific Training

Although there was single session training provided initially, no specific Walk-in training is currently offered. However, education is an on-going process through the delivery of therapy/client consultation. Training-in-exchange for service is conducted through the use of volunteers (a contribution of a minimum of one shift per month, over a period of 12 months).

Walk-In Specific Standardized Assessment

The Walk-in does not provide assessments. Demographic client information is collected and clients complete a form at reception, which solicits information regarding the presenting concern, previous efforts at resolution, strengths, preferences, and desired changes. As part of a formal outcomes research study, participants were administered the Brief Child and Family Phone Interview (Cunningham, Pettingill, Boyle, 2003).

Other Comments

The Walk-In Centre was developed in response to the continuing problem of long waiting lists and delayed access to high-quality mental health services to children, youth and families in particular, and individuals as well. In spite of offering the Walk-In as a resource to clients on their waitlist, Yorktown was not as successful as they would have liked in having clients use it as an alternative to waiting for service. At the time of this writing (Fall 2009) Yorktown continued to have a long waitlist for treatment services. They were excited by the results of their research project indicating the successful impact of single-session counselling, and they were also impressed to learn about the way that other Children's Mental Health Centres were using their Walk-In service as the "gateway" to intake within their agencies. YCFC planned to transition their Walk-In service to reflect these positive outcomes, and focus on reducing their long waitlist through the provision of more immediate service. They planned to restructure the Walk-In service to reflect this goal, and decided to no longer offer service to individual adults as a result. These changes were planned for the next several months.

Research

Timeframe. Client outcomes evaluation has been ongoing since implementation in 2000 (i.e., client satisfaction surveys and analysis of the self-report of problems /symptoms). A formal evaluation was conducted in the fall of 2006 by Yorktown Child and Family Centre (Karen Engel, Linda Sumner, Sharna Cohen), in partnership with the Hospital for Sick Children (Melanie Barwick, Diana Urajnik) and the University of Western Ontario (Graham Reid), with funding from the Provincial Centre of Excellence for Child and Youth Mental Health. The evaluation was concluded July 31, 2009.

Methods

Goals/Objectives: This study is an evaluation of the West End Walk-In Counselling Centre for children and youth with psychosocial problems. The objectives were to: (1) Describe the

mental health characteristics of Walk-In child and youth clients; (2) Examine outcomes (mental health, satisfaction) over a 3-month period of time; (3) Describe the service utilization of Walk-In clients prior to and following Walk-In Counselling Clinic service delivery; and (4) To compare the psychosocial adjustment and service use of Walk-In clients with those accessing usual care at Yorktown Child and Family Centre (it is important to note that those accessing usual care at Yorktown who participated in the research when measured at baseline, had not received any service other than intake at YCFC; perhaps it is a misnomer to name this group “service-as-usual.” It may be more appropriate to name them “those waiting for service-as-usual”).

Procedure: Study participants were clients 4-18 years recruited from both the West End Walk-In Counselling Centre and YCFC. Walk-In clients (n=112) were recruited as they came for service at the Centre. A comparison group of children (n=60) were recruited at the time of intake or their initial consultation meeting with a therapist (note: treatment had not begun at YCFC). Baseline study measures included the Brief Child and Family Phone Interview (BCFPI) (Cunningham, et al., 2003), and a satisfaction survey. Families were contacted by telephone for post (2-week) and 3-month follow-up assessments, at which time the BCFPI and satisfaction measures were re-administered, as was a measure of service use.

Data/Outcome Measures:

The Brief Child and Family Phone Interview (BCFPI-3) is a standardized measure of behavioural/emotional adjustment and functioning for children 3-18 years of age. The psychometric properties of the measure have been well-established with samples of community and clinic-referred children derived from the OCHS (see Cunningham, et al., 2002). Client Satisfaction was measured by a series of closed and open-ended items in a questionnaire developed by YCFC to assess participant satisfaction with the services received from the Walk-In Centre.

Service Utilization regarding formal/informal help sought by the client and his/her family was captured by a semi-structured interview (Reid, 2006). This interview assessed help-seeking behaviour and trajectory of service use in the community.

Results/Tellings

Walk-In clients present with behavioural problems and impaired self/family functioning. BCFPI scores were above or approaching two standard deviations above the mean for family functioning (T=73), child functioning (T=68), and externalizing problems (T=68) (Figure 1). Walk-In clients tended to have higher scores on the BCFPI composite scales (particularly the externalizing and family functioning scales) as compared to our YCFC comparison group. However, there were no statistically significant differences between the two groups of clients on any of the global scale scores at baseline ($p > 0.05$).

Repeated measures analyses showed significant reductions on all of the global scales at post Walk-In access; on average, these clients continued to make gains 3 months after contact – more so for behavioural and family functioning (Figure 2). YCFC comparison clients also showed behavioural improvements up to 3 months post initial contact, although there was some slippage in terms of emotional and child functioning (Figure 3). However, improvements

over time were not statistically significant (with the exception of the internalizing scale, $p < 0.05$).

Figure 1. Average baseline BCFPI T-scores for Walk-In and YCFC comparison group clients (parent informant).

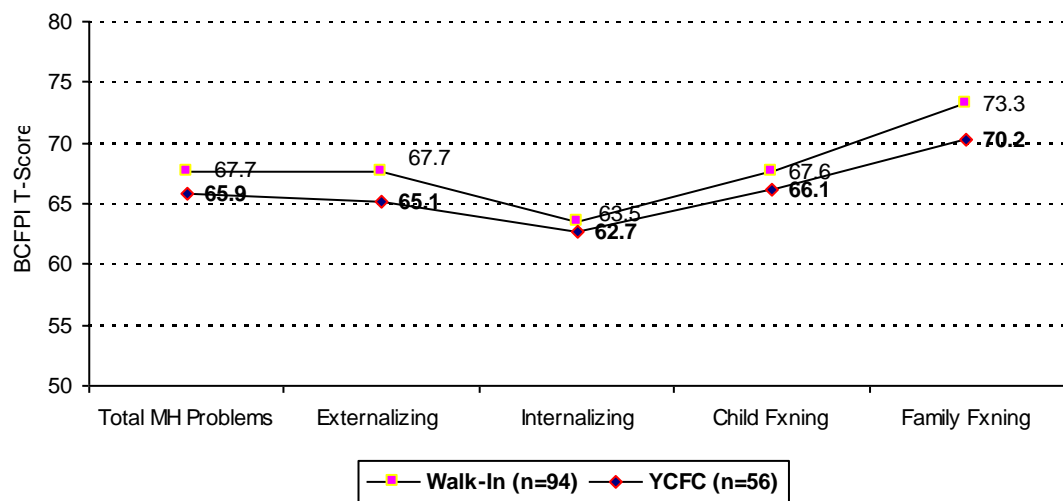
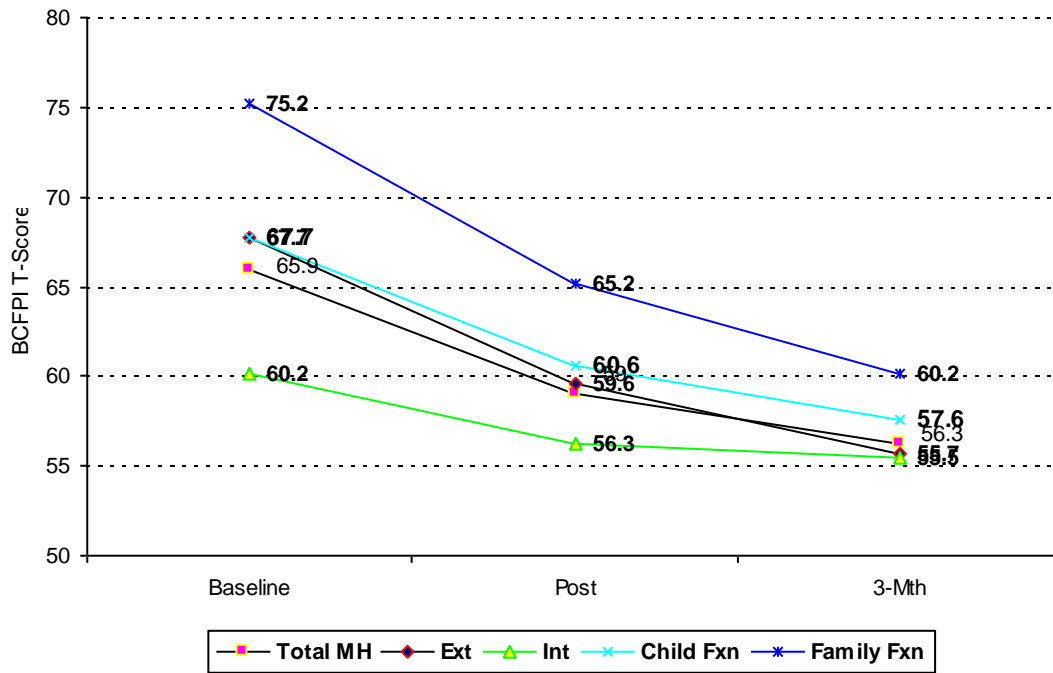


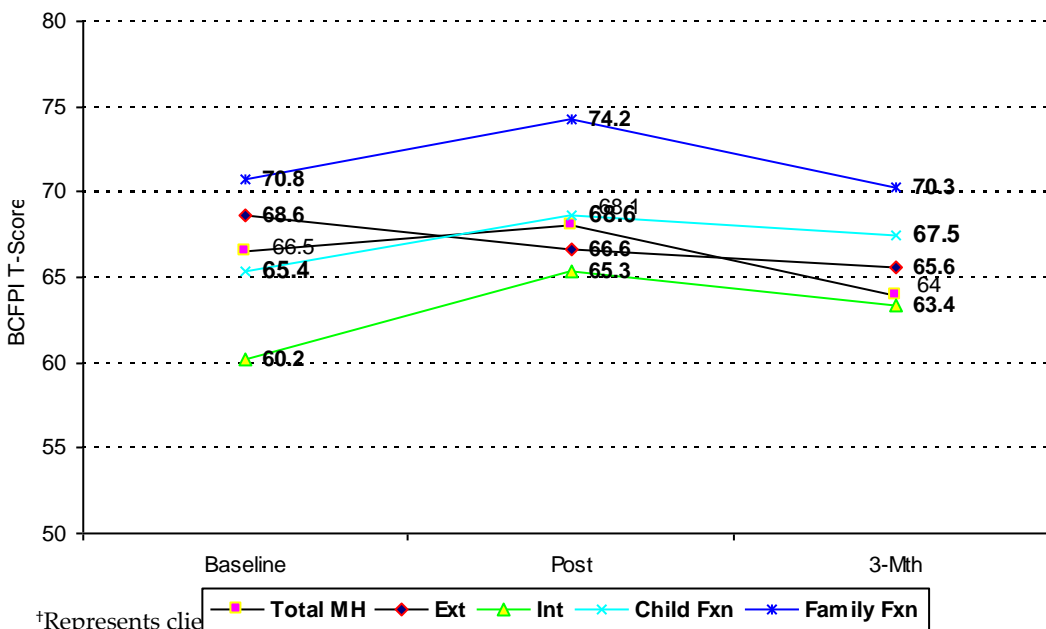
Figure 2. Repeated measures analysis for baseline, post, and follow-up BCFPI global scores for Walk-In clients (parent informant). ^{†,‡}



[†]Represents clients with assessments at all time points (n=40).

[‡]p < .001 for all scales over time.

Figure 3. Repeated measures analysis for baseline, post, and follow-up BCFPI global scores for YFCF comparison group clients (parent informant). ^{†,‡}



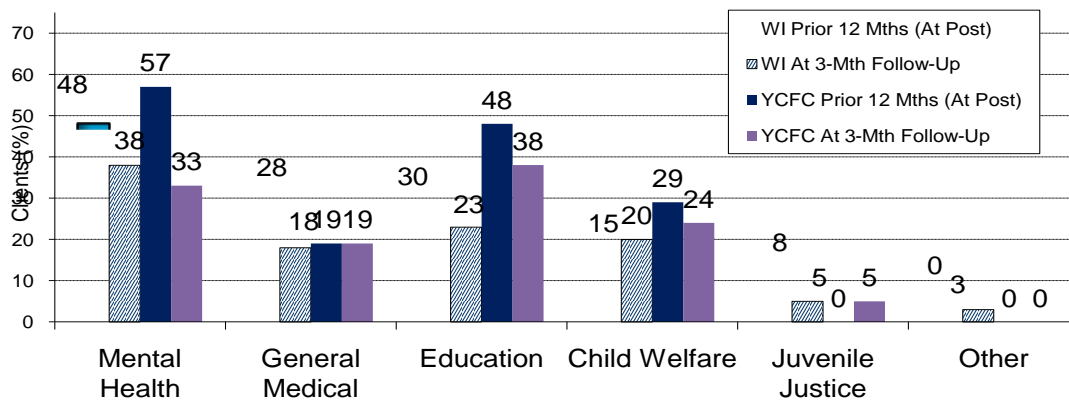
[†]Represents clients with assessments at all time points (n=40).

[‡]p > .05 for all scales over time with the exception of internalizing (p < .05).

Walk-In clients presented with slightly more intense psychosocial problems (behavioural and family in particular) than YCFC clients, and showed significant improvement in these areas over a 3-month period of time. Improvements could have been due to the nature of the Walk-In model, however, YCFC comparison group clients also show improvements. Improvements in adjustment may be partially explained by the use of other services. They are currently tracking service use at post- and 3-month follow-up.

Figure 4 depicts the service utilization (mental health treatment contacts) post contact for Walk-In and YCFC clients in the 12 months prior to their baseline visit (captured at the post follow-up point), and in the 3 months after the initial contact (assessed at the 3-mth follow-up point). The data show service utilization to be highest in the mental health and education sectors for both Walk-In and YCFC comparison clients, as compared to other sectors (e.g. general medical, child welfare). In addition, a larger percentage of YCFC clients had contact with mental health/education, than Walk-In children/youth. Perhaps one would expect that both Walk-In and comparison group clients would have more treatment from mental health and education, as the general medical sector and child welfare mainly refer clients seeking/requiring mental health services. It could also mean that clients still feel the need for, or require mental health services even after a single consultation.

Figure 4. Percentage of Walk-In and YCFC comparison clients with treatment contact across various sectors (parent informant). †,‡



†Represents clients with assessments at all time points (Walk-In, n=40; YCFC comparison, n=21).

‡The Juvenile Justice category represents those having had police/probation contacts, and not "treatment" in the usual sense for MH problems.

Summary: The Walk-In Centre has provided a much-needed counselling resource to the community. Walk-In clients showed significant improvement in all areas of psychosocial functioning over a 3-month period of time, using a standardized measure of adjustment (BCFPI), and were largely satisfied with the structure/nature of Walk-In service (96% of parents

accessing the Centre; 78 of 81 responses). YCFC comparison group clients also show some improvements.

Limitations: Results for the YCFC group must be interpreted with an understanding that they had consented to participate at an intake/an initial client meeting, and do not represent all clients coming to YCFC or receiving service. In other words, the composition of this group of clients waiting for service may represent those who “self-select” (e.g. affected by motivational factors) to come to an initial intake or consultation (“business”) meeting. It may be that more impaired YCFC clients either go straight to service, or have difficulty in attending intake procedures (meeting included), and that these clients are not represented in our sample. This may help explain the findings for psychosocial characteristics and the pattern of outcome results for this group. Caution must also be exercised in terms of YCFC control group outcomes due to the limited amount of follow-up data. They have n=28 and 32 post and 3-month follow-up interviews for our parent informants, respectively, with n=21 parents with full outcomes data. On the other hand, they have 57 post and 51 3-month parent interviews, with n=40 parents with full data for our Walk-In study group.

Recommendations

While these results are extremely encouraging, they are largely descriptive and preliminary. They are continuing to examine psychosocial adjustment data (e.g. group comparisons, outcomes and service use). However, there is need for further follow-up data in order to accommodate more complex analyses and to examine the impact of Walk-In clinics over a longer period of time – from both an individual client and system perspective. An unexpected finding was the possible positive impact of an initial meeting with clients waiting for service (comparison group clients). Although the improvements are not sustainable over time, it is nevertheless interesting and perhaps encouraging that a single business meeting, which may also involve some referrals to services while waiting, can assist clients, at least initially.

Recommendations for future research activity would be to examine: 1) The association between child/family outcomes and service use (within the mental health sector, and across sectors); 2) The functioning of clients who have reported not using services before/after Walk-In Clinic access; 3) Clients with repeat visits to the Walk-In, or who have reported multiple service use; 4) Data for youth, special populations (e.g. immigrants); 5) Longitudinal outcomes using a variety of measures (e.g. service, client); and 6) A further examination of the impact of early-focused support and assistance in the overall plan for improved outcomes for clients.

Overview of the History and Descriptions of the Walk-In Counselling Clinics

Nine agencies sent descriptions of their Walk-In Counselling Clinics for inclusion in this report. Five of the agencies are organizations serving children and adolescents and their families (Children's Mental Health Agencies), and three are Family Counselling Agencies that serve adults as well as children, adolescents and their families. The Thunder Bay Walk-In is unique in that a children's mental health agency and a family service agency partnered to create one Walk-In Counselling Clinic that serves the needs of the clients of both agencies.

Most agencies stated that the primary reason for creating a Walk-In Counselling Clinic was a lengthy waiting list and a desire to provide their communities with more immediate access to counselling. In two cases, it was mentioned that a new Executive Director for the agency influenced the decision to open a Walk-In Counselling Clinic.

The length of time each Walk-In Counselling Clinic has been operating varies considerably. It appears that Yorktown Child and Family Centre took the lead in developing a partnership with three other children's mental health agencies in approximately 2000 to develop a Walk-In Counselling Clinic modelled on one in Calgary, Alberta. This partnership received funding from the Trillium Foundation until 2003 at which time two of the partners withdrew, and the third partner withdrew in 2006. Yorktown has been operating their clinic without partners since that time. ROCK began its clinic in 2001. Oolagen Community Services was one of the four partners with Yorktown and that agency began its own clinic in 2003. Catholic Family Services of Hamilton launched their first Walk-In Counselling Clinic in 2004. REACH began its clinic in 2006 and Thunder Bay, K-W Counselling, Catholic Family Services Peel-Dufferin (CFSPeel-Dufferin) and kidsLink/Lutherwood Front Door opened their clinics in 2007. Oolagen expanded their clinic from four-hours per week to an eight-hour clinic, one day per week in 2008.

In terms of the population that each Walk-In Counselling Clinic serves, those agencies for whom the primary mandate is children's mental health usually serve children and adolescents up to 18 years of age and their families in their walk-in clinics. The three Family Service agencies provide walk-in services to people of all ages. The exceptions include Yorktown Child and Family Centre who, up until recently, served adults as well as children and adolescents, and Oolagen Community Services, which serves only adolescents from 13 to 18 years. Two agencies mentioned that they are now serving more men because of the accessibility of the walk-in clinic. Thunder Bay serves people of all ages, representing both the mandate of children's mental health and the family services agency.

Five of the agencies offer walk-in counselling at one site only (HD REACH, Front Door, K-W Counselling, Oolagen, and Yorktown). ROCK has three sites where walk-in services are offered once per week and CFS-Hamilton has two sites where services are offered once per week. CFS Peel-Dufferin originally had three sites, but currently offers two sites and walk-in counselling is offered once per week in both sites. Thunder Bay operates a Walk-In Counselling Clinic one day per week at two sites, alternating the location between the two host agencies. Most Walk-In Counselling Clinics are open for 7 or 8 hours during one day per week. Until recently, Yorktown offered two evening clinics, one from 5:00 p.m. to 8:00 p.m., and the other from 4:00 p.m. to 8:00 p.m. It currently offers only one evening clinic from 4:00 to 8:00

p.m. because of reduced funding. CFS-Hamilton offers services for 7½ hours, one day per week in one site and for 3 ½ hours per week in the second site

The way that these clinics are funded varies considerably. REACH, Front Door, Thunder Bay and Oolagen report that they receive funding from the Ministry of Children and Youth, and Yorktown reports in-kind support from the same Ministry. K-W Counselling, CFS-Hamilton, CFS Peel-Dufferin, Thunder Bay and Yorktown report funding from United Way. Some family service agencies use a portion of their funding for Violence against Women programs received from the Ministry of Community and Social Services to support services provided through their Walk-In Counselling Clinics. It appears that most of the agencies have diverted a portion of their base funding to the Walk-In Counselling Clinics and few have received funding specifically for the walk-in services. Yorktown received funding from Trillium and CHEO in the past but these funds were time-limited, and services had to be cut when the funding ended.

We see considerable similarity in the therapeutic modalities that are practiced in the Walk-In Counselling Clinics. Several of the agencies noted that their staff members are trained in brief therapies including solution-focused and narrative approaches. ROCK and Oolagen appear to use primarily narrative approaches, whereas CFS Peel-Dufferin and Thunder Bay use primarily solution-focused approaches, and CFS-Hamilton uses both solution-focused and narrative approaches. ROCK and REACH frequently use an “outsider witness” and Yorktown uses a reflecting team when staffing and client agreement permit. Others include “strengths-based” and cognitive behavioural therapies.

The number of staff involved in the Walk-In service is associated with the demand for the services and whether or not the clinic is the “front door” to agency services. All have a supervisor available for consultation, and trained receptionists are necessary. Variation exists with respect to the use of students in the Walk-In Counselling Clinics. Yorktown does not involve students but is unique in that they offer individuals with post-graduate training an opportunity to learn the single-session approach in exchange for providing volunteer service in the clinic. Oolagen also does not involve students, whereas the remaining agencies do involve student interns from a range of programs and disciplines. K-W Counselling has trained volunteers to assist in the reception area.

Most of the organizations have arranged in-house training for therapists working in the clinics. ROCK notes that training sessions were frequent before start-up of the clinic and they continue about twice per year. Others report training events at least yearly, with on-going opportunities to consult either via regular group meetings or through supervision/consultation. A number of agencies have recognized the expertise of Karen Young and Scot Cooper and invited them to provide training for their staff.

We asked organizations to comment on whether or not they use standardized assessments with walk-in clients. Most reported that they do not, but almost all are collecting some information before and after the session. Several clinics are using a version of the Session Rating Scale (Johnson, Miller & Duncan, 2000), and some are using scales developed by the Thunder Bay team, Karen Young and others. K-W Counselling is using the OQ-45 (Lambert,

Hansen, Umphress, et al. 1996), and Yorktown used the Brief Child and Family Phone Interview (BCFPI-3) (Cunningham et al., 2009) in their research study.

We note that there is variation in terms of another characteristic that seems important, namely whether the clinic serves as the “front door” or “gateway” to other services in the agency. For CFS-Hamilton, ROCK and Oolagen Community Services, the clinic is the gateway to other services. For K-W Counselling, CFS Peel-Dufferin, Front Door, Thunder Bay and REACH, it is not the only route to other services the agencies offer. Yorktown reports that for many years the Walk-In Counselling Clinic was separate from the rest of the organization’s programs, but because the wait list for treatment services in their organization continues to be lengthy, and because of positive reports from other agencies, they report a plan to move towards making the clinic the primary means to access services in their agency.

Overview of Research and Evaluation for the Walk-In Counselling Clinics

All of the agencies have collected or are currently collecting some type of client feedback post visit/session using a Likert-type scale. Sample sizes have varied from 26 to 1685. All agencies report very positive responses to the walk-in single-session intervention. Five agencies have studied or are studying client satisfaction (CFS Peel-Dufferin, Yorktown, K-W Counselling, Front Door and Thunder Bay). Those who have completed their studies report that a large majority of clients were very satisfied with the session immediately after the session and at follow-up. One of these agencies reports that 74% of clients indicated the walk-in session was an excellent experience; the other agency reports that 96% of parents accessing the centre were largely satisfied with the structure/nature of the walk-in service.

The kinds of outcomes that the agencies have studied are diverse. One study indicated that participants scored significantly higher on all items of a measure of Hopefulness after the session compared to scores prior to the session (CFS Peel-Dufferin). Another study (Yorktown) compared the characteristics, mental health symptoms, psychosocial adjustment and service use of children and adolescents using the Walk-In Counselling with those accessing usual care. Their data indicated that compared to the norms for the standardized measures, children presenting at their Walk-In Counselling Centre were significantly higher on measures of behavioural problems and externalizing symptoms, and lower on measures of child functioning; families were also lower on measures of family functioning. Walk-In clients tended to have higher scores on the BCFPI composite scales (particularly the externalizing and family functioning scales) compared to the group waiting for usual care, but were not different on any of the global scales at baseline. The study found significant reductions on all global scales at post Walk-In and as a group they continued to make gains at 3 months post Walk-In. The comparison group also made gains over this period of time but not to the same degree as those accessing Walk-In. Similarly, Walk-In clients presented with slightly more psychosocial problems than the comparison group and showed significant improvement over the 3 month time period following the Walk-In session. Service utilization appeared to be less in the three months post Walk-In compared to the 12 months prior to the Walk-In session for both groups.

Another study (REACH) asked participants aged 11 and over to complete a Session Rating Scale after the Walk-In session that assessed whether the client felt understood, agreed with what was discussed, whether the session was useful and whether they felt hopeful after the session. The average rating was 3.7 out of 4. Parents or caregivers completed a participant feedback form; 69% reported that they mostly or very much felt that the session had helped them deal with the problem, 69% said that they mostly or very much felt that the session had helped them develop a plan to address the problem, and 73% mostly or very much were carrying out the plan.

Another agency (ROCK) studied the range of concerns that clients using the clinic were experiencing, the reasons they came to Walk-In, and measured change on a number of desired outcomes. They report that at post Walk-In session, a sample of 408 clients were significantly less worried, felt more competent about their skills as a parent, felt more confident in their ability to resolve/manage the problem, were more knowledgeable about available resources, and had more ideas about how to resolve/manage their mental health problem. At two-month follow-up, improvement on three of the five desired outcomes was maintained. Data also indicated that they were using fewer negative coping strategies and more positive coping strategies at two months follow-up compared to base line. This study also revealed useful information about what the clients had learned during the Walk-In Counselling session.

Based on a mail and telephone survey of former Walk-In clients, another agency (K-W Counselling) reported that 91% of clients who had accessed the Walk-In Counselling Clinic required no further counselling. This study also collected data from staff, students, and stakeholders. Recommendations included frequent training for therapists and students.

Thunder Bay has studied several outcomes and reports improvement in the outcomes the clinic is targeting including: reduced stress, reduced negative physical symptoms related to identified problem, reduced negative coping, increased knowledge of cause of identified problem, increased level of confidence to address identified problem, increased knowledge of resources, and increased positive coping. That agency also notes that increased confidence to be able to fix the problem is significantly higher following the session, but does decline at follow-up. However, the decline is not back to initial levels so that some increase in confidence to be able to fix the problem is demonstrated even at follow-up.

From these studies, it seems clear that the majority of clients are not only satisfied with their experiences at Walk-In Counselling Clinics, but the research has identified a wide range of variables that show change following the walk-in session, and some studies have shown that the change is maintained or that clients are even more improved at follow-up.

Many of the agencies have also reported success in terms of reducing the waiting list for treatment; however, some agencies who did not use the Walk-In Counselling Clinic as the “front door” to all of the agencies’ services report continuation of long wait lists (e.g. Yorktown). One agency (CFS-PD) reports that having all new clients streamed through Walk-In has reduced the “no show” rate for first sessions scheduled as a follow-up to the Walk-In session.

Some agencies reported that the clinic has had a positive effect on staff morale, and several note that it has provided a useful modality for training interns and students. Two agencies noted that with the walk-in clinic they seem to be serving more men than previously.

Recommendations for future research:

The following is a list of the recommendations for future research suggested by the agencies:

Examine the impact of Walk-In Counselling over a longer period of time (longer than the two or three months follow-up that has been studied);

Examine the association between client outcomes and service use within the mental health sector and across sectors;

Examine the characteristics and functioning of clients who report not using other services before or after the clinic visit;

Examine the characteristics and functioning of clients who make repeat visits to the Walk-In Counselling Clinics;

More study of the experience of special populations who access the clinic (e.g. newcomers to Canada, youth, seniors etc.) is recommended;

More detailed study of the impact of early-focused support and assistance on the long-term outcomes for clients;

Focus on the nuanced and various ways that a walk-in session may affect clients' awareness of resources and their knowledge about how to solve the problem;

Use more open-ended questions of clients in future studies – this is a way to learn in areas that we don't know to ask questions about;

Employ more than one item to measure each outcome in order to increase the reliability of the findings.

To this excellent list we would add the following suggestions:

More studies are needed that employ a comparison or control group. This would add to the evidence that it is the Walk-In Counselling session that is associated with the improvement and not simply the passage of time or some other factor.

More studies using standardized measures or outside observer ratings are needed to increase the empirical support provided by studies of outcomes.

References

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Appendix 1

Instruments used at ROCK based on measures developed at Thunder Bay Clinic

Pre-test Questionnaire

Date: _____ Name: _____

Our goal is to provide the best service possible to you. As part of that promise, we are continually checking to see if our walk in clinic makes a difference. Please answer the following questions to the best of your ability. We will ask you similar questions at the end of the session and about two months later. Please know that you do not have to complete these questions in order to obtain services at ROCK. You also do not need to answer any questions that you do not want to. Furthermore, all information that we collect will be kept confidential.

What is the primary problem that has brought you to the walk-in clinic?

How long has this problem been a concern? _____

Why did you choose to access services through the walk-in clinic? Please circle any reasons that apply.

a) We needed to see a therapist quickly.
ROCK.

e) To access further services at

b) We wanted to become more familiar with what therapy is about. f) No other options were.
Available

c) Other people (e.g., school, friends, etc.) recommended it.

g) Other (please specify):

d) Clinic hours and location are convenient.

Please read each question carefully and circle the number (1-10) that best represents your answer. Note that the response options can change from question to question. There are no right or wrong answers, just your opinions.

At this time, how worried are you about the problem?

1	2	3	4	5	6	7	8	9	10
Not worried				Somewhat worried					Very worried

Are you using any negative coping strategies (e.g., drinking too much, eating too much, avoiding, crying, anger, sleeping too much) to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

Are you using any positive coping strategies (e.g., taking actions to make things better, seeking emotional support, looking for resources) to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

Does the problem negatively affect your relationships with your family (partner, children, parents, other)?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

Do you think that you are doing a good job as a parent?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

How much confidence do you have in your ability to resolve or manage the problem?

1	2	3	4	5	6	7	8	9	10
No confidence				Some confidence				A lot of confidence	

Do you know where you can get support or resources to help resolve/manage the problem?

1	2	3	4	5	6	7	8	9	10
No I don't				Some idea				Yes, I know all of them.	

Are you hopeful that the problem will change for the better?

1	2	3	4	5	6	7	8	9	10
Not hopeful				Somewhat hopeful				Very hopeful	

Do you have any ideas about how to resolve and/or manage the problem?

1	2	3	4	5	6	7	8	9	10
No ideas				Some ideas				A lot of ideas	

Post-test Questionnaire

Date: _____ Name: _____

Now that we have finished our session, could you take a moment to help us evaluate our service and answer the following questions to the best of your ability. Please know that you do not have to participate and that all information will be kept confidential.

1. The primary problem you identified today when you came to the walk-in clinic was:

Please read each question carefully and circle the number (1-10) that best represents your answer. Note that the response options can change from question to question. There are no right or wrong answers, just your opinions.

2. At this time, how worried are you about the problem?

1	2	3	4	5	6	7	8	9	10
Not worried				Somewhat worried					Very worried

Comments: _____

3. Does the problem negatively affect your relationships with your family (partner, children, parents, other)?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

Comments: _____

4. Do you think that you are doing a good job as a parent?

1 2 3 4 5 6 7 8 9 10

Not
at all

Sometimes

All the
time

Comments: _____

5. How much confidence do you have in your ability to resolve or manage the problem?

1 2 3 4 5 6 7 8 9 10

No
confidence

Some
confidence

A lot of
confidence

Comments: _____

6. Do you know where you can get support or resources to help resolve/manage the problem?

1 2 3 4 5 6 7 8 9 10

No
I don't

Some
idea

Yes, I know
all of them.

Comments: _____

7. Are you hopeful that the problem will change for the better?

1 2 3 4 5 6 7 8 9 10

Not

Somewhat
hopeful

Very hopeful

Comments: _____

8. Do you have any ideas about how to resolve and/or manage the problem?

1	2	3	4	5	6	7	8	9	10
No ideas				Some ideas					A lot of ideas

Comments: _____

As part of our promise to improve our services and to increase possible funding sources for the clinic, we would like to contact you in about two months to see how you are doing. This contact would be specific to the service we provided and for evaluation and research-related purposes only. I consent to being contacted by ROCK's walk-in clinic.

Signature

Contact Phone #: _____
E-mail address: _____

I would prefer to be contacted by (please circle): a) Phone b) E-mail

2 Month Post-test Questionnaire

Date: _____ Name: _____ Phone # _____

Email: _____

As you know, our goal is to provide the best service possible to you. As part of that promise, we are continually checking to see if our counselling service makes a difference. This is our two month follow up and we would like to ask you a few questions in order to evaluate our service. Please know that you do not have to participate and that all information will be kept confidential.

1. When you attended the walk-in clinic on _____ the primary problem you identified was _____

2. Have you accessed other services at ROCK since your participation in the walk in clinic?

YES NO

3. Is the problem a concern for you now? YES (go to follow-up version A) NO (go to follow-up version B)

Follow-Up Version A (for clients for whom problem is still a concern)

4. If you chose not to access further services at ROCK's walk in clinic, why was this the case? _____

5. At this time, how worried are you about the problem?

1 2 3 4 5 6 7 8 9 10

Not
worried

Somewhat

Very
worried

6. Are you using any negative coping strategies (e.g., drinking too much, eating too much, avoiding, crying, anger, sleeping too much) to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

7. Are you using any positive coping strategies (e.g., taking actions to make things better, seeking emotional support, looking for resources) to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

8. Does the problem negatively affect your relationships with your family (partner, children, parents, other)?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

9. Do you think that you are doing a good job as a parent?

1	2	3	4	5	6	7	8	9	10
Not at all				Sometimes					All the time

10. How much confidence do you have in your ability to resolve or manage the problem?

1	2	3	4	5	6	7	8	9	10
No confidence				Some confidence					A lot of confidence

11. Do you know where you can get support or resources to help resolve/manage the problem?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

No I don't				Some idea					Yes, I know all of them.
12. Are you hopeful that <u>the problem</u> will change for the better?									
1	2	3	4	5	6	7	8	9	10
Not hopeful				Somewhat hopeful			Very hopeful		

13. Do you have any ideas about how to resolve and/or manage the problem?

1	2	3	4	5	6	7	8	9	10
No ideas				Some ideas			A lot of ideas		

14. Do you have any other comments or feedback?

Follow-Up Version B (for clients for whom problem is not a concern)

4. If you chose not to access further services at ROCK's walk in clinic, why was this the case?

5. Did the session at the walk in clinic help reduce your worry about the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

6. Did the session at the walk in clinic help reduce the negative coping strategies (e.g., drinking too much, eating too much, avoiding, crying, anger, sleeping too much) that you used to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

7. Did the session at the walk in clinic help increase the positive coping strategies (e.g., taking actions to make things better, seeking emotional support, looking for resources) that you used to deal with the problem?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

8. Did the session at the walk in clinic reduce the negative impact that the problem had on your relationships with your family (partner, children, parents, other)?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

9. Did the session at the walk in clinic assist you in knowing what you are doing well as a parent?

1 2 3 4 5 6 7 8 9 10

Not
at all

Somewhat

A lot

10. Did the session at the walk in clinic increase your confidence in your ability to resolve or manage the problem?

1 2 3 4 5 6 7 8 9 10

Not
at all

Somewhat

A lot

11. Did the session at the walk in clinic increase your awareness about the support or resources that you could use to help resolve/manage the problem?

1 2 3 4 5 6 7 8 9 10

Not
at all

Somewhat

A lot

12. Did the session at the walk in clinic give you more hope that the problem would change for the better?

1 2 3 4 5 6 7 8 9 10

Not
at all

Somewhat

A lot

13. Did the session at the walk in clinic give you ideas about how to resolve and/or manage the problem?

1 2 3 4 5 6 7 8 9 10

Not
at all

Somewhat

A lot

14. Do you have any other comments or feedback?

Appendix 2

Service Evaluation Forms Used by Thunder Bay Walk-In Counselling Clinic

Service Evaluation - #1

Date: _____ Name: _____

Welcome to the Walk-In Counselling Clinic

One of our goals in the clinic is to provide the best counselling service possible to you and others who attend. A second and equally important goal is to evaluate the effectiveness of our services.

As part of these commitments, we check to see if our counselling makes a difference in your life and if you are satisfied with the service you receive.

Please answer the following questions to the best of your ability. We will ask you similar questions at the end of the session and with your consent we may call you in about a month to ask us how we did.

Please know that participation in our evaluation is voluntary and that all information will be kept confidential. If you choose not to participate, this will not affect your ability to receive service from the clinic.

Thank you again for your time and assistance

1. What is the primary problem that has brought you to our Walk-In Counselling Clinic today?

2. From whom do you currently get support (family, friends, professionals church, work, partner or other)? Please list.

PLEASE TURN PAGE OVER

For each of the following, please circle the number (1-10) that best represents your answer.

3. At this time, how much stress is **the problem** causing for you?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

4. Are you experiencing any negative physical symptoms (headaches, stomach troubles, sleep problems, weight gain/loss, etc) you feel are related to **the problem**?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

5. Are you using any unhealthy coping strategies (drinking too much, eating too much, avoiding, crying, anger, sleeping too much) that interfere with your life?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

6. How are your relationships with your immediate family (partner, children, parents)?

1 2 3 4 5 6 7 8 9 10
Poor Not Good Good Very Good

7. Do you understand what is causing **the problem** for you?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

8. How much confidence do you have to fix or resolve **the problem**?

1 2 3 4 5 6 7 8 9 10
None A little Some A lot

9. Do you know where you can get support or resources to help resolve **the problem**?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

Post Session Questions

Date: _____ Name: _____

Now that we have finished our session, could you take a moment to help us evaluate our service and answer the following questions to the best of your ability? Please know that you do not have to participate and that all information will be kept confidential.

Please circle the number (1-10) that best represents your answer.

10. Following your counselling session, how much stress is **the problem** causing for you?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

11. Do you understand what is causing **the problem** for you?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

12. How much confidence do you have to fix or resolve **the problem**?

1 2 3 4 5 6 7 8 9 10
None A little Some A lot

13. Do you know where you can get support or resources to help resolve **the problem**?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

Please take a minute to tell us how we did in providing service to you.

14. How satisfied were you with the service you received today.

Very Satisfied Satisfied Somewhat satisfied Somewhat dissatisfied Dissatisfied Very Dissatisfied

PLEASE TURN PAGE OVER

15. Did the session help you with the problem you wanted to address?

Yes very much	Yes Sort of	A Little	Not really	No Not much	No Not at all
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16. Did you feel heard and listened to by the counsellor?

Yes very much	Yes Sort of	A Little	Not really	No Not much	No Not at all
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17. Did you feel welcome at the walk-in clinic?

Yes very much	Yes Sort of	A Little	Not really	No Not much	No Not at all
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18. Any other comments you would like to make?

As part of our promise to improve our services, we might wish to contact you in about a month to see how you are doing. This contact would be specific to the service we provided and for evaluation purposes only. I consent to being contacted by the Walk-In counselling clinic.

Signature

Contact Phone # _____

20/06/2009

Service Evaluation - #3 (one month after service – phone interview)

Date: _____ Name: _____ Phone # _____

On (DATE) you attended the Walk-In Counselling Clinic and consented to participating in a follow up call. This will take about 5 minutes. Thank you for taking the time to participate in our evaluation process. Please know that participation in our evaluation is voluntary and that all information will be kept confidential. If you choose not to participate, this will not affect your ability to receive quality service from the walk-in clinic.

19. When you attended the clinic, the primary problem you identified was:

20. At this time, how much stress is the problem causing for you?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

21. Are you experiencing any negative physical symptoms (headaches, stomach troubles, sleep problems, weight gain/loss, etc) you feel are related to the problem?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

22. Are you using any unhealthy coping strategies (drinking too much, eating too much, avoiding, crying, anger, sleeping too much) you wish you could stop or change?

1 2 3 4 5 6 7 8 9 10
None A little A lot Too much

23. How are your relationships with your immediate family (partner, children, parents)?

1 2 3 4 5 6 7 8 9 10
Poor Not Good Good Very Good

24. Do you understand what is causing the problem for you?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

25. Do you feel some confidence to fix or resolve the problem?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

26. Have you developed any positive coping strategies to assist with the problem?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

Ask person for 2-3 examples

27. Did you access support or resources (professional) to help resolve the problem?

1 2 3 4 5 6 7 8 9 10
No A little Sort of Yes

Ask person - Where specifically did you access support/resources?

Client Satisfaction Questions

28. Please rate your overall level of satisfaction with the service you received.

Very Satisfied Satisfied Somewhat satisfied Somewhat dissatisfied Dissatisfied Very Dissatisfied

29. Did the session help you with the problem you wanted to address?

Yes very much Yes Sort of A Little Not really No Not much No Not at all

30. Did you feel heard and listened to by the counsellor?

Yes very much Yes Sort of A Little Not really No Not much No Not at all

31. Did you feel welcome at the walk-in clinic?

Yes very much Yes Sort of A Little Not really No Not much No Not at all

32. If you needed to, would you use the Walk-in clinic again?

Yes very much Yes Sort of A Little Not really No Not much No Not at all

33. Would you recommend the walk-in clinic to other people?

Yes very much Yes Sort of A Little Not really No Not much No Not at all

34. Any other comments you would like to make?

35. Where did you hear about us? _____