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IDEAS FOR ADDRESSING DOUBTS ABOUT WALK-IN/SINGLE-SESSION THERAPY

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This article examines common worries, fears and concerns about walk-in/single-session therapy that have been expressed by those who are considering providing those services. Each area of concern is described along with how the concern is addressed by service providers. The aim is to assist in the decision-making process of those who are considering adding walk-in/single-sessions as an element in their service delivery systems.

Keywords: psychotherapy, counseling, brief, service accessibility

Walk-in/single-session therapy (WI/SST) services[1] are based on two important ideas: first, walking in eases access to mental health services by eliminating the hurdle of waiting for appointments and other administrative procedures, and second, single-session therapy capitalizes on the well-established findings that most psychotherapy is brief. One is the modal number of therapy contacts, and those who attend only one session generally report high levels of satisfaction and positive therapeutic outcomes (for an excellent annotated bibliography on brief, single-session research, consult the Appendix of Hoyt & Talmon, 2014). These findings have been reported in the U.S. (Scamardo, Bobele, & Biever, 2004; Simon, Imel, Ludman, & Steinfeld, 2012), Canada (Harper-Jaques & Foucault, 2015), Australia (J. Young, Rycroft, & Weir, 2010), in U.S. university counseling centers (Center for Collegiate Mental Health, 2018), and elsewhere. Recently, it has been argued (Slive & Bobele, 2018) that walk-in services "make perfect sense." They highlighted three reasons:

[1]In this article, *walk-in therapy* refers to therapy that occurs without an appointment and where the therapist treats the session as if it may be the only opportunity the therapist has to help the client. We will use the terms *counseling*, *therapy*, and *psychotherapy* interchangeably to refer to the practice of providing mental health services to individuals, couples, and families.

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- They seize the moment by removing access hurdles and enabling clients to see a therapist at their moments of peak motivation.
- They are effective, as demonstrated by a growing body of research pointing to high levels of client satisfaction and positive therapeutic outcomes.
- They are efficient by reducing or eliminating wait lists, avoiding the use of more expensive services such as emergency rooms, and lessening overtreatment.

However, despite a successful appeal, an article in this special section demonstrates that there remains considerable skepticism that single-session therapy services are a viable form of mental health service delivery (K. Young & Jebreen, 2019). The authors very capably responded to a recent argument made by a licensing body in the Province of Ontario that one defining characteristic of psychotherapy is that a therapeutic relationship must have been established over the course of several sessions. The argument went on to say that in a single session of therapy, therapists cannot possibly establish a therapeutic relationship, and therefore, if there is no therapeutic relationship, single-session therapy is not psychotherapy. This serious misunderstanding of therapeutic alliances and WI/SST has important consequences for mental health care and for therapists providing mental health services.

In our workshops, conversations with community leaders, and discussions with mental health administrators, other concerns have been expressed about WI/SST. Perhaps, as some have said, we have allowed ourselves to be carried away by our enthusiasm for this work and focused too much on the positives. So, we have decided that it is time to attempt to balance the scales. In this article, we examine the concerns, fears, and worries that we have heard expressed by our colleagues, students, and community members about the viability and efficacy of WI/SST. We hope that by doing so, readers' worst fears will be addressed, and that this will aid in their decision-making process about whether to consider walk-in counseling as one element in their service delivery systems.

"YOU'LL BE OVERWHELMED"

In 1990, at Wood's Homes, some of the staff members began to propose an idea to community members in Calgary, Alberta, Canada of offering a "no appointment necessary" walk-in counseling service. We were concerned about the expanding wait list at our agency's (Wood's Homes) outpatient family therapy service. We had also noticed the rapid emergence and high rates of utilization of walk-in medical clinics in our community. So, we asked community members for their feedback about offering walk-in mental health services. Their comments were uniformly positive. In fact, some were startled that we (mental health professionals) weren't already providing such easily accessible services. However, a few who liked the idea also wondered that we would be overwhelmed with demand, that more people

would show up requesting services than we could handle. That gave us pause for a moment, but we then realized that such "concern" was a sign that we were on the right track. More people accessing mental services was exactly what we were looking for. In the years since, we have never heard of a counseling agency that had to stop offering walk-in services because it became too busy. Most clinics start out slow and find that demand increases as the word spreads. All of the walk-in services that we know of have found creative ways of adapting to increased client flow by adding hours of operation, increasing staff so that more sessions can occur during the walk-in hours of operation, recruiting mental health professionals who volunteer, or utilizing mental health professionals-in-training.

Rarely are clients turned away. We would never turn away a client who indicated a significant level of risk on the intake form. We usually do not get strong negative reactions when clients are told that they cannot be seen that day. Perhaps that is because we are used to all sorts of walk-in services (think of restaurants), and we know that there are times when we will not get a seat at a table. In any case, high client demand is exactly what we are looking for, and we consider that one indication of successfully meeting the community's needs.

RISK CONCERNS

What if a client walks in showing evidence of risk such as suicide/self-harm, or threats of violence to others such as domestic abuse or child abuse? How can we responsibly and ethically address issues like those in a single one-hour/walk-in session? We have concluded that there is a rather simple answer to this concern: in a walk-in session we handle these issues in the same way as in "by-appointment" sessions. We assess risk. We may then work with the client to develop a safety plan. If necessary, we ensure that the person goes to a hospital emergency room for an assessment for possible admission, or we contact the relevant authorities such as police or child protection services. When possible, we may involve family members or other support persons in this process. For example, with the client's consent we may contact a trusted family member to escort the client to the hospital. In one instance, a suicidal man agreed to call his trusted sister-in-law, in the presence of the therapist, to invite her to come to the counseling center to transport him to the hospital. As with more traditional scheduled appointments, sometimes these measures take longer than the scheduled time.

We have also found that in child-serving counseling centers, local schools may mandate a session of therapy when a student makes a verbal outcry such as "I wish I was dead." That student, who is typically accompanied by a parent(s), will be assessed for suicide risk. Often, we find that this outcry is an attempt to draw attention to an issue troubling the student, and the session assists the student and parents to take steps to address that issue. However, the therapist may also pursue further interventions such as those described above. Typically,

the school's expectation is that the parent provides evidence that the child/family attended a session and that the child can return to school. This confirmation could be in the form of a payment receipt or a one-sentence letter stating that the family had attended a session. Frequently, these children are not at significant risk of suicide, and the session turns into a meaningful conversation about issues in the child's/family's life.

PAPERWORK: PRE- AND POST-SESSION

When clients walk in, we know nothing about them. There has been no prior telephone contact in which information has been gathered; there are no online forms that have been completed. There is no pre-assessment (see the next section). When clients arrive in a typical walk-in clinic the receptionist gives them a short form to complete prior to the session (see Chanut, Livingstone, & Stalker, 2010, for the typical process at a walk-in clinic). Usually, it is a one-page, two-sided form that can be completed in 5 to 10 minutes. Clients provide basic demographic information and answer a few questions about what they are requesting help for. Representative questions are:

- What is the single most important concern you would like to address today?
- Is there some background information that you would like to share about that concern?
- Some people find that one session works for them for now. At the end of your session, what will tell you that you have taken a step in the right direction?

We find that the answers to these questions usually provide enough information for the therapist to prepare for the start of the session. Some clients choose not to answer all the questions, and we are fine with that. The session proceeds in any case, and we learn enough through the therapeutic conversation to address what the clients want.

Following, or in some circumstances during, the walk-in session, the therapist completes a session note. Often clinics create a template especially for walk-in sessions. The template includes the client's presenting wants for the session, background information about the concerns, how the concerns were addressed in the session and future plans (e.g., no plans for future sessions, invitation to return for future walk-in sessions, or information about other community resources, which may include options for ongoing sessions). When there were risk/safety concerns, these are described, and details are provided about how these concerns were addressed. Usually, the session note is brief and can be completed in 10 minutes or less.

One reason that many therapists are positive about their walk-in experiences is that frequently, once the session note is completed, that is that. There are no phone calls to make, no appointments to book, and no future no-shows to deal with. It is one complete experience for both client and therapist.

IF THEY JUST WALK IN, DOES THAT MEAN THERE IS NO PRE-ASSESSMENT?

Yes, there are none of the lengthy pre-assessment procedures that are common in many clinics. Walk-in services find that time-consuming questionnaires, psychological testing, and other speedbumps before clients begin to work with a therapist on their immediate concerns are less useful than expected. Some clinicians and agency directors worry that by omitting a comprehensive psychosocial assessment, or a thorough risk assessment, or some other such measure they might "miss something." In practice, we have found that simply having one item on the intake material that clients complete prior to the session is enough to alert the therapist to the need for further risk assessment questions. For example:

> Do you have any immediate concerns that you (or your child or anyone with you) is at risk of harm to themselves, others, or pets?

Even when these risks are not identified on the intake form, they might arise during the session. In either case, when clients respond affirmatively to questions such as these, the WI/SST clinician will assess for risk accordingly.

We certainly cannot underestimate the issue of risk. Nor should we overestimate it. The efforts to screen for and prevent suicide have met with equivocal results over the past 50 years. A recent meta-analysis of such efforts to identify risk factors associated with death by suicide (Franklin et al., 2017) concluded that the current state of the research is insufficient to support common practices in predicting who is, and is not, at risk.

Fifty years of researchers' efforts indicates that no currently identifiable risk factors actually predict death by suicide (see Franklin et al., 2017). Neither suicide prevention strategies (Zalsman et al., 2017) nor primary care screening have been shown to decrease deaths by suicide (Milner et al., 2017). Given that the empirical support is lacking for extensive suicide assessment as a way of assessing for risk, perhaps a brief one question screening on intake that is followed up by the clinician would be more efficient.

Furthermore, directing attention before the session begins to topics such as suicide, abuse, and history of psychopathology, before determining clients' immediate concerns, may be experienced as intrusive by some potential clients. Such preliminaries could hinder the development of a positive therapeutic alliance that is a key to good outcomes. Some prospective clients will be alienated enough by this process to decide to say "no" to psychotherapy at all, thus depriving them of the care we want to provide.

ANYBODY COULD WALK IN!

In a walk-in counseling service, there is no screening of clients. It is the client, couple, or family, and only they, who decide to come. Should we be worried about risk of violence on our site? Is there a risk to staff? When this worry was expressed by some of our clinical staff just before we opened our center in Calgary, we consulted the police. They said that from their experience, the odds of a violent event occurring on our premises was extremely small. The greater risk of violence would be toward a female staff member or client walking to her car in the parking lot at night. In other words, we may have nothing more to worry about than any other business providing services to the community. We have yet to hear a report of a serious incident of violence at a walk-in counseling service. If anything, we experience less hostility from clients in a walk-in service than in traditional by-appointment services because walk-in clients tend to be less frustrated by the usual bureaucratic hurdles involved in getting an appointment. In a walk-in service, most clients arrive at a moment that is most meaningful to them, ready to work on their issue.

WHAT IF CLIENTS WANT SOMETHING FROM THEIR SESSION THAT WE CANNOT GIVE THEM?

Early in our sessions we invite clients to tell us what they want. We may do this by asking, "What are you hoping for today?" or "When you're driving away today and thinking about the time we had together in the session, what would tell you that it's been a good use of your time?" We see the remainder of the session as an effort to give clients what they want. Depending on their response, this could be increased hope and a sense they have been heard, or it could be a new way of thinking about a concern or a next small step in addressing an issue. For many clients, a walk-in session is their first psychotherapy experience, so we always want them leave feeling that they have had a positive experience.

One reason that we like to ask what clients want early in the session is that occasionally, a client might want something that we cannot give. Some examples might be requests for medication, a formal assessment, investigative inquiries about whether a child might have been abused, or a formal opinion letter regarding a legal issue such as a custody dispute or criminal charges. By learning of these requests early in the session we can clarify to prospective clients that our scope of services do not include those services. If desired, we will provide referral information about where clients can obtain those services. Given that there is usually still time remaining, we will then ask if there is something else the client would like to discuss. Interestingly, we have found that most of the time the client does have something to discuss, often related to the above sorts of requests, and a meaningful therapeutic conversation occurs.

WHAT ABOUT CLIENTS WHO ARE CURRENTLY IN THERAPY ELSEWHERE OR WHO SEE THE WALK-IN SESSION AS SESSION "1" OF AN ONGOING SERIES OF SESSIONS?

On occasion, a client arrives at a walk-in service who is in ongoing psychotherapy with another therapist. Some service providers inform their clients about walk-in counseling services in their community to be used as a backup to their ongoing counseling—for example, when there is an immediate crisis or when the provider is traveling or on vacation. With these clients we take care to not start a second course of therapy that could create confusion for the client and interfere with an ongoing therapeutic process. We ask what the client wants today. We check in with the client about the ongoing therapy and whether the client is planning to continue that other therapy. If the client has decided to end that therapy, we proceed with the session and address what the client wants today. If the client is concerned about the progress of the ongoing therapy, we encourage the client to address those concerns with that therapist and advise the client about how to raise those concerns in the next therapy session. When clients use a walk-in service because the current therapist is unavailable, we then say, "How can we use this session today to further the work you are doing with your other therapist?"

Sometimes clients walk in looking for ongoing sessions. We are strong advocates of clients being given choices and then respecting the decisions that they make. One choice is whether the client wants a single session versus a series of sessions with the same therapist. When we learn that a client is primarily interested in a series of sessions, not a single session, we support that. Then we have a discussion of what, specifically, the client is looking for in those sessions and where the client might find a service that fits what is wanted. We then ask if the client is interested in using the remainder of the session as a way of getting a "head start" on their future therapy. We find that most clients are interested in having that conversation.

DO CLIENTS FROM MINORITY AND MARGINALIZED POPULATIONS UTILIZE WALK-IN SERVICES?

We believe that the walk-in counseling option is a move toward a socially just way for clients to access services. For example, we have observed that marginalized minorities that are not accustomed to therapy are more likely to attend this kind of service. However, while we have anecdotal reports, we do not have hard data to back up this claim. Perhaps this is because many services do not systematically collect data about race, ethnicity, and gender of clients.

We provide training and supervision for graduate students of Our Lady of the Lake University at a community-based service in San Antonio, Texas. That service is in a largely Hispanic part of the city. It provides ongoing counseling by ap-

pointment as well as walk-in counseling in both English and Spanish (see Bobele, Lopez, Scamardo, & Solórzano, 2008). That is just one example of the utilization of walk-in counseling by minority clients (see also Hoyt, Bobele, Slive, Young, & Talmon, 2018). The reader will find descriptions of single-session services in Australia, Canada, Mexico, Sweden, Cambodia, Haiti, and the United States.

We strongly believe that an easy-access, no-screening service is less intimidating than more traditional forms of service delivery. It follows that those trepidatious about accessing services, which is more likely for members of a minority population, are more apt to take a chance on a walk-in service. This seems to also be true of one group that is not seen as a minority—those who identify as male. It is generally accepted as fact that men utilize counseling services less frequently than women. However, more men seem to utilize walk-in counseling than we usually see in other services. For example, for a study of client satisfaction and outcomes in a walk-in counseling service, Harper-Jaques and Foucault (2015) recruited the first 100 individual adult walk-in clients who agreed to participate in the research project. It turned out that exactly 50% were male and 50% were female. Why such an unusually high percentage of male clients? We are not sure. But one hypothesis is that a walk-in service is one way that someone who is unsure of committing to a psychotherapy process can test the waters. This may be the case for marginalized and minority clients as well.

WHAT ABOUT CLIENTS WHO USE A WALK-IN SERVICE AS IF IT IS ONGOING THERAPY?

Many clients have been to our walk-in service previously. That previous session(s) might have been a day before, a week before, a month before, or 2 years before. To us, that is a positive development, because we want our clients to develop a long-term relationship with the service (as opposed to with a specific therapist). Clients are routinely invited to return for a future walk-in session, and each session with a returning client is treated as a new single session. However, a few clients decide to use a walk-in service as if it is ongoing therapy. In other words, they walk-in time after time for sessions on a regular basis, perhaps every week. We have come to refer to these as "serial single sessions." In our orientation in clients' first walk-in session, we try to prevent that from occurring by using the analogy of a walk-in medical clinic. "As in a walk-in medical clinic, you walk in and have your session, and if you decide to walk in again at some future date you may or may not see the same therapist." Nevertheless, a few clients will return week after week. Our main concern is that this creates an inefficient use of our resources; it will cause delays for other walk-in clients who are waiting for their sessions to begin. So, when we recognize, usually after just a few sessions, that a client is using the walk-in service as ongoing therapy, we work with the client to find a better fit for what is wanted either at our agency or elsewhere in the community.

WHAT ABOUT CLIENTS WHO WANT TO SHARE THEIR LIFE STORY IN A ONE-HOUR SESSION?

When we ask a client "What do you want today?" or "What are you hoping for today?" we might get an answer like: "I just want to talk" or "There's these things that I've kept buried inside for too long." So, we will open space for that person to talk. As the client talks, we might ask, "Am I doing a good job of listening?" or "What's been helpful so far?" We might offer a gentle reflection like, "With all you've been through, it's perfectly natural that you are feeling this way," or we might offer a commendation like "Given all that you have been through, how are you doing as well as you are doing?" Some sessions end with no recommendation or next steps, just the opportunity for the client to talk to someone who listens nonjudgmentally. Walk-in research (Miller, 2008) has shown that for many clients, the main benefit that clients report is the experience of leaving the session with a sense of being heard and understood. For some clients, that is just what they want for now, and the session ends with the client being invited to walk in again.

THERE IS NO FOLLOW-UP TO WALK-IN SESSIONS. IS THAT ETHICAL?

Typically, we do not make follow-up post-session contact with walk-in clients. On occasion, a session will result in the co-development of a safety plan to address a risk concern. The session might end with an agreement for us to make telephone contact to ask how the plan is working. But this is a relatively rare occurrence. Apart from a prior agreement to make post-session contact for research purposes, the session ends and that's that. The client might return for another walk-in session, or we may never hear from the client again. In our workshops, we are sometimes asked if such lack of follow-up is responsible and ethical. Do we have an obligation to know what happens after a WI/SST? One workshop attendee identified himself as a psychoanalyst with a counter-argument to routine follow-up. He wondered how clients might interpret such an uninvited follow-up call. Would they worry that the post-session contact means that we think there is something seriously wrong with them or that we do not have confidence in their ability to live their lives without our assistance? Is our phone call an attempt to restart or continue therapy? Therapists are not usually challenged about post-therapy follow-up after a client has completed ongoing, long-term therapy. Why not? Shouldn't there be greater reason to be concerned about the well-being of a client following the ending of a long-term therapeutic relationship?

We encourage our WI/SST trainees to operate from the mindset that a walk-in session is a form of consultation. The therapist is the consultant and the client/patient is the consultee. The job of a consultant is to offer ideas. The job of the consultee (in this case, the client) is to be the decision maker: to consider the therapist's ideas

and whether or not to try some or all of them. This consultation mindset may help therapists feel less inappropriately responsible for their clients; it's our clients' lives to live. The idea of therapy as a consultation helps therapists to manage their own concerns about what happens to clients after a walk-in session.

There is another way to think about follow-up in walk-in services. By tradition, we think of therapist-initiated follow-up, but in a walk-in service, follow-up is initiated by clients. Clients follow up with the same ease of access as their previous session—simply by walking in. This is a shift from our traditional mental health service risk-averse mindset. The client is in charge of the process. In this sense, walk-in counseling is not truly a single-session therapy. While therapists enter each walk-in session with a mindset that this could be the only session, all clients are invited to return at a time of their choosing.

ISN'T THIS JUST A BAND-AID?

Be prepared! When you "come out" as a WI/SST therapist, some of your professional colleagues will be critical. Single-session therapy, or even brief therapy, is not often covered in graduate training programs. For many years, we have been teaching in graduate programs and in workshops on the application of brief therapy models, often with a specific focus on single-session therapy. Almost inevitably, a skeptical participant will ask, "Isn't this just a Band-Aid?" Band-Aid, in this context, is always used pejoratively. When we have explored this with the questioner, we hear that "Band-Aid" approaches are viewed as less legitimate, less effective, and perhaps even unethical. In fact, the pejorative use of "Band-Aid" can be found in theology, political science, and other fields to imply a less effective, merely cosmetic, facile, or insincere approach to a problem. Yet Band-Aids are a very useful treatment approach. Just reflect on how many trips home from a medical appointment you have worn a Band-Aid, or other bandage, applied by medical personnel. Band-Aids reduce infections and prevent the spread of disease. In fact, they promote "self-healing." In our context, the prevention of infection can be seen as intervening before an ordinary, everyday problem gets worse and requires a higher level of care. WI/SST prevents the spread of disease by attending to clients' problems before their social system becomes negatively affected.

What we know today as the Band-Aid® was invented in 1920 by Earle Dickson, a Johnson & Johnson employee, for his wife, Josephine, who repeatedly cut or burned herself in the kitchen. In his book *The Tipping Point* (2013), Malcolm Gladwell says this about the Band-Aid:

> A critic looking at these tightly focused, targeted interventions might dismiss them as Band Aid solutions. But that phrase should not be considered a term of disparagement. The Band Aid is an inexpensive, convenient, and remarkably versatile solution to an astonishing array of problems. In their history, Band Aids have probably allowed millions of people to keep working or playing tennis or cooking or walking when they

> would otherwise have had to stop. The Band Aid solution is actually the best kind of solution because it involves solving a problem with the minimum amount of effort and time and cost. We have, of course, an instinctive disdain for this kind of solution because there is something in all of us that feels that true answers to problems have to be comprehensive, that there is virtue in the dogged and indiscriminate application of effort, that slow and steady should win the race. The problem, of course, is that the indiscriminate application of effort is something that is not always possible. There are times when we need a convenient shortcut, a way to make a lot out of a little, and that is what Tipping Points, in the end, are all about. (pp. 256–257)

Research findings about WI/SST services are consistent with Gladwell's observations. In a pilot study, Stalker, Horton, and Cait (2012) found that clients' distress decreased significantly, the agency wait list was virtually eliminated, and no-shows were reduced for scheduled counseling. These authors also found that walk-in clients were diverted from costly services like hospitals and returned to earlier to work and other activities.

So now when we hear a question like "Isn't this just a Band-Aid?," we say with pride "Thank you for the compliment." Perhaps we should consider calling what we do Band-Aid Therapy!

WHAT ABOUT TRAINING AND SUPPORT FOR NEW WALK-IN/SINGLE-SESSION THERAPISTS?

It is understandable that therapists new to WI/SST would experience some apprehension about this new form of service delivery. After all, as we pointed out, many graduate training programs do not offer courses in brief therapy—let alone WI/SST. This is despite the extensive evidence that most psychotherapy is brief, one or just a few sessions (Bloom, 1981; Talmon, 1990). Therapists can be reassured that doing this work does not require an entirely new way of doing therapy. In the training of therapists, a "single-session mindset" (Bobele & Slive, 2014; Slive & Bobele, 2011, 2012) is emphasized. This mindset develops when therapists learn that the first session of traditionally scheduled psychotherapy is often the only session and that most clients who are seen only once, whether or not by design, are satisfied and report positive outcomes. This mindset helps to give therapists confidence that something good can come from one session. With that confidence, therapists can creatively adapt their usual ways of working to the WI/SST format. In our work, we emphasize strengths-based, systemic (Murphy & Sparks, 2018), and solution-focused (Lipchick, 2002) approaches, but we have worked with colleagues who have adapted narrative (K. Young, 2008), cognitive behavioral (Dryden, 2019), emotion-focused (Matthews, 2018), and other models to this service delivery format.

Therapists new to WI/SST also need support in getting started. Organizational support is crucial. Our Australian single-session colleagues J. Young, Rycroft, and Weir (2014) emphasized that this means administrative support from top, perhaps

some introductory training workshops, and a support group of like-minded professional colleagues. It also helps to have what they call a clinical champion: someone who is passionate about this work and is respected by colleagues as a go-to person for clinical consultations.

CONCLUSION

We have attempted to address concerns, worries, and fears about WI/SST. These concerns are understandable given that this is still a new concept for many therapists and administrators, and we hope that by putting these concerns "on the table" we have provided food for thought that will assist therapists and mental health administrators in their decision-making process about whether to implement WI/SST as one component of their service delivery system.

However, it won't surprise readers to know that our minds are already made up. We're now approaching 30 years of WI/SST experience. Why are we convinced? Here's some of the reasons:

- First and foremost, at moments of crisis or despair, at moments of readiness for change, WI/SST gives community members ready access to a conversation with a mental health professional without the usual hurdles. This reduces frustration with traditional appointment-making processes. Our aim is for clients to leave their session with increased hope, increased awareness of strengths and resources, and ideas for a next step to address an issue.
- Clients are used to "no appointment necessary" services of all kinds, such as hair stylists, medical clinics, restaurants, income tax services, and church confessionals. So why can't mental health service delivery systems join the post-modern world?
- In his book *Prescription for the Future*, Ezekiel Emanuel (2017) argued that all physicians, irrespective of specialization, should leave 20% to 50% of their time available to see patients unscheduled, so that patients can make same-day decisions about seeing their doctors. Psychiatric clinics are now offering walk-in sessions (Bebinger, 2019)). There are now nearly 80 WI/SST services in the Province of Ontario alone! Hence the trend toward this form of service delivery clearly exists. All that stands in the way is the hesitancy within our own community of mental health professionals.
- There is increasing evidence that a single session of therapy works to reduce medical utilization, decrease stress, increase coping mechanisms, improve presenting concerns, and produce high rates of client satisfaction (Hoyt et al., 2018, Chapter 1).

"One" is the modal number of therapy sessions, even when clients have the option of more sessions. Most of these one-session clients report satisfaction with

their session as a primary reason for not returning for more sessions. So, what if therapists decide to face our fears head-on and focus our energy on improving our skills at providing single sessions?

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