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HOW BRIEF DOES IT GET? WALK-IN SINGLE SESSION THERAPY

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This article describes how the concept of brief therapy can be effectively taken to its logical extreme: walk-in single sessions. At a community based counseling center in Canada, clients can access mental health services at their chosen moment of need without the red tape of formal intake processes and wait lists. Research that supports the concept is discussed, the model of service delivery is described, and case examples illustrate the basic features of the clinical approach.

Lucy, after assisting a "patient" at her "Psychiatric Help: 5-cents" stand:

"Rats! That's the one thing we psychiatrists have to watch . . . I cured him so fast he flew away without paying."

—Charles Schulz (2005)

An increased demand for accessibility to mental health services accompanied by a diminishment of resources around the world has forced mental health practitioners to innovate and devise a variety of new programs and service delivery strategies (Bloom, 2001; Campbell, 1999; Miller, 2000). As a result, the way mental health service providers practice on a daily basis has significantly altered in many hospital, community, and private practice settings. The notion that interventions must be long and laborious to promote enduring change in clients has been challenged and altered (Kaffman, 1995). There is consistent evidence of the remarkable effectiveness of brief interventions in the literature (Bloom, 2001) and

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consistent findings that most client change occurs during the initial sessions of the therapeutic encounter (Seligman, 1995). Thus, time unlimited intervention has given way to time limited intervention. The most extreme case of brief intervention is a single, self-contained session of therapy (Bloom, 2001).

One form of single session therapy, walk-in single sessions, has been offered at the Eastside Family Centre (Eastside), in Calgary, Alberta, Canada (Slive, McElheran, & Lawson, 2001). Developed in 1990 as a result of community demands for greater accessibility to mental health services, walk-in therapy enables clients to meet with a mental health professional at their moment of choosing. There is no red tape, no triage, no intake process, no wait list, and no wait. There is no formal assessment, no formal diagnostic process, just one hour of therapy focused on clients' stated wants. As well as meeting client needs, walk-in therapy is highly rewarding to professionals due to the simple fact that clients' ability to access the service at their chosen moments of need without having to jump over multiple hurdles means that a large percentage are highly motivated. Also, with walk-in therapy there are no missed appointments or cancellations, thereby increasing efficiency.

The model of practice at the Eastside is based on psychotherapy outcome research with particular attention to research concerning common factors (Hubble, Duncan, & Miller, 1999; Wampold, 2001), brief therapy (Bloom, 2001), and single session therapy (Talmon, 1990). It utilizes ideas from postmodern, social constructionist, and systemic perspectives (Hoyt, 1994, 1996, 1998a). The walk-in therapy model is also heavily influenced by the very structure of the service itself: a whole therapy in one hour, which invites a pragmatic approach to the clients' presenting concerns (Amundson, 1996).

Walk-in therapy differs from single sessions that are prearranged by appointment (e.g., Talmon, 1990). In a walk-in service, there is no intake process and little is known about the client(s) prior to the session other than what is written on a brief, solution oriented intake form that clients complete in the waiting room. Except in certain high-risk situations, there is no follow-up meeting or telephone contact, unless the client decides to return for another walk-in session. Just 50 minutes with a client and that's that. Lucy, Charles Schulz's character in the *Peanuts* comic strip, developed a similar service delivery format, though the Eastside service differs from hers in that her 5-cent fee is more than we charge.

This article provides an overview of the brief therapy and single session literatures. This is followed by descriptions of the walk-in service and of the walk-in clinical model. The article concludes with case examples and some thoughts about the future of walk-in therapy.

REVIEW OF THE LITERATURE ON WALK-IN SINGLE SESSION THERAPY

Over the past 20 years the field of psychotherapy has seen a significant shift in a direction toward briefer forms of therapy. Concomitantly, research has accumu-

lated as evidence of its effectiveness. Among the significant findings pertinent to single-session therapy is that, typically, most of the improvement in therapy occurs in its initial sessions, with further gains slowing in subsequent sessions (Battino 2006; Hubble, Duncan, & Miller 1999; Seligman, 1995). Construing therapy sessions as self-contained entities focused on a specified piece of clinical work or practical problem can produce immediate and positive results (Talmon, 1990). This is especially the case if interventions spring from a collaborative therapist–client relationship that draws on the personal strengths and contextual resources of the client (Amundson, 1996; Bloom, 2001, Duncan & Miller, 2000). Talmon (1990), in his seminal book on single-session therapy, summarized the research literature indicating that the modal number of therapy sessions across many therapy forms and theoretical schools is one, and most clients are satisfied with their unplanned single sessions.

Budman, Hoyt, and Friedman (1992), and Bloom (2001) have reviewed the literature and outlined the many benefits of a single therapy session. Research into the clinical applicability and effectiveness of the single-session approach has burgeoned over these same 20 years. Among other studies, single-session therapy has been found useful in treating family/marital stress (Brown, 1984), adolescent crises (Slaff, 1995), drug and alcohol addiction (Miller, 2000), and adolescent mental health issues (Perkins, 2006). The single session approach has also been used with managing wait lists (Coren, 2001), group treatment (Kosoff, 2003), and in consultation with parents regarding child-rearing practices (Sommers-Flanagan, 2007).

Research at the Eastside

The types of problem presentations described above are often encountered within the single session, walk-in format practiced at the Eastside (Lawson, McElheran, & Slive, 1997; Miller & Slive, 2004; Miller, Slive, & Protinsky, 1997; Slive, MacLaurin, Oakander, & Amundson, 1995; Slive, McElheran, & Lawson, 2001). Research at the Eastside has taken several forms. Ongoing examination of client satisfaction has shown satisfaction rates with the walk-in sessions of 85% to 90% (Miller, Slive, & Protinsky, 1997). These findings compare favorably with other single session services (Talmon, 1990) with regard to clarity of forms, the team approach, confidentiality, and interventions offered. In 2004, a study by Miller and Slive looked at the sustainability of the Eastside's walk-in interventions 3 to 6 months after the session. Sixty-eight percent of clients reported improvement in presenting concerns postsession while 3% of clients reported worsening of their problems. Forty-five percent of clients reported that one session was sufficient to address their issues. These findings of client improvement are consistent with the psychotherapy outcome research literature even though most of that research is based on multiple sessions of therapy. The finding that 3% of Eastside clients reported worsening of problems is of some significance. Given that many Eastside clients attend walk-in sessions during a period of crisis, the fact that only 3% in the Miller and Slive (2004)

study report worsening suggests that the service is succeeding at one of its primary purposes: to provide a safety net for the community.

For approximately one year, the Eastside has been evaluating client change within the single session by utilizing a 10-point distress scale completed by clients pre- and postsession. During that period there has been an average 3-point reduction in stress rating between the client's arrival and departure from the Centre.

In 2006 an in-house study determined that 37% of Eastside clients had returned for additional sessions over a one-year period (Lawson, McElheran, & Slive, 2006). A qualitative analysis of postsession interviews conducted with a random sample suggested that returning clients tended to connect to the service rather than to any particular individual therapist. The clients reported feeling safe, they appreciated the advice and having a menu of suggestions from which to choose, and they liked the use of a therapy team.

CONSUMER ORIENTED SERVICE DELIVERY PRINCIPLES

Eastside is located in the most culturally diverse area of Calgary, an area that includes many new immigrants to Canada and many families that struggle economically. The walk-in service is its centerpiece. A small 5-session brief counselling service serves as an adjunct to the walk-in service. The hours of operation of the walk-in service were chosen by examining utilization trends that fit with client need and in consultation with stakeholders such as city police and community associations. Hours include evenings and Saturday. These hours provide an accessible safety net to the community when other services are not open. There is no cost to the client as the Centre is supported by contracts and community donations making access straightforward.

Eastside provides primary care and early intervention-prevention services that operate in close connection with other community resources such as family physicians, family resource centers, schools, and other health/mental health services including hospital emergency departments. When clients make the decision to come, when they are experiencing the most need, the Centre provides immediate support. The average wait time is 20 minutes. Schools, police, and hospitals use the walk-in service with confidence.

HOW WE MAKE USE OF TEAMS

A therapy team serves all clients. The team consists of three to five therapists, one of whom is the clinical lead, called the shift coordinator. Team members are a mix of experienced therapists and graduate students. Many of the experienced therapists are mental health professionals who donate their time to the walk-in service.

The team receives the forms that have been completed by the clients in the waiting room and meets to prepare one of the team members to conduct the session. These forms include the collection of relevant demographic data, a description of the problem using solution-focused prompts, permission or denial to participate with a team behind the mirror, and a self-determined pre-session measure of distress marked on a 10-point scale. During this "pre-session" the team very tentatively, based on the forms that have been completed, begins to speculate about what it is that the clients might want from the session and how to give it to them. These speculations serve to give the therapist a beginning focus for the session but may change as the conversation with the client progresses.

Each session is 50 minutes in length and is organized using the five-part Milan model (Boscolo, Cecchin, Hoffman, & Penn, 1987), that is, pre-session, session, intersession, intervention delivery, and postsession. The conversation with the client (the session) is about 30 minutes in length and is observed by the therapy team. The therapist takes a break to consult with the team and to develop an intervention (the intersession). The therapist returns to the client, delivers the intervention, and responds to any responses that the client may have (intervention delivery). (Note: The development of the intervention might also take the form of a reflecting team (Anderson, 1987) whereby the team behind the mirror goes in front while the client and therapist go behind the mirror and hear the team hypothesize about the client's situation and offer commendations and suggestions.) At the end of the session, the team debriefs (postsession).*

Before clients leave the Centre the therapist asks them to complete a feedback form that includes a postsession measure of distress, as well as questions that invite the client to address how and if the session met their need. We take this feedback seriously. Any negative feedback around the client not feeling heard or understood is addressed by phoning the client as follow-up.

A WALK-IN THERAPY MODEL

Jay Haley, to a student preparing for a first session with a client:

"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)

Model Underpinnings

The model of practice described in this article is a work in progress. It has evolved over 18 years of experience of direct service, supervising, and teaching

*When the walk-in service is busy some sessions will not be observed. Nevertheless, the five-part session format will be followed and "the team" will consist of the therapist and the shift coordinator.

walk-in therapy. Some of the underpinnings of the model are discussed in this section.

It's Just One Hour

The fact that the entire therapy takes place in one hour with no prior information available to the therapist and no follow-up to the session plays a major role in how this service is clinically conceptualized. The therapist has little time to spare in building a therapeutic alliance. Historical fishing expeditions are ruled out; there is not enough time. Therapists who typically begin their sessions with a multi-generational genogram may, in the interest of time, have to rethink their usual approach. Clients who present multiple issues can be a particular challenge. For these clients, therapists need to hone skills in negotiating a focus that is achievable in one hour. The questions a therapist chooses to ask must be carefully considered through a lens that takes time into account. One "innocent" question could lead to 20 minutes of conversation that is not helpful in assisting clients to narrow what they want from the session.

We Narrow the Database

Fisch (1994) argues that the narrower the database of the therapeutic conversation, the shorter the therapy. Like Fisch, therapists who conduct walk-in sessions at Eastside guide the session in such a way as to shorten conversation time. They do this by focusing on the problem as it occurs in the present. It follows that walk-in therapists guide the discussion toward current (as opposed to past) data with a particular interest in descriptive (as opposed to explanatory) data. For example, the therapist is interested in the who, what, when, how, and with whom of a youth's disrespectful behavior toward parents. The therapist does not focus on questions about the youth's past, theories of "underlying cause," or the function of the problem. We borrow from Solution Focused and Narrative therapists (Berg & Miller, 1992; Freedman & Coombs, 1996; Lipchik, 2002; White, 1986; White & Epston 1990) in assuming that "the problem is the problem" as the client presents it. Assuming underlying cause, pathology within the individual, or unconscious motivations can prolong therapy. Instead, the focus is on problems as aspects of human interaction. Assuming that change requires insight can prolong therapy; viewing change as involving the client doing some kind of task will shorten it. Establishing specific goals described in behavioral terms enables therapist and client to efficiently focus and structure the session.

It's a Whole Therapy

The following statement by Ray & Keeney (1993), though not written specifically about single session or walk-in therapy, captures the essence of how we think about a walk-in session:

> All sessions aim at being a whole therapy. This helps create a focus on achieving a beginning, middle and end. Should the clients return for a subsequent session, that session is treated as a new case. Of course, the new case will have to consider the session that took place with the other therapist the time before. That other therapist, who might be you at another time, will have to be considered now as part of the therapy. (p. 12)

Common Factors

Meta-analyses of four decades of psychotherapy outcome research have supported the conclusion that while psychotherapy is effective for most clients, the effectiveness is not due to the uniqueness of the various models of therapy but rather to the (Hubble, Duncan & Miller, 1999; Duncan & Miller, 2000; Wampold, 2001). Brown, Dreis, and Nace (1999) say this about successful outcome: "70% of the total outcome variance is accounted for when a strong therapeutic relationship is combined with a successful incorporation of client factors in the treatment process." (p. 399)

Common factors attended to in walk-in therapy sessions include utilization of client/system resources, 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 regarding fit between the procedures used by the therapist (the model) and the client's own ideas about what will work.

Therapeutic Influences are Tempered with Pragmatism

Those of us who have been involved in the development of the Eastside walk-in model subscribe to a variety of therapeutic influences that share certain meta-theoretical, philosophic threads. These include systemic, postmodern, social constructionist and Ericksonian ideas. A variety of therapeutic models are derived from these influences, and at any given time one might observe elements of narrative, solution-focused, MRI and strategic therapies in any given session. However, consistent with postmodern thought, no model is considered more correct than another. Our primary interest is in what is useful for this client at this point in time. Therefore, models of therapy that do not usually fit within the above philosophical threads, such as Cognitive Behavior Therapy, may be a good fit for some clients at some points in time. This is essentially a pragmatic perspective (Amundson, 1996).

The Session Is a Consultation

We prefer to think of walk-in therapy as a consultation process in which the therapist offers ideas (many of which have come directly from the client) and the client decides whether to accept them, reject them, or put them on hold. The consultation stance helps therapists to not take responsibility for client change. We believe

that the client is his/her own greatest resource. Our job is to create a context that enables the client to discover those resources and teach us how to be a useful guide.

The Model in Action

Our goal in walk-in therapy is for the client to leave the session with a sense of emotional relief and some sort of positive outcome. The positive outcomes differ from client to client. For one client, it may be as straightforward as having someone hear the 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. We achieve these outcomes by focusing on the following ideas.

What Does the Client Want?

We want to learn, as early as possible, what the client wants from the session. We might ask: "What needs to happen during our time together that will make you feel that it was worth your while to come here today?" Answering this question is an opportunity for the client to guide the therapist. The therapist can then focus on this want and avoid "fishing expeditions" that do not address the client's immediate concern. A client recently began a session by saying, "I've seen two psychiatrists and three psychologists and none of them let me talk." This client was saying to the therapist, "just listen," so that is exactly what the therapist did for the entire session. At the end of the session, the therapist asked if the session was helpful. The client said she was "greatly relieved." Thus, the first step is learning what the client wants. The remainder of the session is about giving that to the client.

It is important to note that what the client wants may be unrelated to the presenting concern. For example, one depressed client might want a referral for medication while another might want ideas about how to sleep better.

Developing a Contextual Understanding

We find that a useful question that helps to narrow the database is "why now?" Why has this parent, who has been struggling for three years to get her son to get to school on time, decided to come for a session on this particular evening? The answer to this question can help the therapist to put context to the problem and to place the problem in present interactions. The answer might tell us, for example, that the school is threatening a suspension. Or, perhaps mother and son had a physical altercation that morning as the mother tried to get her son out of bed. Or, perhaps the divorced father is threatening a custody battle by saying that the son's

lateness is a sign of the mother's inadequate parenting. Each answer to the "why now" question will provide different ideas to the therapist about the next questions to be asked. Other contextual questions could be:

- How is this a problem for you now?
- How did you choose to come today?
- Who else is aware of your situation?

Client Resources

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 mutually discovered. Questions could include:

- What have you done to prevent the problem from completely taking over your life?
- How have others in your life been helpful to you?

Client resources might include the personal resources of the individual client as well as the resources of the client's social network (family, friends, work colleagues, teachers, etc.). It is not unusual, for example, for a session to focus on how to ask a friend for assistance or how to invite a family member to accompany the client to a future walk-in session.

Attempted Solutions

Sometimes, consistent with the Mental Research Institute (MRI) (Watzlawick, Weakland, & Fisch, 1988), it is useful to consider the notion that "the problem is the attempted solution." We want to learn what the client has tried in the past that has not worked and, equally important, what attempted solutions have worked, even if just a little bit for a short period of time. At minimum, we do not want to disempower ourselves by trying something that has not worked before. Also, if the client tells us about something that has helped in the past, it could lead to simple, helpful ideas for the client (see "Exceptions" below). One aspect of the attempted solutions question that bears particular mention is learning about previous professional help. Again, we want to support what has been done before that has worked and not do what has not worked. Occasionally, a client who comes to the walk-in service is actively involved in treatment with another mental health professional. Unless the client is highly dissatisfied with that professional, we will ask the client how we can use this session to support the work she is already doing with the other therapist.

How to Think about Client Motivation

We do not adhere to the concept of resistance in our walk-in therapy work. We agree with de Shazer (1985) that it is best to think in terms of client–therapist cooperation and that it is the therapist's responsibility to build a cooperative relationship. Therefore, we attend closely to the client's motivation for attending a walk-in session. Some clients attend because they want help in solving problems. Some feel coerced by others (parent, probation officer). Some models of therapy (e.g., SFT, MRI) have given particular attention to the question of how to turn opposition into compliance. We utilize those ideas as well as the work of Prochaska and DiClemente (1982) on client readiness for change. Our neophyte practitioners of walk-in therapy tell us that by focusing on client readiness and the therapist–client relationship they learn how not to do more than the client wants them to do, thereby inadvertently producing "resistance."

Think Small

Many clients who attend walk-in sessions have experienced a recent crisis. It helps in those situations to compress time. This can be done by "anchoring the pain in the immediate past, presupposing that today is different, that is, better . . ." (Lipchick, 2002 p. 209). The session then becomes a search for small changes such as "how did you get out of bed today and come to this session?" In this approach, we believe change is constant and that small change leads to big change. An end of session task, using the above example, might be to ask that client to do one small self-care act in the next 24 hours. Therapists who think small take pressure off of themselves and do not make the error of promoting more change than the client wants.

Solution Focused Therapy

Solution Focused Therapy (Berg & Dolan, 2001; de Shazer, 1985) introduced a number of clinical interviewing techniques that we find useful in walk-in sessions. These ideas are designed to move clients away from focusing primarily on the problem and toward a focus on solutions. Some of these ideas include attending to exceptions to the problem (already existing periods when the problem is not occurring), future oriented questions (what the client might be doing once the problem is not dominating his/her life), developing focused goals, scaling questions ("If the problem intensity is currently rated as a 6 on a 10-point scale, what needs to happen to reduce the problem to a 5?"), and coping questions ("In spite of the problem, how is it that you are you doing as well as your are?"). We invite the reader to review the SFT references named above for further explication of these techniques.

Client Theory of Change

According to Duncan & Miller (2000):

> Because all approaches are equivalent with respect to outcome, and technique pales in comparison to client and relationship factors, an evolving story casts the client as not only the star of the therapeutic stage, but also the director of the change process. We now consider our clients' worldviews, their maps of the territory, as the determining "theory," directing both the destination desired and the routes of restoration. (p. 78)

In walk-in therapy, we invite the clients to guide us in how to be most helpful to them. 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 what would help ("theory of change"). Examples of questions might be:

- What will work for you today?
- Are there any questions that you wish to ask that I did not get to?
- For many people a single session with a therapist is sufficient to take action; what would be the smallest step that would tell you that you are headed in the right direction?

A mother and her 15-year-old son recently came for a walk-in session. The mother, convinced that her son had been unhappy since the parents' separation, explained that she had taken her son to numerous therapists, and he had not liked any of them. The son, who looked sullen and had not spoken until that point, said, "I liked one." He then spoke of how he had been helped by a therapist who told stories about the therapist's own family. The boy was invited to ask the therapist any questions he wanted, even if they were personal. The mother watched as the boy had an animated, though abstract, discussion with the therapist about family life. Mother and son left in much better spirits with the mother saying they would return, "If we need to."

Commendations

After taking an intersession break, the therapist returns to share solution oriented ideas from the therapy team. Prior to offering solutions, though, the therapist offers commendations from the team (Houger Limacher, 2003; McElheran & Harper-Jaques, 1994). These are positive statements of what the team has noticed about the client/family. These commendations serve several purposes:

- They highlight resources that the client may not have noticed and thereby may point the way toward solutions.

- They positively surprise those clients who expect to be criticized for their missteps and mistakes.
- They relax clients, making them more receptive to the team's recommendations.

CASE EXAMPLES

Relationship Challenged by Addictions

A 35-year-old woman, Mary, came by herself to the walk-in therapy service. She tearfully spoke about how her addictions to gambling and alcohol were ruining her life. Mary explained that her credit cards were full and she was unable to pay her rent, which was due in three days. She came to the walk-in service as a way of keeping herself away from the casino this day. She told a story that began with her drinking in university some 10 years ago, meeting a man who had alcohol as a dominant theme in his life, staying in the relationship long after she realized it was not right for her, and leaving him six months ago. While she was positive about her decision to leave the relationship, her solution to coping with the resulting loneliness was a return to bars and casinos for a social life, resulting in her becoming addicted to gambling. She reported that she would sit, drink beer and play the machines using her credit cards to sustain her habit. She was on the brink of losing her apartment, her job, and her friends who had been advising her to seek help.

When the therapist asked Mary how she made the decision to come to counselling, given that she had not done so before, she responded by saying that she had already talked with friends and family and realized that they were not objective enough to be of help. They tended to become "emotional," showing anger or disappointment when she "slipped." The therapist then asked "why today?" Mary responded by saying that today she realized that she either had to stay away from the gambling tables or lose herself completely to her addictions. She went on to say that she was the most desperate she had ever been.

Mary was then asked if there were times when she noticed that she was in charge of when she gambles. Mary reported, in a confident voice, a story of moments in time when she felt she was fully in charge of her life and did not go to bars and did not gamble. She also reported that these were times when her friends and family stated they were "proud" of her accomplishments. The therapist asked Mary when the last time was that she experienced being so much in charge of herself. At this point Mary cried, stating it had been about six months. This, she said, was an additional reason for her coming to counselling rather than involving her family, as she believed her family would be very upset that she had returned to the gambling scene.

Mary was then asked to give the therapist her perspective as to how she was able to manage her addictions six months ago. Again Mary very clearly stated that at the time she had met another man whom she found attractive and whom

she thought was attracted to her. As the relationship evolved she realized that he too had problems with gambling. As a result Mary said she had lost faith in her ability to choose a partner and had slipped back into her old habits.

When the team, through a phone call from behind the one-way mirror, asked Mary what she would like from this session, Mary responded by saying that she was looking for ideas that would assist her in getting back in charge of her life without gambling. The team went on to ask Mary what she would like to take with her from this session that would be an indication to her that this was a useful way to spend her time. Mary stated emphatically that refraining from gambling tonight would be the most useful.

After an intersession consultation with the team, the therapist reframed the addictions as Mary's new relationship with herself after her break-up with her partner. The team offered the notion that Mary could think about whether to pursue a relationship with her addictions or pursue relationships with supportive people in her life. She was asked to consider which was most important to her. Mary was encouraged to call a friend whose home she could go to that night and not return to the gambling tables. It was also suggested that she choose an hour each evening for the next week that would typically be her time to leave for the bar. She would instead spend the time reviewing all the events that had caused her sorrow, mourn those losses, and make plans for how she would move forward.

She was given phone numbers for Alcoholics Anonymous and an outpatient addictions treatment center as follow-up resources should she think they would be useful. She was also invited to return to the Centre if she would like.

Mary left the Centre stating that this was the first time in six months she had felt a moment's peace and as if she were in charge of herself. She also stated that she would go to her friend's home for the night. She called the friend from the Centre and made a plan to meet at a local coffee shop as a start to the evening.

A Story of Risk and Safety

A mother Jane and her daughter Lisa came to the Eastside two days after Lisa had taken a serious overdose of medication. The hospital emergency room had recommended that they come to Eastside to follow up on the daughter's continuing safety. As the session unfolded it became evident there were multiple issues to address. Jane was a single parent of seven children who worked evening hours and said she was not always available to her children when they needed her. Lisa, 13, had become involved with a man twice her age, had become pregnant and had an abortion without her mother's knowledge. Her peer group at school had made cruel comments on the Internet when they found out about the abortion. Lisa described racing thoughts that had been with her for some years but recently were intruding on her ability to concentrate, resulting in her beginning some self-harming behavior, particularly cutting, in order to manage her days.

The therapist began the session by asking Lisa if she could describe how she and her mother decided to come to a walk-in counselling center rather than attending her school. Lisa began by stating that her mother was concerned about her cutting herself. When asked if she could tell us a bit about the cutting, Lisa started to talk about the abortion, the trouble she was experiencing with her peers, and her perception that she was not interesting enough for anyone to want to know about her or her troubles. At this point Jane interjected with a sense of dismay. She stated that as much as she tried to tell her, Lisa did not seem to believe that her mother cared about her and only wanted what was best for her daughter. When the therapist asked Jane how Lisa would know this was how she felt, Jane cried and said she likely would not, as she wasn't home much these days.

The decision to come for a walk-in session that day, as elicited by the therapist, was because Jane was frightened that Lisa would in fact kill herself if she didn't find someone to talk with immediately. From Jane's perspective, she and Lisa had seen many professionals over the past few days, none of whom seemed interested in their story, nor in Lisa's dilemma.

Following the team consultation, the therapist first commended the mother and daughter for taking the suicide attempt seriously and being persistent in pursuing counselling. The therapist recommended that they also consider pursuing psychiatric consultation given Lisa's description of ongoing struggles with racing thoughts and recent self-harming behaviors. Knowing that Jane's primary concern was her daughter's safety, the team and family then collaborated on creating a safety plan for Lisa. The plan included talking to her mother as well as using telephone crisis resources and the hospital emergency room if thoughts of self-harming or suicide re-occurred. The team asked Lisa to consider obtaining a "touchstone" object that she could keep in her pocket and touch when she was feeling upset and unable to focus. At that point she could call one of the crisis numbers to explore her current feelings. Jane and Lisa were supported to return to the Centre if any of the resources they were pursuing could not meet their needs in a timely fashion.

One week later they returned for another walk-in session stating that they needed some additional ideas. When asked what was new since the last time they were at Eastside, Lisa stated that her self-harming thoughts and behaviors had significantly reduced. Jane stated that her anxiety about Lisa's life had significantly increased. When asked what she thought was triggering an increase in her anxiety with regards to her daughter, Jane stated that she was finally being listened to by some therapists who took them seriously. This was seen as a very positive statement as she had initially impressed the team as an "under-whelmed" mother. Now she appeared to be a mother who was overwhelmed with responsibility and fear. Jane's comment about Lisa being listened to can be a very positive response for a child who is involved in high-risk behavior to hear, as she has previously perceived herself as unheard.

After the team consultation, the therapist commended the work that mother and daughter had done to date as a team, validating Jane's continuing concern, and highlighting the work that both needed to do to improve their relationship. During the second session, the team concluded that the family had moved from a "visitor" relationship to therapy to a "customer-for-change" relationship (de Shazer, 1985; Slive, McElheran, & Lawson, 2001), given Lisa's significant shift in eliminating at-risk behaviors and her mother's awareness of the gap in their relationship. At the family's request, ongoing counseling was facilitated at a brief counselling service where they felt safe, heard, and respected.

These case examples illustrate many aspects of the Eastside walk-in therapy model. They demonstrate a focus on addressing, first and foremost, the wants of the clients and follow through with interventions that fit. Interventions always begin with commendations, utilize the clients' own ideas, usually involve asking clients to take small steps, focus on the immediate future, take client motivation for change into account, and address risk issues as needed. The examples also demonstrate that "walk-in therapy" is not a pure form of "single session therapy." Many clients return, though each subsequent session is treated, like the first, as a "whole therapy" that responds to the responses from the prior session.

THE FUTURE OF WALK-IN THERAPY

Walk-in single session therapy is not a new phenomenon. The first service of which these authors are aware is the Minneapolis Walk-in Counselling Center, which has been operating successfully since 1969. Since we began our efforts in 1990, other walk-in services have developed in hospital emergency rooms and urgent care centers, outpatient mental health services, community and university counselling services, and in private practices. Walk-in single session therapy is occurring in Canada, the United States, Great Britain, Australia, New Zealand, and elsewhere (Brown, 1984; Campbell, 1999; Manthei, 2006). Some are freestanding services and some are components of a large system of services. Some have developed as an alternative to a traditional intake system and others operate as a more efficacious way to manage a wait list.

Walk-in single session therapy is not intended as a service that provides all things to all people. It has the advantage of being available at moments in time that fit for clients. It reduces frustration with service availability. It offers very focused problem solving and often prevents the need for longer-term services. It de-pathologies and de-stigmatizes. It appears to be a good fit for some ethnic and underprivileged communities that do not readily accept more traditional counselling formats. However, it does not provide formal assessments, nor can it play other than a crisis role in forensic services. Research indicates that approximately 30% of clients require something other than brief intervention (Hoyt, 1998b). Thus

walk-in therapy is best thought of as a useful component of a larger service delivery system.

Fewer walk-in services operate in the United States than in Canada, perhaps due to the differing systems of health service delivery in the two countries. The American free enterprise model would require buy-in from insurers and managed care companies. Perhaps this awaits further research demonstrating the efficiency and efficacy of this form of service delivery. The benefit to the insurers would be the opportunity to make immediate, focused, and very brief therapeutic services available to all of their customers. They will likely find that this actually reduces the total number of therapy sessions needed by their client base as a whole.

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