Walk-In Counselling Services: Making the Most of One Hour

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This article describes walk-in single session counselling, a form of service delivery that enables clients to receive one session of counselling without the usual hurdles of intake and wait times. We distinguish between walk-in counselling and single session therapy by appointment. We describe a mindset for therapists that supports walk-in work. We also describe the workings of a walk-in session using a transcript, with commentary, of an actual session. Benefits and possible applications of the walk-in counselling concept are discussed.

Keywords: brief therapy, accessibility, cost efficiency, mental health services

We begin with a case example that will continue intermittently throughout this article:

> *Arnie*: So maybe we could start, and just explain a little about how we work, to see if you have any questions. You've come for what we call our walk-in service. You can come as you have today; you didn't need an appointment. If you want to at some point in the future, you could come back in the same way. Some people find that one session works for them. You know, they get what they want from it and leave, and that's that. Some people decide they want to walk in again. Some people decide they'd like to make an appointment and see somebody here. When we get to the end, we can talk about that. So what are you hoping for today in coming here?
> *Manny*: Well, we've been together for a little over a year. And we've had, you know, problems in our relationship, and we want to try to . . . I don't know if fix them, but to find out a reason why they're happening, try to find a solution. And I personally think I have a lot of problems psychologically. So I would like to try to find a reason why, or at least try to understand why I have the behavior that I've been having throughout my adult life.
> *Monte*: And how did you guys come to the decision to come today to talk about those things?
> *Vera*: Well, it was my idea. I had already talked to him (Manny) about this several months ago. But we never did anything. But he's threatened to take his own life at least five times in the last two weeks.

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Manny and Vera had called earlier in the day to make an appointment for marital counselling and, when told about the walk-in option, elected to come to the clinic right away. They arrived during a time when we were cosupervising a team of six graduate student therapists at the Community Counseling Service (CCS), a training clinic operated by Our Lady of the Lake University in San Antonio, Texas. The structure of the CCS and our team-based, live-supervision model has been described elsewhere (Bobele, Lopez, Scamardo, & Solórzano, 2008). Typically, the teams schedule one appointment per hour and are also available for walk-ins. (It should be noted that while our training setting allows for a team of therapists, neither a team or cotherapists are necessary to do walk-in work.) In the CCS, two therapists conduct the session, with one or more team members observing. The therapists take a break to consult with their team part way through the session. In this instance, we decided to see the couple as a demonstration for the students, with the students acting as our team.

Walk-In and Single Session Therapy

Walk-in therapy and single session therapy are two related forms of brief therapy. Brief therapy approaches have developed extensively over the last several decades. These models challenge the idea that enduring change must come through long and laborious mental health interventions. There is consistent evidence of the remarkable effectiveness of brief interventions in the literature. The development of brief therapy models has been influenced by schools of thought ranging from psychodynamic to systemic to behaviour therapy (Hoyt, 2009). All are based on the idea that change can occur in relatively few sessions.

Walk-in therapy is both similar to and different from single session therapy (Talmon, 1990; Hoyt, 1994). Both treat each session as a complete therapy, in and of itself. In both approaches, clients present a concern and goals are constructed. Both aim for clients to leave with a sense of hopefulness, knowing that they have been heard, and having gained an increased awareness of their strengths and resources. In some circumstances, clients may have also begun to develop a plan on how to address their issues. The most obvious difference between the two is that walk-in therapy requires no appointment — clients just walk in. Also, walk-in therapy is not a pure form of single session therapy. Clients are invited to return as often as they choose, on their own schedules, though should they return they may not see the same therapist. Finally, there is no prior screening of walk-in clients. Clients determine who is seen simply by walking in. A 'by appointment' service, including a single-session service, offers the possibility of prescreening clients.

What is Walk-In Counselling?

We live in a fast-paced world. Schedules are tight; meetings and appointments get squeezed into ever narrowing timeframes; family, work, and leisure demands compete with one another. In this environment, there are times when it is not possible to plan ahead and make an appointment. The business world has adapted by developing services that are immediately accessible without a prearranged appointment. Hence, we have fast food, drive-in banks, walk-in hair stylists, 'no appointment necessary' income

tax services, instant breakfasts, and even walk-in wedding chapels. Walk-in medical clinics have proliferated since the 1980s. Patients walk in and see a physician without an appointment. Signs advertising 'Walk-ins welcome' have become commonplace. Walk-in services are becoming more common because they fit into our lifestyles. Walk-in convenience is a highly prized commodity in many areas of our lives. This prompts the question: What about walk-in mental health services?

The first walk-in counselling service in the U.S. that we know of was started in Minneapolis in 1969 (Schoener, 2011). It was unique for its time in that it did not require an appointment for services and was entirely staffed by volunteers. In 1990, Slive and his colleagues developed a walk-in counselling service in Calgary, Canada (Slive, MacLaurin, Oakander, & Amundson, 1995). An entire section of the *Journal of Systemic Therapies* (Slive, 2008) was recently devoted to walk-in therapy. A recent international conference in Toronto, Canada, was built around the applications of walk-in therapy in Canada and the U.S. In a recent volume, we described walk-in services in a variety of settings (Slive & Bobele, 2011). Such walk-in services provide the opportunity to have a session of counselling without the hassle of intake processes and waits. Walk-in services reduce or eliminate the traditional administrative hurdles potential clients face. A walk-in session does not even require a phone call. The only steps required are showing up, filling out a brief form, and waiting for the session to start. There is no screening; anyone who shows up is seen. Walk-in clients tend to be highly motivated because they are likely to come at a time when they are ready to change.

The Single Session Mindset

In Slive and Bobele (2011), we summarized the research that has demonstrated that single sessions of psychotherapy are common and effective. Further, researchers have found that most clients, even those with long-standing issues, can be helped in one hour. For therapists to capitalize on this phenomenon, what is needed are alternative ways to think about psychotherapy — a different mindset. We have learned that a crucial element for conducting successful walk-in sessions is the therapist's own beliefs about the effectiveness of brief therapy. Therapists' expectations are communicated overtly and covertly about how rapid and how much change can be expected. We have also developed a motto that we repeat like a mantra to our graduate students and trainees: Every case has the potential to be a single-session case!

Our single-session mindset is based on a number of factors. We think clients know what is best for them. Clients are far less interested in psychotherapy than are therapists. They frequently choose to attend only one session of therapy, and express satisfaction with that session. Many clients prefer a brief therapeutic encounter. It is common for clients to make dramatic initial improvements at the beginning of a therapy experience, with declining improvement as the number of therapy sessions increases (Bloom, 2001; Howard, Kopta, Krause, & Orlinsky, 1986; Seligman, 1995). The dose–response and the phase models literature describe substantial improvements in the early stages of psychotherapy, followed by ever decreasing improvements as psychotherapy continues, (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen 2009; Barkham, Connell, Stiles, Miles, Margison, Evans & Mellor-Clark 2006; Feaster, Newman, & Rice, 2003; Hansen &

Lambert 2003; Harnett, O'Donovan, & Lambert, 2010; Lambert & Forman, 2002; Wolgast, Lambert, & Puschner 2003). Rapid change is not only possible, but also common in human experience. There is no established direct correlation between the duration of the complaint or the severity of the complaint and the duration of the treatment.

Making Walk-In Single Sessions Work

Our minimal goals in walk-in therapy are for the client to leave the session with a sense of emotional relief and increased hope. For one client, a positive outcome may be as straightforward as knowing that someone has heard their story. For another client, it could be a new way of thinking about a problem — the beginning of a new story. The new way of thinking about a problem may, in another instance, involve deciding that this is not a problem after all. Another client may leave the session with a specific task, a new way of approaching a troubling issue. Or a client may leave with ideas about where to get further help. The following are some ideas that help us to achieve these outcomes.

Fisch (1994) argued that the narrower the scope of the therapeutic conversation, the briefer, more efficient the therapy. We focus on the problem as it occurs in the present. We do not focus on questions about the past, theories of 'underlying cause', or the function of the problem. We have borrowed from solution-focused and narrative therapists (Berg & Miller, 1992; Freedman & Coombs, 1996; Lipchik, 2002; White, 1986; White & Epston, 1990) who all assert that 'the problem is the problem' as the client presents it. We work collaboratively with each client to establish specific behavioural goals, which enables us to focus efficiently and to structure the session to work toward those goals.

Although our work is beholden to the strength-based approaches mentioned above, meta-analyses of four decades of psychotherapy outcome research have concluded that the effectiveness of therapies in general is not due to the uniqueness of the various models of therapy, but instead to the common ways the approaches empower factors associated with positive client outcomes (Duncan, Miller, Wampold, & Hubble, 2010; Duncan, Miller, & Sparks, 2004; Wampold, 2001). These researchers have concluded that much of the outcome variance in therapeutic change is attributable to a strong therapeutic relationship that effectively utilises existing client strengths and resources. We make use of common factors by attending to client motivation, focusing on client wants, linking hope with expectations for improvement from the therapeutic process, and seeking continuous feedback from the client about how the methods used by the therapist fit with the client's own ideas about what is helpful.

We begin each session assuming that it will comprise the whole therapy. This idea was well articulated by Ray and Keeney (1993) when they advised that all sessions should aim to be a whole therapy by focusing on a beginning, middle, and end. That is not to say that a client might not come back for another session, but each subsequent session is treated as a new therapeutic episode. This sentiment was foreshadowed by Haley, who said 'Maybe you don't have a case really, except for the first interview. That would be nice I think. Every therapist should shoot for one session' (Haley & Richeport-Haley, 2003, p. 33).

We prefer to think of walk-in therapy as a consultation process in which the therapist offers ideas (many of which may have come from the client), and the client decides whether to accept them, reject them, or put them on hold. A consultation stance helps therapists to resist the temptation to take responsibility for client change. We believe that the clients are their own greatest resource. Clients are in the best position to evaluate the ideas generated during the session. Our job is to create a context that enables clients to discover those resources and teach us how to be their guide.

Even though it is just an hour, therapists and their clients are not rushed in their walk-in sessions. Clients need to leave the session feeling that they have been heard and understood. Therapists need to pay close attention to the nuances of the client's communication. So we encourage therapists to slow down, sit back in the chair and breathe. One hour is plenty of time.

The Model in Action

We now return to Manny and Vera's session to illustrate how we put into action our model of walk-in single session therapy. We think it is important to find out early in the session what the client expects from the session. We have borrowed from the world of business where customers are always right and the successful business gives them what they want. As the session progressed, we learned that Manny had no plans to harm himself. He reassured us that his threats to kill himself were desperate cries for attention as a result of his feelings of hopelessness. Three weeks earlier, the couple had separated after Manny, unemployed, had failed to deal with their landlord's demand for rent, resulting in the family's eviction from their apartment.

> *Arnie*: So what are you hoping for from today's session?
> *Manny*: Well, we've been together for a little over a year. And we've had, you know, problems in our relationship, and we want to try to . . . I don't know if fix them, but to find out a reason why they're happening, try to find a solution. And I personally think I have a lot of problems psychologically. So I would like try to find a reason why, or at least try to understand why I have the behavior that I've been having throughout my adult life.

We want to ask questions that put the presenting concern into context. We do this by asking about why the couple had chosen to come today. Which one was more interested in coming? Who else was involved in the development or maintenance of the problem? Who in their lives would be most affected when they make positive changes?

> *Monte*: And how did you guys come to the decision to come today to talk about those things?
> *Vera*: Well, it was my idea. I had already talked to him about this months ago. But, we never did anything. But he's threatened to take his own life at least five times in the last two weeks. So I talked to him, and I told him, you know, everything has a solution. And I told him that I would call the police. And then he . . . he said it at least five times. And then the last time I talked to him, I told him that we should try to see a counselor. And I guess . . . we're here.
> *Monte*: And so what happened that you decided to come today?

Vera: Because he called. Well, I called and left a message. And then he called, and they told him that today was the best day to go. I mean, to . . . for walk-ins.
Arnie: You called here, and they told you about the option of just coming today.
Vera: Yeah.
Manny: Right.
Arnie: So you decided, you know, okay, if we can come today, we'll come today.
Vera: Yeah. And he needs help. And I'm sure I need help, too. And we need to see if our relationship can be fixed and can be better.

According to the common factors research referred to earlier (Duncan et al., 2010), extratherapeutic factors that clients bring to the session, such as client resources, are the most powerful contributors to therapeutic change. We listened carefully for the couple's descriptions of these resources. In the following segment, Manny offers us an idea about his personal resources.

Manny: I'm not dumb. I consider myself to be an intelligent person. I know how to do things. I know how to fix things. I know a lot more than the average person does. Yet I'm unable to find gainful employment or one that lasts or one where I can be successful at. I asked her earlier, 'How many jobs do you think I've had since I've been working?' And she just took a guess. Twenty. I've had about 20 jobs in the last 12 years. And it's not because I'm not good at them. It's just I get tired of them. I get bored.

And a little later:

Manny: I haven't gone to a job interview where I haven't gotten the job.

And:

Manny: Well, there's a lot of things that I can do. I learned to speak English on my own without going to school to learn to speak English. I lived in Mexico until I was 17. Everything recent that I know about computers, fixing computers, I learned on my own. Fixing cars. I do signs. I learned to do that on my own. Basically, I do graphic design. And I learned to do that on my own, never going to school to learn that. So a lot of those things I just know because I like to read. I like to learn stuff, and I'm quick at learning something.

We adhere strongly to the notion that only clients can solve their problems, and all clients have resources that can be directed toward problem solving. The job of the therapist is to direct the conversation in such a way that resources that could be used for problem solving are discovered.

We strive to define small, obtainable goals during the session. Single-session goals sometimes may be thought of as first steps on the way to meeting larger goals. So, when Manny said that his goal was to be more hopeful, we began to narrow that down.

Monte: So if you were to begin to feel a little bit more hopeful, Manny, what might Vera see that would be a sign to her that you were more hopeful? What would she see?
Manny: What would she need to see in order to believe that? That I can be held accountable for my actions, first of all, that —
Monte: What would be a little sign that you were being more accountable?
Manny: Talk to the people that I had hurt that were involved in this mess. Her parents.
Monte: Oh, her parents. That you would talk with them?
Monte: And what would you say that would give her some hope that —

Manny: I don't know what would give her hope, but I know that they didn't have to do everything they did, that I had to help her when she had to move her stuff, that they didn't have to do that.
Arnie: I think you may be saying if you apologized to these people —
Manny: Right.

So, we helped Manny identify a specific behaviour that would be a step toward achieving his goal of becoming hopeful and accountable. Vera caught on quickly and offered a big goal that needed paring down.

Vera: Well, to me, a big change would be if he stops looking at himself as the victim, because he does this a lot.
Monte: So that would be a big change.
Vera: That would be a huge change, if he stops that behavior for a considerable amount of time so that I can see that he really wants to change.
Monte: What does he do now that gives you the idea that he's thinking of himself as a victim?
Vera: Well, he says, 'Oh, nothing's going well for me. You know, all the doors have closed to me. I'm just a worthless person', or, you know, stuff like that.
Arnie: So when he becomes really hopeless and —
Vera: Yeah. Instead of saying, 'Well, you know what? I did everything wrong, but I'm going to try and fix it.'
Arnie: So . . . okay. So I've screwed up, but this is what I can do about it.
Vera: Yeah. Instead of saying, 'Oh, you know, I feel sorry for myself, because . . . '
Manny: I've never said I felt sorry for myself.
Vera: Okay, not in those words, but you —
Monte: But, that's what you hear.
Vera: Yes.
Monte: Okay. And so if you were to hear him say . . . what would give you . . . what would be . . . he might not be able to completely give up feeling like a victim, but if he were to start turning the corner there, he might say something like that to you? He might say, 'Well, I didn't get that job, but maybe I'll be able to get another job,' or something like that. That would be a small sign to you that he was moving away from feeling like a victim?
Vera: Yeah. Well, first of all, accept the fact that he was wrong and all this. But he has been saying this, and then he blames it on me. And then he goes back and forth, you know.
Monte: Okay.
Vera: So . . . and he says that, first of all. If he really . . . the last thing I told him before we actually decided to talk and come here was, 'You know what? I . . . you just stop saying all these things. I mean, you need to show me, not just say it, because that's kind of getting old, so . . . '

Here we try to get an idea of what Vera is hoping to see Manny do when he abandons his victim stance.

Arnie: And showing you. What would that look like?
Vera: Showing me that he's really willing to change. Like he's not feeling sorry for himself, and he really wants to try and change and make things better, you know.
Arnie: And how would you know? Like what might he do that would tell you he's taken a step in that direction of showing you?

Vera: First of all, act responsible. And if he needs to apologize to some people, he needs to do that. And —
Monte: So that would be … one thing that … being responsible would be to apologize. What would be something else?
Vera: Well, he's trying to find a job, which I think is a positive thing.
Monte: So if he was looking for a job, that would be a bit more responsible.

The end of every session begins with feedback from the therapists and might then be followed with a homework task. Frequently, we refer to the feedback as 'commendations' to remind ourselves that the feedback should be aimed at underscoring the resources and strengths that we have noted during the session. Whether or not clients have previous experience with therapy, they frequently are apprehensive about how the therapists may judge them. They steel themselves in preparation for criticism and diagnostic language. We have found that beginning the last part of the session with commendations puts them at ease, increases hope and expectations, and mobilises their resources for change. After a short consultation break with the team, we returned to the therapy room:

Monte: The team observed that, as a couple, the two of you seem to have a lot of strengths that you can build on. You obviously love one another a lot, or you wouldn't be here. The crisis that you went through in getting evicted from your home, and all of the emotional upset that you went through could have really been devastating. And I'm not saying that you weren't both deeply hurt by it. But you're wanting to overcome that and somehow put this relationship back together. So it's clear that the two of you care about one another a lot. You respect one another, and that's really clear, you may be hurt and have been hurt over the last several months. But it's clear that you have a lot of respect for one another, that you listen to what one another is saying. You might not like what you hear sometimes, but it's clear that you listen to one another. I'm guessing that she thinks you're likely to be a pretty good dad, or she wouldn't have moved in with you and brought you into her family with her daughter.
Vera: Oh, he's great with her. He's a good dad to her, and she adores him. Yeah.
Arnie: I was going to say, I bet she really digs him.
Vera: They have a great relationship. Yeah.
Arnie: And, Manny, we also know that when you set your mind to get good at something, that you do it. You gave us a number of examples of things that you really have decided you were going to learn, and you just did it. And actually, one of the things I sort of was saying to the team, and they suggested that I say to you, is that you set your mind to learn English, and not only have you learned English really well, and you sound more like a Texan than I do.
Manny: Most of the time I worked on the phone. And you learn to do that [mimic accents], and people accept that better, because they feel like they're with somebody that they can relate to.
Monte: Wow. So he's pretty sensitive about picking up kind of cues like that from people over the phone and stuff. That's something that we didn't know about him, too.

We invite clients to guide us toward the most helpful understandings of their situation and possible solutions to their dilemmas. We also think it is important to gain an understanding of a client's theory of change (Duncan et al., 2004). We do this by asking them what they want from the therapy process, their beliefs about the

problem ('theory of the problem'), and their ideas about how to reach their goals ('theory of change').

Whether or not clients express an interest in returning for another session, we try to devise a homework assignment that will keep the therapy session alive after we are done. Frequently, before the consultation break, we will ask clients what has been helpful about the session thus far. Their answers often offer clues about a useful homework assignment. A second useful question we ask before the break elicits what the client is thinking about future appointments and when they might happen. In any case, we tailor the homework to fit with their expectations.

> *Arnie*: So you're a talented guy. When we left, right at the end of the session when we left, we asked if the two of you together could think about how you were going to use those talents to get really, really good at being partners in a relationship, even better at parents to Vera's daughter. You both talked about Manny being more responsible in his work life. Manny, you've impressed all of us as somebody who, if you decided that you were going to figure out how to do that, it would be hard and it would take time, but you would do it. You would do it, because you've done it before. The best sign that you're going to do something in the future is if you've done it before. There'd be struggles with it. It would be . . . it would feel like slow going at times. But you'd figure it out. And in that process . . . you're a self-learner. You went to school and you said you know, the formal education . . . like college. You know, and it didn't quite fit for you. And you . . . but you know how to teach yourself.

Manny and Vera agreed that they would need to come back at some point in the future, but not right away. They both reported that the session had been helpful to them. They had talked about a number of issues that needed airing. They had a handle on what they could do in the short term to begin repairing their relationship. They were reminded that they could return as walk-in clients, either together or separately, or they could call and schedule an appointment in the conventional manner. As frequently happens, Manny walked in several months later for a consultation about some of his concerns about Vera. Thus the couple had reunited since the first walk-in session, and they continued to have some relationship concerns. Suicide threats appeared to have disappeared as an issue. For the second session, Manny was seen by a different therapy team that reviewed the notes from the previous meeting, and the second session was also conducted as a self-contained single session.

Applications and Conclusions

In this paper, we have described how we conduct walk-in–single-session psychotherapy. The case we chose to illustrate this approach was not unusual. If anything, it was typical of most of the cases we see in our walk-in clinic. By focusing on this couple's immediate concerns and offering suggestions consistent with the clients' own ideas about change, they left with increased optimism and hope. They chose, at that time, not to schedule a return session.

For a number of the reasons we have cited, walk-in therapy fills an important need in the delivery of mental health services. This is not simply a modality for low-income or minority clients. There are a number of services that are de facto walk-in services,

such as employee assistance programs and telephone counselling services. Last summer, we consulted with a large nongovernment organisation (NGO) social service agency in México City that provides telephone counselling services to women throughout Mexico. For the most part, the counsellors who answer the calls serve as the telephone equivalent of walk-in providers. Oftentimes, the women's problems are handled in a single phone call, although they may call back as often as needed. Each new phone call is likely to be handled by a new counsellor and is treated as a new session.

Moreover, walk-in services may offer unique opportunities for agencies operating with reduced resources. A walk-in service is cost efficient because more clients can be served in fewer sessions. Walking in can eliminate the need for a traditional intake service, which reduces the length of wait time for other agency counselling services. The bottleneck at the point of entry will have eased or been erased. There are no 'no shows'. The idle hours represented by clients who do not show up for an appointment or cancel at the last minute are filled with walk-in clients.

A walk-in service can be an important component of a larger network of mental health and social service resources (Clements, McElheran, Hackney, & Park, 2011). Many people who access a walk-in service have not had counselling before. They are searching for a resource that will address their needs. Their walk-in session may become a starting point for further services. Hospital emergency services may send clients to walk-in services after their risk level has been assessed. Conversely, therapists at a walk-in clinic may send high-risk clients to an emergency room for possible hospitalisation, or put clients in touch with child protection services.

In summary, walk-in services enhance accessibility of mental health counselling, take advantage of immediate client motivation, and are exceptionally cost efficient. Mental health professionals need more training in these briefest of therapies so that clients will have access to help when it will be the most beneficial to them. Our experience in presenting at workshops and in consulting to agencies reminds us that these ideas are still new and often not represented in graduate training programs. An expansion of single-session and walk-in services is one way to reduce the barriers many people experience when trying to access mental health services.

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