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WALK-IN SINGLE SESSION TEAM THERAPY: A STUDY OF CLIENT SATISFACTION

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This is a study of client satisfaction with walk-in single session team therapy, a clinical delivery system that offers immediate accessibility at moments in time determined by the client. Individual adults, couples, or family members over the age of 18 (N = 403) responded to questionnaires, given immediately after the therapy session, aimed at assessing client satisfaction with their walk-in single session team therapy. Client satisfaction was assessed in five variables: satisfaction with the overall walk-in single session team therapy service, the reception service, intake paperwork, explanation of confidentiality, and consulting team approach. Results indicate 81.9% of the clients reported overall high satisfaction with the walk-in single session team therapy service, with the greatest strengths of the service reported being immediate accessibility and the caring attitude of the therapist. Higher satisfaction was reported for some presenting concerns (sexual abuse/assault, self-esteem, and child behavior issues) than for others (anxiety and stress). Written feedback regarding the perceived strengths and recommended changes for the service is also reported. The article concludes with a discussion of how walk-in single session team therapy has utility in the overall clinical delivery system.

Single session therapy is a model of clinical service delivery designed to meet the changing clinical needs of the community (Clouthier, 1996; Clouthier, Fennema, Johnston, Veenendaal, & Viksne, 1997; Hoyt, 1995; Liske, 1991; Miller & Slive, 2004). These changes are marked by an increasing expectation for convenience and immediacy of services (Miller & Slive, 2004; Slive, MacLaurin, Oakander, & Amundson, 1995) and as a way to deal with the decrease in funding for community mental health agencies (Hoyt, 1995). Previous research has studied the

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possible utility of a single session format; yet, the walk-in single session format remains fairly new in the field of family therapy research (Miller & Slive, 2004).

Research in the single session format dates back to the 1950s when Kogan (1957) conducted research on the frequency of single session therapy in 250 cases at a family services agency in New York. He found that 56% of the cases were closed after one interview and that most of these closings were planned in advance by the client and therapist. Kogan interviewed 80% of the clients in these cases and found that two thirds believed they had been helped by their single session therapy. In addition, Kogan found no differences in client satisfaction between the planned case closings and the unplanned case closings.

In 1975, Spoerl conducted a study of the records at a mental health clinic that served a private health maintenance organization (HMO). Of the 6,708 clients seen that year, 39% made only one visit to the clinic despite full coverage for ten sessions. Spoerl (1975) suggested that it was important to establish single session psychotherapy as a concept in order to allow therapists to continue to explore the possible utility of this clinical delivery system for the field of mental health.

Talmon (1990) studied 100,000 scheduled outpatient appointments from 1983 to 1988. He found that the modal length (how many sessions) of therapy for each of the therapists was a single session. A leading empirical study of planned single session therapy was developed and conducted by Talmon, Hoyt, and Rosenbaum (1990). The 60 clients in this study were randomly assigned to three therapists with differing theoretical orientations. At a follow-up interview, 34 of the cases did not require additional treatment and 85% (n = 51) of them reported significant improvement.

These related investigations offer some evidence of the possible effectiveness and utility of *planned* single session therapy (Talmon, Hoyt, & Rosenbaum, 1990) and single session therapy by *default* (Kogan, 1957; Spoerl, 1975), when the client simply fails to return for subsequent scheduled appointments. There is a paucity of research published regarding client satisfaction with walk-in single session therapy (Miller & Slive, 2004). This service is notably different from previously cited services, in that clients access therapy when *they* choose, capitalizing on the clients' possible high levels of need and motivation for change (Hubble, Duncan, & Miller, 1999; Prochaska & DiClemente, 1992).

PURPOSE

This study was designed to determine the overall level of client satisfaction with the walk-in single session team therapy as it is conducted at the Eastside Family Center in Calgary, Alberta, Canada. Calgary is a vibrant, ethnically diverse, metropolitan city of over 943,000 residents. At the time of the study, Calgary's visible minority population (i.e., Chinese, South Asian, Black, Arab, Filipino, and Latin American) was 164,900 or 17.5% of the Calgary population (Canada Statistics,

2001). The walk-in single session team therapy at the Eastside Family Center was developed in 1990 to provide clinical services for the eastern half of Calgary. At the time of this study, the east side of Calgary was an area of high ethnic diversity, high density, and low socioeconomic status. These families tend to seek clinical services at moments of need rather than accessing the more traditional weekly outpatient sessions (Slive, McElheran, & Lawson, 2002).

The Walk-in Single Session Team and Structure of Therapy at the Eastside Family Center

When it was created, the main goal of the Eastside Family Center in Calgary, Alberta, Canada was to provide more accessible, available, and affordable clinical services than were typically available (Miller & Slive, 2004). To realize this goal, clinical service hours are set at times convenient for families (Monday through Friday, 1:00 P.M. to 8:00 P.M. and Saturday, 11:00 A.M. to 2:00 P.M.) and services are delivered on a walk-in basis where no appointment is required or taken. Clients typically are in therapy session within 10 to 30 minutes after they enter the Eastside Family Center building. Furthermore, clinical services were open to everyone, without exception, and at no cost to clients. Each therapy session typically runs between 50 to 60 minutes.

The walk-in family therapy service at the Eastside Family Center is based on systemic and brief therapy approaches (Slive, MacLaurin, Oaklander, & Amundson, 1995), and the therapeutic consultation team is utilized in the treatment of the majority of clients. The structure of this approach was informed by the work of the "Milan Group" in treating families (Palazzoli, Boscolo, Cecchin, & Prata, 1978). This structure has five distinct phases of therapy involving the team: (1) the pre-session, (2) session part 1, (3) discussion of the session with the therapist and the team during a session break, (4) the conclusion of the session with therapist and client(s), and (5) the postsession meeting with the therapist and the team after the client(s) leave. The team is used in several different ways by the therapists and families at the Eastside Family Center, including in-session consultation and consultation during a break in the therapy session. In-session consultation involves the team observing the therapy session in an observation room complete with a two-way viewing mirror, video equipment, and a telephone line to the therapy room. When the therapist meets with the family, the team approach is explained, and clients are welcome to meet the team behind the mirror if they so desire. Families who wish not to be observed by the team meet with the therapist in a "side room"; however, the team approach is usually still utilized during the break in the session—where the therapist leaves the client(s) for about 10 minutes to discuss the client situation with the consulting team. The team usually consists of one supervisor, and one to three consulting therapists.

In the use of the team approach at the Eastside Family Center, the team is led by a "shift coordinator" who is often an AAMFT (American Association for

Marriage and Family Therapy) Approved Supervisor, or equivalent. The responsibilities of the shift coordinator include consulting to other therapists who are working during the shift (usually four hours long), assigning cases to therapists on shift, and working with the receptionist to manage the client flow throughout the shift. The team serves to keep the therapists "on track" in the session and to help generate interventions. The use of the team approach also helps to insure homogeneity of services in a context where therapists often have varying levels of clinical education and experience. All therapists at the Eastside Family Center hold graduate degrees in counseling or a related field and attend specialized trainings that include: a period of training where they observe teams during shifts; an orientation to the Eastside Family Center philosophy; and supervision with a shift coordinator while conducting the walk-in therapy. All therapists donate their time for clients of the walk-in therapy service, in exchange for training, supervision, and networking opportunities. These professionals usually offer approximately eight hours per month to the Center.

A major philosophical principle of the service is that therapy begins when clients walk in the door. Thus, the entrance, the reception desk, and the waiting area are designed to promote a nonanxious experience for clients. Furthermore, the forms given in the waiting area are brief by design and nonintrusive in that they ask questions that stimulate solution-focused thinking (deShazer, 1988). Another important aspect of the walk-in single session modality is the importance of the first question asked by the therapist at the beginning of the session. Questions such as "What do you need to get from the session today?" and "How will we know at the end of our meeting that this has been useful to you?" help to promote a solvable framing of the problem with a clear direction to proceed (Slive, McElheran, & Lawson, 2002). These questions help focus the client and the therapist on what the client wants from the session, rather than the presenting concern or the history of the problem. A fundamental goal of this service is to provide the clients a clearly identifiable outcome at the end of the session. Though it is important to note that therapists are guided first by the ethic of "do no harm." Thus, when a child is at risk or when there is a threat of harm to the client or other people, the therapist will intervene appropriately even if this does not coincide with the clients' stated goals (Miller & Slive, 2004).

In the single session format, the therapist's explanation of confidentiality takes up approximately 10% of the session time, and is a critical component in the therapeutic relationship. Previous research has explored the importance of client's views on confidentiality. Schmid, Appelbaum, Roth, and Lidz (1983) found that clients highly value confidentiality and are often concerned about the possibility of unauthorized disclosures. Given that confidentiality is important in effective therapy, client satisfaction with the therapist's explanation of confidentiality is included in this study.

In practice, this walk-in single session modality requires a clear focus on the part of the therapist and a pragmatic approach (Slive et al., 2002). For the therapists at the center, this means their fundamental job in session is to negotiate a

solvable framing of the problem and to identify client resources and exceptions to the presenting concern. The "consumer" driven orientation to the walk-in single session modality guides the therapist to focus on what the client is seeking from treatment, further promoting the motivation to change (Miller & Slive, 2004).

Walk-in, single session therapy is relatively new to the field, and research on client satisfaction with this modality is limited (Miller & Slive, 2004). The purpose of this study was to determine the overall level of client satisfaction with the walk-in single session team therapy as it relates to the variables of: impression of the reception service, clarity of the forms used, explanation of confidentiality, use of the team approach, and nature of the presenting concern. A secondary purpose of this study was to explore the clients' views regarding the greatest strengths and recommended changes of the walk-in single session team therapy service.

METHOD

Sample

All 1,790 individual adults (over the age of 18), couples, and families who received therapeutic services at the Eastside Family Center during the nine month period of this study were asked to complete a client satisfaction questionnaire. A total of 417 client satisfaction questionnaires were voluntarily completed and returned anonymously by the clients either immediately following their session or within the week after the therapy session via mail. Fourteen incomplete questionnaires were removed from the data set, thus the response rate for the questionnaires was 22.5%. Of the 403 completed questionnaires, 30% (n = 120) of the questionnaires were anonymously returned via mail, and 70% (n = 283) were returned immediately after the therapy session. The questionnaires returned by mail were usually received within a week after services were delivered.

Questionnaires were dated and numerically coded so that key information, such as the nature of the presenting concern, and whether or not a team approach was used, could be recorded. Demographic questions such as age, gender, and income of the respondents were not included on the questionnaires. Other studies of the Eastside Family Center provide some information on the demographic makeup of the client population at the Center, indicating that of those sampled, 44.2% were male and 55.8% were female. The majority (86%) was Caucasian and the remaining 14% were Asian, Japanese, Chinese, or Native American (Miller & Slive, 2004). These demographics roughly match the overall demographics of Calgary (Canada Statistics, 2001).

Procedure

The Eastside Family Center volunteer therapists were asked to present the Client Satisfaction Questionnaire to each of the individual adults, couples, and/or fami-

lies that they provided services for during their shift. The therapists were instructed to deliver and explain the questionnaires at the end of each session. Clients were informed that record keeping for the questionnaires was set up so that the Center staff would know what kind of difficulties were discussed, but they would not know the client(s) name. Thus, all comments and suggestions could be made confidentially. The name of the Eastside Family Center, address, phone, and fax number also appeared at the top of each questionnaire so that clients would have a way to contact the Center should they have questions regarding the questionnaire after they leave (See Appendix A).

Measures

The *Client Satisfaction Questionnaire* was designed by the Eastside Family Center Advisory Counsel to assess client satisfaction with the walk-in single session therapy service. The questionnaire includes five questions about the services received, with a five-point Likert scale response set (1 = very dissatisfied, 2 = dissatisfied, 3 = neutral, 4 = satisfied, 5 = very satisfied) and a space for clients to add comments for each question. The questions asked for information about the overall satisfaction with the walk-in single session team therapy service, impression of the reception service at the center, clarity of the forms used, explanation of confidentiality by the therapist, and use of the team approach. The last two questions asked clients to write comments about the service's strengths and recommend changes. A stamped envelope with the Center's printed address was stapled to each questionnaire (See Appendix A).

Data Analysis

Responses to the Likert scale items in the questionnaire were coded and entered into a Microsoft Excel spreadsheet. Descriptive statistics for the quantitative data were generated using the Statistical Package for Social Sciences (SPSS), version 6.0. Responses to the comments and the last two open-ended questions were examined by using inductive content analysis (Bogdan & Biklin, 1998; Laszloffy, 2000). Narrative responses were reviewed to identify themes, and an initial coding system was developed. During the second review of the responses, a listing of broad categories was generated. Responses were grouped according to these categories.

RESULTS

A team approach was used in all of the cases in this sample ($N = 403$). The overall client satisfaction with the walk-in single session team therapy service was high, with 57.1% ($n = 230$) of the respondents reporting "very satisfied" and 24.8% ($n = 100$) "satisfied." Sixty-five (16.1%) of the respondents gave "neutral"

responses with only 2% ($n = 8$) rating "dissatisfied." No one rated "very dissatisfied" with the overall service received. Table 1 represents the responses to ratings of satisfaction for each item on the Client Satisfaction Questionnaire.

Table 2 lists ratings of the overall client satisfaction with the walk-in single session team therapy services received associated with the 15 most common presenting concerns, as organized by the primary presenting concerns. This list represents 67% ($n = 269$) of the primary concerns for the entire sample. By far the most common primary concern was marital and couple conflict ($n = 61$), with 83.6% of the clients with this presenting concern reporting overall general satisfaction (having scored a rating of 4 or 5). Thirty clients indicated depression/withdrawn as their primary presenting concern, with 86.7% rating overall general satisfaction. Of the 29 clients who indicated child behavior problems as their primary presenting concern, 93.1% reported general satisfaction. This is similar to the distribution of presenting concerns in traditional marriage and family therapy settings (Doherty & Simmons, 1996). Satisfaction ratings were highest for clients whose presenting concerns included sexual abuse/assault, self-esteem issues, and child behavior problems. Satisfaction ratings were lowest for clients with presenting concerns of anxiety and stress. Although there was some variation in satisfaction ratings as organized by presenting concern, the differences were minor and generally ratings were high.

Respondent Comments

Nineteen percent ($n = 77$) of the total respondents contributed comments about their impression of the reception service. Out of the 77 respondents, 87% ($n = 67$) reported positive comments, using some characteristic of the receptionist's personality (i.e., friendly, polite, helpful). A few indicated that they would have liked to have had a television to watch while waiting to see a therapist.

Walk-in single session team therapy as it is conducted at the Eastside Family Center is viewed as beginning when the clients walk in the door, and the reception service and the paperwork clients are asked to fill out represents part of the therapy process. When clients enter the Center they are asked to complete a "user friendly" (Slive et al., 1995) intake form regarding the nature of their presenting concern, who is involved, any attempted solutions to the problem, and inner strengths of the client(s). Of the 8% ($n = 32$) of the total respondents who contributed a comment about the forms used, half ($n = 16$) reported positive comments about the clarity and focus of the intake form. Twenty-five percent ($n = 8$) reported difficulty communicating their thoughts onto the intake form, while 19% ($n = 6$) reported difficulty listing inner strengths they (the respondents) possessed.

Six percent ($n = 25$) of the total respondents added comments about the therapist's explanation of confidentiality. Eighty-eight percent ($n = 22$) reported positive comments regarding the clarity of the therapist's explanation and the reassurance offered by the therapist.

Table 1. Client Satisfaction Questionnaire Results to the Likert Scale Items ($N = 403$)

	Reception Item #1	Forms Item #2	Confidentiality Item #3	Team Approach Item #4	Overall Item #5
5 = Very Satisfied	$n = 214$ (53.1%)	$n = 180$ (44.7%)	$n = 278$ (70.0%)	$n = 203$ (50.4%)	$n = 230$ (57.1%)
4 = Satisfied	$n = 126$ (31.3%)	$n = 151$ (37.5%)	$n = 103$ (25.5%)	$n = 106$ (26.3%)	$n = 100$ (24.8%)
3 = Neutral	$n = 57$ (14.1%)	$n = 65$ (16.1%)	$n = 20$ (4.0%)	$n = 78$ (19.3%)	$n = 65$ (16.1%)
2 = Dissatisfied	$n = 6$ (1.5%)	$n = 7$ (1.7%)	$n = 2$ (0.5%)	$n = 16$ (4.0%)	$n = 8$ (2.0%)
1 = Very Dissatisfied	$n = 0$	$n = 0$	$n = 0$	$n = 0$	$n = 0$
Mean	4.36	4.25	4.63	4.23	4.37
SD	0.78	0.69	1.09	0.67	0.81

Table 2. Ratings of Overall Client Satisfaction with the Walk-in Single Session Team Therapy Received in Relation to the 15 Most Common Primary Presenting Concern (n = 269)*

	# of respondents		*SD*	General Satisfaction (ratings of 4 and 5)		Neutral (rating of 3)		Dissatisfaction (rating of 2)	
marital/couple conflict	61	22.7%	0.76	51	83.6%	6	9.8%	4	6.6%
depression/withdrawn	30	11.2%	0.92	26	86.7%	1	3.3%	3	10.0%
child behavior problems	29	10.8%	0.74	27	93.1%	1	3.4%	1	3.4%
separation issues	23	8.6%	0.88	19	82.6%	2	8.7%	2	8.7%
family breakdown issues	19	7.1%	0.69	17	89.5%	2	10.5%	0	0.0%
defiant/noncompliant child	17	6.3%	1.03	14	82.4%	2	11.8%	1	5.9%
parenting issues	16	5.9%	1.20	11	68.8%	4	25.0%	1	6.3%
life transition/developmental issues	12	4.5%	0.67	11	91.7%	1	8.3%	0	0.0%
anxiety/stress	11	4.1%	1.00	6	54.5%	4	36.4%	1	9.1%
parent/adolescent & parent/child conflict	11	4.1%	0.82	9	81.8%	2	18.2%	0	0.0%
alcohol	8	3.0%	0.76	7	87.5%	1	12.5%	0	0.0%
custody/co-parenting issues	8	3.0%	1.06	7	87.5%	1	12.5%	0	0.0%
relationship issues	8	3.0%	1.13	6	75.0%	2	25.0%	0	0.0%
sexual abuse/assault	8	3.0%	0.46	8	100.0%	0	0.0%	0	0.0%
Self-esteem issues	8	3.0%	0.46	8	100.0%	0	0.0%	0	0.0%

Note. 5 = very satisfied, 4 = satisfied, 3 = neutral, 2 = dissatisfied, 1 = very dissatisfied.
None of the respondents indicated a rating of 1 = very dissatisfied.
*The remaining presenting concerns (n = 134) were in the categories of: running away, suicide, gender, sexuality, and socioeconomic issues.

Some form of the team approach was used in all the cases in the study and of those who offered a written comment about the use of the team approach (n = 52), 69% (n = 36) reported favorable feedback. Half of them reported that they liked the team approach because it provided more than one person's input and that it helped them to look at things differently. This seems to support Kerns and Markowski's findings (1996) that those who used the team approach received more affirmation and encouragement than nonteam clients and that they were more able to identify new ways of relating to one another. Interestingly, the second most common comment regarding the use of the team (19%, n = 10) was that the break allowed individual clients time alone to collect their thoughts and the opportunity for family members to talk privately with each other after issues had been raised in the first part of the session. Seventeen percent (n = 9) of those who responded to this question found the use of the mirror and the team approach "uncomfortable" or "intimidating."

Seventy-nine percent (n = 318) of the sample contributed a comment about the perceived strengths of the service. Thirty-one percent (n = 100) of the people who responded to this question listed the *immediate accessibility and availability* of the walk-in service as the greatest strength. "Having a person who will listen" was listed by 19% of the respondents (n = 60). Therapist characteristics such as caring attitude and personal touch were listed by 15% (n = 48) as the greatest strength, while 7% (n = 23) listed the advice and direction provided by the therapist. The fact that there was no fee for the service was indicated by six percent (n = 19) of the respondents as the greatest strength of the service.

Twelve percent of the sample (n = 50) commented regarding changes they would recommend for the service. Of this group, 18% (n = 9) listed "ongoing counseling with the same counselor" as a recommended change. "Longer sessions" (increasing the length of the session beyond one hour) were listed by 12% (n = 6) of the respondents as a recommended change, while more advertisement of the center's services was listed by 12% (n = 6). The remaining recommended changes listed included suggestions such as: take appointments, open longer hours on Saturdays, have smoking rooms, get more Kleenex, and have name tags for therapists to wear.

DISCUSSION

Clinical Implications

There is increasing demand from both funders and consumers for therapy to be brief and accessible, yet effective. Talmon (1990) and Hoyt (1995) have offered some evidence of effectiveness of single sessions "by appointment." While Kogan (1957) and Spoerl (1975) offer some evidence for the effectiveness of single session therapy by default, when clients fail to return for further scheduled sessions. *Walk-in* single sessions offer a notable difference, that of immediacy of

accessibility at times determined by the client. The preliminary findings of this study indicate that while there is some variation of reported client satisfaction according to the type of presenting concern, overall satisfaction ratings are high. Also, client reports of what they most appreciate about the service relate specifically to the walk-in nature of the center and the accessibility it affords. Finally, the satisfaction level of the clients seems to be enhanced by the use of consulting teams, although some found the teams intimidating ($n = 9$).

Feedback from community representatives suggests that a walk-in counseling service can have a significant impact on a community by acting as a "safety valve" for citizen concerns. One school counselor described it as her "savior," stating, "Now I can refer a family and they can begin to get help *on the same day*" (Slive, MacLaurin, Oakander, & Amundson, 1995). This feedback seems especially relevant given the recent rash of school violence and the call for therapists to coordinate with teachers (Hudson, Windham, & Hooper, 2005).

While client satisfaction was high and only 2% of the respondents indicated dissatisfaction, it is clear that this mode of clinical service delivery does not meet the needs of all those who seek help. Of the small number of people who did offer suggestions for change in the service ($n = 50$), the most common requests voiced were for "ongoing counseling with the same therapist" and increased time of the single session (longer than one hour). While this would be expected given the predominance of traditional outpatient practice, perhaps what is most interesting is that so few people made this request.

Limitations of the Study

As Gutek (1978) has pointed out, people seem to be satisfied with everything social scientists ask them about, and care should be taken when interpreting positive findings. Caution should be observed in generalizing these results to other clinical populations. This sample included clients who voluntarily returned questionnaires; perhaps those who were dissatisfied with the service did not bother to fill out the questionnaires. Although overall client satisfaction with the walk-in single session team therapy at the Eastside Family Center is quite high, further studies are needed to determine the outcome of services rendered after clients leave the session and return to their lives. Future investigation is needed to determine whether changes in their lives as a result of therapy were simply a momentary comfort, or lasting change.

Couch and Kinston (1960) have suggested that one limitation of client satisfaction studies is the possibility of serious bias occurring as a result of "yeasaying." Clients may also fear reporting negative satisfaction with services because of the expectation of repercussions from the caregiver (Albers, 1977). As is true for most client satisfaction questionnaires (Gutek, 1978; Kalman, 1983; Lebow, 1982; Thomas & Penchansky, 1984; Zastowny & Lehman, 1988; Zastowny, Roghmann,

& Hengst, 1983), the questionnaire used in the study lacks reliability coefficients and validity replications.

Finally, no demographic information was collected on the clients in the data set. It should also be noted that therapists' level of experience, education, and theoretical orientation were not examined as factors effecting overall client satisfaction, although these factors are likely to influence clients' ratings. The team approach is one way to minimized variations in the therapists' style and technique in therapy. Future investigation of client satisfaction and outcome should include both respondents and therapists' demographic information, as well as therapists' theoretical orientation.

Implications

Although client satisfaction with the walk-in single session therapy at the Eastside Family Center was high as measured immediately after the therapy session, it remains unclear if the positive effects of treatment endure after clients leave the center and return to their lives. Further study is required to determine the outcome of therapy (client change). As Edwards, Yarvis, and Mueller (1978) have suggested, client satisfaction and outcome are often correlated, although they must be viewed as distinct entities.

Talmon has called for future research into the *effect of the team approach* on single session therapy. The findings in this study indicate that it was an important factor regarding clients' ratings of overall assistance received, but it remains unclear if clients benefit from the use of an in-session team consultation approach. In this study respondents listed the immediate accessibility and availability of the service, providing someone who will listen, and the caring attitudes of the therapists, as some of the greatest strengths of the service. Although these results provide a glimpse of what clients find useful, the *process of successful walk-in single session therapy* remains unclear. It is difficult to determine from the present data exactly what clients find useful about the approach in resolving their problem(s).

The tragic school shootings in recent U.S. history (i.e., Thurston, Columbine, and Virginia Tech) have reinforced the need for immediate intervention strategies and increased accessibility to counseling services (National Child Traumatic Stress Network, 2007; Walker & Sprague, 1999). In 1999, the Surgeon General published the first national report on mental health. The report indicated that our mental health system is plagued with more barriers to service than any other medical delivery system, and called for a reconsideration of our overall national strategy for clinical service delivery (U.S. Department of Health and Human Services, 1999). This report further indicated that stigma, accessibility, and cost are the main barriers to treatment, with over half of those needing help never seeking service.

While walk-in single session therapy would not be appropriate for all clients, this study suggests that it may provide a valuable access point in the overall delivery system. This format for therapy might be one strategy toward overcoming the known barriers to the mental health system and simultaneously serving as a "gateway" to the world of clinical services. Issues of barriers to receiving treatment have been repeatedly raised by clients, mental health advocates, and service providers. Within the day-to-day operation of community treatment services, general barriers such as long waiting lists for services, cumbersome and/or inefficient intake procedures, limited access points, and limited choice of brief treatment options are encountered by clients. The single session walk-in therapy model is one method to deal with these barriers, allowing people a place to go to find help and support when they need it.

Differences in Treatment Seeking in Canada and the U.S.

Contextual factors, such as the impact of health care policy and national clinical delivery systems influence help seeking behaviors of citizens. Some of the notable differences in the Canadian and U.S. systems include Canada's use of a single payer system (versus the mix of public and private payers in the U.S.), and Canada's provision of full parity for mental health services (versus limited parity in the U.S.). Encouragingly, the differences in Canadian and U.S. treatment seeking behavior have narrowed. A recent study conducted by Mojtabai and Olfson (2006) found that Canadians were twice as likely to see their primary care physician *and* a psychologist or psychiatrist for mental health services than their U.S. counterparts. This difference may be a reflection on the different clinical service delivery system and referral practices. Canada's health care system allows for easier referral practices to mental health professionals, while the U.S. managed health care system constrains referral to mental health providers (Trude & Stoddard, 2003). Also it is possible that Canada's health care information and general education system more effectively educates the populous about the "warning signs" of mental health issues (Mojtabai & Olfson, 2006).

The use of the walk-in single session team therapy at the Eastside Family Center in Calgary, Alberta, Canada is made possible by the therapists who volunteer their services and the publicly funded health care system in Canada. Walk-in therapy services are much more common in Canada than in the U.S., in part due to Canada's universal access system. The provision of community-based mental health care and support, such as walk-in counseling centers, is a cost-effective alternative to increased costs associated with continuous readmissions to hospitals and other facilities (Trainor, Pape, & Pomeroy, 1997). The overall Canadian system of clinical delivery differs from the system in the United States. Canada has a universal public health insurance system that provide coverage to all Canadian citizens, and places greater emphasis (than the U.S.) on prevention and wellness as part of an overall strategy to improve delivery of primary care in

Canada (Romanow, 2002). Further research is needed to determine the cost effectiveness of walk-in single session therapy in the U.S. system of clinical service delivery.

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APPENDIX A. CLIENT SATISFACTION QUESTIONNAIRE

Eastside Family Center
Northgate Village Mall Suite 255
495–36th Street NE
Calgary, Alberta T2A 6K3
Phone: (403) 299-9696
Fax: (403) 248-8851

Eastside Family Center is committed to providing the best possible service to community members who ask for assistance during troubling times. Collecting frequent and detailed feedback from those people who use our services is a good way for us to learn about what we are doing right, what we are doing wrong, and what we might do differently in order to keep the service as useful as possible.

Could you please take a few moments to fill out this questionnaire before you leave. Record keeping for these questionnaires is set up so that while we know what kind of difficulties you discussed while you were at the Center on the day of your visit, we will not know your name. In this way we can assure you that all your comments and suggestions can be made anonymously. You may use the back of the form if you need more room for your comments.

Please use the following scale:
1 = very dissatisfied, 2 = dissatisfied, 3 = neutral, 4 = satisfied, 5 = very satisfied

My first impression of the reception service was: 1 2 3 4 5
Comments:

The forms I filled out were simple and straightforward: 1 2 3 4 5
Comments:

The way the counselor explained confidentiality was: 1 2 3 4 5
Comments:

The use of the team approach was: 1 2 3 4 5
Comments:

The overall assistance I/we received in the session was: 1 2 3 4 5
Comments:

What would you describe as the greatest strength of this service?

What is one change you might recommend for this service?

THANK YOU FOR HELPING US STAY ON TRACK AND TO IMPROVE OUR SERVICES TO YOUR COMMUNITY!